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HIV, AIDS, Sex and Sexualities in Africa

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Alternation

**Interdisciplinary Journal for the Study of the
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HIV, AIDS, Sex and Sexualities in Africa

Guest Editors
Herbert Moyo
and
Beatrice Okyere-Manu

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Editorial: HIV, AIDS, Sex and Sexualities in Africa

Herbert Moyo
Beatrice Okyere-Manu

The HIV and AIDS epidemic is nearly 40 years old since the HIV was first discovered in the United States. At the moment the epicentre of HIV new infections; challenges related to the availability, accessibility and adherence to ART and AIDS related deaths is Africa south of the Sahara (UNAIDS Report 2016; see also UNAIDS 2013 Global Report). A lot of work in the form of research and publications has already been done in responding to the epidemic. The government, Non-Governmental Organisations, Faith Based Organisations, churches and other religious institutions have invested in human, material and financial resources over the years in a bid to mitigate the effects of the epidemic (Moyo 2015; and Haddad 2011). With so much efforts and investment in mitigating against HIV and AIDS, the impact of the disease is still evident in many communities especial in Africa South of the Sahara which has remained as the epicentre.

Two members (Herbert Moyo and Beatrice Okyere-Manu) of The Collaborative for HIV and AIDS, Religion and Theology (CHART), an initiative of the School of Religion, Philosophy and Classics, University of KwaZulu-Natal in Pietermaritzburg – South Africa held 4 research paper writing seminars on HIV for their own academic publications. These two members of CHART also teach in the module: *The Church and HIV and AIDS* offered in the school of Religion, Philosophy and Classics. Other academics teaching in this module are Professors Gerald West and Philippe Denis and Doctor Lilian Siwila. This module exposes participants to the complexity of the HIV and AIDS epidemic as it relates to Sex and Sexuality which is assumed to perpetuate Stigma and discrimination. The module addresses the cultural and gender issues that contribute to its growth as well as attempting to deal with issues of stigma and discrimination. A key aspect of the course focuses

on what the response of religious leaders and the church to the epidemic should be. Class dynamics of this module and the experiences in CHART influenced the expansion of research paper writing seminars to a call for papers on *HIV, Sex and Sexualities in Africa*.

This *Alternation* special issues addresses questions that are similar to those addressed by this church and AIDS module. The question is: What has changed and what has remained the same after more than 30 years of response engagements by religious groups, civil society, individuals and the government? It is indisputable that much has changed, but there are two enduring concerns: stigma and sexuality. HIV continues to be stigmatised, particularly within faith communities. And part of the reason for this is the connection between HIV and sexual intercourse.

It can be argued that communities are now somehow knowledgeable about HIV and AIDS. However, the subject of HIV and AIDS is becoming a boring discourse in community gatherings. There is some level of fatigue in talking about HIV in general. There is even more fatigue amongst the donor communities especial from the West. On the other hand, statistics for new infections, ART defaulting and the number of AIDS related deaths continues to grow. 1.2 million People worldwide died of AIDS-related illnesses in 2015 according to UNAIDS. The challenge of HIV and AIDS is still with us.

The challenge therefore concerns the development of new effective efforts in responding to the epidemic in order to achieve the ‘Zero New HIV Infections, Zero Discrimination and Zero AIDS-related deaths,’ per the theme of 2015 World AIDS day celebration.

It must be noted that the current new infections are located amongst the key population groups some of which are not reachable by the church and other religious organisations in contestation on different forms of sexualities. This makes the discourse on sex and sexualities part and parcel of the narrative of HIV and AIDS.

This special edition of *Alternation* engages questions such as the following:

- Where are the dangerous gaps in current responses to HIV and AIDS?
- What is it that needs to be done more effectively in current responses to HIV and AIDS?

- How best can religious organisations engage the key populations?
- Why are people not applying the knowledge that they know about HIV and ART in promoting healthy sexual practices?
- What new strategies can help to get to Zero stigma, Zero discrimination and Zero new infections from where we are now?

The above questions and many more around sex, sexualities and HIV still need to be asked and answered.

In a way the articles in this special issue are beginning to ask new questions around HIV. There is a tendency in the articles to explore fresh approaches in responding to the socio-cultural and religious challenges in the fight against the HIV epidemic. The content of the articles is premised within a range of academic disciplines in the humanities especial in anthropology, sociology, ethics religious studies and theology. This *Alternation* special issue makes original research based contributions to literature on HIV and AIDS.

This special issue is divided into four sections of related articles beginning with five papers on church and HIV and AIDS, followed by six articles that engage HIV and Stigma and discrimination. The third section has five articles that discuss on the role of culture and traditions in the context of HIV and AIDS. The last section is made up of five papers that critically engage a variety of formal and informal forms of education and HIV prevention.

The special issue opens with Francis Machingura and Norman Chivasa who expose the mainstreaming of HIV and AIDS programmes in the ministry of the Apostolic Faith Mission in Zimbabwe. Owing to stigma and discrimination which is rampant among Pentecostals, the paper by Machingura and Chivasa concludes that not mainstreaming is not an option for the AFM in Zimbabwe as the process is not resource-intensive which puts the denomination at a better position to effectively operate in the face of HIV and AIDS while at the same time fulfilling its mandate.

This is followed by an article by Nomatter Sande who delves into the concept of sexual orientation in the context of Zimbabwe where political some sexualities are not acceptable. Nomatter juxtaposes sexual orientation with the amount of infections amongst sexualities that the church is not even talking to such as homosexuals. Thus, Nomatter's article seeks to understand the extent

to which the Pentecostal faith, practices, and rituals can dialogue with homosexuals in the context of HIV and AIDS. Nomatter utilizes Queer theology, and data collection is through in-depth interviews and sermonic discourse analysis. He concludes that reaching out to lesbians in Pentecostalism create space for the church to mitigate the widespread of HIV and AIDS.

Martin Mujinga and Herbert Moyo then come in arguing that Churches have a unique role to play in responding to HIV and AIDS through demonstrating that there is no other institution that has the reach into society, the continued presence nor the higher reach to respond like the church. Martin and Herbert interrogate the engagement and/or disengagement of the Methodist Church in Zimbabwe (MCZ) on HIV and AIDS. Martin and Herbert conclude by challenging the MCZ to revise its theology of the needy as emphasized by John Wesley.

Chammah Kaunda then comes in at this point with his article on neo-prophetism. Kaunda writes about Neo-Prophetism, gender and 'Anointed Condoms' in a quest for a missio-*Spiritus* of just-sex in the African Context of HIV and AIDS. Chammah engages Sanyangore's theology of safe sex from Pneumatological missiological perspectives. It concludes with some proposals for mission practice for engaging issues of sex and sexuality.

This section on church and HIV and AIDS closes with an article by Martin Mujinga and Herbert Moyo who discuss the response of the Methodist Church in Zimbabwe. Sinenhlanhla Chisale and Herbert Moyo discuss the concept of the sexuality of adolescent girls and church discipline and subsequent absolution in the Lutheran church. The paper exposes the discriminatory nature of church discipline especial following pregnancy by adolescents and some adult single women. This paper further exposes the inadequacies of the concept of abstinence from sexual intercourse until marriage.

The second section is composed of six papers on HIV and stigma and discrimination begin with Elizabeth Pulane Motswapong and Sana Mmolai's article on zero stigma, zero discrimination and zero infection in Botswana. Motswapong and Mmolai argue that zero stigma, zero discrimination and zero infection is a farfetched dream for Botswana. Even though Botswana has been hailed as one of the few African countries that has tackled the HIV and AIDS scourge head on, the country is yet to overcome the scourge of stigma and discrimination. The exposes the sources and the levels of stigma and

discrimination in Botswana. This is followed by the work of Lekganyane Maditobane Robert who discusses courtesy stigma experienced mainly by caregivers in South Africa. Lekganyane gives the narratives of the experiences of the caregivers and how they are coping with the stigma. Seemingly there is some resonance in terms of stigma and discrimination between Botswana and South Africa.

The article that comes next in this section is original research data and analysis from the Lutheran Communion in Southern Africa (LUCSA), Thusanang and the Evangelical Lutheran Church in Zimbabwe (ELCZ). The team of researchers (Nkosingathi Muyambo, Mphendulwa Moyo, Gift Dube, Dennis Muleya, Urethabisitse Mathe, Miss Sibikwaphi Ndlovu, P. Knutson, V Mzezewa and B.B. Dube) offer us data on the pastoral and biomedical responses to HIV and AIDS by the church in Zimbabwe. This article exposes the Pastoral and Biomedical Responses to HIV and AIDS programming by LUCSA and its partners. Data was gathered through engaging with members and workers of the ELCZ regarding their experiences of Home Based Care (HBC) training as a way of managing and holistically responding to the HIV and AIDS epidemic. This study explores the impact of the training for caregivers, nursing staff and pastors in HIV and AIDS management through a case study of the Thusanang HIV & AIDS project and Manama Mission Hospital of the Western Diocese of the ELCZ in Gwanda South. The study concludes that skills training in HBC and Palliative Care have made a positive and remarkable impact on the lives and work of HBC givers and pastors and that such training has contributed to the retention of caregivers. However in the analysis there is demonstration of the resilience of stigma and discrimination.

This section closes with an exposition of stigma and discrimination in the church and in Rastafarianism in Jamaica. Roderick Hewitt exposes the influences of Conservative Christianity, Rastafari and Dance Hall music within Jamaica on Homophobia and Stigma against People living with HIV. Hewitt concludes that in order for a more enlightened attitude towards the LGBT community and victims of HIV and AIDS to emerge within Jamaica fundamental changes are needed in the embedded conservative church and Rastafari theologies on human sexuality. Also the anti-LGBT and hegemonic masculinities narrative culture of Dance Hall music must give way to conscious advocating of healthy life affirming gender relationship.

The third section is composed of five articles that discuss the role of

culture and traditions in the context of HIV and AIDS. This section begins with Gyaviira Kisitu and Lilian Siwila who offer a critique of the construction of discourses on woman's body in African Religious spaces and its effect on Well-being. Through discourse analysis the two scholars argue that although women's bodies have power to control and challenge systems both in societal and spiritual realm as is argued by scholars these bodies are still perceived as subordinate to patriarchal control. Hence, their paper concludes, with a need for urgency in analyzing the way in which women's bodies are located in religious spaces and its effect to women's identity and well-being.

Elijah M. Baloyi's article on 'Theological Reflections on Sex as a Cleansing Ritual for African Widows' discusses the dehumanising nature of the ritual of widow cleansing which he views as entrenched in patriarchal gender inequalities, culture, religion and tradition which are vehicles by means of which structured stereotypes are entrenched. Baloyi demonstrates that cleansing of the widow is done through sexual intercourse. Baloyi argues that besides being both oppressive and abusive, the sex cleansing ritual can also be an instrument of the transmission of sex-related sicknesses such as HIV. The article exposes the vulnerability of widows who have no choice as refusal to be cleansed can lead one to be an outcast. Baloyi highlights how humiliating and unchristian such a ritual is for defenceless widows and their children.

Sinenhlanhla poses questions on cultural forms for the prevention of the spread of HIV. She interrogates the Zulu cultural practice of *ukusoma* as a form of prevention of the spread of HIV amongst young unmarried women. Sinenhlanhla S Chisale argues that African HIV prevention methods are being politicized and racialised. She uses the example of the concept of *ukusoma* as an entry point to the debate. Chisale discusses how these traditional indigenous practices can, on one hand, be limiting and on the other hand, be a source of female power in a context of patriarchy, particularly taking into account the HIV epidemic.

Joseph Kofi Antwi and Beatrice Okyere-Manu look at a cultural and social Easter festival celebrated in Ghana amongst the people of Kwahu. These authors argue that the festival has the potential to become a silent contributor to HIV infection in Ghana. Drawing on a personal observations as well as available literature on the current developments of the festival, the two authors argue that notwithstanding the economic boost that may accompany the festival, as a result of the tourist attraction and other activities, the growing presence of people from different communities and countries who travel to the

festival presents a chance for unintended, unprotected sexual networks as a result of excessive drinking of alcohol, and abuse of drugs, show off of wealth and multiple sexual partners which makes them vulnerable to HIV infections through unreasoned actions/indulgencies.

Herbert Moyo's paper says that the traditionalization of menopause amongst the Karanga and the Shangaan contributes to the spread of HIV. Culture is a major challenge to effective responses to HIV. Moyo argues that the cultural explanations of the meaning of blood released by women during menstruation requires some biological explanation to ease the fears and taboos thereof among the Karanga and the Shangaan Tsonga. Moyo concludes that the continued use of traditionalised explanations of menstrual blood is a possible source for the spread of HIV especial in a trans-generational manner amongst the concerned tribal groupings.

The last section of this special issue is made up of five papers engaging the concept of education and HIV prevention. Chika-Eze's paper on 'Childhood Sex Education Facilitating Zero HIV Infection' argues that the continual prevalence of HIV and AIDS epidemic in sub-Saharan Africa leading to a high rate of AIDS related deaths indicates that in spite of tremendous efforts made so far, humanity is struggling with the epidemic. Chika-Eze argues that children as well as adults need to be well-informed of sex and sexuality related issues to facilitate appropriate decision making on matters of sexual activity. She concludes that now is the time to take children's sexual education serious.

Chika-Eze's paper is followed by Tenson Muyambo's article which investigates why the available information on HIV-AIDS does not translate into effective and efficient HIV intervention measures. Muyambo argues that *ngano* (folktales) as repertoires of indigenous knowledge, can be used for HIV information dissemination. In this paper Muyambo further argues that indigenous knowledge systems are a useful resource for mitigating the HIV epidemic.

Sindiso Zhou, Nhlanhla Landa and Isabella Zhou contend that access to information and resources are critical factors in ensuring that young girls are empowered to handle reproductive health issues. These three scholars conclude that in some contexts young girls have limited access to information, medical services, support and resources that can empower them to prevent unplanned teenage pregnancies and attendant risks like HIV due to common preconceptions about the taboos of teaching 'young' people about 'adult' iss-

ues in a culture-conscious society.

The article by Fairfield Siyawamwaya, ‘HIV Prevention Programmes in Zimbabwe: A Gendered Terrain’ is of the view that gender disparities have a negative effect on the fight against HIV and AIDS in Zimbabwe. Siyawamwaya argues that HIV prevention is a gendered terrain. Through the theory of social constructionism and literature review as well as in-depth analysis Siyawamwaya contends that proper gender equality is a necessity in the battle against HIV and AIDS.

The last article comes from Beatrice Okyere-Manu, ‘HIV Counselling and Testing (HCT) in Schools: Ethical Implications to Long Term Support Structures’. Okyere-Manu, through the lens of ethical theory of Consequentialism, argues that there are long term implications for the families as well as communities therefore all key role players in the adolescent’s life need to rethink their approach of engagement to issues around sex and sexuality, HIV infections, sexual behaviours and HIV testing. Okyere-Manu concludes that if the proposal by the department of Health and Department of education in South Africa for a school-based HIV counselling and testing programme were to be effective, then there is the need to pay much attention to the long term support structures such as Parents, Carers, Guardians and Spiritual leaders as those who will carry the long term responsibilities of the teens once the test is completed.

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Mainstreaming HIV and AIDS Programmes in the Ministry of the Apostolic Faith Mission in Zimbabwe

Francis Machingura
Norman Chivasa

Abstract

The Apostolic Faith Mission (AFM) in Zimbabwe church is one of the oldest Pentecostal denominations in Zimbabwe tracing its origins as far back as 1915. She claims a membership of two million across the country. Like other Pentecostal denominations that broke away from her, the AFM in Zimbabwe remains exposed to the risks and vulnerabilities of HIV and AIDS. This study made a case for HIV and AIDS mainstreaming in the AFM in Zimbabwe. The study was predominantly qualitative and relied on document analysis. Relevant sources of data were identified and critically examined. The study found that HIV and AIDS mainstreaming among Pentecostal denominations is an uphill task because some Pentecostal preachers claim they can cure HIV and AIDS, yet government and other stakeholders firmly established that there is no cure for HIV and AIDS. Another impeding factor was that HIV and AIDS in some Pentecostal quarters is regarded as a demon. The demon perception encourages stigma and discrimination against HIV infected persons. Although negative perceptions of HIV and AIDS are evident, some Pentecostals still encourage biomedical cure for HIV and AIDS while at the same time they embrace faith as an important aspect for coping with HIV and AIDS. That the AFM in Zimbabwe, like other Pentecostal denominations has comparative advantages that put it at a better position to mainstream HIV and AIDS was firmly established. Although, Pentecostal denominations like other organizations struggle due to loss of members through sickness, death, funerals and reduced performances owing to HIV and AIDS evidence showed that they are slowing up to HIV and AIDS mainstreaming. Owing to stigma

and discrimination which is rampant among Pentecostals, the study concludes that not mainstreaming is not an option for the AFM in Zimbabwe as the process is not resource-intensive which puts the denomination at a better position to effectively operate in the face of HIV and AIDS while at the same time fulfilling its mandate.

Keywords: Apostolic Faith Mission, HIV and AIDS, mainstreaming, Pentecostal

Introduction and Background

Of the major Pentecostal denominations in Zimbabwe, the Apostolic Faith mission in Zimbabwe (AFM) church boasts the singular honor of having been in existent for more than a century. In 2015, the AFM in Zimbabwe celebrated 100 years of active ministry across Zimbabwe. She claims to have an estimated membership of about 2,3 million (<http://www.zimbabweyp.com/>). In 2006, the denomination claimed that its membership was estimated at 2, 5 million (IRIN 2006). Machingura (2011:17) notes that due to lack of updates on denominational records, membership figures are liable to amplification. However, commanding a large membership following was not the impetus behind the choice of AFM in the present study, but numerical age of the denomination was the major drive. Togarasei (2016:2) acknowledges that the AFM in Zimbabwe is the oldest Pentecostal of them all in Zimbabwe. As a matter of fact, the numerical age of the AFM in Zimbabwe cannot be overlooked considering that the rise of other popular Pentecostal denominations in Zimbabwe (for example, Johane Masowe) which trace their origins from the AFM in Zimbabwe (Togarasei 2016). Other popular denominations that broke away from AFM in Zimbabwe which have been in existent for more than 50 years or so include Apostolic Faith Mission of Mugodhi which broke away in the 1940s and Zimbabwe Assemblies of God Africa which broke away between the 1950s and 60s. As if that was not enough, in 2010 the AFM in Zimbabwe gave birth to other popular denominations such as: United Family International Church, Heartfelt International Ministries, Apostolic Flame Ministries (Machingura 2011; Togarasei, 2016) and the list is still on-going. Thus, numerical age was an important factor in the selection of the denomination under review.

In 2015, when the church under review had a centenary celebration, Zimbabwe as a nation marked 30 years of active combat against HIV and AIDS (Chingwaru & Vidmar 2015; Mukamuri 2016). There are however mixed reactions and perceptions among Pentecostal denominations regarding HIV and AIDS. Mutingwende (2014) reports that some Pentecostal denominations regard HIV and AIDS as a punishment from God resulting from promiscuous relationships. Supportively, Mairos (2013) reported that some Pentecostal Christians assume that every HIV infected person is under God's curse for loose, immoral and adulterous lifestyles.

In other quarters, Mutingwende (2014) points out that there are Pentecostal prophets who instruct individuals on Antiretroviral Therapy (ART) to stop from taking medication. A case in point was cited by Rupapa and Shumba (2014), when they reported that one renowned prophet declared his anointing oil can cure HIV and AIDS. Similarly, New Zimbabwe.com (2016) reportedly quoted another prophet who claimed he can cure HIV and AIDS through anointing oil. These mixed reactions, perceptions and voices warrant academic scrutiny. However, to avoid generalization of Pentecostal denominations, the authors purposively selected the AFM in Zimbabwe church on the basis of its numerical age to make a case for HIV and AIDS mainstreaming among Pentecostal denominations. In addition, the numerical age of the AFM in Zimbabwe met our inclusion criteria of Pentecostal denominations exposed to risks and vulnerabilities of the epidemic, yet the denomination under review has comparative advantages to HIV and AIDS mainstreaming. To date, it appears, no research has been conducted as much energy has been spent on writing about the history of the AFM (Machingura 2011; Hwata 2005; Togarasei 2016) and its basic belief systems, particularly, the glossolalia and faith healing (Machingura 2011; 2012). Studies on HIV and AIDS issues related to AFM in Zimbabwe have focused primarily on stigma and discrimination perpetuated by Pentecostals against the infected (see Machingura 2012). In fact, extensive literature has firmly established that stigma and discrimination is still prevalent to unprecedented levels among Christians in Zimbabwe (Kane 2012; Mlambo & Chibaya 2012; Mairos 2013; Mutingwende 2014; Chateta 2015; Taruvinga 2015). To interrogate HIV and AIDS mainstreaming systematically, the study was guided by the following questions; why should there be internal mainstreaming in the AFM in Zimbabwe church? What is involved in internal mainstreaming? How significant is internal mainstreaming in the AFM in Zimbabwe? The study has

five sections structured as follows; first section briefly describes the extent of HIV prevalence in Zimbabwe for the past three decades ending in 2015 and appended by the clarification of key concepts. The second reviews the legal and strategic HIV and AIDS frameworks in Zimbabwe. Third, describes methodological issues employed in the current study. The fourth section, analyzes literature on internal mainstreaming and its characteristic features with subsequent examination on the significance of internal mainstreaming. The fifth section concludes with subsequent recommendations.

The Extent of HIV and AIDS Prevalence in Zimbabwe

The extent of HIV and AIDS prevalence in Zimbabwe is worth scrutiny for various reasons. The major one is that it provides the HIV and AIDS picture which informs this study, thus helping to put the present effort into the broader context. In 2015, Zimbabwe marked 30 years of active combat against HIV and AIDS. Chingwaru and Vidmar (2015) praises various sectors such as government, civil society and faith based groups for their involvement in the fight against HIV and AIDS over a span of 30 years. However, they noted with regret that, in spite of efforts by government and other sectors to reduce the impact of HIV and AIDS on human life, this epidemic has claimed about 1,3 million people up until 2012. Statistics showed that in 2006 HIV and AIDS was claiming 123, 000 lives per year and by 2013 the figure had increased to 40, 000. The most affected age group were those between 15 and 49 years (Chitapi & Warinda 2013). According to 2015 estimates, HIV prevalence rate for individuals between 15 and 49 years stood at 15.2 % which was an increase from 14.1% in 2010. Factors that could have contributed to the increase are still yet to be configured.

In similar thought, Mukamuri (2016) points out that in Zimbabwe, the predominant mode of transmission of HIV and AIDS is through unprotected heterosexual relations with an infected person. According to her, this mode of transmission carries stigma with it especially among various social groups and is more pronounced among Christians. Mukamuri sees the unavailability of vaccine or cure as an important factor that generates stigma against HIV infected persons. She notes that stigma and discrimination has permeated every social space from workplace to the family and this generally hinder disclosure of HIV status.

On another note, she argues that HIV and AIDS prevalence estimates

between rural and urban among adult population aged between 15 and 49 years differs to a large extent. Mukamuri reported that HIV prevalence is higher in urban centers than in rural areas recording 17 % in urban and 15 % in rural areas. Mukamuri (2016) has also looked at the gender dimension of HIV and AIDS. From her perspective, the prevalence of HIV on women particularly widows, divorced, and separated stood at 18 % between 2010 and 2011 compared to 12% for their male counterparts. She also reported that, among couples, the 2010 and 2011 estimates showed that 79% of couples were both negative compared to 10% of couples who were both positive and 12 % were discordant. She also notes that 6% of young people aged between 15 and 24 were infected with HIV and AIDS. The battle against HIV and AIDS is still raging on across the globe. In this battle, it is pathetic to note that Pentecostal denominations are more at risk of the epidemic because of their low risk perceptions on the basis of the deep-seated holiness/purity dogmas (Machingura 2012). It is against this background that the writers made a conscious choice to select the AFM in Zimbabwe because being the oldest but has not yet mainstreamed, she is still exposed to risks and vulnerabilities of HIV and AIDS.

Clarification of Concepts

On this section we seek to clarify the concepts; HIV and AIDS, mainstream; HIV and AIDS mainstreaming and Pentecostal because they are forerunners to the problem under investigation.

HIV and AIDS

HIV and AIDS is a short-form for Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). Igo (2009) writes that HIV is a virus that enters the human body to attack cells that protects and sustain well-being of an individual and AIDS is a condition that the human body succumbs to while at the same becoming susceptible to various opportunistic sicknesses.

Mainstream

According to the Collins English Dictionary, the term mainstream is a combi-

nation of the adjective (main) and a noun (stream). The former relates to the dominant, characteristic principle or widely accepted entity while the later designates something regular, tendency, trend, principle, dominant course of action, or a river. For purposes of this study, to mainstream is to get align the ethos, programmes and activities with the widely accepted principles.

HIV and AIDS Mainstreaming

HIV and AIDS mainstreaming ‘is a process of analyzing how HIV and AIDS impacts on all sectors now and in the future, both internally and externally, to determine how each sector should respond based on its comparative advantage’ (HIV and AIDS Mainstreaming Working Group 2002, cited in Chitapi & Warinda 2013: 10). Internal mainstreaming is the primary focus of this study. Mainstreaming will help institution like the AFM in Zimbabwe to develop guidelines, activities and programmes for their denomination on HIV and AIDS strategic areas such as HIV prevention, care, treatment and support (adapted from Republic of Namibia 2008: 5).

Pentecostal

Pentecostal refers to a denomination that is characterized by a number of traits associated with glossolalia (speaking in tongues), public confessions and divine healing (the practice of faith healing) (Engelke 2007:98).

Legal and Strategic Frameworks on HIV and AIDS Mainstreaming in Zimbabwe

In Zimbabwe, issues of HIV and AIDS are regulated by labour laws (Chitapi & Warinda 2013). A case in point is the *Zimbabwe Statutory Instrument 202 of 1998*, revised 2006, *Labour Relations (HIV & AIDS Regulations)*. Section 3 of this instrument spells out that employees have the responsibility to provide education on risk measures against HIV and AIDS, provide facilities for counselling and prevention of the spread of HIV and AIDS. Simply put, stigma and discrimination on the grounds of an individuals’ HIV and AIDS status is a criminal offence according to this Statutory Instrument. Christian denominations are subservient to government authorities (see Romans 13). As

such, like other government interventions elsewhere, Zimbabwe National HIV and AIDS Strategic Plan III (ZNASP III) 2015-2018 is the strategic intervention for all HIV and AIDS. Pentecostal denominations like the AFM in Zimbabwe should figure out from among the strategic areas spelled out in the ZNASP III, compatible with their values and help reduce their risks and vulnerabilities to HIV and AIDS. One of the ways in which the AFM in Zimbabwe can partner with government and other stakeholders is HIV and AIDS mainstreaming.

ZNASP III has a four-year life span. Its predecessor ZINASP II (2011-2015) had a five- year life span. By and large, the current strategic framework is multi-sectoral in its approach to HIV and AIDS which means all sectors involving religion are part of the equation in the fight against HIV and AIDS. Its vision is ‘zero new infections, zero stigma and discrimination and zero AIDS-related deaths ...’. Pentecostal denominations such as the AFM in Zimbabwe should fit into this broader vision and come up with strategies within their reach to help achieve the broader vision. Whether it is going to be preaching, conducting bible studies or conducting workshops that is up to each individual Pentecostal denomination to use its discretion. The bottom-line is each individual denomination should play its part very well in the fight against HIV and AIDS. Government has done its part, Pentecostal denominations must equally play their part-and HIV and AIDS internal mainstreaming is one of strategy that is not resource-intensive.

In order to furnish ourselves with ZNASP’s III strategic areas, it is appropriate to reflect on some of its key strategies. However, it is not possible to include all outlined key strategies, nevertheless, only those deemed relevant to the current study are listed below.

- saving more lives through the enhancement of existing treatment and care facilities;
- scaling up male circumcision to 80 % by 2018;
- implementation of HIV prevention programmes;
- scaling up innovative community HIV testing initiatives; and
- integrate social norm and behavior change interventions and strengthening community systems (Government of Zimbabwe 2015).

Since Christian denominations are some of the major stakeholders in

the fight against HIV and AIDS, strategic areas provided by ZNASP III which are preservation of life, male circumcision, prevention of HIV and AIDS, innovative community testing and behaviors' change are not at law guides with Christian values. In fact, these strategic areas embrace the intrinsic value of human life in that they are aimed at addressing HIV and AIDS which has become one of the major contributors to human suffering and pain. Thus, addressing HIV and AIDS is a gesture of love, compassion, mercy, and kindness. Pentecostal denominations admire the Levite and the Priest characters in the Good Samaritan narrative in the book of Luke Chapter 10 by not remaining aloof, adamant and pretending they are urgent issues to attend to leaving individuals infected with HIV and AIDS laying down helpless. Given comprehensive legal and strategic frameworks in Zimbabwe: *Statutory Instrument 202 of 1998* and ZNASP III, not mainstreaming HIV and AIDS is not an option for the AFM in Zimbabwe church.

Methodological Issues

This study makes use of qualitative research design to make a case why the AFM in Zimbabwe should mainstream HIV and AIDS programmes in its ministerial activities. It relied much on document analysis. According to Blundell (undated), document analysis is a research technique which involves an identification of relevant sources of data and critical examination of such documents. These documents are identified using key words in various search engines and databases. She notes that the analysis process involves identification key themes and relationships contained in those documents. The purposive and snowball techniques were employed in search for sources of data. The strategy employed in searching involved the use of key phrases such as 'HIV and AIDS and Religion in Zimbabwe'; HIV and AIDS and Pentecostals in Zimbabwe' and HIV and Religion in Zimbabwe', HIV and Faith Healing in Zimbabwe'. In the process, titles and abstracts were scanned to ensure relevance of the source. Accordingly, about 10 articles that met the inclusion criteria were retrieved. The inclusion criteria involved articles with first-person accounts, experiences, actions and beliefs on HIV and AIDS in Pentecostal denominations (<http://studentresearch.ucsd.edu>). Through document analysis, these documents were 'interpreted to give voice and meaning'. Results from these documents analyzed were the major motivation to argue for mainstreaming of HIV and AIDS in the AFM in Zimbabwe church.

Factors that Impede HIV and AIDS Mainstreaming among Pentecostals

To put this study into context, it is critical to review the scale of the problem that impede on HIV and AIDS mainstreaming among Pentecostal denominations. For example, the majority of preachers in Pentecostals demonize HIV and AIDS and people living with HIV and AIDS. They are left with dilemmas regarding the position of the church on HIV and AIDS. Rupapa and Shumba, (2014) reported that one popular prophet in Zimbabwe declared that HIV and AIDS is a demon that require exorcism. Mutingwende (2014) reported that one pastor named called HIV and AIDS as a demon. Supportively, Chateta (2015) reported that HIV and AIDS is ‘associated with bad spirits which they [prophets] claim that they can exorcise’. For that reason, faith healing prophets claim to cure HIV and AIDS because they associate the virus with sinful behavior like extra-marital sex, drugs and homosexuality (Kane 2012). For that reason, some of these prophets believe that the status of an HIV and AIDS infected person can change if they use anointed oil (Mutingwende 2014). One of the emerging and popular prophets in Zimbabwe declared in 2016 that he can heal those infected with HIV. In the recent past, government gave a strong warning to faith healing movements ‘against deceiving people taking HIV drugs that they can cure the disease if they follow them’ (Chateta 2015).

Mairos (2013) reported that there are Christians who believe that every HIV infected person is under God’s curse for loose and immoral and adulterous lifestyles. These perceptions make people infected with HIV and AIDS to feel judged, condemned, cursed, unloved, and unacceptable. For Machingura (2012) the negative perception towards HIV infected persons emanate from a *holier than thou* mind-set by some Pentecostals. These perceptions not only hinder but render the urge for HIV and AIDS mainstreaming powerless.

Another problem that impede on mainstreaming of HIV and AIDS is that stigma and discrimination of HIV and AIDS infected persons is still rampant among Pentecostal denominations. Mairos (2013) reported that, those infected with HIV and AIDS are not allowed to share the same vessels and utensils with fellow Christians during a Holy Communion church service. Further on, he says people infected with HIV and AIDS are not allowed to occupy leadership positions as well as participating in church programmes and activities such as preaching, choir practice, ushering and even praying for other people. In the same report, it is stated that HIV and AIDS infected persons that

have disclosed their status are not allowed to wed because their marriages are considered unholy matrimony. Estimates in 2016 on stigma and discrimination stood at 65.5% (Mukamuri 2016).

Factors Working for HIV and AIDS Mainstreaming among Pentecostals' Christian Faith

In a report by Mairos (2013) one woman acknowledges that faith plays a very important role in generating a jovial mood which impacts on the health of people. Woman emphasized that trusting in the power of God helps to create a calm state of mind which is also critical to stress reduction particularly for those that experience illness. Mutingwende (2014) acknowledges the role played by faith in the healing process, he pointed out that there are some destructive practices perpetuated by faith healers regarding their perceptions of people living with HIV and AIDS. In spite of these grey areas by faith healers it is important to argue that Christian faith is an important factor in coping with HIV and AIDS. For purposes of this study, faith is understood as trusting in the caring and loving power of God. According to Mutingwende (2014), faith helps to create conditions that generate a state/sense of happiness. He stressed that a sense of happiness helps to create a stable state of mind. The state of mind, in Mutingwende's (2014) perspective, creates conditions that can ameliorate or cause further damage on the burden of illness. On that note, he acknowledges that faith plays a critical role in that it creates conditions that help to reduce stress in a person's mind. In saying this, Mutingwende (2014) acknowledges the role of a positive state of mind in the medical profession when he said 'with medical conditions you are told not to stress'. At that point, he praised faith for creating a stress-free mind which helps medicine to work for the better. In terms of instilling faith in the minds of people, faith healers are the best. However, Mutingwende warned faith healers that they should not fool themselves into thinking that an HIV condition can change to a state where a person lives without a virus in his/her blood. On that note, Mutingwende (2014) stressed that faith healers must equip their members with the correct information.

ART as God's Healing Package

Mutingwende (2014) urged Pentecostals to celebrate God's provision of anti-

retroviral therapy (ART). From this perspective, Mutingwende (2014) emphasized that ‘there is need to understand healing in the context of cure’. One women (cited in Mutingwende 2014) stressed that ‘taking ARVs does not mean that you do not have faith’. For her perspective, ‘God and ARVs are meant for everyone whether or not they belong to some church or belief system’. Again, she went on to stress that ‘the very same God is the one who made it possible for scientists to come up with this treatment’. In summation, she advised that: We also need to understand faith healing inclusive of biomedicine. God has made it possible to provide ARVs and is still working miracles through ARTVS- this is God’s hand throughout- his healing hand through the power of ARVs.

From this she argues that healing entirely depends on God as well as the methods of healing remains God’s prerogative. In view of the above, Mairos (2013) argues that one pastor posited that evangelism in the era of HIV and AIDS should be two-dimensional: First, it should involve putting the God factor in the equation of infected people in order to instil hope in them that God is on their side. Second and last, educating Christians to stop behaving in manners that perpetuate stigma and discrimination against the infected. If Pentecostals build on these perceptions, HIV and AIDS mainstreaming can effectively be achieved.

Best Practices by Pentecostal Denominations

Elim Pentecostal Church of Zimbabwe

Elim Pentecostal Church of Zimbabwe is one such example of denominations that have attempted to institutionalize HIV and AIDS into church activities and programmes with a view to mitigate the negative impact of HIV in Nyanga district, Manicaland province. The church has established a community-based orphan support center in the mid-1990s and the center is still running up to date (Drew, Foster & Chitima 1996). The process of institutionalizing HIV and AINS into its programmes and activities are beyond the scope of this study.

Pentecostal Holiness Church

Similarly, Taruvinga (2015) reported that one pastor believed that denomination worship service is the right place to preach ‘the safe sex gospel’.

Mlambo and Chibaya (2012) contend that Pentecostal Holiness has declared that its church members should condomize. The purpose of taking this stance was to help prevent the spread and reducing deaths among HIV infected persons. According to this report, other Christians have perceived the position by Pentecostal Holiness as a compromise that bent on promoting immorality. Meanwhile, Pentecostal Holiness have supported their position by saying that ‘if condom use is the way to reduce the spread of the deadly pandemic, we should be real and face reality of life’ (Mlambo & Chibaya 2012).

Evangelical Fellowship of Zimbabwe

Mlambo (2012) reported that about 34 pastors belonging to Evangelical Fellowship of Zimbabwe were trained to preach about HIV and AIDS in their denominations. The objective of training pastors to preach HIV and AIDS was to ensure that the ‘AIDS message is taken to people’. EFZ notes that HIV and AIDS ‘touches the bone and marrow of what affects society today’ (Mlambo 2012). One of the churches that have also taken steps toward a similar direction to institutionalize HIV and AIDS into church activities and programmes is the Assemblies of God. This Pentecostal denomination has put in place structures that specifically target the needs of HIV infected persons within existing structures of the denomination. Having looked at some best practices by other Pentecostal denominations, it is appropriate to look at what the AFM in Zimbabwe is expected to do if HIV and AIDS mainstreaming is to be taken on-board.

What is Involved in HIV and AIDS Internal Mainstreaming in the AFM

However, for a denomination such as the AFM in Zimbabwe to do HIV and AIDS mainstreaming, there are three universally accepted guiding questions to consider (see for example, ACCORD 2008: 35; Chitapi & Warindam 2013). While all these questions were designed specifically for secular organizations in the corporate world not directly addressing Christian contexts, the important thing is that they are aimed at addressing HIV and AIDS which is our common target area. For that reason, after grasping the questioning route, these authors have attempted to adapted the questions to the denomination under review to make them more direct and helpful. These are they:

1. How do HIV and AIDS affect the AFM and its work? These questions are directed towards bishops, pastors, lay workers, and ordinary church members and by extension the community to which the denomination operates? Questions such as how HIV and AIDS affect worship activities, the calendar of activities from local, regional, provincial and national levels.
2. What negative implications with regard to HIV and AIDS internal mainstreaming likely to impose on denomination Leadership-Bishop, pastors, lay workers, youth leaders and ladies unions? How best can the negative effect of internal mainstreaming be mitigated?
3. How can the AFM in Zimbabwe as a denomination help to contribute in the fight against HIV and AIDS? What comparative advantages do we as AFM in Zimbabwe have that can help to contribute towards reducing the spread of HIV and AIDS, to reduce the risks and vulnerabilities and negative effect of HIV and AIDS? (adapted from ACCORD 2008: 35; Chitapi & Warindam 2013:10).

These questions serve as a guide into the HIV and AIDS mainstreaming path. We now turn to look at the significance of the mainstreaming process.

The Significance of HIV and AIDS Internal Mainstreaming

As mentioned already, HIV and AIDS mainstreaming involves changing the denomination's constitution and other programme guides and practice with a view to mitigate the susceptibility of the denomination to HIV infection and its negative effect (see ACCORD 2005:35). Mainstreaming HIV and AIDS should not be viewed as a threat to the core business of the denomination under review but as a strength. As Chitapi and Warinda (2013:12) advise, mainstreaming is aimed at strengthening the core business of an institution in that it does not seek to change focus of the said institution. The goal of internal mainstreaming is to reduce the likelihood of members of the denomination, the community in which they denomination operates from getting infected and reduce their vulnerability to the effect of HIV and AIDS as well as providing support to the infected to meet their needs to cope with their condition. In fact, not mainstreaming is not an option considering that the denomination under review like any other denomination in Zimbabwe, struggle due to heavily

strained and stressed church members, pastors, lay workers, through sickness, death, attending funerals, reduced performances and care of bedridden relatives. That HIV and AIDS has affected all sectors across the globe and Zimbabwe has not been spared need to be emphasized (Chitapi & Warinda 2013; Chingwaru & Vidmarm 2015; Mukamuri 2016).

Trends in organizations have shown that they are improvising strategies to integrate HIV and AIDS into their programmes and activities (ACCORD 2005; Republic of Namibia, 2008). Chitapi and Warinda (2013:9) reported that 'in Zimbabwe, [organizations] are slowing ... to the fact that HIV and AIDS are threatening their performances and effectiveness'. This is true of denominations such as the AFM in Zimbabwe which has up to this day not taken measures to mainstream HIV and AIDS, yet they continue to bury the young, able-bodied and the elderly due to HIV and AIDS. Some members of the denomination may find it difficult to join Pentecostal churches like AFM in Zimbabwe services due to stigma and discrimination which has permeated across the society (Chingwaru & Vidmarm 2015). Some sermons and declarations by some pastors and prophets may contribute to negative attitude and stereotyping of the sick (Machingura 2012). These are some of the risks and vulnerabilities that the denomination under review is exposed to in this era of HIV and AIDS. As mentioned already, not mainstreaming is not an option because the denomination is already affected by the pandemic right from the center. Thus, HIV and AIDS mainstreaming offers hope in that the denomination 'can continue to operate effectively in the face of HIV and AIDS and continue to fulfil its mandated functions' (Chitapi & Warinda 2013:10). The church has a mandate to reach out to the sick, afflicted, the poor, orphans, and vulnerable people and to preach the good news that God loves and cares for them as well as providing them with material needs as outlined in Matthew chapter 25 verses 34-36, 40.

As the book of Matthew seems to indicate there are different types of care which Christin denominations are mandated. These range from visiting the sick; or affected people; provision of psycho-social and spiritual support; medical support, provision of food handouts; cooking; cleaning; assistance with feeding the sick; washing; toilet care to mention but a few. Most Christian churches do not have any problem with visiting the sick and the provision of other services such as counselling, provision of food, and transport facilities to hospitals to patients and relatives and nutritional aid among other care services. Already there are home-based care centers across the globe established by

Christian churches to provide care and support to people living with HIV (see Parry 2013:139-141).

The merits of HIV and AIDS mainstreaming outweigh the demerits. For example, in line with the concept of internal mainstreaming provided above, the process helps to increase;

- members of the denomination's awareness and knowledge on HIV and AIDS;
- the denomination's competence to combat HIV and AIDS (see Parry 2008, for HIV and AIDS competent church);
- members of the denomination's awareness of their rights, responsibilities and services that they are entitled in coping and in the fight against HIV and AIDS;
- individual members' capacities to talk about HIV and AIDS and how it affects their well-being and coping with it;
- the reduction of stigma and discrimination in Pentecostal circles (see Machingura 2012 on inclusion and exclusion of HIV infected persons in Pentecostal denominations);
- the likelihood of the achievement of the goals of the denomination to the anticipated reduction on the negative effects of HIV and AIDS on the performance and effectiveness of the institution;
- awareness by individual members of the denomination to disclose their status owing to the open and non-threatening environment that may be prevailing (see also, Chitapi & Warinda 2013:11).

Having looked at the significance of HIV and AIDS mainstreaming, it may be appropriate to briefly examine some of the challenges of mainstreaming and to propose ways in which they can be countered.

Challenges and Opportunities of HIV and AIDS Internal Mainstreaming

HIV and AIDS mainstreaming is not without challenges. Stigma and discrimination is obviously one of the major factors that will impede the process of mainstreaming HIV and AIDS. The nature of stigma and discrimination referred to in the current study is that individuals place the

difference between a person suffering from any other disease like malaria, typhoid, cholera or Ebola with someone who has contracted HIV in that an HIV infected person suffers moral suspicion and judgment from the significant others, friends, fellow members of the denomination and neighbors (Machingura 2012; Chingwaru & Vidmarm 2015). Stigma and discrimination are social constructions (Machingura 2012) which can be arrested if proper mainstreaming is done. As for Christian denominations, they can reduce stigma and discrimination if they 'deliberately and systematically place HIV and AIDS at the core of its mandate' (Chitando 2008:9). As such, HIV and AIDS mainstreaming, as Chitapi and Warinda (2013:11) advised 'calls for a profound paradigm shift of every member of the denomination in every [local congregation of the AFM in Zimbabwe] right from the denomination's president down to the lowest member of the denomination in the organizational hierarchy'. For denominations such as the AFM in Zimbabwe, which holds triennial elections-across the country for the position of the president and provincial overseers, the challenge is to regard HIV and AIDS mainstreaming as a project of the predecessor. The temptation will be to associate mainstreaming with an individual which should not be the case. Leadership is critical in HIV and AIDS mainstreaming as such change of mind-set at the level of top leadership is an important factor. That said, this study suggests that the sitting Apostolic Council, which is the supreme board of the church under review has an uphill task if HIV and AIDS is to be mainstreamed- failure is to an option.

Another challenge to HIV mainstreaming at denomination level is lack of capacity. Like other theological seminaries, the AFM in Zimbabwe's theological seminary now offers HIV and AIDS as a course- and this development should be commended. However, offering HIV and AIDS as a course should not be equated with capacity referred to in this study. Also, the numerical age of AFM in Zimbabwe should not be equated with capacity either. Capacity as understood in this study relates to the availability of trained personnel whether as pastors, lay-workers, or specialized individuals to deal with HIV and AIDS issues especially in the context of the denomination's core mandate (Chirinda & Warinda 2013). Chitapi and Warinda (2013:11) observed 'some organizations lack capacity coupled with poor working conditions of service for employees which makes mainstreaming an uphill task'. In our view, incapacity by the AFM can be mitigated against if the denomination under review makes use of existing networks to strengthen its effectiveness in the

fight against HIV and AIDS. One useful approach for the AFM in Zimbabwe is to invoke existing networks with Evangelical Fellowship of Zimbabwe (an ecumenical body representing Pentecostal denominations in across the country). The EFZ is better placed and connected to other sister organizations within its rank and file and therefore can help to strengthen the capacity of the AFM in Zimbabwe in mainstreaming HIV and AIDS. A case in point was a training of 34 pastors by EFZ to preach about HIV and AIDS in their respective denominations (Mlambo 2012). These initiatives by EFZ come at a time when some Pentecostal denominations are alleged of misrepresenting the voice of Pentecostals that individual preachers can cure HIV and AIDS (Kane 2012; Mutingwende 2014; Chateta 2015).

By and large, stigma and discrimination, organization culture and incapacity by the AFM in Zimbabwe church can all be countered if its comparative advantages are taken into account. Simply put, the comparative advantage of Christian denominations makes them better placed to mainstream HIV and AIDS. With comparative advantage is meant the process of finding ways by a particular sector to 'intervene, due to its mandate and ways of operating, using opportunities that other sectors do not have' (Republic of Namibia 2008: 5). Common knowledge informs us that one of the comparative advantages of Christian denominations is that they have earned trust from communities to which they operate. For instance, if a membership of two million claimed by the AFM in Zimbabwe (IRIN 2006) is anything to go by this figure makes a case for itself that the denomination under review has earned the trust of people in Zimbabwe. This explains why on each designated day of worship people are still determined to attend worship services. Also, Christian denominations attract people from different walks of life every day of the week. In fact, activities in Christian worship host almost every individual from across the various walks of life such as parents, grandparents, married and unmarried, divorced, separated, widowed, youths, the sick, the afflicted and children of various age-groups.

In addition to that, in terms of sectors/constituencies represented, Christian denominations are the best, in that almost every sector is represented in their membership rosters. Members of Christian denominations are drawn from different sectors such as education, health, security, business, religion, local government, politics, civic organizations-local and international, academics and non-academics, youth groups, women's groups, people living with disabilities are all found in Christian denominations. Thus, Christian

denominations, the AFM in particular, can if they manage to harness this comparative advantage, effectively adapt their policies and practices ‘in order to reduce [their] susceptibility and vulnerability to HIV and AIDS infections and impacts’ (Chitapi & Warinda 2013: 10).

Conclusions and Recommendations

This study has examined factors that can impede on HIV and AIDS mainstreaming among Pentecostal denominations with particular reference to the AFM in Zimbabwe church. The study adds to current literature on HIV and AIDS among Pentecostal denominations by providing cases on why HIV and AIDS mainstreaming is slowing up yet, denominations are exposed to risks and vulnerabilities of HIV and AIDS. This study confirmed previous studies which found out that stigma is entrenched among Pentecostal denominations-which is another challenge for HIV and AIDS mainstreaming. However, this study found out that without HIV and AIDS mainstreaming Christian denominations will not operate effectively and worse still they can in worst case scenarios fail to fulfil their mandates due to their exposure to the risks and vulnerabilities of HIV and AIDS. A gap was identified in which some preachers claim that they can cure HIV and AIDS-yet government and other stakeholders firmly declared that there is no cure for HIV and AIDS. A discouragement of biomedical by some Pentecostal preachers is an impediment to concerted efforts to HIV and AIDS mainstreaming among Pentecostals. While the HIV and AIDS mainstreaming comparative advantages of the AFM in Zimbabwe is encouraging, it is with deep regret to note that there are still some Pentecostals who believe that HIV and AIDS is a demon and a curse from God. The AFM in Zimbabwe is better placed because it is already connected to the Evangelical Fellowship of Zimbabwe which is actively involved in the fight against HIV and AIDS. At policy level, the AFZ should work closely with Pentecostals who still claim that they can cure HIV and AIDS until sense is knocked in their senses to begin to accept biomedical cure as part of God’s remedy to the problem of HIV and AIDS.

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Christian Faith and Sexual Orientation in the Context of HIV and AIDS in Zimbabwe

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Abstract

Nowadays insightful information about the causes, meaning, prevention and management of HIV and AIDS is available. Statistics show new infections especially in areas not penetrated by the church because of different perceptions about sexuality. As such, not much literature exists about the church queer studies and theology in the context of HIV and AIDS. Discourses about sexual orientation in the church have triggered complex debate. The tension includes the inclusion of homosexuals within worship, as well as their identity and space in the worship experience. As such, this raises questions about the compatibility of Christian faith, rituals, and practices. The demise of families, shifting identities of marriages, including marrying and ordaining gays, human rights and religious freedom are fundamentals in this article. Somewhat, there is relegation of the lesbians, bisexuals, and gays, while it is a contributor to issues of HIV and AIDS. Thus, this article seeks to understand the extent to which the Pentecostal faith, practices, and rituals can dialogue with homosexuals in the context of HIV and AIDS. This article utilizes Queer theology, and data collection is through in-depth interviews and sermonic discourse analysis. This article concludes that reaching out to lesbigays in Pentecostalism create space for the church to mitigate the widespread of HIV and AIDS. This article constructively contributes to the understanding of HIV and AIDS, sex, and sexuality in Africa.

Keywords: Christian faith, sexual orientation, homosexuals, HIV and AIDS, lesbigays.

Introduction

The response of African Pentecostalism, particularly in Zimbabwe, towards people living with HIV and AIDS is fraught with contradictions. The paradox of increased cases of new HIV and AIDS infections despite the widespread dissemination of information, HIV management, Antiretroviral Therapy (ART) is a cause for concern in Zimbabwe, Southern Africa and beyond. In fact, within the religious landscape in Zimbabwe, there remains some dark space such as the interplay between HIV and AIDS, sexual orientation and Christian faith. Somewhat, the religious leaders are reluctant to address and provide their position because of various perceptions about sexuality, especially homosexuality. At the same time, the role of religious actors in defining, shaping and prescribing meaning to the attitude towards sexuality in the context of HIV and AIDS is critical. However, in the light of postmodernism, globalization, polarization and religious secularization, homosexuality and bisexual sex have become a central issue in the spread of HIV and AIDS. While embracing this, not only are HIV and AIDS slowly finding acceptance within the Christian faith, but narratives about homosexuals have triggered a complex debate within the church. The term 'homosexuals' refers to a person who is emotionally and physically attracted to some members of the same gender. Some people consider the term outdated and clinical; this article prefers the words lesbians, bisexuals or gays (lesbigays) instead. Though, the discussion about HIV and AIDS epidemic has spun four decades now; there is a continual increase in new infection cases and Antiretroviral Therapy (ART) defaults. As such, further studies regarding the role of lesbians would be worthwhile in understanding the HIV and AIDS, sex and sexuality in Africa.

To date, literature about HIV and AIDS and religion in Zimbabwe have had a steady increase from 2005 to about 2013, after which period it seems to be on the decline. Facts indicate that infections of HIV and AIDS have not stopped and its impact is still vivid in Zimbabwean communities. Recently, there is not much notable stigma about HIV and AIDS; this status quo does not qualify to say people are keen to come to the open about it. It is not clear why there is a decline in the literature, but possible factor may include but not limited to the fact that the subject of HIV and AIDS is perhaps becoming uninteresting. Scholars such as Chitando (2007), Manyonganise (2008), Biri (2011) and Machingura (2013) have shown an increased interest

in the trajectories of HIV and AIDS within the religious landscape in Zimbabwe. On the other hand, the materials available about homosexuality in Zimbabwe focus on the politics and the theology of homosexuality (Gunda, 2010, Van Klinken and Gunda, 2012). So far, there are not many works about the role of homosexuality and theology in the context of HIV and AIDS pandemic, the gap this article is filling. It is important to keep in mind that the word ‘church’ is both fluid and complex. As a consequence of this underlying knowledge, this article focuses mainly on the Pentecostal faith in Zimbabwe. Pentecostalism is a brand of Christianity with particular emphasis on gifts of the spirit based on the book of Acts, and much emphasis is on ecstatic experience (Musoni, 2013). In this wider framework, discussing HIV and AIDS, especially focusing on homosexuality, presents a double tragedy to the Pentecostalism, which is both impressive and worrisome. As such, it is vital to draw attention to the fact that religious people view both those with HIV and homosexuals with suspicion within their religious landscape. The biggest challenge is to understand the extent to which the Pentecostal faith, practices, and rituals can dialogue with lesbians in the context of HIV and AIDS.

Theoretical Perspective and Methodology

The queer theology theory was utilized as a theoretical framework for this study. Queer theology is premised on the supposition that gender non-conformity, lesbians, and gays desire are part of human history including the Bible (Cheng, 2011). Such a theory was necessary to understand the extent to which the Pentecostal faith, practices, and rituals can dialogue with lesbians in the context of HIV and AIDS. In other words, since Pentecostals believe in heterosexuals relationships queer theology helped in deconstructing boundaries of sexual orientation. Simply put, it assisted in exhibiting Pentecostal norms and ethos which limits the space of lesbians. Therefore, queer theology helped with the possibility of bringing new insights and understanding to forms of sexual orientation. However, one major limitation of applying queer theology to Pentecostalism was how can one access and speak freely about ‘sexual orientation’ which usually is construed as private and personal.

Data collection were done through interviews and sermon analysis. The total number of interviews conducted were fifteen from the Apostolic

Faith Mission in Zimbabwe (AFM). Togarasei (2016) asserts that the AFM is the mother of all Pentecostal churches in Zimbabwe with the largest following. The motherhood has necessitated the choice for it to represent other Pentecostal churches in Zimbabwe. Five members were Pentecostal clergy including AFM National Executive members, five laities composed of three elders and deacons, and five ordinary church members. Purposive sampling was used for these interviews, a technique in which the researcher uses own judgment to choose the population (Patton 1990). Twenty-four sermons were analyzed from three AFM National Conferences including the deliverance sessions I attended. Pieterse (2016) argues that sermons enable spiritual self-fashioning aimed at combating the effects of discrimination and marginalization routinely experienced by (gay) members. The content of sermons has remained largely overlooked in dominant anthropological accounts of Pentecostalism (Ilana van Wyk 2014, 28,234). Data analysis involved a comparison of the reviewed literature with the findings for possible links and differences.

Working Definitions of Homosexuality, HIV, and AIDS

Scholars have long debated about the definition of homosexuality, and its meaning is perceived and enacted differently in societies. Neuliep (2012, 121) maintains that minority groups or subcultures like lesbians, gays, bisexuals and transgender people (LGBT) are notoriously difficult to define and are politically contested. One study by Klinken (2016) observes that there is a representation of homosexuality as a foreign and western imposition. In Africa, there is the politicization of homosexuality, and this has attracted both the public and political actors (Awondo 2010). For example, Sallar (2011) argues that about fifty percent of African countries have laws that either prohibit, imprison, fine or sentences lesbigays to death. In Zimbabwe, the penalty is one-year imprisonment plus a fine if homosexuality is proven (Sallar 2011). According to Croucher (2002), the Zimbabwean President Robert Mugabe is on record saying homosexuality were “worse than dogs and pigs” and should have no rights at all. However, in the West, homosexuality is now considered a natural biological and, therefore, constitution right. What is at critical is the compatibility of the Pentecostal faith, beliefs, and practices in the context of HIV, AIDS, and homosexuality. Bisexuality means an individual who sleeps with both males and females, not necessarily having two genitals.

When a person is born with two sexual organs, they remove one in a medical operation. Taken together, these results of definitions suggest that there are varied ways of understanding homosexuality depending on the orientation of the individual. Further studies, which take other variables that affect lesbians into account, will need to be undertaken. HIV is known as (Human Immunodeficiency Virus) a virus which attacks the immune system. Both the virus and the infection it causes are HIV. Both the virus and the syndrome are often referred to together as HIV and AIDS.

Pentecostalism and HIV and AIDS

It is critical to understand the relationship between three elements in this article namely, Pentecostalism, HIV and AIDS and lesbians. Thus, the continuum between Pentecostalism and HIV and AIDS is critical as it creates space for situating the impact of lesbians in the context of HIV and AIDS. Recently, credit goes to Pentecostalism for teaching about HIV and AIDS. In AFM during the conference, seminars, pre-marital counseling the subject of HIV and AIDS is topical. Slowly there is a paradigm shift in Christian theology about HIV and AIDS that views the causes of HIV and AIDS as not solely demonic influences which need the prescription of exorcism. The dialogue about the Church and HIV and AIDS brings to the surface the issues of sex and sexuality. The debate about HIV and AIDS has gained new prominence with many arguing that statistics for new infections and ART defaulting are alarming and the number of AIDS-related deaths continues to grow. There is a widespread acceptance of the use of Antiretroviral Therapy though it has had resistance. The Pentecostal hermeneutics The conceptual notion embedded in gifts of the Holy Spirit, especially the gift of healing is problematic when it comes to the HIV and AIDS pandemic. Rather, the over-emphasis of divine healing by Pentecostal movements and the African Indigenous Churches have brooded Antiretroviral Therapy defaulting candidates. There is an ambiguous relationship between divine healing and the Antiretroviral Therapy whereby the former advocate for the use of faith, declaring and chanting healing while the latter advocate for consistency of use of ART, check-up and administration of medication. Despite a few cases and testimonies, it is a fact that the church has not managed to heal HIV and AIDS. The church has to accept and indeed swallow a bitter pill, which not all infected people will be treated and should

not be guilty about that reality. A plausible approach would be for the church to pray and thank for the management and development of children being born without HIV from infected parents. As such, recent trends in the Christian faith have led to a proliferation of a doctrine that encompasses the use of condoms, artificial inseminations and testimonies of divine healings of HIV and AIDS.

However, much emphasis about the transmission of HIV and AIDS has focused on the heterosexuals than the lesbians. The challenge in the Pentecostal church in addressing HIV and AIDS is the fact the primary transmitter of HIV and AIDS is unprotected sex (Sakala 2016). This article argues that new infections about HIV and AIDS are amongst the key population groups such as lesbians and bisexuals, which are not reachable by the Pentecostals in contestation on different forms of sexualities. Such a groups are critical in the context of HIV and AIDS. Surveys conducted show that Sub-Saharan Africa has high percentages of HIV infection among lesbians (Smith 2009; Luhrmann, 2012; 13–14). In light of this, understanding the relationship of Pentecostals and lesbians is critical in the context of HIV and AIDS. Hence, creating space for lesbians in Pentecostalism does not only benefit them spiritual, but it opens a window for engaging with thematic issues. Since the Pentecostals have begun accepting and teaching people with HIV and AIDS, it is easier for this knowledge to extend to lesbians.

Discussions

The following section is a discussion of how the Pentecostal faith, practices, and rituals can dialogue with lesbians. The Secretary General of AFM argues that the greatest challenge in Pentecostal faith is the existence of ethical issues that are not directly addressed by the Bible. Notable examples are that there are inferences to cases which include masturbation, oral sex, euthanasia, and abortion. Further, each clergy then attempts to bring logical meaning to these issues. In such instances, queer theology is a helpful tool for AFM clergy and leaders to use for understanding the place of lesbians in the space of worship. In the light of the above, one Evangelist (a clergy who focuses on soul winning) opine that the AFM should get off from high pedestals and make efforts to reach out to lesbians. Otherwise, most of the time the church merely reacts to the sexuality challenge, instead of being proactive. For instance, if a believer has a child who becomes a lesbian the Pentecostalism must have a

Christocentric position on how to deal with the matter. What does the born again experience do to the matters of lesbians? Marshall (2009) explains that the born again experience of Pentecostalism constitutes the dimension of subjective that find through the possible of actions.

The information from sermons analysis shows that there are prominent Scriptures used for the discourse of lesbians in the AFM. The most familiar New Testament passages such as Romans 1^{24,25,26,27}, 1 Corinthians 5^{11,13}, 6⁹⁻¹¹, 2 Corinthians 2⁶⁻⁸ and Old Testament books such as Deuteronomy 13¹⁷⁻¹⁸. It is clear that when the preachers evoke such texts, the humanists, human rights and other liberals are fighting a losing battle to liberate lesbians. Such Scriptures does not give room for second thinking about lesbians as part of humanity but just dismisses them. The reading of such texts presupposes that there is no debate to talk about on homosexuality in the Pentecostalism. Is it no wonder then, in the Pentecostal churches, that one hardly sees the attendance repentance of people with sex-related challenges? The Pentecostal churches never seek to foster genuine friendships and associations. The church gleefully awaits an impending judgment on them, for God to prove them right after all, but that is not how love works. In the AFM there is no application of queer theology which may foster new insights about sexual orientation. Thus, for a long time, the believers have skirted around the tough questions that life throws at the Pentecostalism, such as HIV and AIDS and homosexuality, almost to the extent and risk of sounding impractical. Pentecostals have a challenge of judging; just because one is not a homosexual does not mean they are good. The biggest problem in the relationship between lesbians and the Christian faith today is whether one is supposed to redefine theology, the Bible or the lesbians. For example, evidence from sermons analyzed shows that there is much emphasis on the Sodom and Gomorrah account when it comes to issues to do with lesbians. The Pentecostal clergy preaches and warns about the dangers of homosexuality. They paint a picture of a hailstorm, brim storm and fire falling just like the Biblical account. Simply put, the message is that lesbians are heading for a destruction and are not part of the people who profess the Christian faith. Repentance is the prescription for one to evade this eternal condemnation and destruction. Perhaps above is the reason why the lesbians galvanize into mass movements and even try to formulate a theology which may liberate them. Lesbians in the wider society are advocating for their human rights and are coming out publicly.

One Executive member of the AFM argues that the most challenging

issue about lesbians is they destroy the fundamentals of marriage. Also, the Bible do not only condemn lesbians but destroys the future of progeny. Christian faith tradition holds that procreative sex is legitimate (Hilderbrandt, 2015). Quoting the story of creation, one AFM Pastor reiterate that God hates lesbians. In fact, in creation He did not create 'Adam and Steve' but created 'Adam and Eve,' showing that man should marry a woman. According to Reimer (2011), homosexuality opposes traditional family value. There is an insatiable quest in Pentecostalism to control sexual orientation, marriage, and marital unions. In fact, Pentecostals believe that a 'good wife/husband' comes from God. The appeal of Pentecostalism lies in the ways in which its doctrines, rituals, and practices allow adherents to domesticate and demystify modernity in a context of marginalization shaped by globalization and neoliberal capitalist encroachment across the world (Pietersen 2016, 5). In African countries, there is criminalization and demonization of the same sex practices (Ndjio 2013, 126). As such, the demise of families, shifting identities of marriages, including solemnizing gay marriages is detrimental to the Christian faith. The Christian faith tends to defend the sanctity of marriage from a theological position. Marriage is only between man and woman according to Genesis 1:26-28. There is a need to explore the implications of health and social paradigms like HIV and AIDS. Thus, the adherence of Christian faith dismisses that those feelings claimed by lesbians of being trapped in woman/men's body is the devil's trap and does not come from God.

On the issues of how other faith-based organizations is treating lesbians, one AFM Elder (laity) showed despondent why the other churches are ordaining gays into leaderships. It is clear that different faith-based organizations do not have a consistent stance on the Scriptural position on the sexuality issues. Such contestation goes beyond to not loving the lesbians, accepting them or to creating space for them in worship. In some cases, lesbians serve on church boards as elders and deacons, including marrying and ordaining gays to leadership. While other churches lesbians are still not welcome and face hostility. For example, in a recent incident, a man pulled a gun and shot and killed 9 and injured 53 gays.¹ The fundamental challenges between the church and lesbians base on the sanctity of their practices within Christian faith, rituals, and myths. Two AFM church members shared the same

¹ Incident happened in Orlando USA. www.telegraph.co.uk/news/2016/06/14/orlando-gunman-was-a-regular-at-lgbt-nightclub-pulse-before.

view that homosexuality is a spiritual disease that needs healing and treatment. Jurgen (2010) proposes that homosexual orientation is a disorder and to be a homosexual act is sinful and destructive. On the other hand, Spina (2016) holds that homosexuality is an individual choice or a condition brought by abuse or neglect rather than a biological orientation. The Pentecostal's response to lesbians seems to lack the expected biblical response to all humanity regardless of their condition; which is to love, accept and embrace. According to (Meyer 2004, 464), Pentecostal practice serves as the 'symbolic resistance of the marginalized'. In the Pentecostal faith, it is easy to fire bullets of 'biblical verses' from a distance, making people guiltier without practically guiding them on how to come out of their challenges. The AFM clergy classifies lesbians classify lesbians as 'worse sinners' than adulterers, gossipers, fornicators, drug addicts and drunkards.

One AFM clergy argues that lesbians simply needs deliverance from spirits coming from the pit of hell which binds them. Comaroff (2009, 17–38), sustains that Pentecostalism enjoys the semi-paradigmatic status, allows believers to domesticate, demystify modernity in the context of marginalization shaped by globalization. Hence, what Comaroff proposed makes believers and religious leaders in Pentecostalism manipulate the marginalized like the lesbians. A notable example is that the practice of spiritual warfare turns to be a way of dodging around issues which need serious engagement, it is not possible to pray away HIV and AIDS and homosexuality. As a result, a question posed to the church; is the church not a place of refuge for the wounded and a place for rehabilitation and change through spiritual guidance and even life coaching? Typical Pentecostal adherence promoted to 'bind,' 'loose' and 'cast out.' Such attitude is likely to happen when one declares to be lesbians or a known lesbians walks into the church. Such a behavior defies the Christian ethos of love; the underlying struggle is how one can love a neighbor who is a lesbian without condemning them? There is a need for believers to overcome their fears about the lesbians and learn to interact with them in daily activities to reach them and understand their challenges. The current attitude of the Pentecostals towards lesbians indirectly promotes the spread of HIV and AIDS without them coming into the open. Instead, believers must attempt to understand what lesbians are going through and their upbringing before dealing with their condition.

According to the AFM Deacon (laity), the church has labeled those who are exercising these sexual preferences sinners that need salvation. In

Pentecostalism, this creates the impression that the lesbians are candidates that need help. On the flipside of this notion, in Pentecostalism, the existence of lesbians within its ranks is treated as taboo and foreign to their morality. Such an understanding shows that a thin line exists between obeying biblical teachings, condemning evil and biblical warnings about judging others. According to the 'African Postcolony' (Mbembe, 2001; 93), the proliferation of religious movements has brought ambiguous sites where new systems, new languages and new authorities to negotiate. Utilizing Mbembe's category of thought, it is high time that Pentecostals increase promotion to engage with the major thematic issues like HIV and AIDS bedeviling their believers holistically, especially in marginalized groups. Thus, understanding the causes of homosexuality and bisexuality from both medical and theological perspectives is critical. It all started with the Sex Revolution of the 1940s the lesbians started agitating for recognition, and they demand their marriages be recognized. As early as 1928, the genital rights of children and adolescents were in place. The Pentecostals subscribe to the social gospel, which entails proclaiming the gospel for the salvation of humankind. In the 21st century, this commitment must buttress with the social gospel, which includes the impact of HIV and AIDS to everyone especially the lesbians. This article argues that HIV and AIDS are more prevalent amongst lesbians hence the need for the church to look at this group as the highest risk group.

One interviewee explains that the church should remain the church and not dilute the gospel with issues of lesbians. Pentecostals have a fear of being swallowed by movements like liberalism and secularism, at the same time the state is secular and enacts laws which affect Pentecostalism such as the Rights of lesbians. The emergence and emphasis of Human Rights have made people have freedom of action (to marry or not to), to have children (or not to), to choose sexual orientation (lesbian, bisexuals, gays). Now some of the state rules on matters of religion and at times accommodate lesbians the church feels it cannot help it. There is a barrier in that lesbians are stigmatized, excluded and discouraged from coming out in the open. An AFM member argues that there is not a particular way to identify the lesbians in the church, but only to be suspicious of who they are, through dressing and behavior. So, basing identification of lesbians on dressing and behavior is a possible stumbling block in a culturally changing world. Nowadays, it has become common that men and women are dressing in similar clothes and design, both putting on make-up and having same hair styles. It is that clear a distinct

lesbigays identities are hard to sustain in a rapidly shifting world, cultures, goods and people are on the move.

However, what remains univocal is that the Pentecostals do not accept lesbigays. One AFM member argues that lesbigays are hardly allowed in Pentecostals, it is a reality that if we become very sensational about matters, people do not come out. Further, the AFM must not only deny or stigmatize lesbigays but admit that there have challenges and attempt to design programs that help them out. Both Pentecostal faith and indigenous culture have treated the subject of sex and sexuality as sacred, private and taboo for open discussion. There is a Shona proverb *kufukura hapwa* (open up their armpits in public) concerning issues about sexuality. There is no conversation in most Christian homes about sex, the conversation needed at an early age of life. Besides, even if people want to come out in the open, especially the lesbigays, they are afraid of stigmatization and excommunication by the church. To make matters worse, discourses about lesbigays and bisexuals in the church has prompted complicated discussion. Consequently, the debate mostly becomes preachy, hardly making strategic conversation.

Conclusion

The main problem addressed in this article was to understand the extent to which the Pentecostal faith, practices, and rituals can dialogue with lesbigays in the context of HIV and AIDS. This article has argued that there is not much discourse about the impact of sexual orientation on HIV and AIDS within the church. In African Pentecostalism, there remain areas such as lesbigays, which are not exhausted because religious actors shun these areas as a result of their differing persuasions and interpretation of the Bible. In Zimbabwe and Southern Africa, much emphasis about the spread of HIV and AIDS has been on heterosexual sex, leaving lesbigays sex, as the major contributor to the spread of HIV and AIDS. Though HIV and AIDS have slowly found space in the church, the beliefs, practices, and myths in Pentecostalism sustain Antiviral Therapy defaulting due to the ambiguous relationship between divine healing and medical therapy. The findings in this article suggest several courses of action for the interplay between the church, HIV and AIDS and lesbigays. However, continued efforts are still needed to reduce the spread of HIV and AIDS and the church to be more accessible to lesbigays. Therefore, there must

be a plan for the long-term care of lesbians in the church. The content of the church's message is correct, but the methods used are sometimes incompassionate to lesbians.

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Healing Ministry of the Church: An Investigation into the Engagement and/or Disengagement of the Methodist Church in Zimbabwe (MCZ) on HIV and AIDS

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Abstract

Churches have a unique role to play in responding to HIV and AIDS. No other institution has the reach into society, the continued presence nor the higher reach to respond like the church (Parry 2008:82). In response to the above statement, this article will argue that, healing has always been the unique call of the Methodist Church and it also formed its theology. Its founder John Wesley's priority was the physical and spiritual health of the poor of his time (Health and Healing 2001:47). His visiting preachers were instructed when visiting the sick to inquire about the needs of both body and the spirit. Wesley is argued to be one of the key drivers of the healing ministry of the eighteenth century in England. In contrast, the Methodist Church in Zimbabwe (MCZ) living in the same socioeconomic crisis like that of John Wesley is argued to have only engaged in HIV and AIDS programmes 'partially' as evidenced by the conference reports. This article will further investigate the extent to which the MCZ has engaged and/or disengaged from its theology of caring for the vulnerable that form the body of Christ in the twenty first century Zimbabwe. The paper will conclude by challenging the MCZ to revise its theology of the needy as emphasized by its founder John Wesley.

Keywords: Healing Ministry, Methodist Church in Zimbabwe, HIV and AIDS

Introduction

The church by its nature, as the body of Christ has a major role to play in response to the HIV and AIDS epidemic. According Parry, no other organization or government has the reach into the society, the continued presence nor the higher reach to respond like the church (2008:82). In response to the above statement, this article argues that, healing has always been the unique call of the Methodist Church and it also formed its theology. Its founder John Wesley's priority was the physical and spiritual health of the poor of his time. However, Methodist Church in Zimbabwe (MCZ) living in almost the same socioeconomic environment of John Wesley, the MCZ has only engaged in HIV and AIDS programmes 'partially'. Although the church made some attempts to respond to HIV and AIDS, its involvement eventually became compromised. The writer further investigated the extent to which the church has engaged and/or disengaged from its theology of caring for the vulnerable that forms the body of Christ in the twenty first century MCZ.

John Wesley's Understanding of Healing Ministry

The founder of Methodism, John Wesley wrote strongly on how to be health (Thornton & Collie 2004: iv). There are three motivating factors of Wesley's engagement to the healing ministry. First, Wesley inherited a medical involvement from his paternal and maternal lineages both as religious and medical practitioners (Schmidt 2007:13-15; see also Maddox 2007:5-8). For example, Maddox stresses that, Bartholomew Wesley (Wesley's grandfather) had refused to sign the Act of Conformity to the Church of England and was ejected. He later became a physician as an alternative career. Likewise, Dr Samuel Annesley (father of Susanna, John Wesley's mother) had a library which had over twenty volumes on medical references (Maddox 2007:5-8).

The second motivating point grew in John Wesley during his Oxford days where he developed an interest in health care thereby reading the anatomy of physic. According to Huges (2007:5), Wesley began his theological studies in the midst of dramatic shifts in science and in a society surrounded by sickness. It was a custom of the 17th and 18th century clergy candidates in England to study basic medicine in order to be able to offer simple medical care in the remote smaller villages in which they served (Maddox 2007:7). In an effort to enhance his medical skills, Wesley continued to read medical works

extensively throughout his life time (Hudges 2007: 6). Maddox (2007:5) confirms that, when Wesley was serving as a missionary priest in Georgia, his diary show continued reading of medical texts including one by John Tennet listing medicinal herbs that were available on the continent. Wesley's passion for health and healing was a central dimension of his ministry and the mission of the early Methodism (Maddox 2007)

The third stimulating point for Wesley to take healing seriously developed as a result of the plight of the poor in England during his time. According to Guy (1988), there were a large number of starving, unemployed and poor people in England. The majority of the rich had dispossessed the poor in the rural areas by introducing modern agricultural methods. These rich were not concerned about the social well-being of these poor (Gadsby 1988). The rich viewed the conditions of the poor as their own making and as a divine punishment (Gadsby 1988; Maquardt 1992:20). The entire community including its leaders were corrupt and bore some attitudes towards the poor. When these deprived people tried to organize demonstrations in order to make their voices heard, military forces intervened and imposed severe punishments on the initiators (Maquardt 1992).

According to Hudges (2007:8) and Maddox (1994: 146) in Wesleyan theology, spiritual healing contributed to physical health. Both spiritual and physical health are tangibly related and therefore both needs intentional care through not only religious practices, but also through medical care. The two Wesleyan scholars further comments that Wesley's holistic soteriology included not only integrated approach to physical and spiritual health, but also the desire for the wellbeing of the entire community particularly the poor and those without access to health care (Hudges 2007; see also Maddox 1994). Hiatt (2008:4), comments that, healing for Wesley covered the multidimensional aspects of physical, spiritual and relational. Hiatt adds that, Wesley often spoke and wrote about salvation in therapeutic healing terms. Therefore, salvation and healing cannot be separated in Wesley's theology (Hiatt 2008:6). Wesley believed that salvation is healing and healing expressed the transformation of full salvation (Hiatt 2008). In line with healing as salvation, one of Wesley's sympathizers, Maddox, maintains that, Wesley resisted suggestions to refrain from offering medical guidance, leaving it to those certified by the college. But his motive for resisting was grounded in his holistic understanding of salvation (Maddox 2007)

In view of Wesley's passion for the wellbeing of the poor of his time,

he is argued to be one of the key drivers of the healing ministry of the eighteenth century in England (Maddox 2007). Hiatt (2008:13) remarks that, over lifetime, Wesley demonstrated concern for healing as a holistic sense covering physical, emotional, psychological, spiritual, relational and even theological issues in his practical theology. Wesley understood healing theologically and he taught it because healing demonstrated the outward work of the holiness of the community of faith (Haith 2008). Hiatt further avers that, in Wesley's views, healing terminology and metaphors expressed good news as a full-bodied salvation and healing in Wesleyan theology is the most appropriate way of expressing God's loving, restorative, salvific work and throughout the fallen creation order (2008:23).

The Condition of Health Systems during the Time of Wesley

Health systems during the time of Wesley was very bad with the health services not accessible to the poor. Madden (2007) contemplates that, many diseases resulted from overcrowded insanitary dwelling houses among other challenges that includes the health institutions that were subjected to filthy conditions. Hospitals and infirmaries were filled with offensive smells. Beds were covered with straw mattresses and dirty linen and were breeding-grounds for the lethal typhus fever usually referred to as hospital fever (Maquardt 1992:21). England during the time of Wesley was also hit by the scarcity of physicians (Maquardt 1992:21). Added to this scarcity, was what Wesley defined as 'the approach used to study medicine' (Maddox 2007). For Wesley the type of training was resulting in incompetent healthcare physicians as the medical students were spending time in philosophical theories of diseases while neglecting anatomy and psychology and factual causes of diseases which was also affecting the kind of drugs distributed by the pharmacopoeia (Health and Healing 2001). Moreover, the drugs were also expensive or named in complicated terms that the unlearned poor could not interpret.

Amidst these living conditions, Wesley was one of the first not only to see the poor as recipients of alms and objects of charitable care, but also to set forth the genuinely Christian duty to eliminate their wretchedness (Health and Healing 2001). In view of his concern for the poor, Wesley undertook various measures to relieve them. His concern was to inquire if those who were ill were warm enough, well fed and clean (Health and Healing 2001:50). He enquired about the help and support that was available from the local hospitals. When

his researches found little was on offer to the poor, Wesley wrote that:

I will prepare and give the poor physic myself I took into my assistance an apothecary and an experienced surgeon, resolving at the same time not to go deep into my assistance, but leave all difficult and complicated cases to such physicians as the patience should choose I gave notice of this to the society telling them that all who were ill with chronic distempers ... might if they are pleased come to me at such time and I would give them the best advice I could and the best medicine I had (Wesley 264).

In dealing with the physical healing of the poor people of his day, in 1746, Wesley founded a dispensary for the less privileged of London (Wesley 1746: 11). According to Marquardt (1992), this medical center has been claimed to be the first free medical dispensary in England. In 1747 Wesley, published the *Primitive Physic, or an Easy and Natural Method of curing Most Disease* (Hill 1988; see also Maddox 2007). According to Madden (2007:11) Wesley's aim of publishing the *Primitive Physic* was to make health care remedies available to the poor through simple recipes which used household products. The book also contained simplified natural methods of healing for the poor. Maddox (2007 :22-23) comments that *Primitive Physic* relates one account in which Wesley prescribed two hundred and twenty five treatments of which one hundred and eighty four were from plants, seventeen from animals, twenty four from minerals. It is against this background that Madden concludes that *Primitive Physic* was the most popular medical volume published in the eighteenth century England and twenty three editions went on print during his life time and the last and thirty seventh edition was published in 1859 (Madden 2007:12). Madden maintains that; *Primitive Physic* combined the simple traditional medicine with the best scientific discoveries of Wesley's day because healing was central in his theology (Madden 2007:20). For Malony (1995), Wesley's healing methods included electrotherapy which he called 'a thousand machines in one'. Malony, adds that given the manner in which Wesley was experimenting with the electric machine for healing, he deserves to be classified among the four best known electrotherapists (Malony 1995).

Marquardt (1992) notes that although Wesley faced sharp criticism from the physicians in London concerning his health plea, he however did not

allow himself to be intimidated. Wesley remarks that just after creation, humanity knew no sin, no pain, no sickness, weakness or bodily disorder (Thornton & Collie 2004: iv). In view of this theological understanding of healing, Wesley argues that God is involved in lessening any suffering that humanity will go through by reducing the pain. In addition, he highlights that God also provides and reveals medicines to treat the diseases (Maddocks 1988:141-143). Wesley further argues that, Christ as the Great Physician heals our woundedness and semi-diseased souls, Latin (*salvus*) which means healing and wholeness of mind, body and spirit (Maddocks 1988:141-143).

Wesley's healing methods face a lot of criticism from the medical fraternity as they argue that he published books on medicine while he was not a licensed physician (Malony 1995; Gadsby 1998). Marquardt (1992:29), comments that although Wesley's knowledge and passion for healing implied him be an amateur physician. However part of his ministry's expansion carried out three steps to ensure the usefulness of healing ministry among the poor. Wesley offered free medical care not only to the Methodists, but also to the community (Marquardt 1992:29), he distributed his book, the *Primitive Physic* to the poor in England as little or no cost in order to help them not always to seek a physician, whenever there was an affliction that was costly (Maddox 2007:27) and lastly Wesley financially empowered the poor in order to help them maintain a healthy life style and pay the physician's bills. At this point, he gave them interest free loans and helped them find and create jobs (Marquardt 1992:29). According to Maddox (1988:142-143, 2007:9-10), upon Wesley's death his ministry was known throughout in England as were his curing methods applied by himself, families and the communities. Maddox (1994: 147) observes that participating in healing is respecting God's commandment to love God and to love the neighbours. Wesley's belief of healing was part of the whole process of salvation.

The Missionaries' Concept of Healing in the Methodist Church in Zimbabwe

Methodism in Zimbabwe was introduced by the missionaries. Although these missionaries regarded the ministry of the MCZ as threefold; preaching, teaching and healing as suggested by (Zvobgo 1991:71), however, Wesley's concept of healing was never transplanted in the African soil. The missionaries used healing as a token of preaching. This point was buttressed by Methodist Medi-

cal missionary Dr L.G Parson in 1910, who argues that: ‘Medical missions constituted an excellent object lesson in Christianity. If by skillful treatment, a sick native is relieved of pain, or cured of his disease , he must wonder why it has been done, and is far more prepared to receive and respond to the gospel than if this is presented him with pain unrelieved’ (Zvobgo 1991:71).

This understanding of healing ministry made the missionaries to ignore the healing understanding of their gospel recipients and concentrate on their own understanding of healing which was a western scientific. Although Shoko (2007:1) believes that illnesses and diseases of the serious and complex nature in Africa are attributed to *vadzimu* (ancestors) who are the deceased parents, grandparents or great grandparents, Makoti raises a contrasting point that the missionaries did not believe that illness could be caused by ancestors or magic convocations of an enemy (Makoti 2012:14). Such complex illnesses could be classified in the family of HIV and AIDS today.

In making sure that physical healing was attended to, the missionaries opened dispensaries. Makoti alludes that, the medical missions were an effort to wean Africans from their uncivilized beliefs (Makoti 2012). According to Zvobgo (1991:78), the missionaries boasted of these medical missions. He cites Rev H.J Baker, in Kwenda Circuit in 1914 who said: When a missionary toured the mission station, the most important item he should take with him was not the Bible or the hymnbook, but dental forceps for pulling out teeth. The missionary might forget his bible, books, wife and even food but if he forgets his forceps, he would not be easily forgiven (Zvobgo 1991:78).

The need for physical healing led to the building of Kwenda hospital in 1913. Nonetheless, the hospital only lasted to 1916 and Makoti concludes that these medical missions failed to cure many illnesses since many sicknesses for Africans were medical (Makoti 2012). One of the reasons for failure was that, the missionaries’ approach concentrated on the physical healing only and overlooked the African spirituality. In 1977, the MCZ inherited the healing ministry that was physically oriented with the answer only found in the hospitals

Steps Taken by MCZ to Engage and Disengage from HIV and AIDS Programmes

During the period of post-independence euphoria from 1980-1985, Zimbabwe

witnessed a silent HIV and AIDS epidemic, whereas the first case was identified and acknowledged in 1985 (Mboma 2002:1). Upon this identification of the first HIV case, both the government and the church entered into a state of denial (Hove 2013:7). According to Pastor Maxwell Kapachawo (the first pastor to declare himself to be living with HIV in Zimbabwe), the church has been spending more time burying its members than baptizing them because of its silence on HIV and AIDS (Mlambo and RelZim Staff 2012). Tanyanyiwa¹ says the response of the MCZ has been slow and reactionary. Tanyanyiwa (2011) adds that, when HIV and AIDS was publicized, the church was never perturbed and it paid a blind eye and a deaf ear to the epidemic. Tanyanyiwa (2011) bemoans that, it was only after one and a half decades later, when HIV was now an epidemic and had caused a lot of untold suffering that the MCZ decided to respond. The response by the MCZ was handicapped as there was lack of resources and appropriate effort from the leadership (Tanyanyiwa 2011).

The MCZ established the HIV and AIDS unit in 2000 to promote peer education, conduct training on HIV and AIDS, and Home Based Care programmes (Tanyanyiwa 2011). The MCZ joined hands with Centers for Disease control, Africare, World Vision, Hospaz and many government and UN agencies (Tanyanyiwa 2011). The church put structures in all MCZ districts, circuits and societies that would be working with the MCZ National HIV and AIDS Coordinator. In addition, the MCZ engaged in the training of its ministers on HIV and AIDS programmes. According to the Uniting World report through Methodist Development and Relief Agency website, all the 116 ordained ministers in the Connexion were trained in 2010. The other drastic step taken by MCZ was constituting the Health and Social Services Committee at its connexional level (national), district, circuit and society Deed of Church Order and Standing Orders (2007:70). Among the members of this committee is the Presiding Bishop (Head of the Church) and Mission Director (2007:70) who are key people in the daily running of the MCZ.

Apart from coordinating HIV and AIDS programmes, the coordinator was then given other responsibilities to monitor all health issues in the church, thereby renaming the coordinator, Health and Social Services Coordinator (Tanyanyiwa 2011). According to Tanyanyiwa, MCZ has four functional

¹ Tichapiwa Elton Tanyanyiwa was the Health and Social Services Coordinator with the Methodist Church who resigned in 2012.

clinics. The services provided there range from primary health care, HIV testing and counselling, maternity and Mother to child health (Tanyanyiwa 2011). From 2012, the MCZ disengaged on the HIV and AIDS programmes following the resignation of the Health and Social Services Coordinator. Two years after the resignation, the MCZ continues to bemoan the end of the donor community to support her HIV and AIDS programmes. The MCZ Minutes of Conference (2014:41) demonstrate how the church disengaged on HIV and AIDS programmes practically. The Mission Director of the MCZ reports on HIV and AIDS saying that, though there seems to be a dead-end on the thrust of HIV and AIDS within the donor community, as a church we continue to attach great zeal and enthusiasm to this mission focus. As such we have assigned MeDRA to take over the issue of HIV and AIDS for the purposes of both planning and execution (MCZ Minutes of Conference 2014:41). The same minutes indicate that HIV and AIDS programmes are no longer part of the health and social services (MCZ Minutes of Conference 2014:42). An analysis of the phrase, ‘take over the issue of HIV and AIDS’ is an indication that HIV and AIDS has ceased to be a programme but one of the ‘issues’. Unfortunately, in the 2015 Conference both the Mission Director’s report and MeDRA were quite on HIV and AIDS programmes. In the 2016 MCZ agenda for the conference had nothing on HIV and AIDS both as an issue and as a programme. These developments show that HIV and AIDS is no longer a priority in the MCZ.

What Could Have Led MCZ to Disengage on HIV and AIDS Programmes?

It is not clear as to what exactly would be the reason for the MCZ’s disengaged from its theology of healing the sick. In fact there has been a lot of theoretical engagement with HIV and AIDS on reports because of the economic situation of Zimbabwe which negatively affected the economy of the MCZ from the year 2000. The ministry and mission of the MCZ was also compromised because the same members of the churches were heavily affected by the economy which affected the financial income of the church. According to Mangena and Mandizha (2013:134), Zimbabweans having been reckoned as highly religious, sought solace in Pentecostal persuasion. Zimunya and Gwara (2013:190) maintains that , in such a scenario of poverty and uncertain events,

Pentecostal Churches sprouted and offered a much needed solace especially on the spiritual healing of all ailments. These ailments would include HIV and AIDS. The drive to Mega-Pentecostal Churches that were born during this period was necessitated by their promise to provide answers to the healing needs of Zimbabwean. This situation saw Methodist members practicing dual membership or completely transferring their faith to these churches (Mukonyora 2007).

The Impact of the Methodist Church in Zimbabwe's Disengagement from HIV and AIDS Programmes

The theological analysis of the Zimbabwean situation above leaves MCZ with deep-seated experiences of HIV and AIDS. According to Moyo (2015:148) a church that understands Jesus will label itself as HIV positive. In view of this point, the disengagement of MCZ from HIV and AIDS programmes demonstrates that the denomination proclaims Christ who always associated with the health and rich people only, which is a theological fallacy.

Chitando (2007:1), remarks that African churches need friendly feet to journey with individuals and communities living with HIV, warm heart to demonstrate compassion and anointed hands for healing. These characteristics of the church no longer apply to MCZ, but to the time of John Wesley. Maddocks (1981:60-61) argues that Jesus in his healing mission addressed the sick, touched them, smeared their bodies with oil, applied saliva and mud poultices to the diseased part of the body, addressed the individual's faith and their prayer for thanksgiving and for the forgiveness of sins. In contrast MCZ reports demonstrates that the denomination is no longer humble to be either like Jesus, or Wesley in dealing with people living with HIV and AIDS. The act of disengagement on HIV and AIDS by MCZ contradicts the point raised by Kalu that healing is the heartbeat of liturgy and the entire religious life. Healing brings the community of suffering together, it ushers supernatural power into the gathered community and enables all to bask together in its warmth. Healing releases the energy for participatory worship that integrates the body, soul and the spirit (Kalu 2008:253).

World Council of Churches (2005: 100) contemplates that remembering the suffering servant (Isaiah 42:1-9, 49:1-7, 50:4-11, 52:13-53:12), the church is called upon to share the suffering of persons living with

HIV and opening ourselves in this encounter to our own vulnerability and mortality. For the WCC (2005: 101), this action is a walk with Christ and as Christ has gone before us through death to glory, we are called to receive the sure and certain hope of the resurrection. In buttressing this point, Happonen, Jarvinen and Virtanen (n.d.: 5), note that the church should be the first to bring liberation to all people, empower them and erase the stigma which is associated with HIV and AIDS. Instead of causing stigma, the church has to function actively and purposefully to take the side of the infected and affected. The World Council of Churches further argues that, '...when the church properly responds to people living with HIV and AIDS both ministering to them and learning from their suffering, its relationship to them will indeed make a difference and thus become growth producing' (WCC 2005:79). The points raised are what is expected from the church and the MCZ is no exception. The MCZ is being challenged to be an HIV and AIDS competent church which should work towards the transformation of death dealing practices while strengthening life enhancing practices (Chitando 2007:1).

People Living with HIV and AIDS: An Amputated Part of the Body of Christ in the MCZ?

According to the Deed of Order of the Methodist Church in Zimbabwe, 'MCZ cherishes its place in the Holy Catholic Church which is the body of Christ...the church ever remembers that in the providence of God, Methodism was raised to spread Scriptural Holiness' (MCZ 2007:2). However, the mission and mandate of the church has been compromised by its position on HIV and AIDS. People living with HIV in the MCZ are like an artificial leg on the sportsman. Whereas the WCC (2005) thinks that the Church is a communion of one body with many members that are distinct to each other (1 Cor. 12:24b-27), however, the fact with MCZ is that people living with HIV 'no longer exist'. The MCZ is now a limping church with an amputated leg which formed the community of the people living with HIV. There are a number of reasons that have caused a part of the body to be amputated.

However, amputation does not stop life. For life to continue, some people are given artificial legs whereas some would use the clutches to balance up. Although it might not be clear as to what the position of MCZ is on the 'amputated leg', what remains a fact is that the church still carries a mark of

the abandoned community. Parry (2013:3) cites one speaker at the Evangelical Conference in 2008, who comments that, ‘if your church does not address HIV and AIDS, your ministry is of little relevance today’. The Bishop of the Methodist Church in Harare West District Rev T Sungai (2016), bemoans that MCZ abandoned its theology by neglecting the plight of the people living with HIV. Ignoring HIV and AIDS by the church and concentrating on other facets of the ministry is as good as leaving the child to die when one has all the capacity to serve that child (Sungai 2016). The church is the only institution that meets hundreds of people each week at a very personal level.

Parry, mentions that, in HIV and AIDS ministry, the church faces the biggest combined social, cultural, economic, medical and political issues and at the same time , she deals with individual persons one by one, those affected by HIV and AIDS and their families much affected by it (Parry 2013:17). The response of the church to HIV and AIDS needs to be as extensive, broad and deep as the mission of the church itself (Parry 2013). The vision of the MCZ is to be an, ‘an oasis of life, peace, justice and hope’ (MCZ Minutes of Conference 2015: ii). A critique of this vision statement exposes MCZ to a denomination that is preaching Christ without the hardship of the cross. The Dictionary.com defines an oasis as spring of fresh water surrounded by fertile region of vegetation in a desert. By disengaging the HIV and AIDS programmes, MCZ can be viewed to be an oasis that is letting people living with HIV to move from the oasis to the desert where there is no life.

The church cannot ignore the theology of the ‘one body of Christ’ propounded by Chitando (2009) and Moyo (2015). These scholars who are also HIV and AIDS activists challenge the church on what it means to be ‘one body of Christ’ when some members of the body are infected and/or affected by HIV? How can the church claim to be the body of Christ when some of its members have to endure stigma and discrimination within the same body of Christ? The church must have a clearly theological defined response to the HIV and AIDS epidemic (Chitando 2009:155; see also Moyo 2015). By disengaging on HIV and AIDS, MCZ has off-routed from its theological mandate. According to the WCC (2005: 100), the church’s response to the challenge of HIV and AIDS comes from its deepest theological convictions about the nature of the body of Christ and the reality of the Christian hope in which case MCZ is found wanting.

For Sue Parry, there are no reasons as to why the church should disengage from HIV and AIDS. Parry (2013:7), gave seven reasons why the

church should be involved in mainstreaming HIV and AIDS. This is the challenge that this paper is posing to MCZ. The first reason is that, people living with HIV are in the church thus the church should not disengage from its call to the infected and affected. The point raised by Parry does not give MCZ a choice of disengaging with HIV and AIDS, but to tie itself to the call of the people who form its membership and whose status most of whom the church is not aware of, but some of these members are tithers and key contributors to the life of the church. According to Moyo (2015:49) church members (some) are infected by HIV but it is very difficult to disclose. The word 'some' used by Moyo is subject to interrogation. If 'some' church members are infected and cannot express themselves, it might mean that there is a reasonable number of infected and a very big number of those affected by HIV and AIDS which leaves MCZ in a compromising position of wanting to split its members between those affected and infected and those who still enjoy HIV free life which might not be an easy thing. However, this might prove impossible because HIV is a visitor that is common in most families (Mujinga 2012:100)

Secondly, HIV is hurting people by destroying relationships. It has divided some families and communities (Parry 2013:7). Parry adds that HIV has created generations of largely disadvantaged orphans and children whose lives are severely compromised due to the insidious and avert impact of HIV on household's ability to survive. She further argues that, HIV is unlike other challenges faced by the church because it strikes at the very core of relationships and its impact is chronically deadly (Parry 2008:82). For Parry, the response of a HIV competent church to the epidemic should be characterized both in the life of the church and in the lives of those who serve in this field, by the fruits of the spirit, love, joy, peace, patience, kindness, goodness, gentleness, fruitfulness and self-control. If one has to go by the points raised by Parry, it remains critical as to what MCZ could be preaching if it has disengaged from HIV and AIDS programs which has become the center of conflict among the church members.

Thirdly, Parry comments that, the church should be involved in HIV and AIDS because the church has a comparative advantage to secular interventions. This point was buttressed by Garland and Blyth (2005: 278), who argue that the church in Africa is in a uniquely key position to address most of the aspects of the HIV and AIDS epidemic. The two scholars hold that the church has an extensive reach and its influence filters through most African

communities. Garland and Blyth also believe that the church has a massive yet often untapped potential to successfully reverse the causes of the epidemic. Its core values of love, care, support and justice have produced a nurturing and development of strong church run care and support programmes in many communities (2005:278). Failure to engage on HIV and AIDS issues renders MCZ an irrelevant church in the communities it found itself.

The fourth point states that; the church is already involved in development and humanitarian programmes and the linkage between HIV and AIDS are development gaps which the church should well recognize (Parry 2013:7). Chitando supports this point by suggesting that, the church in Africa is undoubtedly a significant presence in the spiritual, social and political economic lives of the people. It is thus strategically placed to make a difference in the context of HIV and AIDS (Chitando 2007: 5). The writer agrees with Chitando that, just like the church in Africa which is a sleeping giant, by being HIV incompetence. MCZ is not an exception. However, there is room for the church to wake up from its slumber by welcoming and reintroducing the HIV and AIDS programmes. Chitando uses the word compassion to describe an HIV and AIDS competent church. In his definition of compassion, Chitando argues that the church should feel pity for people in different circumstances. However, compassion in HIV and AIDS does not mean that the church should feel pit for people living with HIV, but stand in solidarity with them. The MCZ by abandoning HIV and AIDS programmes, has truncated part of its body. Chitando concludes that compassion compels the church in Africa to such indifferences in the face of HIV and AIDS. 'Business as usual' becomes impossible when the churches are moved with compassion, which is also a call to MCZ to translate compassion into concrete action that seek to mitigate and eventually remove the pain caused by HIV and AIDS.

The fifth reason cited by Parry is the church's theological mandate to fulfill the teachings of Jesus in (Matthew 25:31-46) which teaches that, '*whatever you do to the least of these, you do it unto me*' (:7). In this teaching, Chitando adds that Jesus was challenging his society to be more compassionate not by promising the vulnerable that their reward is in heaven, but by acting decisively to restore the full human dignity in this life (Chitando 2007:54). The disengagement of MCZ on HIV and AIDS is sad news because the church has many widows, vulnerable children and orphans and yet the church does not feel compassion for them. For Chitando, efforts to reach these vulnerable groups of people is living up to the idea of religion (Chitando 2007:54). In

reference to MCZ, taking this move is a step towards being a ‘movement’ and not a ‘monument’ as a church.

In the sixth point Parry grapples with the fact that the church is not an island but a community in a community. Parry laments that, if we ourselves are not directly affected by HIV and AIDS, we certainly all are indirectly affected if one of the body suffers (Parry 2013). Moyo (2015:149) holds that what affects the community invariably affects the church. For Parry, the church should be involved in HIV and AIDS because it has disturbed our comfort zone and our conventional theologies have been challenged, making us face inadequacies and our prejudices in the light of the Lord’s transforming love (2013:7). Parry further argues that the HIV and AIDS era has been and remains a Kairos moment for the church to be church to humanity and to bring transforming love, health, healing and restoration of hope and dignity to each other and everyone regardless of HIV status, colour, culture, creed, ethnicity or sexual orientation (2013:7).

Parry concludes the seven point on the church’s involvement in HIV and AIDS by pointing out that, for every humanity, life is created in the image of God and is sacred and is worth of that promise of abundance (2013:7). In buttressing the points raised by Parry, WCC comments that the church’s involvement in HIV and AIDS is affirmation that the church as the body of Christ is to be a place where God’s healing love is experienced and shown forth. As the body of Christ, the church is bound to enter into the suffering of others to stand with them against all rejection and despair (WCC 2005: 101).

The disengagement of MCZ automatically disqualified the church as a sanctuary that remains a safe place and space for healing. WCC (2005:79) notes that for healing, people need a place where they can be comforted in sharing their pain. If one analyses the role of the church as the body of Christ, it shows that Happonen, Jarvinen and Virtanen (n.d.: 5) are right to conclude that an HIV competent church understands healing holistically. The various activities of the church on HIV and AIDS create a supportive environment for healing in which case MCZ has short comings. Happonen, Jarvinen and Virtanen (n.d.: 5) comments that in many African communities, people do not have access to a counsellor, psychologist, family planning counsellor or a medical professional, in such circumstances, they turn to the church. However, MCZ in this case has not proved to be a shelter of hope. WCC (2005:77) observes that the church needs to have an open and acceptance heart. The WCC cites St Basil the Great who taught that, ‘it is upon those in leadership position

in the church to create an environment, an ethos, a disposition for the cultivation of the goodness and love of the community' (WCC 2005:79). St Basil further taught that, creating a safe space for healing one's own story within our church communities is therefore a practical step through which congregations can become healing communities (WCC 2005:79). In our view, in contemporary Zimbabwe, there is no way a church can be a healing community when it is quiet about HIV and AIDS.

The WCC argues that, the church which is built upon and shaped around the master story of the gospel, can offer a forum where those who are afflicted can in trust and acceptance let down their guards and share their stories (WCC 2005:80). The MCZ is currently a community of 117 713 members and 238 ministers (MCZ Agenda of Conference 2016:R52). The membership constitute a big number of people who could not just remain quite on HIV and AIDS. Everyone needs healing, however, WCC (2005:80) sets the ground of healing as a platform where care becomes more possible, as one shares the story within an atmosphere of acceptance, love and continuing concern. WCC challenges clergy who form part of their membership stating that, the task of those in ordained ministry of the church is to leave space in their own hearts and allow their own egos to die in order that this potential source of healing can flourish and bear fruits. They conclude that, this is the only way to create an atmosphere of acceptance in which stories can be said, and this healing need to happen among the people of the church (WCC:2005:81).

Conclusion

It was noted in this paper that the MCZ has side stepped from her definition of being the body of Christ and from the theology of John Wesley on the poor. The disengagement of the MCZ on HIV and AIDS programmes is an indication that the church has somehow concluded that HIV and AIDS is no longer an issue to talk about. This could be as a result of financial challenges to support HIV and AIDS programmes or it could be a socio-theological position that HIV and AIDS is no longer an issue in Zimbabwe. It can also be possible that the MCZ is affected by the general fatigue on HIV and AIDS which affecting mainly the donor community which is fuelled by the lull offered by ARVs. It is an undeniable fact that among the membership of both the clergy and the

laity in the MCZ, there are people that are either infected or/and affected by HIV and/or AIDS. These people need to share their stories, however, since the church has disengaged from HIV and AIDS programmes they find no residence in the place where they are supposed to have the first place in view of Jesus' concept of the love for the wretched of the society. The people living with HIV are struggling and they are teaching and they are learning and they want all of us to enter into a new way of understanding life in the community. The silent message of the people living with HIV and AIDS in the MCZ is a reminder to the church that everyone in the church is vulnerable and in need of healing. The 'us' and 'them' syndrome on HIV and AIDS should be curtailed (Moyo 2015). As the body of Christ, MCZ is compelled to be an agent of both social and theological cohesion otherwise HIV and AIDS will devastate communities under the care of the church which has a healing potential. In order for the healing ministry to have impact in the MCZ, the denomination needs to provide a sense of welcome and inclusiveness. It is only at this point that the church can be relevant. By being a safe place for all infected and affected by HIV, there is an opportunity for healing, reconciliation and the restoration of hope which is the vision statement of MCZ. The Methodism that was founded by John Wesley had the priority of the poor and MCZ is called upon to support, empower, accompany, advocate for, reward and save people living with HIV. It is through this action that the disengaged church can be reengaged and walk with the suffering.

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Neo-Prophetism, Gender and ‘Anointed Condoms’: Towards a *Missio Spiritus* of Just-Sex in the African Context of HIV and AIDS

Chammah J. Kaunda

Abstract

Until recently, African pentecostalism was recognized for its militant advancement of conformist norms and corrective measures in relation to sex and sexuality of congregants. However, the continuous threat of HIV, which has claimed more lives in the context of heterosexual Sub-Saharan Africa than any part of world, is forcing some neo-prophets to become more open and often explicit on issues of sex and sexuality. One such daring voice is Pastor Paul Sanyangore of VictoryWorld International Ministries in Harare, Zimbabwe, who ‘anoints condoms’ as a response to issues of gender and sexuality in the Zimbabwean context of HIV. This article engages Sanyangore’s theology of safe sex from Pneumatological missiological perspectives. It concludes with some proposals for mission practice for engaging issues of sex and sexuality.

Keywords: Neo-Prophetism, Sexuality, Gender, Anointed Condoms, *Missio Spiritus*, HIV

Introduction

An African pentecostal¹ reconceptualization of *Missio Spiritus* (Mission of the Spirit) within pentecostal missiological studies is fundamental and urgently

¹I have used the lower case ‘pentecostal’, ‘pentecostals’ and ‘pentecostalism’ in reference to the general the pentecostal movement – first wave – classical,

needed for understanding what it means to be a ‘Spirit-filled’ and ‘Spirit-led’ Church in the African context of HIV. This means to engage pentecostal responses to African existential challenges, one has to do so within pentecostal emphasis of the ongoing missional activity of the Holy Spirit in the world. It is within this framework that African pentecostalism enables its community of faith as Adam Ashforth (2015:143) argues to ‘respond to spiritual insecurity, much of which is a response to AIDS’.

In keeping with the above argument, this article attempts to engage from Pneumatological missiology, the phenomenon of neo-prophetism in the context of HIV. My intention is to begin a discussion on new pentecostal approaches to HIV in Africa. Thus, I draw from email interviews that I conduct with over ten African pentecostal scholars from Zimbabwe, Zambia and South Africa with the intention to find out what their views are about the ‘anointed condoms’ phenomenon as means to promote women sexual empowerment and HIV prevention. The aim is not to find out whether anointed condoms have made a difference among the users but to problematize the phenomenon within Pentecostal Mission Studies. What became clear during this research was the extraordinary affirmation that pentecostal movements have potential to promote safe-sex and contribute to the reduction of the spread of HIV. However, respondents also felt that the movements need to develop adequate theology of safe sex within its framework of Pneumatology. Drawing on these e-mail interviews, this article seeks to engage Sanyangore’s notion of ‘anointed condom’ and draw some implications for mission praxis in the African context of HIV.

African Pentecostalism and HIV Discourse

At the turn of 21st century, African pentecostalism was recognised as one of the most central institutions in the struggle against HIV epidemic (Adogame 2007; Mantell *et al.* 2011; Togarasei *et al.* 2011; Mpofu *et al.* 2014; van Dijk *et al.* (eds.) 2014; Burchardt 2014; Gabaitse 2015). Social scientists and theologians have highlighted that the extraordinary growth of pentecostalism

second wave – Neo-Pentecostal and third wave - Charismatics (both Protestant and Catholic). I use the upper case ‘Pentecostal’ or ‘Pentecostalism’ when referring to a specific community such as Pastor Paul Sanyangore’s Victory World International Ministries.

has coincided with the astonishing spread of HIV in Sub-Saharan Africa (hereafter SSA) (Dilger 2007; Gabaitse 2015). These scholars have ascribed the increase of these two phenomena ‘to the growing socio-economic insecurities in the context of globalisation, as well as to the structural adjustment policies introduced from the 1980s onwards, and the subsequent increase in poverty and the growing sexual and economic vulnerability of women’ (Dilger 2007:64).

Indisputably, pentecostalism has become an increasingly prominent feature of Africa’s religious landscape more than any region in world (Ngong 2012:216). According to the 2010 figures from the World Christian Database (2016), pentecostals now represent 17.1%, nearly 179,046,000 million people of about 1,044,107,000 billion of Africa’s population. Scholars have also underscored that women make up the largest population of congregants in these movements (Phiri 1997).

Similarly, the 2015 report of World Health Organization and UNAIDS (2015) highlighted that the highest number of HIV-infected people remains in Africa and that women still account for more than half of the total number of people living with HIV. Almost two decades ago, Sally Baden and Heike Wach (1998: v) detected ‘women tending to be infected at younger ages on average than men ... in countries where heterosexual transmission is the dominant mode’. Since then, numerous studies across sub-Saharan Africa have confirmed that young women between 15 and 24 are particularly at high risk of HIV-infection than the young men of the same age group. The sexual relationships between young women and older men are very common and often linked with unsafe sexual practices with low condom use (Leclerc-Madlala 2008). In her book, *Risky Marriage*, Melissa Browning (2013) discovered in Tanzania that, like many other African societies, decisions about sex remain a prerogative of the man, not a woman. Women have neither power to demand their husband’s marital faithfulness nor rights to negotiate sex engagement in the home. In some contexts there are violent consequences if a woman took the initiative in sex matters. For instance, suggest use of condom or refuse sexual advances from an unfaithful husband, the woman is likely to be beaten or risk abandonment (Phiri & Nadar 2009; Ramjee & Daniels 2013; Browning 2013). Thus, scholars have argued that with its unavoidable presence, African pentecostalism is well positioned to make a significant contribution to HIV prevention (Adogame 2007; Togarasei *et al.* 2011; Mpofu *et al.* 2014).

The Phenomenon of Neo-Prophetism

The rise of ‘a new manifestation of prophetism in contemporary African Christianity’ (Omenyo 2011: 40), which Paul Gifford (2004; see also Omenyo & Atiemo 2006)² classifies as Neo-Prophetism (hereafter, NP) within pentecostalism in SSA demonstrate how most African people remain deeply entrenched in African spiritualities (Omenyo 2011; Omenyo 2013; Chitando *et al.* eds. 2013). NP epitomises a degree of hybridity and functions with neo-primal consciousness. They have integrated elements and approaches of traditional African prophetism (TAP), the African Initiated Churches (AICs), the Classical Pentecostal Churches (CPCs) and the Neo-Pentecostal and Charismatic Churches (NPCC). However, their distinctive feature is prioritisation of prophetic ministry, an aspect that attracts thousands of people in search for explanations to ‘the causes of their various mishaps and about their destiny’ (Omenyo 2013:50-51).

The neo-prophets are on cutting-edge in copious rituals with either water or oil, or both, in their ministry of prophesying, healing and deliverance. The neo-prophets are mainly young men, especially in Southern Africa (Chitando *et al.* eds. 2013), who present themselves as indispensable mediators of spiritual resources with great spiritual power to explain spiritual mysteries, perform miracles such as ‘miracle money’, ‘miracle marriages’, cure any kind of disease or sickness such cancer, HIV and claim to raise the dead, and have the power to protect their clienteles from any form of misfortune, especially witchcraft and explain future events (Chitando *et al.* eds. 2013; Omenyo 2013). Some scholars are sceptical of these claims and argue that NP poses a challenge, especially in the context of HIV due to its unproven claims to have the cure of HIV, which has not yet been established, this becomes worse when and in some cases some HIV patients are forced to stop taking Anti-Retroviral treatment (ARVs) (Gabaitse 2015). The movements also seem to function with a paradigm of commodification of spirituality. Despite the dangers associated with these prophetic ministries, there is a general demand for spirituality in many African societies which makes it a viable commodity which can be

² Omenyo and Atiemo (2006:59) rightly argue that the fact that neo-prophetism demonstrates a paradigm shift from the other pentecostal-type trends, should be understood as another type of pentecostalism with its own ethos, mission, style and emphasis distinctive from other pentecostal traditions and as such deserves to be discussed in its own right.

bought and sold and thus consumed according to basic neoliberal-market principles (Omenyo 2013; Quayesi-Amakye 2013; Asamoah-Gyadu 2016).

However, these movements seem to offer hope to many African Christians and non-Christians alike due to their ability to respond in an Africanised way to enormous existential challenges. In fact, they are more trusted by most African people than many secular organizations because most African people's imagination is still deeply rooted in religious interpretation of reality (Quayesi-Amakye 2013; Mpofu *et al.* 2014). Empirical studies are showing that these movements can be viable partners in the struggle against HIV because they attract large numbers of people from all walks of life which means they have a readily available audience to listen to their message, and hence the capacity to disseminate HIV education messages (Haddad 2011; Mpofu *et al.* 2014). Thus, scholars arguing that 'in order to maximize the effectiveness of church-based HIV prevention efforts in sub-Saharan Africa, studies are needed on the ways in which churches understand and implement HIV prevention messages with their congrega[nts]' (Mpofu *et al.* 2014).

The Pentecostal Discourses on Gender and HIV

Numerous studies have been done to analyse various ways that African pentecostalism is engaged in the fight against HIV. Some of these studies which have focused on African pentecostalism, gender and HIV have tended to highlight either the movements' obsession with sexual morality or preoccupation with HIV, witchcraft and healing (Chitando *et al.* eds. 2013). Historians have highlighted that African pentecostalism began responding with a condemnatory theology which perceived HIV as a 'scourge visited by God on a society that has turned its back on religion and morality' (Mantell *et al.* 2011:195). The belief that HIV was punishment from God as a result of sin made many Pentecostals engage HIV in the context of sin and judgment. Thus, most pentecostals were reluctant to engage in HIV prevention or even to discuss issues of sex and sexuality from the pulpit because such actions seemed to support sinners (van Dijk *et al.* eds. 2014). Recently, pentecostalism, especially neo-prophetic movements have responded with the theology of healing and deliverance. These movements placed emphasis on the healing power of God and view HIV 'as a demonic spirit and those afflicted by the illness as victims of spiritual demonic attack' (Adogame 2007:479). Thus,

most pentecostal prevention programmes are permeated with spiritual warfare discourses (Adogame 2007; Asamoah-Gyadu 2007; Attanasi 2008). This does not mean that pentecostal prevention is limited to spiritual warfare, there are a number of churches that have developed a more holistic understanding of HIV, albeit, within the moral framework of sexual purity.

It is important to highlight that pentecostalism is not monolithic but dynamic and manifests differently even within the same context. However, abstinence, be faithful and Christ (ABC) remains the core framework of prevention strategy (van den Bosch-Heij 2012). Yet, this strategy is approached differently in different sociocultural contexts. In other words, pentecostal churches have adopted different approaches to refashion the domains of sex and sexuality and intimacy depending on various context resources available. In Botswana for example, they have integrated the counselling practices promoted by the government within their faith discourses to construct countercultural ideas of sexuality which are communicated in church circles (van Dijk 2013). In Zambia, many pentecostal churches have adopted traditional marriage teaching (Imbusa) to engage issues of female sexuality and HIV (Haynes 2015). The numerous studies across SSA on religion and risky behaviour are demonstrating pentecostal impetus in providing morally acceptable response to sex, sexuality and HIV within the framework of abstinence before marriage and fidelity within marriage and mandatory HIV testing for those intending to get married (Adogame 2007; Gusman 2009; Parsitau 2009). Critiques of pentecostal ABC strategy think that such an approach is reductionist as it limits HIV to sexual disease and obscures the complexities of socio-cultural, political, economic and gender aspects of the disease (Parsitua 2009; van den Bosch-Heij 2012).

Yet, there is recognition that pentecostal social ethics and moral theology empowers some believers to recognise the risk of immoral behaviour (Agadjanian 2005; Attanasi 2008). Studies show that in comparison with other Christian traditions about the role of religion in HIV prevention, pentecostalism has the lowest levels of pre- and extra-marital sex among congregants. It was founded that unmarried female pentecostals were least likely to have children out wedlock and married male pentecostals had lower levels of risky behaviour (Agadjanian 2005; Attanasi 2008). Adriaan van Klinken (2012:234) in his research in Zambia, discovered that 'Pentecostalism does not simply emphasize these moral norms; its born-again program is a discursive regime through which [believers] make a break with the past,

including dangerous forms of masculinity, and—empowered by God—become new male selves that no longer live lives that make them vulnerable to the dangers of HIV and AIDS.’ A similar observation was made earlier by Alessandro Gusman (2009:73) in Uganda. He noted that ‘to get saved means not only to save one’s soul: it implies being ‘safe’, and the way to obtain safeness, according to the *balokole*, is to be born again and follow the AB (Abstain, Be Faithful) precepts.’ Care must be taken not to think that this is an essentialist pentecostal theological approach. The major weakness of ABC approach is that it takes for granted that all believers would abstain until they are married and those already married would remain faithful to their partner until death do them part. This perspective is dangerous as could spark a backlash in that it can paradoxically contribute to unsafe sex practices by young believers left vulnerable without tools of empowerment such as negotiating the use condom in the case where the temptation might overpower them.

In his ‘Bourgeois Abstinence,’ Marian Burchardt (2014:126) discovered that ‘social class is central for understanding the relationships between religion and sexual ideologies, intimacies, and relationship practices. Social class status prefigures sexual choices while such influences are reinforced through an evangelical idiom of life and sexuality as gifts from God.’ Burchardt (2011, 2014) did two studies in two different social classes within South Africa. In the pentecostal middle class youth, Burchardt (2014:126) discovered that the young people valued ‘abstinence because they see their lives as valuable and successful, which is precisely what their class status allows them to see.’ On the contrary, Burchardt (2011:1) found out that sexual practices among poor township youth in Cape Town seriously challenges pentecostal moralism. The morality of premarital abstinence appears as a highly exceptional ideal among these pentecostal youths. If these findings are regarded as bearing some truth, then most these young pentecostals are likely to engage in unprotected sexual intercourse in an event of irresistible sexual temptation.

Social class paradigm is also important in understanding pentecostal masculinities. It is important to highlight that not all pentecostal churches focus on changing men’s behaviour as some studies appear to be suggesting (Agadjanian 2005; Attanasi 2008). This is especially true because it is mostly women who participate in these traditions than men. Jennifer Cole (2012:388), in her research among pentecostals in east Madagascar noted that ‘Pentecostalism helps these women less by reforming their men than by

offering women alternative source of authority, as well as an alternative set of practices, from which to forge social personhood and subjective sense of self.’ This research also must be understood within the context of class-based perspective. Cole’s research was among poor pentecostals, whereas Gusman (2009) and van Klinken (2012) researched among the middleclass pentecostal congregations. However, even in an equivalent economic class, pentecostals are prone to have divergences due to different variables such as the pastor’s level of education and the member’s level of commitment to their faith. In fact, van Klinken (2013:250) found that pentecostalism ‘presents a real gender paradox’ as it promotes gender equality while simultaneously reinforcing male headship. It is important to highlight that van Klinken is studying sermons on masculinities that were presented by a former chairperson of National HIV/AIDS/STI/TB Council of Zambia (NAC) and classical Pentecostal pastor, Joshua Banda with a Doctoral of Philosophy (PhD) from Oxford Centre for Mission Studies. His theological and HIV exposure must be seen to have a level of influence in his understanding of gender and his desire to seek reform headship within the servant leader paradigm. Yet, the tension between wifely submission and male headship is still there as Banda promotes gender justice in public spheres but maintains male headship in the home, as ‘divine order’. Scholars have argued that in the context of HIV, it is the marriage context that is the most dangerous space for a woman than the public spaces. Baden and Wach (1998:7) for example argue that ‘the major mode of transmission in SSA is through heterosexual intercourse, with marriage as the major risk factor for any African woman to contract the HIV-virus.’ Indeed scholars have consistently pointed out that dominant patriarchal culture in many African societies exacerbates the spread of HIV on the continent (Browning 2011; Ramjee 2013; Azetsop ed. 2016).

Unfortunately, pentecostal tradition is not immune to patriarchal attitudes. As already demonstrated most pentecostals have mis-interpreted and mis-used theologies of wifely submission and male headship to reinforce gender inequality and subordination of women to men. This means that the movements’ responses to HIV could be also analysed from gender justice perspectives. In fact, within this perspective, pentecostal roles become more ambiguous than some scholars would acknowledge. On the one hand, pentecostalism has been applauded by some feminist scholars for arguing that the movements empowering women to reject socio-cultural status quo of marginalization in patriarchal societies and legitimizes ambitious women to

achieve economic, social, and political independence (Spinks 2003). On the other hand, other feminist scholars such as Jane Soothill (2010:84) have a different opinion. Soothill (2010:84) in her empirical study in Ghana argued that ‘It should not be assumed, however, that the spiritual and material equality of believers undermines inherent biological and psychological differences between women and men, or that it fundamentally disrupts the rules governing social relations between them. In marriage a woman is still to ‘submit’ to her³ husband (Ephesians 5: 22–4).’ Soothill makes observation that most scholars who have dealt with the question of gender in pentecostalism have not acknowledged. She argues that pentecostal gender ethic promotes gender equality in the public social domains but reinforces wifely submission in marital context. African feminist scholars have argued that African pentecostalism is an inherently conservative force, which reinforces gender inequalities in the home that turn detrimental in the context of HIV (Phiri *et al.* eds. 2003; Nadar 2009). Soothill (2007: 26-27) discovered that ‘the gender discourses of Charismatic Christianity are used in multiple ways to challenge old cultural forms, to create new ones, and to generate renewed forms of legitimacy for ‘traditional’ gender norms.’ She (2007:63) concluded that these discourses do not ‘challenge the structures that reinforce and perpetuate gender inequalities’ especially in the home. In other words, women’s power to negotiate sex is limited in their homes as male headship has failed to promote gender equality between the husband and wife. It is within this context that Pastor Paul Sanyangore’s anointed condom as a response to HIV and women empowerment is located.

Sanyangore’s ‘Anointed Condoms’ and Women’s Sexual Agency

Sanyangore is young man in his early 30s who has founded VictoryWorld

³ The aim of this paper is not to interrogate the notion of submission and male headship. For detailed discussion of these notions within African theological perspectives see Elijah Baloyi (2008) who engages the notion from a traditional Protestant perspective and more recently Priscille Djomhoue (2016) from feminist biblical interpretation. They argued that the misinterpretation of male headship in many African churches has contributed to the imbalance of power within sex relations.

International Ministries in Harare, Zimbabwe. He has a membership of about 5000. Sanyangore believes that God has sent him to deliver his people out of spiritual slavery. He claims to perform numerous miracles including the claim to raising the dead. However, one distinguishing factor about him is the explicit engagement with issues of sex and sexuality and promotion of 'anointed condoms' for HIV prevention. Sanyangore has tried to overcome the problem of public talk on sex and sexuality as taboo within most African cultures. In some African cultures the talk about sex was treated as taboo and confined to private talk among adults only, mostly married adults, meanwhile the consequences of its misunderstandings affects more than adults and married people. Elijah M. Baloyi (2010) writes that open sex talk in some traditional African societies was taboo 'because this was regarded as bedroom talk.' Scholars confirm that 'In African traditional society, it was taboo for a parent and a child to talk about sex and other related issues, but times are changing and this attitude should also change accordingly' (Mugambi & Magesa 1990:78). Sanyangore seems to understand that times have changed by his very missional action of bringing sex-talk within the sacred spaces. He prayed for condoms during the church service and anointed them in order to give them a spiritual interpretation beyond ordinary condoms. An empirical research is yet to be done among the congregants who used these condoms to confirm divine protection. What is clear is that Sanyangore's ministry functions within the paradigm of neo-prophetic spirituality. This spirituality functions in an Africanised spiritual universe which is utilized to articulate Christian theological commitment in response to neo-primal consciousness pervasive among African people.

It is also important to recognise that the concept of anointing is a phenomenon through which neo-prophetic figures mediate their extraordinary events (Asamoah-Gyadu 2005). Sanyangore sees himself as anointed of God. The anointing is understood as consecration and spiritual empowerment for God's service. In this perspective, the neo-prophets see themselves as mediators of divine anointing – the power of God. This means that the anointed person is someone who is with the Holy Spirit in a powerful way to accomplish extraordinary things (Oyedepo 1992). Many neo-prophets believe that whatever they come into contact with or touch become anointed, hence, mediate the power of God. Anointing is believed to vary from person to person. Hence, different prophets manifest different anointing. There are those with 'anointing for protection', or 'anointing for marriage', or 'anointing for finances', or

‘anointing for healing’ and so on. People who function with highly spiritualised consciousness are more vulnerable to the manipulation these prophets.

In 2015, My Zimbabwe News made the heading: ‘Women scramble for anointed condoms during prominent Harare pastor’s church service.’ The Mark Woods Christian Today contributing editor (2015) reported that ‘Pastor’s ‘miracle’ condoms lead to church stampede.’ On Nehanda Radio (2015), it was reported that ‘Church proceedings came to a halt when controversial Pastor Paul Sanyangore prayed for condoms during a service. Several women stampeded to have a box of the ‘anointed’ condoms for use in their homes. This left tongues wagging in the church with some questioning the moral element of having condoms in church. Some argued that what happened at this church made it clear that people are urgently seeking ways to have safe sex and also improve their sex life (Ndlovu 2015). However, this controversial introduction of ‘anointed condoms’ has attracted resistance from experts involved in the fight against HIV. In response the delegates at the International Conference on AIDs and STIs in Africa (ICASA), saw Sanyangore’s approach as retrogressing the ground gain in the fight against HIV (cited in Mbanje 2015). The United Nations Population Fund (UNFPA) senior HIV technical advisor Bidia Deperthes (cited in Mbanje 2015) urged, ‘Please stop praying for the condoms, it misinforms the public and is totally against science.’ The UNFPA chief of procurement services Eric Dupont (cited in Mbanje 2015) added his voice that ‘condoms underwent rigorous tests and were safe to use without being prayed for.’ He cautions, ‘Condoms should not be anointed. It sends a skewered message.’

Sanyangore’s response to these criticisms was based on the spiritual dimensions of sex which added some dynamics which most secular experts on HIV in Africa have constantly ignored. For example, the belief that was spreading that having sexual intercourse with a virgin could cure a man of HIV and AIDS emerged within the understanding that there is a link between sex and spirituality. The traditional healers who were the main proponents of this HIV virgin cleansing rituals, associated virginity with spiritual purity. In some African societies sex is seen ‘mixing blood’ (Maxwell 1983). To have sex with a sexually active person, especially outside marriage is believed to have polluting effects that could cause sickness or disease. In contrast, the blood of the virgin is believed to be pure and to have intercourse with her, links the man to spiritual powers that could cleanse him of the disease and since she is having sex for the first time, cannot be infected in the process (Leclerc-Madlala

2002)⁴. Akintunde Olu and Jacob Ayantayo (2005:2) rightly argue, ‘It is a pity that people who talk about sex even in relation to the spread of HIV/AIDS, protection of women’s dignity against rape, amongst others, tend to overlook the place of religion in understanding human sexuality.’ Olu and Ayantayo (2005:3) add that ‘In traditional society, sex has a spiritual dimension because it involves the fusion of a man and a woman.’ In an email interview with Molly Manyonganise (1 August 2016), pentecostal believer and lecturer at Zimbabwe Open University, in Zimbabwe, she affirmed that:

Africa has always understood the connections between sexuality and spirituality. For example, the very act of creation from the African cosmological worldview is viewed from a sexual perspective ... The ability of humanity to ‘create’ through sex replicates the Supreme Being’s aptitude. Therefore it’s undeniable the sexuality and spirituality are closely linked.

In another email interview with Kennedy Owino (3 August 2016), a Charismatic Christian and lecturer at Seth Mokitimi Methodist Seminary, in South Africa, he argues that sexuality is embedded with African spirituality, which functions as *locus* for pentecostal spirituality. For instance, African pentecostals believe ‘*that sexual intercourse makes the individuals involved ‘spiritually tied’ to each other.*’ Sexual intercourse is believed to establish soul-tie – a mystical union between parties involved whether in marriage or outside. In actual fact, illicit sex is believed to very dangerous because it establishes a permanent a demonic-bond (ungodly soul-tie) between parties involved which can be broken through deliverance (Brown 2011).

Apparently, Sanyangore is aware of critical role spirituality plays in most African people’s conception of sexuality. He argues:

I prophesied to a certain woman that her husband would return two years after his mysterious disappearance. I am not sure but during the week, the husband called her telling her he would come back home. She came to church and during prayer time, she took them (condoms) out

⁴ In her article, ‘On the Virgin Cleansing Myth’, Suzanne Leclerc-Madlala gives a detailed discussion on the belief in HIV virgin cleansing ritual and its contributions to raping of children and persons with disabilities.

and handed them to my assistant asking if they were okay to use when her husband returns... I saw nothing wrong in her using them with her husband after two years of absence. Who knows what he was doing there so it is better to be safe. When I prayed for the condoms, some women came out and wanted to have them (Nehanda Radio 2015; My Zimbabwe News 2015).

He believes that there are two sides to HIV – ‘the physical side and the spiritual side.’ His prayers address ‘the demon; the condom addresses the physical side. We are just working together’ (Ndlovu 2015). He further argued that ‘when he prayed for the condoms, he was addressing the *spiritual side* and, therefore, could not comment on their safety or efficiency’ (*News Day Zimbabwe* 2013, italics added for emphasis). As also already observed above, many neo-prophets classify HIV as a demonic issue rather than a social issue. This appears to help advancement the deliverance discourse. Besides Sanyangore is also concern about apathy in the church’s response to HIV. He underlines, the church is the best social place to discuss issues of sexuality. In actual fact, Sanyangore has also established a prayer house, called spiritual clinic designed to help men with sexual challenges. He noted that most churches in Zimbabwe are not willing to discussion issues of sex and HIV in the pulpit. He feels it’s high time these issues became integrated into the gospel ministry in the church. He laments, ‘I am tired of burying people who are dying of AIDS. I have buried 10 so far, imagine by the time I get to 50.’ He has observed that it is mostly women who attend the church, not husbands and ‘some of them [husbands] *vanoita chipfambi zvekuti mukadzi ndiye anokwara* [lit. are philanderers but its women who suffer]. HIV is a reality which we should all be aware of.’ However, Professor Kudzai Biri (August 8, 2016), a Pentecostal and scholar at the University of Zimbabwe, in an email interview argues that:

This pastor is drawing attention of people from real issues. He wants money, these guys are clever, they know where to reap people’s money and attention. They know people will be attracted by claims of anointed condoms for good sex, our people need to be educated - it’s not about condoms but love. These guys are negatively impacting the institution of marriage and sexuality. The promotion of public sexuality is good but not through wrong means. Pastors should know where and when to talk about sexuality.

Sanyangore's promotion of 'anointed condoms' is fundamental because some church denominations still see discussing issues of sexuality, sex and HIV in the church as taboo (Owino 2016). For Owino (2016), it is important to take note of Sanyangore's argument that the church is the safe place to address issues of sex, sexuality and HIV. For a long time as Madipoane Masenya (ngwana' Mphahlele) (2003:102) observed the churches in Africa have used some sections of the bible to support sexual subjugation of women. She (2003:102) further laments that 'Women's sexuality is often defined and controlled by men both in the churches and in the households.' Thus the church cannot afford to keep silent and continue to perceive sex-talk as bedroom talk. The main concern is not whether safe-sex must be promoted in the church but why is Sanyangore spiritualising the condoms? Is he really concerned about helping people or is a strategy to attract naïve people to his ministry? Manyonganise (2016), *Sanyangore is a desperate prophet seeking relevance in a context with noticeable 'plethora of anointed products such anointing oil, handkerchiefs, towels, wristbands, posters and many other merchandises.'* Thus, the introduction of 'anointed condoms' must be understood as a bid to bring something new on the market. Manyonganise (2016) underlines, *'basically, in any market place, a new product is bound to receive more attention than the old ones.'*

Thus, fundamental missiological questions can be raised. In what ways has his church served as a safe space for discussions on condoms and safe-sex? How has he used the Bible to promote safe sex? Yet an acknowledgment from a pastoral practitioner cannot be taken lightly, however his motive. Not sidelining the fact that there are possibilities that Sanyangore is using 'anointed condoms' to exploiting poor people's vulnerability to HIV. The anointing aspect of it could serve as a marketing ploy to promote the product in his church. Sanyangore added:

We preach but some do not repent Communication is what we preach in our church, husbands and wives should communicate about these things because people are dying. Let us *empower the women* and not beat them because she has suggested using protection. *To those who are not married abstinence is the key.* Most people think condoms are a ticket for sleeping around but that is not it (My Zimbabwe News 2015, italics added for emphasis). I did not say *condoms are not safe*, neither did I say they are from the devil. Married people can sit down and

decide to use them. Condoms should be used, but if people ask me to pray for them, I will (Mbaje 2015, italics added for emphasis). It is actually wisdom from God for one to invent the condom (My Zimbabwe News 2015).

I have cited Sanyangore at length because, he appears to be aware of the ostensible tension between promotion of his ‘anointed condoms’, pentecostal morality of abstinence before marriage and the fact that most African women have no power to negotiate sex in their homes. To begin with the notion of ‘anointing’ has potential to appeal to pentecostal believers and there are possibilities that they might use them for protection. This might contribute to reducing the number of new infections. However, it has also potential for backlash because it gives some immature believers a sense of false security in terms of their vulnerability to HIV and STIs infections. Scientists have emphasized that condoms are not 100 percent safe. Thus, classifying them as anointed is ‘dangerous’ as it can promote promiscuity among young people who might perceive them as full proof from infection (Owino 2016; Manyonganise 2016). In addition, Sanyangore’s approach is limited in that it does not demonstrate how ‘anointed condoms’ can address gender relations in which subjugation and empowerment are deeply entrenched. The very fact that Pentecostal theology of submission and headship remain foundational to pentecostalism, limits the agency of women to negotiate their sex and sexuality. Manyonganise (2016) argues:

Such public promotion of sexuality needs to be accompanied with challenging other structures such as patriarchy and masculinity which have proved to be harmful to women in church and outside.

Owino (2016) is of the same view that anointed condoms promotes an elusive sense of safety in that these women are married and in the homes it is their husbands who make key decisions on issues of sex. He thinks that this sense of false security might also heighten infidelity and promiscuity now that their husbands have ‘anointed condoms’ which promises them divine protection from HIV infection. This means that women cannot be empowered without equally engaging their husbands.

However, there is a sense in which women are challenging status quo about social perception and definition of women’s needs for sex and their

sexual agency. It was the woman who initiated the conversation about the condoms in Sanyangore's church. This is significant because as Zola Ndlovu (2015) on her blog observes, this woman defied the assumptions that sexuality, sex and HIV conversations belong outside the church walls and the long held suppositions that African women have not power over their sexuality. Manyonganise (2016) also agrees that it *'shows the women's desires to be in control of their sexuality i.e. to be able to choose how they practice sex.'* But she also feels *'It's absurd that the condoms were male condoms, meaning that it was going to be difficult for the women to take charge because instead of receiving female condoms they got the male ones.'* However, Owino (2016) thinks that the issue is not so much about the condoms as much as creating a safe space for empowering women to take 'control of their sexuality.' He further argues the empathic response of Sanyangore to the request of the woman affirms *'that women are sexual beings who equally have sexual needs that require satisfaction as in African context where it is always assumed that women's sexuality is for the satisfaction of men.'* Owino (2016) questions, it seems that the church has not done enough to empower women to negotiate not only for safe sex but sexual satisfaction has a matter of urgency. The only troubling question is what difference would it make if the Sanyangore promoted the use of condoms to prevent HIV without claiming anointing on them? Was it only married women who received anointed condoms or singles were allowed too? If married, how did they use the condoms if they are not in control of their own sex and sexuality? How would the anointment pacify their husbands or partners at home? The length of this article will not allow engaging such critical questions.

Foundations for African Pentecostal Missiology of Sexuality in the Context of HIV: The *Missio Spiritus* of Just-Sex

The key people interviewed in this research argue for starting with understanding the role of the Holy Spirit in human sex and sexuality. Manyonganise (2016) for example argues:

An understanding of who the Holy Spirit is may help in promoting a Pentecostal theology of sex and sexuality. For example taking the functions of Holy Spirit and incorporating them in the theology may

create an in-depth understanding of sex and sexuality issues in Pentecostal churches.

But Biri (2016) also cautions that '*the freedom in the Holy Spirit needs to be managed.*' This caution must be yield, especially in the African context that jam-packed with abuse of the Holy Spirit. However Manyonganise's argument is foundational as pentecostals believe that every aspect of human being experiences the infilling of the Holy Spirit. This means that for the believer, every experience is mediated by the Holy Spirit (Yong 2005). The human experience of the Holy Spirit is not qualitatively different from their sexual intimacy with one another in the context of just-love⁵ (I return to this below). In another interview with a Zambian pentecostal Pastor, Mukuka Kabwe (01 August 2016), points out that:

The Pentecostals in Africa have always perceived sex as a form of worship. They have always affirmed spirituality as critical dimension of human sex.' Yet such spiritual conception of sex and sexuality is not void of concrete experiences of sex between the husband and the wife, it is rather a sexual experience that include reconciliation and healing. In our case, we believe that the Holy Spirit helps the couple that prays and studies the Word together to enjoyment intimate relationship and romantic love.

The pentecostals have emphasised the human body as the temple of the Holy Spirit, designed to reflect God's plan for human sexuality. This argument is based on an understanding that sex is prone to abuse; it is a site of injustice and struggle for power. In heterosexual SSA societies, sex is at the base for unequal power relations that have contributed to the spread of HIV and death of millions of people with AIDS. However, sex is neither evil nor a human invention. It is created by God as a medium for expressing human

⁵ Margaret A. Farley's (2006) *Just Love: A Framework for Christian Sexual Ethics* is an excellent work on a framework for Christian sexual ethics. She introduces the notion of just sex offers for sexual ethical discourses and discernment. She also proposes seven norms for Christian sexual ethics in chapter 6 as no unjust harm, free consent, mutuality, equality, commitment, fruitfulness, and social justice.

essence. It is divine glue that binds romantic intimate relationships. Therefore, it is linked to the mission of God in the world. Many ecclesiastic communities have become increasingly aware that sex and sexuality are also other dimensions in which God is engaged in the struggle for justice. The need to respect the dignity of each human being as autonomous, self-determined sexual being created in the image of God inspires the growing ecclesiastical consciousness for promotion of holistic human rights.

The pentecostal have long recognised that they are pentecostals because they are filled with the Holy Spirit and because they are filled with the Holy Spirit, therefore, they have the power to reclaim what it means to be sexual beings who practices sex, express their sexuality as people filled with the Holy Spirit. In my view, the Holy Spirit as the Spirit of creation is the Spirit that created sex and said it was good and is the Spirit that empowers Christians as agents of their sexuality. The breath of God in human being in Genesis narrative suggests that the Spirit as *creator Spiritus* infused the divine breath into humans and creation. This suggests that human beings are pneumatically interrelated in an essential way. However, with the fall of creation, sex and sexuality have become forces of human destruction. But through redemptive work of Jesus Christ, the Spirit of now, potentially, gives sacramental dimensions to human sex. This has a bearing on African understanding of sex as sacred which brings aspects of protection from profane or abuse.

Sex in the traditional African thought and life is sometimes connected with spiritual power (Wuaku 2013). Hence, sex has always being part of African ritual spaces. Individuals are allowed to engage in sexual intercourse only after they have gone through initiation rites. It is divinely entrusted to human beings as an expression of *Ubuntu* - a person is a person because of another person. In other words, a person is a sexual being because all human beings are sexual beings. According to this thought system, to misuse any person for self-gratification as a sexual object⁶ is destruction of life because that act does not promote *Ubuntu* (Uzukwu ed. 2015: 212). The Holy Spirit is the Spirit of *Ubuntu*. This means that the Spirit gives the believer power to humanise their sex and sexuality. In a sense, a human being with humanised sex view upholds justice in matters of sex and sexuality.

The Holy Spirit is the Spirit of Justice. Just-sex is a sexual experience

⁶ For detailed discussion of the notion of women as sexual object in Africa, see Baloyi (2010).

through Spirit who brings justice and healing into the relationship. Just-sex and sexuality takes into account all aspects of the person as a free moral being with capacity to make rational choices, ability to think and feel. The person must be respected as end in themselves (Farley 2006:210). Thus, the mission of the Spirit in the church creates entrance to just participation of women and men in just-sex by enabling them to move from estrangement, wounded, broken, predatory sexual fantasies and destructive sexual relationships into empowering, satisfying, healing, saving sex life. It is also important to note that human experience of the Holy Spirit is also aesthetic in nature, meaning the Holy Spirit moves human beings into the realm of Christ-like-love ethic. The church is the sphere of God's agency in which the Holy Spirit recreates human agency and subjectivity to mirror divine ethic of love. Justice, love and sex are inextricably intertwined.

Implications for Mission Praxis

The African ideal of *Ubuntu*, 'I am because you are' invites the church to reflect on what it means for human beings to be sexual beings in a community of faith. The recognition that 'I am' is based on the radical just-love and acceptance that every human being is sexual being like the 'I am'. Issues of sex and sexual can no longer be perceived as an appendix of God's mission. These issues challenge the spirituality of the church on the meaning of justice and respect for human sexuality. I conclude by suggesting three implications for mission praxis:

First, the Spirit of God is also the Spirit that created sex and sexuality - is the Spirit of sexuality. This means that sex and sexuality are divine gifts and the church is called to participate in the Spirit's mission of redemption and sacralisation of sex and sexuality. The church as the medium of the Spirit's mission must be intentional about engaging with issues of sex and sexuality.

Second, the church must articulate its response through Spirit-empowered sex and sexual as basis for humanisation of romantic relationships. This means that the church's engagement with issues of sex and sexuality will seek to humanise human romantic love through the frame of *Ubuntu*. This means the mission of the Spirit in the context of sex and sexuality will take into account every aspect of the person such as social, political, economic and cultural as factors that too often function as locus

for promoting gender power dynamics.

Last but not the least, the church is called to participate in the Mission of the Spirit to promote just-sex in the world. Just-sex is about empowering the believers especially women (young and old; married or not) to be able to negotiate sex in any context whether home or any other place. In order to humanise sex, it has to be understood in the frame of justice. Justice and sex must be seen as two sides of the same coin, meaning sex and justice should be ontologically integrated. Whenever there is life-giving sex, there is justice. This suggests that sex without justice is void and inhuman at waste. Within South Africa, any sex without consent is rendered rape. Perhaps this is a more viable approach to promote just-sex. Sex must be driven by justice from which, it also must get its content. Sex can no longer precede justice. It must be permeated by justice for humanisation. The church is the missional locus from which God empowers the believers for just-sex.

Conclusion

The discussion above demonstrates that church must make a paradigm shift from being a place where negative views, including the quietness that some African traditions hold relating to sex and of sexuality are presented, to become a safe space for promoting positive views of sexuality and sex that can empower both women to take control over their sexualities as agents and subjects in the context of HIV. This also means that the NP must look to the fruit of the Spirit in order to participate in the holistic mission of the Spirit to heal sex and sexualities in Africa. I have argued that the human experience of sex and expressions of sexuality is mediated by the presence of the divine Spirit. Yet, it is important to acknowledge that this article is only opening up a debate on the possibility of constructing conceptual maps and horizons for African Pentecostal missiology of safe sex.

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Church Discipline as Virginity Testing: Shaping Adolescent Girls' Sexuality in the Evangelical Lutheran Churches in Africa

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Abstract

Church discipline for falling pregnant out of wedlock is in practice discriminatory as it effectively affects girls than boys in the majority of cases. This article seeks to explore the role of church discipline in the Evangelical Lutheran Churches in Africa in controlling and shaping adolescent girls' sexuality. The church teaches about abstinence before marriage to both boys and girls. However reality as evidenced by pregnancies in schools by adolescents and the high rate of new HIV infections attests to the failure of the message of abstinence. The message of abstinence implies that the church views virginity until marriage as a sign of purity. The Lutheran churches' church discipline and subsequent process of public absolution to adolescent girls who fall pregnant out of wedlock is considered by this study as a form of virginity testing that is practiced by the church in order to control and shape women's sexuality at an early age. This qualitative exploratory study is non empirical however some empirical research is taken from participant observation research that was conducted during an earlier research project. The study seeks to present a meta-narrative analysis of the Lutheran church discipline process as a gendered power issue used to control and shape adolescent girls' sexuality. Findings of this study are that the Christian church's emphasis on abstinence is in fact a focus on virginity as a form of purity which is a way of controlling and shaping women's sexuality since in most cases girls are the ones seen seeking for absolution after giving birth. Those who make them pregnant are not usual visible. This way, those who seek for absolution are no longer virgins, ideally implying that those who have not fallen pregnant are still virgins and pure. Findings of this study are

evaluated through African women's cultural hermeneutics and hermeneutics of suspicion.

Keywords: Adolescent girls, Sexuality, Virginity Testing, Christian church, Church discipline

Introduction and Background of Study

Religious traditional practices that are oppressive to women are resilient to the multi-disciplinary approach to the transformation of socio-religious, political and cultural gender based oppressive tendencies. Despite so much research and information on the evils and ills of gender based violence, the practices are still shockingly resilient. African women's studies and gender studies may feel that they have exhausted research on traditional and cultural practices that harm women and girls, but reality is that, these practices are still being implemented in some religious spaces. The Evangelical Lutheran Churches in Africa (hereafter the church) is an accomplice in implementing gender biased practices that contribute to 'the restriction of women rather than helping them to develop. Women are taught to sacrifice themselves for the sake of others and, in doing so, disappear into the background' (Dreyer 2011:2). The Church shapes women's sexuality as early as their childhood and adolescence stages. Virginity is highly valued as sign of purity. However it is always the virginity of the girl child that is put to test both through church practices and traditional cultural practices.

Scholars of adolescents and sexuality studies have extensively written on perspectives of adolescents on sexuality and the factors that influence their developments (Dykstra 2013; cf. Maluleke 2007). Christian churches value virginity as a sign of purity particularly for adolescent girls. As a result, the church has a history of shaping adolescent girls' sexuality by insisting on abstinence until marriage. In some congregations adolescent girls have been identified as a group that needs to be taught about their sexuality while adolescent boys are considered knowledgeable about their sexuality (Chisale 2014). Yet these adolescent girls do not make themselves pregnant. In some cases adolescent girls are pregnant by elderly men in infamous trans-generational sex. In 17 of the church services that we visited in the process of

our data collection during absolution for public sin only girls were absolved¹. The church's disciplinary machinery seemed not to care about the invisibility of the boys and men who pregnant the girls. The pastor would have dealt with the whereabouts of the boys in private while offering pastoral counselling to the girl.

The process of absolution begins with the pastor in pastoral care to a congregant who will have been involved in public sin. The congregant should be able to realise their public sin and feel contrite about it. This happens in private. The pastor can then go on to offer the congregant a choice for public or private absolution. In the majority of cases congregants in Lutheran Churches apt for public absolution to overcome public 'gossip' about their known sin. However in the public confession the congregant does not have to mention their sin(s) by name. In the whole process the emphasis is not on confession but on absolution.

In the Lutheran church, the emphasis on confession and absolution is never placed on confession—listing all the sins one has committed. The emphasis is always on absolution—the forgiveness which Christ Himself won for us by His suffering and death on the cross. In absolution we have a wonderful gift from Christ. By it we can hear with our own ears and know in our hearts that, as our sins have been forgiven here on earth by our pastor, they are just as surely forgiven before our Lord in heaven. The Small Catechism teaches us, 'Confession has two parts. One is that we confess our sins and the other, that we receive absolution, that is, forgiveness, from the pastor as from God Himself not doubting but firmly believing that by it our sins are forgiven before God in heaven' (The Lutheran Church in Canada).

In the absolution the role of the priest is to enable the congregant to hear the words of forgiveness being pronounced as gospel from the mouth of

¹ It must be noted that the authors of this paper are members of the Lutheran Church. One is an ordained minister while the other is a vicar in the church. This means that we are writing from an insider perspective which might affect objectivity. However we tried to remain factual based on empirical evidence of the absolution process and how it is practical skewed against females who cannot hide their pregnancies which are evidence for sexual intercourse.

the minister. The Priest does not have to be sure of the seriousness of the contrition by the congregant because even if they want to know, that is impossible as this will be between the congregant and God. Luther says:

The priest is necessarily uncertain as to your contrition and faith, but this is not what matters. To him it is enough that you make confession and seek an absolution. He is supposed to give it to you and is obligated to do so. What will come of it, however, he should leave to God and to your faith. You should not be debating in the first place whether or not your contrition is sufficient. Rather you should be assured of this, that after all your efforts your contrition is not sufficient. This is why you must cast yourself upon the grace of God, hear his sufficiently sure word in the sacrament, accept it in free and joyful faith, and never doubt that you have come to grace—not by your own merits or contrition but by his gracious and divine mercy, which promises, offers, and grants you full and free forgiveness of sins in order that in the face of all the assaults of sin, conscience, and the devil, you thus learn to glory and trust not in yourself or your own actions, but in the grace and mercy of your dear Father in heaven (Luther's Works Vol 35.15).

In theory church discipline offers a congregant who acknowledges sin an opportunity to do an introspection and meditation seeking to change from sinfulness to a holy life as expected by the Church as an agent for the will of God on earth. It becomes unfortunate as noted in our research that 50% of the pastors and all congregants view church discipline as punishment by the church to church members involved in public sin. In this case any act that goes against the teachings of the church which is publicly visible is considered as public sin. This includes such sins as being found guilty of adultery, corruption in public office or failing to abstain from sexual intercourse before marriage. In the majority of cases public sin affects boys and girls who indulge in sexual intercourse outside marriage. This usually becomes visible when the girl becomes pregnant. The public sin cannot be seen in the boy but it is visible in the girl since pregnancy becomes a sign that the girl was involved in sexual intercourse outside marriage. The church practices church discipline with the intention to reconcile the sinner to the self, church and God. Pregnancy out of wedlock is considered a sin since the 'culprits' will have failed to abstain from sexual intercourse until marriage. Therefore, females who fall pregnant out of

wedlock and males who pregnant females out of wedlock are expected to go through a process of church discipline.

This study explores how church discipline and the subsequent absolution is a form of virginity testing to girls who fall pregnant out of wedlock. The study critically explores and describes how the Christian church blindly implements virginity testing through the process of church discipline and absolution with the same good intentions as that of African Traditional Religions (ATRs); that is to protect adolescent girls from 'sin' and HIV infection. Researched and written from African women's cultural hermeneutics and hermeneutics of suspicion, this study seeks to explore how the church controls and shapes women and adolescent girls' sexuality through its church teachings of sexual abstinence enforced through church discipline.

Methodology

The observations being critically discussed in this article emerged from the empirical research that was conducted between 2012 and 2016. The research was conducted through interviews with 35 Lutheran clergy from South Africa, Swaziland, Mozambique, Namibia, Nigeria, Zambia, Malawi, Tanzania, Zimbabwe, Botswana and Togo. We also interviewed 20 adolescent girls that have experienced church discipline and absolution from Zimbabwe and South Africa. We interviewed church elders, 15 male and 15 females from Zimbabwe, South Africa and Swaziland on their understanding of church discipline and absolution. In the process of data collection we visited and observed public absolutions in 21 Lutheran congregations in Zimbabwe and South Africa. We can already say that all the recipients of absolution were girls that had fallen pregnant out of wedlock. Then there was this seemingly glaring discrimination in the administration of church discipline which could be seen by the number of young women not receiving Holy Communion of which on further investigation we discovered that the young women were under church discipline.

Theoretical Focus

Findings of this study are informed by African women's cultural hermeneutics. African women's cultural hermeneutics developed from feminist hermeneutics

which emphasizes the awareness of the patriarchal bias of the scriptures, leading to a hermeneutic of suspicion. Relevant to this study, African women's cultural hermeneutics argue that the 'one right meaning of male, androcentric exegesis cannot support the desires of women to find good news in the scriptures' (Rakoczy 2004: 164). Critical and significant to this study is that African women's cultural hermeneutics stress that women must 'view the Bible with African eyes and distinguish and extract from it what is liberating' (Oduyoye 2001:11; Dreyer 2011:7) to women and adolescent girls. Religious practices can be both liberative and oppressive depending on context. Therefore, Kanyoro (2001:106) advocates that African women's hermeneutics require women to critically read the Bible in dialogue with their own cultural understanding so that they will be able to reach out to women held in bondage by it. According to African women's cultural hermeneutics any interpretation of the Bible that harms women, vulnerable groups and the voiceless is unacceptable (Oduyoye 2001:11). African women's cultural hermeneutics acknowledge that women in Christian contexts have internalized and accepted the male androcentric exegesis of the Bible and enforce it by socializing young girls and adolescents in the churches and cultural contexts.

Findings are also evaluated through the African women's hermeneutics of suspicion. According to Fiorenza (2001:176) 'hermeneutics of suspicion is concerned with the distorted ways in which women's actual presences and practices are constructed and represented in and through kyriocentric language and media'. Hermeneutics of suspicion are applied in four ways according to Fiorenza (2001). Firstly, to grammatically masculine kyriocentric (Biblical) texts in order to expose their ideological functions and power; secondly, to kyriocentric stories in order to analyze the point of view of the story, demonstrating the ideological perspective of the story and its treatment of women; thirdly, to past and present interpretations of the text; and fourthly, our common sense approach to the text which is so profoundly shaped by our social location and experiences of domination (Fiorenza 2001:176). The phenomenon such as virginity and sexuality should be interpreted and its relevance explained from the perspective of hermeneutic of suspicion.

Tracing Marks of Virginity Testing in Church Discipline

Virginity testing is a 'practice that is used to inspect the genitalia of unmarried girls and women to determine if they are sexually chaste' (Wickstrom 2008:1).

This practice is common in the sub-Saharan Africa in countries such as South Africa, Swaziland, Zimbabwe, Kenya and Ethiopia (Win 2004). Different cultures practice virginity testing for different reasons. In some cultures virginity testing is purely a patriarchal cultural tradition that is linked to the preparation of girls and unmarried women for marriage. In some cases virginity testing increases the value of a woman in *lobola* negotiations, while some countries revived virginity testing in efforts to reduce HIV infections among adolescent girls (George 2008; cf. Kinoti 2005). It is also true that virginity testing is practiced to check the sexual purity of a woman. According to cultural and religious constructions, seemingly, a woman's sexual purity may be defiled either by sexual penetration and or pregnancy out of wedlock. Virginity testing has been widely challenged and critiqued by gender and human rights organizations for its negative implications on the girls' health and dignity.

Since the practice of virginity testing has and is still criticized by gender and human rights organizations, it can be assumed that the church does not want to be associated with this cultural practice, yet it continues to blindly practice it through church discipline and absolution. The church does not practically and openly test adolescent girls for virginity but it practices this tradition through its church teachings and emphasis on sexual purity. The church emphasizes abstinence from sex before marriage as a way of preserving virginity and sexual purity (Chisale & Buffel 2014:292). Consequently adolescent girls live and practice their faith through protecting their virginities. In all the congregations that we visited virginity of unmarried adolescent girls was stressed in different ways. Though the church does not test for virginity physically like in African Religions, this paper argues that their discriminatory practices of separating non-virgins from virgins and pregnant adolescents from other adolescents is a way of testing virginity every Sunday.

Participant observations confirm that the Lutheran churches still practice church discipline to adolescents for falling pregnant out of wedlock and in our view this is one form of practicing virginity testing in a public humiliating form. We observed this in the congregations that we visited, and then we decided to ask other pastors in the interviews if they still practice church discipline to pregnant adolescents out of wedlock. All the pastors agreed that it is still practiced. 28 pastors said that they do not force women and adolescents who are pregnant to go through church discipline and public absolution but in most cases those who are pregnant choose to go through the

process for public reprieve. In our view this not a question of choice as it is part of the culture of the affected churches. African women's cultural hermeneutics state that adult women encourage young women to submit to church teachings so that the image of the church will be protected (Kanyoro 1996:150). This can also be viewed as a phenomenon of internalized oppression. Women take it as a norm that if they fall pregnant they are not expected to participate in the holy things of the church. Pregnancy is visible evidence of having indulged in sexual intercourse. On the other hand, the boys (at times older men) who are responsible for the pregnancies have nothing visible attached to them to compel them to go for absolution. We observed a total of 19 absolutions for pregnancy out of wedlock. Interestingly the concerned pastors who conducted absolutions and church discipline said that the issue dealing with the male counterpart responsible for the pregnancy belongs to the family and not the church. Pastors said that the church deals with contrite sinners who come forward and seek forgiveness. This raises another issue, are adolescent girls more contrite than their male counterparts or it is just an issue of the obviousness of a pregnancy and the invisibility of the boys responsible for the pregnancy?

Pastors, elders and the affected girls all agreed that everyone knows that those who have received absolution are no-longer virgins. In this sense Church discipline is a form of virginity testing as it displays those that have been involved in sex evidenced by pregnancy and celebrating those who are not yet pregnant as if they are all still be virgins. All the girls and a few elders whose own daughters have been absolved in public agreed that the exercise was humiliating and energy sapping because of the fear of standing before the congregation. In fact we discovered that the pregnant girl is suspended from active ministry and participation in the Eucharist for the duration of the church discipline which is usually equivalent to the duration of the pregnancy. According to the tradition a person under church discipline is expected to stop playing any leadership role and partaking in the Holy Communion. Participant observations also confirm that there are some Lutheran churches that still make or force the pregnant girl to sit in the last bench or 'sinners' bench of the congregation until absolution.

On the other hand, during this journey we discovered that some Lutheran congregations and pastors insist on private absolution as a pastoral care intervention by the pastor. However, change is not always easy because the majority feel that the right thing to do is to do a public absolution in front

of the congregation instead of private absolution. 11 pastors spoke about some women who encourage their pregnant daughters to stay at home and not attend church services because the girl's pregnancy out of wedlock is an embarrassment to the church and God. The girls only reappear in church when they are asking for absolution especially when the new born baby is to be baptized. In one Lutheran church it was shocking to learn that pastors do not baptize or touch children born out of wedlock. In their view, these children cannot be members of the body of Christ because they are conceived in sin, implying that they are sin in themselves. In this case the mother of the baby can receive absolution but the child will never be absolved of being conceived in sin. The motive of church discipline is to encourage girls to strictly protect their virginity which is referred to as purity.

The church encourages sexual abstinence to all those not yet married because of teachings of the Hebrew Bible, but emphasis seem to be directed to adolescent girls and single adult women. In the Old Testament virginity is firstly emphasized by the interpretations of the sixth commandment, 'You shall not commit adultery'. However this commandment is not clear as to whom it applies to, because adultery takes place where there is a commitment or marriage but observations on the implementation of this commandment proves that the church's interpretation of this practice is directed to women and adolescent girls. In this case some may argue that it does not apply to adolescents and unmarried women because they are not yet in commitment relationships such as marriage. Additionally, the small catechism of the Lutheran church that is used to prepare children or adolescents for confirmation into the church, explains this commandment in a context of marriage between husband and wife (Luther 2011:5). One may genuinely argue that this commandment has nothing to do with abstinence from sex before marriage. The Old Testament has many scriptures that highlight the value attached to the status of being a virgin (Bruce 2003:56). However we are not going to analyze them in this study. Though the Bible narrates the significance of virginity, its emphasis is on women and girls but not man and boys. In addition there is no virginity testing in the Hebrew Bible though virginity is emphasized.

African Women's Cultural Hermeneutics and Hermeneutics of Suspicion of Church Discipline

In most religions premarital sex is not accepted, with emphasis on purity of the

body. The religions that prohibit premarital sex focus their teachings on unmarried women and girls. The focus of church discipline is on those who have violated the church's teaching with a practical focus on women and girls with references to the Bible. African women's cultural hermeneutics stress that women must read and interpret the Bible through African lens and distinguish and extract from it what is liberating (Oduyoye 2001:11). The use of religion or the Bible to control women and girls in church and families has long been used by the African patriarchal societies to satisfy their male egos. This is because the Bible; particularly the Hebrew Bible and the African culture have similarities (Phiri & Nadar 2010: 224). Therefore Christian feminists link cultural hermeneutics to Biblical hermeneutics and comprehend this link through a hermeneutics of suspicion as a very fertile ground for imaginative theological reflection (Oduyoye 2001:13). Women's sexuality is at the forefront of cultural and biblical hermeneutics' reflections. This is because women's sexuality also seems to be at the forefront of culture and religion.

The Christian church informs and shapes adolescents sexuality in a biased way, the focus on sexual abstinence is enforced on adolescent girls more than adolescent boys. Just like society the church does not put more emphasis on the adolescent boys' sexuality the way it does to adolescent girls. Adolescent girls go through humiliation if they fall pregnant out of wedlock. The process of the church discipline is humiliating and infringing in a private space of adolescent girls. The trauma of experiencing pregnancy out of wedlock without the necessary support system is a challenge on its own to young women. The best the pastoral care ministry of the church can do is to give support to these pregnant girls. Rather than being judgmental the church should be welcoming and supportive.

Our observations indicate that girls and single women who fall pregnant out of wedlock cannot run away from the 'world' to the church because the church will also administer in most cases public church discipline and absolution. In heterosexual relationships a baby is made by a man and a woman or a boy and girl but in the process of church discipline, in most cases the girl is the only one who goes through this confession and the forgiveness of sins. African women's cultural hermeneutics' focus in the intersection of the gospel and culture highlight this bias, by arguing that the experiences of women in church comes with a contradiction between a sense of belonging and silencing them (Kanyoro 1996:150). One pastor explained that; 'though it is believed that both parties should go through the church discipline but boys or

men may choose to reject the pregnancy humiliating the girl even further for not knowing the father of her baby'. This indicates that some men and boys may undergo the process of church discipline on choice. The suspension from Holy Communion is mainly experienced by the woman or girl while a man who rejects the pregnancy enjoys participating in the sacrament if they happen to be in the church. This indicates that church discipline for pregnant adolescent girls is a form of implied virginity testing and like virginity testing it undermines the dignity of women and we do not see the liberative potential or anything that is life affirming from this process. Rather it destroys adolescent girls' pride and may even encourage abortion not out of choice but out of the fear of humiliation by the church. African women's cultural hermeneutics retain and promote aspects of religion or Bible and culture that are liberative and reject those that are oppressive (Dreyer 2011:7; cf. Phiri & Nadar 2010:220).

African women combine cultural hermeneutics and hermeneutics of suspicion in taking a critical stance on African culture as well as promoting its commitment to wholeness and sustenance of life in a community (Oduyoye 2001:14). As a result, the meaning and relevance of church discipline and emphasis on virginity as a sign of sexual purity should be interpreted from a hermeneutic of suspicion. Though virginity and sexuality form a part of fixed Biblical traditions, however interpretations change and they keep changing with time. Virginity testing still needs to be critically studied through the lens of the current African adolescent girls and experiences of adolescent girls in the Hebrew Bible. The liberative potential of virginity testing should be defined by African adolescent girls from their experiences in society and church. These girls should be given a platform to carefully interpret church practices that affect them, this will give them a voice in deconstructing some church traditions that have an impact on their dignity.

From a practical perspective, church discipline and the subsequent absolution following pregnancy has become a gendered practice which can now be described as patriarchal as it affects females more than males. In this view church discipline and absolution needs to be reviewed using African women's cultural hermeneutics. African women's cultural hermeneutics are against the internalization of patriarchy by adult women or Prayer Women's League (PWL) who force adolescent girls to uncritical accept gender roles. African women theologians have indicated that although women are the majority in many churches they still succumb and enforce oppressive,

patriarchal teachings of the church. Old traditional church women expect adolescent girls to respect and enforce those traditions that were introduced by missionaries which socialized women to a culture of silence and submission. Anything that does not conform to missionary teachings is associated with 'sin'. Sexual socialization in religion subordinate women sexuality to men, who own and control it by telling them when, where and how to have sex (Moyo 2004: 73). Therefore, adult women take this teaching to adolescent girls and guide them to adult womanhood through the lens of patriarchy. The church's valuing of virginity also position women in lower positions and uphold patriarchy by socializing adolescent girls and boys; women and men to believe that women ought to be taught how to have sex while men were born knowledgeable (Moyo 2004:73). The valuing of virginity should not overlook the significance of the dignity of humanity as some do not lose their virginity willingly. Some women lose virginity through sports and medical procedures (Phiri, 2003: 67; cf. Chisale & Buffel 2014). Mhlongo's (2009:63) study reveals that the traditional virginity testing through insertion of fingers sometimes breaks the hymen of those who are tested. Therefore the valuing of virginity in church may create a sense of doubt and mistrust particularly to men or husbands who may find their wives no longer virgins on their first sexual encounter, despite the sexual innocence of the wife. Also the valuing of virginity diverts the church's attention from the real social issues that affect women, children and adolescents girls such as gender based violence and sexual abuse. The church should reflect on these social ills through cultural hermeneutics, hermeneutics of suspicion and Biblical hermeneutics.

Conclusion: Tending Boundaries and Telling the Truth

This study has shown that church discipline and absolution are skewed against girls as they are the ones who cannot hide the results of sexual intercourse when they happen to fall pregnant. Observations have shown that absolution is mainly done to girls as if they pregnant themselves. The practice has been described by the girls as humiliating even though at the end it exonerates one from the public enabling one to receive once again all the graces of the church. This study also shows that church discipline and absolution can be viewed as a covert form of virginity testing as it publicly separates those who have been defiled by pregnancy from those perceived to still be pure. It can be argued that the way the church shapes and inform adolescent girls' sexuality is similar to

the way African Religion informs and shapes adolescent girls' sexuality through virginity testing as they both concentrate on the girls and not boys.

The bias of church discipline is a fertile ground for gender based violence and women abuse in communities and households. As a result, African women's cultural hermeneutics challenge the church and all religions to revisit their teachings that perpetuate gender injustice. Church discipline based on pregnancy is a fallacy that the church needs to accept. If the church is interested in abstinence, then it should carry out a survey and see the number of young people that are still abstaining. Those who fall pregnant are just a tip to show that young people are not abstaining from sexual intercourse as taught by the church. Another sign that abstinence is not working is the number of new HIV infections within the 12 to 24 year age group in Sub-Saharan Africa. Those who fall pregnant are the unfortunate ones who does what everyone else does. As a result of this study we started asking new difficult questions:

- What is the problem with sex before marriage especial if it is safe sex?
- Why abstinence?
- What is it that is being put under church discipline, is it the pregnancy since church discipline lasts the duration of the pregnancy?
- Or, is it having had sex before marriage which is then discovered through pregnancy?

May be pregnancy and sexuality should be embraced and celebrated instead of being linked to sin, church discipline and absolution. Though virginity is God given, however interpretations of virginity are socially constructed such should not be used to discriminate people.

The study therefore recommends that:

- Raising the issue of virginity has proven to be a gender biased issue that may cultivate the land for gender based violence and rape; hence instead of valuing virginity the church should value the dignity of a person. Scriptures that address virginity should be revisited and interpreted in a life-affirming and liberative way than discriminatory.
- Church teachings should facilitate for gender justice and equality and protect the dignity of both men and women. The church should not discipline its congregants but rather should be therapeutic to

adolescent girls and help them celebrate the life that a woman or girl is carrying rather than treat the baby as a sin.

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Zero Stigma, Zero Discrimination and Zero Infection: A Farfetched Dream for Botswana

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Abstract

Botswana has been hailed as one of the few African countries that has tackled the HIV and AIDS scourge head on. This is evident in the number of measures she put in place to curb the pandemic, these include among others free distribution of Anti-Viral drugs, preventing transmissions of the virus from pregnant mothers to child by rolling out Prevention from Mother to Child Transmission Programme (PMCT) to mention but a few. Despite all these initiatives new infections continue to rise and people are still dying of HIV and AIDS related ailments. The question that comes to mind is where has Botswana gone wrong? It is as a result of these recurring incidents that the paper argues that in spite of all the concerted efforts, the zero stigma, zero discrimination and zero infection remains a farfetched dream. The paper will discuss at length why the slogan is an impossible dream by looking at specifically male prisoners who have been requesting the Botswana Government to provide them with condoms because of their vulnerability within the prison cells. Secondly, sexual minorities of Botswana who survive behind the mask will be discussed. In the former, the government has refused to bend stating it was unconstitutional. Since male and female prisoners did not share prison facilities by distributing condoms they will be encouraging illegal acts within prisons designated to males. By virtue of being unrecognised by the Constitution of Botswana, sexual minorities of Botswana continue to be under constant attack from the Botswana Government and the Church. Unless these two issues are fully addressed, the paper concludes that zero stigma, zero discrimination and zero infection for Botswana will always remain out of reach.

Keywords: Botswana, HIV and AIDS, Stigma, Discrimination, Infection, Constitution, Prisoners, LGBTs, Church.

Introduction

Botswana just like many African countries has been hit hard by the HIV and AIDS epidemic. The disease which has been dubbed the ‘world biggest killer’ has caused unimaginable devastation not only to the economy but also to the social fabric of the society. Even though the disease is preventable, it has remained the most devastating syndrome humanity has ever encountered. As a result of this devastation Botswana decided to tackle the pandemic head on by establishing major strides in combating the spread of the disease. This includes among others the roll out of free Anti-retroviral Drugs, Prevention from Mother to Child Transmission programme (PMTCT), sex education to mention but a few.

However, despite these efforts, the new infections continue to be registered weekly, while children are born with the virus. It is the intent of this paper to establish why the efforts made by Botswana government have been deemed fruitless. We argue that the main reason is mainly because of some sections of the society which have been neglected and marginalised therefore, contributing to the spread instead of the curb of the disease. In the paper we will:

1. Introduce HIV and AIDS as a Botswana problem
2. Explore the milestone Botswana has covered in a bid to curb the disease.
3. Discuss why zero stigma, zero discrimination and zero infection is a farfetched dream,
4. Explore the position of sexual minorities that is LGBTs position with regards to Botswana government and the Church.
5. Assess the position of the Botswana Government vs. Male Prisoners,
6. Conclude that unless the above issues are resolved, Zero Stigma, Zero discrimination Zero infection are a farfetched dream.

Defining Terms

Before delving into the main argument of the paper it is important that we

define the two contested terms which the papers' argument will revolve around, that is stigma and discrimination. Unless these issues are addressed HIV infections will continue to rise in Botswana, hence rendering the Government efforts futile. In Botswana, sexual minorities and prisoners endure stigmatization and discrimination, hence the fight against the scourge becoming a losing battle since they are left out of the race. As a result they do not have any dignity which is 'the state of being worthy of honour or respect left in them' (*Oxford Encyclopedic English Dictionary*, 1991:403). Stigma becomes a very powerful tool to bring this group of minorities into disrepute since they are never fully considered part of the society's mainstream. Foreman, Lyra and Breinbauer (2003), concludes this discrimination is in most cases characterized by rejection, denial, discrediting, disregarding and under rating of these groups (Foreman *et al.* 2003). Botswana prisoners and sexual minorities suffer the most stigma, because most of their HIV infections are frequently associated only the disease that have severe disfiguring, incurable and progressive outcomes especially when modes of transmission are perceived to be under the control of individual behaviour (Gilmore & Somerville 1994). Furthermore, in their case being infected is perceived as a result of the transgression of social norms, such as socially-sanctioned sexual activity (Mmolai 2007). LGBTs and prisoners suffer because they are seen as outcasts and in cases where they are infected with the HIV they are prejudiced, discriminated and stigmatized because of their conviction in the former and their sexual orientation in the latter.

A study conducted by Mawadza (2004) in Zimbabwe revealed that the shame of having a disease that is strongly associated with sex generates the stigma. Hence it follows that there are challenges of stigma and discrimination especially in cases where Voluntary Counselling and Testing is employed. Stigma mainly comes from targeting marginalised groups which in turn breeds fear and intolerance to these groups in the public domain. This in turn defines their vulnerability and their ability to protect themselves from HIV and AIDS or deal with its impact.

HIV and AIDS in Botswana: A Milestone

According to WHO report Botswana's first AIDS case was reported in 1985. At the time AIDS was seen as a disease that affected male homosexuals in the west and people from African countries (Hoeywood 2014). This turned out to

be mistake on the part of the government of Botswana because the disease spread rapidly through heterosexuals than homosexuals. Gopolang Letamo (2003: 347-348) gives a detailed presentation of the government efforts to curb the disease by introducing different phases since the first victim of AIDS was found. The timeline of the phases introduced have been summarised as follows: During the years 1987-1989, the Government of Botswana introduced screening of blood in a bid to eliminate the risk through blood transfusion. While from 1989 -1997, the Botswana Government further introduced the Medium Term (MTP) where the introduction of information education and communication programmes was effected; however, the response was still quiet narrowly focused. In 1997 the response to HIV and AIDS was expanded in many different directions to include Education, prevention and comprehensive care including the provision of anti-retroviral treatment with the overall goal of not only reducing HIV infection and transmission rate but reducing the impact of HIV and AIDS at all levels of society.

The year 1999 saw the formation of National AIDS Coordinating Agency (NACA) which was formed and given the responsibility for mobilising and coordinating a multi-sectoral national response to HIV and AIDS. In 2001 Government decided to indicate a rapid assessment of feasibility of providing anti-retroviral drugs through the public sector. The programme began at the a single site in 2002, after a slow start expanded rapidly during 2004, so that around half of those in need were receiving medication by the end of the year.

There are programmes in place where there is public education and awareness. The ABC of AIDS, Abstain, Be Faithful, and if you have sex use a Condom was one of them. Furthermore radio drama like '*Makgabaneng*' dealing with culturally specific HIV and AIDS – related issues and encouraging changes in sexual behaviour. There was also work place peer counselling, development piloting and distribution of facilitators manual. Furthermore, education which targeted young people was introduced to provide education to young people with HIV education or prevention in order to protect them from infection. Furthermore, Youth Health Organisation (YHO), a non-government organisation which is run by youth conveys messages through art festivals, dramas and group discussion. School based learner's plays educating young people by introducing Botswana specific HIV and AIDS materials from ministry of education. There was also an initiative of Teacher capacity building programme developed jointly.

In 2016 Botswana government introduced a 90-90-90 programme which is a set of goals. A concept introduced by the United Nations programme on HIV and AIDS. By 2020 the government has set a target of 90 percent of people living with HIV knowing their status and 10 percent on treatment to have viral suppression. There will be a push for a test/treat initiative in which all those who test HIV positive would be enrolled for treatment regardless of their CD 4 count. Currently HIV treatment starts when ones' CD4 count is at 350 (Dube 2015). It is evident that the government of Botswana has worked very hard in curbing the spread of the disease however the disease continue to spread especially amongst the youth who are very educated and very much aware of the ramifications of the scourge. The question that remains are where has Botswana gone wrong in addressing the pandemic?

An Impossible Dream: Zero Stigma, Zero Discrimination, Zero Infections

Despite the milestone covered by the Botswana Government in curbing the spread of the HIV and AIDS the ramifications of the virus continues to surface where stigma and discrimination especially against those who are living with the disease continue to be felt across class and education divides. These new infections renders the government efforts futile making the zero stigma, zero discrimination and zero infection a farfetched dream. So far the ABC campaign has fallen on death ears, PMTCT has not yielded any results because there are babies who are still born with the HIV virus. There is high prevalence of multiple concurrent partnerships (MCP) and recent studies have shown Botswana has the highest divorce rates in Africa because of promiscuity and infidelity among partners. Information from the Lobatse High Court, Civil 2 Registry Matrimonial cases reveals 679 registered cases from January to October 2010. The most affected age group is that from the mid-thirties to 40 (Seitshiro 2010).

In Botswana there are still unequal gender relations in the country resulting in sexual exploitation in sexual relationships. The most recent to be trending is inter-generational relations which have taken a new form of 'Cougars' formerly known as sugar mummies and 'Blessers' who used to be called sugar daddies. Social media like facebook has taken the issues of behavioural change to another level. It is as a result of these issues that the

zero stigma, zero discrimination and zero infection becomes an impossible dream. Although we would like to dwell on that, the scope of our paper does not allow, however we would like to introduce the emerging issues which we believe further contribute to this impossible dream. This is the position of Botswana Government, and the Church versus the sexual minorities of Botswana and the distribution of condoms in Botswana prisons.

The Sexual Minorities (LGBTs) of Botswana versus Government and the Church

The constitution of Botswana does not recognise the existence of homosexuals or LGBTs communities in Botswana. This move we argue has in a way contributed to the spread of the virus thus contributing to the disease growing instead of subsiding. Botswana Penal code does not recognise homosexual as legal. The homosexual acts are listed in Division III: under Offences against Morality. Section 164 states that:

... any person who ... 'has carnal knowledge of any person against the order of nature' or 'permits any person to have carnal knowledge of him or her against the order of nature is guilty of an offence and is liable to imprisonment for a term not exceeding seven years'.

Section 167, continues by saying:

any person who, whether in public or private, commits any act of gross indecency with another person, or procures another person to commit any act of gross indecency with him or her, or attempts to procure the commission of any such act by any person with himself or herself for another person, whether in public or private, is guilty of an offence.

Despite being very strict on the rights of homosexuality, it worth highlighting that the Botswana constitution gives citizens of the country a number of rights, which tend to contradict the ones stipulated above. For instance in Article 3: 'every person in Botswana is entitled to the fundamental rights and freedoms of the individual, that is to say , the right, whatever race, place of origin, political opinions, colour, creed or sex'. The law leaves so

much to be desired because no matter how the penal code is read, there are inconsistencies which exclude the queer community of Botswana in the country. Furthermore, the church in Botswana does not seem to empathise with the queer community, in fact it has recently unleashed an onslaught on the queer community of Botswana.

The Position of the Church in Botswana on Sexual Minorities

Let us reiterate what we mean by the church. Considering the attitude of the church towards the Queer society in Botswana, three classifications can be drawn. Firstly, those that have opted to keep silent on the topic especially the African Independent Churches. Secondly, those who oppose while rejecting homosexuality outright, namely, the Evangelical/ Pentecostal churches and lastly those that have adopted a more tolerant stance that is the mainline churches. We are particularly interested in the second group which stands to oppose and reject homosexuality in its entirety. This is where we fit in the Evangelical Fellowship of Botswana because of the pandemonium when the Lesbians, Gays and Bisexuals of Botswana (LEGABIBO) applied for their society to be registered. For the first time, the issue of homosexuality became a battlefield where beliefs about the Devil, the Anti-Christ and the end times provide a powerful religious language through which people respond to the ‘threat’ (Van Klinken 2013:522).

There is no doubt that the EFB (composed of a group of Evangelical and Pentecostal churches) in Botswana did not want LEGABIBO to register as a society on the pretext that it was a ‘threat to the moral fabric of the society’ is homophobic. There are many pointers to these, for instance EFB see the society as ‘unholy and against biblical terms’ (*The Voice* 2013:1). As a result EFB advocated for stiff measures and penalties against the Queer society. In one of the meetings the EFB Pastors openly attacked the queer society of Botswana by saying:

Protecting lesbians and homosexuals will be a grave mistake that will instigate Botswana’s descent into self-destruction. The police should act fast to curb this vice. These people can be rehabilitated. We must pray for their deliverance (*The Voice* 2013: 1).

For his part Vice president of Evangelical Fellowship of Botswana

(EFB) Bishop Owen Isaacs claimed Christians found it very difficult to accept the society because it goes against the principles of Christianity. He says:

Homosexuality is pure abomination and the Bible clearly defines it as an evil practice, Christians do not hate people but rather they cannot accept the practices of sodomy. Some of us who believe in the principles of God can never accept such practice. The practice is not only unholy but goes against the Setswana practice (*The Voice* 2013:1).

The EFB President further saw homosexuality as violating law of God and cautioned law makers not to legalize it as that would be tantamount to ‘pandering to the whims and selfish desires of the immoral few at the expense of the national interest’ (Ibid.). It is clear he was attacking the Queer Society, he hypocritically cautioned the Church not to attack homosexuals and lesbians, but rather seek ways of assisting them where possible, for he saw them as those ‘in need’.

He concludes by calling upon legislators to properly gauge the mood of the people on homosexuality and uphold the public good and not diminish it by allowing gays and lesbians to be free to practice their lifestyle openly. He even invites the Queer society to his church, telling them ‘I say to my gay and lesbian friends that you have a place in the church’ (Op cit.). He further makes an assumption that homosexuality is a sin and concludes the church is for sinners and those who are spiritually upright because in his words everybody is a sinner whether people accept, condone or like. Worse still he puts together homosexuals in the same categories of ‘adulterous, fornicators, thieves, drug lords and drunkards who will perish’ (*The Voice* 2013). These remarks are not only inappropriate but are also disconcerting. As one would expect, remarks by the EFB leaders did not sit well with the human rights groups BONELA (Botswana Network on Ethics, Law and Aids) and LEGABIBO (Lesbian, Gay, Bisexual in Botswana). The two associations found the remarks not only malicious but threatening to disturb the very peace that EFB claims the homosexuals threaten.

It is statements like these that are damaging especially coming from the ‘men of God’ that render Government efforts futile. If the church is unable to show mercy and tolerance to the queer community, the society will continue to harbour malicious thoughts over the sexual minorities and as a result fearing for their lives and driving to them surviving behind the mask/ veil. It is this

survival behind the mask that makes the groups vulnerable hence the HIV and AIDS virus becoming rampant amongst such communities. Criminalisation of homosexuality activity thus would appear to run counter the implementation of effective education programme in respect of HIV and AIDS prevention (Johnson 2007). It is also worth noting that if the ‘men of God’ could stir so much hatred, what happens when they find the ‘other sheep’ in the midst of their flock?

In general the role of the Church is to bring peace and tranquility within the society, however what Evangelical Fellowship of Botswana had done with its damning remarks was not only contrary with the mandate of the church but was also against a minority group which needed their protection not their vengeance. After the disturbing remarks made by the three Pastors from EFB, we are inclined to conclude that the Church which is represented by EFB in Botswana has become a catalyst in propagating homophobia in a society that is still grappling to come to terms with Queerism. This move has in a way contributed to the spread of HIV and AIDS because the Queer society continues to be discriminated and stigmatized.

The Botswana Government, Inmates and Condoms

Permitting inmates’ access to condoms remains controversial among most correctional professionals (Hornblum 1988). Botswana is no exception. In fact the most debated issue which has dominated Botswana media has been whether inmates should be given condoms or not. There is sexual activity in prisons, which is male to male who have unprotected anal sex, which turns out to be the main route of HIV transmission. Whether we believe it or not one cannot ignore the fact that condoms should be provided to curb the spread of the disease because condoms have been shown to be an effective barrier in the transmission of HIV in the community (Dolan, Lowe & Shearer 2004).

In this paper we wish to argue that prisons and facilities for care should be part of the natural part to combat the spread of HIV and AIDS. According to Botswana HIV and AIDS and Human Rights Charter, Prisoners should be given comprehensive HIV and AIDS education and have the same access to preventative measure as the rest of the population. This will reduce the possibility of HIV spreading in prisons. Furthermore it maintains prisoners and other inmates with HIV should be treated the same as their colleagues and

have standard access to health care work and other facilities, including condoms. (See Section 12. Prisons and Faculties for Care e.g. Mental Hospitals and Schools of Industry).

In many countries, public health campaigns have introduced condoms to their correctional systems without resistance or adverse consequences. Since Botswana constitution does not recognise same sex relations the Government has made it very clear that it will not issue condoms to prisoners. Although the true incidence of HIV transmission in jails and prisons is unknown, but transmission has been studied before (see, Horsburgh, Jarvis, McArthur, Ignacio & Stock 1990). Of the most studies done in the United States, the results were obtained upon testing the inmates on incarceration and then repeating the test 10-15 months later in a yearly physical examination. There was evidence pointing to infection occurring during incarceration. The Former President of Botswana, Mr Festus Mogae who also heads the Botswana government –backed AIDS Council during an interview with Network Africa said ‘failure to give prisoners condoms was worsening the HIV and AIDS epidemic’. He concludes ‘if people can go to prison HIV negative and come out of it HIV positive, it means that prisons, whatever the law says, are one of the sources of infection’.

However, the Prisons Public Relations Officer, Senior Superintendent, Mr Wamorena Ramolefhe said by virtue of his department being a law enforcement agency, issuing condoms will be seen to promote an illegal activity. The only time condoms were to be issued would be if Botswana laws were revisited. He further, compared distributing condoms in prison to supplying inmates with dagga. Since homosexuality was illegal in the country, he claimed there was no way they could promote a crime by distributing condoms to inmates. After concerns were raised that prisoners in Botswana Prisons were indulging in sex after studies because they showed that were negative on incarceration, left prison without the virus came out testing positive. The prison officials do not buy the view and dismissed it on the grounds that prisons department does not have any mandatory HIV tests for prisoners prior to incarceration and after. Therefore the claims were baseless.

Despite the Prison PR opposition to jails not spreading HIV, it cannot be ignored that jails are thought to have less partnering and situational homosexuality due to the shorter term of incarceration, but higher population turnover provides more opportunities for those who are sexually active.

Transmission related to sexual activity in jails and prisons also occur, despite institutional regulations and laws prohibiting it. Isolated cases of sexually transmitted diseases occur periodically in correctional environment and wider outbreaks have been described.

The second reason given why inmates cannot be issued with condoms was that it will encourage cases of rape hence condoms were given only to heterosexuals. It is beyond doubt that sexual activities take place in a variety of ways. Rape is frequently reported, although most believe various degrees of pressurized sexual activity occur regularly without coming to the attention of correctional officers. Overt and subtle forms of pressure stemming from complicated internal prison codes of conduct make large numbers of inmates dependent on others, and sexual actions and favours often occur (Reyes 1997). Consensual sex also occurs. It is seen as less a threat to inmate or institutional security than rape and thus does not demand the attention of more violent behaviour (Saum, Surratt, Incairdi & Bennett 1995).

Sexual partnering occurs among inmates who may or may not have experienced same gender relationships prior to incarceration. Other inmates prostitute themselves among prisoners to obtain, money, food or other goods. Some prisoners are known to be sexually promiscuous for no gain other than personal satisfaction. Heterosexuals still had relations even if condoms are not distributed. Therefore, condoms do not tempt them to engage in sexual activity for they are already active.

Botswana Network on Ethics, Law and HIV and AIDS (BONELA) Director, Christine Stegling has said that denying prisoners access to condoms is depriving them of their right to health. This is in line with the World Health Organisation Global Program on AIDS (1993) and the United Nations Commission on Human Rights (1997) which have advocated for condom provision to prisoners. These organisations argue that denial of HIV prevention measures such as condoms to inmates exposes inmates and the general community to disease. No matter what the Government stance in on the issue, it cannot be denied that HIV infections do happen in prisons. Although this might not seem to be a problem to the Prison warders, the fact remains that once the inmates have done their terms they return to the mainstream society, and in some cases bringing with them the virus, hence contributing to the new infections with in the community. During an interview with Network Africa the Former President of Botswana, Festus Gontebane Mogae, made it clear that Botswana was fighting a losing battle if she promotes safe sex when

homosexuality and prostitution are illegal hence advocating for the two to be legalised.

Conclusions

In this paper we discussed how Botswana has made a milestone to curb against HIV and AIDS not only in Southern Africa but also in Africa. However, the attempts have proved futile because the paper argues there are marginalised groups of people who make Botswana the dream of Zero Stigma, Zero Discrimination and Zero Infection a far-fetched dream. The paper maintains that the criminalisation of same sex relation by the Botswana Constitution and the refusal to distribute condoms in prisons, contribute to the spread of the disease in Botswana. The LGBTs continue to be persecuted not only by the Botswana Constitution but by the Church which is pressuring the Government not to register LGBTs as a society. The influence that is exerted by the Church has spread to jails where prisoners have been denied condoms on the pretext that they were using them to perform illegal acts. Although the Botswana Government denies infections happening within the walls of prisons, one cannot ignore the fact that same sex acts are rampant in prisons making the spread of HIV uncontrollable. In conclusion the paper recommends prisons should be supplied with condoms and the new rolled out programmes 90-90-90 should be introduced in prisons so that prisoners benefit from the programme of test and treat, thus ensuring their safety especially when they join the mainstream society after their incarceration. Unless the Botswana Government decriminalizes homosexuality and distribute condoms to all prisons in Botswana, the Zero stigma, zero Discrimination and zero infections in Botswana remains a far-fetched dream.

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Zero Stigma, Zero Discrimination and Zero Infection ...

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HIV and AIDS-related Courtesy Stigma: South African Caregivers' Experiences and Coping Strategies

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Abstract

Home-Based Caregivers (HBCGs) remain significant in mitigating the impact of Human Immune Virus and Acquired Immune-deficiency Syndrome (HIV and AIDS). They ensure that despite the overloaded health care systems, AIDS patients remain cared, supported and treated with dignity in their family environments. Despite this commitment, HBCGs face several challenges which were not adequately scrutinised from the scientific perspective. This qualitative study aimed to explore and describe the HBCGs' experiences of and coping strategies with courtesy stigma as one of their work-related challenges. Twenty-five HBCGs who were identified and recruited through purposive and snowball sampling techniques took part in this study. Data which was analysed and verified revealed that caregivers are undermined, devalued and even insulted due to their association with people living with HIV. This study further highlighted several pillars of strengths which keep them doing this work despite its difficulties. Implications of the findings are engaged and recommendations drawn from the social work perspective.

Keywords: HIV and AIDS, Coping, Courtesy stigma, Home Based-Caregivers

Introduction

The scourge of HIV and AIDS in most of the African countries have resulted in strained health care facilities and overburdened health personnel, calling for immediate alternative for the institutionalisation of AIDS patients. This led to

the mushrooming of Home-based care (HBC) projects mainly driven by volunteers (HBCGs) aimed to relieve the health care system (Hayes, 2009; Young & Busgeeth 2010:2). By home-based care, the World Health Organisation (WHO, 2002:6), refers to any high quality and appropriate care, including physical, psychosocial, palliative and spiritual care provided to patients and their families within their homes to ensure hope and maintain their independence. Among the advantages of HBC is the multi-purpose role played by HBCGs in sustaining the scale-up of Antiretroviral Therapy; relieving public institutions and families from the burden of caring for PLWH; the ability to encourage patients to be hopeful; to feed, bathe, dress and walk the patients (Wouters *et al.* 2012:11; Akintola 2005:8; Akintola, 2005:2; Akintola 2005:7). In addition, HBC equips HBCGs with various skills which also help them to resolve their own personal problems (Cambell, Nair, Maimane & Gibbs 2008:163).

Despite its benefits to society, HBC is a demanding and strenuous work for HBCGs (Sigh, Chaudoir, Escobar & Kalitchman 2011:2; Department of Social Development, 2006; Akintola 2005:133). One of the difficulties faced by HBCGs is the stigma of caring for PLWH (Singh, Chaudoir, Escobar & Kalitchman 2011:2; Ogunmefun, Gilbert & Schatz 2011; Rödlach 2009:429; Van Dyk 2009: 50). Although much is known about the experiences of HIV and AIDS its related stigma among PLHW themselves, little has been scrutinised and documented around stigma incurred by HBCGs as a result of caring and supporting PLHW. This resulted in scarcity of literature around this phenomenon, suggesting that programmes and policies developed to fight it may be inefficient. Ideally HBC programmes should involve the communities and contribute towards ending HIV and AIDS and its related stigma at the community level (Wringe, Cataldo, Stevenson & Fakoya 2010:3; Steinitz 2003:57). The reality is that instead of fighting HIV and AIDS and its related stigma, HCBGs suffer from the same stigma which they are supposed to end (Turner & Mullan 1998:138). Literature suggests that instead of supporting HBCGs in fighting HIV and AIDS, community members stigmatise them (Mashau & Davhana-Maselesele 2009; Mieh, Airhihenbuwa, & Iwelunmor, *n.d.*:189; Snyder, Omotto & Cain 1999). A South African cross-sectional study by Singh *et al.* (2011:839) revealed that 49% of HBCGs caring for PLWH personally experienced discrimination for caring for PLWH. A detailed understanding of the HCBGs experiences of courtesy stigma is necessary to set

a base upon which to guide appropriate intervention programs and policies aimed at addressing HIV and AIDS stigma.

The Nature of Stigma and HIV and AIDS-related Courtesy Stigma

Stigma is a powerful and discrediting social label that radically changes the way individuals view themselves and are viewed as persons (Goffman, 1963; Link & Phelan, 2001; Petros, Airhibenbuwa, Simbayi, Ramlagan, & Brown, 2006; Visser, Makin, Vandormael, Sikkema, & Forsyth, 2009). Whereas Byrne (2000:65) define stigma as a form of disgrace aiming to discredit and set a person apart from others, Goffman (1963:3) describe a stigmatised person as someone whom we reduce into a ‘tainted and discounted one’.

Stigma is not a new phenomenon. During the seventeenth century, physical marks were used to disgrace and discredit criminals and traitors who violated norms and offending the gods and causing pollution and moral sickness (Shoham, 1970:11). In this case it was adopted as a cleansing mechanism to purify immorality and appease the gods. Slicing, burning and advertising the slaves, criminals and traitors as tarnished and morally polluted was common among the ancient Greeks (Neuberg, Smith & Asher, 2000; Major & Eccleston, 2005). The stigmatised people were avoided, especially in public places as they were unfit for regular society (Goffman 1963; Neuberg *et al.*, 2000).

Resulting from the aforementioned practice is three types of stigma: *abomination of the body*, *blemishes of individual character* and *tribal stigma* (Goffman, 1963:4; Biernat & Dovidio, 2000:100). By *abomination of the body*, Goffman refers to some physical deformities such as the visible and deteriorating body due to illness. In this case people become labelled, blamed, avoided, and even humiliated due to their clearly visible signs and symptoms which are believed to be associated with diseases such as AIDS. *Blemishes of the individual character* refer to a type of stigma which is directed to individuals because of their features such as mental illness, disability, homosexuality and others. In this case, people become stigmatised because they possess features which are different from an average person. With *tribal stigma* (which is also called ‘courtesy stigma’, ‘stigma-by-association’ or ‘secondary stigma’), stigmatisation is extended to those who somehow

associate with the stigmatised (i.e. family members, friends, care givers, colleagues etc.). Although stigma is divided into various categories, Goffman (1963:5) observed that its features are the same. Courtesy stigma as defined by Mitchell and Knowlton (2009:612) refers to being discredited for being associated with a person who has a stigmatizing illness.

The eruption of HIV and AIDS and its fears and misconceptions resulted in stigma directed to PLWH. Those who are living with or suspected to be living with HIV were seen as frightening and immoral and became isolated, humiliated and in some instances even killed because they were living with, or suspected to be living with HIV (Mlobeli, 2007; Pape, 2005). In some cases the practice was through courtesy stigma, extended to their associates who also suffered victimisation and humiliation due to their association with them (Majumdar & Mazaleni, 2010).

Stigma as Ablon (2000:3) noted, can be understood by considering the nature of the illness; its history; its attributed characteristics; its sources of the creation and perpetuation; the nature of the populations perceived to carry the illness; the kinds of treatments and practitioners required for the condition; and how individuals with stigmatised conditions cope with insults that endanger their personal identity, social life, and economic opportunities. HIV is considered infectious and AIDS is an incurable disease associated with immoral acts like promiscuity, injecting drug use, sex work and homosexuality (Snyder, Omoto & Crain 1999:121). Through courtesy stigma, HBCGs experience stigma based on this dimension due to their involvement with an incurable disease associated with immoral conduct of sex workers, drug users and homosexuals.

With the dimension: sources of stigma, Ablon (2000:3) believes that sources of stigma develops from the negative attitudes held by the general society and values which are perpetuated by the media and social interactions. HIV and AIDS is generally frowned upon by society and in some cases the family members of PLWH. These negative attitudes may also be extended to those who provide care and support to the patients.

Thirdly stigma could be understood through the nature of the stigmatised people which in the case of HIV and AIDS relates to the mostly poor and black PLWH who are from the already marginalised racial population. Here the dominant reason for stigmatising the HBCG is their affiliation with these patients who are from marginalised and poor population background.

With the fourth dimension, consideration is placed on the type of treatment and practitioners required by PLWH (Ablon, 2002:2). The drained health care systems resulted in HBCGs who are mostly women from poor background with lower educational qualifications. At the center of this is HBCGs who are poorly qualified, for being involved with this illness which drains the health care system and strain the patient with a lifetime treatment. The HBCG's poor educational level and their association with these groups earns them courtesy stigma.

Finally stigma relates to how PLWH cope with humiliation and derogatory attitudes and treatment that threaten their social standing (Ablon, 2000:2). Lack of support systems for them to cope better will further expose them and their caregivers to stigma. This basically suggests that patients who lack support will by association also expose their caregivers to stigma.

Lazarus and Folkmans' Coping Theory

Coping is a continuously changing process of cognitive and behavioural efforts aiming to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources in a person's possession (Frydenberg 2014:83; Laux & Weber 1991:235; Lazarus & Folkman 1984:141). The coping theory posits that in our interaction with the environment, we encounter stressors of which some are overwhelming and exceed our coping ability. In order to manage the stressors, we engage in appraisal which eventually enables us to adopt either or both emotion-focused coping and problem focused coping. Appraisal means we evaluate the stressful situation as either harmful or challenging and then decide on whether to address it by adopting emotion-focused coping, problem focused coping or both (Frydenberg 2014:83; Barbosa, Figueiredo, Sousa & Demain 2011:491; Ntoumanis, Edmunds & Duda 2009:251; Laux & Weber 1991:235; Lazarus 1993:238). On the one hand emotion-focused approach to coping involves modifying the meaning of the stressful event without dealing with the stressor itself (Folkman, 1984:844; Frydenberg 2014:84). A caregiver would in this instance ignore or avoid the stigma and pretend as if it doesn't exist. The problem-focused coping on the other hand involves taking actions to address the stressor itself by managing its causes. As part of our coping effort, we draw from resources such as health, energy and positive beliefs which are part of our personality features and the

problem solving skills, social skills, social support and material resources from our environment (Lazarus & Folkman 1984:159-164). In other words, how HBCGs decide to cope with stigma is determined by the outcome of the appraisal process and available resources.

Research Methodology

Qualitative research which was exploratory, descriptive, phenomenological and contextual in design was used to understand HBCGs' experiences of courtesy stigma in caring for PLWH as one of the work-related challenges and their coping strategies in dealing with it. Whereas exploratory and descriptive research designs enabled participants to express and describe their experiences openly and freely, phenomenological and contextual designs enabled them to share some of their lived experiences from within their respective working contexts.

Participants and Sampling

Participants who met the inclusion criteria were identified and recruited through purposive and snowball sampling which gave rise to twenty-five HBCGs from South Africa's Gauteng, Limpopo and the North West provinces. Eighteen of them were from Gauteng province; three were from Limpopo province and four from North West province, with 22 blacks, two coloureds and one white. Whereas participants were mainly women (a total of 22) with only three males, their educational qualifications ranged from grade nine and grade twelve.

Data Collection and Data Analysis

Semi-structured interviews contained in a five-item interview guide with open-ended questions were used to explore the participants' lived experiences of courtesy stigma in caring for PLWH within their working contexts. Analysis involved transcribing and translating the data from indigenous languages (Setswana, Northern Sotho and Zulu) to English and later followed the eight steps of data analysis proposed by Tesch (in Creswell, 2014:198).

Ethical Issues

Relevant ethical protocols were observed during and prior the process of research. In addition, permission to conduct the study was negotiated and granted by authorities from all organisations. There was informed consent document detailing voluntary participation, the participants' rights like anonymity and confidentiality clauses.

The Research Findings and Discussions

The study found HBCGs experience courtesy stigma in various forms from people who related to them in different ways. Due to their involvement with PLWH, community members suspected that HBCGs were infected with HIV; HBCGs were undermined by nurses at the local clinics and some labeled and mocked by community members. Negative reactions from both community and family members of their patients were common with some gossiping about and avoiding the HBCGs.

Working with PLWH gave some of the community members an impression that HBCGs are themselves infected.

During their visits to their patients' houses, HBCGs meet community members who suspected that they were also living with HIV since they work with PLWH.

‘What is difficult is being associated with them. Like as you interact with people living with HIV, people tend to think that you are somehow affects you directly and you cannot do this job unless you are also HIV positive...when you walk equally with them, they tend to remain behind because they tend to say, let not people see me walking with this person because if they see me I am going to be associated because he is working with [PLWH]’ [Mokete].

‘They diagnose us through the families. When we going to the families to care for the sick then they just think, they think these people [HBCGs] are caring for the sick patients diagnosed with HIV, it means they are also diagnosed...’ [Lenong].

‘As you see my body is so small, people would say, there is no way that this person can work with [PLWH] if she is not sick herself; she also has AIDS that is why she is working with [PLWH]. Or when they see you coming to the hospice, they would say it means she also has AIDS’ [Lenyalo].

‘... I do this work, and the moment you do this kind of work, they would think that you are also sick. Yes there are those who are sick but they tend to believe that everybody who do this kind of work is sick. They would say we help these patients because we are also sick’ [Jini].

HBCGs are given negative reactions by household and community members

Negative reactions from the patients’ family and community were some of the difficulties faced by HBCGs due to their involvement in HIV and AIDS:

‘The way they [family and community] talk to us and the way they look at us we can see that we are not welcome. When you explain that you are so and so from hospice, they won’t wait for you finish, they would just say, I am busy. I won’t be given a chance to even explain the purpose of my visit’ [Selinah]

‘Yes it happens once you stop the car, then you getting in, especially if you want the address, is this address 1281, no no no [reaction by a household member], you are working with those people with HIV, please don’t park next to our gate, we don’t have an HIV positive person in here. They just say before you even ask’ [Lenong].

‘I remember the [nurse] asked me once to identify families with new born babies and call the parents to come and collect some milk at the clinic. I happened to find myself in a house where I found this man ... and he told me that his child does not eat milk for HIV-positive people’ [Kgomo].

‘One thing that I don’t like is that the moment I enter in a particular

household to execute my duties, you find that you are not taken serious by the family members – the parents and siblings of the patient. They will answer me in such a way that I get hurt. So, if you ask them to prepare some water, a child or a wife will ask me what for, while knowing very well that I am here to bath their father or husband' [Martin].

'...Some as you enter they would increase the volumes on the music and TVs, they won't even give you chairs nor welcome you. They would say, Your person [the patient] is not here... the family would make statements like these people who come here every day are embarrassing us because of you [referring to the patient]' [Dineo].

HBCGs are avoided by community members, patients' families and the patients themselves

What emerged from the participants' narratives was that community members, the patients and their families avoided them due to their HIV and AIDS work:

'As I knock, they [patients' family] would invite me into the house and as I enter they would respond to my greetings and then vanish as if they are going to fetch something outside without saying a word. I would only realise after some time that I am alone' [Pekwa].

'Okay there is a funeral or wedding. You come in on Friday and the family have given some women from the neighbourhood some vegetables to prepare for the wedding or funeral, you... find that they were talking about you and your work. So the moment you take a cabbage and try to assist in peeling, people will mumble and go as far as to ask all of those who were with you in a group to join their groups. So, you will eventually find yourself peeling the whole bag alone' [Pekwa].

'Yeah, they don't want to be associated with me because they know I am involved with [PLWH]' [Paul].

HBCGs are called names due to their involvement with PLWH

Among the HBCGs' experiences was name-calling which they earned out of their caring work:

‘So, when they see us walking they would say, this ones are working for KFC [a derogatory term implying that they are working with PLWH]’ [Mokete].

‘And when we go out for field work, there is a name that we are called with called ‘boMmamakaka [mothers of shit]’ [Selinah].

‘When people see us wearing our t-shirts, they make hurtful comments like, here comes the HIV people’ [Amelia].

People gossip about HBCGs who are caring for PLWH

Community members are reported to be spreading rumours through gossiping about the HBCGs and their work:

‘...I once heard people saying, you see where [Pekwa] is working, they bath HIV-positive people and remove the napkins, so you would never know whether when they do that they put in some gloves or not’ [Pekwa].

‘...she has been bathing patients for sixteen years..., she might be HIV [positive], she might be full-blown [reached AIDS stage]...’ [Lenong].

‘Community members have a way of spreading the news [about HBCGs]. Gossipmongers spread the news and there is no way of running away from it [Zulu].

HBCGs are Mocked by Community Members

Mocking by community members took a center stage in HBCGs' narratives:

‘...Let us say is a group of boys or these women who play some cards under a tree in a family where you are supposed to go in. As you enter

they would begin laughing while you are still at the gate. Yeah, and you could see that they are not laughing at what they are busy with, they are laughing at you. And even as you get closer to them and begin to introduce yourself, they would continue to laugh and ask funny questions' [Nakedi].

HBCGs feel undermined by nursing staff from the clinic

Among the reported experiences of HBCGs was being undermined by the nursing staff from the clinics:

‘Sometimes sisters [nurses] undermine us because we are the caregivers. Mainly as we do our job, we would come across some patients who needs to be taken to the clinic and once we arrive at the clinic you would find sisters who would undermine you as a caregiver because our work is an odd one...’ [Jini].

Contrary to those who reported their experiences of courtesy stigma, it emerged to some that community members were welcoming and appreciating the HBCGs.

‘They were calling us the healers. We were at one of our patient’s gate and one woman passed across us and said greetings to you healers. You really heal people’. Then she just passed. So we often get those kinds of words. Yes even the concerned neighbours they know. Some would say my other cousin was helped by care givers and when she realise that there is a patient, she would go and advise them to contact us’ [Mpshe].

‘I think the community appreciates my work....Sometimes I would be doing my visits to the patients and a woman would just call me and say I see you are wearing black and white [a uniform), there is a patient in so and so address... That to me shows that the people are realizing the importance of our work’ [Pekwa].

‘People know what our uniform looks like. I have already explained that many people know about [our work] They give me respect and they have accepted me. Sometimes people treat me like a fully-fledged

[qualified] nurse. They respect me and they give me dignity’ [Zulu].

The Coping Strategies Adopted in Overcoming Courtesy Stigma

A picture which was painted by the participants in coping with courtesy stigma was a multifaceted one involving to simply ignore the negative treatment and continue with their daily tasks, withdrawing from relatives and spending time with their own families, receiving support from management and other professionals, educating the community on the importance of their work as well as by simply leaning on God.

HBCGs cope by simply accepting the status quo and continue with their work

For some participants, the experiences of courtesy stigma did not bother them. They continued to serve their patients as if they do not have any challenge:

‘People have spoken about me but I have told myself that I am not going to allow them to destroy my spirit. I just leave them and say, if I work with PLWH and I am HIV positive is fine...’ [Lenyalo].

‘I am not sure but even if they can say this and that gossiping, I am not afraid of what they are going to say. I am going to continue doing what I am doing’ [Letsatsi].

‘I am ignoring that, and especially because...is not necessary to tell them that I am not HIV [positive] I was tested I was never diagnosed...Is not my duty to say that...’ [Lenong].

‘In this stage of my life I feel like I am living my own life and I don’t care what they feel. If I feel like I want to care for another person why not? I have had some reactions before from them over the years. I will just do my own things’ [Paul].

‘I do not take it as personal. We know how patients react towards mem-

bers of the community, so in that case I am also a member of that community. So I do not take it personal, I tell myself that I will come again tomorrow until they welcome me' [Dineo].

A HBCG cope by withdrawing from the relatives

Withdrawal from gatherings where relatives would be there was reported as one of the strategies to cope with stigma:

‘...So I try to avoid getting closer to extended family members and relatives because once you associate yourself with them, they develop a negative attitude towards you. They look at you in a negative light and begin to think that you will infect them. I just think so, that is my thought that is why in most cases I do not care about them. I only meet them when there is a specific issue that requires me to be there and I go there just to deal with that issue and leave’ [Mokete].

A HBCG cope through support from management and colleagues

In other instances, management and colleagues were reported to be playing a crucial role of supporting HBCGs to cope with stigma:

‘We have superiors. Like today, is the day for lectures. We don’t do home-visits. At 4, we attend the MGM meeting [Monday General Meetings]. We discuss challenges that we encounter when we do home visits. It is where we tell our superiors about the challenges that we encounter our superiors give us guidance on how to react to different situations’ [Zulu].

A HBCG cope through some help from other professionals

Lenyalo explained how other professionals assist her:

‘There is a professional nurse who tries to support us. most of the time when we encounter these problems we share them with her and she would go out with us and as we enter the households, she would explain to them nicely that we are working with [PLWH] and if we work with this people it does not mean that we are also infected...’.

Caregivers cope by educating the community about their work

In coping with the negative treatment, HBCGs decided to educate the community about their work:

‘...I then started to clarify that with other members of the community by saying, if I am visiting you, it does not mean that I have come for HIV and AIDS’ [Kgomo].

‘Well, in most cases we try to educate the people because that is the main part that we are trying to do because there is no other way that we can reduce the stigma in a community besides through education’ [Mokete].

Caregivers cope by simply leaning on God

What emerged as one of the coping strategies to address the stigma was the HBCGs’ belief in God. They believed that it was through God’s will that they found themselves caring for PLWH:

‘You console yourself by saying even if she closed the door for me, she is sick and one day I will come for her. And because God is there with us, you would even find that they would call you for the same patient [Cassie].

‘The person who helped me was the pastor. We have a pastor here and she would read scriptures in the mornings and revive our spirits... I told myself that God is there, I am going to help them and I did this course because I like it’ [Nakedi].

‘[If] it was not for God, I would have quitted long time ago, is because God is good for me, so, yeah’ [Paul].

‘We are also in that diagnosis. For us is a calling God allocated us to do that’ [Lenong].

Discussion

The findings of this study revealed that HBCGs experience HIV and AIDS-related courtesy stigma, a revelation found in some existing literature (Ama & Seloibe 2011:2; Akintola 2008:362; Akintola 2005:15&16; Bennet, Ross & Sunderland 1996:145). In line with the source of stigma as one of the dimensions identified by Ablon (2002:4), participants' experiences of courtesy stigma were found to be in various forms and from various sources such as members of the communities where the patients were residing, nurses from the local clinics wherein they used to refer their patients and family members of the patients. HBCGs' association with PLWH created an impression around the communities that they are also HIV-positive and were therefore blanketing their HIV-positive statuses by simply being involved in caring for PLWH. This perception earned them negative attitudes and negative reactions from members of the community with some avoiding them whenever they show up. This finding supports what was found in Akintola's (2005:15&16) South African study of the role of HBCGs in HBC for PLWH wherein being visited by a caregiver was attached to stigma, resulting in caregivers being rejected by their patients' families. For Rödlach's Zimbabwean (2009:428) study, families of the patients went as far as to hide their sick patients whenever the HBCGs were around. In another Mexican study aiming to explore the perceptions and experiences of HIV-affected caregivers concerning HIV-related stigma, Poindexter and Linsk's (1999:50) revealed that participants experienced stigma from their friends and families. A South African study which addressed factors most likely to facilitate or hinder mobilisation of community resources by Campbell *et al.* (2008:512) found that in some cases stigma manifested itself through caregivers who would walk distances to houses rumoured to have patients only to be turned away by the families.

The findings in relation to the participants' experiences of stigma from the clinic nurses were not a new revelation by this study. In his Botswana study focusing on the challenges and bottlenecks affecting the referral system, Kang'ethe (2009:60) revealed that medical staff had negative attitudes towards the HBCGs and their patients. This was contrary to Singh *et al.*'s (2011:843) revelation wherein HIV and AIDS caregivers reported support from the nurses leading to willingness to care.

Evidence pertaining to name calling HBCGs was found to be in support of Akintola's (2005:13) South African study where participants

received nasty comments and called names like ‘Good Samaritans’ who waste time through volunteering by members of their communities.

Besides having gone through these odd experiences, it also emerged from my study that not everything was doom and gloom as participants reported some appreciative attitudes and reactions from members of the community, a revelation corroborating with the findings by Chimwaza and Watkins (2004:805) where community members provided support to caregivers.

Despite having to go through these difficulties, HBCGs were not deterred from caring for their patients and families. They manipulated their ways out of these difficulties through a variety of coping mechanisms which both confirmed Lazarus’ and Folkman’s emotion-focused coping and problem focused coping (Barbosa *et al.* 2011:491; Ntoumanis *et al.* 2008:251; Laux & Weber, 1991:235; Lazarus, 1993:238). Problem-focused coping aiming to address stigma became evident from one participant [Mokete] who decided to draw skills from his resources by educating the community on the importance of their work. Emotion-focused coping was also adopted and enhanced by available resources where participants decided to use people like management, colleagues and other professionals as resources to help them cope better with stigma while some opted to simply ignore the status quo and proceeded with their work as if nothing happened. Although positive belief may have emerged as one of the resources used, it was particularly evident when they highlighted their faith in God as one of the adopted coping strategies.

Conclusions

This study attempted to expand the pool of literature around HIV and AIDS-related stigma. It cautioned us that the fight against this epidemic is not yet over. In support of some of the existing studies, it has shown that the plight of HBCs who are supposed to contribute in ending this scourge has turned them into victims of the very stigma which they are supposed to fight. Communities served by these HBCGs and families of the patients were particularly found to be the main culprits. It is however not all of these communities and families that were found to have frowned upon the HBCGs because of their involvement with PLWH; some were touched by the courage and dedication of these men and women to such an extent that they would even offer them

respect by participating in the HBC program through making referrals. As much as it has shed some light on the experiences of HIV and AIDS courtesy stigma by HBCGs, it is crucial to interpret these findings with caution since it involved a sample of only twenty-five participants from South Africa's three of the nine provinces.

This study has shown how HIV-related courtesy stigma interferes with the HBCGs' daily operations. It has shown that unless their challenges, with stigma are addressed, they will find it difficult to successfully fight the scourge of HIV and AIDS epidemic. It is on this note that the following recommendations are made:

- Programmes should be designed by professionals like psychologists and social workers to specifically support the HCBGs to overcome their challenges with courtesy stigma.
- Community education programs must be rolled out throughout the communities to educate the communities on the significance of HBCGs and their roles within the society. These programmes should also empower the communities to also take a responsibility by being involved in HBC programmes.

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Pastoral and Bio-medical Responses to HIV and AIDS by the Lutheran Communion in Southern Africa (LUCSA): Case Study of the Thusanang HIV & AIDS Project and Manama Mission Hospital in Zimbabwe

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Abstract

This article is an exposition of the Pastoral and Biomedical Responses to HIV and AIDS programming by LUCSA. This was done through engaging with members and workers of the church regarding their experiences of Home Based Care (HBC) training as a way of managing and holistically responding to the HIV and AIDS epidemic. This study explores the impact of the training for caregivers, nursing staff and pastors in HIV and AIDS management through a case study of the Thusanang HIV & AIDS project and Manama Mission Hospital of the Western Diocese of the Evangelical Lutheran Church in Zimbabwe (ELCZ) in Gwanda South. The study concludes that skills training in HBC and Palliative Care have made a positive and remarkable impact on the lives and work of HBC givers and pastors and that such training has contributed to the retention of caregivers.

Keywords: HIV and AIDS, Biomedical. Palliative Care, Pastoral Care, Stigma, Lutheran Church in Zimbabwe, Home-based Care.

Introduction

There is a growing need to care for people living with HIV and those affected

by the AIDS epidemic which has resulted in an increased demand for the recruitment, motivation and training of voluntary caregivers. The HIV and AIDS epidemic has put a heavy burden on communities and public health facilities especially in the global south, in countries like Zimbabwe, reducing effectiveness in providing standard health service delivery. In light of the above, caregivers have been trained in various skills and capacities for Palliative and Home Care. However, the impact of the training given to caregivers has not been fully assessed and evaluated to date. As a result, four key questions were posed in the survey:

1. To what kind of training have the care-givers, nurses and pastors been exposed?
2. How does the church work together with its public health institutions and faith-based organisations in reducing the impact of HIV and AIDS?
3. What is the impact of training on the work and personal lives of caregivers?
4. How has such training impacted on HBC volunteer retention?

The study builds on the hypothesis that palliative care and Home care training have made a positive impact on the work done practically by HBC givers, and even on their personal wellbeing and retention as caregivers.

Methodology

The study adopted the methodology framework of the Creative Associates International based on USAID's training impact evaluation methodology developed in 1991. It is a framework that defines impact as 'the economic, social and political change that results from an intervention altering the quality of life for a nation or a designated subset of the population'. In principle, the evaluating impact should measure or estimate the economic, social or political change induced by an intervention; determine the extent the change was attributable to the intervention; estimate the extent the intervention was critical to the change; reveal how and why the change occurred; and assess the role played by internal and external factors (USAID 1991). It is fundamental also to note that this theoretical framework builds upon the notion that 'impact or

induced change occurs at various levels from the individual trainee through the institution, sector, nation and occasionally, the region' (USAID 1991). Such levels can be interrelated. Also, when a change is identified, a link to the training intervention must be established to draw inferences that the training was related to the change – bearing in mind the question that 'can the change be attributed to the training received? Or is there any likelihood that the change would have occurred without the training?

Therefore, to establish the effectiveness of training and its impact on HIV programming, this study used mainly primary sources, with the questionnaire being the main instrument which was administered to a sample of 120 trained HBC givers and pastors. We did not manage to interview the nursing staff because of a lack of time to obtain the required Governmental approval of such communication from the district to provincial levels. Therefore, the analysis of the report on the biomedical response by the hospital was based on annual hospital reports from 2010 onwards. The hospital began to effectively engage in HIV management including the distribution of ARVs around 2009. Thus, the impact and change resulting from the trainings would be assessed based on the statistics documented in the annual reports, including for example, the percentages of condom uptake, voluntary medical male circumcision, response of male partners on PMTCT, and the total population of men, women and children on ART, to mention a few.

Also, FGD guides were used to gather some qualitative data from the caregivers, and Interview Guides were used to collect qualitative data from Key Informants such as church leaders and hospital administrators.

Six wards out of the 11 that Thusanang covers in Gwanda South were randomly selected for the survey. Twenty questionnaires were administered in each selected ward, where about 15 respondents were both practicing and retired caregivers, and at least 5 were both retired and practicing pastors of ELCZ and other partnering church denominations. The survey population was gathered using stratified random sampling in which was wards and zones. The individual interviewees were selected on the basis of their role in the church and or church-run institutions.

Data Analysis and Presentation

The data collected was processed and analyzed through editing, coding and

entry using Excel. We analyzed qualitative statements using matrices and tally sheets. The statistical data was analyzed and evaluated qualitatively.

Literature Review on HIV and AIDS and Lutheranism in Practice – Towards the End of a Witch-hunt in a Lutheran Way!

HIV and AIDS around the Globe: A Scourge against Humanity – A Wake-up Call for Holistic Action!

HIV and AIDS continues to cause a complex development crisis – with social and economic consequences felt widely in health, education, industry and agriculture, to mention a few. The epidemic poses a threat to health and life – with an estimated sixteen countries in Africa having more than a tenth of their adult population aged between 15 and 49 being infected with HIV, with the highest prevalence rate recorded in Sub-Saharan Africa (UNAIDS 2012). As a result, AIDS continues to be a key threat to human life especially in Sub-Saharan Africa. Life expectancy has fallen, the number of orphans continues to escalate, and family or community structures are weakened or destroyed. Increasing financial costs for caring for both the sick and affected cause a strain on already struggling national economies. Some have argued that the pandemic is much more deadly than war itself – in 1998, 200,000 Africans died in war, but more than 2 million died of AIDS (Regan 2002; Jackson 2012).

The United Nations once predicted about a decade ago that about 9 million people would be infected by HIV, while about 5 million would die of AIDS. A more current version of the global statistics (UNAIDS 2015) on HIV and AIDS is summed up as follows: 17 million people were accessing antiretroviral therapy, 36.7 million people globally were living with HIV, 2.1 million people became newly infected with HIV, 78 million people have become infected with HIV since the start of the epidemic and 35 million people have died from AIDS-related illnesses since the start of the epidemic.

The information provided by UNAIDS indicates that AIDS will remain more of a pandemic than a simple epidemic – which therefore challenges actors like the Church to strategize on how to keep on track in the quest for zero new HIV infections, zero discrimination and zero AIDS-related deaths. UNAIDS Research data has exposed us to the realities of the impacts of the pandemic as felt differently along and across gender lines, and also

among children. It, therefore, calls for an engendered approach to HIV and AIDS management and programming. This Lutheran community has to address critical issues such as domestic violence, child abuse and human rights abuses into context as these detrimentally affect decision making of the victims and result in an even greater risk of HIV infection. It is also fundamental for the church to consider the effect of the mobility of youths within countries and across national borders as research has shown that migration exposes the youth to promiscuity and sexual abuse in the quest for a better life (Jackson 2012; UNAIDS 2015).

HIV and AIDS in Zimbabwe

Zimbabwe has the fifth highest HIV prevalence in Sub-Saharan Africa, at 15 % (UNAIDS 2016). There are about 1.4 million people living with HIV in the country, including 170, 000 children, equating to 4 % of the global total (UNAIDS 2014; AVERT 2016). New infections dropped by 34% between 2005 and 2013, with behaviour change communication and ART Adherence thought to be responsible for the decline. However, there were still about 69, 000 new infections in 2013; about 64, 000 deaths due to AIDS-related illnesses; and about 89, 000 children being orphaned due to the AIDS pandemic (GARPR Zimbabwe Country Progress Report 2014). Of the most affected populations by HIV in Zimbabwe are the homosexuals (though homosexuality is illegal in the country), the sex workers (with around 50-70% found in Victoria Falls, Hwange and Mutare), and women (about 720, 000 of whom 70, 000 are pregnant) (ZIMSTATS, 2012; UNAIDS, 2014; AVERT, 2016). Research has also shown that the patriarchal society in Zimbabwe has helped in explaining women's greater vulnerability to HIV (UNAIDS 2016). As for the young population (aged 15-24 years), 41% are living with HIV; and only 52% of young women and 47% of young men do have comprehensive knowledge about HIV, thus limiting their ability to engage in safer sex (UNAIDS 2014; AVERT 2016).

In response to the Good News of God's unconditional love for all people the church is called to respond with compassion to the desperate situation of women and children in Sub-Saharan Africa and beyond, who are affected by the HIV and AIDS pandemic – As companions in God's mission, organizations like LUCSA, the Church of Sweden and the Evangelical

Lutheran Church in Zimbabwe, support each other in responding to the epidemic.

The Identity and Role of the Church of Sweden

The Church of Sweden is an Evangelical Lutheran faith community with the task of holding services of worship, teaching, and carrying out Diakonia and mission activities (CoS 2013). The Church is a place for reflection and communion, and also for social and spiritual support. Therefore, in its international work, the Church of Sweden is a highly recognized actor in humanitarian activities and development cooperation. The Church's international work has special responsibility for tackling the global challenges of our time, including HIV and AIDS, in cooperation with other churches and ecumenical organizations (CoS 2013). This is done on the basis of the belief in a God who takes the side of those who are oppressed or live in a vulnerable situation and in which faith, life, burdens and experiences are shared. In principle, the work done by the Church of Sweden is based on the theology that is responsive towards what people need, inspiring the world to tackle the challenges affecting humanity. This means taking a stand for the promotion of human life and creation of hope for the future. Therefore, it is on the basis of such attempts the Church has facilitated the establishment and running of both Faith-Based and Community-Based Organizations like Thusanang HIV and AIDS project in Gwanda South, Zimbabwe.

The Identity and Role of the Lutheran Communion in Southern Africa (LUCSA)

LUCSA is a voluntary non-profit making fellowship of 15 autonomous and independently constituted Lutheran churches in 10 countries of Southern Africa, namely, Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe. The organization understands itself as a sub-regional expression of the global communion of the Lutheran Church within the Lutheran World Federation (LWF). It supports and initiates diaconal programmes and projects that seek to alleviate human need and to promote justice within member churches and assist them to act jointly to achieve common tasks. LUCSA is an instrument of the member churches

for coordination and support – with its task of fostering reconciliation, promoting social and economic justice and human rights and responsibility for Creation (LUCSA Constitution).

LUCSA and HIV and AIDS Programming: Putting THOUGHT and VISION into PRACTICE from both a Theological and Biomedical Approach!

In 2003, the LUCSA Council mandated the LUCSA Communion Office to coordinate and build the capacity of all member churches for effective strategic planning, implementation, monitoring and evaluation of their responses to the pandemic. The development came as a result of the Campaign held by the LWF in 2002 to ‘Break the silence on HIV and AIDS’ and the need for Care and Support for PLHIV mainly in the church. In response to the mandate, the LUCSA AIDS Action Programme (LAAP), was launched in 2003 to address various social problems resulting from the HIV and AIDS pandemic. One of the notable achievements of the LAAP was to ensure that all of the LUCSA member churches have HIV and AIDS desks and have broken the silence surrounding the pandemic (LUCSA HIV and AIDS Programme 2014). This has been evidenced by a number of Faith-Based Programmes and Projects that are engaged in the quest to reduce the strain caused by the pandemic through Orphan Care and Home Care for AIDS patients.

LAAP also seeks to work with church leaders, individual practitioners and organizations actively engaged in HIV and AIDS programming. This is done in line with the Strategic Plan (2013-2017), which requires results-based management of pandemics (LUCSA HIV and AIDS Programme 2014). The programme realizes and encourages the need for the mainstreaming of HIV and AIDS in word, action and deed. After the adoption of the mainstreaming concept, LUCSA ensured the improvement of the personal wellbeing of PLHIV and those affected by the pandemic through encouraging practitioners and actors within the scope of LUCSA’s work to cater for their spiritual, physical, psycho-social and economic-livelihood needs (LUCSA Statements of Needs 2013).

LUCSA is a vital arm of the Lutheran Communion operating as a Pan-African and global organization. LUCSA appreciates the role played by church leaders and the few mission hospitals run by the Lutheran Church, as it

also considers the importance of collective, inclusive and consultative approaches to HIV programming as no single country or organization can respond in isolation to HIV and AIDS programming. LUCSA encourages the Lutheran community to interact with other relevant stakeholders, including their national governments in response to the pandemic. The Lutheran church responds to HIV and AIDS through its mission hospitals who pursue biomedical initiatives like Voluntary Male Circumcision, PMTCT, STI or Opportunistic Infections Control and Management, ART Adherence and Compliance, and VCT. The church and its institutions played a major role in advocacy and lobbying the government in order that the church institutions and hospitals become roll-out points to increase access to ARVs. However, Faith Based Organizations and Parishes under the Lutheran Church need to scale up their efforts regarding pastoral and spiritual care and support, Home Based Care, Psychosocial Support for youths and OVCs and nutritional support for PLHIV. LUCSA has engaged pastors and leaders of HIV programmes or projects in workshops and training on capacity building, strategic planning and Clinical Pastoral Care.

The Identity of the Evangelical Lutheran Church in Zimbabwe (ELCZ)

The ELCZ has three Dioceses, namely, Central, Eastern and Western, each under the administration of a Bishop. The position of a Presiding Bishop rotates from one Diocese to another over a period of five years. Within the Dioceses, there are two Deaneries, each headed by a Dean. All the church parishes within a Deanery report to the office of the Dean, who in turn reports to the Bishop. The Bishops, Deans, Pastors-in-charge of Parishes, the General Secretariat and Management of the ELCZ Head Office, administer all the church institutions from a tripartite approach, offering Evangelism, Health and Education to the Zimbabwean communities and beyond (ELCZ Constitution). Each Diocese has a right to develop medical and Education policies for their institutions.

One of the broad aims of the ELCZ is to take care of the sick and suffering and exercise the ministry of the helping hands of Jesus (Diakonia). It is in this regard that the ELCZ derives its responsibility to participate in and complement the efforts of National Government in the provision of effective public health to the communities in question. The ELCZ runs and administers

faith-based HIV programming and the hospital health service delivery, including for example, Thusanang HIV and AIDS Project and Manama Mission Hospital in the Western Diocese; Betseranai HBC project and Mnene Hospital in the Central Diocese, and Tariro HIV and AIDS Project in the Eastern Diocese.

Research findings

Research Demographics

Of the respondents who participated in this study, the majority were females (90%) and (10%) males, with most of them falling between the 19 and 55 year age bracket. Those aged between 40 and 55 years constituted a larger percentage of the total number of respondents (88%). The respondents above 55 years of age constituted 12% of the total respondents. A closer analysis of this statistical demographic distribution indicates that fewer young people pursue care work, as they are very active with other priorities including taking care of their own children and are occupied with studies, work and business. The male percentage representation is lower than that of their female counterparts because of aspects relating to culture and tradition, among others. This means that a lot has to be done by the church to lobby and encourage male involvement in HIV and AIDS.

In terms of marital status, most of the respondents were married (60%), and of these 95% were female and 5% male. 30% of the respondents were widowed, and 6% were single while 4%) were divorcees and 98% of these were female. This data implies that many women in the research area are widowed most probably because of AIDS-related deaths. This has resulted in many women joining the HBC program in larger numbers.

The church has to do a lot to have its ministers practically engaged in HBC programming, by conscientising the women and men of the clergy that HBC is more of a call and tool for effective pastoral ministry and the growth of the church. This implies that the HBC concept has been voluntarily pursued by those with low literacy levels, a situation which challenges our church today to lobby and campaign for more engagement and participation of the literate population in HBC programming. It is critical to note that those who are educated often seek better paying jobs therefore much more needs to be done to enlighten the Christian community about the true essence and nature of HBC

as more of a calling than anything else. The disparities noted in terms of gender and literacy levels point to the effects of traditional and cultural ideologies that suppressed the progress of females in the context of educational attainment and job pursuits.

Most of the respondents' households had over three persons (85%). The majority of the households (80%) had 2 and 5 household members aged below 18 years. This indicates a higher degree of dependence ratios among most of the households, with an adverse effect on the economic wellbeing of the households. Also, the study found that at most each household supported 3 or less orphans (60%). This also points to the fact that the household heads are burdened with the challenges of caring and supporting the OVCs.

The study also established that farming, especially growing of crops and animal husbandry, constituted the major source of income among the respondents (75%), followed by informal trading (15%), menial or piece jobs (6%), and salaried jobs (4%) as the smallest category. The implication here is that the area in question is an agrarian region which takes an agro-based response through subsistence means. Zimbabwe's economy has of late become more informal with increased engagement of its citizens in small businesses. The country's unemployment rate has continued to escalate. The fact that only a few HBC givers earn a salary to sustain their lives is a challenge to the church when it comes to motivating more volunteers who are not on a salary to join HBC. Also, the study discovered that most of the respondents' income per month was below US\$100 (98%), pointing to the fact that it is really hard for the respondents to cope with the daily needs for themselves and their families. More has to be done to motivate and retain caregivers despite their low monthly incomes.

Pastoral Response to HIV and AIDS by LUCSA: A Case Study of Thusanang HIV and AIDS Project

The Background Role of Thusanang HIV and AIDS Project

Thusanang HIV and AIDS Project was initiated in 1993 with funding from Church of Sweden (CoS) as a programme of the ELCZ Western Diocese. The project envisions a society that is free of HIV and AIDS, through its commitment to capacity building for its membership, partners, local communities, and PLHIV – through motivating them to respond positively

towards the pandemic. The name of the project sums it all – ‘THUSANANG’ – a Sotho version of ‘HELP EACH OTHER’. Thusanang seeks to lobby and motivate individuals, communities and other stakeholders to work together in the face of HIV and AIDS and other adversities. The Project covers two neighbouring districts of Gwanda and Beitbridge in Matabeleland South province, and is being implemented in 11 wards in Gwanda District and 3 wards in Beitbridge.

The Thusanang Project focuses on three thematic areas, which are:

- i. Home Based Care (HBC);
- ii. Care of Orphans and Vulnerable Children (OVC); and
- iii. Information, Education and Communication (IEC) about HIV.

Thusanang does management of HIV and AIDS through Home-Based and Palliative Care is done in a consultative, inclusive and holistic way. Communities have been capacitated in the caring and support for chronically and terminally ill clients, through training community volunteers on HIV and AIDS Management, and basic HBC concepts. The project has also advocated for attitudes of acceptance regarding PLHIV among community members with the view of reducing HIV and AIDS related stigma, shame, denial and discrimination. Through community volunteers (caregivers), and in partnership with relevant stakeholders including AIDS Service organizations, the Church (ELCZ and other denominations), and also government structures, have encouraged the formation and running of PLHIV Support groups and Income Generating Projects (IGPs) such as keeping of poultry, goat rearing and nutritional gardening.

Under ‘Care and Support for OVCs’ the project has largely focused on the provision of basic needs such as education, health, shelter and birth registration. Thusanang has also been engaged in livelihoods development initiatives and Psychosocial Support Services (PSS) for youth. Thusanang has placed youth at the forefront of a holistic response to HIV and AIDS, considering the fact that the youth are very mobile, and the ELCZ Western Diocese is geographically located close to the borders of Botswana and South Africa. Many of the youth move to these neighboring countries in search of jobs, which is not always found to be the case! Research and reality have shown that many return home either pregnant (girls), sick, or even dead!

Through IEC, Thusanang has disseminated vital information using various channels in the Church, the Local Authority and the community at large. A number of platforms such as community meetings, training workshops, roadshows, and also participation in AIDS Awareness activities like World AIDS Day, have been used to ensure more effective IEC programming on HIV and AIDS.

Thusanang HBC Program realizes the growing need for caring for ailing patients suffering from AIDS-related illnesses, and also support for the OVCs and the elderly. The holistic approach to HIV and AIDS programming and management through voluntary caregiving by Thusanang includes: Psychosocial support, Youth Peer Education, Nutritional counseling, Spiritual counseling and support, Adherence and Compliance to ART, PMTCT and Referral mechanisms and other related services.

It is important to mention that much of the work done by Thusanang largely depends on the funding provided by the Church of Sweden. LUCSA has also played a significant role in capacitating the Thusanang Project Administration staff, and also the Church Leadership through Pastoral Clinical Training, training of carers as well as the youth OVC peer educators.

HIV and AIDS Programming at Thusanang Project

The Nature and Frequency of Training Provided within the Church and Thusanang

The study found out that there is a plethora of HIV-related training activities and initiatives, mostly pursued and done under Thusanang. These include Home Care (100%); Palliative Care (90%); Counseling (85%); ART Adherence (80%); Hygiene (65%); Nutritional Support for PLHIV (60%); and Life Skills Development (55%). The above data indicates that Home Care is the most predominant course that respondents have undergone. 100% of the respondents confirmed that they have been trained on Basic Home Care for ailing patients, and the affected. It proves therefore that the church, through its HIV projects like Thusanang, pursues the fight against the pandemic through HBC programming, which holistically addresses the issues affecting humanity. This is done when spiritual and psychosocial needs of the affected are contextualized, including giving attention to the bio-medical response to the pandemic.

Degree of Uptake of Training by HBC Givers and Pastors

The data provided by the respondents showed that HBC givers do attend training in large numbers, with 88% indicating that they have, since their engagement in voluntary HBC programming, attended every training session offered by Thusanang in a month. For those who indicated that they have failed to attend all the trainings offered (12%), the most predominant reason they gave is that of bad timing of the training sessions (90%); followed by the training being too basic and not challenging at all (8%). The shortage of transport facilities to ferry them to the workshop venues (2%) played a lesser role. It is fundamental for projects like Thusanang to improve the education and training which they offer to the caregivers, to avoid repetition of the same teachings to veteran caregivers. More has to be done to provide research-informed programming.

Impact of Training on the Work of Caregivers and Pastors

In the light of application of acquired skills from the training offered to the caregivers and pastors, the study discovered that most of the respondents had put into practice what they learnt from the training workshops. 90% of the respondents reported that they have applied what they have learnt to a great deal, especially in the context of Home Care and Palliative Care. Even the qualitative data collected through FGDs and interviews indicated that most of the respondents (85%) have managed to put into practice what they learnt. This is an indication that the caregivers are highly motivated to pursue their work, and that this church is therefore challenged to consider such good work done by both those who train the caregivers and the caregivers themselves. The study further investigated why some could not be able to put into practice what they have acquired from training. Most of the respondents (98%) indicated that they were not so sure why they failed to apply the skills. 2% reported that they have no adequate time to practically engage on full-time HIV programming since they are new recruits in the programme. This therefore gives the impression that the seriousness of a task pursued largely depends on intrinsic motivation of the one pursuing the task, regardless of the training acquired, a person can still underperform.

A number of pastors (85%) interviewed reported that they have been more involved in counseling of the sick and affected than with Basic Home

Care, owing to the training they acquired under the concept of Clinical Pastoral Care. The remaining percentage (15%) of pastors reported that they have not been able to practically engage on HIV programming. Such a distribution gives the impression to say a lot has to be done by the church and partnering actors to motivate pastors to do more with what they acquire as training and skills development. They have to go beyond counseling and practically engage on HBC programming. It is interesting to note that of the pastors who reported that they have put what they learnt into practice to a great deal, most of them (75%) were retired pastors. This indicates that caregiving from a pastoral point of view is currently a duty after retiring from full-time ministry. This church is therefore challenged in this regard to create awareness among pastors to realize that caregiving starts from within the individual Christian, right through the church as a community, and goes beyond the pulpit!

When asked whether the improvement of work and practice was resulting from the acquired skills, an overwhelming positive response was noted (98%), with the respondents indicating that they could not have done what they have done if they were not taken through skills development training sessions. Of these respondents, most of them (95%) reported that their attitudes towards HIV programming, the HBC concept, PLHIV and OVCs have greatly improved as a result of the training and skills acquired. This is an indicator that change occurs as a result of the training acquired, pointing to the vitality of skills training in service delivery, especially in HIV management and programming. It means that training is critical for performance improvement.

The study also established that most respondents (96%) have benefited from the trainings they undergo in HIV programming. The greatest benefit cited by most of the respondents was an increased understanding about the pandemic (100%); increased awareness of the importance of voluntary community work (85%); and improved self-confidence (60%). This implies that the trainings have contributed largely to the work of the caregivers through knowledge gain and societal networking with active stakeholders. It means the training also boosts the presentation skills of the caregivers as they get exposure and build communication links with other practitioners in public health service delivery.

When asked about the limiting factors in practicing caregiving after training, the respondents reported that performance after training has been halted by cultural and religious factors (100%); economic actors (65%); behavioral attitudes and biases (52%) and government policing and legislation

(15%). Cultural and religious factors were identified by all the respondents as the major limiting factors that constrain the application of skills acquired by caregivers and pastors. It means that the cultural and religious beliefs of the different communities are key in affecting the realization of the impact of training on the performance of caregivers. Partners and other Civil Organizations have to put into context the role played by HBC projects in HIV management and avoid biases and disturbing attitudes towards such projects like Thusanang. During the FGDs, most respondents pin-pointed the poor working relations between caregivers and Village Health Workers, a situation that requires intensive awareness of the public health sector to address because the two parties play a significant role within the communities. Hospitals, clinics and Thusanang have to work together for a single goal of redressing the strife placed by the epidemic upon human livelihoods.

On the question of recommendations for the trainings offered through Thusanang, half of the respondents (50%) recommended that the programme should offer more advanced training. They strongly believed that advanced training would improve public health care service delivery through the HBC concept. The respondents also recommended that the stakeholders and Thusanang should provide transport allowances for caregivers (25%); offer monetary incentives (15%); and refresher courses (10%). This implies that the church has to do more to improve the training offered to caregivers, and more funding has to be made available for such activities. Also, more has to be done to cater for the caregivers, especially ensuring that they attend the training sessions in big numbers by ferrying them to and from the workshop venues. In principle, caregivers have to be motivated to get more active on HIV-related programming, and by so doing the impact of training on their work performances would be realized.

Impact of Training on the Personal Lives or Well-being of Caregivers and Pastors

The study found out that training has impacted positively on the personal lives and wellbeing of most of the caregivers (98%). All of the respondents reported that they have gained knowledge about HIV and life in general. 90% of the respondents reported that they have gained respect within the communities they work in and beyond. Also, 85% of the respondents reported an increased general wellbeing of living. However, in the light of the improvement of

household income, most of the respondents (85%) reported that they have experienced stagnant or declining income levels since they acquired training. The distribution of the above points to the fact that training impacts positively on the personal lives of caregivers, implies a greater need for training as it improves the lives of individuals. It is critical though to note that training negatively impacts on the household incomes of the caregivers, in some cases causing the income to diminish or even remain stagnant. This challenges this church to consider the plight of the caregivers and even to motivate volunteers with better or stable incomes to join HBC. More income-generating projects have to be provided by the funding agencies and the church to cater for the socioeconomic lives and wellbeing of the caregivers.

The study also established that training was very effective in the management of stress-related personal experiences of the caregivers. Most of the caregivers (90%) reported that they have applied the skills they have acquired from training in dealing with stress-related experiences. 6% of the respondents reported that they have never applied any of the skills in dealing with stress management, and 4% indicated they are not sure about whether they have applied the skills or not. This distribution implies that training is fundamental to management of stress by individual caregivers, and hence the greater need of engaging the caregivers on training that is relevant to their personal lives and life skills development. Also, caregivers have to be encouraged to apply what they have learnt to personal life experiences, as this can motivate the communities to realize the vitality of HBC to life in general. This can result in improved uptake of the HBC concept and more people can even join HBC voluntarily.

On the question of the impact of training on personal performance and upkeep, 70% of the respondents reported they have had their personal care and upkeep improved; 15% indicated they have had their attitudes towards voluntary work improved; 10% reporting they have improved family time and friends; and 5% having a lower temper and mood swings. This implies that the courses and learning outcomes acquired through HBC training are fundamental in that they provide the caregivers with relevant exit profiles that give them dignity and societal relations as they actively engage and participate in their communities. This means they can be societal resource persons that people can consult over a variety of issues. If the caregivers are formally presented before the people, they can talk to the people who will listen to them if they have faith in them as life resource persons.

Impact of Training on the Retention of Caregivers and Pastors

Research data revealed that most of the respondents (70%) have agreed that the training they acquired broadens the future employment opportunities for caregivers to a great extent. 15% reported that the training exposes the caregivers to employment opportunities to some moderate level; 8% reported the training opens up employment opportunities to a lesser extent; while the remaining 7% indicated that the training does not broaden in anyway the employment opportunities of the trained caregivers, both the practicing and the retired. This provides evidence that effective training is relevant and applicable in the caregivers' search and access to employment opportunities beyond voluntary care work. There has to be a life after HBC for the exiting caregivers.

When asked whether they are aware of any caregiver who left voluntary caregiving after being offered paid employment, 98% of the respondents said they did not know of any, with only 2% reporting they knew of someone who left HBC for paid work. In a more practical sense, such a distribution would mean that cases of caregivers dropping out of voluntary HBC for paid work are not that much common in the areas in question. It implies that most of the caregivers are determined to do voluntary work and this has to be applauded by our church. Drop-outs by caregivers for paid employment could only be possible in cases where an individual is made to rise from daily care work to office and field work from an administrative point of view, as supported by the evidence gathered from the FGDs and Key Informant interviews where examples of such individuals who left caregiving to join Thusanang office full-time were cited. The contention to be upheld here is that the caregivers who leave caregiving for paid work rise within the church administrative channels. The study did not document any case of an individual who left for other organizations outside the Lutheran domain. This means the spirit of Lutheranism still influences and holds the commitment of those who leave HBC for paid work.

The study discovered that an average of about 52% of the respondents thought that training contributed to their continued work as caregivers. 25% percent believed that training has contributed to a moderate level; 13% indicated that it has contributed to a lesser extent; while 10% reported that training has not at all contributed to their continued work as caregivers. One key informant argued during an interview session that there is nothing like retirement in caregiving – a caregiver is on duty for the rest of his or her life.

Caregivers have to continue practicing care work even after full-time voluntary caregiving. They should remain societal advocates and resource persons within their localities and beyond. Most of the respondents (99%) felt that there were no negative issues to raise and discuss regarding their attendance and participation in trainings. This suggests a positive and commendable impact of training on the retention of caregivers.

Biomedical Response to HIV and AIDS by LUCSA: A Case Study of Manama Mission Hospital

The Background Role of Manama Mission Hospital

Manama Mission hospital belongs to the ELC). The institution is situated about 85 km south of Gwanda town, the Provincial capital of Matabeleland south Province (Manama Hospital Annual Report 2010). Manama Hospital follows and is guided by the WHO universal principles for the management and the administration of HIV-related programming. The hospital falls under the administration of both the ELCZ and the Zimbabwe Government, under the Ministry of Health. The Ministry of Health holds the primary responsibility for the daily running of the hospital. Most of the HIV-related programmes and activities, including the trainings on HIV management undertaken by the nursing staff, are from the Government and its partners rather than directly from the ELCZ. The Church owns the Health facility, but the Ministry of Health and Child Welfare and the National AIDS Council (NAC), runs and implements the HIV programming activities on the ground. Manama Hospital has embraced the need for mainstreaming HIV and AIDS in the quest for improved human health and service delivery. This has been evidenced by the running of a vibrant Opportunistic Infection (OI) clinic, Antenatal Care (ANC) at Maternity and Prevention of mother-to-Child Transmission (PMTCT) facility.

As argued by UNAIDS (2008) in Mzezewa (2015), the involvement and participation of the church in HIV prevention remains minimal, especially in countries like Zimbabwe, Lesotho, Swaziland, South Africa and Botswana. In addition, Mzezewa (2015) has opined that there has been limited research on the possible impact of personal perceptions of church leadership, their beliefs, norms, values and attitudes on the importance assigned to their participation in HIV-related programming. Research has indicated that the

majority of the Lutheran churches in Southern Africa were more involved in the provision of care and support than HIV prevention activities (LUCSA 2008; LUCSA 2012) and in Mzezewa (2015). It implies therefore that the church, through its hospitals, has responded to some degree to biomedical means of HIV management, than from a pastoral perspective which puts more emphasis on care and support for people living with HIV.

HIV & AIDS Programming at ELCZ Manama Hospital (2010-2015 Annual Reports)

This study discovered that AIDS has remained among the top five diseases resulting in the death of patients at Manama Hospital. HIV and AIDS remains amongst the top five reasons for medical admissions and remains one of the top five reasons for the admission of children under five years of age (Manama Hospital Annual Report 2015). This implies that the epidemic remains a central issue affecting the Church and society at large. It has exacerbated the mortality and morbidity levels within the hospitals and the surrounding communities. Children (under 5) are greatly affected, as they are admitted to the hospital in large numbers.

According to the information gathered through discussions with the Hospital Medical Superintendent and a selection of Pastors of the ELCZ, who would have been in some HIV-related programming with the hospital, it appears that the ELCZ has responded to the management of the epidemic in various ways. This includes having its pastors engaged as Hospital Chaplains who are officially appointed and deployed at the health institution. All of the pastors who were interviewed regarding the relationship between the church and the hospital, especially in the light of HIV programming, agreed that through the service of chaplaincy pastors play a crucial role, which includes conducting prayers for the hospitalized patients with chronic illnesses including those related to AIDS, counselling both the patients and those taking care of the bed-bound patients. The study also discovered that the pastors often go the extra mile and engage with the nursing staff to encourage them spiritually as they care for the terminally-ill patients. 80% of the pastors indicated that they have talked to nurses to understand how the work of taking care of patients with AIDS-related illnesses might negatively affect them. Some of the issues encountered included fatigue due to the heavy and

emotionally draining work load, stress, stigma, alienation, and discrimination by other members of the staff or the community at large. The pastors reported that in some cases they could find one or two nurses, especially in the wards with terminally ill patients and those that work with PLHIV who attend Opportunistic Infection clinics, complaining about the job as being too strenuous. In such cases, the pastors have spiritually supported the staff and counselled and motivated them to keep up the good work and do it to their best. When asked about where and how they could have acquired the counselling skills to motivate the staff as well as relatives and friends taking care of the patients, 90% of the respondents indicated that this was the result of the good job done by LUCSA through its workshops and trainings in Clinical Pastoral Care and Counselling.

Even though the ELCZ may not have done enough in terms of biomedical response to HIV management, as has been argued by the Hospital Medical Superintendent, still commendable work has been noticed through the Pastoral Clinical Care pursued under LUCSA. All of the pastors interviewed reported that they also advise both patients and care givers on the importance of ART compliance. The pastors also indicated that they advise and give encouragement regarding the significance of nutritional support for the patients especially when they start on ART. The implication of this observation would be that the ELCZ, through LUCSA's programming on HIV and AIDS in the context of workshops and trainings geared towards the skills capacity development of the Clergy, complements to some extent the work done by the government and its partners in reducing the negative impact of the epidemic. This means therefore that the Church should continue supporting and implementing more training for pastors through LUCSA to reduce the detrimental effects of the epidemic. Pastors are significant players in this work as they have constant direct contact with communities.

Information gathered from the annual reports pointed to the fact that the hospital has engaged in a variety of HIV-related activities since 2010 such as: Pre and Post Test Counselling, ART follow-ups, Dispensing of ARVs and Ordering of ARVs (Manama Hospital Research Data 2016).

The study also found that the hospital nursing staff have also been engaged in HIV-related training. The study found that the hospital has engaged in frequent Antenatal Clinic (ANC), PMTCT and ART activities since 2010. The following is a summary of the activities, staff trainings and services provided to those affected and infected by the pandemic:

Pastoral and Bio-medical Responses to HIV and AIDS

HIV Patients		YEAR				
	2010	2011	2012	2013	2014	2015
Total patients pretest counselled		958	779	696	876	1312
Patients tested for HIV	749	958	779	696	876	1312
Tested Positive	339	316	202	160	138	164
Positivity rate	45,26	32,99	25,93	22,99	15,75	12,5
Patients on cotrimoxazole prophylaxis		4081	4221	4372		
Pre ART registration	956	408				
Patient on ART	377	1855		4361	969	994

Antenatal Clinic						
First ANC visits	263	179	144	137	180	126
ANC pretest counselling (Extras from RHC)	353	179	155	137	180	126
ANC women tested for HIV	263	185	155	137	178	126
ANC women positive	51	26	23	26	19	8
ANC women post test counselled	263	185	155	137	178	185
Positivity rate	19%	14%	15%	18%	10,6%	6,50%
ANC women dispensed Tenolom						627
ANC women dispensed NVP+ATZ		20	27	13	2	
ANC women dispensed NVP	63					
Total number of deliveries	641	607	411	396	578	675
Deliveries by HIV positive	138	116	77	68	89	99
Mothers swallowed NVP	121					
Exposed infants swallowed NVP	121					

Infants tested at 18 months	6					
Exposed infant tested positive	1					
Male partners tested	4	9	7	9		
Male partners positive	1	4		2		

STAFFING						
Midwife	0	0	2	3	2	2
RGN	1	0	2	4	4	9
PCN	3	4	4	1		
Nurse Aides	3	3	3			

PMTCT						
Nurses trained in rapid HIV testing	5	5	3	6	3	
Nurses trained in PMTCT	3	3	2	4	6	17
Nurses trained in MER	3	4		4	4	4
Nurses trained in CD4 count	4	4	1	3	4	3
Nurses trained in early infant diagnosis	2	4	2	3	2	8
Nurses trained in RPR	3	3	4	4	3	5

SOURCE: Manama Hospital Research Data, 2010-2015

The above data gives a picture as to how training could have impacted on the work done by the nursing staff in the hospital. It concurs with the theoretical perspective by USAID (1991) that training does result in change. It shows therefore that the hospital's engagement and commitment towards addressing the effects of the pandemic have impacted well upon the improvement of human lives, behavior change and responsiveness of the communities towards HIV and AIDS. The above statistics show that the trainings that the staff have received have improved service delivery as they address the effects of the epidemic.

The study further found out that some activities at Manama Hospital have been crippled by some critical challenges in its quest for the implementation of HIV-related programming. As documented in the Annual Reports from 2010-15, the challenges in order of importance were as follows: Delay in Dried Blood Spot (DBS) results; Inadequate equipment for effective HIV management/ control; Poor male participation in PMTCT, counselling and testing programmes; Lack of adequate knowledge on PMTCT and RPR by all nurses in maternity ward/ clinic – (RPR is a blood test used to screen for syphilis infection); Lack of adequate space / room for practical PMTCT sessions or services and No PCC to conduct counselling sessions.

A brief summary of the improvements or achievements since 2010 in light of HIV and AIDS management is as follows: Received a CD4 count machine, Use of serial testing instead of parallel testing, Ability to collect DBS specimens for Early Infant diagnosis, Nursing staff development through training on HIV-related programming and Introduction of extended nevirapine (NVP) in PMTCT.

Collaborative Work between the Faith-Based Project, the Hospital and the Church at Large

It is useful at this point to give a brief outline of the collaborative work and practical activities that Thusanang Project and Manama Mission Hospital have engaged in as a joint structure and venture, under the administration of ELCZ. Thusanang Project is situated within Manama Hospital grounds.

The study found that through the discussions held with the administration of both Thusanang and Manama Hospital, the hospital has responded positively towards HIV and AIDS management and programming through initiatives such as Voluntary Medical Male Circumcision, PMTCT, ART Adherence, Opportunistic Infections Management, Voluntary Counselling and Testing (Manama Hospital Research Data 2016). The question here is how then does the hospital engage Thusanang in pursuit of such programmes or initiatives? The research information gathered through the discussions with both Thusanang Programme Coordinator and Manama Hospital Medical Superintendent, suggested that both the parties invite some members of staff to be facilitators on HIV-related topics during workshops, where Thusanang would cater for the spiritual, emotional, psychosocial teachings and the hospital largely focus on the bio-medical issues.

This is essential as it also highlights the importance of cooperation between the Church and the Government. The hospital is an entity that falls under the political administration of the Ministry of Health, while the Church remains the Responsible Authority of the Mission Hospital. It therefore implies that most of the initiatives and activities that Thusanang and Manama Hospital could have jointly engaged in are not always those that are initiated and sponsored by the Church or LUCSA. Some of the most significant activities are run and sponsored by the Government and its partners in public health like UNICEF, Population Services International, USAID and the Global Fund, to mention a few (Manama Mission Hospital Medical Superintendent 2016). In this way Thusanang receives exposure and accessibility to the government's work and practice through the hospital connection, and therefore it is fundamental to strengthen the links between Faith-Based programming and the Health Institutions like hospitals. At present the link between the Government and FBOs like Thusanang is very weak. There is no direct collaboration between the two especially regarding the funding or mobilization of funds for initiatives such as the HBC concept by the Government (Thusanang Research Data 2016). We are obliged therefore as the Lutheran community today to do more in ensuring good and effective collaborative work between our FBOs and the Mission Hospitals, as the hospitals are in a better position to access funds for effective public health programming through the Ministry of Health. There is also a need to continue lobbying our governments to realize the importance of FBO programming through HBC and related programmes in HIV and AIDS management – we need more mutual support as a Church from our governments towards meeting our goals of reducing the strain caused by the pandemic upon humanity. Let us not operate in isolation, let us join hands with the government and the community and ensure a fruitful collaboration between church, state and society.

Conclusion and Recommendations

The study began with the hypothesis that training in Home Based Care and related issues has positively impacted on the work, personal lives and retention of caregivers. Thus, the analysis in this report supported the hypothesis, with some notable critical factors that impact negatively on the lives and retention of caregivers being cited and evaluated. There were noticeable disparities in terms of gender, literacy levels and representation and uptake of the HBC

concept in the selected wards. This suggests that more has to be done to ensure an improved male involvement and participation in HIV programming; and also motivation of formally educated individuals to join voluntary care work. Pastors have to be encouraged to be actively involved in caregiving. Members of the church have to realize and consider that home based care work is more of a calling than a job, which gives the church a unique and distinctive role and identity within the society. With evidence of positive changes in the performances of the care givers resulting from the trainings clearly more training opportunities are needed. Also, the current viability of projects like Thusanang largely depends on the funding mobilized and provided by partners such as LUCSA and Church of Sweden. More has to be done to go beyond these partners to source funding support from other interested parties and role players especially in the context of livelihoods development.

In the light of the foregoing discussion, the study therefore recommended that:

- More advanced training that exposes the caregivers to practical work should be provided to the caregivers;
- More emphasis on Practical Research and Innovation, to pursue community development thought and practice from a more informed and evidence-based position;
- More focus on livelihoods improvement programming that is more relevant and responsive to issues affecting community development today;
- More involvement and participation of LUCSA in Faith-Based programming through effective resource mobilization and financial support for HBC;
- More relevant and realistic trainings to be offered to the caregivers to give them a fruitful exit profile for community engagement and retention as caregivers. Caregivers should be capacitated with skills that even go beyond HIV programming, that is, to expose and train them in income-generating programming e.g. clubs, petty businesses, hand work, for them to be self-reliant. Involvement in care work should be sustainable. This means to provide the caregiver with a full package to assist the individual as he or she exits voluntary work or even when still engaged as a caregiver – a package that addresses the socioeconomic challenges faced by the caregivers in their daily lives;

- Capacity building of field officers at Thusanang to be sources of knowledge in community development initiatives including HIV programming, especially the bio-medical response to the pandemic. The Thusanang staff has to be capacitated to become trailblazers and think-tanks in the field of participatory community development;
- More funding for the HBC concept and related issues like incentivizing caregiving. Funds should be released in time to ensure effective service delivery;
- More advanced pastoral involvement in caregiving. Let it be mandatory to all the Lutheran parishes and congregations that HIV management through HBC is fundamental and each and every pastor has to implement the HBC concept in their Evangelical Ministry programmes. We encourage the church to use the offerings gathered through tithing and thanksgiving also to fund and support HBC programming at congregational and parish levels;
- Motivate and engage more youth towards joining voluntary care work
- Motivation and recruitment of caregivers with stable incomes. We argue that volunteerism is an opportunity to serve that comes in addition to what the individual is fully engaged in – HBC should not be viewed and understood as a job or stepping stone for those who are desperate, but as a calling and challenge for true discipleship and stewardship in God's mission that all might have life and life in its fullness (John 10:10).

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The Influences of Conservative Christianity, Rastafari and Dance Hall Music within Jamaica on Homophobia and Stigma against People Living with HIV and AIDS

Roderick Hewitt

Abstract

This article argues that the conservative patriarchal bias Christianity of the Jamaican churches' understanding of human sexualities, Rastafari's selective use of the Hebrew Scriptures to oppose homosexuality and the rouge masculinities and the anti-LGBT (Lesbians, Gays Bi-sexual and Lesbian Gay, Bi-sexual and Transgender community) narrative culture of Dance hall music constitute three potent sub-cultural forces within Jamaican context that promote negative influences of homophobia and stigma against people living with HIV. In spite of intense and persistent international pressure from LGBT and other human rights groups to force the government of Jamaica to change the colonial bequeathed laws that discriminate against homosexuals, public opposition from religious groups have also prevented the government from taking steps to liberalize and legalize homosexuality.

In order for a more enlightened attitude towards the LGBT community and victims of HIV and AIDS to emerge within Jamaica fundamental changes are needed in the embedded conservative church and Rastafari theologies on human sexuality. Also the anti-LGBT and hegemonic masculinities narrative culture of Dance hall music must give way to conscious advocacy of healthy life affirming gender relationships.

Keywords: Rastafari, Conservative Christianity, Homophobia, Stigma, Reggae, Dance hall, HIV and AIDS

Introduction

Jamaica is known around the world as a prime tourism destination with its pulsating and dynamic culture, fast runners, Reggae music, Rastafari movement, white sand beaches, Blue Mountain coffee, excellent cuisine and hospitable people. However, below the surface of the Brand Jamaica, advert of 'Jamaica ... No Problem' lies the reality of a dark dehumanizing homophobic subculture that thrives on an intense intolerance of Lesbians, Gays Bi-sexual and Lesbian Gay, Bi-sexual and Transgender community (LGBT) lifestyle. The paradox is that the nation boasts a multi-ethnic population of 2,950,210 million (Jamaica population: 2016) with a 'Out of Many one People' national motto. The national anthem constitutes a prayer requesting: Eternal Father Bless our Land and the country is generally classified as a Christian Nation with more churches per sq. kilometer than any other country (Jamaica Religion: Data 2016). From the time of the arrival of the Roman Catholic Church with the first Europeans in 1493 (Sherlock & Bennett 1998:63-64) and the change over to the British in 1655 with the Church of England being the State Church, followed by Protestant Missionary movements in 1754 (Senior 2003:332) that resulted in what is classified as the 'Traditional or mainline Churches'. However, the period since national independence in 1962 has seen a fundamental shifted in church allegiance where majority of the Christian population has changed their membership migrating into a diverse mix of pneumatological driven Pentecostal/ Charismatic churches.

The chapter argues that the contemporary international focus of human Rights bodies on the plight of the LGBT community in Jamaica has exposed the deeply rooted religio-cultural opposition of the Jamaican government and people to liberalize and legalize homosexuality that is currently outlawed under the colonial influenced constitution. In order to adequately explore the nature of the place hostility to homosexuality and the stigma linked to HIV and acquired immune-deficiency syndrome (AIDS), this chapter has chosen to interrogate the unholy toxic mixture of conservative evangelical patriarchal bias Christianity of the Jamaican churches in ideological solidarity with Rastafari selective use of the Hebrew Scriptures health laws from the book of Leviticus to oppose homosexuality and the rouge masculinities, anti-LGBT narrative culture of Dance hall music.

A Colonial Bequeathed Hegemonic Masculinities

These three culture shaping forces on attitudes towards gender relationships in Jamaica have bequeathed a fundamentalist literal reading of the Bible on issues of sex, sexuality, gender, masculinity, patriarchy and homosexuality that has created unhealthy gender relationships. In addition, the structural European white supremacist political domination of the society and the systemic marginalization of the underclass African-Jamaican male since colonization and slavery have ensured minimum social advancement through education and economic capital attainment (Hope 2010:8). The system was fixed and set to keep the African-Jamaican male down and never was able to attain middle-class 'the masculine ideal' and was therefore playing catching up all of the time. In this can't win social environment, alternative forms of masculinities emerge to survive and 'provide financial support for his children and 'baby mother'. Being head of the house was internalized as having sexual power over women (Hope 2010:10f).

This resulting hegemonic masculinities developed within the Jamaican socio-political landscape and reinforced by patriarchal evangelical Christianity, Rastafari ideology and Dance hall musical narrative have influenced the evolution of a highly toxic life denying environment that creates negative social factors, including the strong stigma associated with AIDS and homosexuality that engenders intolerance and even violence. The high levels of homophobia and negative gender stereotyping are nurtured in the mis-education given in the reading of the bible and structure Christian education for children and young people about sexualities, gender roles ensured that stigma and discrimination thrives and therefore weakens prevention and treatment measures for HIV and AIDS victims. These victims are ignorantly viewed as being divinely punished for participation in gay sex. The issue of hegemonic masculinities is very important to deal with because the social, cultural, religious and economic contributing factors to the spread of HIV are primarily linked to behaviour of men engaging in unsafe sex with multiple partners and also having sex with underage female that expose them to risk at an early age. The Euro-American brand of missionary Christianity that evolved in a colonized society where peoples of African ethnicity were commoditized and enslaved to meet economic objectives of imperial powers. Christianity as the dominant religion in partnership with the State forced other religious expressions linked to African Retentions to the margins because they were not legally

allowed to practice in the open public sphere.

The Socio-Political Linkages

HIV and AIDS became a health issue in Jamaica in 1983. The disease was thought to be linked only to practice of unprotected sex between homosexuals. However, research data has linked the spread of the epidemic to include other actors such as sex workers that engage in unprotected sex and illegal drug users who inject drug into their bodies using unclean contaminated needles (Figueroa, Brathwaite Ward & DuCasse1995). There is increasing recognition that HIV spread is directly linked to underdevelopment that contributes to economic inequality. Poverty has been a persistent reality built into the design of the Jamaican economy since the period of colonialism and slavery (Beckford 1972). It was meant to dehumanize and control peoples of African ethnicity to reinforce their ideology of white supremacy. The injustices that are structured (Anderson 2001:1) into the contemporary labour market ensures the continuation of poverty. It is this phenomenon of injustice that breeds gender inequality in the labour market that plays a key role in increasing the vulnerability of women to HIV through unsafe sex because of their need of money to survive and take care of their family.

The relatively stable political climate in Jamaica since independence in 1962 with its smooth change of government every five years belies the deep hostile opposition towards any governmental measure to legislate for a more tolerant environment towards homosexuality in the country. The electorate and general public is deeply influenced by the unholy partnership of convenience between the conservative Church community, the Rastafari religio-cultural hostility and the dominant use of Dance hall music to communicate and educate the people to put up resistance against any political measures to legalize homosexual practice.

According to 2012 data:

Eighty-eight percent of respondents believe that male homosexuality is immoral and nearly 84 percent believe that female homosexuality is immoral. More than 75 percent of respondents are against repealing the 'buggery' law and 65 percent oppose amending the Charter of Fundamental Rights and Freedoms to protect the rights of members of

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the LGBT community (Human Rights First-LGBT Issues in Jamaica, Fact Sheet).

Jamaica has had Buggery laws on its legal books since the British Colonial period (1864). It is also referred to as ‘buggery Statue’ that classifies homosexual acts to be illegal ‘levying sentences of up to 10 years of imprisonment with hard labor for those convicted under Article 76 of the Offences Against the Person Act’:

‘Whosoever shall be convicted of the abominable crime of buggery [anal intercourse] committed either with mankind or with any animal, shall be liable to be imprisoned and kept to hard labour for a term not exceeding ten years’ (Human Rights First-LGBT Issues in Jamaica, Fact Sheet).

This law is mainly used against homosexual men and it contributed to members of the LGBT community being discriminated against exercising their basic human rights in their local communities and this has made them vulnerable to persecution, violence, homelessness and HIV. The political parties that make use of Reggae and Dance hall music to communicate to the people have also embrace some of the antigay rhetoric in their electioneering campaign in order to gain popular support. One of the Prime Ministers, Bruce Golding in his effort to strengthen his political base, declared in 2011 that he would never appoint a practicing homosexual into his cabinet (Gleaner November 6, 2011) Jamaica has come under intense international pressure to remove the Buggery laws and make homosexual acts legal. However, even when Parliament acted in 2012 to pass the updated Charter of Rights. It failed to recognize the right to same sex marriages. Another Prime Minister, Portia Simpson tried in 2014 as a result of her election promise to repeal the Buggery statues but her years in office up to January 2016, failed to act because the political will to confront the opposition forces within the nation and Parliament (Pink News: 19th May 2014). It is therefore the political inaction by failed leaders that are scared of losing political power that has also helped to create the environment of homophobia and stigma against HIV and AIDS. They have failed to challenge and openly oppose the cultural bias that linked HIV and AIDS primarily to homosexuality than to the hegemonic masculinities.

The Church, Homophobia and HIV and AIDS

The majority conservative evangelical Church community embrace a fundamentalist theology that unleashed divine judgement ‘of Brimstone and fire’ upon those deemed to be anti-God in their sexual lifestyles. Literalist reading of scripture such as the Sodom and Gomorrah story of Genesis 19, condemnation of homosexuality in Leviticus 18:22 and 20:13, the paradigm of a pro-creative norm being emphasized in Genesis 1:28 have all being used to marginalized the arguments used by the LGBT community to legitimize their lifestyle. It is from this base that Rastafari and Dance hall music borrow to advance their narratives against the LGBT community and that which flows over into stigma against people living with HIV.

The number of people living with HIV and AIDS in 2015 was 29,000 and the number of deaths was estimated at 1,200 (Jamaica Religion data: Protestant). The rate of HIV and AIDS has remain steady around 1.7%-2% and this has weakened the sensitiveness of persons to the plight of persons facing the challenges of stigma and social rejection (Dawes & Lambertson 2014. Shame: HIV and AIDS and The Church in Jamaica). Sections of Jamaican Church have sought to give support to the efforts to increase awareness and acceptance of people living with the disease but it remains a difficult task. Because of its many years of narrow conservative teachings on issues of sex, sexuality, homosexuality and gender there is a credibility gap between the church’s theological certainties and the need to save the lives of victims. The result of this self-inflicted contradiction is an unacceptable silence and neglect of the plight of victims. In a study of the church’s response to the epidemic and its understanding of homosexuality, Kwame Dawes and Andre Lambertson interviewed a cross-section of ministers, theologians, church workers, activists and advocates, and people living with HIV identified a complex secret world in which the victims of HIV and AIDS live with shame, bravery, compassion, paranoia, anxiety, hopefulness, anger, and fear (Jamaica Health Data). The moralistic underpinning of the conservative brand of Christianity in nation has therefore created a kind of religiosity that thrives on anti-gay rhetoric that provides oxygen for stigma against victims of HIV and AIDS.

Rather than seeking to fight stigma in society as it primary task, the church should focus on reeducating its own faith community to counter the ideology of stigma that it created, nurtured and later transported into the wider society. With its majority membership/adherents within the general population,

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its capacity to influence change of attitudes toward people living with HIV is very limited because the stigma prejudice is very deep in its identity and witness. One positive example of the slow changing attitude towards persons who are affected is embodied in the work of Rev Delroy Harris who work to challenge and transform the church's negative attitude through its policies and the behaviour of ignorant members. He argues that:

‘If society doesn’t show love and care, the person is going to turn to the church. It’s at the point now where some persons who are HIV positive no longer want to come to the church because they feel that the church people are rejecting them. Now we need to change that... ‘We had persons that were HIV positive sharing with us [one] Sunday morning ... the high point for me ... was when I pronounced the benediction, afterwards, the same people who had a problem with me doing the session, lined up to embrace the persons living with HIV with tears in their eyes (Christian Aid, Jamaica: Fighting HIV Stigma in Church: November 2014).

The conservative Evangelical Christian narrative that is constructed around a bi-polar world of good and evil sees the world outside of the church community as ungodly with people like gays and other victims being scapegoat as threats to God’s standard for righteous living (Pavlovitz 2015). The Bible plays a critical role in the ideological moral construct of Jamaicans toward justifying their prejudices towards Homosexuals and persons living with HIV. The Euro-American ministry and mission heritage bequeathed by white conservative Christians into the Jamaica ecclesial culture has uncritically accepted their imperial bias interpretation of scripture that once legitimized the enslavement of African-Jamaicans. It is paradoxical that the contemporary Jamaican Church has also internalized the life denying misuse of the bible in evangelical conservative political theology to support homophobic prejudices. Therefore, any serious commitment to overcome stigma against requires the church to revisit its theological underpinnings which according to Hewitt requires an,

...an intentional but sensitive process of uncovering/unmasking the cultural ‘baggage’ of Euro-American Christianity that has been accepted uncritically as orthodox Christianity (Hewitt 2012).

Contradiction and Opportunities within Rastafari Religio-cultural Discourse

The conservative theology of the Jamaican evangelical Christian ensures that no revolution or transformation in its worldview on sex, sexuality and gender issues will be achieved quickly. Therefore social transformation in attitudes towards people living with HIV must come for other life affirming cultural forces of change. Rastafari constitute a powerful and influential religio-cultural movement within society however its capacity to be a change agent for the reduction of stigma is also greatly reduced through its ideological enslave and addiction to aspects of non-life giving ‘overstanding’¹ (Afari 2007) of the Bible. Rastafari can be identified as an Afro-centric religio-cultural belief system that critiques Euro-American missionary Christianity and its use of the bible to oppress people peoples of African descent. It constitutes the contemporary expression of the long continuum of agents since the era of colonialism and slavery who have resisted the Euro-American imperial worldview through their radical African retention that postulates an alternate discourse on human dignity and other issues of injustice unleashed by the ‘Babylon System’ (Cooper 1993: 121) that is expressed through the social, religious and economic systems of Western imperialism.

Rastafari philosophical hermeneutics is built on a strong anti-imperialist, anti-colonialist and liberative ideology. However, on the subject of sexuality its liberative discourse on sexuality is severely compromised in some of its adherents advocating violence toward homosexuals. The Rastafari faith seems is embedded in an ideological selective use of the scriptures especially the Hebrew Scriptures with the ancient social laws code in the book of Leviticus. It could be argued that Rastafari theological reflections have also become psychological enslaved to a bias conservative reading of the Hebrew Scriptures like other conservative and fundamentalist Christians churches. Their nutrition and other aspects of their lifestyles are modelled on ancient Jewish practices.

The Influence of Reggae and Dance Hall Music

Reggae music is central to the understanding of Jamaican culture. It tells the

¹ ‘Overstanding’ Rastafari uses the term to mean ‘Elevated intelligence’.

story of the people's journeys of struggle for fullness of life. Various Rastafari musicians embraced and developed the music as their primary means of communicating their faith and to educate the public how to respond to imperial forces of oppression that threaten their wellbeing and finally it serves to bear witness to Rastafari's prophetic, emancipatory, raw, justice-oriented, anti-imperial and anti-colonial message of hope (Safi 2013). However, in spite of the global reach with its revolutionary ethic and life-affirming narrative, the subject of gender justice and protection of LGBT practitioners' rights do not feature. The two most influential contributors of stigma against people living with HIV are the embrace of toxic masculinities and the powerful impact of Dance hall music a derivative of Reggae music on the local culture. Dance hall music constitutes the transporter of music and lyrics that promote homophobic, misogynous and violent outlook on what it classifies as deviant sexual behaviour such as homosexuality. It emerged in the 1980s during a period of political upheaval within the inner cities communities of the capital, Kingston. The more upbeat heavy bass rhythms rap narrative that embraced sexual domination of the female body and violence to homosexuals (Afari 2007:132), and promiscuous polygamous heterosexuality aimed at subjugating the feminine and elevating the hegemonic masculine (Hope 2012: 19). Dance hall lyrics are obsessed with male sex using many creative colloquial and slang terms created in the inner city poor communities as and used as synonyms to describe the male and female sexual organs. The masculinity paradigm of Dance hall, authority, control and producing life is acted out on the female body with aggression and even violence. It is this dysfunctional masculinity that is at the heart of homophobia and stigma within the Jamaican society.

Popular Rastafari Dance hall artists Buju Banton whose real name is Mark Myrie, released in 1992 a very popular song: *'Boom Bye Bye'* that became an anthem of Dance hall culture calling for deadly violence against homosexuals. The controversial song done in a deep booming voice speaking patois that the non-Jamaicans would find unintelligible a haunting powerful message was communicated calling for death to all Gays referred to *'BattyMan'* The song catapulted him to national fame but it also triggered the international Gay Rights movement to work toward bringing him down for his murderous lyrics. Selective extract from the song is very frightening:

‘Boom Bye Bye’

World is in trouble
Anytime Buju Banton come
Batty bwoy get up an run
A gunshot me head back
Hear I tell him now crew
(Its like) Boom bye bye inna batty bwoy head
Rude bwoy no promote no nasty man
Dem haffi dead Boom bye bye inna batty bwoy head
Rude bwoy no promote no nasty man dem haffi dead

(Two man) Hitch up on an rub up on
An lay down inna bed hug up on another
Anna feel up leg send fi di matic an di Uzi instead
Shoot dem no come if we shot dem--
Don't want Jackie. Give dem Paul instead
Dem don't want di sweetness between di leg
Gal bend down backway Aan accept di peg
An if it really hot you know she still naw gon fled
A some man still don't want di panty raid
Pure batty business dem love

(Me say) Boom bye bye inna batty bwoy head
Rude bwoy no promote the nasty man dem haffi dead
Boom bye bye inna batty bwoy head
Rude bwoy no promote no nasty man dem haffi dead

(Woman is di) Greatest thing God ever put pon di land
Buju lovin dem from head down to foot bottom
But some man a turnaround where dem get that from
Peter is not for Janet Peter is for John
Suzette is not for Paul. Suzette is for Ann
Where the bomboclot dem get dat from
Here come the DJ name Buju Banton
(Come fi) ((Straighten yuh talk?))

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*(Caw me say) Dis is not an bargain (Me say)
Dis is not a deal Guy come near we
Then his skin must peel burn him up bad like an old tire wheel
Gwaan buju banton yuh tough*

*(Two man) A hug up on an kiss up on
An lay down inna bed hug up on another
Anna rub dung leg Send fi di matic an di Uzi instead
Shoot di batty boy come if we shot dem--
Dem don't want Jackie give dem Paul instead
Don't want di poom poom between Patsy leg
All dem want Is the body from Fred
But dis is Buju Banton Me say (Banton 1992).*

The narrative is frighteningly filled with violence: *Batty boy* (a derogatory term used for men who engage in anal sex); *A gunshot me head back* (shoot him in the back of his head); *Boom bye bye* (The sound of gunshot aimed to kill the gays that engage in sex). Within the Dance hall culture gay anal sex is viewed as being done by 'nasty boys' who are not real men. On the other hand Dance hall culture celebrate the female but primarily for her body which should be available for rough (hard) sex. Therefore this misogynistic music culture in essence does not promote healthy masculinities nor respect for the female. The woman's body is viewed as a trophy that must be conquered. The addiction is with sex, right and wrong sex. Wrong, when it is done between men and right, when it is done between men and women. It is this toxic masculinity promoted by certain Dance hall artists that creates the stigma among people living with HIV because they are all falsely linked to gay sex. One of the many derogatory dehumanizing terms used by Dance hall culture to describe the unacceptable identity and behaviour of Homosexuals is 'Chi-Chi Man' (Hope 2010: 78-81). This word was originally used in the culture to describe very small insects-termites that can destroy the wood of a home and weaken its foundations until it falls. Therefore, the owner of the house must do whatever is needed to eradicate the termites. Not surprisingly, the local Dance hall quartet T.O.K in the year 2000 gave the public his anti-homosexual anthem:

From dem a par inna Chi-Chi man cyar

Wave di fiya mek we bun dem
From dem drink inna Chi-Chi man cyar
Wave di fiya mek we bun dem (Hope 2010:80).

The English translation of this narrative is shocking: ‘Once they are see sparring (having sex) in a homosexual’s car, wave the fire and let us burn (kill) them’. This violent anti-homosexual approach within Dance hall culture confirms and affirms ones powerful masculinity.

Tim Padgett writing for the Time magazine questioned whether in the light of Jamaica’s deep cultural opposition to gay lifestyle that Human Right Watch is correct in classifying the country as *the most homophobic country on earth*. He pointed to the work of Dance hall Artists such as Elephant Man (aka O’Neil Bryant) who expressed in one of his songs ‘When you hear a lesbian getting raped/ It’s not your fault ... Two women in bed/ That two Sodomites who should be dead’ (Padgett 2006).

Tanya Stephens a Dance hall artist in 2004 offered what could be classified as a Womanist Dance hall Narrative critique of unhealthy sexual relationship between men and women within the Jamaica culture. In her hit song: *Weather Change (So many Men)* (Stephens T. 2004) she uses the medium of Dance hall music as the discourse through which she interrogate toxic masculinities. Tanya is an influential Jamaican female Reggae and Dance hall artist who is known as one of the premier singers that offer a particular genre of ‘seductive lover rock’ Reggae music. Prior to her song, ‘Weather Change (Too many Men)’ in 2004, she was best known for her song ‘Yuh Nuh Ready Fi Dis Yet’ (*You are not ready for this as yet*). This was a stinging rebuke to men who exercise their sexual prowess without due respect for the feelings or readiness of the female. She exposed the immaturity of men and their lack of sexual education that would equip them to respond positively to the felt needs of women.

In *Weather Change (So many Men)* Stephens called upon women to raise their level of conscientization in their sexual relationship with men. The title sums up the mandate of her commitment to advocate for women to realize that they have choice in making the right decision concerning their relationship with men. She postulates that there are more than sufficient men who are around in the society for women to decide who they want to be with and should not therefore be pressured into making decision based on access to a limited number of available men. Women should exercise their freedom in deciding

who they want to be with and they should not shed tears if their male lover moves on to be with another woman. Rather, she argues, the woman should exercise her sexual freedom and exercise her right to change partners. In order to maintain the sexual health and be psychologically strong the Jamaica woman must not cry when men prove to be unfaithful but should set their own agenda that is not dictated by men behaviour. Stephens discourse on male/female sexual relationship dynamics seems to suggest that the Jamaican woman must not depend up patriarchal bias power system to decide on the sexual rights or health of the woman. The answer to the challenges of stigma within the society begins not with moralistic pleading with religious and cultural power systems that are dedicated to maintenance of the status-quo. Rather the quest for a stigma free future for women whether it is linked to her sexuality or prevention of HIV, should begin with her taking action in claiming her sexual freedom in not being controlled by toxic masculinities. Donna Hope argues that the lifestyle impact of the toxic form of masculinities ultimately result in dysfunctional gender relationships (Hope 2010: 1-15). Stephens postulates an alternative sexual health affirming model of gender relationships in which the woman should not depend on any man to decide of her rights to exercise her sexual freedom by having any control over her body. The woman alone must be the final authority because only when there is mutual respect and reciprocity in sexual power relations that discrimination which leads to stigma in HIV and AIDS will be overcome.

Conclusion

This paper began with the assertion that behind the tourism headlines of Jamaica being a prime destination with excellent attractions, lies a dark dehumanizing homophobic subculture that thrives on an intense intolerance of Lesbians, Gays Bi-sexual and Lesbian Gay, Bi-sexual and Transgender community (LGBT) lifestyle. An unholy alliance between patriarchal bias conservative evangelical Christianity unhealthy gender relationships, solidarity with Rastafari selective use of the Hebrew Scriptures health laws from the book of Leviticus to oppose homosexuality and the rouge masculinities, anti-LGBT narrative culture of Dance hall music. All of these have influenced the evolution of a very intolerant and homophobic society that nurtures hostile and even violent response to the LGBT community that also

flows over into stigma against HIV and AIDS victims. For a more life giving attitude towards the LGBT community and victims of HIV and AIDS to emerge within Jamaica a fundamental changes would be needed in the church's theology on human sexuality. The church will have to go far beyond the 'keeping up of appearances approach' simple holding workshops to talk about the state of HIV and AIDS, a more in depth integrative approach is needed by all of the key public opinion stakeholders within the nation to agree on key intervention strategies. The Church and The Rastafari community have a challenging task to revisit their theological certitudes on human sexuality. Their addiction to a patriarchal bias power relations in their understanding of the bible have also resulted in extreme discrimination against homosexuals and people with other expression of their sexuality. Finally the anti-LGBT and hegemonic masculinities narrative culture of Dance hall music must give way to conscious advocating of healthy life affirming gender relationship. This is the only way that these religio-cultural forces can be transform the Jamaican society to overcome their homophobia against the LGBT community and stigma against people living with HIV.

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Whose Body Whose Language? A Feminist Critique of the Construction of Discourses on a Woman's Body in African Religious Spaces and its Effect on Well-being

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Abstract

The autonomy of a woman's body and the space it occupies in many religious spaces appears to be embedded in a contested terrain. An African woman's body is located in a space that seems to be safely controlled in order to save it from its supposed vulnerability. Such interventions have been championed by many factors such as colonialism, patriarchy, and religio-cultural ideologies derived from different religious traditions such as African Traditional Religions and Christianity. Within these interventions the female body seems to be silent, spoken for, acted upon, amidst situations that locate it in subordinated hierarchies of society. These hierarches appear to be carefully secured by the patriarchal rhetoric that cuts across the secular and religio-cultural traditions. This paper is a critique of how religions such as Christianity and African Religions construct women's bodies which in turn affects their wellbeing in society. The paper uses discourse analysis to argue that although women's bodies have power to control and challenge systems both in societal and spiritual realm as is argued by scholars these bodies are still perceived as subordinate to patriarchal control. Hence, the paper concludes, with a need for urgency in analyzing the way in which women's bodies are located in religious spaces and its effect to women's identity and wellbeing.

Keywords: Woman, Bodies, Religious spaces, subordination, Christianity, African Traditional Religions Sexuality, Feminism.

Introduction

One of the key elements that motivated the contemporary wave of Western feminism was to address the issue of female subordination. This meant challenging male dominance so as to recognize women's rights and autonomy over their bodies¹. Previously, theories of knowledge with regard to women's bodies and their potential in society were mostly championed from a male epistemological standpoint. This dominantly male championed knowledge cut across the secular and religio-cultural traditions. For example, from the western secular world philosophers such as Plato, and Aristotle, whose thinking and teachings are influential even in today's contemporary society, attest in some of their classical works to the inferiority of a female body in comparison to a male body. (Buchan 1999). Comparatively, the male body was thought to be depository of the superior soul and well equipped for heavy tasks such as fighting, state protection and leadership, and for generating souls of perfect humans, whereas, the female body was considered the host of an inferior soul (Buchan 1999:46). Such a soul necessarily residing in a female body was considered a product of the imperfect seed, which is weak, slow in resisting stress, and in need of protection from the 'super' male body (Allen 2002). These secular teachings from the Greek philosophy found their way into Christian traditions through the church fathers such as Augustine and Thomas Aquinas (Thetcher 2011). On the other hand, religio-cultural traditions in many African societies too have their own perceptions on female bodies. Hence religions such as Christianity and African Traditional Religions have to a certain extent created a considerable force to influence how the female body is talked about in the contemporary society. Most of the discussions on women's bodies are closely linked with issues of sexuality. From the western perspective issues of sexuality emerged within women circles as a consequence of women's endeavor to take charge of their bodies. Some of the radical feminists argued that 'sexuality in a male-dominated society inevitably involves danger for women' (Caplan 1987:9). African scholars such as Matroy (2005), Oyewumi (2005) and Tamale (2011) view sexuality as a complex and often silenced phenomenon that can be exploited by the patriarchal systems present within African societies. We have therefore argued in this paper that the subordination of an African female body does not seem to arise from a vacuum.

¹ For more information on the subject matter see the work of Annie Clifford in her works on the history of feminism.

Instead it is embedded in certain cultural, religious, and colonial imperialistic theories of knowledge which are 'coated' and 'flavored' by intentions to promote health, liberation, religious morals, and sexual excitement for the African woman. The paper locates its argument in the context of religio-cultural socialization of the female body and its effect to women's wellbeing, while deriving examples from specific geographical contexts within the continent. We believe that such an approach helps to guard against the generalization of women's narratives which tend to undermine the value of context in academic research.

Discussing Theory and Method

The paper employs a feminist approach to discussing discourses on sexuality and women's bodies using Lisa Isherwood's conceptual framework on sex and body politics. Through a textual analysis as its method of analysis, the paper critically examines discourses that influence the way in which women's bodies have been perceived and the space that women by virtue of their bodies have occupied in African religious spaces. It also attempts to analyze discourses of power and control that have been exposed in these religious spaces when constructing epistemologies that define female bodies. The discourses on human bodies suggest that there is a contestation in defining the spaces these bodies occupy in society. Lisa Isherwood observes that any attempt to venture into the phenomenon immediately reveals a 'highly constructed reality reflecting the power structures of the society' (2000:20). The author further states, unlike the male bodies, female bodies are usually treated as the 'other' members second in hierarchy after male bodies. This can be observed in patriarchal societies where religion and society join as liberating parties yet end up forming a super power force that attempt to hierarchically rank female and male bodies (Isherwood 2000:21).

Some of the dominant male led epistemologies pre and post-Christianity have attempted to argue against women bodies. These levels of knowledge have conceived and through ages sustained claims that female bodies are not always necessary unless only as material support for male souls' survival (Thetcher 2011:8-10). From such assumptions Isherwood (2000) demonstrates that the demonization of women bodies has for ages been experienced especially where women were reduced to reproduction of wealth and human labour. Isherwood's claim is relevant in helping to understand the

space occupied by women in the colonial and postcolonial capitalist societies in Africa. This is because in many African societies, at the interplay of religion, colonialism and patriarchy women became dwellers of private life as mothers while men retained active public life as leaders in religious and civil spaces (Falola & Nana 2012:73; Tamale 2014:159). Literature has also revealed that as women bodies were retained from public to private affairs they gradually became spoken for and acted upon by the active male patriarchy. Revisiting the implication of the Christian model as pointed out by Isherwood as well as paying attention to how colonialism and patriarchy ordered women bodies is key in the current society as we attempt to deconstruct various epistemologies that subordinate women. Such engagement, cannot in a context where health and wellbeing has been highly associated with women's bodies. For instance in their ethnographical research on women agency amid the prevalence of HIV in South Africa scholars such as Morrel *et al.* (2012) discovered that gender inequalities perpetuated by the societies' view of male and female bodies pose a great threat to women's agency to evade HIV. The Circle of Concerned African Women Theologians with scholars such as Phiri and Nadar (2003), Hinga *et al.* (2008), Dube and Kanyoro (2004) and Haddad (2011) and many others, together with male gender activist scholars such as Ezra Chitando (2009) have extended the debate further and indicated that discourses on sexuality and HIV and AIDS pandemic reflect a female body that is talked of, acted on and perceived as the key player in the spread of the pandemic.

Governmentality Theory

The theory that this paper proposes is Foucault's theory of governmentality. Nyanzi (2011:482) proposes that the theory of governmentality is an 'analytical tool [t]hat facilitates the analysis of the locus and the dynamics of power in sexual relationships and sexual cultures'. It examines how the conceived norms and practices within a society are deemed 'normal' and acceptable in controlling peoples' behaviour. A critical analysis of how language is constructed around women bodies suggests an imbued power of control that has effect on how individuals perceive women bodies in the outside world.

Religio-cultural practices in many African societies promote governmentality of female bodies not only through the power of the 'said

word', but the language of silence and symbols. This is despite the fact that women's bodies are perceived to have certain spiritual powers that can be used to control the community. Through the promotion of silence certain members of society are initiated to communicate their bodies' affairs through symbols. This kind of communication can either be positive or negative. Although the notion of silence is contested within cultural contexts we argue that it has also opened avenues in which women bodies have been acted upon by society. Among the Baganda of Uganda, like many other African contexts when the girl child is of age, she goes through initiation rites that involve sex education. In most cultures the girls are kept away from the public arena. In this time the construction and expression of female sexuality depends on the acceptable form of body operation. During such sessions girls' bodies are under strict observance and instruction by the paternal Aunt who can be said to represent the patriarchal authority.

A religio-cultural perspective shows that that during these rituals, it is the body that has to conform with the dictates of culture and society, thus we see a scenario where a woman's body is regulated by cultural power systems. This is in line with Isherwood's (2000:21) theory of body construction, where she attests, the female body is not exempted from being possessed and acted upon by different forces. Therefore, Synnott (1993:1) affirms that, 'the body is not a 'given' but a social category with different meanings imposed and developed by every age... as such it is therefore sponge-like in its ability to absorb meanings'. If bodies absorb meaning by being acted upon, what meaning does a stretched labia minora, none stretched, and a 'cut' and 'uncut' clitoris infer? How about a body that is displayed for media purpose? A body used to assess health statistics? Who then determines the meaning of the body the beholder or by the society? Cultural analyses point out the fact that female bodies are often acted upon in silence and secrecy. Therefore, constructions of power in this case are displayed through prescribed cultural domains.

Language as Tool to Govern the Dichotomies between Male and Female Bodies

Language is one of the most powerful tools for communication in defining women's bodies. As an instrument of governing bodies, language seems to locate female and male bodies differently and perhaps influence which bodies

are best suit to lead others. In this analysis a close attention is given on the sexual language which appears to be one of the most controversial means in which bodies are governed. The power imbalances in relations expressed in sexual communications has to a great extent contributed to sexual and gender based violence coupled with concepts of powerful and dangerous masculinities that see themselves as being superior over the femininities. Although in many African traditional societies, sexual language is communicated metaphorically² (Muyinda *et al.*, 2001:354) the metaphors used seem to portray the underlying power relations within sexuality. . Metaphors among the Baganda are called:

... *okwambaza ebigambo*’ (dressing words) ... [t]hey are an acceptable medium of accessing the secret world of un-verbalised sexuality, shifting it from the ‘private’ to the ‘public’ realm. ...As cultivating is the primary economic activity of the Baganda, many of the sexual metaphors and symbols... are couched around this theme Hence a man who is impotent is described as ‘no longer able to cultivate his farm’ (*takyalima nnimiro*); one who is lousy in bed is a ‘bad farmer’ (*ennima embi*); one who gets premature ejaculations is referred to as ‘unable to complete his *lubimbi* (piece of arable land apportioned for the day)’; to ‘eat one’s dinner’ (*okulya eky’ekiro*) or ‘digging one’s *lubimbi*’ both refer to having sex; ‘food must be eaten with *ebirungo* (spices)’ means to introduce variety in sexual activity. A woman is referred to as *asiriza entamu* (burns the pot) if she is not adequately lubricated. The sexual symbol of mortar and pestle is universal: thus *omusekuzo* (pestle) is an erect phallus and *okumusekula* (pounding) refers to its motion in sexual intercourse (Tamale 2006:92).

A critical analysis of the sexual metaphorical language of the Baganda seem to indicate that while a man is compared to a farmer (who carries the identity of a human being) the woman is associated with land and seen as a garden (carrying the identity of an object). This could be assumed that one body is active while the other is passive. Further analysis can also suggest that

² To speak metaphorically is to communicate using words, sentences or phrases to describe ‘an object or action to which it is not literally applicable’ <<http://www.oxforddictionaries.com/definition/english/metaphor/>>.
(Accessed on 20 September 2014.)

the sexuality of a man is expressed in terms of power while that of a woman is viewed as dormant and receptive.

Another important indicator of how metaphors tend to imply inequalities in sexualities is how the male and female sexual objects are defined. The sexual organ of the man (penis) is presented with a powerful image of the 'pestle' which hits the 'mortar, an axe that cuts the wood, a spear or a hoe that cultivates the land,' i.e., the receptive image of the female sexual organ the vagina. Hence, according to Chirwa (1997:7):

In Malawian culture, a man courting a woman for marriage affirms his commitment to her by giving her or her parents or guardians a material gift called *chikole*, from the word *kukola* meaning 'to get hold' or 'capture' or 'take control'. The *chikole* gift thus symbolises the man's access and claim to the woman's sexual territory, and the exclusion of other men from her.

Although, Chirwa (1997:8) has argued that the *chikole* does not necessarily connote a man's control of his wife's sexuality, but is a symbol of affection, love and willingness to enter into a life-long relationship, nevertheless its root *kokola*, could be interpreted to show the imbalances between a woman and a man's sexualities. The language drawn from the meaning of *kokola* thus locates a man and a woman at far distance from each other. Similar to Isherwood's description of a man's sexuality that 'screws' the woman, and the Baganda's male sexuality that 'cultivates' a woman, the Malawian male sexuality 'captures' the woman, thereby portraying how powerful male sexuality is understood and expressed (Isherwood 2000:28; Tamale 2006:92; Chirwa 1997:7). It can therefore be argued that these expressions attempt to portray a reality of how power is distributed in the discussions of sexuality which later reviews how the female body is perceived by society.

Discourses on Women's Subordination in Religious Spaces

For the indigenous people of southern Africa, the introduction of Christianity meant that they had to deal with the dualistic nature of faith adherence in their conceptualizing of the female body. This had a considerable impact on the way

Africans perceived their humanness within religious spaces. Having embraced Christianity, African Christians were compelled to view themselves as people of two separate entities-body and soul of which the soul (as it was taught in many Christian theologies of the time) was superior to the body. The Christian teachings viewed the body as that which needed thorough ongoing purification to reduce its potential of corrupting the soul. The whole notion seems to have been a battle of sexuality and the soul a condition that put women bodies on the spot light, whose sexuality was already under control by the western and African patriarchal societies³. Rakoczy states that feminist theologians reject the dualistic model because it assumes that the male is the better, stronger and more gifted one between the male and female and that women need men in order to be complete. The model also locates women in a biological context as though women are only created for procreation (Rakoczy 2005:49).

Further, a woman's body and her sexuality has not always occupied an appraised space in the history of religions such as Christianity as indicated earlier. For example, informed by mostly Platonic and Aristotelian philosophies, greatly acknowledged church fathers such as St Augustine, and Thomas Aquinas both had reservations on women bodies. As an influential exemplar of Christian conversion and monasticism St Augustine seemingly believed that for men to attain holiness they had to retain a certain distance from women. In chapter VI of his rule St Augustine warns monastic men of the danger of looking at women bodies: *'...you must not fix your gaze upon any woman. seeing women when you go out is not forbidden, but it is sinful to desire them or to wish them to desire you, for it is not by touch or passionate feeling alone but by one's gaze also that lustful desires mutually arise'* (Augustine, IV, 4 as cited in Karen & Hermes 2009:196). It appears therefore that women bodies were not only capable of corrupting the 'holy' men's souls but also destabilizing monarchical lifestyles of men. The rule seems to further portray that women had no decision or control that informed their behaviors but could be dictated upon by the desires of men. Similarly, appeased by Aristotelian philosophy which insisted on women's inferiority as products of defective male seeds⁴ (Allen Prudence 2002:141). It is from such discourses

³ Cf. Caplan P. The Cultural Construction of Sexuality (1987: 9); Tamale Exploring the contours of African Sexualities (2014:160).

⁴ Aristotle believed that women were only created due to the lesser hotness of the sperm and this was a defect. While the female bodies provided the material

and perceptions about a woman's body that some of the religious derive their teachings which deny women the right to emancipate their bodies from religious teachings that are life denying and fail to promote the wellbeing of women. Therefore, a need for feminist epistemology that will challenge such a status quo.

Feminism, Religion and Women's Bodies

From a feminist perspective, the call towards the liberation of African women from religious discourses that promote patriarchy is one of the major issues that has attracted the attention of African women feminist theologians. African feminism is contextually understood. It seeks to respond to a diversity of African women experiences as influenced by a number of forces such as religion, colonialism and traditional cultural norms Kanyoro (2002).

In their edited volume Phiri and Nadar (2006) argue that one of the areas that some African women feminists and theologians have greatly contributed has been to redefine a woman's place in religious circles a space which has been for centuries predominantly male-controlled. It has also been rightly noted by many African feminist theologians that religion has been used as a tool to suppress women's voices, bodies and experiences, and in some way, as a systematized mechanism of surveillance over women's theological reflections on their being.

Although Oduyoye is equally keen at appreciate the contribution of religion and its relevance in the African context, she raises concerns on religious orchestrated silences when it comes to issues that directly undermine women's liberation:

My criticism of African churches is made to challenge them to work towards redeeming Christianity from its image as a force that coerces women into accepting roles that hamper the free and full expression of their true humanity the church seems to align itself with forces that question the true humanity of 'the other' and, at times, seems actually

support during reproduction it was the male's sperm that provided life. Women's bodies were thus only necessary for a nourishing environment (cf. Thatcher 2011:8).

to find ways of justifying the oppression or marginalization of ‘the other’ (Oduyoye 2005:480).

For some time now, African women feminists and theologians have called for the liberation of women’s bodies from all forms of oppression by challenging society to accord women the freedom to assume equality due to them as humans (not just complementarity).. Traditional body theologies that tend to categorize men and women as unequal partners in both strength and exercise of responsibilities have continuously found beacon in the contemporary African church. As rightly raised by Rosemary Radford Ruether (1993) body politics are constant determinants for women positions and hierarchy in religious spaces. A good example can be drawn from the Catholic church where the ordination of women is vehemently challenged by referring to the apostolic tradition that never saw the ordination of women; to the supposition that Jesus chose only men for apostleship⁵ and John Paul II’s most recent statement that ‘while men and women are equal in worth and dignity, their physical and anatomical differences are evidence that God intends different roles and purposes for them’ (Manson 2014). An emphasis that would lead one to conclude that such exclusion is justifiably focused towards the woman’s body and not her being as a human being. Thus the idea that women in most cases are judged by the church on grounds of *who* they are and not *what* they. In this this way the body becomes the place of contestation.

The discourses on body-based argument that seem to take for granted women’s liberation theologies in many Christian denominations have been as a consequence of failure to positively address issues related to body theology. One of the reasons for this failure could be argued from an existentialist point of view that society can hardly respond positively to issues relating to women’s bodies historical social and religious constructions of women’s bodies. Further the sustained limitation to respond to women’s experiences can also be seen as agenda of alienating women from the center to the peripheral. A recent study by Falola and Akua, 2012 affirms Ruether’s (1993) point of view that while the center of leadership and ministry is visibly under male control, women are left with less options than to occupy the peripheral. But the seemingly successive push of women to the peripherals of religious spaces can, in some sense, be a subsequent effect of the ‘WHO’ and ‘WHAT’ hermeneutical

⁵ Cf. John Paul II ‘Apostolic Letter *Ordinatio Sacerdotalis*’ 1994.

interrogation of a woman through her body. The two W's when used through a patriarchal interpretative lens often locate a woman as a co-helper, complementary, productive and reproductive 'asset' of the male. The two W's further present a woman's body one that should acted on, silenced and talked for by society. Accordingly, Falola and Akua argue that 'based on its interpretation of the Bible on the Who a woman is and What her capabilities entail the Church has positioned women in a childlike state and effectively rendering them as needing care; attention; and most importantly, directions in order to function properly in society and live a righteous life' (2012:73).

It would be however inappropriate to fail to recognize some traditions that have made effort to deconstruct and reconstruct the position of women in their religious spaces. While this development is noteworthy, the platonic sexism that denounces the woman's body seems to still exist in most of the religious circles. In the context of HIV and AIDS, marriage and Gender based violence, African women theologians have often critiqued the Christian church not for being ignorant of the gospel of equality and humanness but for failing to put into practice that which is believed, read, and taught (Phiri 2007: 20).

It would also be misleading if it is generalized that African religions treated women and men equally. At least not as far as their bodies were concerned. At the same time, it would also be misleading to see African Traditional religions and Christianity as monolith in their perception of women's bodies this is because bodies that defined masculinities and femininities always dictated which place one occupied.

Conceptualisation of Female Bodies as Health Threats

The paper has debated discourses on body theology and its effect on women's wellbeing drawing much of its ideas from an African perception of women's bodies. In relation to African sexuality Amadiume (2007:26) argues that most of the studies done on African sexualities have created more fear for the African woman than pride and joy for her sexuality. She observes that the woman's body has been reduced to a figure for scrambling between different forces for purposes of advising, controlling, health assessment, entertainment (own words) or offering direction. The theory of governmentality equally clarifies this phenomenon by asserting that in any human society, at the helm of power and control individuals learn 'to act on others ... (and this through

these relations,) it bends, it destroys, it breaks, it forces, or it closes all possibilities' (Foucault *et al.* 2003:137). To this end, women usually identify themselves with little self-esteem inferiority and subordination.

In the Christian tradition, one of the powerful means used in exerting control of women bodies in religious spaces was through demonising African traditional practices that sought to promote and revere the woman's body. As maintained by Tamale (2014), Messianic religions failed to appreciate the woman's body as did the African traditional religions. As Christian missionaries sought to instil the sacredness of worship spaces the gaze was much directed towards the women bodies' disposition. Traditional dances and dressing as appreciated by African cultures seemingly portrayed a sense of 'immorality' before the 'holy men of God.' For many of the early Christian missionaries in Africa as Tamale (2014:153) would argue 'the female body was viewed as the seat of sin, moral corruption and a source of distraction from Godly thoughts'.

Similar sentiments are held by scholars such as Phiri (2007). In her analysis Phiri observes how certain aspects of the Chewa initiation ritual (*chinamwali*) ended up being demonised and banned. Among the key elements that the Christian missionaries deemed inappropriate and sinful were, 'cultural taboos associated with [menstruation] blood and sex' (2007:62). Christian missionaries argued that such practices were not only contrary to Christian teaching, but were also enslaving to women and girls. Religion as such was seen and presented as a liberating mechanism for the enslaved body of a Chewa woman. Borrowing Hertog's (2010:121) words we argue that 'religion can influence people's opinions, attitudes and behaviour'. About issues such as health and wellbeing. In dictating how the women bodies are viewed, theological assumptions such as these carry overwhelming influence considering the fact that they are pronounced from religious seats of authority overseen by the patriarchal structures. In the era of HIV and AIDS the female body continue to be viewed as a threat to the male body in as far as infection is concerned. This kind of threat reflect a battle of the genders, (i.e., the male power which is seen as superior and the female power which is considered as inferior to the male) (Tamale 2014:152). When negative attributions are associated with an African woman's body there seem to develop tendencies of psychological inferiority that tend to gradually limit one's abilities to challenge tendencies of subordination a situation that increases one's vulnerability.

From African Traditional Religion point of view, women occupied

significant spaces as diviners, healers, prophetesses that performed leadership role as priestesses (Falola & Akua 2012:70). We therefore argue that in an effort to find redemptive ways of addressing the women's body in the context of health and wellbeing African traditional religions can offer a reliable critique to reviewing how women's bodies can be perceived in such a context. Other than being perceived as weak, African Tradition often view women's bodies as spiritually powerful. This however does not mean that African Traditional Religion is devoid of women subordination in relation to the physical bodies. Although women performed roles of diviners, priestesses and others, their bodies could in many ways at times be perceive as obstacles for community purification. For example, woman's menstruation period is continuously associated with impurity and possibility to defiling the sacred shrines. This type of blood is believed to 'render impotent or reduce the efficacy of any herbal medicine or talisman' (Oduyoye & Kanyoro 1992:20), hence affecting the health of any male who comes in intimacy contact with a women observing menstruation. It is such kinds of assumptions that have also contributed to the way in which women's bodies are perceived as health hazards in most societies

This paper has theoretically analysed the construction of women's bodies in Religious spaces. The main focus of the paper as discussed earlier was to show how religious constructions of women's bodies affect the way in which society view women as health threats and how such constructions has led to how women view themselves in relation to realizing their wellbeing. The location, perception, the gaze or spiritualizing of women's bodies in religious spaces needs to be critiqued if women's emancipation is to be attained. Without this engagement, we argue that women's bodies will continue to be subordinated and this will perpetuate negative perception of women's identity in society. Further this kind of approach to women's bodies will continue to undermine women' agency in responding to contemporary challenges such as HIV and reproductive health.

Conclusion

We conclude this paper with an argument that knowledge with regard to how women should express their bodies and sexuality has served more instances of subordination than equipping women with autonomy to direct their health and wellbeing. This is despite much effort by women to liberate themselves from

such human perceptions. The conception of this knowledge has been greatly informed by a number of forces such as colonialism, Christianisation, African tradition Religions, and other forms of epistemologies informed by patriarchal tendencies. At the centre of these constructions is a discovered framework of hierarchy in which even in issues relating to wellbeing bodies are ranked first and second class positions. This does not exempt religious spaces despite the 'preached gospel of equality.' As the paper demonstrates patriarchy continue to provide structures of control over women's bodies through arms of culture, health and religion. This makes women's subordination inevitable. However, identifying traces of subordination remains critical since these forms of knowledge are presented with codified sentiments of health intentions, sexual excitement, cultural identities and 'life-saving' intentions that women ought to enjoy. However, in as much as certain forms of epistemologies attempt to forward good intentions for the female body, the failure to engage women experiences and actively provoke their voices, creates states, pauses a great challenge to the current call for women emancipation that leads to women's realisation of their identity.

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Theological Reflections on Sex as a Cleansing Ritual for African Widows

Elijah M. Baloyi

Abstract

Violence against women is deeply rooted in human history. The patriarchal gender inequalities, culture, religion and tradition have been vehicles by means of which these structured stereotypes were entrenched. In trying to keep the widow in the family as well as forcing her to prove her innocence, certain rituals were introduced, one of them being the sex cleansing ritual. Besides being both oppressive and abusive, the sex cleansing ritual can also be an instrument of sex-related sicknesses such as HIV and AIDS. Although some widows are willing to undergo this ritual, others succumb because they fear dispossession or expulsion from home, thereby forfeiting the right to inherit their late husbands' possessions. It is the aim of this study to unveil by way of research how African widows are subjected to this extremely abusive ritual and exposed to HIV and AIDS. Their vulnerability will be examined from a theological point of view and guidelines will be given. The article will highlight how humiliating and unchristian such a ritual is for defenceless widows and their children.

Keywords: Sex cleansing, ritual, widow, inheritance, sex cleansers, oppression.

Introduction

According to Afoloyan (2004:185), it is widely believed amongst Africans that the demise of a husband does not mean the end of a marriage. The author intends to introduce the problem at hand with a quotation from LeFraniere (2005: 1) which states:

I cried, remembering my husband. When he was finished [with the sexual intercourse], I went outside and washed myself because I was very afraid. I was so worried I would contract AIDS and die and leave my children to suffer.

These are the words of a woman who was forced to perform a sexual cleansing ritual after her husband had passed away. This practice is part of the rituals that widows undergo as part of the mourning process and entry into widowhood in many African tribes. Although this issue has been touched on in my previous work, it did not receive much attention as it was not the focus of the study. The author realised that the issue of sexual cleansing in itself deserves some research.

Traditionally, widows have been expected to uncritically accept this ritual as a way of completing the mourning period and reintroducing herself into normal life. It is the aim of this article to unveil how the ritual of sexual cleansing dehumanises and subjects widows to unconditional subordination and oppression. It is also the intention to argue that theology has a role to play in eliminating this kind of pathology which degrades and humiliates women. Besides the humiliation, this practice involves unprotected sex, which increases the chances of HIV infection (Curnow & Watts 2013:1).

Relevance and Method of the Research

The passing of a husband amongst some groups of black people is followed by several rituals. It is the author's opinion that one of the most horrific rituals in this context is that of sexual cleansing, where the widow is expected to have sexual relations with a cleanser. Widows who rejected the practice were disowned by their families or stripped of their husband's inheritance. It is unacceptable that theology (particularly the black and liberation theologies) turns a blind eye to the plight of widows in this regard. Modise (2016:5) is correct in arguing that the struggle against oppression, poverty, hunger and death is at the heart of the theology of liberation.

Practical theology cannot be indifferent to the plight of grieving widows who face this kind of oppression. It is unfair to relegate the responsibility of correcting gender imbalances among African people to the Commission for Gender Equality. The number of legal battles against traditional leadership continues to rise since what is traditionally accepted

about these ‘sexual cleansing’ rituals is often contrary to the democratic constitutions of many African countries. For example, in Zambia a 79-year-old widow went to court because she refused to submit to this practice (Hambuba 2006:1).

The research will be theoretical and, therefore, the perusal of books, articles, newspaper reports as well as other media sources will be critical. The theoretical framework will look at the definition before examining the possible reasons for this practice. This will be followed by the outcomes or consequences of the practice and a theological evaluation and concluding remarks will be given after that. The humiliation, gender inequality and health threat that this practice causes women is the subject of this research. Though it is not practiced by all African clans and tribes, the mere fact that it happens in South Africa, calls for research. Although the focus will be on the Tsonga-speaking people of South Africa, African people have much in common. During this research I will often refer to ‘some Africans’ thereby indicating that Tsonga people live among other African tribes.

What is ‘Sexual Cleansing’ and How is it Performed?

In the African context the transition period between the death of a husband and the reinstatement of his widow in normal life is regarded as an abnormal and extremely dangerous time for both the widow and other people (Ayikukwei, Ngare, Sidle, Uyuku, Baladdawa & Greene 2007:35). Therefore, for the protection of both the individual and society, ritual cleansing is necessary. A widow is not allowed to have sexual relations with anyone before undergoing a cleansing ritual involving some herbs and a healer (Bala2014:34). Gunga (2009:170) is of the opinion that there is agreement among many African scholars that sex is central to the cleansing ritual (e.g. Kunda 1995. Butlerys *et al.* 1994; Landry & Mathui 2005).

In Tanzania a widow was declared an outcast after the death of her husband because she refused to be inherited by her brother-in-law through the practice of sexual cleansing (Makoye 2013:1). According to Makoye’s report, the widow was supposed to undergo the cleansing sexual ritual with her brother-in-law, not an outsider. Another example is a widow who was forced to undergo the cleansing ritual with her late husband’s younger brother. When her family started to pressurise her to marry this younger man, she decided to flee from her home in Giyani (Nkhwashu 2012:2).

The question about who is eligible to perform the ritual cleansing can be answered in one of two ways. The first is that in some African countries, every village has professional cleansers. According to White (in Curnow & Watts 2013:1) widows' families pay these so-called cleansers for their services. Cleansing is considered as their employment and whenever a woman becomes a widow, these men are called upon to perform the ritual. The Global Widows Report (GWR 2015:111) indicates that most of these sex cleansers are social outcasts (GWR 2015:111). In a Human Rights Watch interview held on 2 November 2002, a widow indicated that her family paid a herdsman to, against her will, have sex with her without using a condom. In Malawi, a mentally unstable, ostracised man is often identified to perform this ritual. The role of this person is to have sexual intercourse with the widow to chase away or 'cleanse' the cause of the death in the family. The practice is called *kupita kufa* or *kochotsa fumbi* and the cleanser is paid for these services. The whole process is usually arranged by the widow's in-laws without consulting her or seeking her consent (Kapuma 2011:3-4). According to Gunga (2009:170) there are two kinds of professional cleansers: the first is a member of the family or clan (called a *jatiek kwer*) and the second is somebody from outside the clan (called a *jakowiny*). Kimani (2004) and Ocholla A. Ayayo (1996:4) agree that only someone who is sexually perverse or a psychopath is capable of doing what normal human beings cannot do. In other words, a mentally disturbed person is considered the ideal person to sever the cord between a widow and her deceased husband. An outsider is preferred because, similar to a sacrificial lamb, he assumes the contamination or uncleanness.

Another form of cleansing involves the brother or a close relative of the deceased. Sometimes a widow is forced to have sex with her late husband's brother, as in the case study of Reneilwe. In some Zambian contexts the relative of the deceased, accompanied by family members, goes to the widow's house and hosts a party during which he is ushered into her house. The relative is then left behind for the night to perform the ritual. If, a few days later, the relative decides to marry the widow, the usual rituals follow and the families of both gather to bless the new marriage (Kalinda & Tembo 2010:1).

According to Mulango (2001:376), there is another form of sexual cleansing called thigh brushing or *kucuta*. This requires the brother of the deceased to rub his genitals against that of the widow without having sex. The author assumes that it is a later version of cleansing which came about as a result of HIV and AIDS. Apparently the cousins and siblings of the deceased

cover the widow in a long cloth called a *chitenge* so that there is no nudity when the widow slides or thigh-brushes against the man enveloped in the same cloth (Mulango 2001:373).

The Reasons for Sexual Cleansing

Death is one of the most feared and most universal occurrences. Many Africans are of the opinion that this mystery deserves a ritual to explain it and avert bad luck (Tjibeba 1997:19). It is believed that if death is not removed through certain rituals, it can either bring bad *xinyama* or *setshila* (bad luck) or wipe out the whole family (Baloyi 2015:247; Wade & Eguchi 1984:113). According to Baloyi (2014:6) Africans believe death can be stopped or confined by performing certain rituals.

According to the online *Encyclopaedia of death and dying*, the cleansing ritual is thought to exorcise the evil spirits associated with death and if a widow refuses the ritual, it is believed that her children will come to harm. It is understandable that the fear of misfortune befalling her children could impel the widow to assent to the ritual. Hambuba (2006:1) indicates: ‘Sexual cleansing is a traditional African custom for some African tribes in which a widow is inherited by her in-laws after she has sex with one of her dead husband’s male relatives’. According to the traditional beliefs of many Tonga – who live in Mozambique, Zimbabwe and Zambia – the ritual frees a widow from her husband’s ghost. There is a belief that when the husband dies, he immediately becomes a ghost who follows his wife wherever she goes and tries to prevent her from remarrying. Wade and Eguchi (1984:113) state that the sexual ritual called ‘*kugaana*’ (a word from one of the Zambian languages) is performed by a witch doctor and the widow outside the homestead.

This view was echoed by a woman living in the Chilala community in Zambia. ‘Sexual cleansing is important in our culture’, said Mable Cheelo, a middle-aged woman from a village in the Chikuni area near Chilala. ‘It is done to drive away ghosts from a widow because immediately after a husband dies, the wife carries a ghost. If not sexually cleansed, one can die early or even run mad’ (Hambuba 2006:2). According to the Global Widows Report (GWR 2015), those who support the ritual argue that it breaks the supernatural or spiritual bond between the widow and her husband’s spirit. It is also believed that if the practice is not performed, the husband’s spirit will cause a range of negative outcomes for the widow’s community (GRW 2015:110). This

indicates the stereotype internalisation of the ritual by women who end up contracting sexually transmitted diseases like HIV.

Another motivation, according to Awuor (2007:1), is that the cleansing provides protection for the widow, her children and the whole village. Although Awuor does not go into detail about what kind of protection and against what or whom it is needed, the author thinks that the protection against their husband's families. This is because many widows are disowned by their husbands' families if they refuse to undergo the ritual. Furthermore, the immediate family and parents of the widow may also turn against her. It should be understood that because of the communal way of life that many Africans have, disownment by one's family means that one is rejected by the community or village. This terrible destiny is feared by all widows.

Many African ethnic groups are of the view that the reason behind all mourning rituals, including sexual cleansing, is the belief that the entire family of the deceased is contaminated or polluted because of their contact with death. That is why Baloyi (2015:256) argues that the 'removal of death in the family' is one of the reasons for these rituals. They result in a spiritual reunion between the family of the deceased and society (Ngubane 1977). Gunga (2009:170) uses the term 're-incorporation into society' when he refers to one of the purposes of this ritual. Setsiba (2012:20) states that rituals form part of the taboos when there is death in the family. Widows are also made to believe that there will be a curse on them if they do not adhere to this practice. One woman was quoted saying: 'I don't want to die, I don't want a curse to come from my husband' (Curnow & Watts 2013:1). According to Idialu (2011:9) this ritual, amongst others, demonstrates that the widow is not complicit in her husband's death and, moreover, it protects her and her family. In other words, when the widow complies with this ritual, it is an indication of her loyalty to the family and that she did not have a hand in her husband's death. This kind of pathology needs to be eradicated. The author agrees with Nwachuku (1992:61) that instead of suffering emotional and physical violence, a widow deserves to be pitied and helped. There is no denial that widowhood in Africa reveals the reality of violence against and abuse of women (Martey 2009:222).

The Side Effects of the Ritual

Psychological Effects on the Widow and her Children

According to the *Encyclopaedia of Death and Dying* (online), despite clear

indications of the brutal impact on the widows' children – some children are forced into child marriage and prostitution and others fall victim to child labour and human trafficking – the public displays an astonishing ignorance and lack of concern. Discussions about African widowhood usually centre on women, family and other adult relatives, but scant attention is paid to the fate of the deceased's children. Sengendo and Nambi (1997:2) maintain:

Unfortunately, adults do not seem to appreciate that children are also adversely affected by bereavement even though they may not have an adult's understanding of death. Little attention is therefore given to children's emotions. Children are not given the required support and encouragement to express their emotions nor are they guided to deal with them. For example, children are not always talked to, nor listened to, and therefore their emotions are not understood.

This introduces us to the challenges that many orphaned children face. While some drop out of school because of the death of a breadwinner, others are forced into early marriage or have to seek employment at a relatively early age to support their mothers. Helping children to go on with life without their fathers is very difficult for most widows. Kapuma (2011:6) indicates that her daughter used to cry whenever her schoolmates were fetched by their fathers, because her own father had recently died. Besides being depressed, some children's performance at school is affected when they see how their mothers are mistreated and disrespected by family and community members. According to Mulaudzi (2007:35), these rituals are said to be intended for the protection of both the widow and her children, but the opposite is accomplished instead.

Martey (2009:223) is correct in arguing that some widows commit suicide when they realise that their husbands' family, on whom they have always relied on, have suddenly turned against them and maltreat them. According to Trivedi (2009:2), the psychological problems widows have to contend with include loneliness, loss of self-esteem and considerable grief, as well as depression and anxiety. A loss of personal contact is often the result of withdrawal. According to Trivedi, several scholars agree that widowhood has an adverse impact on the psychological well-being of women (e.g. Davar 1999; Reddy 2004; and Thompson *et al.* 1989). The insecurity and violence that widows endure usually have psychological after-effects. The truth, according

to Martey (2009:219), is that besides the spiritual violence, African widows also suffer emotional as well as psychological trauma.

HIV and AIDS and other Sexually Transmitted Diseases

It has been proven that sexual intercourse is not the only way HIV is transmitted and that the majority of HIV and AIDS related cases result from multiple sexual relationships. For the sake of this research it is important to indicate that one of the dreadful things which can happen when widows are forced to undergo sexual cleansing is infection with HIV and other sexually transmitted diseases. In some countries the use of a condom during sexual cleansing is not allowed (Curnow & Watts 2013:1).

Hambuba (2006:2) indicates that because of the campaign to curb and eliminate HIV/AIDS, many countries try to abolish the sexual cleansing ritual. In some areas where it is still practiced, it has been modified and called *kucuta*, and a man merely rubs his private parts against that of the widow without penetrating her (as has been described above). A high percentage of orphans as well as street children on the African continent are orphaned as a result of AIDS and other sexually transmitted diseases. Kapuma (2011:3) emphasises that the biggest danger attached to sexual cleansing is the transmission of HIV and AIDS. Sexual cleansers have cleansed countless other widows and are most probably carriers of the virus. One Malawian widow cleanser who acknowledged that he might have infected a lot of women indicated that widows would not be cleansed properly if a condom is used. In other words, only unsafe sex will cleanse them (Ethics, Gender, Human Rights 2009:1).

Degrading of Women's Status in the Family and Community

Kapuma (2011:2) maintains: 'I realized that my status had changed from married to widowed. My identity changed without me having any choice or say in the matter. I realized that the stigma attached to widowhood will now be attached to me as well'. These are statements of sorrow coupled with the realisation of the relegation or degradation that one faces in African widowhood. The pride taken in being a 'Mrs So-and-so' or being under the protection of 'Mr So-and-so' disappears and all the widow faces is a forceful subordination. The author is completely against this ritual because it targets widows only, whereas widowers are untouched.

It is true that gender inequality perpetrates violence against women. One widow cleanser indicated that Malawian tribal custom dictates that he first sleeps with the widow, then with all his wives, and then once again with the widow – all in one night (Kalinda & Tembo 2010:9). For the author such enslavement of women is unimaginable in this day and age. It confirms that women are still treated as mere objects and that men dictate down to their sex lives. Although African people respect marriage and sexual intercourse and regard them as important aspects of life (Kalinda & Tembo 2010:10), the ritual of ‘sexual cleansing’ is humiliating and a violation of women’s rights as human beings. Women’s rights must be understood in the context of human rights. Although Nomvula Makgotlho argued that the issue of female transformation is a sensitive one, the discrimination and deprivation found on the continent, particularly in rural areas, are nonetheless unbearable (Nyamunda 2015:1).

Theological Reflection as a Way Forward

A patriarchal mindset uses sex as a means of domination in many African ethnic groups. African widowhood usually forces widows to perform certain rituals which run counter to biblical faith and Christian principles (Martey 2009:219). These rituals conflict with the biblical principles of love and support that the Bible teaches with regards to widows. This makes theology responsible for addressing the widowhood situation. Liberation theology calls for the contextualisation of theology in the circumstances and situation of the people. Besides that, God is a liberating God; theology must wage war against any form of discrimination regardless of sex or gender. After all, both men and women are created in the image of God. Ratele (2008) is correct in arguing that it is impossible to create gender equality in Africa if the daily experiences of men are not considered. This confirms that theology cannot claim to liberate women unless it starts changing men’s ideology about women. The oppressive man must be reprimanded and discouraged. Chitando and Chirongoma (2012), Morrell (2007) and Van Klinken (2011) agree on male mentoring programmes that can be initiated by either government or NGOs to help men to become agents of change for the reconstruction of masculinity. This would encourage men to make better choices and decisions and to contribute to a more gender-equitable society. It is unfortunate that, although the issue of gender equality is one of the major topics discussed throughout the world, few men address the

domination of women. I am in full agreement with Van der Walt (1994:154) that the liberation of women will not take place without the cooperation of men. In many African ethnic groups, it is still men who debate and take decisions that affect the whole group or clan. It is for this reason that theology should target men at their indabas and other communal gatherings. Pastoral caregivers and preachers can use this opportunity to get involved in their communities to end violence against widows.

Theology and the church must seek ways of protecting the rights and dignity of women in society. The truth is that many churches end their support when the deceased is buried, which leaves room for his family to humiliate his widow. Although it has been indicated many times that a funeral is a family matter, the mere fact that the church is invited to conduct the burial opens an opportunity, not only to evangelise the family, but also to stand firmly on the side of the widow. The fact that Jesus wept and grieved alongside Mary in John 11:35 is an indication of the compassion He had for the loss of her brother. The Greek word for 'weep' has a connotation of silently bursting into tears in contrast to the loud lament of the group. According to Beyer (2007:206), 'The servant's life was marked by sorrow and emotional pain, and he knew suffering and grief well. The church do(es) not have an option, but to emulate Jesus in its compassion to the widows'. The church as God's representative on earth must, amongst other things, be characterised by 'mourning with those who mourn, and rejoice with those who rejoice' (Romans 12:15). This is the calling of the Christian church who intends to serve God faithfully. Banda (2008:51) is correct to blame the church: 'It is not only the patriarchy's legal system and political structures which are a problem, but also its social and cultural institutions (especially the family and church)'.

Since many congregations still have male pastors, these pastors have to train women in their congregations to stand up for each other. This will help to change the negative perception that many families have of pastors who support widows. Some have been said to inherit from or to be in love with the widows and so on. Theologians and pastors need to make the Bible as relevant as possible to the plight of widows and their families. Cone (1975:17) is correct in surmising that human experience should be the source of theology.

While some children of widows are forced to drop out of school at an early age in order to help their mothers, others are obliged to relocate and make many adjustments. Therefore, their maltreatment is wide ranging (Idialu 2010:9). In Malachi 3:5 we read:

So I will come to put you on trial. I will be quick to testify against sorcerers, adulterers and perjurers, against those who defraud labourers of their wages, who oppress the widows and the fatherless, and deprive the foreigners among you of justice, but do not fear me, says the LORD Almighty.

The oppression of widows in this context may include forcing widows to undergo the humiliating ritual of sexual cleansing. It should be advised that a negative practice such as the sexual cleansing of widows must be discouraged in the strongest terms (Phillip *et al.* 2015:57). Widows' vulnerability due to their economic dependency needs theology to come up with empowerment strategies to help widows to regain their status and dignity in their communities.

According to Kapuma (2011:8) women need a theological ear to listen to their untold stories and she continues: 'Telling your story of obedience to a higher goal is a liberating act'. Pastoral caregivers, ministers and preachers need to give widows a platform and listen to them when they tell of their experiences. Pastoral counselling as well as emotional support should be available to help them to heal and redirect their lives. It is also the duty of theologians and pastors to prepare married women for the possibility of becoming a widow one day. This will prepare them to stand up against cultural practices that discriminate against them.

Another challenge that theology is confronted with is the fact that the practice of widow cleansing has its roots in tradition, not the Bible. Although sexual cleansing is connected to wife inheritance, there is a realisation that both inheritance and sexual cleansing are not biblically founded (Mulango 2001:378). Ntozi (1997:125) is of the opinion that although widowhood is influenced by both culture and religion, it is imperative that religion helps to reverse humiliating widowhood rituals, including sexual cleansing.

Although I distance myself from the unfounded view which connects HIV and AIDS (held by Van der Walt 2004; Douma, 1987; and Clifford 2004) with God's judgement, it is important to note that theology cannot dissociate itself from pointing out how immoral it is to force someone to have sexual intercourse as part of a cleansing ritual. In his article entitled 'Towards a Theology of HIV/AIDS' Van Wyngaard (2006) indicates how negatively the discussion of sex and sexuality affect people in the context of HIV and AIDS.

The liberation of women would be incomplete without their economic

liberation. The stereotypes owing to their dependency invite theologians to think about helping vulnerable, uneducated and unemployed widows. The economic emancipation and empowerment of women should not only concentrate on the government's BEE and AA programmes (specifically in SA), but the church must think of more projects that will ensure that widows and women in general are economically empowered. Theology cannot avoid addressing the issue of poverty, which plays a role in subjecting women to sexual violence in the name of 'cleansing'. If women are not economically liberated, their dependency will expose them to severe harassment by those who financially support them. Lastly, theology must find a way, through its pastoral services and preaching, to encourage widows to discard the policy of silence and voice their feelings and concern about their families (Akujobi 2009:14).

Conclusion

The research clarified that widowhood in the African context entails a change in lifestyle, social status, identity and role. It is painful when, after the loss of her husband, a widow is also forced into rituals such as sexual cleansing. As if the pain of her loss is not enough, the dreadful rituals that can infect her with sexually transmitted diseases, are forcefully performed on her. Although many widows try to resist these practices, their refusal to comply is often answered with physical and sexual violence. The role of poverty and unemployment in subjugating widows is also noted and, therefore, the empowerment of widows should include the economic challenges they have to contend with. Widowhood affects the children of widows in different ways and theology should acknowledge the importance of assisting fatherless children as well.

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Decolonising HIV Prevention: A Critical Examination of *Ukusoma* and Virginity Testing

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Abstract

A question that the Southern African region has been struggling with for some time is that, despite the efforts at preventing HIV through various methods, the region is still experiencing new HIV infections. Although this happens at a low rate, it still raises an alarm. Some, if not most, of the traditional HIV prevention methods from Africa have been criticised and rejected as human rights violations and as 'sinful'. For this reason, this study is a critical examination of two African traditional practices namely *ukusoma* and virginity testing. These are two of the traditional methods of HIV prevention, particularly in KwaZulu-Natal, South Africa. Adopting African feminists' critical hermeneutics, this paper explains the different and complex implications of both *ukusoma* and virginity testing on the lives of girls and on the prevention of HIV. The study argues that generally it would be an oversimplification to claim that *ukusoma* and virginity testing are unequivocally either good or bad for girls, without a critical analysis of these practices while taking into account the shadow cast by HIV on *ukusoma*. I discuss how these traditional indigenous practices can, on one hand, be limiting and on the other hand, be a source of female power in a context of patriarchy, particularly taking into account the HIV epidemic.

Keywords: HIV and AIDS, *ukusoma*, virginity testing, African feminist critical hermeneutics

Introduction

A number of African cultures and traditions considered to be violations of the rights of women, children and men became widely known due to HIV and

AIDS. At the peak of HIV in Africa, traditional cultural practices were criticised for increasing the exposure of women and girls to HIV (Chisale 2014:75). Among the traditional cultural practices under close observation and often criticised is virginity testing. Virginity testing is currently causing a public outcry because a mayor in KwaZulu-Natal recently gave bursaries nicknamed 'virginity bursaries' to girls who passed the virginity test. The loudest protests have mainly been from feminist movements and human rights organisations that are challenging this move as a violation of young women's sexuality. Efforts to explain the municipality's point of view are in vain, as opposition political parties such as the Democratic Alliance (DA), human rights and feminists' movements demonstrate lack of insight.

In this study issues about African women's sexuality are criticised from a human rights perspective. Interestingly, these critiques of cultural customs surrounding the sexuality of women from the African continent have ignored the call by the African Renaissance and other theorists such as African feminists to extract what is liberating from culture and religion (Dreyer 2011:7; cf. Oduyoye 2001:11). Despite efforts by scholars from the African continent to explain African people's cultural customs, critics continue to label African pedagogies of sexuality as human rights violations.

Written from an African feminist's critical hermeneutics perspective, this paper is a critical examination of two traditional African practices, *Ukusoma* and virginity testing. These practices are selected from among other traditional methods of HIV prevention, particularly in South Africa's KwaZulu-Natal province, as they are often criticised as violations of young women's human rights. The paper examines how the two traditional practices are accepted by the Zulus as crucial HIV prevention methods. The Zulu is a large, ethnically South African group of people with its origins in KwaZulu-Natal. Their way of life is commonly guided by indigenous African culture and religion. In Africa, different stages of sexual development of children, such as puberty, are marked by different rites of passage. Because virginity is valued among the Zulu, virginity testing has become important. The Zulus and other Nguni tribes regard reaching sexual maturity as central in the development of a child; as a result they have put structures in place that are aimed at protecting the sexuality of their children (Bennet 2004: 295). Virginity, which is the core of a child's sexuality, is valued in African contexts and is a source of pride for the girl as well as her family during marriage negotiations (Chisale 2014: 75). In order to make sure that girls jealously guard their virginity, African

traditional societies collectively mentor girls about issues of sexuality (Wickström 2010: 543).

As soon as children reach puberty, women and men among the Zulu such as aunts and uncles mentor young girls and boys about sexual issues and usher them into adulthood. The guarding of virginity is central in mentorship. Thus, virginity testing is not a new cultural practice among the Zulu and other African indigenous cultures. The guarding of virginity has a long history, since the value of virginity is not only in Africa as part of African culture, but also has a religious background and is valued in Western traditions as well (Denmark, Rabinowitz & Sechzer 2005).

Suspensions about and criticism of virginity testing increased during the HIV and AIDS era, particularly in Africa. Scholars and human rights movements have examined this phenomenon and criticised it as a practice with patriarchal roots. Feminists have particularly observed, in their critiques of virginity testing that putting a value on virginity in marriage initiations is patriarchal (Tamale 2014). Human rights movements and feminist movements have challenged this cultural practice as unhygienic and a health hazard (de Wet 2012). Fears are that the use of one glove by the tester increases girls' vulnerability to HIV (Phiri 2003: 74). It is also assumed that young women are forced by tradition and by their parents to undertake virginity testing (Chisale & Buffel 2014:291). Questions about ethical obligations, such as consent by the girl being tested, are constantly asked by human rights and feminist movements. African feminists such as Phiri (2003) argue that those influenced by a Western worldview are the ones who observe virginity testing as a patriarchal tool. They also see virginity testing as a human rights issue because the rights of young women are perceived to be violated (Chisale & Buffel 2014; Ntuli 2002). Rather than a violation of human rights, Chisale & Buffel (2014:292) see virginity testing as a strategy that is used by African communities that practise it to enforce 'good' or 'cautious' sexual behaviour among adolescents.

Ukusoma on the other hand, is not as widely researched as virginity testing. This practice is used to encourage a sexual debut among young women and men. *Ukusoma* and virginity are connected as they are both in the category of sexuality in an African context. *Ukusoma*, *Ukuhlobonga* or *Ukumentsha* are Nguni words that refer to non-penetrative sexual acts that may be compared to masturbation. The difference between the two is that the former does not involve self-satisfaction, but two people satisfying each other in the absence of

penetration. *Ukusoma* has not been attacked like virginity testing; instead *ukusoma* is identified by previous research in the context of the prevention of HIV and pregnancy (Sighal & Rogers 2003: 219) as good sexual conduct that discourages penetrative sex. Missionaries objected against this form of sex as it was inappropriate for the purpose of procreation (Harrison 2008: 177). Christian missionaries found African forms of sexuality evil and old-fashioned. However, research identifies *ukusoma* as a strategy that helps young people understand the changes in their sexually developing bodies while satisfying their needs without risking their lives due to sexually transmitted infections (STIs), particularly HIV, or unwanted pregnancies (Buthelezi 2006:3).

Methodology

In this paper I used participant observation and literature review. I have been observing the developments of the debate on HIV prevention using African traditional approaches especial the use of virginity testing. In KwaZulu-Natal there is media talk about the use of virginity testing to curb early sexual intercourse debut by young people. This approach is more practicable amongst girls as it is a bit difficult to test the virginity of boys. As a South African resident exposed to the news and socio-academic life I have observed that the debate on virginity testing especial scholarship incentives on virgins has divided society on racial lines. Whites are in the majority against virginity testing while blacks are equally in the majority for virginity testing.

I have also used literature review to check on the meaning, history, practices and effectiveness of virginity testing. What does literature have to say on the different views about virginity testing? Why is virginity testing a racialised issue in South Africa in particular and Africa in general? Is it possible to use virginity testing as a form of prevention of the spread of HIV?

HIV Prevention in South Africa

The questions addressed in the following sections are about whose human rights critics actually refer to and in what ways are *ukusoma* and virginity testing forms of feminine power in the context of HIV prevention. In as much as it is observable that the African continent is still considered a 'dark continent', it is to be noted that the metaphor 'dark continent' is a key term in

Euro-American discourses that describe Africa in dualistic terms: ‘places and peoples appear as quintessential objects, historically frozen within a web of dualities such as light/ dark, found/lost, life/death, civilized/savage, known/mysterious, tame/wild, and so on’ (Jarosz1992:106). Africa, as a dark continent, is associated with disease and death and the continent is typified as belonging to the ‘other’ and as such is negatively interpreted and reinterpreted by those from outside Africa (Jarosz1992:106). Thus, human rights movements, particularly those that are guarded and funded from outside Africa, are still influenced by the metaphor that Africa is a ‘dark continent’ that needs to be put under constant surveillance. Flint & Hewitt (2015: 296) argue that ‘Africa, in European discourse, has remained ‘ungovernable’ in as much as it is ‘enigmatic’, ‘unhealthy’ and, more often than not, ‘irrational’.

There was a time when HIV was considered a disease from Africa, when it was linked to Kinshasa in the Democratic Republic of Congo where it was believed that around 1920 HIV crossed species from chimpanzees to humans (Moyo 2005). The debates about the origins of HIV were due to denialism and confusion about this epidemic. Being considered the darkest continent, any deadly disease was assumed to be from Africa. The colonial perceptions of Africa as an unhealthy (Flint & Hewitt 2015: 297) and ‘dark continent’ (Jarosz 1992) influence the views of people from Euro-America about Africa even today. Critiques of the continent hide behind human rights tools and use academic discourses to portray African sexual practices as abnormal, untamed, and dangerous (Phiri 2003).

Human rights movements seem to target Africa because for them Africa is a ‘backward continent’ (Museveni 2000). Contemporary Africa still struggles to have indigenous traditional practices accepted as valuable. As a result, the HIV prevention strategies that are used by Africans are considered ‘backward’ and inhumane because they are linked to traditional indigenous practices. There is evidence, provided mostly by the Circle of Concerned African Women Theologians; that Africans prefer to incorporate their indigenous traditional practices into HIV prevention strategies (Phiri 2003; cf. Siwila 2015, Moyo 2005). African traditional indigenous practices include a combination of mainly behavioural and structural interventions (Chisale 2014). UNAIDS defines programmes that aim for a combination in ways of prevention as ‘rights-based, evidence-informed, and community-owned programmes that use a mix of biomedical, behavioural, and structural interventions, prioritized to meet the current HIV prevention needs of

particular individuals and communities, so as to have the greatest sustained impact on reducing new infection ...' (UNAIDS 2010:8).

Biomedical interventions use medical, clinical, and public health approaches (UNAIDS 2010). Biomedical interventions that were proposed by South Africans, like *Ubhejane* 'black rhinoceros', African Potato and *Umbimbi*, were marketed under the government of Thabo Mbeki, who denied the link between these and HIV and AIDS and was supported in this by Herbert Vilakazi (Specter 2007: 36). When Mbeki took office as president in 1999, it is believed that Mbeki's stand on questioning the link between HIV and AIDS and withholding the distribution of antiretroviral (ARV) drugs to public hospitals was due to his 'anti-colonial, Africanist ideology and his desire not to see Africa 'blamed' for a sexually driven epidemic' (Natrass 2008:164; Mbali 2004).

Despite substantial criticism from a scientific perspective, South Africans, particularly black indigenous people, resist biomedical intervention, particularly the use of antiretroviral drugs and resort to behavioural and structural strategies. Structural interventions include social and cultural strategies while behavioural interventions target the human behaviour by addressing risky behaviours that increase vulnerability to HIV (Coates, Richter & Caceres 2008: 669). Virginity testing and *ukusoma* fall under structural and behavioural interventions for the purpose of the prevention of HIV in South Africa. *Ukusoma*, which is not criticised as a human rights violation like virginity testing, is under-researched.

Previous research on HIV prevention in South Africa addresses *ukusoma* in combination with virginity testing with the result that virginity testing ends up taking precedence over *ukusoma*. Mchunu's (2005) study entitled, *Zulu Fathers and Their Sons: Sexual Taboos, Respect, and their Relationship to the HIV/AIDS Pandemic* clearly explains the significance of *ukusoma* among Africans, particularly the Zulu. He states that '...in all African countries, boys and girls were not expected to abstain from all sexual contact. They were discouraged from indulging in full sexual penetration but were allowed to engage in *ukusoma* or sex 'between thighs', which would technically maintain a woman's virginity' (Mchunu 2005). Mchunu's findings indicate that young males see *ukusoma* as a good male practice that displays that a boy has respect for his girlfriend. Penetrative sex among courting young men and women, according to Mchunu's participants, is contrary to Zulu culture (Mchunu 2005). Young men avoid penetrative sex to respect their

father's dignity and protect the whole family's good image (Mchunu 2005). It is assumed that a boy learns his behaviour from his father, therefore random sex with girls or penetrative sex with a girl out of wedlock displays the character of the father through the son. Non-penetrative sex is encouraged by some communities in Africa for HIV prevention purposes. This strategy has a three-fold purpose: that of protecting the girl's virginity, pregnancy prevention and preventing HIV or other Sexually Transmitted Infections (STIs).

Feminists and human rights movements are mute about *ukusoma*, but have spoken against virginity testing. The challenge of human rights is that their agenda is not clear when it comes to African traditional practices. It seems they disguise themselves as rights protectors while they are pushing the colonialist agenda in Africa.

Decolonising Sexuality and Human Rights in Africa

The Human Rights Watch seems to be abusing the human rights treaties by attempting to control the African continent, particularly African women's sexuality by hiding behind the mask of human rights. A critical question that we need to ask is: whose rights are being violated? Who is the victim in this case, is it the young woman or the human rights organisation? The 1995 Fourth World Conference on Women (FWCW) in Beijing endorsed that 'human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence' (FWCW 1995: Para 96).

From an African perspective, the dispute on sexuality highlights the tension and resistance that exists between human rights discourses and those Africans who conform to their indigenous theories of knowledge about sexuality. This argument between human rights and African discourses demonstrates a symbolic example of a continuous human rights narrative that implicitly controls the African female's sexuality by constantly putting it under surveillance. In this way women's resistance against oppressive African narratives of sexuality is complexified. The constant surveillance by human rights organisations and the guardians of African culture subverts the power of women (Tamale 2004). The constant surveillance by the Human Rights Watch, I believe, disempowers women by objectifying them and reducing them to victims.

Tamale (2007) calls the tension that exists between rights and culture absurd, because according to her the two should not be seen as ‘polar opposites with no possibility for locating common ground where new synergies can be developed for social transformation’ (2007: 149). As much as both instruments may have weaknesses, they also both have strengths and a strong possibility of empowering and liberating women if applied critically. At the moment the two are seen as opposites and are regarded as threats to each other. The threats exist, because the origin of culture is in dispute.

An African Feminist Critical Hermeneutics Perspective

Written from an African feminist critical hermeneutics perspective, this article sees culture as offering both liberation and oppression. According to Kanyoro (2002), the proponents of African feminist critical hermeneutics argue that by using cultural hermeneutics one should be able to reflect by questioning, scrutinising and examining cultural practices and narrative scripts for their oppressive as well as liberating potential in women’s lives. In agreement, Tamale (2014: 150) observes that ‘culture’ as a twofold tool ‘can be as oppressed, colonized, exploited, submerged and depreciated as [it] may be liberating and empowering’.

An African feminist critical hermeneutics enables one to understand the context of virginity testing and *ukusoma* as perpetrated by women themselves in their efforts at liberating themselves. As a result, proponents of African feminist critical hermeneutics acknowledge that culture in Africa is not homogenous; however, there are some characteristics that are ‘widely shared among Africans (e.g., the communitarian, solidaritarian and *Ubuntu* & ethos)’ (Tamale 2007:151; cf. Kasomo & Maseno 2011). Female sexuality in Africa is treated as homogenous and is usually portrayed in negative terms (Tamale 2007: 153). A call by African feminist theologians, such as Kanyoro (2001), challenges African women to learn to defend their good heritage that is liberating, rather than accepting and allowing criticism from outside which attempts to demonise it. A critical feminist hermeneutics allows one ‘to sift usable from unusable culture while acknowledging the fact that all cultures are not free from negative practices nor are they immune to external changes’ (Kamaara & Wangila 2010: 132; cf. Kanyoro 2001).

Positioning culture against rights in Africa hides an agenda for destroying morals as practised in African culture. Tamale (2007) discusses this

and argues that since women are the custodians of culture and morality, the conflict that exists between gender, culture and rights is unclear, since culture and women are two sides of the same coin. For women to enjoy rights, according to critics from outside, they are required to first separate themselves from culture.

Virginitv testing and *ukusoma* are cultural practices that are practiced in the context of the preservation of virginitv and the prevention of HIV. The former is widely criticised for violating young women's sexual rights, while the latter is criticised mainly by religious groups as immoral because it obstructs procreation. My aim of using African feminist critical hermeneutics is to discuss how the two Zulu traditional practices can be limiting but on the other hand can also be a source of feminine power over patriarchy, particularly in the context of the prevention of HIV.

Virginitv Testing and Feminine Power in the Context of HIV Prevention

The virginitv ideology is constantly associated with females. It is about girls who lose their virginitv and girls whose virginitv is to be protected. There is power behind this practice, the power of females. Due to the fact that HIV is a life-threatening epidemic, prevention is prioritised among African communities who fall back on cultural practices that can shape and inform human behaviour. Protecting and nurturing life is a woman's traditional role that begins from when the child is conceived through to the child's birth and through the stages of life up to death. Using African feminist cultural hermeneutics, I see virginitv testing as one of the strategies African women from KwaZulu-Natal use to protect and nurture their daughters. Phiri's (2003) study conducted in KwaZulu-Natal indicates that virginitv testing is nurtured by women and girls. A recent study by Chisale & Buffel (2014), conducted in a refugee community in Johannesburg, also indicates that women and girls are the custodians of virginitv testing. It is, however, contested whether the insistence on virginitv is patriarchal or whether it is a feminine concept used by women to resist patriarchy. I regard virginitv as a hidden patriarchal tool of power but also as a hidden feminine tool used by women to claim authority to their sexual bodies. The dynamics are complex.

From a feminine perspective there are critical and hidden pedagogies

that underlie virginity testing. Adult women, who are the primary guardians of virginity testing, use this tool to raise awareness among young women about how to use their virginity to exercise their sexual power (Chisale & Buffel 2014). Virginity is symbolic of female sexuality; therefore virginity testing makes young women and men aware of women's control over their sexuality. Women's jealous protection of virginity proves that they use their virginity to control and detect their destinies in the patriarchal order (Chisale & Buffel 2014). This power in real terms may seem to be worthless, but from an African feminist critical hermeneutics point of view, this power is worth being preserved in the context of rape, unwanted pregnancies and HIV. It is clear that virginity testing is not only a cultural practice related to sexuality, but that this practice goes hand in hand with schooling that liberates young women.

Chisale & Buffel's (2014) findings indicate that adult women transfer their knowledge of sexuality to younger women and that they see that knowledge as a source of feminine power. Research by African women theologians acknowledges the liberation virginity testing offers to young women (Chisale & Buffel 2014; cf. Phiri 2003). That women feel so possessive of their virginity confirms that they use this to control male sexuality as well; they do this by managing the timeframes for sex. The defence of virginity testing by women and young girls, who participate in the process, proves that virginity has sexual politics related to it. That young women treasure their virginity and that older women act as the proud custodians of virginity presents a challenge to researchers and human rights activists. What this seems to point at is that they need to change their lens of analysis and look at the matter from the viewpoint of women's understanding of their hidden power over their sexuality.

Kanyoro (2002) rightly argues that attempts towards transforming cultural practices should take into account the value attached to that practice by the custodians of that culture. Virginity testing might be unjustly assessed just because it has its origins on the so-called 'dark continent'. Is there anything good that has ever come out of Africa anyway? This is a question that some researchers and human rights activists, who are influenced by Western world views, ask behind closed doors. According to Siwila (2015) communities have some cultural traditions that they preserve because they have elements that they value in the nurturing of their people. Virginity testing is cherished by those who preserve it as having major elements offering liberation (Chisale & Buffel 2014; cf. Phiri 2003). The guardians of virginity testing insist that it is an

effective method of HIV prevention particularly for young girls and women.

The current controversial ‘virginity bursaries’ were defended by the African National Congress (ANC) Mayor, Dudu Mazibuko (2016), as an incentive to encourage girls to abstain from sex. According to Mazibuko (2016), girls are targeted by sugar daddies that infect them with diseases and STIs including HIV and they are critically vulnerable to unwanted pregnancies. Research indicates that those who pass virginity testing have always been awarded printed certificates, a sticker or a smear of white clay on the forehead which they proudly wear or show to the community (Scorgie 2002: 58; cf. Gundani 2004; Phiri 2003). The awarding of bursaries, which has caused so much commotion among human rights activists and some gender scholars, is not a human rights issue at all.

One may argue that this issue was politicised by political parties like the Democratic Alliance (DA) for their own good. The DA questioned this because it was rolled out by the ANC. What seems to be the problem for the DA is not the idea, but who came up with the idea. The argument of the DA is linked to the metaphor of the ‘dark continent’ that I discussed above. Because virginity testing has been politicised, it would be unjust of me not to speak about how the issue of virginity may be unjustly used in party politics. The ANC has control of KwaZulu-Natal (KZN) and the DA has aspirations to win control of this province as well; the awarding of virginity bursaries by the ANC that could have stabilized and sealed the ANC’s power in KZN was a threat to the DA’s agenda. The DA, because it is a white-dominated party, is believed to be influenced by Western world views. This then weakens the party’s judgement of African indigenous cultural practices. As a result, it is possible that the party’s resistance against ‘virginity bursaries’ being awarded, to the extent of getting human rights monitors involved, discreetly protects the Western world view and political agenda. The outcomes that confirm that ‘virginity bursaries’ are a violation of young women’s rights by discriminating against those who are no longer virgins is not clearly justified by the human rights investigators. The preconceptions of human rights movements are clouding their vision. In an era of the empowerment and liberation of women, the judgment seems to be leaning more towards the Western views on traditional African indigenous pedagogies. Human rights movements want to dictate to African women what is right or wrong for them without consulting them.

The issuing of ‘virginity bursaries’ is in line with how previously certi-

ificates were awarded or a white dot was painted on the forehead. This move values both the body and mind. Surely, the issues surrounding ‘virginity bursaries’ confirm the observation that human rights activists are in a power struggle with African traditions in policing African women’s sexuality and their reproductive roles. This power struggle then blinds both parties, although they both do what they do for a good cause. It is confirmed by research that virginity testing helps in identifying those girls who have been sexually abused because the *abahloli* (the testers) question them to find out if they lost the virginity willingly or if they were forced and if so, the perpetrator will be brought to book to seek justice for the girl (Scorgie 2002: 58). This way the growing concern about the incestuous abuse of young girls can be partly resolved through early detection. By this the *abahloli* acknowledges that some girls do not consent to losing their virginity. The rape of women is an injustice and if virginity testing exposes it, why should the process be criticised? Virginity testing is a tool that is used to protect young women from the sexual exploitation they could face (Chisale & Buffel 2014). According to Phiri, virginity testing is not an injustice but what is unfair are unwanted pregnancies and HIV (Phiri 2003:74). Those who criticise virginity testing are the promoters and nurturers of patriarchy. Virginity testing is a tool that can be used to expose the evils of patriarchy.

Using African feminist critical hermeneutics confirms that the means to an end may be problematic but the end is crucial in the context of HIV prevention, sexual abuse of children, rape and incest. The defence of African traditions is complex, because for some, defence of these traditions is influenced by the fear of breaking cultural norms (Kanyoro 2002:56). On the other hand some are influenced by the need to keep young women safe (Chisale & Buffel 2014). Unlike other cultural practices that lose momentum after outside criticism, virginity testing seems to be gaining momentum, particularly because it is supported by young women who consistently show up to be tested in numbers. The power virginity testing lends females is downplayed, which threatens African heritage and the dignity of good, life-affirming cultural traditions. The link of sexuality to religion and tradition justifies the means to an end for Africans, particularly African women, who are the custodians of morals and traditional values (Tamale 2007:157).

Through the use of African feminist critical hermeneutics, one reaches the conclusion that not all culture or religion is dehumanising. It is argued that we must extract what is liberating and reject what is dehumanising (Oduyoye

2001:11). African feminist critical hermeneutics stress the significance of time and context in every theory of interpretation. The stress on time and context positions virginity testing as an acceptable HIV prevention strategy. This is because virginity testing targets the sexual behaviour of both the girl and the boy. HIV prevention initiatives for young people target their sexual behaviour; hence research confirms that behavioural initiatives seem to be working positively (Pettifor, *et al.* 2013).

The constant surveillance of young women's sexuality contributes to the surveillance of young men's sexuality. Young men are encouraged to delay their sexual debut in the absence of sexual partners. There is, however, the danger that young men may resort to having sexual intercourse with older women, which may increase their exposure to HIV. This is noticeable with a development of Ben 10s¹ and sugar mommy relationships; hence behavioural cultural teaching that discourages such relationships should be re-introduced. HIV intervention prioritises a combination of behavioural, biomedical and structural methods (Pettifor *et al.* 2013). In most cases behavioural interventions are prioritised with the aim of reducing the risk of HIV infection. This is why a delay in a person's sexual debut is encouraged, the use of condoms is advocated and concurrently, partner change and substance abuse are discouraged (Pettifor *et al.* 2013). According to research, 'numerous behavioral interventions have been evaluated; however, few have HIV end points and those that have, have not shown a reduction in HIV incidence' (Pettifor *et al.* 2013: S155). It is argued that in order to understand the success of behavioural intervention one has to understand the broader context (Mathews, Aarø, Grimsrud *et al.* 2012:114). It may be true that virginity testing is implemented in a patriarchal society and it may be assumed that this affects the success of the intervention; however, guardians believe that the intervention is successful in preventing HIV and unwanted pregnancies among young women (Chisale & Buffel 2014; cf. Phiri 2003).

Like other behavioural interventions, virginity testing targets the behaviour of a large number of young women. Young women influence each

¹ A Ben 10 is a young boy who dates or marries an old woman. This idea comes from an American animated television series where a 10 year old, Ben Tennyson, finds a magical wristwatch that can turn him into 10 different alien heroes, each with its own unique abilities. This cartoon series is mainly played on the DSTV cartoon network.

other to participate in virginity testing (Sourgie 2002: 58). Research confirms that young women are not forced as claimed, but encourage each other and volunteer to participate in the process (Phiri 2003). In an effort to protect their virginity and prevent HIV and unwanted pregnancies, young women and men use *Ukusoma* to satisfy their sexual desires.

***Ukusoma* and Feminine Power in the Context of HIV Prevention**

Ukusoma is labelled a male sexual activity by literature and is common in KwaZulu-Natal and among other African traditions throughout Africa (Mchunu 2005). Young women and men use *Ukusoma* to protect the virginity of young women. This sexual practice is also identified by traditionalist as an HIV prevention strategy. *Ukusoma* is a non-penetrative sexual practice during which both a woman and a man enjoy a sexual encounter without any penetration. The absence of sexual penetration decreases the chances of HIV infection (Chisale & Buffel 2014).

Mchunu's (2005) findings on *ukusoma* identify this practice as a male practice used by a young man to show his respect for his virgin girlfriend and to display that his father taught him to be respectful. In an African traditional context, particularly among the Nguni, a boy's behaviour mirrors that of his father (Mchunu 2005). Thus, sons in traditional African contexts try to preserve their father's dignity through their behaviour (Mchunu 2005). It is assumed that good behaviour indicates that the father of that young man is a dignified man, likewise bad behaviour indicates that the father has failed to mentor his son. Similarly, a daughter's behaviour is connected to her mother's behaviour. This understanding challenges those who construct masculinity and femininity from an essentialist approach. Mchunu's (2005) findings present African Zulu masculinity from a social constructionist approach, where behaviour is learned rather than inherent. The good part of learned behaviour is that it can be unlearned.

Ukusoma seems to be not only a behaviour acquired by males, but by both males and females. It is a mutual form of respect where the respect a young man has for his father contributes to the respect the shows for a young woman's sexuality and her family. The fact that there is no penetration, which is a form of power exercised by a men over women, means that *ukusoma* gives young women power over their bodies because they decide when and how to

allow penetrative sex. *Ukusoma* is not widely researched in gender studies and HIV studies but those who research virginity and HIV argue that some adults encourage young people to use this practice as an HIV prevention strategy (Chisale & Buffel 2014). The aim of *ukusoma* is beneficial to both parties.

The interconnectedness of virginity testing and *ukusoma* demonstrates the political dynamics of African sexuality. Scholars taking the position of African feminist cultural hermeneutics have provided a clear understanding on the links between HIV, culture and gender. An African feminist hermeneutics of *ukusoma* positions this sexual practice among life-affirming cultural practices. However, this sexual act reveals a broken link between sexuality and reproduction. If sex is primarily for reproductive purposes, *ukusoma* stands in opposition to it. It affects the continuity of life since there is absence of penetration that may lead to the process of conception. Since *ukusoma* is encouraged among young couples who are still in the process of shaping their futures, it is a positive life-affirming sexual encounter that needs to be promoted particularly in the context of HIV and AIDS.

When it comes to the degree in which women's sexuality is controlled, particularly in African spheres, an African feminist cultural hermeneutics of *ukusoma* is able to evaluate culture and its belief systems in the process of seeking liberation (Kamaara & Wangila 2009). The evaluation of African cultural practices such as *ukusoma* and virginity testing is a significant step towards the decolonisation of HIV prevention strategies in Africa.

Calling African cultural practices inhumane invites resistance among Africans, leading to an increase in new HIV infections. The constant surveillance of the sexuality of African women by human rights movements and gender activists complicates HIV prevention, particularly as might be effected by behavioural interventions. This raises the suspicion that the constant surveillance of African sexualities and HIV prevention strategies is a colonial agenda, by those who want to protect colonial legacies in Africa. African indigenous pedagogies are threatened by the expansion of the market for technological products from the West. Virginity testing and *ukusoma* are natural practices that do not use man-made products; therefore promoting these practices impacts negatively on the profits of the manufacturers of contraceptives and related products. The economic colonisation of Africa is perpetuated if traditional strategies are ignored. Human rights organisations have become the protectors of colonial legacies in Africa. They overlook that Africans had rights before the declaration of human rights.

Conclusion

This study, written from the perspective of African feminist cultural hermeneutics, argues that HIV prevention in Africa has been overpowered by Western ideology leading to resistance by African people who reject the use of Western HIV prevention strategies, which seek to replace theirs. Virginity testing and *ukusoma* are life-affirming cultural practices; however, they are rejected by human rights activists and some gender activists. Virginity testing, which is heavily criticised as a violation of young women's sexuality, has caused a lot of tension between the custodians of virginity testing and human rights activists. An African feminist cultural hermeneutics of this cultural practice confirms that it is liberating and life-affirming. To conclude, those who criticise these practices are influenced by the Western world view that perceives Africa as a 'dark continent' that needs to be put under constant surveillance. In addition the study confirms that 'virginity bursaries' are in line with the certification process or 'white dot on the forehead' that has always been part of virginity testing in the history of Africa. Those who criticised virginity testing politicise this because the initiator of the idea (virginity bursaries) is aligned to a political party. *Ukusoma* on the other hand, has not been criticised like virginity testing, thus the significance of *ukusoma* as an HIV prevention strategy has remained concealed. Those who criticise African sexual practices are protecting the colonial legacies in Africa. The debate of sexuality as a human rights issue is pivotal; however, justice will only prevail if human rights are defined and owned by Africans.

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Cultural and Social Festivity as a Silent Contributor to HIV Infections: A Moral Challenge of the Easter Festivity to the Kwahuman Leadership in Ghana

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Abstract

This article takes a look at cultural and social festivals celebrations, particularly the Easter festival celebrated amongst the people of Kwahu in Ghana. It argues that the festival has the potential to become a silent contributor to HIV infection in Ghana. This claim is based on recent incidence during the celebrations. The three day Easter observance among the Kwahu in the Eastern region of Ghana has become one of the most celebrated festivals in Ghana, far exceeding any other festivals in terms of popularity and participation. Currently the festival attracts both local and international tourists with many activities on offer including paragliding and street carnival, jam night and the like. Drawing on a personal observation as well as available literature on the current developments of the festival, the article argues that notwithstanding the economic boost that may accompany the festival, as a result of the tourist attraction and other activities, the growing presence of people from different communities and countries who travel to the festival presents a chance for unintended, unprotected sexual networks. This and many more activities and occurrences can be a major contributing factor to the increase risk of HIV infections in the country. This is because during the Easter festivities, most of the people who travel to the Kwahu area engage in excessive drinking of alcohol, and abuse of drugs which makes them vulnerable to HIV infections. Others also use this opportunity to showcase their wealth with the view of attracting potential girls and women as life partners.

These behaviours do not only compromise the cultural and religious values of the festival, but also pose a serious risk to HIV infections. This unintended activities, ultimately challenges the gatekeepers of the Kwahu communities and other stakeholders to offer a contextual and relevant voice within the complex challenge of tourism, cultural and social festivity, morality and HIV.

Keywords: Culture, social festivity, HIV infections, unprotected sex, morality and sex, alcohol and sex

Introduction

Since the dawn of HIV more than 30 years ago, many behaviours and factors have been identified as risk factors contributing to the spread of the disease. Among the numerous factors include the following: migration (Crush 2005), gender violence (Haddad 2002); misleading information on HIV and STDs (Dinkelman *et al.* 2006); harmful cultural practices, (Steven Sovran 2013); exposure to globalisation on electronic media that distort local culture and values (Lee 2007); cultural practices that promote early marriages, and traditional practices such as forced or arranged marriages (Wellings *et al.* 2006; Clark 2004); Polygyny (Reniers 2010); concurrent partners (Mishra 2009; Morris *et al.* 2007; Halperin *et al.* 2007); Excessive alcohol intake (Mitchell *et al.* 2006); poverty, famine, low status of women in society, corruption (Nyindo 2005) just to mention a few.

With the current global move in response to the UNAIDS target call of the 90, 90 90 strategy by the year 2020 which suggest that by the year 2020, about 90% of people living with HIV should know their HIV status, 90% of people who know their HIV-positive status are accessing treatment and 90% of people on treatment have suppressed viral loads and lay a foundation to end HIV epidemic by 2030, (UNAIDS 2016). As a result of this call, all countries are being challenged to intensify their responses by educating as well as making resources and treatment available to their citizens. Ghana is no exception, for example, the recent estimation of HIV infection as at the end of 2015 was: 270 000 [230 000 - 330 000] Adults aged 15 to 49 prevalence rate was 1.6% [1.3% - 1.9%], Adults aged 15 and over living with HIV was 260 000, [210 000 - 300 000], Women aged 15 and over living with HIV 150 000

[130 000 - 190 000], (Girmay Haile 2015). As can be noted, the above statistics indicates a low infection rate which may be attributed to 2 major reasons: either most people have not confirmed their HIV status through testing or it can be attributed to the strong governmental dedication in providing affordable and accessible antiretroviral (USAID 2010). Of the two major reasons given, the later maybe a strong possibility because it has been noted that the President of Ghana, John Dramani Mahama has been instrumental in seeing the eradication of the disease, he was quoted as saying that in order to get HIV under control, 'This is not the time to let our guard down. This is the time we should be stepping up our responses to get to the end of aids' (Girmay Haile 2015). Surely, with the moral responsibility to step up responses to end aids in 2030, all potential contributing factors to HIV infection must be explored and interrogated, given the devastating impact the disease has had in the country in the year 2015. The recorded death due to AIDS in that year was, 13 000 [10 000 - 16 000] and Orphans due to AIDS aged 0 to 17 were 160 000 [130 000 - 190 000] (Haile 2015). It is with this background that this article proposes an area where much attention has not been drawn to particularly in the Ghanaian context. This is the potential contribution of cultural and social festivals to the risk of HIV infections.

To my knowledge, there has been little work done on the possible contribution of social and cultural festivals and to the risk of HIV infections. Yet such occasion has been noted as a potential environment for promiscuous behaviours and unplanned sexual networks activities. Erick Tenkorang reiterated this idea that 'community festivals may be hotspots for HIV transmission, as they enable casual sexual relations and complex sexual networking' (2014: 75). One of such festivals is the Kwahu Easter in Ghana, unofficially known in recent times as the Kwahu Pilgrimage (Musah Yahaya Jafaru 2015). This festival is celebrated by the Kwahus' in the Eastern Region of Ghana.

This article argues that the recent high visibility and the new developments in terms of the multiple activities that has drawn the attention of both locals and internationals can be a hotspot for HIV infection. The article maintains that notwithstanding the economic benefit that is attached to it, moral values are slowly being compromised during the festivity presenting a potential risk of HIV infections. This argument is based on a personal observation of the festival over the last three consecutive years from 2014, 2015 and May 2016, peculiar incidences that has been highlighted as well as available literature. It must be noted that in recent times, the festival attracts more young people

particularly aged between eighteen (18) and thirty-five (35) who are classified as the key population group within the HIV discourse, more than the older generation. Also there is excessive abuse of alcohol and drugs which contributes to immoral sexual activities contrary to traditional and religious essence of the festival. In addition, there are a number of people both young and old who also use this occasion as an opportunity to showcase their wealth with the view attracting innocent girls, women and young men. At the same time some also use the occasion as a homecoming period to look for potential life partners. Thus the current activities and practices is not only upsetting the cultural and religious values of the 12 towns on the Kwahu ridge namely Obo, Mpraeso, Obomeng, Abetifi, Tafo, Nkwatia, Bepong, Pepease just to mention a few, but to the Ghanaian society as a whole. Gatekeepers of the festival are therefore being challenged to provide a contextual and relevant voice within the complex crisis of immoral status that has taken over the festival. For which I consider to be the major contributing factor that is not only destroying the image of the once an honorable celebration but also presenting a risk of HIV to the Kwahu Communities and indeed the country as a whole, giving the culture of the unusual sexual behaviours that goes on during the festivity.

I begin the article by describing the recent practices during the festival. Second I will show how the current activities can be a potential a contributor to the spread of HIV in the area. The third section will ethically challenge the Kwahuman traditional council who are the gatekeepers of the Kwahu cultural, moral and religious values and other stakeholders on the need to strategically interrogate the situation to minimize people's vulnerability to HIV. They have ethical duty to practically respond with a contextual and relevant voice.

The Current Development of Kwahu Easter Festivity

One of the most colorful aspects of the Ghanaian culture is its annual traditional festivals and durbars held in almost all the ten regions of the country. These festivals that are protected by the traditional leader's appeal to the very heart of each local community in the country. The common features of these festivals are that the communities involved use the occasion in the remembrance of ancestors, purification of the traditional state, fund-raising activities for development projects, and a general feeling of family reunion, which comes with lots of feasting, drinking and merry making over a number of days.

Among the numerous festivals include: The Odwira ‘purify/cleanse’ festival which is mainly observed among the traditional people from Akuapem area in the Eastern region. It is a time to remember the dead, harvest, thanksgiving as well as to settle any dispute that may have arisen during the year within the families and the community alike. (Warren 1973: 32). The Homowo festival is observed among the Ga people in the Greater Accra Region, the Ewes’ from the Volta Region also have Hogbetsotso as their annual festival, the Fantes in the Southern region have the Aboakyere (deer hunt) festival which is celebrated yearly, the Akwasidae and Wukudae for the people in the Ashanti region, this is celebrated twice every 42 days where they offer food and drinks to ancestral stool (Nukunya 2003: 59, 64-65).

While almost all the traditional areas of Ghana have succeeded in keeping the core of their traditional festivals, there is one group of people: the Kwahu from the Eastern region, who appear to have totally changed their traditional festival: the ‘Kwahu Brenya Afahye’ over the years and have adopted Easter, which is rather a religious celebration among Christians as their main traditional festival (Raphael Ofori-Adeniran 2013). The Kwahu people are of the view that the Easter festival has been handed down to them by their forefathers as a traditional heritage to be followed (Kate Gyasi 2013:20). It is believed that the Kwahus’ original festival: the ‘Kwahu Brenya Afahye’ was replaced with the Easter festival, and the reason for this change is that the Kwahus’ are noted as the most intellectual traders among the various ethnic groups in the country and as such, most of them have migrated from their traditional communities to other major trading centers such as Accra, Kumasi, Suhum, Koforidua, Takoradi to pursue their trading activities. Statistics have it that by the end of 2011, the estimated number of migrant populations among the Kwahus was 32.1% of all the twelve towns on the ridge (KSDA 2011). This suggests that in almost every homestead on the Kwahu ridge there was at least one family living outside the traditional community. It must be noted that most of these migrants only come home occasionally for funerals, marriage ceremonies and other important occasions that might arise. For some, the only time they came home was during the festival. Gyasi cited the Kwahu traditional council that the Kwahu ‘afahye’ used to be celebrated during the peak of trading activities which was between October and December (2013:20). But being migrant traders, their attendance to the festival was affected negatively because between October and December are usually the peak season for the traders and consequently the Kwahu traditional council had

to adopt the three days Easter period as the appropriate season to celebrate the festival, hence the Kwahu Easter Festival. To the traders, the three day Easter period was the appropriate time to close down their trading activities since that period is not as productive as the Christmas period. Over the years, the festival was accepted by all as the fitting period to celebrate the achievements of the previous year, fundraise for community development projects in the Kwahu area, as well as homecoming period for these business minded people (Gyasi 2013:20).

However, in recent times, this festival has taken on a new dimension, it has become part of the tourism industry in Ghana, through the introduction of many activities. According to a document by the Ministry of Tourism Culture and Creative Arts, the recently developed and branded of the Easter Festival in Kwahu has promoted social and economic growth with the introduction of paragliding activities at Atibie in 2005 (2016:6). The new development has contributed in making the festival an international event, attracting local spectators and many visitors to the once insignificant communities on the Kwahu ridge. For instance, the paragliding activities attracts both experienced and new pilots from all over the world such as the United States, Peru, France, Japan, Belgium and Switzerland to the Kwahu area. (Emmanuel Torny 2015). In addition, activities such as street carnival, highlife concert, choral festivals and joint-traditional durbar of chiefs, health walks, and a number of sporting activities, continue to attract people to the Kwahu area every Easter. Food vendors and a number of curio sellers from all over the country also take advantage of the tourists to showcase and sell their products.

It is also a home coming event for the native Kwahus' from other cities as well as people from the Diaspora. As mentioned above, for most of the people this is also an opportunity for choosing their potential spouses. Others use this opportunity to showcase their acquired wealth in the course of the year. The common scenario during this time is that a number of people are seen dressed in their best and latest fashion clothing and driving in their latest vehicles up and down the streets of the 12 towns on the Kwahu ridge. Gyasi cited a newspaper article which gave a vivid picture of some of the scenario that has become the common trend across the 12 towns that: 'some young men and women sitting on the doors of saloon cars with the upper part of their bodies outside and clutching to some bottles of liquor kept zooming from one end to another on the main street, amidst tooting and shouts of *'yaba bio moo'*!

To wit we have come again. That kind of dressing, during Easter is a major challenge to the cultural norms' (2013). Food vendors are also seen everywhere, all day and night taking advantage of the local and international visitors around. Hotels and drinking bars as well as pubs are seen filled to their capacity with music dancing and noise everywhere. These activities go on all day and also into the night. In the night sex workers are seen standing along the major streets in the towns waiting for clients. Pedestrians are seen moving up and down the streets all day and night throughout the three days.

The Easter Festivity Practices and its Implication for the HIV and AIDS Context

As mentioned above, even though the current tourism touch to the Kwahu festival presents an opportunity for development in the area, the number of activities that goes on exposes a number of people to the risk of HIV infection. Some of such activities includes the Street Carnival, street dance and jams led by famous artists and various FM stations amidst thousands of fun lovers, drinking, dancing and screaming throughout the night. During the 2015 celebration, *Adom FM* one of the famous FM stations in Ghana present at the celebration, was unofficially named '*Adom FM Street*', because people from all walks of life filled about a kilometer of the street to participate in their street performances amidst heavy drinking, merry making and the like. Even though to a number of people, such events, 'provide the host community with an opportunity to secure a position of prominence in the tourism market for a short, well defined period of time' (Hall 1992), as well as creating revenue for the local communities, authorities as well as the entire country, the down side of it is that moral values are compromised at such popular events, putting a number of people at risk of HIV infection through exposure of casual sexual activities and networks at the event and the aftermath. Undoubtedly, at the end of the festivity and after indulging in such activities, the participants return to the wider society and to their husbands, wives, partners and lovers, thereby spreading any sexually transmitted diseases they might have picked up. Therefore, the moral challenge that confronts the gatekeepers of the Kwahu Easter is their obligation to uphold the moral values of their people. The Kwahu South District Assembly's 2014 report revealed that the, 'prevalence rate of HIV in the District is still high as at fourth quarter 2013 (2015: 16). If the rate

of infections in the District is high, then the important question that may arise is whether the present activities at the festival have potentially contributed to the high rate of HIV prevalence in the area? As mentioned above, the behaviours evident during the Easter festivity could have implications for HIV infection. A typical example is an article published by the Daily Guide, with the headline ‘Open sex at Kwahu Easter’ (Thomas Ofosu 2011). This article sparked a number of public debates thereby tarnishing the image of the communities in Kwahu, even though the incident was deemed fallacious in the long run. Further to this, the Kwahu Traditional Council reacted and warned the public against indecent behaviours, excessive drinking and immoral activities with a tough penalty. However, Victor Kwawukume and Seth Bokpe believe that the ‘advice has fallen on death ears’ (2015), because subsequent years has seen activities and behaviours that put people at risk of contracting HIV. An incident that became a great concern was when it became public knowledge in 2015 that condoms had run short in all the pharmacy shops in the whole Kwahu area during the Easter festivity. In a personal communication with a leader from obo, Opanyin Kofi Antwi-Boasiako, he lamented that ‘the festivity has to be interrogated because the current practices were not the original intention of the festival. Our elders revered the festival, but now the younger generation has changed the content. The new development is not honoring our culture, but has giving the Kwahus’ a bad reputation’ (personal communication 2015). This comments confirms the fact that the traditional leaders are concerned about the new trend that the festival has taken because it is possible that the reported cases are just the ‘tip of the iceberg’ there may be a number of unreported cases. However, speaking to some fans of the street carnival at Obomeng: the heart of the festival, they argued that it is their right to be happy and have fun. Nobody gave them the money so they decide where, how, when and on what to spend it (personal communication 2016). From all that has been discussed so far, the question that comes to mind is, how do the traditional authorities ensure that their moral values are upheld in the era of human rights and freedom? This may be an area worth researching into. The next section examines the ethical implications of the practice.

Moral Implications of the Practices of the Festival to the Traditional Authorities

As stated above, the recent development of the Easter festival as an interna-

tional event attracting both local and foreign, young and older tourists to the Kwahu area in Ghana do not only carry with it an economic gain for the local communities and the country but also has in many ways attracted a number of acts and behaviours that can potentially contribute to HIV infection. These acts have compromised the once honourable and cherished Easter celebration presenting a challenge to the traditional authorities in all the 12 towns on the Kwahu ridge. The traditional authorities have shown grave concern at the negative messages cast over the festival and they believe that the current generation have missed the essence of the Easter celebrations and are gradually turning it into something that the Kwahuman never imagined (Prince Kwasi 2015). Gyasi reiterated the sentiments made by the Kwahu Traditional council that ‘Immorality by the youth during the occasion cast a slur on our cultural heritage as Ghanaians and we would not countenance that’ (2013: 95). The sentiments above, portray the unpreparedness of the authorities for the booming tourism in the area. Being unprepared for the changing nature of the festival in terms of the new dimension, explosion of attendees to festivity and the challenges accompanying it require an ethical interrogation. An important concern is the relationship between, the moral status and standards cherished by the Kwahus’ amidst the new developments of the festival. Should the need for economic boost in the name of tourist attractions overlook the moral values of the local people and making them vulnerable to HIV infections? In as much as the festival is generating income, this article is a call to the traditional authorities to evaluate their leadership role in the current situation. An Akan proverb says that: *‘opanyin a ɔtena fie ma mmɔfra we nanka no, yebu nankawefoɔ a ɔkaho bi’*. The literary meaning of the proverb is: ‘The elder who looks on as the young people feasts on a snake, is considered a snake eater himself’ (Isaac, Opuni Frimpong 2014). The moral of this proverb is that the eating of snakes is not allowed in the Akan culture. To them, a snake has a spiritual representation that is, it may be seen as a god, and in most cases as a symbol of evil, as such the elders have the responsibility to prevent hungry children from eating snakes’ meat. If they overlook their important responsibility of warning as well as preventing the children from feasting on the snake and calamity strikes, they will not be spared. Of course some snakes are poisonous and once eaten, there will definitely be negative consequences. Using this proverb as a moral lens in viewing the situation at hand, it is clear that the traditional authorities and the other stakeholders have a moral obligation to interrogate and confront any negative activities and behaviour

that is likely to increase people's vulnerability to HIV as well as tarnishing the name of the festival. Overlooking such obligation and adopting the silence route can have tremendous negative consequences not only on the community but the country as a whole.

So practically how can the situation be contained so as not to increase people's vulnerability to HIV? Haddad has drawn our attention to the fact that 'issues of sexuality and cultural practices shape responses to the epidemic both negatively and positively' (2009:17). Therefore, in the current discussion, such a task demands the input not only of the traditional leaders in the Kwahu area but also other stakeholders such as the District Assemblies, National tourism board, National AIDS commission, the Media, religious leaders and families. They are being challenged to understand their responsibility within the ongoing development and trends of the festival and how some of these activities at the festival are likely to increase people vulnerability to HIV in order to respond positively. A major positive respond can be that these stakeholders can strategically use this period as an opportunity to educate the crowd on issues of HIV. For example, since the FM stations attract more people to their stands, they can use such platforms to break the taboo of speaking about sex and HIV in public places.

Another practical response can be the response from the churches in the area. In addition to the high turnout of people to the organised football galas, coral musical performances, drama etc, during this period, it is clear that churches are also filled to their capacity, therefore church leaders can use their pulpit to preach messages that go beyond the dos and don'ts, of sex and sexualities to issues of disruption of normal social relations in families, promiscuity, YouTube videos and other social media portraying the unhealthy sexual behaviours and networks.

The local council can also use the traditional durbars as a platform for HIV education. An important collaboration that can contribute effectively in responding to the current situation can be the joint effort of the National tourism, Board and the AIDS commission and the Kwahu traditional leaders. These structures can collaborate to set up stands during the three day celebrations where people could be invited for HIV counselling and testing. At the same time these structures have the obligation to ensure that condoms are readily available to avoid the situation where condoms run out in all the pharmacies in the 12 towns on the ridge.

Conclusion

In order to achieve the global HIV target of 90 90 90 by the year 2020 and the subsequent eradication of HIV by 2030, governments particularly the Ghanaian government will have to intensify its efforts to reduce the risk factors of HIV in the country. One important area of concern that is still under research is the contribution of cultural and social festivals to the HIV infections. In this article, it has been argued that the activities at these events can be hotspots for HIV infection. This claim is based on the casual sexual relations and complex sexual networking that characterizes the period of such celebrations. One of such events as noted in this article is the Kwahu Easter celebration in Ghana that has been transformed over the years to an international event. From the discussion above, the festival now attracts local and international tourists to the area yearly. Though the article is by no means arguing against the transformation of the festival and the tourism touch or the number of people who come to the area. But HIV being a global problem, there is a need to emphasize and interrogate the risk factors that are accompanying such events. At the same time, the article has challenged the gatekeepers of the Easter festival and the Ghana tourism board to take their responsibilities around the events of the festival seriously. In order to reach the AIDS free generation, there must be efforts to control all contributing factors to HIV by all stakeholders where possible. Certainly the key success for reducing the new incidences of HIV and prevent people contracting the disease is to be aware of all contributing risk factors.

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Cultural and Social Festivity as a Silent Contributor to HIV Infections

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The Traditionalization of Menopause among the Karanga of Zimbabwe and the Shangaan Tsonga of Mozambique in a Context of HIV

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Abstract

The spread of HIV in Africa South of the Sahara is alarmingly high especial among girls aged between 12 and 24 years despite the knowledge that society has about how HIV spreads particularly through unprotected heterosexual sexual intercourse. In Mberengwa there is also a rise in infection cases among older men aged 50 and above. On the other hand sexual intercourse is premised in the private space. It is general frowned upon for anyone to openly talk about sexual intercourse. In the midst of the silences about sexual intercourse people are very active sexual. Of note is that women who reach menopause amongst the Karanga and the Shangaan Tsonga communities are barred from having sexual intercourse. This paper reflects on traditional beliefs and explanations of menopause amongst the Karanga people of Mberengwa, Zimbabwe and the Shangaan Tsonga of Mozambique which I think have a contribution in the spread of HIV amongst young girls and old men (and some old women) through trans-generational sex with multiple sexual partners in some cases. Findings through focus group discussions in Zimbabwe and Mozambique demonstrate that the traditionalization of sexuality regardless of developments in biological knowledge contribute to the spread of HIV especial among the older men. The cultural beliefs have resulted in behaviours that lead to trans-generational multiple sexual partners. This paper argues that the cultural explanations of the meaning of blood released by women during menstruation requires some biological explanation to ease the fears and taboos thereof among the Karanga and the Shangaan Tsonga. This paper concludes that the continued use of traditionalised explanations of menstrual blood is a possible source for the spread of HIV

especial in a trans-generational manner amongst the concerned tribal groupings.

Keywords: Menopause, sexual intercourse, trans-generational, menstruation, HIV, extramarital

Introduction

Menopause means the end of menstruation periods for women. ‘As a woman ages, there is a gradual decline in the function of her ovaries and the production of oestrogen’ (Baloyi 2013:2). Gupta, Holloway and Kubba (2010:222) define menopause as the permanent cessation of menstruation that is caused by ovarian failure. Martin and Jung (2002:15) share the same opinion, calling menopause ‘the permanent cessation of menstruation’. Menopause has been traditionalised in Zimbabwe and in Mozambique. ‘A tradition is a way of behaving, thinking or doing something that has been followed by people in a particular community, society, family, etc. for a long time. A tradition can be an idea, belief that is passed down from one generation to another’ (Pediaa: n.d.). The traditionalised understanding of menopause makes it a taboo for a woman at menopause to have sexual intercourse. On the other hand the husband of the same woman will have the right to continue to have sexual intercourse with younger women. At times this happens openly with the husband marrying a younger wife. In church circles sexual intercourse outside marriage is shunned therefore the affected parties may have secret relationships or go the route of engaging commercial sex worker. The traditionalization of menopause has become a cause for multiple sexual partners which eventually places people at risk of infection.

On the other hand in both Zimbabwe and Mozambique there is high prevalence of new HIV infections amongst female teenagers especial in the 12-24 year age group. There is a high prevalence amongst girls than teenage boys because of trans-generational sexual intercourse where mainly older men sleep with younger women¹. One clear sign of trans-generational sex is teenage

¹ Teenage pregnancies and HIV infections are complicated by the complex relationship between males and females. Other than issues of abstinence, there are challenges of culture, patriarchy and economic factors that seemingly favour males over females in sexual relations. This is staff for another paper.

pregnancies which are not linked to teenage boys. Of note is that these teenage pregnancies are linked to the high HIV infection rates. In as way back as 2001 research has shown that in Southern Africa 1 out of 5 teenage pregnancies is also HIV positive (Jewkes 2001: 733-744). Jewkes Rachel et al say that teenage pregnancy ‘... reflects a pattern of sexual activity which puts teenagers at risk of HIV. Currently one in five pregnant teenagers is infected with the virus. This creates a new imperative to understand teenage pregnancy and the pattern of high risk sexual activity of which it is one consequence’ (Jewkes 2001: 744). The statistics from the UNAIDS and the African Union for 2015 show that:

... young African women and adolescent girls are especially vulnerable to HIV. Globally in 2013, 15% of the approximately 16 million women aged 15 years and older living with HIV were young women of these over 80% live in sub-Saharan Africa. Despite declining HIV infection rates, in 2013 globally, there were approximately 250 000 new HIV infections among adolescent boys and girls, 64% of which are among adolescent girls. In Africa, 74% of new infections among adolescents were among adolescent girls. In addition, AIDS-related illnesses are the leading cause of death among adolescent girls and women of reproductive age in Africa, despite the availability of treatment (UNAIDS and The African Union 2015:8).

The above statistics are a sign of the high levels of new HIV infections which are mainly through heterosexual intercourse in Africa. The statistics show that teenagers do not use protection against STIs hence high infection rates. The HIV and AIDS response in Africa South of the Sahara needs to be revised by all interested parties including the pastoral ministry of the church.

Traditionalization as a Theoretical Framework

In many African communities there is a tendency for people to appeal to tradition to authenticate, protect or defend beliefs, behavioural traits and practices. Tradition is basic principles, values, practices and beliefs that are passed on from one generation to another. The basic understanding of a tradition is that it is a phenomenon that is static, permanent, unchangeable and valuable as is and therefore needs to be passed on without any alterations.

Whatever ends up becoming ‘our tradition’ should have been part of culture. The particular aspects of culture is then transformed and given a status of being everlasting and begin being referred to as ‘our tradition’.

The transformation of cultural practices to tradition is what I call traditionalization. Traditionalization transforms cultural concepts and practices to make them permanently acceptable without question by society through generations. Traditionalization is when the guardians of a culture, usually the powerful, pick up a cultural practice and enable it to continue to be applicable through generations of a community. Not everything in culture is traditionalized. What is traditionalised is selected carefully as per demands from the context. At times a seemingly forgotten cultural practice can be retrieved from the past to respond to a contemporary phenomenon and for that cultural practice to be uncritically accepted it must be traditionalized (see Linnekin 1989; see also Williams 1977:115’ and Glassie 1995:395). Traditionalization can benefit the whole of society or it can also benefit those in authority at the expense of certain sections of society. According to Lisa Gilman (2004:34) ‘The hegemonic potential of using tradition is largely dependent on the fact that people are often unaware of the selectivity of their own practices, especially in cases where a dominant group is invoking tradition as a strategy to control or oppress a subordinate group’ (see also Williams 1977:115–16). The concept of traditionalization can be understood from an analysis of the term ‘traditional’. Gilman defines the traditional ‘...as those cultural elements and practices that are directly connected to the past: superorganic, bounded, static, transgenerational, ‘things’ or practices that can be inherited or passed down from generation to generation; tradition has also been understood to comprise the cultural canon of a group’ (Gilman 2004: 33; see also Ben-Amos 1984). In the light of Gilman’s argument above then traditionalization means taking what is ‘traditional’, and link it symbolically with the glorified or dreaded past (see Hymes 1975: 353-54). Gilman (2004:33-34) goes further to say, ‘When people label a practice traditional, they elevate it to a special status, and then members of that group often feel an obligation to repeat the practice in order to perform their identity and meet the requirements of that group’. Once a cultural practice is labelled as ‘traditional’ it assumes a status of permanence and that it cannot be questioned just because ‘it is our tradition’. The traditionalized culture is then repeated generation after generation without any criticality on its benefits or harm there in. In fact the traditionalization is as a result of repeated references to the practice. Gilman

(2004:34) makes reference to Eric Hobsbawm and Terence Ranger (1983) who argue that ‘Many practices that groups of people hold dear because they feel that they represent continuity between the past and present were consciously constructed or selected, often strategically, at specific moments in history. Through repetition and rhetorical associations, people eventually come to call them tradition and thus endow them with special value’. This concept of wanting permanence of certain practices is central to traditionalization. In fact traditionalization is about creating permanence of aspects of culture.

Traditionalization can be premised in the sphere of insecurity posed by change. Guardians of culture and community leaders may be afraid of change and to protect ‘the way things have always been done’ they traditionalize their culture. New developments can be uncritically blocked using the ‘this is our tradition or this is not our tradition’ motif. The powerful can oppress society using traditionalization of their oppressive practices. Gilman says ‘...the potential of using ‘tradition’ to oppress—through processes that are inherently selective and strategic—is contingent upon people’s perceiving certain practices to be static and superorganic artifacts (sic.) that *should* not be altered and that *should* be transmitted over time. And, it is the difference between the *reality* of tradition as process and the *idea* of tradition as static that makes traditionalizing such an effective hegemonic tool’ (2004:34-5). So the powerful in society can use traditionalization as a tool for power and control. This becomes possible since society will not question any oppressive practices that are ‘our tradition’. Alternatively society will not delve into ideas that are not part of ‘our tradition’. For domination to work through traditionalization the subordinates should be made to inherently feel strong about the tradition so that they feel committed to perpetuate it. Traditionalization works well where there is successful spiritualization, emotionalization and internalization of the ‘tradition’ (see Williams 1977:115016; Gilman 2004: 34). Gilman further says that ‘...Tradition is perceived, used, and manipulated in highly complex and contradictory ways in people’s day-to-days lives’ (2004:34).

In this paper the concept of traditionalization is used to understand the phenomenon of menopause and taboos on sexual intercourse among the Karanga and the Tsonga. Sexual intercourse is a sphere that is highly traditionalised with controls and taboos which are not open to critical analysis. Society sanctions and prescribes on who is qualified to have sexual intercourse, with whom, when, how and the why of sexual intercourse. In patriarchal communities males seem to inherently have control of the sphere of sexual

intercourse. Menopause is one aspect of sexuality that is sanctioned by society and it has been ritualised. Amongst the Karanga and the Tsonga a woman in menopause cannot have sexual intercourse because it is 'our tradition'. This is a sign that menopause has been traditionalized.

Literature Review

Literature on menopause and culture demonstrates that it is a highly traditionalised phenomenon in many African communities. According to Baloyi (2013:2) 'There is an ancient mythology amongst some African people indicating that menopause is a sign that renders it forbidden for women to engage in sexual activities, and that myth is still evident in some African cultures today'. Baloyi's observations are in agreement with Kimathi (1994:13) who says that menopause among some African ethnic groups marked the end for the need for sexual activities as the woman was considered too old for sexual intercourse. Kimathi further says that in some cultures these women who have reached menopause would advise their husbands to marry younger women as she was now exempt from sexual intercourse. This observation implies that the man is will still be sexual active and at no age point will they reach a point where they will have to stop having sexual intercourse.

Kyomo and Selvan (2004:35), say that some African communities believe that it is a taboo for a woman to have intercourse after reaching menopause. This is a sign of the traditionalization of menopause and sexual intercourse. Breaking this kind of a taboo can result in unpleasant physical ailments such as one's stomach growing very big or they may produce a stinking seminal fluid through their vagina making it difficult for such women to go to public places. Baloyi also writes about the bulging stomach among the Tsonga speaking people. He says 'Amongst other reasons the Tsonga speaking people refer to this big stomach as *xikuru-nyimba*, this belief makes it very clear that every woman who engaged in sexual activities after menopause is risking her own health. In this way, many women voluntarily abstain from sexual encounters in order to preserve their own health' (2013:2).

The way menopause is treated by both men and women varies from culture to culture and mainly depends on taboos that are based on traditionalization instead of rational biological facts. Collins (2011:65) says, '... women's experience of and attitude towards menopause are influenced by

beliefs and expectations inherent in the prevailing socio-cultural paradigm. Thus, factors such as cultural beliefs, values, and attitudes towards menopause determine the experience of individual women of that stage of life as negative and troublesome or positive and liberating'. Baloyi concurs with Collins when he says '...Africans' sexuality is greatly affected by their attitudes and expectations. First there is a myth in African society that after menopause women are 'past it'. This stems from the exclusive association of sexual activity with reproductive ability: Once fertility is over, sex is irrelevant. It is true that, if a woman had endured sex only because she wanted to conceive, after menopause she would have a sense that she has lost her worth' (2013:3). Cultural in African communities women have been made to believe that they get married for sexual intercourse and bearing of children. Menopause then becomes a sign that the woman can no longer bear children and therefore their worth is diminished. The above literature reduces a woman to a child bearing machine and a tool for satisfying the sexual desires of men. Once a woman reaches a point when she cannot perform sexual because of biological developments then she will have reached expiry date. Then for society to make this kind of mentality to work, sexual intercourse after menopause has been ritualised to a point of being a taboo. Because of this no questions can be asked about the tradition. This is an example of a context where traditionalization is oppressive and abusive to women as it seemingly affects women while men are free to have sexual intercourse until they die. The assertions by the tradition are not open to questioning using biological facts about menopause to take away unsubstantiated fears.

Men whose wives reach menopause will still be sexual active. This creates a situation of extra-marital sex as they cannot have sexual intercourse with their wives. Baloyi (2013:3) who cites Kyomo and Selvan (2004:35–36), says that the taboo on sexual intercourse after menopause is strengthened by threats of strange sickness eventually leading to death. If one dies after breaking the taboo the ancestors will also not accept them in the place of the living dead. Such threats have made women to become the guardians of the tradition. Baloyi concludes by saying, 'Because of this taboo, men whose wives reach menopause are left with three possibilities: abstaining from sex, getting involved with prostitutes or taking another official or unofficial wife (concubine)' (2013:3). Literature shows that traditionally African men are free to marry a younger wife or have sexual relationships outside marriage when

the wife reaches menopause (see Labeodan 2007:45; Oduyoye's 1995; Nasimiyyu-Wasike 1995:102; Khathide 2007:41).

Interestingly, literature also shows that, relatively, there are no health related challenges caused by menopause as described by Kyomo and Selvan (2004:35). From a biological perspective responses to menopause vary from person to person. The majority of women may have lower sexual desire, some may have significantly increased sexual desire, while some may have difficulty in having sexual intercourse due to the dryness of the vagina. A research by Avis *et al.* discovered that 'Menopause status was significantly related to lower sexual desire, a belief that interest in sexual activity declines with age, and women's reports of decreased arousal compared with when in their 40s. Menopause status was unrelated to other aspects of sexual functioning in either unadjusted or multiple regression analyses...In multiple regression analyses, other factors such as health, marital status (or new partner), mental health, and smoking had a greater impact on women's sexual functioning than menopause status' (2000: 297). The taboos and the threats of strange illnesses are not based on biological evidence but on traditionalization.

In addition to the above arguments, Wambua (1997: 645-646) discovered that a number of women experience some changes in their sexual life as a result of menopause such as lack of sexual desire and too much sexual desire. Wambua links these sexual changes to a number of variables by arguing that 'Sexual function is influenced by biologic and none biologic factors. Sexual arousal, including sensory perception, central and peripheral nerve discharge, peripheral blood flow, and the capacity to develop muscle tension, as well as sexual desire and frequency of sexual activity, can all be influenced by ovarian hormone levels. Sexual function is also influenced by the interplay of psychological, sociocultural, and interpersonal factors' (1997: 645-646). Following Wambua's research findings one realizes that menopause can best be understood from a biological perspective. Most of the traditionalization of menopause feeds on the lack of biological knowledge. In this regard Wambua rightly suggests that 'Health care professionals can play an important role in the evaluation, education, counseling, and treatment of the menopausal woman' (1997: 645-646).

Wambua makes it clear that 'Menopause for most African women marks the end of reproductive potential...Cultural beliefs and practices vary with the different communities in Africa. It is important for health providers to identify such beliefs and practices if reproductive health problems that emerge

in the climacteric have to be prevented and managed correctly' (1997: 645-646). The assertions by Wambua that keep on insinuating the need for the participation of health workers demonstrates the need for traditional beliefs to be coupled with knowledge from Biology.

The above literature survey has shown that menopause is a biological developmental phenomenon that, natural, cannot be avoided. Literature has also shown the discriminatory nature of tradition in that while the sexuality of woman is negatively affected, the man is permitted to get married to a younger wife and continue with sexual intercourse. This paper contributes to the above literature by discussing the traditionalization of menopause without any due consideration for biological facts.

Method for Data Collection

This paper is sharing part of the findings from a project sponsored by CHART on religion, sex and sexualities, stigma and discrimination in a context of HIV and AIDS in Africa. Data for this paper was gathered through a qualitative study that used semi structured questions to guide group discussions in a workshop setting. Between 2014 and 2016 I facilitated 4 workshops for a total of 60 church leaders on the sources of the spread of HIV and the drivers for stigma and discrimination in Maputo, Mozambique and in Mberengwa District in Zimbabwe. In 2014 I managed to facilitate a workshop for 12 pastors in Maputo from across Mozambique. In 2015 I facilitated a second workshop with 10 pastors in Maputo. I facilitated my first workshop in Mberengwa in Zimbabwe for 20 pastors in 2015. The second workshop for 18 pastors in Zimbabwe was in 2016.

For ethical reasons this paper will not disclose the denominations and identities of the pastors that participated in the workshops. Suffice to say that they were a mixture from different denominations as well as of varying educational levels. The lowest academic qualifications for all the groups was a certificate in theology while the highest qualification was a PhD. The age range was between 24 and 73. In Maputo there was a total of 7 women four whom had reached menopause. 4 of the male pastors in Maputo had wives who had reached menopause. In Zimbabwe there were 13 female pastors. 9 of the female pastors had reached menopause while 11 of male pastors' wives had reached menopause.

Data was gathered through open group discussions based on guiding questions (What are traditional practices that have a potential to contribute to the spread of HIV in your context? How is your church pastorally responding to these traditional practices?) Follow up questions depended on the direction and dynamics of each group. I also had a one to one discussion with all the participants on issues raised in the group discussions to hear personal experiences. One such experience was the issue of menopause and taboos around it amongst the Tsonga in Mozambique and the Karanga in Mberengwa. The one on one discussions were also qualitative in nature so as to allow participants to elaborate on issues raised and even show emotions. For purposes of this paper, two of the guiding questions on the one on one discussions were: What is your understanding of menopause from your traditional perspective? What are the taboos related to menopause? Menopause was picked for further discussion because of its frequency in the group discussions as a major cause for the spread of HIV. The group was actively and critically engaging in the discussion topics.

In general, the context of the workshop made it possible for pastors to talk openly about the positions of their denominations and their personal positions on different aspects of sex and sexualities in a context of HIV and AIDS. The workshop setting was a safe and sacred space that enabled ministers to engage the otherwise difficult subject of sex and sexualities.

Research Findings

The major concern for this study is menopause. Traditional among the Karanga in Zimbabwe menopause marks the end of sexual intercourse for the woman concerned. The explanation is that at menopause the woman stops menstruating. Menstruation is believed to clean sperms from women. When women do not fall pregnant after having sexual intercourse it is believed that the sperms accumulate in the womb. Once a month a woman will have the flow of blood that cleanses her of all the unused sperms. After menopause woman cannot continue with sexual intercourse as they will not have a cleansing system for the accumulated sperms. It is believed that women who continue to have sexual intercourse after menopause develop a huge stomach because of sperms that will keep on accumulating. Amongst the Karanga it is an embarrassment to have an old woman with a big belly as this is a sign that the

woman did not stop having sexual intercourse after menopause. The tradition says that the woman's belly can grow to point of bursting to death.

To protect the woman from temptation, the Karanga will perform a ritual called *kugura nhowo*² (Cutting of the reed mat). The ritual of *Kugura nhowo* is a ceremony for separating a couple so that they can no longer share a bed or have sexual intercourse after the woman reaches menopause. The couple may still use the same room (hut) but in the contemporary context they will have two separate beds since the sleeping mat will have been cut. As noted earlier on, having sexual intercourse is forbidden for the woman. However the man can still have sexual intercourse with younger women.

At this point in some cases men marry younger women to meet their sexual desires. In some instances the woman will bring her own relative to satisfy the sexual desires of their husbands with the hope that the new wife will protect her if they are related. Cultural the woman is allowed to bring her young sister or the daughter of her brother as a wife to her husband. If this does not happen the man can marry a stranger who may win the heart of the man against the old woman at menopause, rather have a relative.

In Mozambique there is a strong belief that it is unsafe for a man to have sexual intercourse with a woman in menopause. It is believed that the blood that used to come out of the woman in menstruation which no longer comes will enter the men during sexual intercourse. If that happens the testicles of the man will swell until the man dies. So for fear of death men amongst the Tsonga do not indulge in sexual intercourse with women at menopause. It is a no go area. However the men will still seek for sexual satisfaction from other younger women.

I also found an interesting scenario amongst educated women from both cultures. These women now understand the biological facts around menopause. The myth of the bulging of the stomach in females and testicles in males has been dismissed by these elite women. The women who participated in the study said that they still also have sexual desires even after menopause. In some cases some women have very higher sexual desire than before menopause and because of tradition they cannot try sexual intercourse with their husbands. Instead they seek sexual intercourse elsewhere. Some male participants were also aware that biological the myths around bulging were not true. They also know that the women have sexual desires even after

² *Kugura* is Shona for cutting and *Nhowo* is mat which was used for sleeping.

menopause. However because of tradition they could not have sexual intercourse with them. One would rather have sexual intercourse with another woman who is not their wife even if that other woman has also reached menopause. The challenge is breaking the taboo with one's spouse.

On the question of the church's response to traditional beliefs and practices on menopause in the context of HIV, all the pastors said that their churches have never dealt with the subject of menopause. However all the pastors acknowledged that some communities do not have access to information except from the church. The participants noted that the pastoral role of the church can include sex education which can give information on menopause and related sexuality issues.

Other than menopause this study also discovered that there are other resilient traditional practices that have potential to spread the HIV. The traditional practices that have a potential to contribute to the spread of HIV in Zimbabwe and in Mozambique are the same. The following issues were raised: Wife or husband inheritance following the death of a spouse. Families do not care to find out the cause of death of the spouse before arranging for inheritance. The second major issue is the aid offered by a young brother to an impotent elder brother who cannot father children. Seemingly family members especially the aunts will organise secretly that the younger brother of an impotent man pregnant his brother's wife. This has the potential to spread the HIV. Related to this is a situation when a woman is barren and asks her younger sister to join her in marriage and bear children for her husband. Another major challenge raised by the pastors was the cleansing of widows through sexual intercourse. When a woman loses a husband she is considered unclean until she performs sexual intercourse with a relative of her deceased spouse. In some cases the widow should have sexual intercourse with a mad man whom she should not know. So she has to be in a dark room, then this mad man enters the room and engages with her in sexual intercourse. All this is organised by aunts and uncles.

Discussion

Traditional beliefs on menopause affect women negatively while they give men the leeway to continue to have sexual intercourse with younger women. The traditional understanding and practice is inherently exploitative of women.

Women have mentally accepted the tradition as authentic and protective for them in the case of the Karanga. Similarly amongst the Tsonga the women feel they have an obligation to protect their husbands from developing bulging testicles. Even when women have a choice through biological knowledge, some women continue to respect the tradition by abstaining from sexual intercourse, indicating that on some level they have come to accept the traditional practice as legitimate. In so doing, women participate in their own domination by men (Glassie 1995). In this oppressive tradition the church has been silent as the church also seemingly blesses male domination. 'Patriarchal attitudes are also found in Christianity and these have strengthened the traditional customs, which men use to control women's sexuality (Human Rights Monitor 2001).

Wambua (1997), Kyomo and Selvan (2004:35) and Baloyi (2013) that the traditional understanding of menopause permits men to continue with sexual intercourse with younger women as they are allowed to marry a younger wife. This came out in my research findings that men continue to have sexual intercourse with younger women.

In context of HIV this is problematic in that it leads to intergenerational sex. Old men are in a way traditionally licenced to have sexual intercourse with younger women. In this way we will see young women falling pregnant because of elderly men. In addition this has the potential of spreading HIV in an intergenerational manner. As noted earlier on, women also do seek for sexual intercourse outside their marriage when they reach menopause. This can explain some growing challenges of HIV infections amongst the 12 to 24 year age group amongst girls while the same age group of boys is not as infected. The tradition in this sense is no longer useful. Both men and women continue to have sexual intercourse which is against the dictates of the tradition making it redundant. On the other hand the unintended result is intergenerational sex which has resulted in the spread of HIV in an intergenerational manner.

For male mainline church members whose wives reach menopause, there will be no option for marrying another wife. The obvious route is extramarital sexual intercourse to quench sexual desires. This is very dangerous as it is a possible route for multiple sexual partners thereby entrenching the spread of HIV. This becomes a silent route for the spread of HIV since the church is also silent about the traditional beliefs of menopause. In this silence is not a solution. The church should empower itself with information and pass it on to its members as part of sex and sexuality education.

Conclusion

This paper has managed to expose the biological understanding of menopause. Biologically we have seen that there is no connection between the bilging of stomach and testicles in women and men respectively. The whole argument is founded on the strength of the unquestionability of traditionalized phenomenon. The paper has also managed to expose the ritualised Tsonga and Karanga understanding of menopause in women as the end to ovulation which has been traditionalized. As a traditionalized practice it is now applied without questions. According to Lightfoot-Klein *et al.* this because tradition and 'Custom in Africa is stronger than domination, stronger than the law, stronger even than religion. Over the years, customary practices have been incorporated into religion, and ultimately have come to be believed by their practitioners to be demanded by their adopted gods, whoever they may be' (Lightfoot-Klein *et al.* 1989:47 cited by Okome 2003:71). Both the Tsonga and the Karanga attested to respecting their traditions and culture despite being Christian. There is an uncritical acceptance of traditionalized phenomenon without questions because 'it is our tradition'.

The traditional practice of beliefs around menopause both amongst the Tsonga and the Karanga poses a high possibility of extramarital sexual relationships there by exposing people to HIV infection. Spouses would want to observe cultural taboos within the family setting while indulging in illicit sexual intercourse with younger people for sexual satisfaction. This applies to both the females and the males in the identified groups. This becomes high risk behaviour as people can easily get infected through multiple sexual partners.

The traditionalization of menopause has resulted in intergenerational sexual intercourse thereby resulting in intergenerational HIV infections. The church is not discussing the issue of menopause. It is my considered view based on the above research findings that the church through pastoral care should start empowering communities with knowledge on sexual and sexualities which can enable communities to question some of their traditions that are not pro-life.

The cultural beliefs have resulted in behaviours that lead to trans-generational multiple sexual partners. This paper concludes that the cultural explanations of the meaning of blood released by women during menstruation requires some biological explanation to ease the fears and taboos thereof among the Karanga and the Shangaan Tsonga. This paper concludes that the

continued use of traditionalised explanations of menstrual blood is a possible source for the spread of HIV especial in a trans-generational manner amongst the concerned tribal groupings.

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Childhood Sex Education Facilitating Zero HIV Infection

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Abstract

The continual prevalence of HIV and AIDS epidemic in sub-Saharan Africa leading to high rate AIDS related deaths indicates that in spite of tremendous efforts made so far, humanity is struggling with the epidemic. Families have to invest more in sex education of their children/wards. Many families and faith-based communities continue to shy away from critical discussion around the discourse of sex education for minors. Often the commonest attempts made in line with sex education have always been to educate the youth who are in their teens, but what happens to those who are outside the age bracket of being teenagers. This paper raises a serious concern that aspiring for zero HIV infection means revisiting families and faith-based communities' commitment to sex education of children. In this regard, one of the preoccupying issue is; at what age should children be exposed to in-depth sex education leading them to understand the implications of the vitality and nuance of sexual activity, which happens to be one of the major sources of HIV transmission? In other words, children as well as adults need to be well-informed of sex and sexuality related issues to facilitate appropriate decision making on matters of sexual activity. Therefore, now is the time to take children's sexual education serious.

Keywords: Childhood sex-education, In-depth sex education, HIV and AIDS epidemic, zero HIV infections

Introduction

Although the conception of childhood sex education may be thought-provoking but it is an obligation that calls for attention; specifically in the face

of on-going prevalence of HIV and AIDS epidemic including other sexually transmitted diseases. It is a fact that childhood sex education has proved beneficial in preventing varying occurrence of unwanted pregnancy (Boonstra 2010:27; The World Bank 2011-2015:1). The paper's key argument for childhood sex education is built on the premise that everyone needs to make informed choices regarding sexual engagement based on exposure to open, honest conversation about love and relationships (De Melker 2015:1). Besides, in sub-Saharan Africa where 23.5 million people are living with HIV infections (UNAIDS 2013), childhood sex education is needed to aid all other efforts made to curb further HIV infection. Equally, childhood sex education is affirmed by the fact that sexual development is a normal process that everyone undergoes. Therefore, children are sexual and gendered beings who need to exercise their rights, particularly with regards to making informed choices in the face of HIV and AIDS epidemic (Bhana 2007:309). Consequently, it is anticipated that children as well as adult (including emerging adults) be exposed to appropriate sex education that is honest, frank and trustworthy in order to equip them with the necessary skills in the context of their involvement in any sexual activity.

In this context, even babies who suck at their mother's breast are described as exhibiting sexual energy (Freud 1856-1939; Erikson 1902-1994). The on-set of human sexual activity starts from infancy to childhood and continual development span through adolescence to adulthood and old age. For this reason, it is necessary that families including faith-based families (communities) take the demands of childhood sex education as serious as it could be, and where shortcomings exist, the necessary measure must be taken towards improvement. For example, Netherlands has attracted international attention regarding early sex education for children, which proves to be valuable in equipping children with the needed skills for understanding sexual diversity, sexual assertiveness and above all developing capability for self-protection against sexual coercion, intimidation and abuse (De Melker 2015:1; Rutgers WPE 2015). The stance for equipping children with the necessary skills for self-protection against sexual coercion, intimidation and abuse associated with the possibility of HIV transmission leading to AIDS related death is the primary objective of this paper. In view of the foregoing, the paper advocates for childhood in-depth sex-education as part of the essential tools needed to curb the increasing rate of HIV and AIDs epidemic in Africa and the world in general. This childhood in-depth sex education should reflect broader

engagement on issues of self-awareness, self-respect/right, responsibility, and respect for others. Arguably, children will grow into responsible adult engaging personal agency needed for making informed decision regarding involvement in sexual activity and achievement of sexual health, facilitating zero HIV infection.

Why Childhood Sex-education?

Beginning a conversation about sex early and continuing that discussion as the child grows could be described as childhood sex-education. Sex education helps children understand their body and specifically helps them to appreciate their sexuality (Parent Guide 2009:7), which includes talks about the anatomy of the body and reproductive health, gender identity/role, relationships, love and affection and body image. This is a privilege that cannot be taken away from children, they need the space to talk about their concerns and pleasures, anxieties and hopes, as well as issues relating to sexual rights and resistances (Bhana 2007:309). It is a strategy that parents ought to employ in order to ensure that children get the right sexual information (Kaufman 2011a:2). The right information about sex-education includes teaching the right values and norms appropriate and acceptable not only to the parents but also within the cultural circumstances in which the child is located. For example, if parents believe that sexual intercourse should be saved for marriage, then in embracing early sex education, the parents have the opportunity to transmit such attitude to children rather than wait for when they have become adolescent. It is not that an adolescent cannot be taught sex-education but there is greater chance of higher risk of non-receptivity since the adolescent may be dealing with many other issues, besides sexual identities and rights.

The argument for early sex education is particularly significant considering the continual spread of the HIV epidemic of which children are not exempted. Although, UNAIDS (2014:1) reports that between 2002 and 2013, there was a 58% reduction in the number of new HIV infections among children (under 15 years of age). The emphasis on the reduction were associated with improved innovation towards mother to child transmission which is slightly different from the empowerment that comes from aiding children become active agents in making informed decision regarding their involvement to sexual activities, particularly as they grew into adolescence and emerging adults. Besides, UNICEF (2016:1) reports that out of 2.0 million

adolescents living with HIV infections across the globe, 1.6 million are located in sub-Saharan Africa. Basically, the essence of early childhood sex education portrays the recognition that from childhood, children need to develop a healthy sexual identity; leading them to becoming active participators in making informed choices regarding what they do with their bodies. And such sex education need to be thoughtfully planned and executed.

In this context, parents are the first source of information about life. Therefore, their ability to inculcate the right information about sex helps children avert making risky mistakes as they grow up. It is important to note that if parents fail to educate their children about sex, the children will still learn about sex from somewhere else even at an earlier age than the parents least expect. Alternatively, children learn sex-education from many other sources such as the media particularly from TV, and other internet sources including their peers (Strasburger 2012: 1). Children easily access pornography from the internet. What children learn from the media might be sensational and superficial pointing to the fact that parents must review what their children learn through the media (Brown, Greenberg & Buerkel-Rothfuss 1993:513; Gruber & Grube, 2000:212). Studies show that the more children are exposed to sexual images in the media, the more likely it is they will engage in sexual behaviours at a younger age (Strasburger 2012: 1). Studies have also found a cause-and-effect relationship between viewing sexual content in the media and earlier age at first sexual intercourse (Brown, Greenberg, Buerkel-Rothfuss 1993: 501; Gruber, Grube 2000:211). The major concern over children's learning of sex education through the media is based on the fact that they may not have the cognitive skills to question what they learn. The implication is that children might most likely follow thoughtlessly what they see, hear and observe, and this kind of learning has lasting consequences in the face of HIV and AIDS epidemic. Therefore, if Africa and the world at large have to curb HIV to zero infection, then childhood sex education administered by parents is an essential alternative needed to counteract what the media and other sources offer that are not profitable.

In the same way, learning about sex-education from their peers could be detrimental because such information given by peers might not carry the appropriate messages. Even when children learn sex-education from school, parents must be involved and interested in knowing what their children are taught in order to ensure that the right messages are transmitted unto their children. Otherwise, parents risk exposing their children to misinformation.

Therefore, when parents fail to have the conversation around sex with their children it means that parents will have little or no control over what their children know about sex and possibly their level of involvement and activity. In the light of such situation, parents cannot expect their children to behave appropriately when they have not been properly taught, and the bigger problem about children's behaviour in relation to sex is linked to the possibility of their contracting sexually transmitted diseases of which HIV is part of the sub-systems.

In the pedagogy of learning, children's sex education ought to follow the procedure of open and truthful conversation which must be on-going. And one of the major argument for such engagement is to equip children with skills for understanding their sexual rights and putting such rights in action whenever the need arises. Consequently, parents must design an action plan for the process of sex education to unfold and become realistic aspect of their child rearing activity. There is no doubt that appropriate sex education has proved to be a powerful agent in bringing about behaviour change leading to reduced sexual activity, especially among young people (Acedo 2009:20; UNAIDS/WHO 2010:5).

Common Parental Attitude to Childhood Sex-education

Globally, parents tend to shy away from childhood sex education on the basis that children are young, and as such not able to deal with the complications associated with sexual activity. In this regard, Wilson, Dalberth, Koo and Gard (2009:56) posit that parents' common excuse for delaying talking to pre-teenage children about sex is based on the argument that they are young and the parents themselves do not know how to handle such conversations. Supportively, Nyarko, Adentwi, Asumeng, and Ahulu (2014:21) in reporting a research findings of a study conducted among Ghanaian parents towards sex education for lower primary school, indicated that 58% of a sample population of 100 parents expressed unfavorable attitude towards children's sex education on the grounds that children are too young. Furthermore, Bastien, Kajula and Muhwezi (2011:1) reviewed studies of parents-child communication about sexuality and HIV and AIDS in sub-Saharan Africa across 1980 to 2011 and reported that among other things, the over-all features of sex education between parents and children seems authoritarian and characterized by vague warning rather than direct and open discussion. Convincingly, it can be said

that parents do not feel comfortable talking to their children about sex at an early age.

In addition, such position taken is not different for Christian based communities. Athar (1996:2) argues that faith-based communities conceive sex as a taboo, therefore often resort to giving moral education not sex education. Affirmatively, Ankamah (2010:200,) emphasizes that faith-based communities perceives sex education for children as ways of encouraging immorality. And this kind of attitude is not far from what school teachers think about children's sex education. For example, this extract from Bhana (2007b:309) research findings present a school teacher's opinion regarding talking to children about sexual issues including HIV and AIDS as follows:

I don't think that they know too much about HIV/AIDS (sic). I think that it's just a few of them that know but generally 'cos you can't really talk about it. I mean, as their teacher, I would not want to get too much into that 'cos they're too small. Children should not be introduced to this sort of thing at such an early age. They're too young and then they start to experiment t... that is why I would not like to sort of talk about sex If they ask any question, I give them innocent answers...they don't really know about it or sex. They're very innocent

The extract was reported in a research study that explored what HIV and AIDS mean to seven- and eight year-old children in South Africa and how sexual and gender dynamics are embedded within these meanings. The extract reflects that teachers in school are protecting the children from engaging in honest conversations around sexuality education; and directly it reflects the same attitude of parents at home. Irrefutably, the issue of sex education in schools has been very controversial with respect to the age/stage at which it should begin. In his essay, 'Sex Education in Ghanaian Society: The Skeleton in the Cupboard', Osei (2009:3) illustrates how his mother lost her teaching job in 2004 for teaching her class one pupils the parts of the body. Much of such attitude are grounded on the notion that a child is innocent (Bhana 2007a:413; Faulkner 2011:1), therefore, should not be bothered by adult's anxieties. In this regard, some parents' argument focus on, at what age should children be talked to about sexuality. The association is that such attitude is linked to social-cultural orientation most especially in Africa where sex education is reserved for initiation ceremonies (McLaughlin, Swartz, Cobbett,

& Kiragu 2015:210). As earlier mentioned, sometimes, when children are taught sex education, the dominant perspective that parents and care-givers present is the notion that ‘sex is bad’ (Pattman & Chege 2003:103; Pattman 2006:90), in order to scare children away from possible participation.

Some parents and care-givers constantly get into the debate, reflecting arguments such as aren’t words like penis and vagina too complicated for children to understand (McLaughlin, Swartz, Kiragu, Walli & Mohammed 2012:2; Parent Guide 2009:9)? The irony is that these children are born with penis and vagina, so why not begin a sincere conversation with them early regarding these parts of their body. Such conversations will enable them to at least develop the use of appropriate language in terms of naming parts of their body and could as well be helpful in medical situations, specifically when reporting cases of abuse for which children are not necessarily exempted.

Another issue that likely lead parents to assume the attitude of avoidance regarding starting early conservation around sex with their children is based on whether they should talk to boys and girls differently about sexuality (Parent Guide 2009:9). Probably, it is important to recognize that both boys and girls need the same important information to become healthy persons who understand their human sexuality enabling them to develop proper self-awareness including self-respect for self and others. In the context of HIV and AIDS epidemic in Africa where UNAIDS report emphasizes that:

Globally women comprise 52% of all people living with HIV in low- and middle- income counties, and men 48%. However, in sub-Saharan Africa, the centre of the global epidemic, women still account for 57% of all people living with HIV. In addition to the greater physiological vulnerability of women to HIV, gender inequalities includes vulnerability to rape, sex with older men and unequal access to education and economic opportunities. (UNAIDS 2013b: 78)

These points to the fact that both boys and girls should be taught same information regarding sex in order to equip the girl-child, who may likely be abused to improve her resilience and at the same time improve the boy’s responsibility skills as he grows into a man to resist abusing any woman including avoiding same-sex abuse whenever such abuse abound. In this sense, sexuality education is a powerful agent in bringing about behaviour change leading to reductions of sexual abnormal behaviours including the transmission

of HIV and other venereal transmitted diseases, especially among young people. Knowledge is power which parents cannot withhold from their children, thus, there is need to start empowering children with early sex education in order to sustain their human right and dignity.

At what Age should Children be Exposed to Sex-education?

Prescribing the age at which children should be exposed to sex education would be difficult but based on the premise that sex is a natural phenomenon for which everyone is curious about, entails that children too are inquisitive about sex. Accordingly, children should not be excluded from proper sex-education appropriate to their age. For instance, research findings show that children from the age of 4 and/or earlier in the Netherlands are exposed to comprehensive sex-education (De Melker 2015:2). In this regard, it is anticipated that children from the Netherlands have been equipped with resources to navigate their sexual choices among other things. According to the World Bank, teenage pregnancy rate in the Netherlands is one of the lowest in the world, five times lower than the United States of America (The World Bank, 2011-2015:1). Likewise, HIV infection rate including other sexually transmitted diseases are low (The World Bank 2011-2015:1). This means that starting early to engage children to active sex-education has tremendous advantages.

McLaughlin (2012:2) argues that ‘the young people have a vigilant awareness of a highly sexual world around them, including prostitution, pornography and drug-related sex, and a fairly sophisticated knowledge of adults’ sexual practices. Therefore, it is not an exaggeration to argue that children are at risk if treated as innocents in matters regarding sexuality including HIV and AIDS education. Bhana (2007:211) advocates that early childhood sex education is a necessity needed to be incorporated into South African school curriculum for children, specifically for 7-8 years old, which beyond equipping them with sexual right ought to broaden their knowledge and understanding of HIV and AIDS. One of the major arguments was based on the fact that in the face of HIV and AIDS crisis in South Africa, teachers need to engage school going age children creatively with knowledge of HIV and AIDS in order to broaden their understanding as well as facilitate their negotiating right, in terms of empowering them with life skills for resisting sexual abuse of any kind (Bhana 2007:309).

The argument regarding resisting sexual exploitation has greater risk associated with some shocking incidences wherein baby-girls (children) have been found pregnant at the age of five. The case of Lina Medina, a Peruvian woman who became the youngest confirmed mother giving birth to a son at the age of five years seven months in 1939 is a reality that cannot be contested (Delaney, Lupton & Toth 1988:51; Mikkelsen & Mikkelsen 2004:10; Time 1957:1). Although conception at age five could be disputed but medical science has proven that such is possible due to precocious puberty, which is described as early onset of hormonal development leading to sexual maturation and it can commence as early as at age 6-8 for girls and at the age of 9 for boys (Kaplowitz, Kemp 2015:1; Woodham 2015:1). Globally, there is a list of youngest birth mothers presenting an overwhelming figure of about 109 young mothers across the age of 5-10 years (Wikipedia). Significantly, most nations of the world are represented as having at one time or the other experienced this youngest birth mothers, and specifically the African countries represented are Kenya, Namibia, Nigeria, Senegal, South Africa, Rwanda and Zimbabwe. These kind of news, though could be contested seems worrisome not only for the rudeness of unwanted pregnancy but the associated consequences of contracting sexual transmitted diseases, including HIV. One of the newest news of such kind is the story of a five year old pregnant girl in Nigeria who is pregnant for an unknown person (Naijahints.com, 2016:1). In a survey undertaken by Lim and Kui (2006:1), boys as young as nine years old said they have had sexual experiences.

Moreover, young people are having sexual intercourse at a much younger age (Naidoo 2001:1 Small & Luster 1994:181; Stack 1994:204), and sometimes even as young at the prime age of three. On this basis parents cannot continue to overlook the fact that children could sometimes become sexually active, whether by coercion or act of their own personal agency, therefore the onus fall on families and faith based communities to reassess their commitment towards childhood sex education if the HIV and AIDS epidemic really need to be curb to zero tolerance. In this perspective, this paper advocates that children from infancy be exposed to adequate sex education appropriate to their age. It means that parents must be alert and eager to assist their children understand their bodies starting by helping infants name the different parts of their body including the genitals. And this effort must be continuous as children grow until they become emerging young adults who are capable of making informed decision regarding sexual activity. The implication is that appropriate action

needs to be developed to help parents be active teachers of children's sex education.

Proposed Program of Activity for In-depth Sex-education

In line with teaching and learning principles, this proposal for in-depth sex-education for children will start by stating the purpose, the objectives, teaching methodologies and content, bearing in mind that the outcome measure will reflect in the long term desire of reducing HIV infections among other things.

Purpose

The purpose of childhood sex education is to equip children with the necessary knowledge and understanding about sexuality including sexual activity appropriate to their age. In this way, assist children exercise their human right including building resilience capacity in face of any possible voluntary sexual participation or abuse which might expose them to HIV infection. To a great extent the program of activity aims at encouraging African parents (including parents across the globe) to talk to their children early and often about delaying sexual activity.

Legible Teachers

The first teachers for this in-depth sex-education are the parents and other primary care-givers. It is anticipated that faith-based communities should be coopted to extend their moral teaching of values and norms to early sex-education for children. The emphasis on legible teachers is based on the fact that many parents, specifically African parents would argue that traditionally they were only taught about sex during initiation ceremonies (Bhana 2007:312; Mnguni 1999:75; Zimba 2015:1). This kind of argument stems from the fact that sex is reserved as an adult activity for which children are exempted from. Besides, Africans perceive talks around sex as taboos (Bastien, Kajula & Muhwezi 2011:1; Dimbuene & Defo 2011:129). On the one hand, some parents would rather prefer that teachers take the lead in teaching sex education in school-settings (Nyarko, Adentwi, Asumeng & Ahulu 2014:25). On the other hand, based on-going conversation it is anticipated that parents cannot

shy away from teaching their children everything they need to know about life (Driscoll & Nagel 2008:175), including sex education. In this context, the parents and care-givers (family) as the primary source of socialization processes must take the lead in initiating children to appreciate and befriend their bodies, which are closely associated with progressive holistic human sexual development.

Objectives

The specific learning objectives for the anticipated childhood sex-education should include the following:

- To help children learn about their sexual self
- To assist children learn factual information on all aspects of sex
- To help children learn about the opposite sex
- To enable children learn and understand the sexual behavior of others
- To help children appreciate that sex is part of life
- To help children develop critical views regarding sexual messages transmitted through the media and other sources
- To equip children with life skills needed to negotiate and make informed decision regarding sexual intimacy
- To help children access information about HIV and AIDS (including other venereal diseases) in order to reduce possible infection
- To help children maintain healthy sexual life

Teaching Methodologies

Parents should use all possible available means to teach children about sex-education including explanation, questions and answers, discussion, storytelling, songs, riddles, dances, proverbs, cultural narratives of values and norms etc.

Course Content with Appropriate Age Brackets

The course content is presented in table form portraying a suggestion of what could happen at the various age bracket. It is important to note that this

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presentation is not prescriptive but descriptive in the form of making recommendation of what could happen at various age as there is no specific model available to parents. Therefore, this serves only as a guideline bearing in mind that children develop at different pace and parents also have a right to take different approaches according to what appeals to them. The most important thing is that parents do something in view of carefully orienting their children to appropriate sex education appropriate to their age and the context in which they are located.

Age bracket	Course Content	Course Activity
0-2 years old	Introduction course: i. Love and affection ii. Touch and facial expression iii. Play & laughter	Primarily, parents need to show children at this age bracket a lot of love and affection which will help them to develop proper sexual relationship. Learning through mom and dad's kisses, including other care-givers Learning through touch, play and toilet training. Children learn from what they observe. In this sense, breast sucking should be properly planned and administered including timing. Children learn about the world through touch. Just as babies enjoy playing with their fingers and toes, they will play with their genitals too, because it feels nice. Many children may touch their genital for pleasure or comfort. So, parents need to be attentive to not frown when children touch their genitals.

		Much of the activities here are to be initiated and sustained by parents and care-givers, since the infant is likely not able to use language effectively. It means that parents & care givers are the one who should do much of the reading of materials available on human sexuality & education in order to know the limit of what they can do at this stage.
2-4 years old	i. Naming different parts of the body & its functions, including the genitals. ii. Develop positive self-concept: s/he needs to value who they are and are becoming. iii. Approve friendship	Parents should continue to introduce children to appropriate touch practices and language use for genitals either by self or others. Appropriate game/play materials & videos clips could be used to help children learn the different parts of the body. Also, role playing could be employed as well as songs that teach simple lessons on morals and values. In addition, parents who are Christians could use simplified spiritual passages to tell the child stories about sexuality. Besides alternative materials according to faith orientation of the parents should be used. Encourage them to express their feelings.

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		Parents should show interest in who their children's friends are. Parents should listen attentively and answer questions sincerely. Parents should be involved in knowing, participating and controlling what the child watch or have access to in terms TV & other internet sources.
4-6 years old	i. Reproductive organs ii. Self-image/concept iii. Gender role/category iv. Relationships/intimacy v. Responsibility	In addition to play charts, video clips, some activities around storytelling, dancing, proverbs, riddles and songs could be used. Tell them stories of family values – let them value their root. Much emphasis should be placed on factual facts about the human body. Talk to them about reproductive organs including inappropriate touch and its consequences. Parents and care givers need to help children understand the dangers of sexual abuse and equip them with skills to report any possible attempt of abuse from others. Guide them to understand gender roles and respect for each gender category.

		Continual positive development of self-concept is needed here. Make them take pride in who they are. Encourage them to talk about their friends- value their friends but gently challenge what may need to be challenged. Use drawings and paintings. Make them draw as well. Let them express themselves in drawing. Encourage them at this stage ask questions & answer them trustworthily. Pay attention to what they have access to in terms of internet, phones and other media sources.
6-8 years old	i. Reproductive organs ii. Ethics of relationship-moral/values iii. Lessons on puberty	Listening attentively to children's stories which may include anxieties that they feel, inquiries about reproductive organs etc. Give them the space to freely express themselves and be sincere in your responses. Intensified discussion around reproductive organs, emphasizing the implication of respecting their bodies and other people's body. Help them to understand sexual orientations and the implications each orientation holds in different cultural settings.

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		Introduce them to ethics of moral code in terms of boundaries. Parents should begin conversation around puberty which is anticipated to set in sooner or later. Help them to understand that it is a normal process of human development. Encourage them to ask questions, expressing their feelings and what they may need to do if they feel inappropriately touched by the other.
8 - 10 years old	i. Discussion on sexual choices. ii. Boost their ego identity. iii. Lessons on puberty	Sincere discussion on issues of sex and implication of the choices that they make. Let them understand that choices go with responsibility. They may have started developing changes associated with puberty, therefore devote time to helping them know what to expect and to love this transition period. Continue to enable them appreciate the essence of respecting others in terms of sexual language they use. This should include sincere conversation around code of ethics, morals & values. Use cultural materials that teach norms & values.

		Proverbs, riddles and dances could also be used.
10 - 15 years old	i. Lessons on adolescence stage ii. Code of conduct etc.	At this stage the child is a teenager, so parents should treat them like emerging adults that they are. Help them to understand the physical changes that they are experiencing. Make them feel comfortable with those changes and the implication of making right choices. Again, ensure that the discussions are as sincere as it could be. Give them honest responses. They need to know exactly how the reproductive process works. Help them talk sincerely about their feelings and experiences. Respect their space.

Implication of the In-depth Program

Basically, having outlined a program of activity means that parents and care givers are challenged to do everything possible to ensure that they start a conversation early with their children/ward regarding sex education. The sole responsibility falls on parents and care givers to empower children to make informed decisions regarding participation in sexual activity. Early sex education might not completely eradicate HIV infections but hopefully it will go a long way towards reducing the frequency of infections. In addition, to the effort made by parents, faith-based communities and school settings need to be active participators in this process of early sex education in order to ensure that children are not left ignorant. The slogan should be to teach the children the appropriate sex education that they should know.

However, they are some delimitations particularly in the face of the fact that some parents might not be well educated to take up the challenge of reading and understanding the available literature of how to go about early sex education. In this regard, such group of parents might not participate actively in the on-going debate about early sex education. As much as such challenges abound, they are not insurmountable. In order to address such, this paper advocates that faith-based communities and Non-governmental Organizations including all shareholders invest interest in disseminating the information about childhood sex education in their different local area of operation. Another problem that could suffocate such early childhood sex education is the reality that some children might be experiencing lack of parental care either because their biological parents are ill or have passed-on. Again, care givers need to take up the challenge and particularly in Africa where collective responsibility is obtainable, this should not stir much dust. The act of child rearing is a collective responsibility for the Africans, so this challenge should not overwhelm the process of early childhood sex education which aims at reducing HIV infections through childhood sexual empowerment.

Closing Remark

To sum up, it is important to recognize that early sex education could be a daunting task but not absolutely an impossible assignment. Parents and care givers have what it takes to socialize their children to appreciate and comprehend how involvement in sexual activity could be life giving as well risky when not appropriately negotiated, particularly in the context of continual HIV infections that threaten to claim over 35 million lives globally since its inspection (UNAIDS 2016:1). Therefore, children and emerging adults as sources of future hope need to be equipped with life skills tact geared towards zero tolerance for HIV infection.

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Indigenous Knowledge Systems: An Alternative for Mitigating HIV and AIDS in Zimbabwe

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Abstract

HIV, as one of 21st century crises, has caused great suffering. Nations, worldwide, have doubled efforts to mitigate the effects of the HI virus. Multi-sectorial approaches have been employed to reduce its transmission. Paradoxically statistics of new infection, Anti-Retroviral Therapy (ART) defaulting and HIV related deaths continue to increase despite the fact that communities in Zimbabwe, rural and urban, have access to HIV information. The paper seeks to investigate why the available information does not translate into effective and efficient HIV intervention measures. Is this to do with the nature and form (language and packaging) of the information? Can indigenous knowledge be helpful? These were some of the questions that underpinned the study. Since the study is a qualitative one, five prominent figures in Zimbabwe were interviewed. One chief, one acclaimed folklorist, two renowned scholars on traditional religion and indigenous knowledge and one theologian with expertise on religion and HIV and AIDS were the research participants. Findings revealed that *ngano* (folktales) as repertoires of indigenous knowledge, can be used for HIV information dissemination. The study argues that indigenous knowledge systems are a useful resource for mitigating HIV and suggests their use in dealing with existential challenges, chief among them being the HIV pandemic.

Keywords: HIV and AIDS, *Shona* community, indigenous knowledge, *ngano*, Zimbabwe

Introduction

The HIV pandemic has caused great suffering in the world, particularly Zim-

babwe where in 1999 the Zimbabwe government declared the pandemic a national disaster (Chirovamavi 2012:222). Efforts have been expended on trying to mitigate the epidemic with minimal strides having been achieved. Despite the abundant education available to people (Bankole *et al.* 2004) new cases of HIV infection, ART defaulting and HIV related deaths continue to be on the increase. This paradox calls for a paradigm shift in terms of the conceptualisation of HIV in the 21st century era if the clarion call: Zero New HIV Infections, Zero Discrimination and Zero AIDS-related deaths is to be realised in the near future. Given such a scenario this paper investigates why HIV is on the increase in spite of the fact that awareness about HIV and AIDS has increased and suggests the use of indigenous ways of disseminating information as a possible alternative. The paper argues that *ngano*¹ can be useful in HIV and AIDS information dissemination in the 21st century. This paper progresses by reviewing related literature, discussing the methodology used in gathering data, presents and analyses findings and concludes by way of a summary, conclusions, and recommendations.

Objectives of the Study

The intentions of this study were to:

- Examine the place of indigenous knowledge systems in contemporary Zimbabwean society
- Ascertain whether traditional deep *ngano* language can be manipulated for the 21st generation audience
- Assess the efficacy of *ngano* in the dissemination of HIV and AIDS awareness information

Theoretical Framework

The study is underpinned by Afro-centrism, a theory that calls for African

¹ These are stories told to young children from about five to eleven years of age, although adult persons are not forbidden from listening to the stories (Mawere 2013). This is a genre of storytelling where certain values and virtues were taught. This has been translated as ‘folktales’ by the missionaries with the intent to belittle the African mode of schooling. This genre, because of its efficacy among Africans, withstood the test of time and is still enduring in the 21st century.

phenomena, activities and way of life to be looked at and be given meaning from the standpoint and world view of Africans (Gray 2001; Asante in Hudson-Weems 2007; Makaudze 2013). The theory argues that using colonial and western perspectives in order to understand African epistemologies and ontologies usually results in distortions. In this regard, it is prudent that Shona folktales be interpreted by the Shona themselves as they tap their knowledge into solving challenges confronting them. Using this theory, the study argues that *ngano* (as an artefact Shona people are familiar with from time immemorial) can be a useful tool in HIV information dissemination.

Literature Review

Under this section, I intend to review literature related to concepts that underpin the study. There are always contestations as to definitions of terms in scholarship. In order to put the study into proper context literature on indigenous knowledge systems, HIV and AIDS and *ngano* shall be reviewed.

Indigenous Knowledge Systems (IKSs): Definitional Contestations

Scholarship lives by its debates over terminology and many terms and concepts used in the humanities remain contested (Chitando 2009:8). Scholars have expended considerable energy trying to clarify the concept Indigenous Knowledge Systems. These scholars include, among others, Mawere (2010; 2011; 2012; 2014a; 2014b; 2014c; 2015), Mapara (2009), Gudhlanga and Makaudze (2012) and Hoppers (2002).

Hoppers (2002) makes an essential contribution towards the conceptualisation of IKSs by, first and foremost, attempting to define the word 'indigenous'. For her the word *indigenous* refers '... to the root, something natural or innate (to) ...' (2002:8). Indigenous knowledge systems are then the combination of knowledge systems encompassing technology, social, economic and philosophical learning, or educational, legal and governance systems (ibid). This definition points to the fact that indigenous knowledge systems cut across all facets of human existence. They cannot be restricted to one aspect but are ubiquitous in human life.

Similarly, Mawere (2014a:4) is of the conviction that the concept of

indigenous knowledge is a combination of two fundamental terms: *indigenous* and *knowledge* that need to be separated before the whole concept is unpacked. For him, the term *indigenous* literally mean original, first, native to a place or aboriginal people to an area (ibid). Without necessarily wanting to be philosophical, Mawere (2014a:5) understands knowledge as a personal belief that is somehow justified and with the capacity to influence one's thinking, action and behaviour. In the same book: *Culture, Indigenous Knowledge and Development in Africa: Reviving Interconnections for Sustainable Development*, Mawere admits that *indigenous knowledge* has been approached by scholars across disciplines. These include social/cultural anthropology, cultural studies and sociology among others. For Mawere Indigenous Knowledge (IK) and Indigenous Knowledge Systems (IKSs) are inseparable and as such he has decided to use them interchangeably for they mean one and the same thing. The former derives its meaning from the latter.

In an earlier book: *The Struggle of African Indigenous Knowledge Systems in an age of Globalization: A case for Children's Traditional Games in South-Eastern Zimbabwe*, Mawere (2012: 6) understands IKS as local knowledge(s) that is unique to a given culture or society. For him IKSs are the enduring African heritage that has failed to die despite the racial and colonial onslaughts unleashed on them by western imperialism and arrogance (Altieri 1995:114). This understanding by Altieri (ibid) assumes that IKSs are only for areas that were colonised, a position that Mawere (2015:23) in Mawere and Awuah-Nyamekye (2015) refute. IKSs are ubiquitous, both in colonised and colonising societies (developing and developed worlds alike). They have survived the test of time and history. From the definitions offered by Mawere, what he stresses is that this form of knowledge is intergenerational and is passed from one generation to another by those who hold it such as the elders in society (2014a: 6).

From the foregoing some scholars are of the opinion that the categories of this form of knowledge as 'indigenous', 'local' or 'traditional knowledge' has caused contradictions (Lanzano 2013:4). Nyamekye (2015:224) contends that the term *indigenous* needs delineation because it has assumed various connotations. For him the term is quite problematic in that it has assumed a diversity of meanings. For some scholars the term is pejorative to refer to group of people as *indigenes* (ibid). Other contradictions involve who the locals are and traditional has negative connotations. The concepts of local and traditional have been heavily discussed and problematized by scholars. These submissions

point to lack of a common understanding of the concept of *Indigenous Knowledge Systems*. While some scholars want to maintain IK (Mawere 2014a; Lanzano 2013; Nakata 2002; Olatokun & Ayanbode 2008) as an alternative to IKS, others still want to use IKS without violating what the concept stands for (Kamwendo & Kamwendo 2014; Makaudze & Gudhlanga 2012; Mapara 2009). Crossman and Devisch (2002:107) settle for *endogenous knowledge* as a shift of vocabulary having realised the pejorative connotations inherent in the use of the term *indigenous*.

Having discussed the different perspectives on the concept of indigenous knowledge systems, this paper is quite enthused by the definition offered by Marrewijk which I intend to quote at length.

Indigenous knowledge is the sum total of the knowledge and skills which people in a particular geographic area possess, and which enable them to get the most out of their natural environment. Most of this knowledge and these skills have been passed down from earlier generations, but individual men and women in each new generation adapt and add to this body of knowledge in a constant adjustment to changing circumstances and environmental conditions. They in turn pass on the body of knowledge intact to the next generation, in an effort to provide them with survival strategies (Marrewijk 1998:1)

The above insight highlights the fact that Indigenous Knowledge (IK) which is also known as Indigenous Knowledge Systems (IKS) by Mawere (2012) refers to what indigenous people know and do, and what they have known and done for generations- practices that evolved through trial and error and proved flexible enough to cope with change (Melchias 2001). For purposes of this paper IK and IKS shall mean the same and hence shall be used interchangeably. With this in mind the next section assesses IKSs as an African resource worth protecting, promoting, developing and conserving (Hoppers 2002) for sustainable development in Africa. Given this understanding of indigenous knowledge systems, *ngano* qualifies to be part of a people's indigenous knowledge where the young, especially, are taught to care for, conserve and exploit the natural environment to ensure the continued thriving of resources (Mawere 2013: 13). As Zimbabweans battle to come to terms with challenges such as HIV and AIDS, indigenous knowledge systems such as *ngano*, told long back and still being told, continue to provide solutions thereof.

Indigenous Knowledge Systems: An African Resource

There has been unprecedented interest in indigenous knowledge systems. This renewed interest in indigenous knowledge systems and practices is widespread and global (Nakata 2002). This renewed interest comes after colonialism and its enlightenment science (heretofore referred to as modern science). Under colonialism, African traditional scientific knowledges and technologies (heretofore referred to as indigenous knowledge), bequeathed from their forefathers, has been despised, labelled as irrational, void of logical thought, unscientific and anti-development (Mawere 2015:1). Resultantly, the users of this knowledge were either discouraged or forbidden from using them with modern science and technologies either being encouraged or imposed on the indigenous peoples of Africa (ibid). This left a trail of demonization of African ways of knowing. Thanks to the period of renaissance, the once despised and trivialised indigenous knowledge were (and are still being) resuscitated no wonder the renewed interest in IKSs. Hoppers (2002: 8) argues that indigenous knowledge systems represent both a national heritage and a national resource that should be protected, promoted, developed and, where appropriate, conserved. She further asserts that this resource, IKSs, must not only be protected, promoted and conserved but should be put at the service of the present and succeeding generations (which is sustainability of IKSs). What she means by this is that IKSs must become handy in dealing with existential challenges that confront humanity today and generations to come. Ntuli (2002:53) sums up this point when she calls for African solutions to African problems. This is what Crossman and Devisch (2002:116) calls charting a new direction where a people's understanding of knowledge entails privileging local, practical, differential, site-specific/situated knowledges and competencies in contrast to western scientific tradition. This is not meant to oppose science to local knowledge but to emphasise that no one form of knowledge should trivialise the other.

Mawere and Awuah-Nyamekye's book: *Harnessing Cultural Capital for Sustainability: A Pan-Africanist Perspective* argues that the basic component of any society's social security and sustainability is cultural capital. This cultural capital is largely informed by a people's indigenous knowledge systems. Contributions in this book focus on the efficacy of indigenous knowledge systems in combating natural disasters such as droughts and famines. To cite just one example, Mawere and Mubaya (2015:8-9)'s article

focuses on *Zunde raMambo* whose main objective was to ensure collective well-being of humanity. It was a traditional social security arrangement designed to address the contingency of drought or famine. In cases of severe droughts and famines the local people would use the chief's granary to secure grain harvested from his *Zunde raMambo*. If African people, Zimbabweans in particular could harness such IKSs to deal with existential problems such as droughts or famines, what can stop the same people in the 21st century to harness the same IKSs in dealing with pandemics such as HIV and AIDS? This is the cardinal question this study attempts to answer by looking at how *ngano* (folktales) can be harnessed to disseminate awareness about HIV and AIDS in the Zimbabwean context and to Africa by extension.

IKSs have been largely referred to in crises such environmental dilemmas like climate change (Hadgu & Gebremichael 2013; Ajani, Mgbenka & Okeke 2013; Mawere & Mabeza 2015), environmental degradation (Tatira 2015; Asiana 2015; Kwarteng 2015) and food insecurity (Olatokun & Ayanbode 2008; Grantham 1996; Kamwendo & Kamwendo 2014; Seleti & Tlhompho 2014). All these cited examples evidently point to the undeniable fact that IKSs indeed, if harnessed properly, can be the panacea for some of the challenges that threaten to exterminate humanity on earth. Given such truisms the paper seeks to investigate if the Shona people of Zimbabwe can use *ngano* as a tool for disseminating HIV and AIDS to 21st century generation. There has been a deafening silence on target at the efficacy of *ngano* in addressing some existential challenges confronting humanity. As if that is not enough *ngano* has not been documented as a tool that can be harnessed to educate the Zimbabwean populace about the dangers of HIV and AIDS. This yawning gap is the target of this research. It is prudent to briefly review literature on the effects of HIV and AIDS in the midst of interventions put in place by governments and international agencies to reduce the impact of HIV to manageable levels.

HIV and AIDS: Navigating the Tumultuous Terrain

Of the total population of people living with HIV in the world 71% are in sub-Saharan Africa². These statistics are worrisome at a time when people talk of zero new HIV infections, zero discrimination and zero HIV related deaths.

² Star FM News at 18.00 on 16 June 2016.

Statistically, Parry (2013) provides information to the effect that despite the interventions put in place to curb the HIV epidemic, the spread of the virus is on the increase. She states that by 2011, 34.2 million people, including 3.4 million children less than 15 years of age, were living with HIV (Parry 2013:3). She further posits that this rapidly, relentlessly expanding global epidemic was, by 2006, claiming the lives of more than 2.2 million people each year (ibid). Barker and Ricardo (2005:37) equally state that in sub-Saharan Africa, there are nearly 10 million young men and women, ages 15-24, living with HIV and AIDS (statistics from UNAIDS 2003). There could be arguments that the cited figures could have been overtaken by events since then. Be that as it may evidence of the decline of the spread of the virus seems to be as elusive as a mirage. Admittedly, efforts have been expended to bring down these figures but with nominal successes.

Having realised this trend the Church took the bull by its horns. Parry (2013) talks of the comparative advantage of the church in dealing with the pandemic. She unequivocally discusses an HIV competent church that ensures that the pandemic is fought against from all fronts: from a children perspective, women's fellowship front, men's fellowship front, engaged couples, married couples, people with disabilities and parent groups' perspectives. The list is endless. This has made some possible recordings in terms of HIV awareness. But the question still remains unanswered as to why are we still recording new infections, why are there ART defaulting and HIV related deaths?

Chitando (2009)'s *Troubled but not destroyed: African Theology in dialogue with HIV and AIDS* seems to suggest the vantage position theology has when dealing with HIV and AIDS. The female theologian seems to keep up the pace as compared the male counterpart. The title suggests a resilient stance that Igo (2009)'s *A window of hope: An invitation to faith in the context of HIV and AIDS* also seems to be affirming. For Igo there appears to be light at the far end of the tunnel. The book is about how HIV and AIDS 'challenges us to question our very understanding of what it means to be human and motivates us to search for ways to fulfil our deepest desires and dreams ...' (back cover comments). What all these point to, is the fact that the HIV epidemic has been approached from multiple points of view but alarmingly no solution seems to be forthcoming. Being in such a quagmire calls for the local people's ingenuity as had been the case in times of droughts or famines from time immemorial. How did our forefathers (and of course foremothers) deal with eventualities such as droughts or famines, epidemics like *maperembudzi*

(leprosy) and other outbreaks such as rinderpests (foot and mouth diseases)? It is at this point that the same can be said about *ngano* in mitigating the HIV pandemic.

Methodology

While this work remains chiefly a product of critical literature review, it is spiced with data from in-depth interviews held with four renowned scholars and one folklorist of repute. The interviews lasted an average of one hour. WhatsApp was used in gathering data. WhatsApp, as a social media platform is gaining a lot of currency in this 21st century. The WhatsApp platform, which was used with the folklorist was found quite useful and effective given the tight schedule of the folklorist. Questions were given to him on the platform and would respond to them at his own convenience and the interviews took some days. This enabled the researcher to reflect on responses given and in the succeeding interviews certain aspects raised in earlier discussions could be followed, a scenario that could not have been possible in a face-to-face interview unless one makes another appointment. This also removed the close contact of the interviewer and the interviewee which, in most cases, compromise the kind of responses. WhatsApp was like a self-administered interview and produced reliable and valid data. Listening to the folklorist's radio programme was another methodology used for this study, where he narrated *ngano* and listeners asked questions and made comments. This proved useful for the interactive radio programme brought out issues pertinent to this study. Both data from the interviews (WhatsApp included) were recorded and transcribed. The data collected was anonymised and analysed thematically.

Findings and Discussion

The study suggests that *ngano* can be an effective means of disseminating HIV information. It is an indigenous way of imparting knowledge and has been argued to be even effective in the 21st century. Amali (2014:88) makes this clear by arguing, using Idoma folktales, that children stand to benefit from lessons derivable from folktales. Folktales educate and prepare children for 21st century challenges with the HIV pandemic being chief among them. In the past, folktales were targeted to the youths with a view to prepare them for

adulthood but they can also be useful to all and sundry in this context of HIV and AIDS.

Interviews with Three Scholars and one Chief

All the four interviewees agreed that *ngano* used to function as a teaching tool in a number of African communities, especially to children, using a language accessible to the audience. They (*ngano*) were a school for the young as they prepared for adult life. Arguing from a different perspective but with the same intent, Mawere (2012) meticulously discusses games that African children in general and Zimbabwean children in particular engaged in as they sharpened their creativity, accuracy, motor skills, endurance, determination, physical fitness, hygiene and vigilance just to mention a few. These games are a part of the cultural capital (Mawere 2015) that our progenitors passed from one generation to another. The games were (were because they seem to be extinct due to colonialism and globalisation) a form of African education that played a significant role (ter Haar 1992). For Mawere (2013) *ngano* were meant to educate people of many aspects of life including knowledge about how the natural environment should be cared for, conserved and exploited to ensure the continued thriving of natural resources. If this was the case then, *ngano* can also be tapped in teaching HIV and AIDS. Arguably *ngano* can be some of the media through which HIV information should be disseminated.

One interviewee noted that the make-believe world created by the *ngano* teller (*sarungano*) made everything possible. Even the impossible would appear possible because they happened in a faraway country (*nyika iri kure kure*). Animals could marry human beings, trees could speak and human beings could change into animals. The interviewee stated that the *sarungano*'s manipulation of the audience's immediate environment of human and animal kingdoms did not only make the stories interesting but accessible in terms of the language used. The manipulation of the immediate environment made a lot of sense to the audience. HIV and AIDS messages come packed in a language that is not accessible to all and sundry. The information is largely in English metaphors and imagery that may prove difficult for a local community member to grasp. It is only recently that translation has been done. But again once translation is used a lot of meaning is lost in the process. It is at this point that the paper posits that HIV and AIDS dissemination of information must be done

in a language and imagery that local communities are conversant with. *Ngano* can be such a medium.

Speaking to one renowned scholar with an impeccable expertise in studying indigenous knowledge, the following idea was quite clear. He argued that if *ngano* could be used in the past to disseminate information on outbreaks such as leprosy and foot and mouth diseases, the same can still happen in using *ngano* to conscientise people about HIV. He further argues that what could account for the continuous HIV prevalence rate in spite of the education about the epidemic could be the forms in which the education is disseminated. For him people understand a language in their own idioms, proverbs, and riddles. This, therefore, means *ngano*, when tapped into HIV information dissemination, can be effective and useful in bringing about behaviour change. Arguing from a music point of view Mlambo (2015) concurs that indigenous knowledge can be tapped into dealing with 21st century challenges. Music, for him, from time immemorial has been an important aspect of life. He cites a number of Zimbabwean musicians who use their songs to conscientise people about the HIV pandemic. This paper argues that if music can be HIV information disseminator with a high impact factor, *ngano* can equally play a significant role towards the realisation of zero new HIV infections, zero stigma and zero HIV related deaths.

During the interviews it came out clearly that *ngano* has been imparted upon by colonialism and globalisation such that their efficacy as an African resource in crises such as the HIV epidemic has been done a big blow. Notwithstanding this, the interviewees made it clear that *ngano* has withstood the test of time. One of them had this to say:

Ngano played and still play a fundamental role in the communities, especially in the rural areas where grandparents are still keen on educating the young on *Ubuntu*. The youth are taught what it means to be humane, what it means to be a real man, a real woman and how to coexist with others. Stories being told are of hare and baboon always at odds, thereby inculcating in the youth the need to coexist peacefully. This is why even the school curriculum emphasises as well the teaching of such stories to mould in the youth good citizenry (Interviewee).

Arguing from the same perspective, Chivasa and Mutswanga (2014) examine the role of *ngano* in promoting peace building among the

Shona people. They argue that Shona indigenous peace promoting and sustaining methods are still a thriving forest which has not been lost in oblivion. This is acceptance of the African people's ingenuity in dealing with human challenges that threaten their very existence such as violence. Folktales were part of the Shona people's way of life. They (folktales) were mainly concerned with sustaining relationships, maintaining and inculcating peaceful co-existence between individuals and groups within communities (Chitando 2008).

In the same vein Mukonyora (2007: 32) emphasises the significance of *ngano* by arguing that Shona women elders used *ngano* to teach a philosophy of coexistence among people and the animal kingdom. She cites a *ngano* she got from her grandmother about an elephant who used to steal hare's pumpkins. When elephant was finally caught he was humiliated. Lesson learnt from the folktale is: it is wrong to steal. Mukonyora learnt a lot from the stories told by her grandmother. The stories were narrated in a language the storyteller and the audience understood very well. If *ngano* were meant to teach the audience issues of their time, this study is quite convinced that the same genre of teaching can be used to teach people about HIV and AIDS. The language used full of animal and human metaphors are not only vivid but are likely to leave a lasting impression in the minds of the audience. If people manipulated their indigenous knowledge systems to teach, can 21st century generation not benefit from the same in the context of HIV and AIDS? This is the thrust of this paper.

WhatsApp interview with Ignatius Mabasa

Asked about the efficacy of *ngano* in the 21st century, a folklorist Ignatius Mabasa argues that, *ngano*, just like in past, address challenges of the time. They, in this century, address challenges posed by HIV and AIDS. He made it clear during the interview that he had taken *ngano* to another level where people begin to appreciate them. To illustrate his point he briefly narrated a *ngano* in which a young girl used up her transport money on buns at school. She then walked home after school. On the way 'a good Samaritan' offered her transport. She was given an intoxicant and lost her consciousness only to wake up dumped, brushed and besides a dump site. She had been raped by an unknown stranger who initially pretended to be good to her.

From the foregoing Mabasa is teaching using *ngano*. One of the lessons in this folklore is that we must not trust people we do not know. This is a clear case of rape. More to this grave offence, the survivor could have been infected with HIV.

Arguing from an Afro-centric perspective, and concurring with Mabasa, Makaudze (2013) opines that folktales constitute a serious body of literature to which contemporary Zimbabweans must not only pay serious attention, but also tap from for a better understanding of reality and for them to cope with challenges (Makaudze 2013:521) in their day-to-day lives. He refutes a colonialist thinking that relegates folklore in the form of folktales as an art of the past with no place in ‘modern’ society. His (Makaudze) citing of some Shona *ngano* ‘Vasikana vakaroorwa nemadzvinyu’ (Girls married by lizards) demonstrates the Shona philosophy that marriage is not a one-man event but a process that involves many people. The girls realised later that they had married lizards who could change to human beings (changelings) but the realisation came a bit late when vows had been exchanged.

This folktale, like Mabasa’s teaches a number of lessons: that people must marry people they know and within their proximity (*rooranai vematongo*, a loaded Shona saying that emphasises the importance of marrying within proximity where no one is stranger). This folktale can be tapped and be effectively used to teach against marrying people we do not know, especially in the context of HIV and AIDS. Knowing in both *ngano* (Mabasa’s and Makaudze’s) may not necessarily be limited to just knowing one’s life background but may be extended to mean knowing would be husbands’ and wives’ HIV statuses. These are old *ngano* which ‘still make sense!’ in the 21st century. Therefore, relegating folktales to the margins, arguing that they do not have place in the world of globalisation and sophisticated technology is being myopic. Mabasa is already using technology such as YouTube, twitter and clouding to access his audience but the *ngano* maintains its intended purpose.

In the said interview, Mabasa categorically made it clear that the use of *ngano* in the context of HIV as an information dissemination tool is long overdue. Asked on the impact of *ngano* to realise zero new HIV infections, zero stigmatisation and zero HIV-related deaths, Mabasa bemoans the lack of trust in our people whom he said have a serious colonial hangover. For him *ngano* are not static but dynamic. They are part of a people’s heritage and using them to teach about HIV is quite possible as illustrated by his programme on one of Zimbabwe’s radio stations, which shall be discussed later. He

emphasised that *ngano*, from the past, taught and still teaches in the 21st century.

The efficacy of *ngano* as a teaching aid is also emphasised by Amali (2014) who focuses on the functions of folktales in traditional societies. Among the functions Amali identifies include but not limited to imparting educational, traditional, cultural, religious and social ideologies of the society to growing children (2014:88). Looking at the Idoma folktales in Nigeria, Amali (2014:91) cites Amadi (1980:92) who argues that folktales serve many functions in African society. In addition to providing entertainment, they have certain didactic qualities. They are used to educate the young; they help to establish social norms. In other words, folktales were (and are still for communities still using them) ‘schools’ where the young are under the tutelage of *sarungano* (storyteller). The Idoma folktales teach about good upbringing and acceptable behaviour of children. They check indulgence in societal ills. It is this checking and control mechanism of folktales that can be tapped for use in the 21st century challenges such as HIV and AIDS. The deafening silence by available literature on this slant is a cause for concern. The Idoma folktales punish acts such as wickedness, theft, stinginess, unfaithfulness, dishonesty, hatred and rewards such attributes as honesty, sincerity, love, generosity, kindness, faithfulness, helpfulness (Amali 2014:92).

On the effectiveness of *ngano* language as a medium to educate people on HIV, Mabasa made it abundantly clear that the language is ‘modernised’ not westernised so that the 21st century audience understand it. I had raised a concern on the accessibility of deep *ngano* language to his audience. He asked me to listen to his Star FM Thursday radio programme where he teaches a lot of contemporary issues such as domestic violence, rape, child marriages and HIV using *ngano*. The language is made easy allaying fears that *ngano* language cannot be contextualised to suit the current audience. Using animal and human characters (Mazuruse 2010), folktales ‘speak’ in a language that vividly captures the minds of the audience. Whilst they entertain, they have a moral vibe that runs through most of the folktales. This paper argues that such vitality imbued in folktales can be handy in the dissemination of HIV information to people in a language that they know and understand better. More often HIV information dissemination has been in packages that indigenous people are not familiar with. Speaking of abstinence, faithfulness to one faithful partner and condomization may be mouthfuls to certain sections of

people. When such talk is packaged in indigenous knowledge systems such as *ngano* the impact factor may be more comparatively.

Listening to Ignatius Mabasa's Thursdays programme on the most widely listened to Star FM, a radio station in Zimbabwe at half past nine in the morning, one has no option but to appreciate the beauty of the Shona language that he weaves with 'modern' diction that 21st century generation identifies with. Comments made by his audience speak volumes. One listener had, on one of the occasion, this to say:

I never knew that our Shona language is this rich. It is a language that captures our very life experiences through its rich diction. I wonder how vaMabasa (Mr Mabasa) does it. He makes *ngano* language so sweet to the ear and this makes them (*ngano*) very popular to both the youths and the adults (Listener).

Mabasa, as *sarungano* (storyteller), discusses many themes ranging from rape to HIV. On rape he talks of a story (*ngano*) where a female student (represented by elephant in the story) used her bus fare at school on scones and had to walk home. On the way she got so tired that she was offered a lift by *shumba* (lion). She was given intoxicants in the car only to gain consciousness in a bin brushed and bloody. This is a story where one has been raped by a stranger. Lesson (s) learnt here is that we must not trust strangers and this may also help in avoiding contracting HIV. Rape has also been responsible for the spread of the virus given its violent nature. Chances to protect oneself under rape are very minimal. The said folktale therefore warns against getting along with people we do not know. Admittedly most rape cases are from known relatives but as the folktale illustrates it can also be perpetuated by strangers. In another *ngano*, Mabasa teaches about the need to fight stigma and discrimination associated with being HIV positive. He narrates of the animal kingdom where some animals mock and discriminate others because they are HIV positive. From the discussions that ensued it was made clear that there was need to be positive about being HIV positive. All the animals ended up accepting their HIV positive colleagues and vow to assist each other in the fight against HIV stigmatisation and discrimination.

From the foregoing, it is clear that *ngano* has never been static and trivial as suggested by colonialist thinking (Makaudze 2013:521). This colonialist thinking believes and takes *ngano* to be an art of the past with no

relevance to today's experiences. This thinking finds expression in scholars such as Bascom (1965:4) who argue that such a genre of literature needs not be taken seriously since it is not considered history or real life. Thanks to luminaries like Mabasa who resuscitate the use of *ngano* as a genre that 'still makes sense' (Makaudze 2013) even in this 21st century.

Summary, Conclusions and Recommendations

My aim in this paper was to think through the impact of indigenous knowledge systems as an alternative to mitigating the HIV and AIDS pandemic. This was done through discussing the efficacy of *ngano* (folktales) as a genre that still makes a lot of sense in the 21st century. Despite the trivialisation of indigenous knowledge systems by the colonialist thinking, *ngano* can still be tapped to with challenges that confront humanity and HIV and AIDS is no exception.

In this study I have emphasised that *ngano*, as illustrated by the lessons derived from some of them, can be a resource that indigenes can rely on when dealing with outbreaks. They can be used to disseminate HIV information in order to realise zero new HIV infections, zero Anti-Retroviral defaulting and zero discrimination. Evident in the discussion is that *ngano*, as an artefact of the Shona people's indigenous knowledge, is not static but can be modernized to suit the 21st century audience who are in a different socio-economic and religio-cultural milieu from the past. Fortunately, *ngano* proved in the discussion that they can be adapted to suit any eventuality and this demonstrates their (*ngano*) flexibility and resourcefulness. They are normally told in a language audience know best and lessons drawn from them are plenty. Having been given folktales' usefulness, the paper makes the following recommendations:

- IKS can be a useful resource to alleviate the effects of HIV. By mainstreaming *ngano* for preservation and using the language to teach and disseminate HIV information, the pandemic's effects can be minimised. *Sarunganos* from a number of communities can be trained on how to use *ngano* and its rich language to teach and disseminate HIV information.
- Since *ngano* used to take place during the evening, their usage occupies the audience such that they do not find time to frequent places where they may contract the virus such as bars. There is need to have planned

concerted efforts towards having the story tellers have the youth during the day, especially during school holidays teaching them using *ngano*

- Community workshops can also be done where facilitators like Ignatius Mabasa, with the assistance of the Ministry of Health and Child Care in Zimbabwe in collaboration with non-governmental organisations, teach about HIV using *ngano* in the villages.
- Academic conferences on this aspect from various communities of Africa can be held and publications made which then can be used for HIV information dissemination

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Communicating Reproductive Rights to Marginalised Girls and Teenage Mothers at Risk of HIV Infection in Rural Zimbabwe

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Abstract

Access to information and resources are critical factors in ensuring that young girls are empowered to handle reproductive health issues. This is especially significant in the context of teenage Landa mothers' phenomenon, which has a generic relationship with the problem of HIV infection in rural Zimbabwe. The UN Population Fund (2013) indicates that 92% of sexually active women between the ages of 15 and 19 in largely rural Zimbabwe are in a relationship or engage in sexual intercourse regardless of being uninformed about their reproductive rights. It is this paper's position that uninformed girls and women pose a risk unto themselves and their children, which impacts on the fight against new HIV infections. We argue that reproductive health information is central to the prevention of HIV infection and AIDS related deaths. This paper critically appraises existing communication strategies in the dissemination of reproductive health information in rural, marginalised areas; discussing gaps, weaknesses and possible future directions in reaching vulnerable girls and women in the periphery. Young girls have limited access to information, medical services, support and resources that can empower them to prevent unplanned teenage pregnancies and attendant risks like HIV due to common preconceptions about the taboos of teaching 'young' people about 'adult' issues in a culture-conscious society.

Keywords: health communication, teenagers, girls, information, resources, culture, HIV, mass media

Introduction and Background

The media in Zimbabwe is awash with success stories of reproductive health and HIV and AIDS programming in the country (UNAIDS 2015). However, we argue that this programming is concentrated in the metropolises, with the latest youth initiative, Students and Youth Working on Reproductive Health Team (SAYWHAT) that was founded in 2003, focusing solely on higher and tertiary education institutions of Zimbabwe. All these institutions are located in urban areas. Clearly, there is need for more deliberate and more rigorous programming that takes into consideration girls and teenage mothers at risk of HIV infection in the rural parts of Zimbabwe. The rural girl (and teenage mother), seems to be excluded from this programming. Even the few programmes that are taken to the peripheries of Zimbabwe, for example the National Behaviour Change Programme rolled out starting 2006, are designed from an urban perspective.

This paper argues that for any reproductive health and HIV programming to be successful and to have impact on the majority of Zimbabwean girls and teenagers, it should have, as its central driving force, a deliberate and targeted health communication framework. This emanates from the reality that access to information and resources by the youth is the critical tool that can allow young girls and teenage mothers to deal with reproductive health issues and dilemmas they are faced with. In a significant number of cases, adolescent girls are prematurely catapulted into motherhood, and therefore, adulthood. Further, they often find themselves dealing with more than just motherhood as they have to contend with life threatening and debilitating health and wellness issues like Sexually Transmitted Infections (STIs) including HIV.

Youth sexual and reproductive health and HIV and AIDS have been topical issues in Zimbabwe from the past three decades to date as government and non-governmental organisations have spent millions of dollars in reproductive health and HIV and AIDS programming. Programming for the twin health challenges has often been integrated in some of the cases and mostly separated. For instance, the government of Zimbabwe has two huge parastatals; the Zimbabwe National Family Planning Council (ZNFPC) and the National Aids Council (NAC) that solely attend to reproductive health and HIV and AIDS respectively. This paper calls to attention the centralisation of communication in the implementation of all programmes relating to these two

potential threats to wellness and prosperity. The study proposes the Health Belief Model (Becker 1974), for the achievement of sustainable health intervention among girls and teenage mothers in rural Zimbabwe. The Health belief Model proposes that a person's behaviour can be predicted based on how vulnerable the individual considers themselves to be.

Health communication concerns itself with the communication strategies sought and used by individuals in a society in an attempt to maintain healthy lifestyles and contend with health and wellness related issues in all spheres (Rosenburg 1996). Health communication, therefore, places communication at the centre of the strategies that groups and individual members of a community can use to help make decisions that enhance and promote health and wellness (Jackson & Duffy 1988; Piotrow *et al.*, 1997). Over the last few decades, health communication has been proved to be critical to both individual-based and community-centred disease prevention and health promotion interventions (Finegan & Viswanath 1990).

In Zimbabwe, health communication still needs to be promoted as programming is still not taking into consideration the communication variable of health interventions. Mass media is still hardly utilised as a tool for health communication as indications on the ground are that the reproductive health issues are hardly covered. The reproductive health story, which seems to be separated from other health issues like HIV and AIDS in the news, is sparse and infrequent in the Zimbabwean mass media. Where it appears, it is often a recital of statistical issues relating to teenage mothers, early sexual intercourse among girls in school and several other figures often lifted annually off the Zimbabwe Demographic Health Surveys (ZDHS).

Literature Review

The Zimbabwean Context

The total population of Zimbabwe was 12 973 808 in 2012. Females were 6 738 877 and males were 6 234 931. The proportion of the male and female population was 48% and 52% respectively (Zimbabwe Population Census 2012). A total of 48 percent of the female population was in the age group of 15 to 49, years which forms the reproductive group. Zimbabwe has a broad base population pyramid indicating that the population of Zimbabwe in 2011 was youthful (42% under 15 years). In the same year, girls aged between 10 and 24 years constituted 33% of the population. This is the age group under

study in this paper. The Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), Article 14 states the need for State Parties to take into account the particular problems faced by rural women and the significant roles which rural women play in the economic survival of their families, including work in the informal sector. State Parties are also obliged to take all appropriate measures to address issues of rural development and access to basic services such as health, family planning, education and access to credit for rural women. The 2011 statistics revealed that 68.6 % of the population resided in the rural areas while the remainder, 31.4 % resided in urban areas. A total of 52% of the population living in rural areas were females. Rural women constituted 36% of the total population (Zimbabwe National Statistics Agency 2012).

Zimbabwe is one nation that is still steeped in conservative customs that govern relations between parents and children (Kambarami 2006). It is not surprising, therefore, to find a home in which parents have never discussed sexual and reproductive health issues with their teenage children. Subjects such as sexuality, safe sex, contraception, dual protection from Sexually Transmitted Infections (STIs) and unwanted pregnancy are still perceived as specifically tabooed, especially in rural areas where there are conservative cultural and religious beliefs, norms and values. While countries signed agreements at the 1994 International Conference on Population and Development (ICPD) to protect and promote adolescent reproductive health education, information and care; Zimbabwe is one nation in which adolescents, particularly girls, are treated as if they were children who are not in a position to access information on sexuality, reproductive health rights or dual protection (Centre for Reproductive Law and Policy-CRLP 1998). Dual protection information deals with knowledge of simultaneous prevention of STI transmission; and prevention of unwanted pregnancy (CRLP 1998).

The Zimbabwe Population Clock indicates that the current population sits at 15,937,973 with the female population constituting 50.7% with 8,076,444 females. Males constitute 49.3% with 7,861,530 males (United Nations Department for Economic and Social Affairs 2016). Following the 2011 and 2012 official statistics trends, it therefore follows that while the population is experiencing effects of the shrinking government resources directed towards health and education; and the reduced interventions from Non-governmental organisations; the adolescent population in need of education and health intervention has continued to grow hence the need to

interrogate efforts to improve health knowledge and health seeking behaviours that mitigate teenage pregnancies and transmission of HIV.

According to a comprehensive report published by the CRLP in 1998; the bulk of the challenges that adolescent girls and boys face emanates from their parents' and their government's state of denial. Both rural and urban parents in Zimbabwe share a common belief that adolescents are too young to indulge in sex. Their ideal expectation of abstinence till marriage engenders resistance in preparing for the inevitable; which is early sexual debut. As reported in the Zimbabwe Demographic Health Survey of (2010-2011), 33 percent of women aged between 20 and 49 were married before reaching 18 years of age; 22 percent of the Zimbabwean women had their first sexual intercourse forced against their will and 30 percent of Zimbabwean women had experienced sexual violence since the age of 15. What worsens the risk of girls being violated sexually in Zimbabwe is that 'the girl child is more likely to drop out of school, to work in the farms and not to go to school at all than the boy child in Zimbabwean homes' (Zhou & Landa 2013; 402). Zhou and Landa (2013) observe that while such practices as wife inheritance, forced marriage and appeasing of avenging spirits by offering a girl as compensation have decreased significantly over the years, there are still isolated cases of such occurrences in Zimbabwe.

The Zimbabwe Multi-Indicator Cluster Survey (Mics) of 2014 indicates that girls in rural areas enter marriage before the age of 15 to spouses 10 years older than them. Furthermore, 24.5% girls aged between 15 and 19 were already married or in a sexual union, compared to 1.7% of boys in the same age group. This further positions girls and teenage mothers at more a risk of contracting HIV than their male counterparts. This study argues that while girls are more at risk than their male counterparts, rural girls are in an even worse position as compared to their urban counterparts. It was the purpose of this study, therefore, to explore ways in which health communication can be brought into reproductive health programming to mitigate these risks.

The government of Zimbabwe has, as recently as 2016, actively reacted to the abuse of girls and women. The Constitutional Court of Zimbabwe banned the marriage of children under the age of 18, striking off the Section 22 (1) of the Marriages Act (Chapter 5:11) which allowed children of 16 years to marry. The court upheld Section 78 (1) of the Constitution that sets 18 years as the minimum age of marriage and declared that any law to the contrary was unconstitutional. This reconciliation of the Marriages Act with

the constitution has been seen as the first step towards stopping the abuse of women, which has an impact on the reproductive health.

A qualitative formative audience research conducted by Jana *et al.* (2012) explored the challenges faced by youths in accessing credible sexual and reproductive health information in nine countries namely Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe. The findings of the regional study revealed that youths face a plethora of challenges that range from client-health worker communication dynamics to unfriendly government policies all exacerbated by a media exhibiting double standards. Jana *et al.* (2012) engaged in their study from a prevention and human rights paradigm. While the study makes a critical contribution to intervention frameworks with regards to youth sexual and reproductive health, it does not address the immediate crisis of teenage/adolescent mothers in rural or marginalised communities. To state that girls in rural areas of the global south are a forgotten and disadvantaged group is axiomatic. It is therefore fundamental to explore how sexual and reproductive health information can be communicated to them in-order to minimize the risk of early and unwanted pregnancies and HIV as intended in this paper.

Ngwenya (2015) recently engaged in a case study exploring Filabusi youths access to sexual and reproductive health information in rural Zimbabwe. The study obtained data through focus group discussions and in-depth interviews to ascertain existing knowledge, behaviours and gaps. Findings demonstrated that youths did not have adequate access to health information that could sufficiently inform sexual and reproductive health behaviour. Ngwenya (2015) further established that sexual issues are not sufficiently dealt with in schools or in the home. This study is essentially relevant to the discourses of youth sexual and reproductive health as it focuses on youths in the margins. However, there is a yawning gap in which the organic relationship between lack of or inadequate health information and adolescent mothers is left unexplored. This paper therefore, seeks to interrogate the nagging questions that drive the teenage mothers' phenomenon all drawing from the communication of credible health information.

Theoretical Framework

This paper adapts Becker's (1974) socio-psychological Health Belief Model to

provide a framework for sustainable reproductive health and HIV programming in rural Zimbabwe. The framework manipulates effective communication strategies for development of sustainable programming premised on access to information by rural communities. We propose that collective individual preventive health actions, where individuals are aware of benefits of and barriers to taking a preventive action, contribute towards an effective communication strategy that can be utilised for the creation of sustainable reproductive health programming and for sustainable public health programming in general. It locates communication, which involves awareness campaigns, educational drills and mass communication, at the centre of efforts of sustainable programming and health consciousness. It has been found that failure by individuals to comply with health and wellness actions is mostly to do with communication. An effective communication strategy functions to help change mindsets to focus on prevention as opposed to mitigation, which is very costly both in terms of resources and where human life is concerned.

The Health Belief Model is premised on several variables. However, two of the variables are closely related to this study and these are; ‘risk (perceived susceptibility) and the seriousness of consequences (severity)’ (Corcoran 2007). Of course, ‘an individual’s perception of the benefits of and barriers to taking and preventive health action to prevent disease or illness’ (Rosenburg 1996), which is another variable, is subsumed in the two dimensions stated above. We argue, in this paper, that for an individual to know what risks they are exposed to and for them to estimate the severity of the consequences of their behaviour, access to information is critical. These risks are central to reproductive health and HIV and AIDS as wellness issues. Communication, we argue, should take centre stage in any intervention relating to the two health issues of sexual and reproductive health and HIV. It is only through access to information that one can be able to weigh the cost and benefits of a certain behaviour pattern (Naidoo & Willis 2000).

The Health Belief Model of health communication is very relevant to this study in that it places mass media at the centre of communication strategies that are effective in getting advocacy messages to the communities and in packaging the messages in a comprehensible manner. However, the effectiveness of mass media as a communication tool in health or any other issues rests on the nature of the mass media a country has in the first place before we infuse health messages into it.

The potency of mass media lies in the allure that it holds for adole-

scent. The sample age group that we are focusing on comprises of persons who are transitioning from childhood to adulthood. Their fancy is captured by the 21st century digitized world of technology. With digital technology infiltrating even rural Zimbabwe, and with print newspapers having online versions, it is important for the media to exploit this opportunity to highlight the reproductive health story, the HIV story and the adolescent mother's story in order to reach various stakeholders, particularly the adolescents themselves. There is also need to utilise the social media, inclusive of such platforms as WhatsApp, facebook and sms. These have penetrated rural Zimbabwe in an unprecedented rate.

Methodology

The paper is a qualitative study. It employed critical discourse analysis (CDA) in the assessment of the frequency and depth of newspaper articles focusing on reproductive health, teenage pregnancy, teenage motherhood and HIV and AIDS in Zimbabwe. CDA as a methodology focuses on text as social practice in social contexts. It exposes how social inequality is initiated and reproduced in society (van Dijk 1993) and shows hidden causes of the status quo (Fairclough & Wodak 1997). Articles were drawn from the online versions of five newspapers in Zimbabwe in the period spanning from 2013 to 2016. A total of ten (10) newspaper articles drawn from The Sunday Mail, The Zimbabwean, Newsday and the Daily News were analysed.

Data was also drawn from in-depth interviews with a total of 120 teenagers drawn from two rural districts in the Midlands Province of Zimbabwe; Kwekwe rural and Gokwe South rural. These were female (80) and male (40). These ranged between the ages of 13 and 19. A total of 20 of the 80 female participants were either mothers, married or both at the time data was collected. A further 20 participants were drawn from elderly parents from the two selected districts. These were over the age of 30 and were not necessarily couples. While the study targeted specific age groups, the selection of the actual participants was done randomly. The two districts, Kwekwe and Gokwe South were purposively selected for their unique characteristics of being mining and farming communities respectively. These two activities (mining and farming) had been observed to bear an influence on the kind of lives families in these communities generally led. Furthermore, the school, home and church as institutions of all kinds of education and information

dissemination were assumed to be threatened by the hand-to-mouth lifestyle of farmers and miners suffocated by their precarious socio-economic realities. The lack of robust home and school pillars therefore leads to the examination of what the mass media has to offer as a mainstream source of information.

Discussion of Findings

Analysis of data relating to demographic profiling indicates that a total of six (30%) of the 20 elderly parents who participated in this study reported that they had been married before the age of 16. The legal age at which people in Zimbabwe are expected to get married is 18. Further, data shows that a significant number of these participants had fallen pregnant before they were married, suggesting that pregnancy could have contributed to their getting married early.

It can also be deduced from the data that only seven (35%) of the 20 teenagers, who were either married, mothers or both at the time data was collected, had attained the age of 18 then. The rest ranged between 14 and 17 years of age. Also, only 2 (5%) of the 40 male teenage participants were parents and none of them were married at the time they were interviewed. Further, one of the two male participants who were parents at the time of the study was still going to a formal school while none of the teenage mothers in the sample were in any formal school. This could suggest that once they get pregnant or get married, it is difficult for girls to continue going to school. Even returning to school after delivering the baby seems not to be much of an option to the girl child while boys can continue going to school even when they become husbands and/or fathers.

Of the 20 female married teenage participants only one had been staying in an urban setting and only returned to her rural home after getting pregnant. The rest had been staying at their rural homes and had gone to schools in their rural homes since birth. This means the majority of the female teenage participants had a purely rural background.

Of greater interest in the data collection was the issue of access to information relating to reproductive health. Data indicates that there is a lot of HIV and AIDS education, especially in schools but little of reproductive health education anywhere in rural communities in Zimbabwe. There was even lesser of education relating to reproductive health and HIV and AIDS in the home. Parents find it a lot easier to talk to their children about anything except

reproductive health and HIV and AIDS, which are still tabooed issues in some parts of rural Zimbabwe. Talk of reproductive issues in the home front is unheard of. One participant said:

Hazvitaurewe kumba izvozo. Ndingataure izvozo nababa vangu here?
(That is not a subject to be discussed at home. How can I discuss that [reproductive health and HIV and AIDS] with my father?)

This emphasises the reality on the ground; where subjects such as reproductive health and HIV and AIDS are tabooed subjects in such places as the home and the church. In line with the Health Belief Model, the particular participant above does not see the benefits of a discussion of such issues between parents and children. Cultural barriers and religious beliefs render sex a dirty and prohibited subject in the home. This leaves girl children at the mercy of just the school and the would-be abuser or violator. These findings relate to findings by Rimgheim and Gribble (2010) who established that with the exception of Senegal, reproductive health information was scarce among teenagers in African countries.

A total of 93 (76%) of the 120 teenage participants indicated that they had never been engaged in reproductive health and HIV and AIDS discussions with their parents beyond being told; *‘ukaita nhumbu onotsvaga kokugara kwako wega’* (if you get pregnant you will have to move out of my house). Sometimes they are told; *‘ungathola igcikwane ngelakho wedwa’* (if you contract HIV it will be your own problem). A total of 17 (14%) of the teenage participants had regularly had discussions about reproductive health, HIV and AIDS with their parents. The remaining 10% had discussed reproductive health, HIV and AIDS with their parents but not enough for the discussions to be described as productive and informative.

Data generally indicates that most of the parents also did not believe in open discussions about reproductive health and HIV and AIDS with their children. A total of only three (15%) parents said they had regularly sat their children down to discuss issues relating to reproductive health proactively; without relating to any specific incident. A further six (30%) claimed they had talked to their children about reproductive health issues only after certain incidents relating to their children misbehaving, which was reactive. One participant (5%) said she did not have children old enough to discuss reproductive health issues with as her first born was only four (4) years old.

The remaining 10 said they had never discussed reproductive health issues with their children at any point. The majority of parents (50%), therefore did not discuss reproductive health related issues with their children. The picture being painted here is that there is need for government and HIV programming partners to reinforce programming that encourages open discussion of reproductive health issues in the home.

A survey of newspapers indicated that the reproductive health story is infrequent and a critical discourse analysis of the sample articles when they appear the few times revealed that the reproductive health story is often just statistical as opposed to critical and educational. The stories are also often mere reports of whatever research findings academics and organisations would have established. This way, the reproductive health story is communicating to academics and programmers and not to the poor girl in the rural areas in Zimbabwe. These findings are not different from findings of a Zambian study by Radu and Gribble (2012), which established that the coverage of reproductive health issues was both low and poor as focus was on national and international issues and not on localised contexts.

The first sample story that was analysed was taken off the Sunday News of 5 July in 2015. The article is entitled; *Teenage pregnancies soar*. An analysis of the story reveals that the reporter is just presenting the facts and figures emanating from some research findings, comments of politicians, gender activists and experts. In one paragraph we read that a development analyst, Enock Musara said:

The rural environment is not friendly to the girl child. It leaves her vulnerable. For example if in a family there is a boy and a girl and parents are struggling to send both to school, parents often decide to send the boy to school while the girl stays at home. That redundancy will leave her vulnerable to abuse as on most occasions marriage appears to her as her only escape route from her family's poverty.

In a typical hard news story fashion, the story does not have a message for the ordinary people. It does not even address programme implementers as it offers no suggestions on what then needs to be done, either by programmers, the girls themselves or their parents.

Another story, taken off the Newsday (of 30 May 2016) and is entitled

‘Teenage pregnancies still high in rural areas’, is also not communicating to the teenage pregnancy candidates. It is very statistical in nature and is a report on research findings of a survey. The statistics are given as early as the lead (introduction), which reads:

CASES of teenage pregnancies have remained high in the rural areas, with one in 10 adolescent girls giving birth each year, despite massive awareness campaigns against child marriages, latest statistics from the Zimbabwe Demographic Health Survey (ZDHS) 2015 have indicated.

Subsequent paragraphs are also purely statistical. Focus is entirely on giving statistics as exemplified by the following excerpts:

In 2010, 28% of adolescent girls from rural areas were already mothers compared to 16,4% of their counterparts in urban centres.

For 2015, the percentage for the urban adolescent dropped to 10,3%, but for the rural adolescent girls, it was still high at 27,2%.

The question a critical discourse analyst would then ask after reading such a story is; so what? The approach needed therefore would be one that focuses on reaching out to the affected, vulnerable girls in a bid to provide credible information that will halt the teenage mothers’ phenomenon as well as transmission of HIV. Mass media in all its forms presents a neutral and competent ally in breaking cultural and religious barriers through encouraging and improving parents and adolescent girls’ communication on sexual and reproductive health issues.

Conclusions and Recommendations

Some parts of Zimbabwe remain preoccupied and obedient to traditional perceptions of girls and women as subservient to patriarchal rule despite advances in the global urban culture of empowering women that other parts of the country are adopting. In a society where it is not yet universally accepted that women’s rights are human rights, it is important to think of alternative and creative ways of advancing women’s reproductive health issues. Recognizing the power and effect of advocacy communication, the explored possibilities

that communication should play a central role in health programming in rural Zimbabwe can be implemented in areas located in the margins. Essentially, failure for girls and women to recognize their rights impacts negatively on them, their families, as well as their communities.

We also propose an advocacy role by the media where women's reproductive rights issues are topicalized, headlined and advanced in both national and community newspapers and radio. In this approach, media such as radio, television, print and electronic news editions, which are key communication vehicles in Zimbabwe, would have to invert their traditions in which male figures are idolized, interviewed and hero-worshipped. Women can then be raised in status and allowed to discuss their reproductive rights issues in public spheres. Such a large scale headlining of women's rights and reproductive health issues by the media is set to change mindsets of not only those men and women with access to the various media but also policy makers and traditional leadership that can lead in favour of the women whose rights are not being recognized. This paper acknowledges the challenges of confronting existing systems of patriarchy in all sections of society where there is authority; and proposes different strategies of exploiting communication trends and media space for the benefit of girls and women is as far as reproductive health is concerned. The study continuously pointed to the fact that reproductive health and HIV and AIDS issues cannot be dealt with separately as these inform each other.

The government of Zimbabwe should address the gap by enacting legal frameworks that protect against discrimination on specified grounds such as gender, age, marital or socio-economic status. More specific would be the creation of public education campaigns and awareness raising activities addressing the cultural taboos surrounding adolescent sexuality. Targeted advocacy with an emphasis on encouraging parents to override taboo and communicate with their children about sexual matters is critical in dealing with the adolescent mothers' dilemma in the face of HIV and AIDS.

The study established that health communication is central to disease and un-wellness prevention in rural Zimbabwe as it increases the community's awareness of potential risks and attendant consequences associated with certain social behaviours. Advocacy centred sexual and reproductive health communication has the potential to alter perceptions and attitudes of individuals and communities towards certain behaviours, norms and social patterns. This consequently fosters a rigorous and deliberate disease prevention

culture and a positive and proactive health seeking behaviour in the rural communities.

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HIV and AIDS Prevention Programmes in Zimbabwe: A Gendered Terrain

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Abstract

Efforts to curb the HIV and AIDS epidemic have reached a deadlock. This emanates from the manner in which gender has been understood in these programmes. Gender has not been tackled in all its complexities that is to include men and children. It is therefore unfortunate that gender has been epitomised as a women's issue. In these gender discourses men are given two or three lines. The ostracisation of men in the domain of HIV and AIDS related issues have created dangerous gaps that has made it difficult for the epidemic to be combated. The paper observed that for HIV and AIDS to be thoroughly dealt with, there must be concerted efforts from both men and women. Feminist theologians should desist from blatantly attacking men as the perpetrators of HIV and AIDS for within these men lies great potential to fight the HIV and AIDS epidemic. The paper in light of social constructionism, literature review and in-depth analysis contends that proper gender equality is a necessity in the battle against HIV and AIDS.

Keywords: HIV and AIDS, gender, social constructionism, feminist.

Introduction

The global Human Immune Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) epidemic has called for drastic measures from various governments to curb it. In this regard, the Zimbabwean government is not an exception. What has been observed in most discourses on HIV and AIDS is that women and girls have been hit the hardest by the HIV and AIDS epidemic. Most African theologians such as Musa Dube, Isabel Phiri and Nyambura

Njoroge have enamoured protracted efforts towards gender and HIV and AIDS issues. These scholars are in unison that women have been affected the most by the HIV and AIDS epidemic. Accordingly, Muyambo (2011) articulates that HIV and AIDS disproportionately affect more women than men. To this effect, Teresa Okure cited by Musa Dube asserts: There are two viruses more dangerous than the HIV virus The first virus is one that assigns women an inferior status than men in society. This can be epitomised as the feminization of the HIV and AIDS epidemic.

In related studies two South African theologians, Tinyiko Maluleke and Sarojini Nadar argue that the unholy trinity of religion, culture and gender socialization have formed 'a covenant of death' against women in Africa. They observe that this unholy trinity empower men at the expense of their female counterparts and this has made women to be at the mercy of the HIV and AIDS epidemic. This has compelled a lot of interventionist strategies to focus on women in Zimbabwe to be particular. Furthermore, most of these programs are headed by women and they are for women. This has created a dangerous gap that HIV and AIDS is preying on. What has been done on the male gender is also the same that is being done with the female gender. Unfortunately, the intended results of saving women from the plight of HIV and AIDS becomes a mirage.

The above highlighted gender bias is the one that I intend to fill in this particular study. It is good that the epidemic has brought to surface problems chief amongst them is the vulnerability of women. However, within the problem also lies the solution. It is not my intention in this paper to dismiss the vulnerability of women to HIV and AIDS but rather to offer a spirited analysis of how women's efforts to fight HIV and AIDS can be complemented. It is against this backdrop that I wish to argue that the ostracisation of men in HIV and AIDS prevention programmes can be detrimental as that can be a breeding ground for the spread of HIV and AIDS. Chitando cited in R. Nicolson (2008:45) argues for a reflection of the impact of masculinities in the spread of HIV and AIDS in the region. It is Chitando's strong conviction that this reflection must take into cognisance the fact that the involvement of men in HIV and AIDS awareness programmes is a prerequisite.

The need for the participation of men in HIV and AIDS awareness and prevention programmes is best captured by Gary Baker and Christine Ricardo. Gary Baker and Christine Ricardo envisage that gender mainstreaming requires a comprehensive focus on gender in all its complexities including men

and boys, not marginalizing it as a women's issue (Gary Baker & Ricardo 2005). I submit to the findings by Gary Baker and Christine Ricardo bearing in mind that many at times it is the attitudes of men and boys that contribute to the main problems of greater gender equality. It is in this regard that I contend that a focus on women alone in the face of HIV and AIDS can be dangerous since there are plethora factors that militate against them. It is against this backdrop that I am of the view that HIV and AIDS has bedeviled humanity and efforts to fight it must focus on both men and women, small and great, rich and poor, educated and uneducated.

The inclusion of men in the fight against HIV and AIDS is plausible because the extent to which men have been responsible for the widespread of HIV and AIDS is the same extent to which they can be panacea to the HIV and AIDS. Studies by T. Muyambo and J. Marashe have shown that men can contribute immensely to curb the HIV and AIDS epidemic. This is a truism in light of emerging masculinities that are life affirming. This prompted T. Muyambo (2011) to posit that men and boys cannot afford to do 'business as usual' in the context of HIV and AIDS. They need to do 'business as unusual,' that is, becoming real men by redefining and renegotiating masculinities such that they become liberating rather than oppressive and health threatening.

According to J. Hlatshwayo, the issue of HIV and AIDS is not just a fundamental problem of existence, nor an occasion for imputing blame between men and women, but an opportunity to reflect more deeply on the work of God. If all humanity has been created in the image of God (Gen. 1:28), then there is no justification to treat women as second class citizens, because we are all equal in God's family (Gal. 5ff' Romans 8:28). I subscribe to the notion that regarding men and women to be at par has some positive results as this will ensure efficient involvement in nation building and a realization of health and wellbeing since both genders have got fundamental roles to play (Hlatshwayo 2012:124).

In this study I employed social constructionism as a working philosophy that undercuts this study. I argue that the existence of gender misapprehensions makes effective HIV and AIDS prevention programmes a mammoth task. I structured the paper by firstly giving my hypotheses and theoretical framework. In the second section, I gave an overview of gender discourse in Zimbabwe. In the third section, I highlighted the manner in which gender sensitivity help curb the HIV and AIDS epidemic. In the fourth section, I interrogated the need for a holistic gender approach. I therefore concluded

that the elimination of gender bias has tremendous contributions towards the mitigation of the HIV and AIDS epidemic.

Hypotheses

My hypotheses are that 1) the lower position of gender focal points in ministries contribute to the ineffectiveness of the institutional mechanism to mainstream gender; 2) there is a low level of understanding of gender and development issues by policy makers; 3) women alone have failed to successfully mitigate the HIV and AIDS epidemic; 4) the involvement of men in HIV and AIDS prevention programmes can help complement women efforts in combating HIV and AIDS amidst their vulnerability; 5) gender bias remains a stumbling block for energies to alleviate the HIV and AIDS epidemic.

Social Constructionism

The paper is highly informed by social constructionism. This is a theory that was popularized by Luckman and Berger in their highly regarded work, *The Social Construction of Reality: A Treatise in the Sociology of Knowledge*. Social constructionism regards individuals as integral with cultural, political and historical evolution, in specific times and places, and so resituates psychological processes cross culturally in social and temporal contexts. Apart from the inherited and developmental aspects of humanity, social constructionism hypothesizes that all other aspects of humanity are created, maintained and destroyed in our interactions with others through time. The theory centers on the notion that human beings rationalize their experience by creating models of the social world and share and reify these models through language (Gergen 1985).

Social constructionism bids us to be suspicious of the manner in which the world and reality around us have been portrayed. It views the world and reality as results of social processes and interactions, the description of which –through power and knowledge–sustain some patterns of social action and exclude others (Burr 2003:4-5). At the heart of social constructionism is the view that reality is constructed by people, in social interaction with others, and that language is a crucial factor. Who we are, how we talk to others about who we are, the concepts, metaphors that we use to refer to ourselves, others and

the world around us, are determined by culture and history. It is not something that we were born with. It is rather something that we over a period of time—maybe even unconsciously—were informed into. This therefore, means that people are at the origin of culture and history, culture and history in turn forms people into who they are and how they perceived themselves and the world around them. This knowledge which is culturally and historically determined and sustained by social processes, is institutionalized and legitimated through language (Freedman & Combs 1996:23).

Methodology

This research falls under the qualitative paradigm. There are plethora methods that can be used in data collection. I engaged interviews. Miller and Selter (1992:70) describe interviews as an indispensable tool for social research. It is a face to face conversation meant to solicit information by the interviewer from the interviewee. Despite the fact that there are multifarious interviews that can be used in this particular study, I employed unstructured interviews because it gives room for probing. Since in a qualitative research numbers do not matter much as compared to quantitative research, I had to apply snowball sampling. Snowball or chain sampling (Patton 1990:110) is a method of selecting interviewees by looking for those who can give information on what one is looking for. This is regarded as looking for information-rich cases. I therefore chose to interview teachers and lecturers most of who were females. This was propelled by the need to have an idea of gender conception from the females' viewpoint.

Again to avoid bias of looking at a subject that is purported to have affected women more, I had to employ the phenomenological approach. It uses two main principles derived from Husserl, namely, *epoche* and eidetic intuition. *Epoche* comes from the Greek term *epecho*, which means, 'I hold back'. This requires the scholar or researcher to remove or to suspend any preconceived ideas or previous judgment or knowledge one has on the specific subject of research (Mapuranga, Chitando & Gunda 2013:313). In this particular case, *epoche* helps to suspend all previous judgment on AIDS since I am a man who is writing about issues that concern women. By employing the phenomenological method, I sought to have a balanced and unbiased research.

Gender Discourse in Zimbabwe: An Overview

Before I progress with my journey on gender, it is imperative to define the term gender as it has been subject to a lot of misrepresentation, misconception and misunderstanding. Gender is not a physiological but a social concept that refers to sets of culturally defined character traits labelled as ‘masculine’ and ‘feminine’ (Peterson & Runyan 1999:257). Similarly, Riches in Chibaya (2007) refer to the term gender as the cultural interpretation of maleness and femaleness as masculinity and femininity. In other words, gender refers to socially learned behavior and expectations that distinguish masculinity and femininity. Copper (1993:94) says, ‘gender is socially constructed, describes the characteristics we ascribe to people because of their sex, the ways we believe they have, based on our cultural expectation of what is male and what is female’. This is also buttressed by Butler when he argues that gender is a show that we put on.

It is noteworthy that gender is a social construct that is neither fixed, permanent nor static. This entails that gender is an idea that is socially constructed in our everyday life. This socialization is engendered in individuals at an early age to the extent that these constructs are consciously or unconsciously embraced. Accordingly, Tomeh (1975) postulates that from a young age, boys are taught to perform proper masculinity. The criteria they must allegedly meet to achieve manhood are taught to them through their most important institution, the family unit. The family is the most important because it is the family that instils the expectations of society in the young boy, and defines masculinity. Within the family, the parents generally teach young girls that they are expected to be obedient, nurturing, and responsible, while the young boys are taught the importance of success and self-reliance. I concur with Tomeh’s submission, cognizant these are the gender ideologies that have been inextricably embedded within the heart, the minds and the souls of most Zimbabweans. It is surprising to note that despite the efforts to emancipate women, most women in Zimbabwe still subscribe to these gender ideologies. This becomes a mammoth task for women alone to successfully wage a campaign against the HIV and AIDS campaign.

In Zimbabwe, meaningful gender discourses are traced to the Beijing Conference of 1995. The Beijing Conference brought together almost 50000 men and women focused on the cross cutting issues of equality and development and peace, and analyzed them from a gender perspective. It

emphasized the crucial links between the advancement of women and the progress for society as a whole. It reaffirmed clearly that societal issues must be addressed from a gender perspective in order to ensure sustainable development. The role of the Beijing Conference in trying to address gender disparities is quite ambivalent in Zimbabwe. This has been viewed with a pinch of salt by most men. This is captured in a song by one Zimbabwean artist Taso, *Akanga abva kuBeijing kwaakanga andodzidza zvema* equal rights (She had come back from Beijing where she learnt about equal rights).

Taso laments bitterly, the effects of the Beijing Conference to the societal concepts of gender in Zimbabwe. The Beijing Conference has fostered an attitude in women that is not in tandem with cultural mores. As such, men who are the gatekeepers of culture feel threatened. It is against this backdrop that most men in Zimbabwe feel that gender discourse is a foreign concept/imposition that had negative repercussions to the societal setup. It is interesting to note that gender discourse is not being denigrated by men alone but also by some women. One of the interviewees, Rebecca (not real name) echoes that whenever she stands up to speak about gender and equal rights she is constantly labelled by some women *Ndiwoka ma Beijing*.

To make matters worse, men might be present in these gender fora but would not be giving a listening ear especially when women are on the vanguard. In this regard Lubunga Ewusha (2012:85) rightly observes when he says, 'The involvement of men in the response to HIV and AIDS does not only depend on men being valued and comfortable in their manhood but, for the most part on the one who is calling them. In Bembe culture to summon a meeting in which men should participate is solely a male prerogative'. Though writing from Bembe culture, Lubunga Ewusha's submission resonates with what is happening in most societies and Zimbabwe is not an exception. I concur with Lubunga Ewusha, cognisant that most HIV and AIDS programmes are not fruitful because they teach women with an assumption that they will empower their male counterparts, which is not always the case. It is a mammoth task for men to adopt practices initiated by women as they feel that their masculinity would be on the verge of disintegration.

Paradoxically, there is need for a call to men so that they become partners with women in the struggle against HIV and AIDS. In this call it would be noble for men to call one another. This view point is well expressed in Oliver Mtukudzi's song, *Tototsiurana pachedu vakomana tapera* (We have to rebuke one another because our lives have been endangered). It appears at the

back of Oliver Mtukudzi's minds that it is no longer ideal for men to brag about life threatening versions of masculinity. Group work is also a powerful means to engage men in discussions of the connection between men and gender issues (Shoko 2012:10). This has some lasting solution as in other countries actions of groups for men have been established and these provide a platform through which to challenge and critique male stereotypes (Shoko 2012:10). In this section I have highlighted the challenges that have ostracized men in participating in HIV and AIDS programmes. I therefore proceed to look at the benefits of male inclusion in HIV and AIDS prevention strategies.

Celebrating Positive Masculinity in the HIV and AIDS Context

Scholars are not in unison whether masculinity should be spoken about in singular or in plural. However, this raging debate is beyond the scope of this study, conversely I will try by all means to show awareness of scholarly permutations pertaining masculinity. For the purpose of this discussion, I propose to adopt Edley and Witherell's definition of masculinity as a gendered category that feeds on the differences in what women and men within a particular culture can or cannot do. It can also be seen as the sum of men's socially produced and gendered characteristic practices at work, within their families, in their communities, in groups and institutions (Edley & Witherell 1995:95). Because of its association to culture, masculinity is allergic to universalistic categorizations. There are, therefore, as many masculinities as there are cultures, classes, times and places, and their contours change over time (Morrell 1998:607).

The notion of masculinity is susceptible to power and this power finds expression in what I would term hegemonic masculinity. Morell identified it as the form of masculinity that is dominant in society. It is against this backdrop that it is revered and desired in society (Pitones 2004:3). Accordingly, Morell asserts that it is renowned for its predilection for the oppression of women, as well as subordination of other versions of masculinity while bestowing power and privilege on men who embrace it. This is the kind of masculinity that most people have in mind leading many especially feminist theologians to regard male contributions as trivial to the HIV and AIDS epidemic. There is another version of masculinity that I call redemptive or liberative masculinity which is well defined by Gerald West.

Gerald West (2012) arguing from the biblical story of Tamar's rape

defined redemptive masculinity when he postulates that ‘Tamar summons forth, anticipates, hopes for, a man who is able to resist from using force, who respects the sociocultural traditions of his community, who is able to discern and desist from doing what is disgraceful, who considers the situation of the other, who considers the consequences of his action for himself, who is willing to listen to rational argument’ (West 2012:184). The kind of masculinity presented by Gerald West is the one that needs to be embraced in the context of HIV and AIDS. Over the past years, there has been a paradigm shift from hegemonic to redemptive masculinity. Redemptive masculinity has envisaged gender in a manner that is life affirming. It is against this backdrop that there would exist a dangerous gap if men’s participation in HIV and AIDS prevention strategies is undermined.

In arguing my case, I am heavily inspired by the findings made by the Christian Aid (2008). According to the Christian Aid, even when AIDS interventions address gender issues, they often fail to address men’s gender roles. Only when programmes are designed to directly address men’s sexual activity can there be a significant reduction in the rate at which the epidemic is spreading. The main mode of transmission is through sexual intercourse. Men are usually the ones who make decisions with whom, where and how to have sex. We need to involve men as partners in social change in particular in terms of challenging gender stereotypes that disempower women (Christian Aid *et al.* 2008:5). What can be inferred from the Christian Aid’s submission is that there are cultural constraints that impact negatively on women making it difficult for them to successfully campaign against HIV and AIDS.

The cultural constraints that hinder women in their effort to curb HIV and AIDS are well expressed by Lubunga Ewusha when he articulates that in some instances women were taught about testing and means of protection against HIV and AIDS infection but could not convince their husbands to do the same because in their culturally conscripted script, women are not supposed to teach men anything related to sex (Ewusha 2012:85). It is against this backdrop that the success of all programmes and treatment is gravitated on benevolence of men to cooperate with each other with love and compassion in their response to HIV and AIDS. It is therefore unfitting to read the conclusions of some disparaging images of men that have been fabricated in some feminist writing which can only result in restraining men’s potential.

In the Zimbabwean context, positive masculinity has actually complemented women’s strenuous efforts to fight HIV and AIDS. Writing

about the role of traditional leaders which is a replica of what is transpiring in redemptive masculinity in most Zimbabwean societies, Marashe (2014) posits that male leaders have got a role to play in fighting HIV and AIDS cognisant of their influential position. He argues that most male traditional leaders have contributed immensely in curbing HIV and AIDS. For instance, Chief Mapuranga in Chipinge, South East Zimbabwe indicated that using his government donated vehicle, he personally drives rape victims in his community to the hospital as soon as he receives a report of the crime so that the victim can receive medical treatment immediately. He subsequently ensures that his policemen arrest the culprit with the assistance of the whole community before handing him over to the state police for incarceration. (Marashe 2014).

The case of Chief Mapuranga is one amongst many cases of men who are being actively involved in the fight against HIV and AIDS. There has been a serious level of deconstruction in the context of HIV and AIDS. Whereas over the decade macho attitudes have been eulogized, most men have now realized it is high time to deconstruct life denying attitudes. Muyambo (2011) in his study among the Ndau people has noted that plethora practices that used to define patriarchy have undergone cultural renegotiation. There are multifarious practices that have been redefined. Chief amongst them is the idea of *kugara nhaka* (widow inheritance). The Ndau men have come to the realization that widow inheritance is not a question of having sex with the wife of the deceased but rather taking care of the family that he left behind. Accordingly, Oliver Mtukudzi sang a song, *Kugara nhaka sandibonde* (widow inheritance is not a matter of having sex with the wife of the deceased.) The deconstruction of widow inheritance rituals can be seen as a mile stone in curbing HIV and AIDS cognisant that daggers were drawn against widow inheritance as one of the perpetrators of HIV and AIDS.

The contribution by Chief Makoni of Rusape in Zimbabwe also speaks powerfully on the role of men in fighting the HIV and AIDS epidemic. Chief Makoni reversed the most controversial practice of using a girl child to pay for an avenging spirit. He devised a plan that instead of giving a girl child to the family of the one who would have been murdered, the family of the accused should provide *lobola* (bride price) when the one member of the deceased family is set to marry. The initiative of Chief Makoni is a subtle way of paying avenging spirits in such a way that resonates with human rights discourse as well as being gender sensitive. He has proved beyond any reasonable doubt

that men can also be passionate about the emancipation of the girl child. It is against this backdrop that I argue that men's involvement in HIV and AIDS prevention programmes should not be treated as trivial. Some men are willing to forego the patriarchal dividend and identify with women and children. By identifying and promoting the progressive virtues of masculinities, African men are returning to their roots, while also laying the foundations for safer, healthier, and more peaceful and productive African communities, since the characteristic negative self-concepts and low self-esteem that breed violence against women will be virtually non-existent (Dobash & Dobash 1977).

Gender-based Violence: Getting the Facts Right

In Zimbabwe, gender-based violence (G.B.V.) has been a topical issue. However, G.B.V has been subjected to a lot of misrepresentation and misunderstanding. As such, it is very unfortunate that gender-based violence has been envisaged as an issue that affects women only which might be a serious fallacy cognisant that there are a lot of unreported cases of male victims though their number would obviously not match that of their female counterparts. According to Philomena Mwaura (2001), gender-based violence and violence against women are terms that are often used interchangeably as most gender-based violence is inflicted by men on women and girls. However, it is important to retain the 'gender-based concept' as this highlights the fact that violence against women is an expression of power inequalities between men and women.

There is a growing awareness that the epidemics of gender-based violence and HIV and AIDS are linked (Musasa Project 2003). Women who are exposed to gender-based violence are more vulnerable to HIV and AIDS. In this regard, addressing gender-based violence is an effective HIV and AIDS prevention strategy. The nexus between sexual and gender-based violence is well expounded in the following words, 'Sexual and gender-based violence (S.G.B.V) is linked to HIV transmission. Coerced sex in all its forms-from rape to age-disparate sex to transactional sex- is usually perpetrated by men. It facilitates inter alia, transmission of sexually transmitted infections including HIV. Sexual violence may cause damage to avoid infection by sex with younger, possibly virgin, partners might be already HIV positive and infect the women (Agadh *et al.* 2007:12-13). It is with this in mind that one can argue that gender-based violence has been identified as a significant driver of HIV

and AIDS infection in women. This means that there is need for protracted efforts to be enamoured to battle against the spread of the epidemic.

A study focusing on the Zimbabwean male psyche with respect to reproductive health, HIV, and gender issues (Chiroro *et al.* 2002) established that most men regard having many sexual partners as normal. This has prompted a growing awareness of the need to rethink masculinities, violence, and AIDS (Gibson & Hardon 2005). It is in light of men's strategic positioning in the struggle against HIV and AIDS that the call for greater focus on men has been gaining momentum. Men tend to have multiple partners and perpetrate gender-based violence. There is therefore an urgent need to tackle inequitable gender norms, especially those associated with masculinity, in the overall response to HIV and AIDS. Sonja Weinrich and Christopher Benn (2004) have observed that conventional male-role stereotypes relating to multiple sexual partners, sexual violence, unprotected sexual intercourse as signs of manhood must be corrected. They challenge men to be involved in the provision of care, and to visit counselling centres more often. They also discourage the use of alcohol and drugs, as they increase the vulnerability of men.

While history is replete with facts that points to men as the major perpetrators of violence, it would be foolhardy to confine the spread of HIV infection to men alone. I remember vividly asking one of my uncles who was a sex maniac why he has contemplated promiscuity. He retorted that, 'You will never realise the excruciating pain that some men are facing from their female counterparts'. I later discovered that he was being denied conjugal rights by his wife. It is only because of cultural barriers that my uncle including many other men are not coming into the open to explain the ordeals that they are going through. This emanates from the fact that it is ill omen in the world of men to be seen as being superintended by their wives. This would see one being labelled as living under the 'petticoat government.'

The case of my uncle that I highlighted above challenges the traditional understanding that men can have sexual escapades any time they feel like. It is clear that my uncle clearly acknowledged that in order for a sexual encounter to transpire, there is need for the consent of the female counterpart. Unfortunately, he was being deprived of his conjugal rights which then forced him to engage in extra marital sex. This argument is reinforced by Baumeister when he writes, 'women constitute the refraining force on sex. That is, they refuse many offers or chances for sexual activity. When sex happens it is because the woman has changed from no to yes' (2013). It is Baumeister's

strong conviction that in sexual affairs, women's position matters the most despite the fact that they are being presented as inferior to men. This argument was buttressed by one of the interviewees who argued that 'women having been ruling men in private, the real challenge they have now is that they want to rule in public and this has seen a stumbling block of men's adherence to biblical and cultural mores' (Rwizi, interview 2016).

The fact that women can also pose a threat to men's reproductive health is echoed in Charles Charamba's song, *Kune vakadzi vakatendeka vakatisiya mhosva ndeya baba. Kune vana baba vakatendeka vakatisiya mhosva ndeya mai* (There are many faithful wives who died because of their husbands. There are also faithful husbands who died because of their wives.) This is also supported in Kireni Zulu's song, *Nyaya yekuzvibata iyi inotonetsa* (The concept of faithfulness is a mammoth task). What can be deciphered in Charamba's song and Kireni Zulu's song is that the tables have been turned. Whereas history is replete with men being involved in promiscuous behavior, some women have also joined the bandwagon. In this regard, to look at the causes of HIV and AIDS with patriarchal lenses is to admit to play according to the divide and rule policy which has been proliferate to the spread of HIV and AIDS. This becomes a gendered terrain that need not be dismissed only but be dismissed with scorn.

Henrietta Mgovu, a theologian and lecturer at Zimbabwe Ezekiel Guti University who purports to be a liberal feminist is one of the few women who has chosen not to discuss HIV and AIDS with masculine tendentiousness. Her point of departure is that both women and men are involved in the spread of HIV and AIDS cognisant that sexual intercourse takes place between two people. It follows that when men are accused with having many sexual partners it means that a lot of women are also involved. Confining the consequences of sexual escapades to one gender is one of the fallacy that has also been committed in biblical times. In the Bible tradition, the Jews went to Jesus with a woman who had been caught in adultery. This opens a Pandora box of plethora questions, did the woman commit the sin in solitude? If a man was involved why it that the man was not brought to Jesus? Why did the Jews choose to bring the woman alone? These questions depict how gender construction has impacted negatively on people's perceptions on evils bedevilling humanity.

From the above stated scenario, the Jews would attribute the folly of prostitution to women alone where as in a Zimbabwean context, daggers have been drawn against men as the chief culprits in the spread of HIV infections.

This has created malicious gaps that has been fertile to the growth of the HIV and AIDS epidemic. Henrietta Mgovo made some meaningful insights pertaining gender disparities in the context of HIV and AIDS. According to Henrietta Mgovo people are majoring on the manner. The issue at stake is not to look at who is responsible for the spread of HIV and AIDS or who is more vulnerable but to look at effective ways of combating HIV and AIDS that has wreaked havoc in Zimbabwean societies. She gave an illustration of a leopard attack. She says, 'When an individual is being attacked by a leopard it is foolhardy to look at whether the leopard is male or female but what is need is to offer immediate rescue to the victim' (Mgovo, interview 2016). Henrietta Mgovo's argument is that there is no need to concentrate on certain discourse like men's promotion of the spread of HIV and AIDS but instead to come up with a combined effort for women and men to deal with the HIV and AIDS epidemic.

Towards a Holistic Gendered Approach

Linda Mabwe a lecturer at Zimbabwe Ezekiel Guti University envisages that there is need for a holistic gender approach if policy makers are seriously concerned about combating HIV and AIDS. (Mabwe, interview 2016) In concurrence to Linda Mabwe, Mwaura (2001:178) writes, 'Theology on gender concern should be a task for both men and women and not women alone. Women's or men's concerns are the concerns of everybody'. It is a moribund that gender perspective and gender mainstreaming from most feminist writings has ignored the gender of men and boys. It is against this background that Musa Dube in Muyambo (2011) calls upon theologians and others to be actively involved in transforming the terrible twins of culture and gender. She articulates, 'Any theologian, leader, lecturer or worker who lives in the human-rights era-who believes in democracy, and wants to contribute to the fight against HIV and AIDS, which is turning our dark-peopled continent into a red fire-inflamed continent of death-must not seek to understand fully how gender is socially and culturally constructed, how it fuels the spread of HIV and AIDS, but also to change gender' (Muyambo 2011:25).

What is emerging is that some faulty gender misconceptions need to be demystified in the context of HIV and AIDS. In Zimbabwe, Carol Nteletsha, a peer educator in Zimbabwe Assemblies of God Africa, Hatfield District is ready to admit that Betty Makoni did a splendid job when she inaugurated the

Girl Child Network (G.C.N). The Girl Child Network in Zimbabwe had contributed immensely towards the emancipation of the girl child through the leadership of Betty Makoni. However, since the organization is focusing on girls alone it can be deciphered that the Girl Child Network has achieved half of what it could have done had it offered a holistic gendered approach. The argument by Nteletsha Carol is that the organisation should have preoccupied itself in dealing with the throbbing of both girls and boys so that instead of it being a 'girl child's network,' it would have been a 'children's network' (Nteletsha, interview 2016).

The premise behind the above supposition is that whilst it is a prerequisite to educate the girl child, educating the girl child alone is tantamount to being dishonesty as this is offering a half solution. This is compelled by the fact that even an educated girl can be preyed upon by even an uneducated man. In Zimbabwe, it cannot be disputed that many young girls have sex with older men (sugar daddies) for money, gifts, or status. It is imperative for one to bear in mind that most of these girls will be even studying at universities. This leaves one to question the role of education to the girl child in a bid to mitigate HIV and AIDS. It is against this background that I argue that men should also be taught at an early age to do away with macho attitudes that are risky. As Martin Foreman cited by Muyambo rightly observes, 'Boys grew up believing that it is natural for men to have frequent sex and having many sexual partner is a sign of virility' (Muyambo 2010:25).

This entails that there is need for boys to epitomize girls as equal partners. Accordingly, Mapuranga argues that, '...the roles of women should not be looked down upon'. It is Mapuranga's strong conviction that assigning women an inferior status than men in the society is quite lethal. This is the feminization of the HIV and AIDS epidemic. According to Dimingu Caroline (interview 2016), the feminization of HIV and AIDS is best portrayed in the concept of male circumcision. For Dimingu, at the heart of male circumcision is the idea that male circumcision reduces the risk of HIV and AIDS by 60%. It follows that by so doing, men would be protecting themselves against their female counterparts. This demonstrates a misapprehension that women are the oasis of HIV infections. What is ideal is to have a protective measure that protects both women and women. There is need for the elimination of gender bias.

Conclusion

In conclusion, one can state that gender misconceptions, misrepresentation and misunderstanding have been the fertile ground for the spread of HIV and AIDS. The perception of gender as a women's issue should be interrogated. The success of HIV and AIDS prevention programmes does not solely depend on women alone. Just as in the Bible God rightly noted that it is not good for a man to be alone, by the same token, in the context of HIV and AIDS, it must be acknowledged that it is not ideal for women alone to deal with the HIV and AIDS epidemic. This emanates from the fact that strategies of HIV prevention like change in sexual behavior cannot be effective when women are the protagonists of HIV and AIDS awareness campaigns.

There has been a growing awareness that there is need for men to identify with women as equal partners in areas like education, employment and in economic opportunities. However, culture that has given men comparative advantage over women remains a stumbling block cognisant that the deconstruction that men are willing to embark on is only to a certain extent. What is needed therefore is to come up with the positives out of the negatives. This entails that the same manner in which male predilections have endangered humanity is the same way in which they can offer solutions to the HIV and AIDS epidemic. It is against this backdrop that broadly speaking I argue that there is need for men to partner with women in the struggle against HIV and AIDS. The elimination of gender bias is therefore a window to mirror effective HIV and AIDS prevention programmes.

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HIV Counselling and Testing (HCT) in Schools: Ethical Implications to Long Term Support Structures

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Abstract

The argument of this article is that if the recent proposal by the department of Health and Department of education in South Africa for a school-based HIV counselling and testing programme were to be effective, then there is the need to pay much attention to the long term support structures such as Parents, Carers, Guardians and Spiritual leaders as those who will carry the long term responsibilities of the teens once the test is completed. This argument is based on the fact that though the recent promises a potential and positive response in seeing that a number of people know their status and those who test positive can access early medication, the programme may well have negative consequences for families ill-equipped to deal with the outcome of the testing. Through the lens of ethical theory of Consequentialism, the article suggest that there are long term implications for the families as well as, communities therefore all key role players in the adolescent's life need to rethink their approach of engagement to issues around sex and sexuality, HIV infections and sexual behaviours

Keywords: Support structures, Teenagers, HIV and AIDS, sex education, sex and sexuality

Introduction

Even though the recent proposal by the department of Health and Department of education in South Africa for a school-based HIV counselling and testing programme promises a potential and positive responses, there are a number of

ethical implications which has not surfaced in the discourse around the campaign that needs to be considered. One of such implications is that if the campaign is to be effective, we need to pay much attention to long term support structures such as Parents, Carers, Guardians and Spiritual leaders as those who will carry the long term responsibilities of the teens once the test is completed. There is need to reconsider their communication and support skills and strategies around sex and sexualities as a response to the HIV and risk behaviour among the teens in their care. This is because their responsibility in the campaign has been peripheral and overlooked. Currently the two public debates around the campaign are that while some people have grave concerns regarding the campaign and its impact on a number of young people, others argued that this move promises an effective potential to contribute to the reduction of infection (Gwandure *et al.* 2014: 42).

It is with this background that the article through the lens of ethical theory of Consequentialism, suggest that the programme may well have negative consequences for families ill-equipped to deal with the outcome of the testing. There are long term implications for the families, community, schools and even religious sectors directly consequent on the outcome of testing. Consequentialism as George Chryssides and John Kaler (1993) has noted premises on the fact that the consequences of an action determine whether that particular action is ethical or not (Okyere-Manu 2014: 30). This article must not be misconstrue as suggesting that testing is bad and should not be done, but rather aims to ensure that we do not overlook the practicalities on the ground and the implications for those involved. Therefore, there is need for all key role players in the adolescent's life to rethink their approach of engagement when it comes to communication around issues of sex and sexuality, HIV infections and sexual behaviours that may prove risky.

The article is divided into four sections: first, it begins with the background that necessitated such a drastic campaign, second it discusses the discourses around the campaign taking into consideration the arguments for and against testing learners particularly teenagers in schools. Third, it examines the possible ethical implication of such a move not only on the children as has been mentioned above but also for parents and all long term support structures as well as spiritual leaders. Finally for support structures to be relevant, the article ways of reconstructing teaching on sex and sexuality in order to restore effective communication skills in the face of the challenge HIV infection.

The Background to the Campaign

Since the first case of Human Immune deficiency Virus (HIV) was recorded over 30 years ago, globally and nationally, governments and other organisations have sought to embark on prevention campaigns and strategies to control the spread of infection. Yet still HIV and AIDS remains a challenge to nations globally and more so sub-Saharan Africa.

The global estimate of people living with HIV as at the end of 2015 was 36.7 million, of which 1.8 million were children (<15 years old). There were 2.1 million new HIV infections, of which 150,000 were children. About 1.1 million people died of HIV-related disease the same year.

It was estimated that about 25.5million of all people living with HIV in 2015 were from Sub-Saharan Africa, which suggests that about 71% HIV positive people in the world live in sub-Saharan Africa. The report continues to say that 40% all people living with HIV do not know that they have the virus (Global Statistics 2015). The above figures clearly show that the pandemic has claimed and continues to claim an astounding number of lives. People are affected in their most productive years, leaving behind a number of orphans to be cared for by their older siblings and in most cases by their grandmothers. This in turn makes them more vulnerable because of their age as well as overburdened by the workload and limited resources in terms of financial support and for the grandmothers in particular, deteriorating health issues (Okyere-Manu 2012).

With the 2011-2015 global vision aiming at zero new HIV infections, zero discrimination and zero AIDS-related deaths, Michel Sidibé UNAIDS Executive Director argued for the need to do all that is needed to reach the goal by saying that ‘To reach these targets and bring the end of AIDS in sight we must step on the Accelerator’ (2011: 7). To him this vision will be realised only if the efforts of governments, NGOs and others are intensified in terms of rethinking and improving our strategies of responding to the disease. With the number of infections dropping and majority of people on treatment, various governments have committed to getting at least 15 million people onto lifesaving antiretroviral by 2015 and increasing it to 20 million people by 2020 as propagated by UNAIDS (UNAIDS 2013:4). After 5 years and in an interview with *aidsmap* in 2016 he again said that:

‘If we take our foot off the pedal I am convinced that we will be unable to double the number of people on treatment again, and we will not see the

major decline that we are expecting. Because of competing priorities, 13 countries out of 14 reduced their contribution to the HIV response globally. If this trend continues we will have a rebound, we will not be able to achieve our goals of 90-90-90 and [a reduction in incidence] by 2030' (Keith Alcon 2016). This suggest that in order to reach the new global vision, all countries need to step up to the call for 90% of people living with HIV to know their status, 90% of people living with HIV to be on HIV treatment, and 90% people viral load suppressed.

According to UNAIDS, the number of people living with the virus has increased from an estimated number of 4 million in 2002 to 7 million by the end of 2015 and 380.000 new infections (UNAIDS GAP Report 2016). One of the reasons for the escalating number of new infections is that there is a lack of persistent HIV effective prevention strategies. According to the mid-term review of the National Strategic Plan 2007 - 2011, the Human Sciences Research Council (HSRC) reported that even though the HIV pandemic in South Africa has stabilised to some extent as a result of the multi-faceted programs available, the majority of South Africans still do not know their HIV status (Shisana *et al.* 2009:4; Makhunga-Ramfolo 2011:2). Despite Shisana *et al.*'s observation, it must also be noted that currently South Africa is the country with the largest antiretroviral (ARV) programme in the world, as at 2013, there were about 2.4 million people receiving anti-retroviral treatment (ART) (Stats South Africa 2013:150). Suggesting that almost a half of all those known to be positive have access to medication, a positive sign on the part of the government's effort to respond to the global call. At the same time the question that is raised is why is it that there is availability of medication yet as noted by the HSRC above, most people do not know their HIV status: could it be that people are not aware of the availability of the medication? Has all the educational programmes been effective? Are there some significant group that have been overlooked? Clearly there seems to be a gap that requires our attention.

According to the South African National Prevalence (SANP) incidence and behaviour survey 2012, South African youth, particularly from 15-24 years who are currently classified as among the key population (2014: 53) continue to demonstrate high rates of practices such as drug use, drinking and sexual activities that places them at risk for HIV and other sexual transmitted infection. For instance it has been noted that 'Globally, over 100 million STIs occur each year in people under the age of 25 years' (UN Report

cited in Sales & DiClemente 2010: 1). A UN report, in 2010 the global statistics of children aged < 15 years who were HIV positive was 3.4 million and out of this number, 90% were living in sub-Saharan Africa (UN 2010). In addition, the mid-year population statistics revealed that out of the 5.26 million people living with HIV in South Africa, young people between the ages of 15 and 24 accounts for 8.5 per cent of the people living with the disease (2013:53). Without a doubt young people are at risk and in need of the nation's attention.

Despite the high prevalence of HIV among both adult and children in the country, It has been argued that Health-facility-based HIV counselling and testing (HCT) fails to capture all children and adolescents who are at risk of HIV infection (Strode *et al.* 2013:161), suggesting that the numbers of HIV positive children and teenagers could be higher than reported. Ramirez-Avil *et al.* has reiterated Shisana *et al.* that 'HIV prevalence rapidly rises through adolescence with an HIV prevalence of 3% among 2–14 year olds, 15% among 15–24 year olds, and 24% among those 25 year olds. In spite of the high HIV prevalence, youth testing rates are low in the country (2012:1). My experience in working with an HIV and AIDS organisation¹ for about 11 years and particularly working closely with the youth has shown that the low rate of testing among adolescents are as a result of a number of barriers. Ramirez-Avil *et al.* agree that the barriers may include the fact that most young people think that they are not sexually active or because they are using condoms therefore there is no need of testing. To most of them, testing is only for those who are sexually active and those who are involved in sexual risk behaviours without using condoms. Others also convince themselves that because they look healthy and not showing any signs of sickness there is no need of going for testing. Sadly those who want to go for test are unsure of age of consent especially those who do not want their parents or caregivers to know their intentions for fear of questioning, stigmatization and discrimination should they present with positive results (2012: 2). I also believe that a number of teenagers may not want to participate for fear of being pressurized by their caregivers, teachers or peers to disclose their confidential results of which they may not be prepared for.

¹ The author has been part of the community care project in Pietermaritzburg since 2002. This is an HIV and AIDS project that serves Pietermaritzburg and its surrounding areas on educating the learners in High schools, churches and families on HIV and AIDS issues.

In addition to the barriers discussed above, Ramirez-Avil *et al.* continues that other barriers that account for the unwillingness for the adolescents to go for testing may include ‘concern for confidentiality, stigma of using a testing facility, unfriendly clinic staff, and that South African youth over 12 years are regarded as adults and managed in adult healthcare programs’ (2012:4). Clearly for lack of human capacity and resources, there are currently no healthcare programmes and facilities for young people in the country and therefore the general facilities available to all citizens young and old alike may pose as a barrier for teenagers to be involved in the testing should their result require them to access further healthcare programmes. In my interaction with most young people, another major obstacle is using health facilities within one’s own community. This barrier seems to be a major concern not only because of the perceived unfriendly clinic staff but also those who may overlook their ethical and obligations and spread rumours about the teenagers and their HIV results in the neighbourhood.

Another important obstacle to young people going for testing is ‘the fear of death’ (Mpintshi 2010:1), since up till now many people associate HIV with death, despite the availability of medication that can help people manage the disease. All these concerns are accumulated by the fact that we live in a country where particularly among the black communities, it’s a taboo to discuss issues around sex and sexuality openly or with adults particularly parents and caregivers. Yet the reality is that whether we like it or not, globally most young people from 12 years and above are sexually active rendering them vulnerable to the disease by their own sexual activities as has been noted by Strode *et al.* (2013: 161). For instance a study in the US reported that about ‘47.8% of all high school students are involved in sexual intercourse and about 7.1% had their first sexual encounter intercourse for the first time before age 13 (Sales *et al.* 2010:2). Even though this study was based on teenagers in the USA, I believe the situation is similar to the experiences of teenagers in other parts of the World. In South Africa, there is a growing amount of scholarship that has indicated that there is a decline in teenage pregnancy in the county. Yet a recent survey conducted among teenagers indicated that about 30% of all teenagers between the ages of 15-19 reported of having been pregnant before (Willan 2013: 7). Evidently even with the decline in teenage fertility in the country, for 30% to declare that they have been pregnant before suggest that the rate of teenage pregnancy remains high and a comprehensive education remains a critical need.

In most African communities, silence around sex and sexualities forms an indispensable part of the African culture in order to keep it from those considered un-entitled to it. It must be noted that issues around sex and sexualities in the African worldview is seen as sacred and preserved in secrecy by taboos. Therefore one's ability to preserve this sacred knowledge is rewarded with virtuousness (Diallo 1987) and 'empowering' (Sylvia Tamale 2011: 13). In the same way breaking it is seen as disrespect and dishonour, and as such people opt for the silence theory. Yet as has been noted by a number of scholars, in this era of HIV and AIDS, sexual silence is seen as an aspect of contention and its viability has been challenged (Okyere-Manu 2010).

Another most important observation is the fact that clinics in the country are opened during weekdays from 8am to 4pm during which most adolescents are in schools. Therefore despite recent studies and campaigns that have shown that HIV testing may be an efficacious strategy for identifying HIV-infected youth, in the primary clinic setting this has become a challenge. More so as there is no specific health services allocated to young people in the country and Africa as a whole (Morobadi *et al.* 2014: 5), getting young people to voluntarily test for HIV needs reinforcement. Morobadi is of the opinion that HIV positive children in transition into adulthood, are overlooked a group therefore there is need for programmes and policies to address their needs because they as 'Adolescents evidently contribute substantially to hospital admission in sub-Saharan Africa and this can be avoided by early diagnosis and timeous initiation of ARV therapy' (2014:5). It is with this background and the fact that South Africa is among the countries with the highest number of people living with the virus in the world that the department of education and health proposed the HCT campaign (Integrated School Health Programme 2012:3). Among other programmes, HCT was to be part of the integrated school health program which outlines the role of our respective departments in addressing the health needs of learners, with the aim of ensuring that a strong school health service operates according to clear standards across the country. This is to enhance the all-inclusive sexuality education that is considered an important means of addressing adolescent risk behaviours (Kirby 2007; and Wellington *et al.* 2006, cited in Harrison *et al.* 2010: 2). The discussion above constitute the background to which the campaign was introduced.

Current Discourses around Testing Teenagers in South African Schools

As noted above, as part of the South African government 'putting children first' in line with United Nations Convention on the Rights of the Child (UNCRC) (1996), the Integrated school health programme, proposed a package of school health services which includes oral health, mental health etc. In addition, learners who are 12 years and over in all secondary schools in the country will be given the opportunity of taking an HIV and AIDS test in school. It must be noted that this is in line the age of consent according to the Children's Act requirement for consent (Children's Act 2005), 'however, learners who are older than 14 years may also consent to their own treatment, although they should be advised to inform and discuss their treatment with their parent or caregiver' (Integrated School Health Programme 2012: 17).

This legal document explains that children have the rights to consent independently not only to HIV testing but also to a number of health interventions (2011: 69). The Children's ACT describes clearly when and how HIV testing may be done with children. Sections (s) 130 - 133 of the Children's Act specifically has four guidelines for regulating HIV testing. These include the following: that a child (i) may only be tested for HIV in specific circumstances (s 130 (1)(a) - (b)); (ii) must be counselled before and after the HIV test (s 130 (1)(a) and 132); (iii) can consent independently to an HIV test from the age of 12 years (s 130(2)); and (iv) has a right to privacy regarding their HIV status (s 133) (Children's Act 2005).

The above suggests that any child from 12 years onwards can independently choose to go for an HIV test with or without parents or carers consent. The government proposed HCT to be performed in schools as part of the sexual and reproductive health services. The aim is also to speed up access to care and support even though all participation will be voluntary; parents as well as children have the right to decline. The policy provides that to make this campaign successful:

the parents of that school are actively consulted and given the opportunity to agree to, or decline the service (see section on SRH and rights above); human and infrastructure resources are available to maintain privacy and confidentiality; - ongoing psychosocial support is available; - HIV testing and counselling services are offered by a

professional nurse in a private consultation; and - active parental consent and learner assent (12 years and older) are sought (HCT Policy Document 2012).

In addition the school governing body will also have a role to play in making sure that this program runs smoothly. Children who opt to undergo this test will be counselled before they participate. All nurses involved are supposed to hold each learners cases and information confidential (HCT Policy Document 2012). As noted above, the campaign is to enhance service delivery to teenagers who may test positive so they can access prompt treatment care and support at the earliest stages of their infections (*The Lancet* 2011: 528).

Since the announcement of the HCT campaign, there have been discussions and debates on the efficacy of such a drastic move. As has been mentioned above whilst some are positive about it, the vast majority of people have reservations. It is with this background that the department of health has promised that HCT will be professional and responsible (South African Government News Agency 2011). This statement is to assure parents and carers that all the necessary procedures will be taken to ensure the effectiveness of the campaign.

The Argument for Testing in Schools

The argument amongst those who see the potential of the campaign is that the 'Widespread HIV counselling and testing is likely to be feasible in South African schools and provide many benefits including HIV prevention education and familiarisation with the testing process' (*Lancet* 2011: 528). It is seen as an opportunity for those who will test negative will be counselled to continue to protect themselves from future infection. The assumption is that they will be able encouraged to evaluate their behaviours and make some lifestyle changes and stick to the ones that will protect them. In the same way the South African National AIDS Council (SANAC) also argues that:

Based on the understanding that HIV Counselling and Testing (HCT) is an entry point to prevention, as well as treatment, care and support services, the campaign's aim is to bring about positive behaviour change, encouraging individuals and communities to take responsibility for their health by knowing their HIV status (2010).

Clearly just like any other health program in schools, testing is ‘ideal for early detection and treatment’ (Clayton *et al.* 2010: 1594), of HIV for teenagers. For those who will test positive, early treatment as well as support and care can be readily accessed. They will also be counselled to make lifestyle changes to live ‘positively’ with the virus. As has been noted by Makhunga-Ramfolo *et al.*, that ‘Early diagnosis improves health outcomes of those who are HIV positive, while ensuring that they are provided with information to reduce transmission’ (2011: 3). In addition, it can also be seen as cost effective in delivering services at the door step of South African teenagers in the comfort of their own familiar environment. This is because as noted above, most young people are not able to access these services because their schools schedule clashes with that of the clinics and also clinics are not open to the public over the weekends. Holiday’s period is not an option for most of them because they may be required permission from family members which will compromise confidentiality. Again the proximity from most homes to the clinics is a challenge, Some of them live very far therefore bringing the services to where they spend most of their time can be effective way of reaching them (Clayton *et al.* 2010: 1594). In addition to the above, follow up can easily be made in the school-based testing programme compared to testing services provided in the clinics. On the basis of the above arguments the HCT campaign seems set to promise a good result, therefore needs to be embraced by all.

Arguments against Testing in Schools

Apart from the foreseeable issues around testing teenagers in schools discussed above, a number of people have raised their concerns about the campaign. Most people have argued about the readiness of civil society for such an initiative that encourages children as young as 12 years to go for an HIV test independently. For instance in an interview with some parents, Gwandure *et al.* reported that out of the 20 parents, only 6 supported the idea of the campaign but felt that a positive result will be stressful to the child, and that their relationship with the child will be ruined by the results (2014: 40). The article continued that 5 of the parents were concerned that if the child tested positive at school, the result will affect the child’s performance and some children may even decide not to return to the school (Gwandure 2014; 40). I tend to agree with the above statements because if the test is not carefully planned out, and strict confidentiality issues adhered to, children who test positive are liable to

be ridicule in the school and as a result of peer pressure, the consequences may be disastrous. If the processes involved are not handled well, children will be made vulnerable in an environment that should be considered safe and nurturing. At the same time, whether or not the service is provided at school may not be an issue because the 12 years can decide to access the service from any clinic without parents concern.

Another major ethical concern that testing in schools has raised is in area of vertical transmission. Vertical transmission refers to transfer of the HI Virus from mother to child at any point from pregnancy to soon after birth. Some of these teenagers may present with positive results not because they have been sexually active but rather that they have been infected vertically and parents either do not know or have not disclosed to them. Therefore allowing them to test independently in schools might expose most parents before planned disclosure. Such situation is likely to cause trauma, distrust, rebellion and in extreme cases suicide because of parental failure to disclose to the children their HIV status. In these situations most of them are likely to test positive before ever indulging in any risky sexual activities and they may want answers from parents and family members who have kept the truth from them. A number of scholars such as Nglazi *et al.*, 2012 and Dowshen and D'Angelo have noted that about 62% of HIV positive young people in South Africa between the ages of 9-28 had acquired the disease around the time of birth and are surviving because of the efficacy of medication (Hornschuh *et al.* 2014: 421). The assumption is that if disclosure has not taken place, allowing those children to test independently will be a big challenge. This point confirms an experience that confronted me during my involvement at the community care project where a teenager needed answers because she was told by her grandmother that she was on medication as a result of asthma yet from her life orientation class she could identify with the symptoms of an HIV positive person. She therefore went for a test independently from a local clinic and her suspicions were confirmed. Her argument was that she had never been sexually active and yet she tested positive and again the family had lied that she had asthma instead of telling her the truth that she was infected perinatally. As can be imagined from this story, disclosure to a child where vertical transmission has occurred is a very sensitive issue that requires much tact, planning and sensitivity. This is because there are a number of issues to consider such as age appropriate, location of disclosure, maturity, emotional intelligence, stage at

school, presence of support systems, confidentiality issues, co-existing neurodisabilities (Morobadi *et al.* 2014:3; Kmita *et al.* 2002).

Another important question that arises with the testing in schools is what about those who are not in school for various reasons: either they are drop out, or cannot access formal education for various reasons but are sexually active? What incentive do they have to encourage them test for their status? Since such a group exist in the communities and some possibly dating the school going teenagers, their neglect will be detrimental to the whole programme. Another concern about the testing in schools is that teachers may want to know the result from those who choose to access the service. Again sexually active teenagers who test positive may find it difficult to disclose their status to family members which may have implications for long term care and support.

Ethical Analysis of the Debates on the HCT

So far the article has given the background to the HCT campaign and the various discourses generated by parents and civil society as a whole since its proposal. As noted above this campaign is situated in a culture that perceives issues around sex and sexuality as taboo (Okyere-Manu 2013: 44) and as such people do not openly and frankly discuss it among themselves let alone with their teenage children. Issues of sex and sexualities have always been perceived as a private issue. But as Haddad rightly put it, the consequences of the pandemic in terms of the millions of young people it had claimed had to 'forced such issues onto its public arena' (2009:16), suggesting that in the era of HIV the issue of sex and sexuality cannot be seen as private issue anymore, because of the potential consequences of our silence. Clearly there are a number of ethical issues around the HIV pandemic that we failed to deal with and have claimed a number of lives and as such silence around issues of teenage sex and sexuality is no more an option. There is the need to embrace strategies aimed opening up communication lines in order to protect our current and future generations.

Unfortunately parents, carers and spiritual leaders, have not been equipped effectively with the necessary skills to interrogate such ethical complexities around the disease particularly issues to do with teenage sex and sexualities. Even with the various strategies such as ABC and other HIV prevention method through the media etc, long terms support systems still lack

skills in dealing with the cultural aspects of sex and sexualities. Our attempt to respond to such issues has been done through our deontological ethical approach. Irene Van Staveren says that ‘deontological ethics is about following universal norms that prescribe what people ought to do, how they should behave, and what is right and wrong, it is a morality of principles not of consequences’ (2007:23). Obviously such an approach that is concerned with the principles of morality can only approve the ethic of sexual purity for teenagers with no room for negotiations. However whether we like it or not as indicated above, most of the teenagers in our care are sexually active and some are involve in risky sexual behaviours rendering them vulnerable to the disease. So the issue is how long term support structures can educate teenagers not to underestimate their personal risk but embrace behavioural change and sexual responsibilities. It must be noted that our deontological approach has always centred on ‘dos’ and ‘don’ts’ without proper explanations or allowing young people the opportunity to ask their pressing and complex questions. Elsewhere I have argued that currently the media through technology is influencing the ethical behaviours of our children (Okyere-Manu 2013) so we cannot continue with our outdated approach to ethical behaviours. With the Children’s Act giving legal opportunity for 12 years to concern to HIV test there is need for us to relook at our approach of dealing with these teenagers. Particularly as we aim to become part of the long term care and support structures to those in our care who might test positive.

In light of the HCT campaign, as noted, there is need to re-examine our cultural practices and spiritual teachings that encourages silence around issues of teenage sex and sexuality and reconstruct a life giving communication channels with teenagers. Musa Dube has warned that when it comes to HIV pandemic in Africa, there are a number of unanswered questions which calls for Consequential approach in dealing with them (Haddad 2009:17). This ethical approach according to George Chryssides and John Kaler, premises on the fact that the ‘result of our actions determines the truth or falsity of moral judgement about them (1993: 88). The above quotation from Chryssides implies that if the result that follows our action is of benefit to a number of people, then the action is considered ethically good, on the other hand it the result of the action does not benefit the greatest number of people but rather it brings harm to them, then the action is considered unethical (Chryssides *et al.* 1993:88). Currently the consequences of our ineffective communication skills that have resulted in the silence around teenage sex and sexuality do not bring

the greatest happiness to the greater number of teenagers. Their questions are not answered appropriately by those they trust, the dos and don'ts have not been beneficial to them. It only proposes issues around sex and sexuality as dangerous and unsavoury. Through the lens consequentialism explained above, it is clear that taking HIV test to learners at school and giving them the opportunity to know their status and protect themselves is an appropriate action. Without a doubt what this means to parents and carers is to reconstruct their approach in dealing with teenage sex and sexuality.

Towards an Ethical Response by Long Term Support Structures

Clearly from above discussion there is the need for practical response from carers, parents and spiritual leaders, if we are to take the HCT campaign seriously. As noted the campaign challenges both our parental skills and spiritual support strategies for families and teenagers alike. Even though the national policy on HIV and AIDS for Learners and Educators requires parents and caregivers 'to provide their children with healthy morals, sexuality education, and guidance regarding sexual abstinence until marriage, and faithfulness to their partners' (National Policy of HIV and AIDS 1999), the challenge that arises concerns how to deconstruct the deeply rooted cultural practice of silence around the language and issues of sex and sexuality that proposes 'dos' and 'don'ts', which in many instances has resulted in dangerous as well as unsavoury sexual practices especially among teenagers.

As have been noted by most scholars '... effective approaches are multifaceted. All adolescents need access to quality youth-friendly services provided by clinicians trained to work with this population' (Bearinger *et al.* 2007:1220). To them the their focus is on trained clinicians to offer services including sex education programme for adolescents and the content of such education should be accurate and all-inclusive information and at the same time build skills for negotiating sexual behaviour. I am of the view that such an education should be opened to not only to clinicians but long term support structures as well. I also believe that in order to offer quality sexual education for them, there is the need to hear the voices of teenagers and the challenges that they experience. Such an understanding will foster a meaningful conversation without any judgemental attitudes. What I see coming out of the campaign is that it is challenging long term support structures to re-examine

the contest as well as the content of their sex education.

The content of such training must challenge long term support structures to deconstruct their approaches influenced by the different cultural beliefs and practices in order to communicate liberating sexual education messages that goes beyond condemnation, violence, 'do' and 'don'ts' to education that encourages behavioural change, responsible sexual activities that does not underestimate their own personal risk. Families and long term support structures are to be encouraged to engage in open discussions in the comfort of their home or available safe spaces. There has to be the engagement of young people in such educational programs so that they will be able to make responsible sexual choices.

Conclusion

Thus far, the article calls for long term support structures such as parents, carers, guardians and even spiritual leaders to deconstruct their sexual educational strategies to teenagers in their care, in order to support the testing in schools campaign proposed by the departments of health and education. This is because even though the campaign has been received negatively by a number of people in the country, it promises to be an effective strategy to reach the young people who are considered among key population groups. A closure look at the campaign reveals that its prospective benefits far outweigh its potential risks if all the support structures are well informed to take their responsibilities seriously. It proposes that the content of such an education must move beyond the 'dos' and 'don'ts' deontological approach to a more liberal and life giving approach which allows for proper engagement with teenagers at the comfort of their homes and spiritual safe spaces. By deconstructing perceptions and attitudes, the content and the contest of our educational strategies and reconstructing a new form of strategy to meet the growing pressures and challenges that teenagers face, the success of the campaign can be assured.

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