

**Community engagement in response to the impact of HIV and AIDS:  
Ruvheneko Programme in Chirumhanzu, Zimbabwe**

**by**

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## Declaration

I, Christina Tafadzwa Dzimiri, declare that this dissertation which I hereby submit for the degree of Master of Social Science in Development Studies at the University of Pretoria, is my own work and has not previously been submitted by me for a degree at this or any other tertiary institution. Where secondary material is used, this has carefully been acknowledged and referenced in accordance with University requirements.

Signature..... Date.....

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## Abstract

Since the identification of the HI virus in Zimbabwe in 1985, the epidemic impacted seriously on every facet of human security. Rural areas by virtue of being the periphery and constrained in terms of health care provision bear the brunt of the epidemic. It is against this background that Ruvheneko Programme was established at St Theresa's Hospital in Chirumhanzu. By contributing to the discourse of development studies, the quest for this study is to examine how the rural initiative leading to the establishment of Ruvheneko Programme at St Theresa's Mission Hospital has helped to mitigate the impact of HIV and AIDS in Chirumhanzu. The study gives primacy to how the Ruvheneko Programme managed to successfully engage with community members despite the failure usually associated with HIV and AIDS engagement projects. It also reflects on how the successful implementation of Ruvhenekos Programme led to the creation of other related programmes in Manicaland and Masholand East Provinces in Zimbabwe. The study utilises insights from the social capital theory in its endeavour to demonstrate how social cohesion resulted in the establishment of the Ruvheneko Programme. A qualitative research design was adopted and convenience sampling was used to select participants for interviews and this included those who were directly involved in the phenomena. The study deduced that, unlike other HIV and AIDS programmes that are exported from the urban to the rural areas, Ruvheneko Programme is a model for grassroot level response to HIV and AIDS. The main finding is that despite receiving donor support, the success of Ruvheneko Programme is attributed to social cohesion fostered by such aspects as religiosity, cultural ethos of *Ubuntu* and consultative approach that was adopted in engaging the community. More importantly, Ruvheneko Programme remains an example of how communities can effectively respond to the challenges which face them through utilising

locally available networks and resources. The study however recommends that further research should also focus on finding how the Ruvheneko Programme may be self-sufficient financially, amid fears of donor fatigue and centralisation of donor funds by the Zimbabwe National AIDS Council (NAC).

**Key Words:** HIV and AIDS, Ruvheneko, Chirumhanzu-Zimbabwe, rural setting, Ruvheneko, community home-based care, engagement, participation, orphans and vulnerable children, prevention of mother to child transmission, St Theresa Mission Hospital and Roman Catholic Church

## ABBREVIATIONS

ABC	Abstinence Being Faithful to one Sexual Partner and Condomising
ADB	Asian Development Bank
AIDS	Acquired Immuno Deficiency Syndrome
AIKS	African Indigenous Knowledge System
ANC	Antenatal Care
ARV	Antiretroviral
ART	Antiretroviral Treatment
BEAM	Basic Education Assistance Module
CADEC	Catholic Development Commission
CCLA	Chirumhanzu Church Leaders Association
CHBC	Community Home Based Care
CHH	Child Headed Household
CIDA	Canadian International Development Agency
C-SAFE	Consortium for Southern Africa Famine Emergency
DAAC	District AIDS Action Committee
DDA	Demand Driven Approach
EBF	Exclusive Breast Feeding
ESAP	Economic Structural Adjustment Programme
FAO	Food Agricultural Organisation
FBO	Faith Based Organisation
FGD	Focus group Discussion
FHH	Female Headed Household
FO	Field Officer
FTLRP	Fast Track Land Reform Programme
GoZ	Government of Zimbabwe
CHH	Grandmother Headed Household
HA	Hospital Administrator
HBC	Home Based Care

HIV	Human Immunodeficiency Virus
ICAD	Interagency Coalition on AIDS and Development
IDU	Injecting Drug User
IKS	Indigenous Knowledge System
ILO	International Labour Organisation
MDC	Movement for Democratic Change
MMC	Medical Male Circumcision
MoE	Ministry of Education
MoHCW	Ministry of Health and Child Welfare
MSM	Men having Sex with Men
MTCT	Mother to Child Transmission
NAC	National AIDS Council
NATF	National AIDS Trust Fund
NACP	National AIDS Control Programme
NBCS	National Behavioural Change Strategy
NGO	Non-Governmental Organisation
NPA OVC	National Plan of Action on Orphans and Vulnerable Children
OI	Opportunistic Infections
OPD	Out-patient Department
OVC	Orphans and Vulnerable Children
PAAC	Provincial AIDS Action Committee
PACT	People Acting in Community Together
PAR	Participatory Action Research
PC	Programme Coordinator
PCG	Primary Caregiver
PEPFAR	President's Emergency Programme for AIDS Relief
PHR	Physician for Human Rights
PLA	Participatory Learning Action
PLWHA	People Living With HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission

PPTCT	Prevention of Parents to Child Transmission
PRA	Participatory Rural Appraisal
PSS	Psycho Social Support
RCC	Roman Catholic Church
RCT	Randomized Controlled Trial
RRA	Rapid Rural Appraisal
SIDA	Swedish International Development Agency
SKS	Scientific Knowledge System
STERP	Short Term Economic Recovery Programme
STI	Sexually Transmitted Infection
TAWG	Tanga AIDS Working Group
TB	Tuberculosis
THETA	Traditional Healers and Modern Practitioners Together Against AIDS
UNAIDS	United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations International Children's Education Fund
VCG	Voluntary Care Giver
VCT	Voluntary Counselling and Testing
VCTC	Voluntary Counselling and Testing Centre
VMCC	Voluntary Medical Male Circumcision
WAG	Women Action Group
WASN	Women AIDS Support Network
WB	World Bank
WFP	World Food Programme
WHO	World Health Organisation
ZACH	Zimbabwe Association of Church-related Hospitals
ZAN	Zimbabwe Aids Network
ZANU-PF	Zimbabwe African National Unity Patriotic Fund
ZCBC	Zimbabwe Catholic Bishops Conference
ZINATHA	Zimbabwe National Traditional Healers Association



ZNASP Zimbabwe National HIV and AIDS Strategic Plan

ZNHTCSP Zimbabwe National HIV Testing and Counseling Strategic Plan

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## CHAPTER 1: INTRODUCTION

### 1.1 PROBLEM STATEMENT AND STUDY OBJECTIVES

St. Theresa's Hospital in Chirumhanzu District in the Midlands Province of Zimbabwe is renowned for its successful HIV and AIDS project called Ruvheneko. The hospital is one of three major hospitals in the province. Chirumhanzu rural farming area is hard hit by the scourge of the HIV and AIDS epidemic. The hospital inpatient deaths are largely HIV and AIDS related and have been disturbing for the hospital health workers and the community at large. It is against this background that Ruvheneko HIV and AIDS project was established in 1995 on the initiative of the Roman Catholic Dominican Sisters, hospital health workers, senior nurses, foreign doctors and the community.

Etymologically, the name 'Ruvheneko' in Shona language is translated to mean 'light' or 'enlightenment' and in the context of the challenge of HIV and AIDS, there is a religious meaning ascribed to the name where in the former St Theresa's Hospital Matron, Dr. Stoughton, cited by the 2003 Mission Doctors Association News Letter, *Heal the Sick*, quotes the biblical saying 'And God said, 'let there be light'', and Jesus' statement that, 'I am the light' and it is this light which should be used to solve the HIV and AIDS problem. It is further elaborated that the idea is to meet the needs of the affected and infected in their homes and families so that the light and warmth brought to them by care-givers brings hope, thereby combating fear, desperation and stigma associated with HIV and AIDS.

I carried out a pilot study for three weeks in December 2009 with the intention of exploring possibilities of carrying out research on the Ruvheneko Programme. I gathered that the Programme is responsible for the provision of HIV and AIDS information, home-based care (HBC) skills and support and care to HIV positive people in the community. I also discovered that the Ruvheneko Programme adopted a holistic and comprehensive approach in its response to HIV and AIDS by providing voluntary counselling and testing (VCT), treatment, palliative care, opportunistic infection treatment, prevention of mother-to-child transmission (PMTCT), nutrition, HBC for people living with HIV and AIDS (PLWHA), care for orphans and vulnerable children (OVC) as well as awareness and prevention for the general public and specific target groups such as the youth and married couples. I learnt that opening up on HIV

and AIDS status by community members was more of a process than an event since in the early days most HIV and AIDS patients resisted. In some scenarios, family members went to the extreme of hiding the patients for fear of shame and stigma. Today, Ruvheneko Programme encourages local people to take greater responsibility in accepting and caring for its members who have been infected and affected by HIV and AIDS. I realised that the community members voluntarily work in the hospital garden, growing vegetables for the inpatients as well as growing herbs like *tsine/nhungunira* (black jack) and *Moringa Stenopetala* commonly referred to as ‘the miracle tree’ which are renowned for boosting the immune system of HIV and AIDS people (Jahn 1991). The Programme relies heavily on voluntary service from community members who are both HIV positive and negative. It is usually those who are HIV positive who openly disclose their status without fear and prejudice. Given the prejudice, stigma and discrimination usually associated with HIV positive status, one wonders how the project has managed to reduce, if not eliminate, stigma among community members.

An interest to pursue research on Ruvheneko Programme was also triggered by the fact that it has been referred to as a model of an HIV and AIDS project in resource constrained rural settings (Jackson & Anderson 2001). It was also reported in the main local newspaper in Zimbabwe, *The Herald* (2003) that Ruvheneko Programme is successful given that 80% of pregnant mothers volunteer to get tested and it is the first rural based institution to implement prevention of mother-to-child transmission (PMTCT). It was the intention of this study to embark on investigating the initialization of Ruvheneko Programme and examine how such a rural initiative attracted so much media attention.

One common trend is that most community engagement projects which are HIV and AIDS related are usually confronted with operational and financial challenges, leading to their failure. Ruvheneko Programme however presents a perplexing case where despite being situated in a resource constrained rural setting, it is rated one of the most successful rural based HIV and AIDS projects (see Jackson & Anderson 2001). This study therefore sought to unpack the forces behind the popularity of Ruvheneko Programme as well as establishing why it is regularly cited as an example of a sustainable and successful HIV and AIDS project locally, nationally and internationally (see Jackson & Anderson 2001, The Herald 2003, CDC 2003).



The following objectives were formulated for the study:

- To establish whether the positive portrayal of the Ruvheneko Programme by the media and other academic publications reflect the reality on the ground.
- To explore how the project managed to successfully engage community members despite the failure usually associated with HIV and AIDS community engagement projects.
- To find out how stakeholders in Ruvheneko Programme managed to address the challenge of stigma usually associated with HIV and AIDS in Zimbabwe.

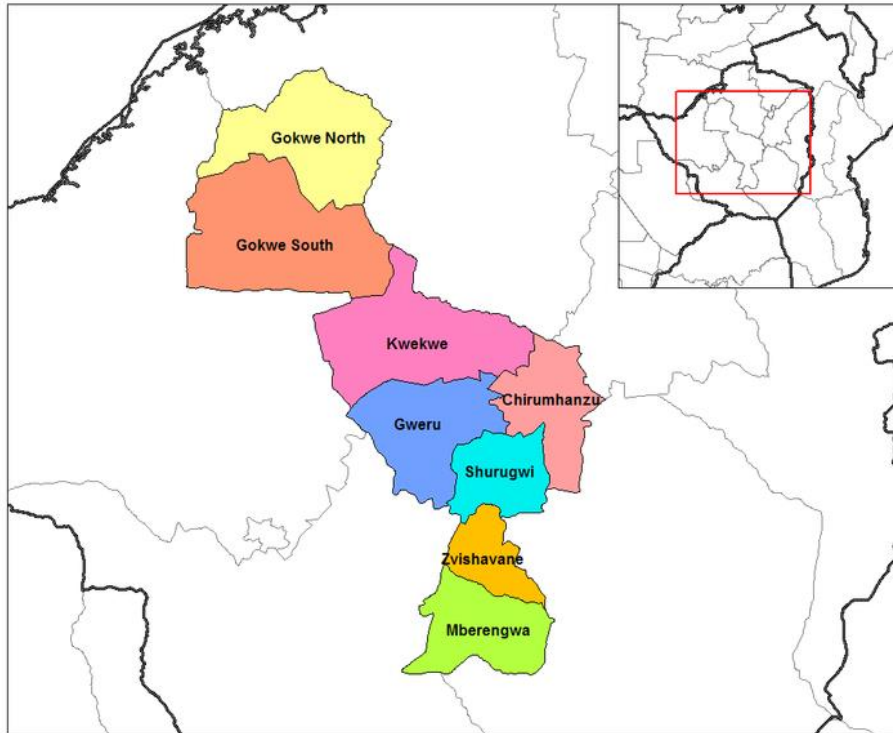
The study also aimed to find answers to the following research questions:

- What evidence supports the positive portrayal of Ruvheneko Programme by the media?
- What factors influence the successful engagement of the community through the Ruvheneko Programme in Chirumhanzu?
- How do stakeholders in the Ruvheneko Programme cope with the stigma which is usually associated with the disease?

## **1.2 DESCRIPTION OF THE STUDY AREA**

The study area is St Theresa's Hospital where the Ruvheneko Programme is housed and is situated in Chirumhanzu District in the Midlands Province of Zimbabwe, located 255 kilometres southwest of Harare, the capital city (see Figure 1 below).

**Figure 1: Location of Chirumhanzu District in the Midlands Province of Zimbabwe**



Extracted from United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA) (2009)

Chirumhanzu District is a rural area which is occupied by predominantly Shona-speaking people. In terms of religion, the inhabitants of Chirumhanzu District are dominantly Roman Catholic though recently Pentecostal churches are mushrooming as in other parts of Zimbabwe. There are four main mission hospitals in the District which are all Roman Catholic, namely, St Theresa in the southeast, Moyo Musande in the southwest, Holy Cross in the central area and Driefontein in the northeast.

Chirumhanzu District borders four others districts: Chivhu to the north, Masvingo to the east, Mashava to the south, Shurugwi to the west, and Gweru to the northwest. The discovery of gold in the 1990s in the Chinyuni, Mashamba and Mvuma areas of the District has seen gold-panning becoming one of the major activities attracting unemployed people from the surrounding rural communities. Many unemployed people in Chirumhanzu District have been

attracted to gold-panning as an economic alternative to agriculture since land in the district is rocky and dry, rendering it agriculturally unproductive. The lifestyle of the informal gold-panners, popularly known in Zimbabwe as *makorokoza* (informal gold-panners who mine gold without permission/premits from government and keep proceeds for themselves), is usually associated with recklessness leading to risky sexual behaviour and the spread of sexually transmitted diseases and HIV and AIDS. Charandura growth point which houses St Theresa mission and other local government service delivery institutions is also a centre where most of the gold-panners come to enjoy after they have sold their proceeds. In the process, this has attracted sex workers around the area, exacerbating the spread of HIV and AIDS.

The researcher chose Chirumhanzu District as a study area mainly because it is said to be the first rural area in Zimbabwe to initiate a successful community response to HIV and AIDS (see 1.1 above). Moreover, the researcher's familiarity with the area made it easy to access the stakeholders and participants. My father-in-law's rural home is in Mahaso village which is about two kilometres from St Theresa Mission hospital and as such I did not incur transport and accommodation costs. In addition, his neighbours are also active participants in the Ruvheneko Programme. I am also accustomed to the language, customs and religious beliefs of the local people. While my insider status worked to my advantage in the field, one might want to question whether such familiarity was not a bias during my research. In my case it was not and more details are provided in the section on ethical considerations below (see 1.6.4).

One discovery from my field research was that the success of the Ruvheneko Programme led to its expansion into three other provinces in Zimbabwe, namely Manicaland Province, Midlands Province and Mashonaland East Province. Services were also rendered at the following mission hospitals: Musume Mission Hospital of the United Lutheran Church, Mutambara Mission Hospital of the United Methodist Church, Regina Coeli Mission Hospital of the Roman Catholic Church, Nyadire Mission Hospital of the Methodist Church, Old Mutare Mission Hospital of the Methodist Church, and St Mary's Mission Hospital of the Roman Catholic Church (see Ruvheneko Programme End Of Phase 1 Report).

### **1.3 DEFINITION OF KEY CONCEPTS**

The literature reviewed in this study explores key thematic concepts such as community engagement, participation and partnership as approaches to community engagement in general. With regard to Ruvheneko Programme in particular, relevant case studies of community engagement and HIV and AIDS related stigma in Zimbabwe were also studied. The sections below describe the key findings of the review.

#### **1.3.1 Conceptualisation of community engagement**

Various scholars and community development practitioners have varying conceptions about what community engagement entails and these all depend on the context (Cernea 1992; Chiplin 1996; Emmett 2000; Midgley 1986; Sarkar 2010; Swanepoel & De Beer 2006). According to Bowen, Newenham-Kahindi and Herremans (2010: 302) the term ‘community’ is normally defined in terms of geography, interaction, and identity. Geographically speaking, people living in the same geographic location or region are said to be a community regardless of the absence of interaction. Regular interaction may however be used as the only attribute to define ‘a community’. In terms of identity, the term ‘community’ can also refer to groups of people, whether they are stakeholders, interest groups or citizen groups with shared beliefs, experiences, and values. Thus ‘community’ can refer to a community of place, a community of practice or a community of affiliation or identity (Bowen, Newenham-Kahindi & Herremans 2010: 302). Cavaye (2002:1) further notes that by engaging the community it means participation of ‘a community of people rather than an individual citizen’ (Cavaye 2002:1). Chiplin (1996) also reminds us that the notion of community in the context of South Africa has become associated with a variety of other referents such as class, race and ethnicity.

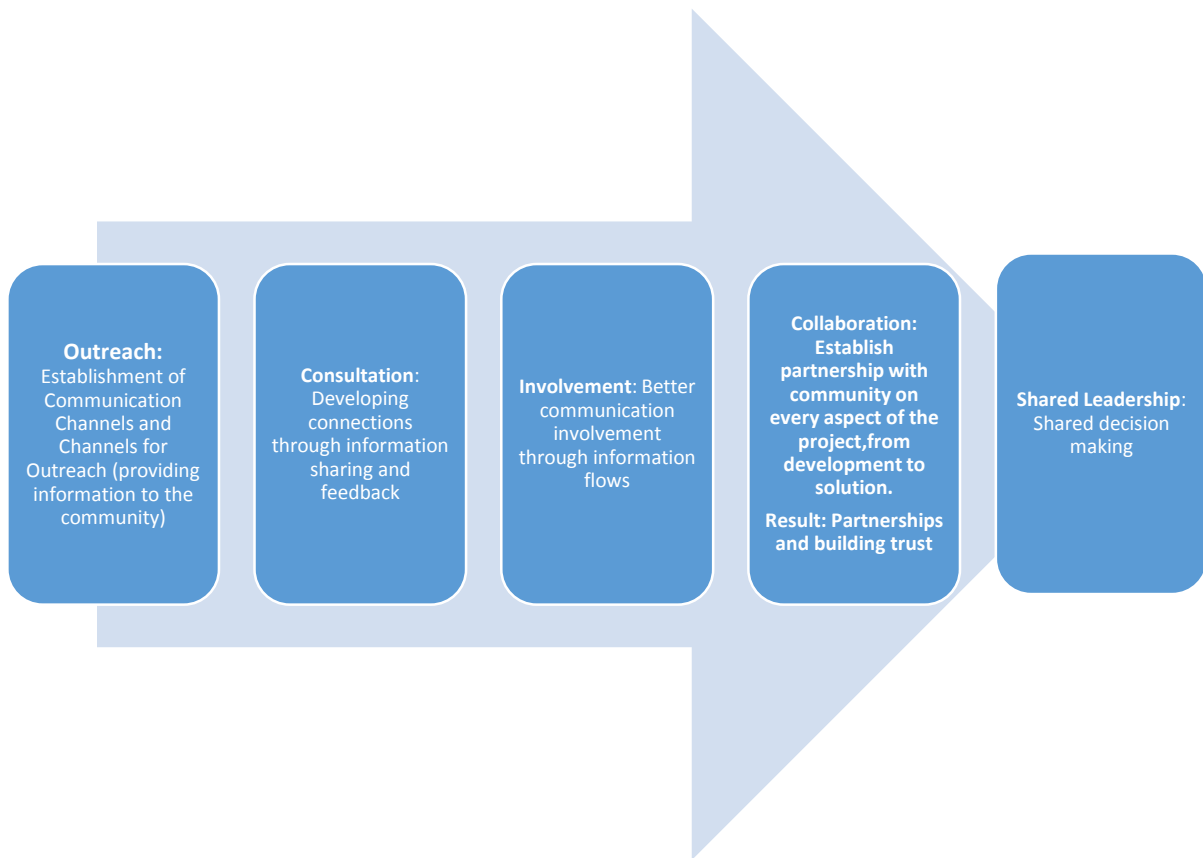
Having examined the term ‘community’, it is equally pertinent to define the term ‘engagement’. The UN Report on Civic Engagement in Public Governance maintains that engagement is regarded as a ‘critical governance norm and can strengthen state decision-making’ as well as fostering accountability and transparency (UN 2008: 9). It is in this context that engagement surfaces as an integral component for attaining the Millennium Development Goals (MDGs) (UN 2008: 23). On the other hand, ‘community engagement is regarded as the process of

working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people' (Fawcett, Paine-Andrews, Francisco, Schultz, Richter, Lewis, Williams, Harries, Berkley, Fisher & Lopez 1995: 678).

Furthermore, community engagement involves the process of working collaboratively with those who share the same goals and objectives (Tindana, Singh, Tracy, Upshar, Daar, Singer, Frohlich & Lavery 2007). Fundamental to engaging the community is the need to 'build authentic partnership including mutual respect, active participation, inclusiveness, power sharing, equity and mutual benefit' (Zakus & Lysack 1998: 3). In essence, community engagement is all about collaborative partnership (Jones & Willis 2007).

Worth noting is that linking of 'community' to 'engagement' helps to broaden the scope, shifting the focus from an individual to a collective in order to cater for the diversity that exists within communities. However, there is no universally binding definition of what it entails. This is because 'communities are seldom, if ever, homogeneous and unified' (Emmett 2000: 503). Sarkar (2010: 12) defines 'community engagement' as 'the process of involving community members in matters that are of developmental benefit to them' and what it means is shifting from 'for the community' to 'by the community'. By so doing, one can talk of capacity building. Capacity building refers to a process of allowing people to lead their own change by being actors themselves, not merely the subjects of change (Gran 1983: 345). An elaborate description of community engagement proffered by the Centre for Disease Control (2011) involves a continuum of different actions or steps. As illustrated in Figure 2 below, outreach is the first step in engaging the community and it entails informing the community on the project through establishment of communication channels. From outreach, the next step is consultation. The aim at this stage is to forge a connection with the community and this is achieved through information and feedback sharing. Involvement, which is the third step, carries on from consultation by emphasising better communication flows through information sharing. This creates a fertile ground for collaboration since people tend to collaborate when they are well informed about the aim and objectives of the project. Collaboration, which is the fourth step, concerns involving the community in all the aspects of the project from initiation to development and problem solving. When all these steps are followed, the last step to be adopted is leadership sharing. What makes leadership sharing possible is the strong partnership, trust and relationship building that emerges from all the preceding steps.

**Figure 2: Community Engagement Continuum**



Adapted from Centre for Disease Control (2011: 8)

The next discussion is on the most integral part of community engagement which is participation.

### **1.3.2 The concept of participation in community engagement**

The idea of participation in development is characterised by practical and conceptual difficulties. For Emmett (2000) these are linked to the ideological nature of the concept which is deeply imbedded in beliefs derived from social and political theories about how societies should be organised. In their discussion of the concept of participation in community development, Swanepoel and De Beer (2006: xiii) argue that the liberal approach to development ‘sees participation as something given to the poor by the authority or non-governmental organizations (NGOs) working for the alleviation of poverty’. Such an approach

is castigated for marginalizing the poor and instead, like Chambers (1994), they argue for a ‘bottom up approach to development’. The main argument being advanced here is that people must be empowered and take full responsibility for their own development and the role of authorities or NGOs must be enabling and supportive.

Midgley (1986: 35) notes that despite the generation of new techniques and strategies to community participation, Rapid Rural Appraisal (RRA), Participatory Rural Appraisal (PRA), Participatory Learning Action (PLA), Demand Driven Approach (DDA) and Participatory Action Research (PAR), ‘all these approaches lack rigorous research, theoretical insight and conceptual clarity’. Instead, they are generally driven by practical experience and ideological orientation. He therefore calls for serious analysis of community life and its complex characteristics and dynamics by developmental agents instead of the existing cheap rhetoric. Echoing the same sentiments, Woelk (1992) contends that community participation practice hinges on ideology and rhetoric rather than clear goals and methods. Cernea (1992) supports this idea by pointing out that there is actually a widening gap between rhetoric and reality in the implementation of community participation. Due to a lack of clear methodology and goals and objectives, community participation happens in an ‘*ad hoc* manner’ which is unsystematic and which cannot be transferred from one generation to the next, thus jeopardizing the sustainability of projects (Cernea 1992: 1).

Emmet (2000) notes that project failure usually occurs when it fails to meet the expectations of the community. Community members participate out of self-interest but that participation does not guarantee project success. Examples that are given by Dreyer (1998) and Hagg and Emmet (2003) as they relate the failure of community water supply (CWS) projects in South Africa. According to Dreyer (1998), a third of the CWS projects failed because communities anticipated direct and immediate financial benefits. In some cases, projects do fail because of the withholding of information by development workers who face resistance when they disclose the information during later stages of the project. An interesting case study of dam construction provided by Swanepoel and De Beer (2006: 265) demonstrates the poorly-planned community involvement can cause despondence and power struggle between development agents and project recipients. In this anonymous case study under discussion, the government had promised that the locals would benefit from the construction of the dam through employment and water for irrigation. Contrary, to their expectations, ‘only a few locals

were employed since the developers brought their own personnel and a few locals were employed' (Swanepoel & De Beer 2006: 265). The local farmers felt excluded and short-changed when they were not involved in the dam construction and as some were forcibly relocated as a result of the danger posed by the flooding dam. The displacement caused by the dam that saw some people getting relocated to higher ground, five kilometres from the dam site and such developments frustrated the community members who felt embittered and powerless about the project.

In some cases, development projects even disadvantage and further impoverish the local people. This led to the conviction that power sharing must always accompany participation otherwise there is no participation. Complexities associated with participation are discussed by Arnstein (cited in Swanepoel & De Beer 2006: 262) who forward that participation without power is an empty and a frustrating process for the powerless yet relinquishing of power to the recipients remains a myth. Acknowledging the importance of community participation in development projects, Van Diessen (1998: 46-47) comments that it is impossible for development agents to be 'catalyst of social change as well as co-learner with the people'. Development workers find themselves in a moral dilemma because they have to deliver and spend donor money according to given programmes and time frames so that they can apply for new donor funds. It is quite difficult to avoid agency-led development projects since development agencies have their mandate to which their constituency holds them accountable.

Literature points to the fact that there can be no participation without power politics in development projects and because of the financial muscle, the development agents are at times in control of the powerless community members or beneficiaries. The issue of genuine participation therefore becomes unachievable. It is through such evidence that a paradigm shift has occurred from participation to partnership in development. This brings us to the next section of partnership as a form of community engagement.

### **1.3.3 The concept of partnership in community engagement**

Fundamental to the discourse of community engagement in recent years is the concept of 'partnership'. Buchanan (1994: 9) defines partnership as 'a working relationship that is



characterized by a sense of purpose, mutual respect and the willingness to negotiate'. Lister (2000: 228) cites such elements like the existence of mutual trust, mutual support, joint decision making, reciprocal accountability, financial transparency and long term commitment as necessary for a 'successful partnership'. Common usage of the term however leads to multiple interpretations and lack of clarity. Crawford (2003: 143) gives two conceptions of participation, namely 'instrumental' and 'genuine' participation. In the former, participation is seen as a means by which to accomplish agency objectives through consultation and limited involvement of the local communities. Donor agencies remain in control. In contrast with 'instrumental participation', 'genuine participation' entails true empowerment of the locals by allowing them to set the development agenda from the onset and remaining in control throughout. Where participation is genuine, it is valued as an end in itself and the potential of transformation manifests. In contrast, where participation is instrumental there is no true empowerment of the locals. If anything, the development agencies impose their objectives on the beneficiaries. In like manner, it is becoming more and more apparent that the process of 'partnership' is being abused instead of bringing mutual benefits or finding the win-win possibility (see Zakus & Lysack 1998). The following section discusses Ruvheneko Programme in relation to other HIV and AIDS projects in Zimbabwe.

#### **1.4 RUVHENEKO PROGRAMME WITHIN THE CONTEXT OF OTHER HIV AND AIDS PROJECTS IN ZIMBABWE**

Jackson and Anderson (2001) argue that the success of the Ruvheneko Programme has reached beyond Zimbabwe's borders as an example of basic standards of home care and optimal service delivery in resource constrained settings in Africa. They point out that the project has a 'comprehensive approach' to care which ensures that the medical, social and emotional needs of its beneficiaries are met while encouraging the community to take greater responsibility in taking care of community and family members who are infected and affected by HIV and AIDS. In addition, Ruvheneko Programme is said to support and build on Shona traditions of mutual obligation and family support. Furthermore, Jackson and Anderson (2001: 595) make reference to the family as the most important resource for the target beneficiaries. The Programme trains family care-givers in nutrition, hygiene, oral rehydration and control of simple infections. In 2001, Ruvheneko Programme established six support groups consisting

of 12 to 22 members and these provided a forum for sharing and mutual support as well as increasing members' economic self-reliance through the teaching of self-help skills for sewing, gardening and small business initiatives (Jackson & Anderson 2001).

The success story of Ruvheneko Programme is also illuminated when the Programme is compared with other HIV and AIDS projects in Zimbabwe such as the Mutambara Mother and Child Survival Training and Programme Development. The project focused on the health situation of mothers and children and the living conditions of particular patients and orphans. The project is reported to have thrived in the early phases especially in terms of health education, vaccinations, growth monitoring, health care and antenatal care (Mossinge & Gwaze 2007). However, the training of home-based care volunteers, traditional mid-wives and HIV and AIDS awareness campaigns did not carry on as planned, despite the financial support from the United Methodist Church of Norway. The main reason for failure was due to the alleged 'dependency syndrome' created by the Project Coordinator who was an expatriate who did not transfer her management skills to the two nurse aids and other personnel at the United Methodist Church Hospital. As a result, when she failed to get her work permit renewed in July 2004 to cover for the period, July 2004 to December 2006 as initially planned, she went back to Norway and the project lacked continuation. Failure to incorporate other HIV and AIDS actors in the area (such as The Girl Child Network, New Life, and The Memory Book under the Family AIDS Trust) also meant that there was no continuity in the project as a result of the expatriate's absence. The project evaluation report by Mossinge & Gwaze (2007) stipulates that in future, developmental workers have to utilise local personnel to implement projects so that the development worker(s) should be more of advisors and not project coordinators. There is need for capacity building so that projects can continue to exist without the inputs by development workers.

Another example of an HIV and AIDS project with mixed results is that of Rutendo HIV and AIDS Project in Gweru in the Midlands Province of Zimbabwe. The project was initiated in 2003 by Sisters of the Child Jesus of the Roman Catholic Church (RCC) with the aim of providing human and social relief to people who are infected with HIV and AIDS in the Mkoba High Density Suburb Project (Seeds of Hope: Sisters in Action Around the World 2009). This project is successful not only in its provision of food, clothes, herbal medicine, nutrition counselling and bereavement support to home-based patients but also in mobilising the

community, especially the youth, in awareness raising and the need for behaviour change to prevent the spread of HIV. The major challenge of the project however is the harsh economic conditions in Zimbabwe which make fundraising efforts futile. The SCJ sisters cited political obstacles as the major reason for their inability to expand the project. Apparently, the Gweru City Council refused to give them permission to expand their premises because the space adjacent to the center was ear-marked for a new business center (Seeds of Hope: Sisters in Action around the World 2009).

In another study on the evaluation of the projects of the Swedish International Development Agency (SIDA) in Zimbabwe, Madzingira, Muhwava, & Mapfumo (2007) discovered that despite the efforts to prevent the spread of HIV and AIDS in project areas, conditions still exist for rapid spread of infection in the target and general population. SIDA had entered into partnerships with non-governmental organisations (NGOs), civil society and the private sector to mitigate the impact of HIV and AIDS on vulnerable populations. Basically, SIDA supports community-based programmes except for a few sector specific organisations such as the National Railways of Zimbabwe, Zimbabwe Iron Steel Company and Desert International. Although SIDA supports 19 partnership organisations in Zimbabwe, only 14 were evaluated including organisations such as the Catholic Development Commission (CADEC), Farm Orphans Support Trust, Mashambanzou Care Trust, Pact Zimbabwe, Population Services Zimbabwe (PSZ), Women Action Group (WAG), Zimbabwe AIDS Network (ZAN), and Zimbabwe AIDS Programme Support Organisation. The other five could not be reached for assessment and others had given non-existent addresses reflecting badly also on the part of SIDA for lack of proper monitoring and evaluation structures.

The evaluation team noted that while partner organisations engaged communities through participation, they were not directly involved in the conceptualisation and planning of the projects. As such, community involvement was mainly limited to implementation and interventions like the OVC and HBC relying heavily on voluntary skills. Of the five hundred volunteers recruited in the Mashambanzou project, two hundred (40%) were still active. Organisations like CADEC and WAG were however utilising community structures to help with the identification of beneficiaries and assessment of their needs. Besides volunteer skills, community resource mobilisation has been marginal across the evaluated projects. In Chimanimani, clients complained that the PSZ youth centre was run like a private institution

with little and insignificant input from the targeted population. Such reports point to the fact that instrumental participation is at play, adopting a top-bottom approach instead of the recommended bottom up approach in contemporary development discourses (see Chambers 1994).

## **1.5 HIV AND AIDS RELATED STIGMA IN ZIMBABWE**

Stigma associated with being HIV positive affects every sphere of human activity and leads to failure of HIV and AIDS prevention programmes. This is mainly due to the fact that HIV positive people hide their status, creating an impression that AIDS is not present in the community. Consequently, treatment, care and support services cannot be accessed. Stigma can be described as ‘a significantly discrediting attribute’ (Goffman 1963). Borrowing from this description, Alonzo and Reynolds (1994: 304) define stigma as ‘a powerful discrediting and tainting social label that radically changes the way individuals view themselves and are viewed as persons’. Stigma is associated with the ascription of negative opinions, attitudes, and beliefs about those infected as well as those associated with HIV positive people. In most cases, it is deeply rooted in moral assessments, and blame about the ways HIV is transmitted. In a study conducted by the Department for International Development (DFID) in 2007, it was revealed that despite having knowledge about HIV and AIDS, a certain sector of society still believed that being HIV positive was shameful and was viewed as a punishment from God as result of sinful acts. It emerged from the same study that fear of causal transmission and lack of empathy were the major reasons for the high levels of stigma and discrimination in Zimbabwe (DFID 2007). As a result of stigma, people were hesitant to get tested, seek treatment and reveal their HIV status to others.

An ethnographic study carried out in Zimbabwe by Duffy in 2005 showed that shame, suffering and silence were consequences of HIV related stigma and had an adverse effect on health promotion efforts. HIV positive people faced stigma and social, political, cultural, and economic discrimination. In fact, even when they sought treatment in health institutions they experienced stigma. In this regard, stigma has to be understood in the context of broader notions of power and domination because it plays a key role in producing and reproducing relations of power and control (Parker & Aggleton 2003: 16). Collymore (2002: 2) expresses

a similar viewpoint that ‘stigma related to HIV and AIDS feeds off well-established relations of power within society – those associated with race and ethnicity, economic status, sexual orientation and women’s low status’.

In a study conducted focusing on 29 countries in Africa, including Zimbabwe, it was noted that HIV positive women were more likely to be the victims of discrimination. They risked eviction from their homes and being physically assaulted, especially in patriarchal societies (Benotsch 2008). Izumi (2006) presents case studies of how some Zimbabwean women were victimised and had their property taken by their in-laws upon the death of their husbands from HIV and AIDS. They were however fortunate to recover their property when the Zimbabwe Widows and Orphans Trust intervened. One wonders what is happening to other widows and vulnerable children who do not have access to similar NGO services. They are often accused of having killed their husbands and they face stigma throughout their lives.

HIV and AIDS related stigma is not only confined to the domestic sphere but also exists in the workplace (Masanga 2010). Most companies in Zimbabwe do not have HIV and AIDS workplace policies prohibiting discrimination and stigma. As a result, lack of such policies renders HIV positive people vulnerable to stigma and abuse. Augmenting this assertion, are the results of a study by Jackson and Pitts (cited in Malcolm, Aggleton, Bronfman, Galvao, Mane & Verrall 1998) involving 94 companies in Zimbabwe. They found that twenty two percent of the companies surveyed acknowledged that HIV screening was being done, sometimes without consent. Such a practice negates the issue of ethical considerations which are meant to ensure the protection of confidentiality, privacy and human rights. Those who are HIV positive face discrimination by being denied access to training, promotions, reduced benefits and in some cases lose their jobs. Given the choice, many Zimbabweans would prefer to stay without knowing their HIV status since HIV testing is not confidential and often results in unwanted disclosure to family, employers and others in the community leading to discrimination and stigma (UNAIDS 2000). In addition, unavailability of treatment for the majority of HIV positive individuals discourages people from getting tested. One informant is quoted to have asked, ‘Why should I go and get tested when I know for a fact I won’t be able to get the necessary treatment?’ (Brown, Macintyre & Trijillo 2003).

## **1.6 RESEARCH DESIGN AND METHODOLOGY**

This section presents and justifies the theoretical and the methodological approaches that I adopted with regards to data collection, analysis, and interpretation.

### **1.6.1 Research design**

Basically, there are two approaches to research in social sciences, namely a quantitative and a qualitative approach. Conceptually, quantitative research which emphasises on studying society objectively through the use of ‘large samples designed to reflect and be representative of the population being studied’ (Pierce 2008: 42). Emphasis on exactitude (objectivity) means that quantitative researchers make use of computers and other modern technological devices. This is opposed to qualitative research which allows the researcher to examine people’s experiences by using a specific set of research instruments such as in-depth interviews, observation, content analyses and group discussions (Hennink, Hutter & Bailey 2011: 9). Qualitative research seeks to embrace and understand the contextual influences on the research issues and it is more useful in exploring complex issues such as people’s beliefs and behaviour and for identifying social and cultural norms in society (Hennink, Hutter & Bailey 2011; Babbie 2007). In the context of HIV and AIDS related studies, the inductive and descriptive nature of qualitative research provides in-depth understanding of the socio-behavioural aspects of the epidemic (Power 1998). Qualitative methods enabled me to critically reflect on, analyse and interpret different dimensions that surround the integration of the stakeholders in Ruvheneko Programme. Furthermore, qualitative research is said to ‘provide measures with greater validity than do survey and experimental measurement’ (Babbie 2007: 313). Quantitative data collection techniques were not utilised because of their inadequacies in accounting for the dynamics and complexities of the social setting as they only seek to quantify social phenomena.

In this study, a qualitative approach was used because HIV and AIDS research involves people’s feelings, interactions, attitudes and aspirations addition. One of the strengths of a qualitative approach is that it offers opportunities to learn and understand the underlying values of society through interviewing and observation. Furthermore, it enables theory to be created

by induction through learning the social meanings that subjects apply to their world. In Pierce's words, researchers are better able to 'see the world through the subject's eyes' (Pierce 2008: 45). Babbie (2007: 313) also argues that qualitative research 'provide(s) measures with greater validity than do quantitative surveys and experimental measurement'. While quantitative research is hard and reliable, qualitative research is deep and rich as it allows further probing and flexibility in the field.

Qualitative research also allows the participation of individuals and groups in the study, making it friendly in gathering information. In addition, it aims at exploring and understanding interactions and social contexts without the use of quantification. It is observational and the researcher gets closer to the people being studied. Individual experiences of the participants and the researcher's observations were blended to achieve a deep description and analysis on how Ruvheneko HIV and AIDS Programme managed to overcome most challenges and become a success story in the fight against HIV and AIDS.

A case study approach was utilised as the essential 'building block' of empirical research (see Pierce 2008). The case study approach is defined as 'an empirical inquiry that investigates a contemporary phenomenon within its real life context' where more than one sources of evidence are explored to gather evidence from a given area (Yin 2003: 13). Complementing this view is Berg (2001: 225) who says the case study approach involves the systematic gathering of enough information about a 'particular person, social setting, event or group to permit the researcher to effectively understand how it operates or function'. Consequently, extremely rich, detailed, in-depth information characterise the information gathered in case studies. Within the case study approach, I chose interpretivist and social constructivist paradigms to underpin the research process and data analysis. This allowed me to view reality and knowledge as flexible and not rigid; multifaceted rather than uniform; contextual rather than general and qualitative rather than quantitative (Cresswell 2007).

### **1.6.2 Sampling and data collection techniques**

Data collection for this study involved field research. Field research can be defined as primary research that transpires 'in the field' – that is outside the controlled settings of the library or

laboratory (Hobbs & Wright 2006). One of the distinguishing characteristic of field work is the inclusion of the observer in the subject matter itself.

A volunteer sample was used to select research participants. This means that participants voluntarily consented to take part in the research process. One of the advantages of having used a volunteer sample was that the participants cooperated fully. Given the nature of the study, there was a need to purposively select a sample of people who had experienced the impact of the HIV and AIDS scourge and had knowledge on the establishment, activities, and challenges faced by Ruvheneko Programme in Chirumhanzu District. A combination of convenience and purposive sampling was used because it enabled me to select participants on the basis of their availability and accessibility. Although conveniently selected, the sampled participants were knowledgeable on the subject matter. Several different data collection techniques were employed during the field research. Each of these is described in the sub-sections below.

#### **1.6.2.1 Focus group discussions**

Focus group discussions (FGDs) were one of the major data collection methods during my field research. This involved bringing together a small group of people for a semi-structured discussion or themes under the moderation of the researcher. Six FGDs were conducted which involved a total of 53 participants in the following groups:

- Ten community home-based care (CHBC) voluntary care-givers (VCGs) of whom two were men and eight were women. Four were HIV positive and six were HIV negative. I took advantage of the monthly VCGs meetings from various villages conducted at Ruvheneko Centre and drew participants from that group on the 13<sup>th</sup> of December 2010.
- Ten orphans and vulnerable children (OVC) during the Christmas party on the 15<sup>th</sup> of December 2010, of whom three were girls and seven were boys all above the age of 18. Five of the OVC also participated in the youth FGD.
- Ten women of the St. Anne's Sect on the 20<sup>th</sup> of January 2011, during their usual Thursday gatherings at St. Joseph's Hama Roman Catholic Church. Two of the participants had participated in the VCG FGD since they also serve as VCGs.



- Ten PMTCT women at St. Theresa's Ruvheneko Centre who had come for ante-natal care and they were from various villages served by Ruvheneko Programme on the 16<sup>th</sup> of February 2011.
- Ten youth members all above the age of eighteen who regularly participate in awareness raising campaigns, dramas, poem recitations, condom distribution, welding support group on the 18<sup>th</sup> of February 2011.
- Ten HIV and AIDS Support Group members (all women who are HIV positive) which were drawn from five support groups (gardening, sewing, bun making, mat making and welding) which are run by the Ruvheneko Programme on the 18<sup>th</sup> of March 2011.

The FGDs that were conducted were informative since the participants were drawn from both the infected and the affected. Furthermore, they provided an important tool for assessing the experiences and attitudes of people living with HIV and AIDS (PLWHA) and orphans and vulnerable children (OVC) who are vulnerable groups in the Zimbabwean society.

### **1.6.2.2 In-depth interviews**

Focus group discussions were complemented with several in-depth interviews. The informants consisted of three staff members of St Theresa's Hospital, four personnel of the Ruvheneko Programme, three members of the Roman Catholic Church of St Joseph's Hama Mission, three orphans, nine residents of Mahaso village. The individual experiences expressed by the informants and the researcher's observations during the face to face interviews were blended to achieve a deep description of the activities of Ruvheneko Programme. An interview guide (see annexure) was used to provide some structure during the interviews. This ensured that specific information required for the purpose of the study was collected while at the same time leaving room for probing.

One of the strengths of interviews experienced during the field research was that they allowed the informants enough time to think through their responses and to seek clarification when necessary. As a result, people's personal experiences, life stories, and feelings were documented. Although I had not planned to collect life histories and testimonies from

informants, these were given spontaneously during the interviews an additional advantage of the interviews was that the informants were able to explain their feelings in their mother tongue.

### **1.6.2.3 Observation**

Throughout the field research I took note of my own experiences. These varied from my own reflections and interpretation of non-verbal cues of informants during in-depth interviews, FGDs and observations of the activities of the various support groups at Ruvheneko Programme. Observations were also made when I accompanied CBHC-VCGs over a period of two weeks during their routine visits to five households in Mahaso Village to provide care and support to PLWHA. These were valuable additional data collection opportunities, especially with regard to unravelling social and political norms and values.

### **1.6.2.4 Life histories**

After having established rapport with PLWHA, OVCs and CHBC-VCGs through FGDs and observation, people felt free to open up and share their personal experiences without fear of stigma and prejudice. A clear sign of this was when most informants preferred being called by their real names. The data collection process benefitted from five life histories which were voluntarily given by five infected and 3 affected orphans and vulnerable children during in-depth interviews. A life history is about the ‘unfolding history of one’s personal experiences’ (Abu Baker & Abdullah 2008: 4). Life histories also help in narrating and recounting a sequence of events. In this study, life histories generated thick layered information about how people contracted HIV, their experiences after testing positive, how Ruvheneko impacted on their lives, and also how they deal with community perceptions and attitudes about their status.

### **1.6.2.5 Use of secondary sources**

Apart from the collection of primary data, the objectives of this study also required collection of copious secondary sources. Among these were the reports of Ruvheneko Programme, End of Phase 1 Report: May 2003-March 2006 and Ruvheneko Programme Report on Key

Programme Achievements for the period 2003-2009. Also reviewed were St Theresa's Hospital Annual Reports of 1999, 2001, 2009 as well as the St. Theresa's Hospital PMTCT of 2009. As illustrated in 1.1 above, Ruvheneko Programme which was formerly St. Theresa's Home-based care has been cited by Jackson and Anderson as an example of basic standards of home-based care and optimal service delivery in resource constrained settings in Africa (Jackson & Anderson 2001). Literature on local newspapers headlines which portrayed Ruvheneko Programme positively were also reviewed (The Herald 2003; The Herald 2009 & The Tribune 2004.) It is this positive publicity in these reviewed literature which triggered my interest in carrying out further studies on Ruvheneko Programme, especially to learn how they have managed to successfully engage the community and sustain the programme given the failure of similar HIV and AIDS programmes in Zimbabwe (see 1.4 above) for Mutambara Mother and Child Survival Training and Programme Development by Mossinge & Gwaze 2007 as well as Rutendo HIV and AIDS Project in Gweru (see 1.4).

Also reviewed was literature on how various scholars define community engagement by first defining community (see 1.3.1; Bowen, Newenham-Kahindi & Herremans 2010; Chiplin 1996 & Cravaye 2002), and engagement (see Fawcett, Paine-Andrews, Francisco, Schultz, Richter, Lewis, Williams, Harries, Berkley, Fisher, & Lopez 1995 and UN 2008). The literature sources that were useful in defining the concept of community engagement were Centre for Disease Control (2011); Emmet (2000); Gran (1983); Jones & Willis (1997); Sakar (2010); Tindana, P, Singh, Tracy, Upshur, Daar, Singh, Frohilich, J & Lavery (2007) and Zakus & Lysack (1998). Reviewed literature discusses that Community engagement can be either in form of participation where community involvement is more bottom up, involving, empowering in order to be sustainable rather than top bottom and imposed by community members who will be on the receiving end (see 1.3.2; Cernea 1992; Chambers 1992; Emmett 2000; Midgley 1986 Swanepoel & De Beer 2006 & woelk 1992). Partnership as a form of community engagement is defined (see 1.3.3; Buchanan 1994; Crawford 2003; Lister 2000 and Zakus & Lysack 1998). All scholars unanimously agree that where partnership is genuine, there ought to be a working relation between the community and development workers which is characterized by willingness to negotiate, power sharing and mutual respect. This brings about a win-win situation for both parties. If these elements are lacking, partnership becomes a mere rhetoric and disempowers the community members.

Literature review in Chapter 2 covers the history of HIV and AIDS in Zimbabwe since the first identification of the virus in 1985 and this include works by Rembe (2006); United Nations Programme on HIV and AIDS (UNAIDS) 2002; 2010 & 2014; United Nations Development Programme (UNDP) (2003) & Zimbabwe National HIV and AIDS Strategic Plan (ZNASP) (2006). The severity of the impact of HIV and AIDS in Zimbabwe is demonstrated by the multi-sectoral approach adopted in the fight against the pandemic by the government (Lurie 2001; Khumalo-Sakututwa 2002; Zimbabwe Human Development Report (ZHDR) 2003 & ZNSP 2006) and the civil society (Broom & O'Brien 2011; Clifford 2004; Kaya 2007; Mupindu, Muvandi, Changunda, & Maphoshere 2003; Parry 2002 & Physicians for Human Right (PHR) 2003). Ruvheneko Programme's response to the impact of HIV and AIDS forms part of the civil society response to HIV and AIDS in Zimbabwe at grassroots level in the rural areas with the help of the Roman Catholic Church.

### **1.6.3 Data analysis**

Data was analysed qualitatively using a thematic approach. This was accomplished by linking the emerging themes to the data collected. These themes captured findings derived from research questions and objectives. Data was coded without 'trying to fit it into a pre-existing coding frame' (Braun & Clarke 2006: 83) or the researcher's preconceptions or theoretical interests which would make the approach analyst driven and deductive in nature (Hayes 1997: 112-113). The analysis was therefore data driven and all the themes which were derived were solely from data findings, whether latent or explicit.

Data analysis involved inductive scrutinising of raw data in order to identify themes on the operation of Ruvheneko Programme and how the community coped with the HIV and AIDS pandemic. The raw data was then organised or coded into categories and sub-categories that emerged from data gathering before the final analysis was done. The data was then matched and data networks were developed by bringing together ideas/views with the same meanings. I then mediated between the different meanings the participants gave and my direct observations and distilled them into the findings of the study.

#### 1.6.4 Ethical considerations

Ethics are the codes of conduct in research aimed at ensuring no harm to participants. Ethics can also be defined as a system of moral beliefs about what is right and what is wrong and a system of moral beliefs about what a researcher can and cannot do. It concerns professionalism when dealing with humans as subjects of research (Babbie 2007; Grant & Sugarman 2004). Since this study involved human subjects, I ensured that ethical concerns pertaining to voluntary participation, informed consent, confidentiality and anonymity were taken into consideration. Bennett, Glatter and Levacic (1994:93) assert that ‘research involving human subjects all requires that the participation of individuals be completely voluntary’. Informed consent implies that informants base their voluntary participation in research projects on their full understanding of the possible risks involved during and after the research proceedings (Babbie 2007). Before the research proceedings commenced, participants were all informed about the purpose of the study and that their participation was voluntary. They were informed that should they decide to disengage from the study, they were free to do so. Since participation was voluntary, consent was verbally given. All informants were above the legal age of majority which in Zimbabwe is eighteen years.

Confidentiality which involves the protection of information as provided by the participants (particularly sensitive and personal information) was maintained. Christensen (1994: 147) points out that ‘information obtained about the research participants during the course of an investigation is confidential unless otherwise expressed upon’. To ensure confidentiality and anonymity, all informants were assured that information collected from participants was at all times going to be kept confidential and used only for the purposes of academic research. The right of the informants to provide information on the basis of anonymity during focus group discussions, interviews, field visits and life histories was observed. In fact, all the names in this study are pseudonyms (not real names) except for Dr. Stoughton only, which is a real name because his name appears in the secondary sources of data and I did not get the opportunity to interview him.

In order to guard against researcher bias since I am Zimbabwean myself and I am familiar to the research area, I conducted debriefing sessions with my informants at the end of each data collection session. This helped in ensuring data trustworthiness since it allowed cross-checking

of the findings. Triangulation with regard to the different data collection techniques (focus group discussions, in-depth interviews, life histories, observation and field visits) allowed for greater trustworthiness of the data since emerging themes from one data collection method could be verified in another data gathering tool before conclusions were reached.

Although the use of focus group discussions in HIV and AIDS related studies raises serious concerns about privacy and confidentiality, most of the informants in this study actually preferred not to conceal their identities. Given the level of awareness on the importance of disclosure most of them preferred to be called by their real names. However, I decided to abide by the ethical principles regarding the disclosure of participants' identities. My decision was based on insights from Cohen and Manion (1994: 363) who advise on the need for researchers to ensure that participants in research which involves failure or moral inadequacy are not left humiliated, insecure and alienated than they were before taking part in the research.

### **1.6.5 Limitations of the study**

The write up could have been finalised soon after the field research in 2011 but due to health related problems which I experienced in between 2012 and 2013, I could not accomplish this. This actually explains the gap between the finalisation of my write up in 2014 and the time the field work was accomplished in 2011. Time and financial containments also prohibited me from visiting six other Ruvheneko Centres which were established in three other provinces by PACT ZimAIDS (see 1.2 above) as replicas of the St Theresa's Ruvheneko Programme.

## **1.7 STRUCTURE OF THE DISSERTATION**

The dissertation consists of four other chapters besides this current Chapter. A brief outline of the chapters that follow is given below.

Chapter 2 provides a broad discussion of the heightened attention to HIV and AIDS in Zimbabwe. It also pays attention to the human security ramifications of AIDS in Zimbabwe. The chapter provides an overview of the state of the HIV and AIDS crisis in Zimbabwe in

relation to the general causes and trends in Sub-Saharan Africa and the rest of the world. The chapter further explores the impact of the HIV and AIDS epidemic by discussing scholarly debates on the inordinate prevalence of the epidemic in southern Africa in general and Zimbabwe in particular. The chapter reflects on several responses to the epidemic by the Zimbabwean government, the private sector and local communities.

The prime focus of Chapter 3 is to proffer a detailed background on the establishment of Ruvheneko Programme as a rural initiative in responding to the impact of HIV and AIDS in Zimbabwe. The chapter examines how the transition from what was known as ‘St Theresa’s Home-Based Care’ to ‘Ruvheneko Programme’ resulted in a comprehensive rural response to HIV and AIDS. More importantly, the chapter examines the determinants and processes of community engagement which led to the establishment of Ruvheneko Programme. It further examines the rationale for the establishment of Ruvheneko by highlighting the roles of stakeholders such as the Chirumhanzu District’s rural community, the hospital leadership, and the Roman Catholic Church, among others who helped to spearhead the programme. This chapter builds from several in-depth interviews and focus group discussions which were conducted during the course of the field research.

Chapter 4 builds from the previous chapter by focusing on the various services rendered by the Ruvheneko Programme. These include voluntary counselling and testing (VCT), prevention of mother-to child transmission (PMTCT), antiretroviral treatment (ART), and specific services that cater for the psycho-social needs of the infected and affected. The chapter provides a critical analysis of the activities by highlighting opportunities and challenges in the day to day running of Ruvheneko Programme.

The objective of the last chapter, Chapter 5 is to provide a summative analysis of the study. It analyses emerging themes against the study objectives. This is accomplished by revisiting the findings from the preceding chapters. Chapter 5 further provides the study conclusion by reflecting on the research questions and by giving a summation of all the chapters in the dissertation as well as highlighting areas for further research.

## 1.8 CONCLUSION

The current chapter served to introduce the research by outlining the thematic background to the study. It also spelled out the aim and objectives of the study in view of the particular problem statement. The chapter provided an overview of some of the reviewed literature by explaining key concepts. The geographical study area was described before the different research methods are explained. This chapter also highlighted ethical considerations that guided the research process as well as limitations of the study before outlining the structure of the dissertation. The next chapter will give the historical background of HIV and AIDS in Zimbabwe since the diagnosis of the virus in 1985.



## CHAPTER 2: HISTORICAL BACKGROUND OF HIV AND AIDS IN ZIMBABWE

### 2.1 INTRODUCTION

Community engagement in response to the impact of HIV and AIDS at St Theresa's Hospital's Ruvheneko Programme cannot be discussed in isolation of the impact of the scourge of the HIV and AIDS in Zimbabwe. Available scholarly and empirical evidence shows that the HIV and AIDS epidemic has proven to be an unprecedented global human security crisis which has created multifarious problems as indicated by the harrowing catalogue of lives lost and reversal of hard-earned socio-economic gains. From its discovery in Zimbabwe during the early 1980s, currently approaching its fourth decade, the phenomenal scourge of HIV and AIDS has ravaged virtually every facet of human livelihood. The epidemic has permeated into the structure of economies, integrity of communities, viability of families and in extreme cases have called into question the survival of some states. This explains why the 2003 United Nations Human Development report (UNDP) posits that the scourge of HIV and AIDS should be treated as a human development issue, hence, human security. The 2010 UNAIDS report estimates that about 33 million people were living with HIV and AIDS with a staggering 22.5 million of these people being found in Sub-Saharan Africa, particularly southern Africa (UNAIDS 2010). The scourge of HIV and AIDS continue to ravage the African continent. Statistics of 2012 show that Sub-Saharan is the most affected by the HIV and AIDS epidemic in the whole with almost 25 million people believed to be living with HIV and AIDS. Statistically, this accounts for approximately 70 per cent of the total global infections (UNAIDS 2013).

In light of the above, the aim of this chapter is to provide an overview of the state of the HIV and AIDS crisis in Zimbabwe in relation to the general trends in Sub-Saharan Africa and the global world. This chapter sets out to explore the impact of the HIV and AIDS epidemic as well as the possible factors and dynamics that account for the inordinate prevalence of HIV and AIDS in southern Africa with particular reference to experiences in Zimbabwe. Pertinent to this discussion is a need to examine the responses of the Zimbabwean government, the private sector and communities to the HIV and AIDS crisis since the diagnosis of the first HIV case in 1985.

## 2.2 IDEAS ON THE ORIGINS OF THE HIV VIRUS

HIV and AIDS have variably impacted on world regions and has affected all humanity regardless of race, class and age. The literature also shows that HIV and AIDS has disproportionately affected certain population sub-groups like commercial sex workers, injecting drug users (IDU), men who have sex with men (MSM), and generally persons living in abject poverty (see UNAIDS 2002).

There is no precise explanation of the origins of the HIV virus which causes AIDS. Several explanations, theories and hypotheses have been propounded to unpack the genesis of the virus, but to date, there is no universally agreed upon position on the issue. A ten year research study conducted by Keele (2006) posits that the HIV virus originated in Africa. The study claims to have found a strain of the Simian Immunodeficiency Virus (SIV) in chimpanzees in Cameroon and further claims that the SIV is a viral ancestor to the HIV-1 that causes AIDS in humans (Keele 2006: 523-526). Lemey, Pybus, Wang, Saksena, Salemi and Vandamme (2003), basing their argument on a computer simulation model argue that the SIV was transferred to humans between the 1930s and 1940s as ancient hunting communities in West Africa got exposed to the virus through monkey meat which formed part of their diet. Scholars take the prevalence of Opportunistic Infections (OIs) like cryptococcal meningitis, Kaposi's sarcoma, tuberculosis and pneumonia in Kinshasa in the 1970s to indicate the existence of HIV in Africa (see Lamey et.al 2003).

Virologists who subscribe to this zoonosis theory claim that the presence of these now-known HIV and AIDS related OIs signify that HIV and AIDS was already present in Africa way before the first confirmed case was discovered in 1981 in the United States of America. It is further alleged that the nomadic and migratory tendencies of African societies catalysed the spread of the virus from West Africa especially to East and Southern Africa where the virus' spread was rapid due to labour migration, rapid urbanisation and consequently, the emergence of a 'devastating urban sexual network' (Iliffe 2006: 19). It is also argued that the patriarchal nature of communal African society fuelled the spread of HIV and AIDS in Africa as a result of polygamous marriages. Having many wives and children in traditional Africa was viewed as a symbol of manhood, wealth and power. The capitalist political economy brought by colonialism and the introduction of the migrant labour system, most prevalent in southern

Africa, exposed both men and women to sexually transmitted diseases (STDs) as it separated families. Initially, men left the family in the homelands for work in the towns and as the number of women increased in the cities (with no clear avenues of survival), the city became accustomed to such activities as prostitution, hence increasing cases of STDs and HIV and AIDS. As men in the cities became trapped in extra-marital relationships, the women who were left in the rural areas were also not spared from such activities, exacerbating the spread of HIV and AIDS (Piot 1987; Naucler 1989).

There are some scholars who have since been labelled as ‘conspiracy theorists’ who argue that the HIV and AIDS disease came as a result of the concerted laboratory efforts to genetically engineer biological warfare hardware (Graves 2001). Graves (2001) argue that HIV and AIDS are man-made. He further argues that the United States government through Doctor Robert Gallo began developing the HIV and AIDS virus code named ‘Special Virus’ with the intention of culling the black population and further argued that by 1976, 15 000 thousand gallons of the HIV and AIDS virus had already been bioengineered and was being ‘proliferated’. Robert (2001) remarks that HIV and AIDS was an ‘organized plague’, and a premeditated secret weapon which was meant to destroy humanity and this made HIV and AIDS a manmade disease. However, virologists have dismissed the bio-engineering account of the origins of HIV and AIDS as an uninformed political hypothesis which is yet to be scientifically proven. Despite all these contrasting explanations of the origins of the HIV and AIDS epidemic, scholars concur that it has caused untold suffering globally.

### **2.3 CAUSES OF HIV AND AIDS IN AFRICA**

Scholars have identified several causes of HIV and AIDS. Sexual behaviour, poverty, gender imbalance and inter-regional migration among other causes suggest that some cultural and religious beliefs and the colonial legacy of migrant labour are factors which are used to explain the cause of HIV and AIDS in Africa (Velayati, Bakayev, Bahadori, Tabataeli, Alaei, Farahboud & Masjedi 2007). Many studies on African AIDS epidemiology have reiterated that sexual behaviour is a risk factor contributing to the spread and prevalence of HIV and AIDS. As explained by the ‘sexual network theory’ multiple and concurrent sexual relations enhance the propagation and explosive capability of the HIV and AIDS epidemic (Douglas, Heckathorn,

Broadhead, Anthony & Weakliem 1999: 162). It is further argued that the probability of the epidemic's explosion is enhanced in situations where commercial sex, unprotected sex and cross-generational sex is embedded within the sexual network (Luke & Kurz 2002). In recent years, there is a view that lack of male circumcision as well as practicing dry sex are risky behaviours which enhance the progression and transmission of HIV (Weiss, Quigley, & Hayes 2000).

Several theories and explanations on the transmission of HIV and AIDS unanimously agree that heterosexual relations are the main mode of transmission (Webb 1997; Hunt 1996). This however does not rule out the efficaciousness of homosexual people and intravenous drug users. Furthermore, the issue of mother-to-child transmission (MTCT) should not be underestimated in as far as the spread of HIV and AIDS, particularly to infants. The Ministry of Health and Child Welfare (MoHCW) prevention of mother to child transmission (PMTCT) data base shows percentages of HIV positive women who were on antiretroviral (ART) to reduce the risk of MTCT; 6,6% in 2005, 22% in 2007 and 42,6% in 2009 (United Nations General Assembly special Session (UNGASS 2010: 7)

Migration is also singled out as a catalyst in the spread of HIV especially in light of socio-economic and political vulnerabilities in Africa which trigger non-voluntary large-scale movement of displaced persons (DPs) (Decosas & Adrian 1999; Lurie 2001, 2000). In the context of Zimbabwe, its economic crisis, human rights crisis, political violence and social distress have caused massive outflows of refugees from the country. By 2007, there were an estimated 3 million Zimbabwean refugees in South Africa, with an estimate of between 200000 and 300 000 in Botswana and many others seeking asylum elsewhere (Hanson 2008). This has the net effect of separating husbands and wives, destroying the family structure and increasing extra-marital affairs (see 2.2 above).

Scholars who subscribe to this view reiterated the importance of gender and power dynamics in explaining the high prevalence of HIV and AIDS in Africa. Mungwini (2008) argues that the radical patriarchal nature of Sub-Saharan societies is one of the factors which exacerbate the extent to which Sub-Saharan Africa is severely plagued by HIV and AIDS. Mungwini (2008: 204) is of the opinion that the patriarchal system condones high risk behaviour by allowing and even sanctioning certain high risk sexual practices at the same time weakening

the ability of women (the most vulnerable population group) to protect themselves from infection.

It is alleged that there is need for 'breaking the cycle of HIV infection using a broadened multi-sectoral development approach (Zimbabwe Human Development Report (ZHDR) 2003: 1). Building from the experiences of Zimbabwe and southern Africa, there is a conviction that development patterns affect the dynamics of how HIV and AIDS thrive in different environments (ZHDR 2003). This entails that statistics on AIDS in Zimbabwe and Sub-Saharan Africa as a whole should be understood in the context of poverty and other socio-economic vulnerabilities (Khumalo-Sakutukwa 2002; ZHDR 2003). Lurie (2001) and Webb (1997) argue that individual human behaviour is particularly determined by global, economic and political structures that act on an international and national level. They cite debt crisis, poverty, urbanisation, government policy and power relations within society as forces driving the spread of HIV. This speaks to the tight nexus between development and the spread of HIV and AIDS.

## **2.4 HIV AND AIDS TRENDS IN ZIMBABWE**

As mentioned before (see 2.1), Southern Africa is the world's highest HIV and AIDS infested region, which Zimbabwe is part of (UNAIDS 2005). In this respect, the first reported cases of HIV and AIDS in Zimbabwe were in 1985, when an estimate of 119 cases of HIV infections were recorded countrywide (Garbus & Khumalo-Sakututwa; Rembe 2006; UNAIDS 2002, ZNASP 2006). Since 1985, the HIV and AIDS epidemic spread rapidly throughout the country and the mode of transmission has been mainly heterosexual contact which constitutes 92 per cent, prenatal transmission 7 per cent and others 1 per cent (Rembe 2006; UNAIDS 2002 & ZNASP 2006). Statistically, Zimbabwe as a whole has been ravaged by the scourge of HIV and AIDS and studies on HIV and AIDS prevalence show that by 2005, national infection estimates were at 1 610 000 out of 11.6 million people living with HIV and AIDS. In addition, 55 per cent of those known to be infected were women between 15-49 years, while those between 15-29 years were rated as the most vulnerable (ZNASP 2006). The Young Adult Survey conducted between the period 2001-2002 revealed that the youth being the most sexually active are the most endangered group, with 18 percent of the youth between 15-24 years of age believed to be HIV positive (ZNASP 2006). By 2009, 1 187 822 adults and

children in Zimbabwe were living with HIV and AIDS according to The Zimbabwe Country Report and UN General Assembly reports of 2008 to 2009. In its illustration of the devastating impact of HIV and AIDS, UNICEF (2003) reported that about 1.3 million orphans were mainly HIV and AIDS related. This is also supported by the joint study conducted by the Ministry of Public Service, Labour and Social Welfare and UNICEF OVC (2003) which adds that 30 per cent of the children were orphaned by HIV and AIDS mainly in rural and high density urban areas of Zimbabwe. Recent statistics by the 2013 UNAIDS Global report on AIDS Response Epidemic indicates that 74 per cent of orphans are orphaned by AIDS.

Statistics as of December 2013 however, show gradual decline in HIV and AIDS prevalence. Estimated prevalence rate between the ages 15-49 was at 15 per cent (UNAIDS Global AIDS Response Country Progress Report 2014). Adult HIV incidence was pegged at 5.5 per cent in 1992, and dropped to 0.98 in 2013. This is attributed positive behavior change and high ART coverage. Further decline in new infections in children up to 15 years of age are a result of lower levels of both infection in women and mother to child transmission (UNAIDS 2014).

## **2.5 HUMAN SECURITY RAMIFICATIONS OF HIV AND AIDS IN ZIMBABWE**

The non-discriminatory and non-violent nature of HIV and AIDS threaten every facet of all human livelihoods. Price-Smith (2007: 1) asserts that HIV and AIDS increase stress or upon seriously affected societies, and might over time generate or exacerbate macro-level destabilisation. Since the first HIV and AIDS report in Zimbabwe in 1985, the proliferation of the epidemic had a direct bearing on the state's capacity to address the problem. It is alleged that there is a direct relationship between the population's health and the state's capacity to protect its citizens from such calamities as disease and where the state is incapacitated, population health declines as noted by Price-Smith (2007: 5). In the context of poor governance in Zimbabwe, characterized by, economic decline and low levels of political will to assure human security, the epidemic causes unrest among societies and this has a potential of threatening the state itself or compromising prosperity, political stability and national security (Price-Smith 2007: 2). In addition, mortality and morbidity caused by HIV and AIDS are said to intensify hopelessness and despair within the citizenry leading to the undermining of the government's legitimacy. Currently, there is rampant belief that the government of Zimbabwe

has failed to deliver on its responsibility to protect its people from all threats to human security including HIV and AIDS. This may explain why people prefer the opposition party, the Movement for Democratic Change (MDC) to the ruling Zimbabwe African National Union-Patriotic Front (ZANU-PF) as evidenced by the growing support of the MDC during the 2000 parliamentary elections, 2002 presidential elections and 2008 March harmonized elections. Rupiya (2006) reinforces that there is need for a more nuanced approach to fighting HIV and AIDS given the fact that it threatens state security and human security structures. In Zimbabwe for example, no sector has been left unaffected by HIV and AIDS, be it, health, education, agriculture, production, transport, mining or industry.

The tragedy with HIV and AIDS in Zimbabwe is that it is mostly affecting the economically productive population between the age of 15 and 49. Professionals, academics and skilled workers are the most affected thereby undermining the production of the country (McPherson, 2003). Arguing from a macro-economic perspective, Haacker (2002: 2) contends that HIV and AIDS have a long term impact on the country's development in view of the fact that the disease induced mobility and mortality reduce the gross domestic product and also causes 'depletion of tax payers'. At the micro level of households, it has been observed that there is AIDS-induced poverty in which most young and productive (15-49 years) are the most affected, resulting in child headed households (CHH) and widow or female headed households (FHH) (Bollinger, Stover & Riwa 1999). In terms of the social safety-net and household impact, Decosas and Adrien (1999) posit that the epidemic increases household expenditure on medication and funeral expenses thereby burdening widows. For most widows, they often loose property claims to their husbands' relatives when their husbands die (Izumi 2006). The disease has also stretched the African extended family system and as a result HIV and AIDS orphaned children (OVC) do not get adequate support from their relatives and they drop out of school as they assume adult or parental duties to fend for their families or sick parents (Andrews, Skinner & Zuma, 2006).

Price-Smith (2007) gives an elaborate discussion of the economic impact of HIV and AIDS and how it has affected the manufacturing, tourism, mining and agriculture sectors. For example, Zimbabwe's productive capacity in the manufacturing industry declined by 25 percent and the mining sector lost 20 percent of the mining output since 1999. Tourism earnings

also declined by 50 percent and this is attributed to the loss of skilled labour due to HIV and AIDS related illnesses and deaths.

Madavo and Sarbib (1999) allege that food insecurity in Zimbabwe is attributed to HIV and AIDS related deaths of skilled farmers while Price-Smith (2007: 5) adds that the HIV and AIDS epidemic has been contributing to economic decline, thereby, ‘exacerbating income inequalities and undermining social productivity’. Resources meant for agriculture are channelled towards HIV and AIDS medication and lowered productivity in the fields as time is spent taking care of the sick instead of manning the fields. The education sector is no exception since it is equally affected by the HIV and AIDS epidemic. Since 1980, the Government of Zimbabwe (GoZ) has invested a lot in educational infrastructure but due to the scourge of HIV and AIDS, skilled educators have been infected and some have died, leading to a decline in educational standards (Rembe 2006; UNAIDS 1998). In most tertiary institutions, degrees and diplomas are conferred posthumously as a result of HIV and AIDS leading to a gross loss on human capital. UNAIDS (1997) reports on how the HIV and AIDS epidemic has undermined the government’s capacity to maintain a healthy population in Zimbabwe and found that by 1997, 50 to 80 percent of hospital beds were occupied by people suffering from HIV and AIDS related diseases.

## **2.6 IMPACT OF HIV AND AIDS ON WOMEN**

HIV and AIDS in Zimbabwe impacts on men and women differently, with women being more vulnerable since they are socially and economic dependent on men. Zimbabwe is a patriarchal society and consequently patrilineal society. (Garbus & Khumalo-Sakututwa 2002; Mungwini 2008). This means that descent is traced through the father’s lineage and as such men assumes power and control of family affairs. Furthermore, there are strict controls which are placed on womens’ sexual behaviour while men are spared of such measures. A good example is on the issue of virginity. Men are free to enjoy their youth, sleeping around with a lot of girls before marriage, but the Shona culture is strict on the girl’s virginity on marriage. Customarily, among the Shona, a virgin girl fetches more in terms of bride price compared to a non-virgin. As a result, parents are stricter with their girl children when it comes to virginity. The case in point is Makoni District in Mashonaland East province where girls are forced to undergo virginity



tests every year. Surprisingly, the same is not done to boys. On a negative note, men from cities flock to Makoni District to marry the virgin girls, exposing them to HIV and AIDS. The belief particularly shared by traditional healers (N'angas/Sangomas) that a virgin girl can be used to cure HIV and AIDS has also seen the cases of rape of young virgin girls by infected men on the increase. Such a scenario places women at the risk of getting infected when they get married since their partners would have been exposed to sex long before themselves. It is also because of the same patriarchal practices that women tend to be labelled prostitutes if they try to negotiate when, if and how sex should take place (Chimhanda 2011: 828). Siwela (1991: 12-13) advocated for a critical examination of culture by asking an incisive question "Is this the Zimbabwe apocalypse? Before we had infanticide but now we have rampant child abuse. Which is the lesser of the TWO EVILS?"

Amaro (1995) explains how condom use is a sexual behaviour which is directly controlled by men in patriarchal societies and the social inequality between men and women make the latter feel inferior and unconfident to negotiate safer sex. This concurs with Garbus-Sakututwa (2002: 7) who points out that by the end of 2001, about 60% of the total HIV positive population were women. Findings from the research conducted by Garbus and Sakututwa-Khumalo (2002) revealed that about 14% of women who were married were in polygamous relationships (when a man has more than one wife) and this places women in such relationships at high risk of contracting HIV and AIDS. As observed by Chimhanda (2011: 44), the problem is worsened by the culture of silence which exposes women and the girls to sexual abuse by male relatives and they don't report the perpetrators, consequently placing them at a high risk of contracting HIV and AIDS. In most instances, women's willingness to challenge or refuse sexual relationships or define the terms of those relations is hindered by a combination of 'dependence and subordination' as well as lack of sufficient knowledge on sexual reproductive health of HIV and AIDS (UNAIDS 2002: 18). Fear of partner violence is also another reason given by Heise (2003) and Frieze & McHugh (1992) and such gender-based violence goes unreported in most cases.

One observation is that women's subordinate socio-economic status makes them vulnerable to contracting HIV and AIDS at a younger age than men. The 2014 Global AIDS Response Country Progress Report attests that the HIV prevalence rate in women between the ages of 15-24 is 1.5 times higher than in men. In the period of economic and political hardships in

Zimbabwe (2000 to 2009) women resorted to commercial sex work for survival. Sex work has become a means of survival as the country is still challenged by high levels of unemployment, especially among women (Duri, Stray- Pedersen and Muller 2013; Garbus and Sakututwa-Khumalo 2002 & ZNASP 2006). Duri *et al* and Mundi 2009 point out how women resorted to cross border trading, both regionally and inter-continental during the period 2000-2008, thereby rendering them vulnerable and prone to sexual abuse in the process. Statistics as of 2014 show that border towns, growth points, mining and resettlement areas remain high HIV and AIDS prevalence areas (Global AIDS Response Country Progress Report 2014). Chimhanda (2011) adds that most girl children who find themselves heads of families overnight after losing both parents resort to sex work to fend for their siblings. The unequal power relations which exist between the commercial sex workers and their male clients' make it almost impossible for them to negotiate for protected sex, again, placing them at high risk of getting infected by HIV and AIDS. This explains why 86% of sex workers tested HIV positive in Harare according to a research carried out between 1994 and 1995 (Chimhanda 2011). It is for these reasons that Baylies (2000) asserts that in order to understand the sources of women's vulnerability to HIV and AIDS infection, there is need to examine the link between their powerlessness and the risk to infection.

Women (mothers, grandmothers and girl children) as traditional care-givers find themselves overburdened with the caregiving role to their sick, dying and dead family members (women take the centre stage at funerals) (Chimhanda 2011: 827). Rural women are the most affected since even the town dwellers resort to their rural homes when they are sick to seek care and a decent death among their loved ones. Moreover, fear of stigma from fellow colleagues forces some HIV and AIDS patients in the towns to prefer to hibernate in the rural areas. The care giving role women assume are in addition to their daily chores especially in the rural areas where they also have to till the land, gather firewood and fetch water for long distances on a daily basis. The girl children often drop out of school to take care of their sick parents or to head the family in CHH of orphans and vulnerable children (OVC) and have to assume adult roles. This makes women and girl children the most affected and infected by HIV and AIDS especially in the rural areas where the women themselves also lack knowledge to protect themselves from contacting HIV through care for the infected.

## 2.7 HIV AND AIDS AND FOOD SECURITY

Food security can be defined as ‘year round access to sufficient food of appropriate nutritional value’ (ICAD 2001: 1). Food can either be produced through home production, that is, subsistence farming or having a paying job which provides remuneration enough for food security in the household. As the impact of HIV and AIDS is felt in every sector of human undertaking in Zimbabwe, the agricultural and food security sector has not been spared. The majority of Zimbabweans live in rural areas (more than 70%) where they rely on subsistence farming as their main source of livelihood (Broom and O’Brien 2011). Mutangadura, Mukuratiza and Jackson (1999) assert that HIV and AIDS is becoming a major threat on food security as it reduces agricultural productivity as well as it diminishes families’ ability to produce food. Despite the loss of labour due to ill-health and deaths, there is also reduction in time allocated for farming especially by women as they care for the sick through community home-based care (CHBC) in addition to their day to day duties in the farm. In some cases, farm assets and inputs such as draught animals, fertilizers, and ploughs are sold to meet hospital costs and to cater for funeral bills, leaving families more impoverished. In addition, HIV and AIDS erode the households’ resilience and ability to cope with other shocks, particularly as the asset base is eroded and livelihood options are reduced (Drimie & Gandure 2005). In child headed households (CHH), orphans and vulnerable children (OVC) fail to produce enough from agriculture like in the days when parents were alive because they lack the farming knowledge (Mugara & Gabayi 2011). Food and Agricultural Organization (FAO) estimates that between 1985 and 2020, Zimbabwe would have lost 23% of its agricultural labour force to HIV and AIDS.

Given all the challenges that the household faces due to HIV and AIDS, the overall outcome is food insecurity that is caused by the reduction of production and loss of income from household members employed in the agricultural sector and the rural areas are the worst affected as pointed out by Drimie & Gandure (2005). As a result, 65% of the rural populace is living in utter poverty and with the high HIV and AIDS related deaths of women in Chivi district in Masvingo Province there is high food insecurity, leading to about 48% of households relying on food aid from non-governmental organisations (NGOs) (Drimie & Gandure, 2005).

## **2.8 MULTI-SECTORAL RESPONSES TO THE SCOURGE OF HIV AND AIDS**

The response to the HIV and AIDS epidemic in Zimbabwe can be described as multi-sectoral as numerous actors have been involved at different levels albeit with varying degrees of success. The government and non-governmental actors have been collectively involved in trying to curb the scourge of HIV and AIDS through various initiatives ranging from prevention, awareness programmes, reducing new infections and abating the damage inflicted by HIV and AIDS.

### **2.8.1 Governmental responses**

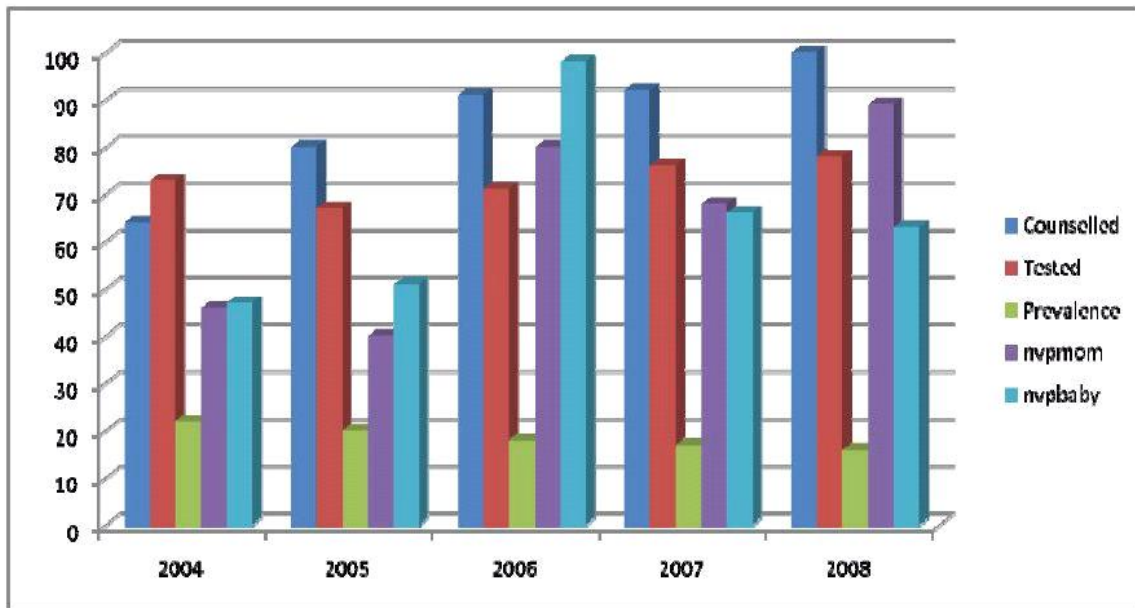
It is alleged that the spread of HIV and AIDS in Zimbabwe in the early phases was mainly due to the government's reluctance and lack of political will to formulate and implement measures to curb the spread of the disease. (Fourie 2006 & Marais 2000). Khumalo-Sakutukwa (2002) and Rembe (2006) concur that the reluctance to respond to the HIV epidemic was caused by the perception of the problem as being a health concern. However, from 1987, efforts were put to fight the disease. The National AIDS Control Programme (NACP) was established to coordinate and spearhead all the HIV and AIDS related programmes. Between 1989 and 1994, the Medium Term Plan managed to promote behaviour change and to expand the treatment of sexually transmitted diseases (ZNASP 2006). Another contribution from this development was the care and support of PLWHA and this also meant addressing cases of HIV and AIDS related stigma. In 1999 the National Policy on HIV and AIDS was introduced to formulate strategies to stop the spread of the disease. The most notable response to HIV and AIDS adopted by the GoZ was the formation of the Zimbabwe National AIDS Council (NAC) in 1999 and this establishment was through an Act of Parliament. In fact, the formation of NAC was to revamp the operations of NACP and this was complemented by the government's introduction of the AIDS Levy (Khumalo-Sakutukwa 2002).

According to the Ministry of Health and Child Welfare, the AIDS levy was meant to support HIV prevention and care for infected people (ZNASP 2006: 7). NAC's mandate was however, expanded to cater for PLWHA and the labour sector. In 2001, New Start Centers for HIV testing and counselling were established at strategic locations throughout the country. The

centers offered free voluntary testing and counselling to the public. The New Start Centers played a central role in making people aware of their HIV and AIDS status and this promoted positive living for those infected. In addition, the Prevention of Mother to Child Transmission Programme (PMTCT) was also launched in 2002. PMTCT is meant to prevent mother to child transmission of HIV during pregnancy and at birth through the pacification of the virus or through breastfeeding (Van Dyk 2008). One key area in which the GoZ excelled in its fight against the HIV and AIDS epidemic is on PMTCT. In 2003, the government then declared HIV and AIDS a national emergency and this helped in bringing awareness on the debilitating impact of the epidemic. The Zimbabwe National HIV and AIDS Strategic Plan (ZNASP), also established in 2003, gives an elaborate outline of the initiatives that were to be adopted by the government in response to the scourge of HIV and AIDS. The Ministry of Health and Child Welfare (MoHCW) and the National Blood Transfusion Services introduced the screening of blood as the first measure to combat HIV and AIDS transmission through blood transfusion. ZNASP (2006) further notes that NACP was complemented by public awareness of HIV and AIDS, training of health personnel in such areas like counselling and caring for people living with HIV and AIDS and interventions such as promotion of good behaviour change as well as epidemiological surveillance (ZNASP 2006: 7).

Through the establishment of the multi-sectorial national PMTCT Partnership Forum, mother to child transmission of HIV declined significantly between 2004 and 2008 as illustrated in Figure 3 below.

**Figure 3: Decline of mother to child transmission of HIV and AIDS in Zimbabwe (2004-2008)**



The National PMTCT Programme Database (UNGASS (2010: 19)

Recently, the GoZ developed a second HIV and AIDS Strategic Plan for the period 2011 to 2015 and this is meant to reduce the percentage of HIV infected infants born to HIV-positive mothers (*The Zimbabwe Herald*, 06 September 2011). Statistics by UNAIDS (2014) show an increase in PMTCT for HIV positive pregnant women. In 2009 it was 59 per cent, in 2012, 85 per cent and by 2013, 93 per cent. This progress is attributed to increase in access to ART for HIV positive women. As a result deaths averted by PMTCT increased from 2910 in 2011 to 5 400 in 2013 (UNAIDS, 2014) leading to reduction in HIV and AIDS related infant mortality rate.

In the light of human rights violations and HIV and AIDS related stigma, the GoZ took a number of legal measures in order to complement efforts in fighting the epidemic. In 2000, the Criminal Procedure and Evidence Amendment Act and the Sexual Offences Act were promulgated in order to criminalise the wilful transmission of HIV and AIDS and this applies even between husband and wife. Furthermore, a twenty years penalty was put in place for raping and those convicted of infecting their victims with HIV (UNGASS 2009). In 2006, the GoZ enacted The Child Adoption Act and this allows for HIV testing in children up for adoption. The idea is to protect the rights of the OVCs respectively. Another positive development in relation to fighting HIV and AIDS in Zimbabwe was the promulgation of the

Domestic Violence Act in 2007 and this criminalises all forms of violence from psychological, physical and sexual (UNGASS 2009: 15).

Stigma and discrimination associated with HIV and AIDS are some of the major setbacks in the global fight against AIDS. In that respect, the GoZ came up with the Statutory instrument (SI 202) of 1998 and the HIV and AIDS Policy of 2000. These pieces of legislation prohibit discrimination of HIV and AIDS positive people, as well as screening of HIV and AIDS for purposes of employment (UNGA-Special Session Report on HIV and AIDS, 2009). It is further provided that any HIV and AIDS oriented research should be sanctioned by the Medical Research Council of Zimbabwe. This addresses all the ethical concerns surrounding HIV and AIDS related researches (UNGA-Special Session Report on HIV and AIDS 2009).

Macroeconomic policies were also put in place following the intractable link between poverty and the spread of HIV and AIDS, especially that the spread of the epidemic is high under poverty stricken conditions. The GoZ introduced the National Economic Development Priority Program (NEDPP) from 2005-2007. This was replaced by the Zimbabwe Economic Strategy (ZES) in 2007. The Ministry of Finance also introduced Short-Term Economic Recovery Plans (STERP 1) and STERP II for the period 2010-2012 (Ministry of Finance 2009). These were all aimed at addressing the economic conditions of the country and also to improve the general human security conditions. In line with the aspirations of the Millennium Development Goals (MDGs), the GoZ developed a comprehensive National Behavioural Change Strategy (NBCS) for the period 2006-2010 with the aim of achieving less than 10 per cent HIV prevalence by 2010. The NBCS gives primacy to promotion of behaviour change in respect of transmission through increased leadership and gender equity as well as reduction of stigma associated with PLWHA. This also envisaged increased safer sexual behaviour and risk reduction (UNGA-Special Session Report on HIV and AIDS 2009).

The 2008 launch of the Zimbabwe National HIV Testing and Counselling Strategic Plan (ZNHTCSP), which aimed at providing comprehensive outreach programmes on counselling and testing, was also another governmental response in a bid to check HIV and AIDS transmission in Zimbabwe through voluntary counselling and testing (VCT) (ZNAC 2008). VCT in this case, is a tool for prevention, that is, if found positive, then the infected person is legally and morally bound not to deliberately infect their sexual partners and if found negative,

to keep away from high risk behaviour which makes one vulnerable to HIV infection. VCT in Zimbabwe is also used for screening positive people and link them into treatment if the CD4 count is below 200. The (UNAIDS) 2014 Global AIDS Response Country Progress Report shows a progression in the number of adults between the ages 15-49 who were tested and received results. In 2009, 1108264, while in 2012, 2240344 and the figures increased to 2274328 in 2013 (UNAIDS 2014: 8)

Another governmental response to the prevention of HIV infection is the introduction of voluntary medical male circumcision (VMMC) following the randomized controlled trials (RCTs) in South Africa, Uganda and Kenya which proved that MC though not a cure for HIV and AIDS, reduces chances of contracting the virus in males by about 60% (Sawires, Dworkine, Fiamma, Peacock, Szekeres & Coats 2007). The government of Zimbabwe through the Ministry of Health and Child Welfare introduced its mass male circumcision strategy in 2008. The scaling up of VMMC in its initial phase targeted state security forces like the army and the police and has recorded a positive response. Between the period May 2009 and April 2010, an estimated number of 6 070 men got tested and were circumcised. Statistics as of December 2013 show that 176, 604 men got circumcised and this translates to 14 per cent of the target of 1, 3 000 000 men between the ages 15-49 in the period 2012 to 2017 (UNAIDS 2014: 10). Given that Zimbabwe is a non-circumcising community, the 14% of the target reached so far would seem significant though this is too far from the set target of 80 percent of 1,300 000 required to achieve public health benefit from the VMMC programme.

Provision of ARVs is one area which the GoZ took to address the HIV and AIDS crisis. In 2004, MoHCW introduced nationwide provision of ARVs for those infected with HIV and AIDS. It is estimated that by December 2008, about 39.7 per cent of both adults and children who were HIV positive and eligible for ARVs were receiving ARVs. The number increased to 215 109 (56.8 per cent) in November 2009 (MoHCW 2009). By 2013, adoption of WHO guidelines by the government of Zimbabwe saw 77 per cent (618 980) of adults living with HIV and 46 per cent of children (46 319) of also living with HIV initiated on ART (Global AIDS Response Country Progress Report 2014). The government's response did not only end with prevention and treatment as discussed above. It also stretched as far as care and support for the infected with HIV and the affected orphans and vulnerable children (OVC), (The National HIV and AIDS Estimates, 2010). Previously, the GoZ had developed a National Plan



of Action for Orphans and Vulnerable Children (NPA of OVCs) and this was initially meant to render interventions such as education through the Basic Education Assistance Module (BEAM), medical, legal and psychological assistance. The success story recorded on the NPA-OVC programme is that by 2009 it managed to help more than 393 197 OVC (NPA-OVC 2009).

## **2.8.2 Civil society responses to HIV and AIDS in Zimbabwe**

The devastating nature of the HIV and AIDS pandemic in Zimbabwe has attracted not only government responses as discussed above, but also collaborated efforts from local and international Non-Governmental Organisations, Faith-Based Organisations and Traditional Healers Association among others.

### **2.8.2.1 NGO responses**

Zimbabwe like many other countries hit by the scourge of HIV and AIDS experienced an increasing role of NGOs in mitigating the impact of HIV and AIDS. Examples include the US President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund for the fight against HIV and AIDS, Malaria and TB, UNICEF, UNAIDS, WFP, Red Cross, MSF, Care International, Christian Care among others. Most of these donor agencies worked together with WFP and whenever food disbursements are made to the needy, HIV and AIDS patients, Child headed families and HIV and AIDS related orphans get the first preference. This has gone a long way in assisting immunally-challenged people with food, thereby boosting their immune systems (an important condition for the body to fight the HIV and AIDS virus). Church organisations and The Zimbabwe National Traditional Healers Association (ZINATHA) also came in with programmes to fight HIV and AIDS. The corporate world also took part by introducing HIV and AIDS related support programmes at workplaces. According to the Physicians for Human Rights (PHR) (2009), the role of NGOs in healthcare delivery system in Zimbabwe cannot be underestimated. Physicians for Human Rights (PHR) (2009) points out that UNICEF coordinated a number of critical interventions and sourced key inputs for the health systems especially towards the end of 2008 in response to the collapsing health system

in Zimbabwe. PEPFAR assisted Zimbabwe with its HIV and AIDS programme during this same period by supporting 40 000 patients with ARVs. The Medicines San frontiers' the Doctors without Borders help with medical staff, transport and other logistical support to hospitals and clinics throughout the country.

Through ZINATHA the Traditional Medical Practitioners Council was established and the organization managed to organize workshops throughout the country, educating its members on safe methods of healing like the use of gloves. It also discouraged its members from using sharp objects like razor blades and needles on more than one patient. The same workshop also raised awareness as to how traditional healers as health practitioners could be both at risk of getting infected as well as transmitting HIV. According to the WHO (1990) report, the workshop aimed at raising awareness on HIV and AIDS prevention, care among traditional healers and encourage them to share this knowledge in the communities they work in.

Since then, there has been a collaborative effort between the use of African indigenous knowledge systems of healing and the scientific knowledge systems in the fight against HIV and AIDS in Zimbabwe. Such a response is congruent with the call by the UNAIDS in 2000 for 'respectful attitude of open exchange of ideas and information' in the fight against HIV and AIDS in Africa. In the same fashion, several African governments responded to the call by the UNAIDS by forming collaborations such as Traditional Healers and Modern Practitioners Together Against AIDS in Uganda (where traditional and modern health care practitioners work together to fight AIDS and other diseases) and the Tanga AIDS Working Group (TAWG) in Tanzania (which strives to alleviate suffering of HIV and AIDS using indigenous knowledge). TAWG workers have been trained to test patients for HIV, treat them and provide counselling (Kaya 2007). It is further pointed out that the World Bank supported a Zambian initiative to conserve biodiversity for HIV and AIDS treatment through the establishment of botanic gardens and forest reserves for medical plants with some of the seeds coming from spiritual forests which have been preserved because of traditional values, norms and taboos associated with them.

### 2.8.2.2 Church responses

Churches run 45% of the National Health System and 68% of the rural health facilities in Zimbabwe (Parry 2002). These churches range from Roman Catholic, Methodist, Seventh Day Adventist and the Lutheran among other churches who are actively involved in HIV and AIDS work in Zimbabwe. The Zimbabwe Association of Church related Hospitals (ZACH), a medical arm which was formed in 1974 with the main objective of sharing common forum in order to render quality health care and service delivery to the most vulnerable groups especially those in rural areas. Initially, the churches in Zimbabwe were generally slow to respond to the HIV and AIDS pandemic mainly because being infected by the disease was seen as a punishment from God. The stigma associated with HIV and AIDS by the church made it more of a taboo to discuss issues of sexuality in the church environment and it was therefore left for the health sector to handle such issues. Consequently, the negative attitude on HIV and AIDS held by most Christians made infected people to hide their HIV status for fear of being excommunicated from the church. Churches were also against the use of condoms, arguing that it promotes prostitution and adultery.

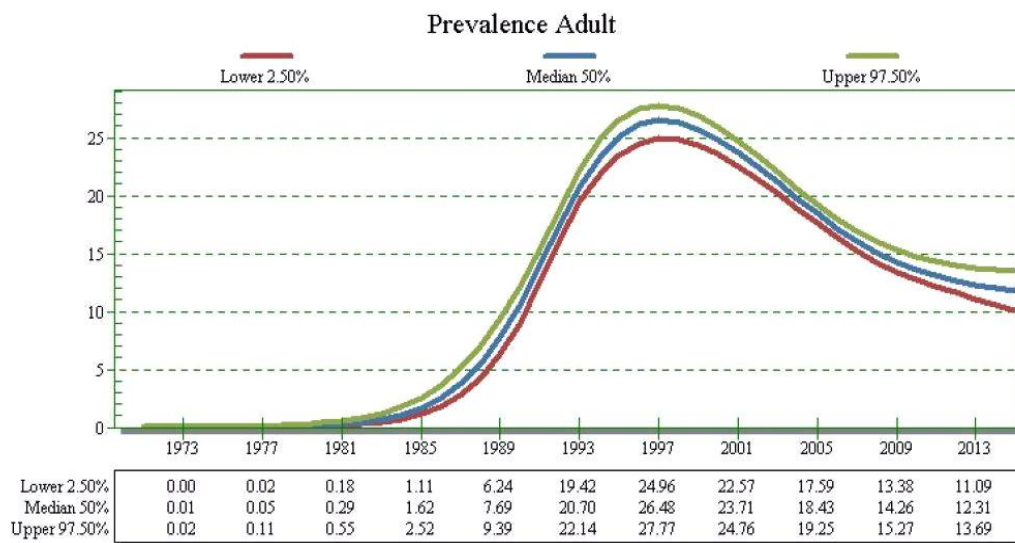
However, as HIV and AIDS continued to spread, infecting even church leaders, there was a growing realization that HIV and AIDS was not a curse from God. If anything, the church needs to comfort instead of condemn the infected and affected (Clifford 2004). Doing this would be a reflection of God's love and hope for all, hence, putting one's faith into action. Betty Gittens of the Methodist Church, during a Methodist Board of Global Ministries held on 8 February 2000 said, 'more than any other disease HIV and AIDS has proved its ability to disrupt the social fabric of the community'. As such, she helped to organize a consultation in Kadoma which focused on education, awareness and prevention training on HIV and AIDS which was sponsored by the Zimbabwe United Methodist Annual Conference.

The RCC which is also a leading member in education, justice, peace, poverty alleviation, health provision through its mission hospitals nationwide has done a lot in the field of HIV and AIDS (Parry 2002). Maluleke (2004: 59) asserts that the RCC is guided by the belief that the church is the body of Christ and if therefore 'part of the body is infected, then the whole body is affected and risks being infected'. Some Apostolic church movement as noted by (Mupindu 2003: 15) started to change some of its practices such as polygamous marriages. Although the

church responded late to the fight against HIV and AIDS in Zimbabwe, churches are now indeed actively involved and according to Broom and O'Brien (2011), their concerted efforts have contributed to the reduction of the HIV and AIDS incidence rate from 25,6% in 1996 to about 13,7% in 2009. St. Theresa's Hospital is among many others which are scattered throughout the country and it is credited for coming up with the first rural HIV and AIDS programme under the auspices of Ruvheneko Programme.

In general, there is convincing evidence that HIV and AIDS in Zimbabwe has become everyone's child and there is collaborated effort between the NGOs, the GoZ, churches, traditional healers and communities in trying to fight and reduce the impact of the epidemic. This collective effort has led to decline in cases of new infections in the country. The adult population infections declined from an estimated at 23.7 per cent in 2001 to 18.4 per cent in 2005 and 14.3 in 2009 (UNGASS 2010). Figure 4 below shows the decline of infections among people aged between 15 and 24 years.

**Figure 4: Decline in HIV and AIDS Adult prevalence in Zimbabwe**



UNGASS (2010:11)

## 2.9 IMPEDIMENTS TO RESPONSES TO HIV AND AIDS IN ZIMBABWE

Despite efforts by the government, NGOs and the corporate sector in fighting against HIV and AIDS, several problems have been experienced and in some cases efforts were even reversed as will be discussed below. Some of the major problems include the political crisis which culminated into economic decline and social distress between 2000 and 2009. When looking at the human security implications of the crisis situation in Zimbabwe, it can be noted that the health sector was among the most affected to the extent that by 2008, the health delivery system in the country was in chaos (Mlambo & Raftopoulos, 2010). Deterioration of health care service provision in most parts of urban suburbs needs also to be understood in the context of politicisation of the public service sector. Civil servants especially municipal workers responsible for refuse and water supply were recruited on partisan grounds, mostly after getting indoctrinated in ZANU-PF ideologies, just like the national youth service (Coltart 2007; Physicians for Human Rights (PHR) 2009). In light of the political incompatibilities between the ruling party ZANU-PF and the MDC, it can be argued that the politicisation of the public service eroded professionalism in the health sector and benefitted ZANU-PF card carrying members only.

This can be understood as some form of scorched earth policy whereby MDC supporters suffered while their ZANU-PF counterparts were cushioned from economic hardships. The government deliberately withheld the provision of services and amenities as a way of punishing the residents for not voting for ZANU-PF as well as to sabotage MDC development activities in the urban area (PHR 2009; Zimbabwe Association of Doctors for Human Rights 2009). The collapse of the health sector exerted a huge toll, especially with the outbreak of cholera between August 2008 and June 2009. The U.N. World Health Organisation's March 2009 report reveals that over 98 500 cases of cholera and 4 300 cholera related deaths were recorded since the outbreak of the pandemic. MDC strongholds in Harare such as Glen View, Budiriro, Chitungwiza and Highfields experienced a high incidence of cholera cases and this was attributed to government negligence.

The alleged embezzlement of US\$ 7.3 million by corrupt government officials indicates another challenge to effective responses to HIV and AIDS. This money was part of the US\$ 12, 3 million humanitarian aid allocated to the government of Zimbabwe under the Global HIV

and AIDS Fund to combat HIV and AIDS, malaria and TB. This maladministration of public funds resulted in a shortage of ARVs in government hospitals. The Physician for Human Rights Report (2009) noted that doctors at government hospitals initially resorted to switching patients from their established regimes of treatment based on drug availability not on clinical need. The misappropriation of the Global Fund resulted in the disruption of ARV supplies thereby leaving the few people enrolled for ART vulnerable to life-threatening adherence inconsistencies and consequently drug resistance threats. The embezzlement of HIV and AIDS funds also led to withholding of the Global HIV and AIDS Fund and other donor funds which were indispensable in the fight against HIV and AIDS in Zimbabwe. UNAIDS which administers the Global Fund actually withheld releasing Zimbabwe's allocation of the Global Fund until the US\$7.3 million was reimbursed in 2008. In its struggle for political survival, the government of Zimbabwe channelled most of its resources to military and political projects, instead of investing in health (Coltart 2007). One example is the 2008 incident when ZANU-PF opted to import military equipment from China while the bulk of the country was facing a serious health care decline (Du Plessis 2008). The health crisis was also galvanized by what can be loosely termed 'politics of the last supper' when security services and other ZANU-PF leadership having been shocked by the MDC victory in the March 2008 harmonized elections, scrambled for the scant resources. It can be alleged that ZANU-PF elites want to milk all the available resources so that the MDC should have a difficult start as a new ruling party.

The political and economic crisis in Zimbabwe adversely impacted on HIV and AIDS prevalence in Zimbabwe. Since the crisis, Zimbabwe recorded the highest percentage number of HIV and AIDS orphans globally (The United Nations Children's Fund 2006). The decline in the health sector resulted in increased child mortality rates from 76 to 132 deaths per 1000 live births between 1990 and 2005 and a decline in life expectancy from 63 years in 1990 to 40.9 years in 2005 (Mlambo & Raftopoulos 2010). Despite progress made in awareness programmes, especially high condom usage, in recent years, the high mortality rate has been linked to HIV and AIDS (UNAIDS 2007). It is further alleged that despite a success story on the high uptake of antiretroviral drugs (ART) in Zimbabwe poor diet and food insecurity disrupt the effectiveness of the medication. The Zimbabwe government is allegedly said to have introduced the AIDS levy, but the funds are channelled for political ends (Physicians for Human Rights 2009).

Shortage of healthcare facilities for water treatment and a massive exodus of skilled health personnel due to economic stress, all contributed to health care collapse (PHR 2009). The deterioration of the national health system did not only affect governmental response to HIV and AIDS. Basically some NGOs like PEPFAR relied on a functional national health system to roll-out and sustain their own operations. In this regard a collapsed health system posed a dual challenge to the HIV and AIDS response with both national and NGO programmes being hampered. This was evident in 2008 when virtually all government hospitals were closed leaving no point of ARV or VCT distribution.

The crisis in Zimbabwe had a huge toll on rural women living with HIV and AIDS who found it difficult to access ARVs. This had been attributed the low income levels in rural households (IRIN News 2008). The 2003 Zimbabwe Human Development Report (ZHDR) attributes the slow progress in combating HIV and AIDS to economic stagnation, citing such policies like ESAP, sanctions and the general poor economic performance in the post-2000 political dispensation in Zimbabwe (ZHDR 2003) This means that improving the economic condition will be the way to go, given several affinities between the spread of HIV and AIDS and poverty. Slow progress in combating the spread of the epidemic also attributed to the fact that since the discovery of the first incidence of HIV and AIDS in 1985, the epidemic has remained largely the preserve of the health sector alone. A more nuanced approach that engages all sectors of society is required since the epidemic knows no boundary. Some people in Zimbabwe still live in denial and would not bother knowing their status (ZNASP 2006). Such kind of behaviour militates against all the concerted efforts in the prevention, care and treatment of HIV and AIDS.

The government position on the gay community needs special accommodation in Zimbabwe. It is legally constituted that the GoZ does not recognise the gay community and this intensifies their marginalization. Despite the effectiveness of all the legal developments on HIV and AIDS, the policies and statutory instruments are criticised for excluding 'sub-populations' like commercial sex workers, gay people and intravenous drug users. In fact, homosexuality is deemed illegal in Zimbabwe and this has excluded men who have sex with other men and transgendered people from the general government HIV and AIDS programmes. In fact, since 1987, the Zimbabwean President, Robert Mugabe has criminalised homosexuality and in 1995 was quoted in *Global Post* saying, gay people behave 'worse than dogs and pigs' and publicly

announced that gays and lesbians must be arrested (Skoch 2012). Dunton and Palmberg (1996) point to the anti-gay attitude of President Mugabe when he referred to the Zimbabwe's Gays and Lesbians of Zimbabwe (GALS) as an association of sodomists and sexual perverts. In fact, to him, allowing GALS freedom was as good as allowing drug addicts to operate freely under the auspices of human rights and he would not allow that in Zimbabwe as he publicly announced during his Book Fair Opening speech of 1995. Given the fact that lesbians, gays, bisexual, transgendered and intersexed people (commonly known as LGBTIs) represent a fair share of new HIV infections in Zimbabwe, there ought to be a revisit on this issue, starting on policy so that LGBTIs be in a position to access health facilities and seek information on HIV and AIDS like all other citizens in Zimbabwe.

This section has demonstrated that the unstable political situation in Zimbabwe largely contributed to the poor health system that was experienced after 2000. In fact, political crisis is singled out as the major impediment to fighting HIV and AIDS in Zimbabwe and this may imply that without a lasting solution to the crisis, all efforts to prevent the spread of HIV and AIDS will be fruitless.

## **2.10 CONCLUSION**

This chapter provided an overview of the situation of HIV and AIDS in Africa at large and Zimbabwe in particular. The origins and causes of the virus which causes AIDS were explored. Whilst the causes of the spread of the virus can be explained, its origins are still not known. Among the causes and factors which contribute to the spread of the virus, unprotected sexual relationships with concurrent partners have been singled as the most prevalent. However, other factors like culture, religion, migrant labour system, rape and homosexuality also contribute to the spread of HIV. On the impact of the disease, the chapter show that the young and economically productive people between the age of 15 and 49 are the most affected, with triple effects on the economy and the well-being of the country as production is negatively affected. The impact on women and children is also high as they represent the most vulnerable groups in society. The nature of the Zimbabwean society being predominantly patriarchal leaves little room for women to decide on sexual issues and this exposes them to infection. High levels of unemployment among women also makes them more dependent on their male counterparts,



affecting their bargaining power for safe sex and sometimes forcing them into sex work. It has also been shown that the economic crisis in Zimbabwe since 2000 made most people food insecure thereby increasing their vulnerability to HIV and AIDS. Despite the multi problems presented by the disease to the people, the chapter presents how the government and the civil society responded to the HIV and AIDS pandemic, though with varying degrees of successes. Among the major challenges experienced in the fight against HIV and AIDS, the political and economic crisis in Zimbabwe in the new millennium has been singled out as the major stumbling block in winning the war against the disease. This however does not suggest that other problems like culture, religion and unsuitable community engagement programmes do not stand as challenges in the fight against HIV and AIDS. It is from this background that the next chapters discuss the establishment, role, activities and successes of St. Theresa's Ruvheneko Programme as a community response to HIV and AIDS.

## **CHAPTER 3: THE ORIGIN AND STRUCTURE OF RUVHENEKO PROGRAMME**

### **3.1 INTRODUCTION**

The previous chapter examined the impact of HIV and AIDS in Zimbabwe since the discovery of the virus in 1985. It pointed out that HIV and AIDS impacted on every facet of human security and had a huge toll on all the age sectors. The chapter illustrated that at first the fight against HIV and AIDS was limited to the health sector and later on a multi-sectoral approach involving non-medical stakeholders was adopted. The prime focus of this chapter therefore is to proffer a detailed background on the establishment of Ruvheneko Programme. It outlines that what is now Ruvheneko is a transition from St Theresa's home-based care (HBC) which was initially the hospital's own initiative meant to ease pressure from the overwhelming number of HIV and AIDS patients. The chapter further examines the genesis of the idea of Ruvheneko, its stakeholders, vision and mission statement. It further sets out to determine how the partnership between Chirumhanzu rural community, the hospital leadership, the Roman Catholic Church and other concerned stakeholders helped to spearhead the programme. This chapter is informed by several in-depth interviews as well as focus group discussions which were carried out. Information was obtained from Ruvheneko Programme staff, the infected and affected as well as from available written documents on Ruvheneko. The information in this chapter illustrates how Ruvheneko Programme managed to sustainably engage community members despite the failure usually associated with most HIV and AIDS community engagement projects.

### **3.2 THE ROLE OF THE ROMAN CATHOLIC CHURCH IN THE FIGHT AGAINST HIV AND AIDS IN ZIMBABWE**

The church in Zimbabwe was slow in responding to HIV and AIDS and this was mainly because of the fact that the epidemic was perceived as a preserve of health practitioners alone. More so, cultural and religious taboos on open discussions around sex and sexuality acted as a hindrance to the church's positive involvement in the early days (Parry 2002). Initially, HIV and AIDS was construed as consequences of sin and as a result, the belief was that the epidemic

was not the community or church's responsibility but rested solely with the individual, hence, the stigma and discrimination against people with HIV and AIDS. Such an attitude led to a general delay in effective church response and exacerbated stigmatisation of the affected and infected persons.

Parry (2002) however notes that the Roman Catholic Church has been involved in HIV and AIDS issues through its various mission hospitals all over Zimbabwe, especially in the remote, hard to reach rural areas. It is further noted that the social arm of the Bishop's Conference and the Catholic Development Commission (CADEC) have been actively involved more than the Methodist, Dutch Reformed and Apostolic Faith Mission churches in HIV and AIDS work (Parry 2002). Priests and seminarians have been brought on board as key stakeholders and have been work-shopped and trained through attending winter schools which are meant to cover current HIV and AIDS related topics. This was meant to equip them with the necessary skills for conducting counselling sessions and support home-based care (HBC) and other related programmes run in various parishes.

The Zimbabwe Catholic Bishops' Conference (ZCBC) has made joint pastoral publications notably, *Save our families, 1991* and *Responsibility-Honesty-Solidarity April 1997* which were released covering issues of sexuality, youth, staying faithful in marriages and behavioural change as well as condom distribution. In 2002, the winter school produced a booklet called *The body of Christ has AIDS*, showing clearly how the church stands in solidarity in the fight against HIV and AIDS without segregation. The winter schools involve all Catholic Religious Congregations nationwide as well as the National Catholic Health Institutions involved in HIV and AIDS work. Their main functions are to give participants an opportunity to discuss and share experiences, learn from each other, thereby improving their service delivery in the HIV and AIDS related work. The church, through its winter school in 2002 came up with a Participatory Strategic Planning Framework specifically meant for situation analysis and scenario mapping/setting in the Roman Catholic Church's response to the impact of HIV and AIDS nationwide (Parry 2002).

All Roman Catholic Mission Hospitals are members of the Zimbabwe Association of Church related Hospitals (ZACH), a medical arm which was formed in 1974. Its main objective is to share common forum in order to render quality health care and service delivery to the most

vulnerable groups especially those in rural areas and to have a common voice vis-à-vis the Ministry of Health (ZACH Constitution 2010). It coordinates all the activities of Mission Hospitals, 124 of them nationwide 119 of which are rural based and 5 are in urban centers. Churches run 45% of the National Health System and 68% of the rural health facilities in Zimbabwe (Parry 2002). St Theresa's Mission Hospital forms part of the 68% of mission run rural hospitals, situated in a very poor densely populated rural area of Chirumhanzu District.

In order to satisfy one of the key objectives of this study, the next section examines the origins of St Theresa's Ruvheneko HIV and AIDS Centre. Worth noting is that Ruvheneko is renowned as the first rural initiative in Zimbabwe to step up to the challenge of HIV and AIDS in rural Zimbabwe.

### **3.3 RATIONALE FOR THE ESTABLISHMENT OF RUVHENEKO CENTRE AT ST THERESA'S MISSION HOSPITAL**

St Theresa's Hospital where Ruvheneko Centre is situated is run and owned by the Roman Catholic Dominican Missionary Sisters of the Sacred Heart of Jesus in Gweru, making it a faith-based organisation. It was founded in 1957 with 42 beds but has expanded to 188 beds since 2009. St Theresa is one of the three major hospitals within Chirumhanzu District in addition to Muvonde in Driefontain (located north of the District) and Mvuma Hospital, which is found at the Rural District centre. The Hospital is located 70km west of Masvingo town.

According to one St. Theresa's Hospital Senior Official Mr Tigere, initially, Theresa's Hospital had an internal HIV and AIDS arrangement called St Theresa's Home-based care (HBC) which was meant to educate people on the dangers and impact of HIV and AIDS. This was mainly managed by professional nurses who conducted domicile visits to discharged patients. Pertinent to the discussion of the origins of Ruvheneko is the need to account for the social environment under which the idea was crafted. This was exacerbated by lack of knowledge of the disease and expertise on how to care for the sick. More importantly, most of the government-led programmes on HIV and AIDS did not cater for the needs of rural people. The fact that the hospital was overwhelmed by the number of HIV and AIDS related illnesses and that a number of sick people were discharged and left to be taken care of in their homes by untrained relatives, compelled the community, church, and the hospital to join hands in the

fight against HIV and AIDS (Report of the Ruvheneko Programme on its Achievements for the period 2003-2009). At this stage, it is pertinent to unpack the socio-economic activities in the catchment area of Ruvheneko Centre.

Ruvheneko Centre marked a remarkable paradigm shift in the Christian understanding of the HI virus and AIDS. It has been observed that traditionally, Roman Catholic Church was known for preaching against the use of condoms, but at St Theresa's Hospital, the Dominican Sisters played a pivotal role in trying to bridge the polemic divide between orthodox Catholic beliefs and the reality of HIV and AIDS. This explains the severity of the HIV and AIDS crisis not only in Chirumhanzu, but in Zimbabwe at large. It was no longer an issue of exalting traditional norms and values of the church at the expense of people's lives. It was out of this humanitarian conscience that this profound paradigm shift became necessary in the eyes of priests, nuns and ordinary church members who used to believe that HIV and AIDS was a punishment from God. The impact of the HIV and AIDS pandemic in Chirumhanzu District led to the hospital staff members and church members to acknowledge that the only way to curb the deadly disease was to make HIV and AIDS everyone's responsibility; from individual, family, community up to national level. The only way they could preach this gospel to the ordinary community members was to involve them in the initiative for action speaks louder than words.

### **3.4 SOCIO-ECONOMIC ACTIVITIES IN CHIRIMANZU DISTRICT**

A profile of the location and the catchment area for Ruvheneko Programme is important in accounting for its origins. Chirumhanzu District consists of several villages and communities that survive on subsistence farming and this is due to erratic rains and the general aridity of the environment. A small number of people domesticate animals such as donkeys, cattle, chickens, and pigs. During the colonial period up until 1999 when the government of Zimbabwe introduced the Fast Track Land Reform Programme (FTLRP), many people used to be seasonal workers on the surrounding white owned farms, returning to their homes. Because of the general increase of the levels of unemployment caused partly by the FTLRP and the closure of White-owned industries as a result of political violence in the country, most unemployed people from the villages turned to gold-panning for survival. With the proliferation of gold panning in the Mvuma (Chirumhanzu Central), Zoma (Chirumhanzu north) and Mutenderende

(Chirumhanzu South), many people resorted to gold panning and these people assumed the name *Makorokoza* which literally means informal gold-diggers.

Proximity to Mvuma mining town and the discovery of gold at Mutenderende village promoted a significant commercial sex industry and this intensified the spread of HIV in the most of the villages in the District as gathered in a focus group discussion (FGD) with community home-based care (CHBC) voluntary care-givers (VCG) on the 13 December 2010. It emerged in the same FGD that the spread of HIV and AIDS in the area was exacerbated by some liquor business operators who allegedly hired sex workers from places as far as Harare and Chiredzi to come to entertain the illegal gold-panners (*makorokoza*) at places like Charandura Growth point in order to attract customers. Upon discovering the new arrivals, most men allegedly engaged these sex workers and in turn returned to their wives, with a high probability of having contacted HIV and AIDS from the sex workers. This resulted in high rates of infections and transmission of HIV and AIDS in the area. As a result, the hospital was on the receiving end and its incapacity to tend to many patients at the same time was another factor that played a part in the establishment of St Theresa's HBC project which later transformed into Ruvheneko Programme. The increase in the number of HIV and AIDS related deaths and those falling sick in the mid-1990s due to the scourge of HIV and AIDS were signs through which the hospital authorities and the Roman Catholic Church together with the community were compelled to establish what came to be known as the St Theresa's HBC project in 1995. The number of out-patients visiting the hospital was also another motivating factor for establishing the HBC project as well as high death rates from HIV and AIDS related illnesses - see Figure 5 below for HIV related deaths in the period 1996-2002.

**Figure 5: Deaths resulting from HIV and AIDS related illnesses, St Theresa’s Hospital, 1996-2002: St Theresa’s Hospital Annual Report (2002).**

Year	HIV and AIDS related deaths per year
1996	133
1997	136
1998	146
1999	178
2000	188
2002	146

HIV and AIDS had claimed many lives in the rural areas of Zimbabwe, Chirumhanzu included. Figure 5 shows the average deaths per year in the period 1996 to 2002 which saw the establishment of St. Theresa’s HBC project. An average of 15 people died every month, translating to an average of four people dying from AIDS related illnesses every week. However, the decline of the deaths from 188 in 2000 to 146 in 2002 could have been caused by the awareness which was part of the efforts of St. Theresa HBC Project and later Ruvheneko Programme.

### **3.5 INITIAL ACTIVITIES OF ST. THERESA HOSPITAL**

Initially, the hospital nurses made domicile visits to discharged patients but they became overwhelmed and could not cope with their daily hospital duties as well as home visits. It is worth mentioning that HBC activities started as informal arrangements by a women’s prayer group of the St. Anne Sect locally known as *Madzimai Enzanga yaAnna* (women of St. Anne’s Sect of the RCC). *Madzimai Enzanga* is made up of married women, who have wedded in the Roman Catholic Church and this makes them a distinct and the most respected group of women in the church. They are senior and respected compared to the St Mary’s Sect and St Monica’s Sect. St. Mary’s Sect is made up of young and unmarried girls, mostly in their adolescence and St. Monica’s Sect is made up of the women who are either divorced or widowed. These women are renowned for their charity work both in the church and for the community at large and are

highly regarded as the engine of the church. They meet every Thursday for prayer sessions as well as community service where they are involved in helping the poor and sick with prayers, food stuffs, and clothes as part of their charity gestures. Upon realising that the hospital nurses were overwhelmed by the increasing number of HIV and AIDS patients, they took over the domicile visits that were conducted by the nurses. They started helping with tasks like bathing the sick, doing laundry, praying for the sick, watering gardens, weeding in the sick's fields as well as providing food stuffs. According to Mai Mukuru (the leader of *Madzimai Enzanga*), "it is a religious obligation to care for the sick and the poor". In an interview, she told me that "*kutenda kusina mabasa kwakafa mwanangu*" (faith which is not supported by good works is dead my daughter). The point being made in this context is that acts of charity are considered as good deeds which are a reflection true faith. It forms part of the Christian ethos to fulfil humanitarian responsibilities in order to substantiate one's Christian values.

Involvement of women prayer groups marked the origin of HBC in 1995, though informal at that stage. On this note, it is important to define the concept and praxis of HBC. The practical definition of HBC according to the WHO envisages any form of care given to ill people within their homes. It means that care can be given by professional or non-professional people to ill patients in the comfort of their homes. Mohammad and Gikonyo (2005: 2) add that

'HBC is care given to individuals within their own environments by their families while supported by skilled welfare officers and health personnel to meet physical, health, spiritual, material and psycho-social needs. In essence, HBC is established as a form of community response to the impact of HIV and AIDS'.

The HBC model at inception in 1995 was however informal in the sense that the hospital assisted families to cater for their sick loved ones and they were neither given any special training nor resources to do such tasks. Since the HBC programme was more of a self-help mechanism, there was no structured or organised way of assisting HIV and AIDS patients. While the nurses made the home visits an extension of their hospital duties, HBC was considered as a mode of the mission hospital's health delivery, what Blinkhoff, Bukanga, Syamalevwe, and Williams (1999: 11) refer to as 'hospital-based outreach'. The initiative taken by the church women was grounded in the ethic of volunteerism. As a result, the role of taking care of the sick in their homes shifted from HBC to CHBC upon realising and appreciating the effectiveness of the home visits by the church women. The hospital personnel played more of a technical and supportive role.



CHBC relied heavily on volunteers from the community who gave their services for no payment. They took care of the sick by visiting discharged patients' homes and providing palliative and spiritual care to them. The notion of volunteerism in this context has its foundation in religious practices as the faithful are expected to render assistance to the sick members of society. In addition, most of the volunteers are church members who are pushed by biblical teachings such as 'love always protects, always trusts, always hopes, always perseveres' (1 Corinthians 13:7) as forwarded by the St. Anne's Sect leader. From the interviews and focus group discussion with the women of St. Anne's Sect, *Madzimai Enzanga*, most of them do voluntary work out of altruism, the need to show empathy and love for the sick without getting any material gains in return. They in turn get a feeling of self-worth by earning respect from the community instead of money. Volunteerism is thus religiously construed as putting one's faith into practice.

There is also a traditional explanation of volunteerism in Chirumhanzu where volunteering is seen as a duty enshrined in cultural and community values. It is regarded as a sign of *ubuntu* translated in Shona as *unhu* or *hunhu* meaning 'responsible human being' (Kaseke and Dhemba 2007:91). Mbiti (1969:1) asserts that volunteerism appeal directly to Africans' natural religiosity rather than their material self-interest. Volunteerism has thus seen homes shunning away from the individualistic or inward looking families to ones based on collectivism. During an interview with one of the leaders in Mahaso Village, he gave the following idiom which he said fosters cooperation among his people: '*chaona hama hachisekanwi*', which literally means that, you do not need to laugh when your neighbour is in trouble. Among the Shona communities, the idiom is used to discourage the community from spitting or laughing at those who are poor or experiencing a problem, like illness or disability. The idiom was later adopted in order to warn people against laughing and discriminating against People Living with HIV and AIDS (PLWHA).

According to the Mahaso Village leader, the philosophy is based on the belief that if one laughs at someone infected by HIV and AIDS, then in future, it might be that person or his/her relatives suffering from the diseases and would be in need of community support. Helping others is thus seen as some kind of 'social investment' since there is hope that community members will reciprocate the good deeds should one need the same help in future. It is this sense of

community belonging which encourages many to participate in community work. In addition, the notion of kinship and extended family among the Shona is another motivating factor for volunteers in taking care of their loved ones. There is a belief that people on their death beds need to be surrounded by their loved ones.

Youth who are out of school and unemployed also find some sort of occupational duties by being involved in CHBC in addition to religious and cultural motivations. They said that they feel occupied when they make daily visits and meet with others of their age rather than getting bored sitting at home since they are unemployed. During a focus group discussion with 10 youth members, one of the youth commented that ‘...instead of drinking beer and smoking *dagga* (cannabis), I rather give back to my community something they can cherish by taking care of the sick’. These young people have taken some duties involving HIV and AIDS awareness campaigns. They are also involved dramas and role plays in schools. Apart from this they also distribute condoms as well prevention pamphlets with information related to the disease. They also hope for employment in future should the programme expand and get more funding. Some even admitted to have joined Ruvheneko after 2003 when some volunteers were employed through the funding of Canadian International Development Agency (CIDA) and Swedish International Development Agency (SIDA) through Pact ZimAIDS. The reopening of St Theresa Nursing Training School has seen most of the volunteers with the opportunity to train as nurses because they were given first preference in the recruitment of nurses.

The active participation of the young people according to one of the senior counsellors at Ruvheneko, Cephas has been a noble practice since the youth are ‘fast to learn, implement and give feedback’. The Counsellor also commented that the integration of the youth and the elderly in CHBC gives a sound transition of caregiver heritage to the coming generation, thereby, assuring the continuity of the programme even after the older members have left. Another aspect that motivated the youth is that most families had been haunted by the HIV and AIDS epidemic as they nursed their loved parents without much knowledge and watched them die in their arms. As a result, they got motivated to get training so as to have the necessary know-how on the management of HIV and AIDS in the homes. In this case, experiences of the disease motivated many to volunteer for the CHBC since they were convinced that after acquiring CHBC knowledge, they could take care of their sick loved ones. One of the Ruvheneko Programme staff members Ruth attested to have joined CHBC after testing positive and gave

birth to an HIV negative baby. She gave a testimony that she volunteered to become a caregiver as a way of paying back to the community by using her own experience as a living testimony. ‘There is life after testing positive, pregnant mothers who are HIV positive need not deny themselves, but to continue to look after themselves and their unborn babies’, she said.

In 2001, St Theresa’s CHBC program had 67 volunteer care-givers which assisted 817 clients and 2700 AIDS orphans, according to the *Narrative Report on Key Project Achievements 2003-2009*. Significantly, by 2002, 132 volunteer care-givers had been trained and had served 2 932 patients and distributed over 200 HBC kits (gloves, bed sheets, towels, napkins, disinfectants and detergents) (Mupindu, Muvandi, Changunda & Maphoshere 2003). Noteworthy is the fact that even men who are not usually associated with care giving traditionally formed part of the 200 care-givers at Ruvheneko in 2010 (34 men and 166 women). The HBC project thus brought a paradigm shift in the traditional gender roles of leaving household chores like fetching water and caring for the sick for the women and girl children only. The positive contribution of men in CHBC is also acknowledged in the *Narrative Report on Key Project Achievements 2003-2009*.

CHBC VCGs were tasked with the identification of the needy and the sick in their respective villages so that the Ruvheneko Programme could provide them with material support as well as emotional support through home visits. Other duties included assisting immediate family members on how to care for the terminally ill, for example, bathing and feeding them. The existence of CHBC has created a long lasting solution to providing basic needs for the chronically ill especially in resource constrained settings like Chirumhanzu.

In retrospect therefore, members of the community understand volunteerism from a biblical, cultural, traditional and personal context but all contributing positively towards solving community problems, including HIV and AIDS.

### **3.6 TRANSITION FROM ST THERESA’S CHBC TO RUVHENEKO PROGRAMME**

The introduction of the CHBC activities described above witnessed a reduction in stigma and discrimination of people living with HIV and AIDS in the area. They felt supported psycho-

socially, spiritually, medically, physically and materially in their lives and began to open up about their status without fear of prejudice and rejection. As a result more and more people in the community became attracted to the project. The hospital board then realised the need to expand and formalise CHBC activities. The first step in the formalisation process involved sourcing funds from overseas which support the order of the Roman Catholic Nuns (Mupindu *et al.* 2002). They also applied for inclusion into the PACT-SIDA CHBC programme and were successful (Mupindu *et al.* 2003). After securing funding they then engaged on the process of recruiting more CHBC volunteers through the church parishes and *madzisabhuku* (village leaders) for training. So, the CHBC who were trained were elected by the various villagers who saw them fit to represent them.

As pointed out by Cephas, the training of CHBC was meant for capacity building in order to strengthen local community responses and encourage participation, which was more of a bottom up approach than a top bottom imposition. HIV and AIDS awareness campaigns continued through poems, drama clubs and preaching on various themes like the impact of HIV and AIDS on individuals, friends and family; behaviour change; traditional practices and cultural norms which fuel the spread of HIV and AIDS and ill-treatment of orphans and vulnerable children as well as safer sex negotiation skills. The exploration of these themes helped to break the silence about HIV and AIDS which indeed was not an easy topic to talk about openly because of associated stigma and discrimination. Tapera, one of the youth who takes part in raising awareness through dramas and poetry pointed out that

‘The poems and dramas which we do as part of the awareness programme in the community attract people to listen because people are entertained and at the same time are learning more about the HIV and AIDS’.

This approach augers well with what Goldstein, Usdin, Schleepers & Japhet (1999) refer to as edutainment in their discussion of the role of entertainment in HIV and AIDS education. They talk about how music and drama for example can be used as vehicles for both entertainment and educating people about HIV and AIDS, as in the case of Ruvheneko. This was the beginning of the collaborated effort in the fight against stigma and discrimination that had exacerbated the raging virus.

During the first CHBC volunteer training workshop, it is reported in the *Ruvheneko Report on Key Project achievements 2003-2009* that the then Hospital Superintendent, Dr. Stoughton

(real name) gave the background on the impact of HIV and AIDS in Chirumhanzu and how the high prevalence rate had seen so many people visit the hospital well above its capacity. Members of Ruvheneko Programme acknowledge that Dr. Stoughton was the pillar to the founding of the programme which he served wholeheartedly until 2009 when he resigned because of old age. He further appealed to the community at large to assist with the role of caring for the sick regardless of religious affiliation, gender and age. Mr Tigere who is one of the hospital officials pointed out that with the hospital serving about 50 000 inhabitants, that is, in its catchment area, it was recording about 140 HIV and AIDS related cases per day and it became the busiest hospital in the district. Following the volunteer training workshop, a tripartite partnership was formed which consisted of the Mission Hospital, the Roman Catholic Church, and the community (including schools, villages, local chiefs, village headmen and the police) in order to fight the HIV and AIDS pandemic in a more holistic way, medically, spiritually and socially.

The positive outcome of the CHBC project prompted all stakeholders, the hospital, the church and the community to propose a name for the HBC project. Given the fact that St Theresa's CHBC had expanded its activities to include testing through VCT, ART, catering for OVC, PMTCT and psycho-social services (PSS), there was need for a neutral name which described the integrated programme which had evolved from a project to programme. The process of choosing the name involved consultation with the community members who freely participated in coming up with three names, namely *Ruponeso* (Bringing back life), *Rusununguko* (Independence) and *Ruvheneko* (Light) were suggested at a local stakeholder meeting which involved the Ministry of Health and Child Welfare (MoHCW), Chirumhanzu Church Leaders Association (CCLA) representatives, chiefs and headmen, the Ministry of Education (MoE) represented by school headmasters and school health masters and Pact ZimAIDS representing the funders that is the CIDA and the SIDA. Through the voting process, the name Ruvheneko got the most votes.

Key to unpacking the origins and rationale for establishing the Ruvheneko Centre is the need to address the etymology of the name Ruvheneko as it is understood in the Shona language. *Ruvheneko* in Shona language designates 'light', 'giving light or 'brightness'. There is also a religious meaning ascribed to the name Ruvheneko wherein the former St Theresa's Hospital and patron for Ruvheneko, doctor Stoughton linked the name Ruvheneko to the biblical context

in John verse 12 which reads ‘I am the light of the world’ (Heal the Sick ,2003). The idea of linking the light to HIV and AIDS was meant to give people hope and courage in the fight against HIV and AIDS. Campbell (2009) adds that the idea of Ruvheneko was invoked against the backdrop of trying to meet the needs of the infected and affected in their homes and families so that the light and warmth brought to them by care-givers brings hope and help to combat fear, desperation and stigma associated with HIV and AIDS. The biblical traits in the founding of Ruvheneko illustrate the synergy between the community and the church in the battle against HIV and AIDS.

More importantly, there was a generic label attached to the patients and people involved in HIV and AIDS projects, calling them *Vanhu veAIDS* which means people with AIDS. This label caused stigma and most of the CHBC members who were not infected were not comfortable with the name *Vanhu veAIDS* (people with AIDS). The name Ruvheneko therefore, helped to address also these concerns as it promised hope and a sense of collectivity among various stakeholders. Both the infected and affected could now work well without any negative connotation as expressed by one of the community leaders, Mr. Gore during my interviews with him. Mr. Gore is among the people who played a pivotal role in the establishment of Ruvheneko as was pointed out by Ruvheneko Programme personnel, St Theresa’s Hospital officials and the leader of the St. Annes Sect.

Another senior staff member of Ruvheneko programme, Garapo pointed out how community mobilization became a key factor to sustaining community home-based care. In other words, the HIV and AIDS pandemic taught the Chirumhanzu community to be unified in order to address the challenges of the disease instead of shifting the blame and discriminating the infected and affected. CHBC also eased the rural households which were generally poor of the financial burden for hospitalisation of their patients in terms of the drugs and the transport costs to and from the hospital. Furthermore, CHBC was seen as a way of improving the quality of life for the PLWHA especially with the provision of CHBC kits which contained gloves, bed sheets, towels, napkins, disinfectants and detergents which were outsourced from donors by the missionaries.

The understanding at this point was that of forming an effective partnership between the ‘users’ and ‘providers’ so as to support grass root responses to the devastating impact of HIV and AIDS in the community. One of the senior counsellors at Ruvheneko, Cephas said;

‘The collaborative efforts of the community, the church and the hospital professionals in both leading and implementing the programme is the source of Ruvheneko’s success and sustainability since they were and are still working as equal partners in the day to day running of the programme’.

The formalisation of CHBC also came with infrastructural and human resource development in 2003. Through funding from Pact ZimAIDS, two vehicles were bought to allow easy mobility as well as the building of Ruvheneko Centre where testing and various support groups operate together with various programme activities to date. In the past, CHBC did not have its own infrastructure but was housed in the main hospital where counselling took place and blood samples were drawn. At this point, blood samples were sent to Bulawayo for results since VCT infrastructure was under construction. The funder also employs eight salaried staff to run the programme under the leadership of the Programme Coordinator (PC). The Programme Coordinator in turn reports to the Hospital Administrator because Ruvheneko remains an extension of hospital work and does not operate in isolation of hospital activities. These eight are regarded as full time level of effort employees because they are full time occupied with Ruvheneko Programme work only. In fact, the programme is considered as any other department of the hospital, hence, its privilege to enjoy the support of hospital technical staff as pointed out by one of the senior members of St. Theresa’s Hospital, Mr. Tigere. The hospital personnel are not paid by Pact ZimAIDS since their level of effort to Ruvheneko is 50%, as rightly pointed out by the Hospital Senior Official. However, it is also worth stating that the founding of Ruvheneko Centre was not without resistance from other community members. It was faced with various challenges which will be discussed below.

### **3.7 SET UP CHALLENGES OF ST. THERESA’S RUVENeko PROGRAMME**

The establishment of Ruvheneko faced a lot of challenges. There were a number of social, cultural, economic and political factors which hindered the smooth implementation of the Programme. Furthermore, the negative attitudes about the HIV and AIDS were some of the

obstacles in the catchment area. The sick were hidden by relatives in their homes for fear of stigma and the shame the disease was perceived to bring to the family. As a result, many people died and witchcraft and evil spirits were the prime causes according to them. The features/characteristics of their sick relatives made them believe that a *chikwambo* (goblin) was draining blood from the sick person that's why they had become skinny with curly/weak hair, expressed one of the Dominican Nuns, Sr. Lizzie who was active in the formation of Ruvheneko Programme.

She further pointed out during the in-depth interviews how she remembered a few years back when they made village visits only to find sick relatives locked away, unattended to and denied access. Relatives were shy to be associated with an HIV positive or AIDS patients because of the stigma which was associated with HIV and AIDS. The researcher learnt that it was through these continued community engagement and community sensitisation activities like HIV and AIDS related dramas which were conducted in schools, at the hospital and in church during and after mass, poems, capacity building workshops as well as CHBC volunteer care-givers' door to door dissemination of HIV and AIDS information which led to an attitude change towards PLWHA.

Religious beliefs in the area which is largely Christian were other obstacles to the establishment of Ruvheneko. The shift by the church from prohibiting the use of condoms to allowing the use of condoms as well as distributing them received varying reactions from church members especially the elder members. In an interview with *mai mukuru* (the leader of St. Anne's Sect), she said that initially, the community thought the church was now promoting promiscuity by taking initiatives in distributing condoms as many Christians and Catholics included still saw HIV and AIDS as a 'punishment from God'. As a result, the majority of Roman Catholic Church members were not in support of condom distribution. In an interview with one woman who belongs to the Apostolic Church in the Mahaso Village, it was pointed out that the move by the Roman Catholic Church to distribute condoms was wrong and unchristian. To her, condom use goes against her Christian ethos and it influences the youth to indulge in early sexual activities instead of abstaining from sex.

Cultural beliefs and practices as noted above were also an impediment to the establishment of Ruvheneko Programme in the early days. Women who were pregnant who were found to be



HIV positive faced discrimination and had to be forced to breastfeed their children after delivery. In the Shona culture, a woman is always expected to breastfeed her child after delivery, otherwise she is suspected of witchcraft or unfaithfulness to her husband during pregnancy. Some people still hold this view up to now although others now understand that there are circumstances where the mother cannot breastfeed, and one of such a condition is when the mother is HIV-positive. One of the informants who participated in a focus group discussion of VCGs and is HIV positive reported to have been forced by her mother-in-law to breastfeed her child against the doctor's instruction after delivery. 'For fear of being divorced, I breastfed my baby', she said wiping her tears. She later on lost the baby to HIV and AIDS and she strongly feels that her baby had good chances of survival since she was on PMTCT during her pregnancy. A nurse at St. Theresa hospital, Ms. Sello said that other cultural practices which fuel the spread of HIV and AIDS include *barika* (polygamy), *kugarwa nhaka* (widow inheritance) and *chimutsa mapfihwa* (forcing of the wife's young sister to marry her deceased elder sister's husband). According to her, these cultural beliefs and practices derailed progress in the establishment of Ruvheneko Programme.

Ms. Sello also blames socially constructed gender imbalances as another factor which impeded progress during the initial stages of the formation of Ruvheneko programme. Being a patriarchal society where there is male domination in all spheres of life, women and girls in the Chirumhanzu area like any other part of Zimbabwe are more vulnerable to HIV infections than men. Their economic dependence on men makes especially the young girls prone to forced sex and engaging in commercial sex work. Married women are equally vulnerable as they fail to convince their husbands to use condoms even if they have evidence that they have been unfaithful to them. One of the HIV positive Ruvheneko programme staff member, Ruth, during in-depth interview with her gave her own testimony of how she tested positive and was placed on ART. Her husband refused to get tested but demanded sex from her, unprotected for that matter. Knowing very well that there is the danger of 're-infection and increasing my viral load, I refused', she said. She however still felt very unsafe and endangered in her own home. She is an example of a woman who after getting tested, was put on treatment and made knowledgeable about HIV but remained endangered to her husband. He insisted that he had married her and paid *lobola* to her parents and this gave him conjugal rights over her. Most women when faced with such a challenge fall prey and cannot stand against their husbands because of cultural beliefs and fear of being divorced.

The period of Ruvheneko's establishment was also marred with economic challenges which haunted the whole country. Since 2000, to the time of Ruvheneko's formal establishment in 2003, Zimbabwe experienced hyper-inflation to the extent of wiping out the Zimbabwean dollar and replacing it by temporary money, called bearer cheques. These were cheques which were printed by the Central Bank of Zimbabwe to act as currency when the real Zimbabwean dollar was rendered worthless because of hyperinflation. Buying programme stuff became a problem and fuel shortages negatively affected home visits as well as food distribution in the various centres of the catchment area to the sick who needed such support. The programme managed to survive in such difficulty because of the donor partner, Pact ZimAIDS who paid salaries for staff in US dollars. They travelled to the neighbouring South Africa to buy programme stuff like detergents, gloves, sheets, uniforms and incentives.

The political terrain was quite rough as well and some programme staff were allegedly harassed by the ruling party, Zimbabwe African National Union- Patriotic Front (ZANU-PF) since they were suspected of being opposition party members. It is at this time that the government introduced an NGO bill which constrained the operations of donor partners and NGOs. Political violence was rife and there was no respect for the sick let alone funerals, said one of the programme staff, Cephass. Through all these difficult circumstances, Ruvheneko Programme managed to thrive and its contribution to the fight against HIV and AIDS went as far as district, provincial as well as national levels. It is for this reason that it attracted so many other partners in addition to Pact ZimAIDS like Oxfam GB, WFP, Global Fund and the MoHCW. Involvement of donor funders made the expansion of Ruvheneko and provision of food aid to HIV and AIDS patients as well as OVC possible. The donors however were merely external agents of change because they found the programme already integrated and in existence.

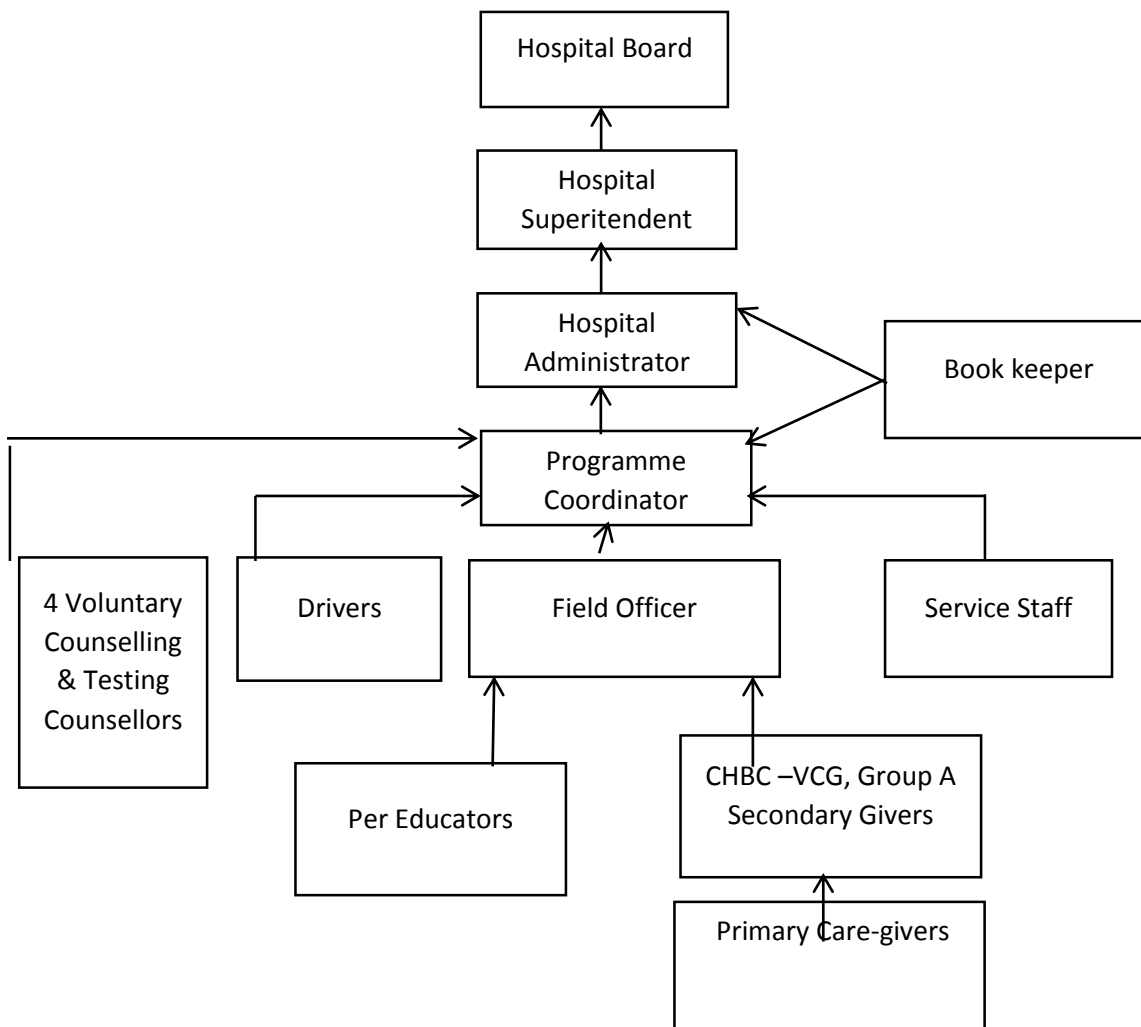
It was also reported by Manwere (2009) in the local newspaper, *The Herald*, that Ruvheneko Centre is the first successful rural based institution to implement PMTCT and that 80% of pregnant mothers volunteer to get tested. Garapo, one of the senior staff members at Ruvheneko programme revealed that the effectiveness of the programme had prompted one of the donors, Pact ZimAIDS to design a Comprehensive Rural Church and Community HIV and AIDS Prevention, Care and Mitigation Programme called Ruvheneko in the other provinces of Zimbabwe. He referred to all the other six centres which were opened as their replica as their

‘off-spring’. In the interest of time and available resources, I did not manage to visit any of the ‘off-spring’ sites. The Ruvheneko programme primarily targets rural communities hitherto ignored by mainstream HIV and AIDS interventions. The overall goal of the programme is to level the rate of new HIV infections in Zimbabwe and develop community momentum and competence for progressively reducing HIV transmission and mitigating the effects of HIV and AIDS within the rural communities. The rural population in Zimbabwe is deprived of many services and travels to towns to access these, VCT alike. Thus, with the Pact ZimAIDS establishing the Ruvheneko Centers nationwide in conjunction with the Roman Catholic Church, Lutheran and United Methodist Mission Hospitals, their efforts have gone a long way in assisting the rural community members to become self-aware of HIV and AIDS.

### **3.8 ORGANISATIONAL STRUCTURE OF RUVHENEKO PROGRAMME**

Due to the fact that Ruvheneko Programme is a branch of St Theresa’s Hospital, the programme coordinator reports to the Hospital Administrator who in turn reports to the Medical Superintendent. The Medical superintendent also reports to the hospital board as is shown in Figure 6 below. All the staff of Ruvheneko is salaried except CHBC supervisors, volunteer care-givers (VCGs), primary care-givers and peer educators who provide their service without any financial compensation, voluntary workers. These voluntary workers are at times given food aid together with PLWHA and second hand clothes donated by the Dominican Sisters’. All the job descriptions below are as they were described by the Hospital Senior Official, Mr Tigere as well as what I observed the various occupants of the positions doing during my research. Although my descriptions give the ideal, I am aware of some power dynamics and variations in what staff members are expected to do and what they actually do. For the purposes of confidentiality and anonymity, I did not capture any of their voices for they will be easily identifiable.

**Figure 6: Organogram of Ruvheneko Programme**



### 3.8.1 Hospital Board

The hospital board holds the reins in the governing and running of the Ruvheneko Programme. It consists of The Hospital Superintendent who is a medical doctor, the Hospital Matron, Sister-in Charge, Hospital Administrator, Mother Superior of the Dominican Sisters, Project Coordinator and two nursing sisters from the outpatient department and maternity ward, Leadership of Chirumhanzu Church Leaders Association, the chief and village heads as well as Pact ZimAIDS representative representing the donor funders. This board meets quarterly to review the work of the programme, proposals to funders and progress reports. All the board

members are virtually active, that is, they participate in the day-to-day running of Ruvheneko. The Out-patient Department nurses and the Hospital matron for example are actively involved in workshop designing and facilitation for CHBC trainings.

### **3.8.2 Hospital Superintendent**

The current Hospital Superintendent took over soon after the retirement of Dr. Stoughton in 2009. Dr. Stoughton however remains the patron of the hospital and he, together with his wife Loretta conduct occasional visits to the hospital and is still the overseer of the Ruvheneko Programme. Currently, he lives in Plant City in Florida, United States. Every year he visits St Theresa's Hospital for a month to evaluate how all the programs are going although I did not get to meet him personally. By the time I embarked on my research, he had already made his yearly visit to Ruvheneko. Moreover, he is still raising funds to help the hospital to continue to function at a high level in spite of tremendous difficulties within the country. More importantly, doctor Stoughton is now on the technical side conducting monitoring and evaluation upon his yearly visits in what he calls 'Let's see how things are going' trip (Dick and Loretta Stoughton 2011). The transition from doctor Stoughton to the current Hospital Superintendent occurred without any disturbances to the progress of the Ruvheneko Programme. The Hospital Superintendent has maintained responsibility of taking care of the sick and the orphans and vulnerable children (OVC). He has also become a good mentor of the younger doctors employed at the institution.

The Hospital superintendent oversees the operation activities at St Theresa's Mission Hospital as well as the whole of the treatment program (both ART and PMTCT). He is responsible for the formulation of all operational policies and internal procedures which have to be complied with. All programmes are run in fulfilment of the government's Ministry of Health and Child Welfare (MoHCW) policies and guidelines. It therefore means VCT, administration of ART and the day to day running of Ruvheneko are done in compliance with the department of health's standards. For example, to make sure that all clients attending VCT are being pre-advised or pre-test counselled and written consent is being sought before one is tested and that each client receives post-test counselling before results are disclosed. The Superintendent, together with the hospital board ensure that they secure funding from external stakeholders for

the running of the Ruvheneko Programme, donation of drugs and food for the infected clients as well as OVC. He is also the one with the final say in the issuing of drugs be it ART to positive clients whose CD4 count would have been found to be below the recommended number (200 for all people) or for pregnant mothers (below 350 for PMTCT). The Superintendent also participates in the hiring of program staff as well as staff training sessions on regular basis like CHBC courses, training of trainers and effective communication skills to CHBC-VCG.

### **3.8.3 Hospital Administrator**

The Hospital Administrator post is responsible for drawing up budgets for the various projects; VCT, HBC, peer education and OVC as well as submitting them before the hospital board for approval. She is responsible for creating work schedules for program staff, that is, both the salaried staff (program coordinator, HBC field officer, VCT counsellors, the bookkeeper, the driver and general hands) and non-salaried staff (CHBC-VCG supervisors, CHBC-VCGs and peer educators). The HA manages finances, budgets for the various projects, workshops and processing of programme material like flyers, booklets and brochures, manages the payroll system as well as scheduling programme events, workshops and training for various stakeholders like peer educators. In addition, she organises and coordinates meetings with both internal and external stakeholders on the financing of the program as well as accounting for given funds. The HA is also responsible for writing minutes and project reports in the absence of the Programme Coordinator for internal and external evaluations and impact assessments for all funded projects.

### **3.8.4 Programme Coordinator**

The Programme Coordinator is responsible for coordinating the daily running of the programme in line with laid down policies and procedures that is, putting plans into action. He is the one directly involved in the training of programme staff, CHBC field officer, VCT counsellors, CHBC supervisors, VCGs and peer educators. He is also the one who does the planning and execution of food distributions and writing reports on how all projects are running

which he then presents to the HA. He also gives progress reports of all projects and keeps HIV and AIDS statistics in high confidence. Some of his duties like minute taking in programme meetings and report writing overlap with that of the HA and they work hand in glove in the running of the programme.

### **3.8.5 Book Keeper**

The book keeper manages the program finances of the day-to-day running expenses. She also maintains bank account records, reconciles bank accounts and balances and chequebooks for the various program grants as given by the donors on a monthly basis. In addition, she prepares various accounting summaries and reports for monthly submissions to the PC and HA, who she reports to. She helps the HA in preparing budgets and proposals for the various programme activities like workshops, travels, trainings and purchasing of programme staff.

### **3.8.6 CHBC Field Officer**

The CHBC Field Officer post is responsible for managing the CHBC-VCGs in the various villages. She ensures that the CHBC-VCHs are making their weekly visits (which are usually done every Thursday) to HIV positive clients. There is one CHBC supervisor in each village that was chosen by the people through the office of the Village Headman and there are 10 of these in the St Joseph Centre. In addition, the villagers have chosen two CHBC-VCGs who help the primary care-givers in their role of taking care of the sick. All these report to the field officer (FO) who in turn reports to the PC as will be illustrated on the organogram below. The FO monitors the work of CHBC supervisors through making visits to their respective villages they are responsible for as well as checking their monthly reports which they submit to the FO. These reports give greater detail of all events in their villages with PLWHA, challenges experienced and how they would have solved them as well as any identified situations of OVC in their areas of operation.

### **3.8.7 Voluntary Counselling and Testing Counsellors**

There are four voluntary counselling and testing (VCT) counsellors at Ruvheneko who are responsible for pre-test counselling, testing and post-test counselling of all clients who come to Ruvheneko Centre. They all report to the PC. VCT is the entry point for all patients since it is after testing positive that the counsellors refer the client for further clinical diagnosis for ART or PMTCT or for community services like HBC, OVC and support groups. VCT is therefore the ‘heart’ of Ruvheneko Centre as rightly said by one of the senior counsellors, Cephas. The counsellors keep the information of all clients in high confidence and they offer ongoing counselling and support to all clients. They also help in food distribution and community outreach programme where PLWHA are visited in their homes to monitor their adherence to treatment as well as topping up their ARVs.

### **3.8.8 Community Home-based Care (CHBC) Voluntary Care-givers (VCGs) Supervisors**

The CHBC-VCGs supervisors are responsible for the management and supervision of VCGs, also referred to as secondary care-givers. These received training which was facilitated by Pact ZimAIDS on management, supervision, leadership and report writing. They all report to the community home-based care Field Officer (FO) and make monthly reports which they submit to her. They train the VCGs (secondary care-givers) and make home visits to the sick patients, asking them if their VCGs are of help to them, that is, monitoring and evaluation of the VCGs work.

### **3.8.9 Community Home-based care-givers (CHBC) Voluntary Care-givers (VCGs) CHBC Group A**

CHBC Group A are secondary care-givers who are responsible for the provision of care to PLWHA in their homes. They were elected by the villagers in the various villages to do this work and they are helped to extend this care and support to PLWHA by primary care-givers, commonly referred to as CHBC Group B’s. They also manage the various self-help projects like vegetable gardening which take place the various villages. CHBC have been trained in ART uptake and the importance of adherence and PMTCT in addition to the care for positive



people in the homes like bathing them and dietary requirements. It is for this reason that they encourage adherence to all clients on ART and explain to primary care-givers (those taking care of the sick at home) and treatment buddies (those who help the PLWHA to take their pills on time and correctly) the importance of adherence. In some instances, they go to the extent of collecting pills for the sick from the hospital and bring them to the PLWHA if they are unable to collect on their own may be because they are too sick to do so themselves. It is for this reason that they have been given bicycles for easy transport as they make their home visits. It is the VCGs who also help in the identification of OVC in their villages and put it in their field diaries for their weekly and monthly reports to the HBC supervisors who in turn present them in their monthly meetings with the FO. They also collect donated food and consumables (cooking oil, beans and washing soap) which are usually given monthly for their sick who are bed ridden or cannot walk on their own.

The CHBCs were also trained by Pact ZimAIDS in home-based care skills and psycho-social support in issues revolving around basic nursing skills, treatment, basic counselling, bereavement counselling, referrals and hygiene (primary health care). They as well use the self-help projects as social events where they get to meet and share their experiences.

### **3.8.10 Primary Care-givers or CHBC Group B**

Primary care-givers (CHBC group B) also do unsalaried work. They constitute relatives and family members who live with and take care of the sick patient at home. Many as they are, they are not trained by the hospital but by the secondary care-givers when they go around making home visits. When the programme has some budget towards the end of the year, they are at times called for refresher courses for the care for HIV positive patients so that they in turn do not get infected in the process. They report any difficulties to the CHBC-VCGs who in turn make reports to the HBC supervisors to report to the FO in their monthly meetings.

### **3.8.11 Peer Educators**

The peer educators are non-salaried individuals, mainly out of school youth who are involved in awareness campaigns on behavioural change, prevention, testing, treatment, care and support. They do so through performing dramas, poems and role plays in schools, churches and various gatherings. They are also involved in condom distribution as well pamphlets with various information on prevention, correct condom use, testimonies of those who have benefited from Ruvheneko Programme's activities; VCT, ART, PMTCT and various support services available. They too report to the Field Officer.

### **3.8.12 Driver**

The driver is a salaried staff member responsible for driving programme staff for various activities like shopping, meetings, workshops, home visits and food distribution sites as directed by the Program Coordinator who he reports to.

### **3.8.13 Service Staff**

There are two salaried general workers who are responsible for the cleaning and maintenance of Ruvheneko infrastructure and outside on a day to day basis. They too report to the Programme Coordinator.

## **3.9 CONCLUSION**

Since this chapter set out to account for the evolution of St Theresa's Ruvheneko HIV and AIDS Programme, it discussed it within the context of the high HIV and AIDS prevalence rate in rural South East, Chirumhanzu. The chapter outlined the pivotal role of the Church where it emerged that Ruvheneko was established in line with the Participatory Strategic Planning framework of the Roman Catholic Church meant to respond to the scourge of HIV and AIDS nationwide, thereby making it a Faith Based Organisation (FBO). It has been demonstrated that St Theresa's Ruvheneko Programme started informally and later metamorphosed into a project which offered a single service, HBC, before it became a programme which is holistic,

comprehensive and integrates education, prevention, testing, treatment, care and support. The next chapter therefore examines the activities being undertaken at Ruvheneko as an integrated CHBC programme, highlighting the sources of the sustainability of the entire programme.

## **CHAPTER 4: ACTIVITIES AND CHALLENGES OF RUVHENEKO PROGRAMME**

### **4.1 INTRODUCTION**

The previous chapter discussed the background of the origin and structure of Ruvheneko Centre since its inception in 1995 up until December 2011 when my field research ended. Chapter four gives a comprehensive discussion of Ruvheneko programme and its various activities ranging from prevention, education, counselling, testing, treatment, care and support for both the infected and affected. As will be revealed in the chapter, Ruvheneko Programme offers services such as voluntary counselling and testing (VCT), prevention of mother-to child transmission (PMTCT), antiretroviral treatment (ART), orphans and vulnerable children (OVC) and support groups which cater for the psycho-social needs of the infected and affected. The chapter concludes by discussing challenges in the day to day operations of Ruvheneko Programme, despite the touted success story.

It emerged from the study findings that Ruvheneko Programme evolved from a project into a programme in a bid to address HIV and AIDS in a more holistic and integrated approach. This explains why it is more of a programme than a mere project. The programme caters for prevention, testing, treatment, care and support, that is, ‘housing all the eggs needed by our clients into one basket’, to reduce the distance, time, and travel costs for clients as pointed out by one senior member of the Ruvheneko Programme, Mr. Garapo. It emerged from the study that Ruvheneko’s positive transformation was necessitated by the promulgation of community needs as well as availability of funding from donor partners such as the Order of the Dominican Sisters of the RCC, Pact ZimAIDS, Oxfam GB, Global Fund, the Ministry of Education (MoE), Ministry of Health and Child Welfare (MoHCW), World Food Programme (WFP) and CARE International. According to one St. Theresa’s Hospital Senior staff member, Mr. Tigere, Ruvheneko Programme’s establishment is a grass root response to HIV and AIDS which was initiated by the local community and later supported and driven financially by external actors through partnership formation and donations. Despite its grassroots foundation, it emerged that the community lacked the finances to drive its running and expansion. It was through the injection of donor finances that the programme expanded into the following programmes.

## 4.2 COMMUNITY HOME-BASED CARE (CHBC)

The vision and mission statement of the CHBC is to reduce the stigma of HIV and AIDS surrounding it within St. Theresa's Hospital's catchment area by giving quality care to clients on CHBC and promote psycho-social support to the Orphans and Vulnerable Children (OVC) of the society. The vision according to the preamble of Ruvheneko is to reduce HIV transmission and alleviate suffering by those already infected and affected. This also targeted at improving ties between the infected and affected and creates a conducive care and support environment at home for the CHBC clients. Moreover, the policy emphasizes the need to reduce HIV transmission by educating people on prevention options and providing the requirements for prevention such as condoms and training youth on abstinence. In defining the church's position, Sr. Lizie pointed out that St Theresa's Hospital believes that HIV and AIDS is not a punishment from God and that the problem is everyone's responsibility from individual, family, community up to the nation. As a mission hospital we value greatly God's intervention (spiritual support) for the sick and their relatives as a source of inspiration for the caretakers (nurses, doctors and care-givers).

CHBC is the back bone or rather as rightly said by Mr. Garapo, the 'mother' of all the HIV and AIDS interventions that are running at St Theresa's Hospital. As of December 2010, there were 200 care-givers at Ruvheneko, 34 men and 166 women. Although there are no specific official statistics available, being a rural community, the proportion of men and women is unequal given the fact that most men migrate to urban areas to seek employment, leaving women and children behind to till the land. Also, in the patriarchal Shona society, the care role is usually ascribed to women and girl children and it is such that even the men who live in the community trivialize involvement in HIV and AIDS activities. During my fieldwork, I visited the sick with CHBC voluntary care-givers (VCGs) in Mahaso Village, I witnessed VCGs monitor people living with HIV and AIDS (PLWHA) in their homes and training family members and relatives (primary care-givers) of the sick on how to care for the terminally ill, how to bath them, support them spiritually, psycho-socially and with treatment adherence. The fact that HIV and AIDS are incurable, PLWHA suffer from emotional stress, stigmatisation and discrimination from their relatives and the community at large. The VCGs help to ease these emotions spiritually as they share the word of God with them, assuring them of God's love for them regardless of their situation as well as His healing presence. As a result, PLWHA

feel free to open up and share their emotions with the VCGs. On two occasions during my field visits, I witnessed families being re-united after the patients shared how angry they were with people who were taking care of them because they felt discriminated and unloved. The VCG facilitated reconciliation between the parties and they forgave each other. In the process, psychological wounds were healed and a sense of hope instilled. In addition, the PLWHA get social support as they get material support from donors to cater for their needs like mealie-meal, cooking oil and clothing. CHBC therefore helps PLWHA to cope psycho-socially with the disease this way.

Treatment adherence teaches the PLWHA to take their tablets as per the doctor's prescription that is, taking the right dose at the right time as one of the CHBC Leaders in the Mahaso Village, Rutendo explained during my home visits to PLWHA with VCGs. The CHBC Leader said she was elected by the community members to serve as a VCG and she accepted the responsibility. According to her, helping PLWHA in her village feels like a calling as she believes she will be serving God. This was a common sentiment from female Christians involved in VCG work whom I had interviewed. The VCGs are given CHBC kits which comprise of gloves, bed sheets, towels, napkins, disinfectants and detergents.

The provision of CHBC kits help the VCGs and primary care-givers to do their work without fear of being infected through care. One of the primary care-givers in Mahaso Village during my interview with her expressed how she feels protected when she uses gloves to clean her sick mother. 'I feel protected when I use detergents and disinfectants to clean my sick mother', she said. Her mother however made her feel bad in the early days saying '*ndiri kuvasemwa*' (I am being despised as if I am vile or infectious) when she wore gloves. This means that she felt her daughter was treating her like dirt by using gloves to touch her. It was through the VCG's education that she later understood the importance of protecting her daughter who was taking care of her from contracting HIV. In terms of ethical guidelines, it emerged that the Ruvheneko Programme's CHBC services are provided as per the Zimbabwe National Home-based care Policy (2001) and the Zimbabwe National Community Home-based care Standards of 2004 as stated in the Ruvheneko Programme End of Phase 1 Report of May 2003 –March 2006 to ensure and maintain quality service delivery.

The VCGS through village visits help in the identification of OVCs in the villages who they meet as they make village visits or as they are reported to them by community members. The work of VCGs was applauded by all my informants. According to them, care-givers came to the communities to give a ray of hope to both the infected (HIV positive and AIDS patients) and the affected (family members of the sick and OVC) who in most cases take care of the sick (primary care-givers). They expressed how the VCGs play a pivotal role in the provision of care and support which brings them warmth, love, care, and spiritual support.

One of the Ruvheneko Programme Officials, Ruth informed me that VCG supervisors have also been given bicycles to allow easy movement from one home to the next as they monitor the VCGs work in the villages. Before then, they walked

‘...long distances in the scorching sun or rainy weather to visit the sick in their homes, providing spiritual and psychological support, fetching firewood, bathing the sick and in some cases transporting sick people in wheelbarrows to the hospital’.

Complementing the VCG’s commitment is also the observation by one community leader, Mr. Chimuti, who attested that ‘the sustainability of CHBC is owed to the positive attitude of the VCGs who work relentlessly for no payment in difficult circumstances of hopelessness and utter poverty.’ It is through their efforts that people’s negative perceptions about the infected and the affected were gradually changed. The continued workshops and training of hospital staff, care-givers (primary and secondary), church leaders, the community at large, traditional leaders and councillors helped a great deal in the reduction of stigma, discrimination, emotional tension and fear of the infected by the uninfected and those who did not know their status. It also emerged that through dramas real life experiences were dramatized and this helped in the delivery of behaviour change, prevention, testing, treatment, and care and support messages to the community. I witnessed one such drama during the 2010 Christmas Party which I attended at St. Theresa’s Ruvheneko Centre. It is at this same party that the community members I spoke to expressed how they benefit from the dramas.

The existence of CHBC gives coping mechanisms to both the sick and their family members who take care of their sick relatives (primary care-givers). The support and love extended to the sick prolongs the life spans of parents living with HIV and AIDS, thereby reducing the number of OVC and child headed households (CHH) as well as grandparents headed households (GHH). Emphasising on the role of the Church, Schwobel (2006: 57) asserts that it

is precisely when human dignity is compromised that it becomes imperative for the church to engage in ‘critical and affirmative public theology.’ Christians have a moral obligation to show love, integrity, and compassion both individually and communally. This is what the Ruvheneko VCGs and primary care-givers strive to achieve everyday of their lives as evidenced by the observed activities during my 2 weeks field visits in Mahaso Village. One of the Roman Catholic Dominican nuns who works closely with the Ruvheneko programme, Sr Lizie explained how the VCGs acts of love and compassion are also guided by the Roman Catholic’s response to the Mission Dei (mission of God) in a situation of HIV and AIDS which follows the great commandment in Luke 10 which requires Christians to love their Lord God with all their minds and strength and to love their neighbours as themselves.

Ruth commented on the power of CHBC and ART and how most PLWHA become fit enough to even go back to work and fend for their families as before, thereby increasing household income which was no longer there or had diminished as a result of ill health. Some PLWHA would have left the cities like Gweru, Bulawayo or Harare as a result of ill-health and after their recovery go back able bodied to continue working for their families. During my field research among VCGs in the Mahaso Village, I found out that CHBC helped to bring cohesion and cooperation between families and the community at large as they work together to fight HIV and AIDS regardless of their religion, class, or political affiliation. CHBC also necessitated the establishment of ‘*zunde ramambo*’ (chief’s granary), where villagers collectively produce food using a communal field given by the village head. The produce benefits CHBC clients who can no longer produce for themselves or OVC, according to need. The Mahaso Village Head, together with the village members decide on one day during the week where all community members work on the community land. The main crop grown is maize which produces mealie-meal to make *sadza*, the staple food.

In a focus group discussion with ten CHBC volunteers on their role in HIV prevention, it was revealed that they help in the dissemination of information and condoms in the privacy of people’s homes. As a result, those who feel uncomfortable to take condoms from the hospital are also accommodated. The use of condoms has always been associated with promiscuity and if seen collecting condoms, derogatory terms like *pfambi* or *hure*, words used to describe unfaithfulness or promiscuous people. Contrary to this belief, Ruth actually said they ‘teach PLWHA that *makondomu musimboti wehupenyu hwevanhu vanorarama nehutachiwana*’



meaning, condoms are a source of life for all sexually active PLWHA. She said it is as a result of the prejudice that they are faced with challenges as they try and shift people's perceptions about condom use. Condoms prevent reinfection and deliberate transmission of HIV to sexual partners. Women are also encouraged to use female condoms which are available so that they do not only rely on their male sexual partners for protection. However, during a focus group with PMTCT women, it emerged that female condom usage among women is rare since they are hesitant to use them. This is attributed to fears of divorce or rejection by husbands or sexual partners should they insist on condom usage since patriarchal structures allow men to have more say on how and when sex is done.

It is through the VCGs' advocacy that stereotypes on gender roles have been reduced as seen by male involvement in care giving. I observed male VCGs being actively involved in primary care giving in their individual families. VCGs' work helped in mobilising youth participation in peer education in the fight against HIV and AIDS as well as care giving. Besides teaching people about ways of contracting and transmitting HIV, gender roles and the care role, VCGs also distribute flyers with various behavioural change intervention messages like 'keep the promise', 'know your status today', 'my friend who is HIV positive is still my friend' and illustrations of the correct use of male and female condoms. The fliers as a mode of communicating HIV and AIDS information to the community has been effective as pointed out by respondents I asked during my field work in the Mahaso Village. CHBC-VCG also conduct awareness campaigns and group talks with commercial sex workers commonly referred to as '*Sisonke Ladies* (Sex workers we are together). Just like one of the Senior Counsellors, Cephas, Garapo also emphasized how the youth's participation in HIV and AIDS work has bridged the gap between the youth and the elderly, thus guaranteeing continuity in the running of the programme. Youth involvement satisfies the quest for addressing the challenge of HIV and AIDS through the prism of the youth since they are deemed the most affected and vulnerable in the pandemic's prevalence (Santis, Rosenblum, Whitman and Bloome, 2007).

During an in-depth interview with one of St Theresa's Hospital Senior nurses, Sr. Sello, it was pointed out that the existence of CHBC has also led to a reduction of treatment bills by 50% since patients that should be staying in hospital for longer are released earlier and start receiving home care. This means CHBC has managed to relieve pressure on hospital resources like staff, beds, and food thereby improving doctor/nurse patient relationships since there will be less

people to be taken care of who are hospitalized. She said while nurses made home visits in the beginning, they were overworked since they still had to fulfil their hospital duties, leading to staff burnout. The VCGs relieved the nurses of this burden. Through the cooperation of the health and non-health professionals in caring for the sick, the formalisation of CHBC through training of VCGs at Ruvheneko came as a ‘...messiah for the infected and affected’, the nurse added. She further asserted that in light of the high exodus of health professionals to urban areas in Zimbabwe and other neighbouring countries, the availability of VCGs helped to bridge the staff shortages.

### **4.3 VOLUNTARY COUNSELLING AND TESTING (VCT)**

Since the inception of Ruvheneko, VCT became part of the HIV and AIDS programme. The VCGs advocacy managed to educate and raise awareness among the people in the continued struggle against HIV and AIDS. The Ruvheneko programme personnel pointed out how the increased awareness in the community through peer education, talk shows and drama led to an increase in the number of people seeking VCT. In the beginning however, results took long to be communicated to clients since blood samples had to be sent to Gweru, about 100 kilometers from St. Theresa’s Mission Hospital, to be analysed. This meant that no matter how critically ill the people were, they had to wait for two to three weeks for results to come back before anti-retroviral treatment (ART) initiation. Such delays and inconveniences prompted Pact ZimAIDS to sponsor the construction of a VCT Centre at Ruvheneko in 2003. Community members expressed great appreciation for the establishment of VCT centre at the hospital because it eliminated anxiety which was created during the waiting period since results had to come from Gweru.

One of my informants in Mahaso Village, Mai Chipu, (who unfortunately passed away in February 2012) who had been living with the virus for about 10 years in 2011 believed that

‘If it was not for the Godliness of the Roman Catholics and the donors, who would have thought of us the rural people by building a voluntary counselling and testing centre for us? We should have been buried long ago because of lack of knowledge and access to counselling and testing’.

Indeed, it seemed the rural people had been forgotten in terms of pre-test, post-test and ongoing support counselling, an important element the church and the donor community have managed

to foster in the remote area of Chirumhanzu. In fact, as pointed out by Broom and O'Brien (2011), most NGOs in Zimbabwe prefer to work in the cities and towns where they are based while Faith Based Organisations (FBOs) have tended to provide services to the rural areas where 70% of the population resides.

Ruvheneko Programme's success story also stems from the fact that it was the first VCTC to be opened in rural Zimbabwe. Its existence has led to the creation of other rural VCTCs in 2 other provinces, Manicaland and Mashonaland East in addition to Midlands, where St. Theresa's Ruvheneko Centre is situated. St. Theresa's Ruvheneko has thus been used as a training centre for other mission hospitals on how to plan, execute, and manage viable CHBC programs. Six 'off-spring', as they are referred to by Mr Garapo bearing the same name, Ruvheneko, have been established at other mission hospitals (see 1.2 above).

These followed St. Theresa's Ruvheneko by offering comprehensive HIV and AIDS support to rural communities with their main thrust on HIV testing and fighting stigma. They are all funded by Pact ZimAIDS (Ruvheneko Programme End of Phase 1 Report May 2003 –March 2006). In essence, this is a reflection of the sustainability of the Ruvheneko model. In its operation, it has moved from patient initiated VCT to provider initiated VCT. In provider initiated VCT, the VCT staff goes for outreach visits in the community using a mobile operating unit to conduct HIV and AIDS discussions with family members and couples on the need to be tested and actually provide the testing in their homes should they agree to test. HIV and AIDS have threatened the family institution in a number of ways and VCT has helped in relationship building.

The Canadian Ambassador to Zimbabwe, John Schram justified their support for the Ruvheneko Program's expansion arguing that it had taken a bold stance in the fight against HIV and AIDS from the comfort of Harare to the villages (Kubatana.net 2004). John Schram pointed out that their funding for Ruvheneko was aimed at improving livelihoods of the rural population because '...HIV and AIDS is a problem for all of us. It knows no urban or rural boundaries' (The Tribune, 2004).

VCT is the entry point to all the activities of the HIV and AIDS programmes, namely prevention of mother to child transmission (PMTCT) for pregnant women, antiretroviral

treatment (ART), community home-based care (CHBC), orphans and vulnerable children (OVC) and support groups. VCT is seen as a prevention mechanism in the sense that the counsellors during post-test counselling inform those found negative to prevent risky behaviour which may expose them to HIV infection. Behavioural change interventions and campaigns are also done through community sensitisation and mobilisation. Encouraging condom use, staying faithful to one sexual partner, and abstinence for those who are still single and have not indulged in sexual activities (ABC) approach constitute the main messages. At the same time, for those diagnosed HIV positive, it prepares them to accept their emotional loss of health, life, relationships, relatives as well as access to be on ART or PMTCT. One of the Ruvheneko Senior counsellors, Cephas pointed out how VCT remains a preventive measure since the HIV positive people are taught about re-infection which increases their viral load as well as warning them against deliberate spread of the virus. He pointed out that the VCT process at Ruvheneko is done in compliance with the Zimbabwe National Guidelines on HIV Testing and Counselling (2005) and the Centre was renovated to meet the MoHCW standards on VCT.

One of the VCGs in the Mahaso Village, a twenty-four year old woman, Muchareva narrated how she and her husband had separated after learning that he was HIV positive but through continued support and couple counselling from Ruvheneko counsellors, they later on re-united. She is just but one example of couples who were separated upon discovering the other was HIV positive. The Mahaso village head pointed out how in some cases neighbours and relatives had witchcraft accusations or *ngozi*, (the avenging spirit) or sorcery accusations which separated them only to realize that the people were HIV positive. Upon realising that HIV and AIDS is their enemy and not their neighbours and relatives, they have re-united as well.

Mr. Godfrey Rwizi, one of the beneficiaries of the Ruvheneko Programme gave a testimony of how after receiving VCT at Ruvheneko changed from his high risk behaviour which had led him to contract HIV during an in-depth interview with him. He previously worked at a highly mobile job in telecommunications which made him travel between various growth points nationwide. He admitted that he had multiple sex partners at the various growth points he visited and that he never used protection. When he fell ill in 2004, Mr. Rwizi went to be tested for HIV and AIDS on the recommendation of Dr. Stoughton, the then hospital Superintendent. Unfortunately, he had already passed the virus on to his wife and son who were also tested after he disclosed his status to them. He was initiated on ART in 2005, his wife in 2008 and their

last born son, in 2009. During our conversation, Mr. Rwizi said; ‘I learnt my lesson the harder way and I am telling my story so that it can be used for the betterment of other peoples’ lives’. According to Mr. Rwizi, those in a situation similar to his should be strengthened and know that there is hope after testing positive and that it is never too late to change from high risk behaviour. He encouraged men who have not been unfaithful to stay faithful to one sexual partner to save the lives of their sexual partners and children.

My informants who are living with HIV and AIDS acknowledged that the existence of VCT has helped them to make informed decisions when it comes to family planning (reproduction) and sexual intercourse (sexuality). Quite a number of youths cited loss of a close family member, relative or friend to HIV and AIDS as the reason which inspired them to get tested and change their risky behaviour. Pregnant women welcomed VCT because it helped them to access PMTCT and to give birth to healthy children. Mrs. Tasara, one of my informants in the Mahaso Village, believed that, were it not for Ruvheneko, she should not have had an HIV negative son. She said, ‘he is a living testimony to what Ruvheneko Programme has done for my family.’ She gave birth to an HIV negative baby despite the fact that she and her husband had both tested positive before conceiving. She said she joined Ruvheneko to spread the good news of the new hope for pregnant mothers. The aforementioned Ruvheneko Staff member, Ruth also gave testimony of how she had given birth to an HIV negative son as a result of PMTCT she had received from Ruvheneko after she had tested positive. She said she was healed by the negative status of her son.

In an in-depth interview with two HIV positive respondents in the Mahaso Village, they contended that they had undergone HIV and AIDS testing in the hope that they would be positive because then they could benefit from food aid and school fees for their children. According to them, they did not have any problem disclosing their statuses and joining the support groups because the benefits associated with being positive like qualifying for food aid, access to free nursing care and ART and school fees payment for their children outweighed fear of stigma and discrimination. Such revelation brings out the relationship between poverty and disclosure especially for poorer PLWHA. There is a possibility that given the economic hardships which Zimbabweans had experienced during the period 2000-2009 because of political and economic unrest, although not so covert, HIV positive people could have disclosed their HIV statuses because of the material benefits associated with being positive. Had they

been in better social and economic positions, they possibly would not have gone for testing, let alone disclose their statuses openly. In such a scenario, it becomes very difficult not to attribute the high turn up for VCT at Ruvheneko to the benefits associated with testing positive. Castleman, Seumo-Fosso and Cogill (2004) point out that food aid acts as an incentive to access VCT participation. Megazzini, Washington, Sinkala, Lawson-Marriott, Stringer, Krebs, Levy (2006) echo the same sentiments and are of the opinion that food support plays a pivotal role in increasing uptake and adherence to treatment. This seems to be the case of Ruvheneko Programme although most of the informants who are PLWHA except a few did not cite material benefit as their reason for testing and disclosure.

Most women and girls expressed that they feel empowered to make sexual decisions once they know their status whether positive or negative. Knowing their status propels them to initiate safer sex practices and decide on how, when, where and with whom they have sex. ‘From the day I tested HIV negative, I swore never to have unprotected sex again. I told my boyfriend that he would wear a condom or there would be no sex at all!’ exclaimed one of the young women who sells clothes at Charandura growth point. The latter is about 50 metres from Ruvheneko Centre and is the main business Centre in the catchment area. While the majority of my informants received VCT positively, it emerged during focus group discussions with church women of the St Anne’s Sect that some people still do not access VCT for fear of being stigmatised, being forced to get divorced or for fear of the unknown. They said they would rather not know their status out of fear of depression, early death and rejection by male partners. In their perception, the latter would lead to loss of economic power since they depend on their husbands for economic survival.

#### **4.4 ANTI-RETROVIRAL TREATMENT (ART) AND PREVENTION OF MOTHER –TO-CHILD TRANSMISSION (PMTCT)**

Ruvheneko Centre also runs the treatment programme which encompasses ART and PMTCT. The treatment programme benefits more from the referral system in place between Ruvheneko Centre and St. Theresa’s Hospital. Ruvheneko Programme enjoys the technical expertise of hospital staff for further diagnosis and treatment. In line with the vision and mission of the Ruvheneko Programme, the Family and Child Health Programme was introduced in a bid to

promote primary prevention of HIV infection in fathers, mothers and their children. Moreover, this was also meant to provide high quality maternal health services during pregnancy, delivery and the post-partum period to ensure optimum health of the mother and the infant.

Ruvheneko Centre's PMTCT programme has a throughput rate of 80% (The Herald 2003 & The CDC Prevention News Update 2003). In fact, all pregnant women who attend antenatal care (ANC) at St Theresa's Hospital are encouraged to get tested and get health education on the importance of knowing their HIV status. When an informed decision to get tested has been made, the pregnant woman undergoes pre-test counselling, gets tested and also gets post-test counselling whether positive or negative. The Ruvheneko Programme VCT counsellors pointed out that if one tests HIV negative, they are given follow up counselling so as to empower them to desist from risky behaviour especially if it has been established during pre-test counselling that the individual is involved in risky activities like unprotected sex, having multiple sex partners and abusing drug and alcohol for example which make them vulnerable to contract HIV. They also encourage their clients to practice safer sex, that is, correct and consistent use of female or male condoms depending on preference the first three months after testing (window period) to make sure they are HIV negative. In some instances individuals may test negative while they are in fact positive and can still spread the virus if they engage in unprotected sex. In addition, they are now encouraging their clients to bring their spouses (sexual partners) for testing so that they too know the importance of prevention of parent to child transmission (PPTCT) thus, the change of name from prevention of mother-to-child transmission (PMTCT) to prevention of parent to child transmission (PPTCT).

Ante-natal care (ANC), PMTCT education and testing of pregnant mothers at Ruvheneko Centre are conducted weekly on every Wednesday. The Ruvheneko Programme's treatment programme is commendable for making follow ups on their clients. HIV positive pregnant mothers receive follow up counselling to reinforce taught prevention strategies and to emphasise the importance of seeking early treatment of opportunistic diseases/infections (OIs) like Tuberculosis (TB), sexually transmitted infections (STIs). They are also taught about family planning (FP), required nutritional needs for pregnant mothers as well as psycho-social support. Exposed babies are given Nevirapine soon after delivery. According to the St. Theresa's 2009 Annual Report, 98% of their positive mothers practice exclusive breastfeeding (EBF) because they are unemployed and lack financial resources to buy formula milk. Sr. Sello

pointed out how the hospital is guided by the 2006 World Health Organisation's (WHO) guidelines which encourages mothers to breastfeed exclusively unless replacement feeding is available, what the sister-in-charge referred to as AFASS, that is, affordability, feasibility, acceptability, sustainability and safe (WHO 2006).

Even after delivery, routine health education is given to mothers to ensure compliance with treatment and safer sex practices. Home visits and weekly follow ups have been made possible by the availability of a vehicle which was donated to Ruvheneko Programme by the Global Fund. The vehicle is used for ART and PMTCT outreach programs which are done twice weekly. During these visits, CD4 counts are done as well as ART initiation (giving ART for the first time) and refills (topping up of ARVs for those already on treatment). Sr. Sello informed that by 2009, St. Theresa's Hospital managed to place 3 080 HIV positive people on ART.

The success of Ruvheneko's HIV and AIDS treatment programme has also been documented by the programme patron, Dr. Stoughton in the newsletter entitled 'Let's see how things are going trip.' In the report, it is claimed that, by October 2011 over 3200 people had been put on ART and most were doing well (Stoughton 2011). He further asserted that considering that most of these people could have been dead were it not for the treatment programme, St Theresa's Ruvheneko Programme remains an example of what can be done in rural Africa and can be done extremely well, Stoughton (2011). He further compliments all hospital and program staff for their attention to detail, dedication and commitment to their work as they see large numbers of clients and do bi-monthly and monthly follow up visits.'

During my interviews, people living with HIV and AIDS (PLWHA) respondents gave testimonies of how they had 'risen from death beds' through the power of ART. One of them, already alluded to, Mai Chipo, expressed her appreciation on how ART had prolonged her life when she said:

'We thank Ruvheneko for training us on the importance of adherence. As I swallow the pills every day, I know I am lengthening my life span. It is through ART that I have managed to see my grandchildren who I should not have known if I had not received treatment'.

She lost her husband to HIV and AIDS in 2002. All of my informants who are living with HIV and AIDS said they had disclosed their status to either their sexual partners or family members.



Mai Chipo further added that she did not regret having disclosed her status to her family members. If anything, it actually gave her the opportunity to educate her own relatives and children on HIV and AIDS. She cited the disadvantage of non-disclosure when she said;

‘How will I be able to take my pills at the correct time every day if I am hiding from my partner or family members? I would end up skipping or taking the wrong dosage since I will be in a hurry not to be seen.’

One of my male informants John who is now on the second line treatment gave testimony of how non-disclosure almost coasted his life. He said, ‘I failed to adhere to my treatment the first time because of secrecy. I had not disclosed to my wife and this resulted in non-uptake and inconsistent uptake on my pills.’ He later on fell seriously ill and was told that he could not be put back on the first line treatment since his body was now resistant to it. This explains why he is now on the second line treatment regimen.

Another example of a family who benefited from ART is that of Sarudzai. She fell ill in 1999 and was diagnosed with tuberculosis (TB) while she was breast feeding her last born girl. Although she was treated, her daughter later fell sick in 2002 and was admitted to hospital. They were both found HIV positive. She experienced traumatic stress and did not know how to disclose the news to her husband. Through ongoing support from her counsellor, Cephas already alluded to, she finally disclosed her status and that of her child to her husband who did not take the news lightly. According to Sarudzai, her husband started to stigmatise her and her daughter by calling them names and was also joined by his immediate family members who scolded Sarudzai for testing positive. ‘Fear of death was on my neck and I started having sleepless nights and was confused’, she said. She even blamed herself for her marriage and regretted ever having a child without having been tested. In 2003 her husband fell ill and was hospitalised for two months. He later tested HIV positive and was put on ART. They both went for adherence and couple counselling where they were taught about the importance of taking their ARVs correctly and at the right times. They eventually became a source of strength and support for each other. They both recovered drastically together with their daughter and today they are fit and doing well. Their love was rekindled as they started to have protected sex by using condoms supplied by the CHBC VCGs to their home. She explained how she and her husband became an example to their surrounding neighbours and those who were scared of getting tested learnt from them that there is life and hope after testing positive.

It also emerged from my informants that societal beliefs present a major obstacle to the realisation of the objectives of the PMTCT since Zimbabwean women are supposed to remain submissive and subservient to their husbands. I gathered in a focus group discussion with pregnant women on their perceptions of hurdles to accessing PMTCT. I learnt that some pregnant women are not getting tested because they have to seek permission from their husbands who may not agree. Although the community is nowadays generally knowledgeable about ART and PMTCT, there were other obstacles in the beginning such as religious beliefs which forbade seeking medical treatment when ill. The Apostolic Faith, commonly referred to as '*mapositori*' is an example of a religious sect with such beliefs. Those who are allowed by their husbands to get tested and are found positive are at times accused of having brought the virus into the family or of having extra marital affairs especially when they were diagnosed first. Even though they are knowledgeable about condom usage, girls' and women's socio-economic status make them vulnerable and dependent on men for food and shelter. This is a true reflection of some women's experiences in Chirumhanzu who most likely fail to convince their male partners to use condoms. In the words of one HIV positive woman, she said;

'Even though I have been taught about the importance of using condoms at Ruvheneko Centre, I cannot put it into practice because my husband refuses to use condoms. He says he cannot eat a sweet in the plastic after he paid lobola (marriage goods) for me'

This was a source of bitterness in some of my HIV positive women informants in ANC who participated in the focus group discussion. Some said they had been married virgins and never had any sexual relationships with anyone else but their husbands.

From the same focus group discussions (FGDs), it also emerged that before the establishment of Ruvheneko Programme, HIV and AIDS had caused social fragmentations and souring of relations among couples and their in-laws. It was also revealed that some HIV positive women had been accused of witch craft (eating their own children) when they had still birth or gave birth to children who are constantly sick and who eventually die because of HIV and AIDS related illnesses. One pregnant widow Juliana during the focus group discussion expressed her bitterness with her husband's relatives because they had accused her of bewitching her husband when he died. According to her, she only discovered that he had died of AIDS when she tested positive after his death. 'I have only known my husband and no other man in my life. I was shocked when I tested positive and really felt betrayed', said Juliana tearfully.

It is in the same FGD with pregnant women where it was pointed out that such bitterness as revealed above, results in uncooperative behaviour by married women when their husbands eventually get sick or are diagnosed HIV positive. They refuse to be their treatment buddies (close and reliable person an HIV positive person needs to choose to support them when they start ART). Delay or failure to get a treatment buddy acts as a hindrance to getting initiated on ART as pointed out by One Senior Sister-in-Charge at St. Theresa's Hospital, Sr. Getrude. The sister-in-charge further explained that only people with treatment buddies to support them when their CD4 count is below 200 can start their treatment.

Most clients at St. Theresa's Ruvheneko Programme are semi-illiterate as a result, some of the people living with HIV and AIDS do not administer and manage their drugs well at home or may at times mix up the times to take the drugs. In addition, the low literacy rate leads to lack of thorough understanding of some important issues such as consulting with the doctors and counsellors, having their period of fertility calculated before getting pregnant if HIV positive as well as having their CD4 constantly checked. Another finding concerns power relations between men and women with regards to issues that concern family planning and reproduction. Coupled with lack of education, it was revealed that lack of decision making powers among women is another contributing factor to high incidence of HIV and AIDS related infant mortality. A local non-governmental organization (NGO) called Women Aids Support Network (WASN) has played a pivotal role in raising awareness among HIV positive pregnant women at Ruvheneko Programme. This has been possible through conducting various workshops on themes such as adherence and implications of non-adherence; importance of getting a treatment buddy; the importance of PPTCT and exclusive breastfeeding as a cost effective option for HIV positive mothers.

#### **4.5 ORPHANS AND VULNERABLE CHILDREN (OVC)**

The Ruvheneko HIV and AIDS programme is also taking care of orphans. Duri, Stray-Pedersen and Muller (2013) define an orphan as a child who lost either one or both parents due to HIV and AIDS related illnesses. One of the Ruvheneko Programme staff, Mr. Garapo further explained the difference between what they call full orphans and half orphans. He said full orphans are those children who lost both parents due to HIV and AIDS related illnesses, while

half orphans are those children who lost either parent due to HIV and AIDS. Mr. Garapo clarified that in terms of age, ‘orphans’ are those below 18 years of age although in the case of the Ruvheneko programme the ages of their OVC go as high as twenty-four years since most of these orphans will be still at school.

The programme continues to support OVC up to tertiary level because they do not have anyone to pay for their educational expenses though above eighteen, hence, they remain the responsibility of Ruvheneko Programme. Orphans and Vulnerable Children (OVC) are identified by Community Home-based care (CHBC) voluntary care-givers (VCGs) as they interact with the community during their home visits in consultation with village heads. School headmasters and teachers in the various primary and secondary schools in the catchment area are critical players in the identification of orphans and vulnerable children since they will be aware of children whose parents experience financial difficulties or orphaned children whose parents or either parent died of HIV and AIDS. Some of the orphaned children live on their own (child-headed households) and some stay with grandparents (grandparent headed households). Another development that seems to be impeding the fight against HIV and AIDS is the erosion of the extended family structures which has been replaced by nuclear ones. It emerged from the field research that extended families are generally unwilling to take over orphans because of the increased burden implied as pointed out by VCGs in Mahaso Village. They further pointed out that some foster parents who adopt OVC are reported to abuse them either through child labour or sexual abuse. Some foster parents do not even allow OVCs to mix with their own children, let alone share clothes or kitchen utensils. Some orphans and vulnerable children’s relatives are allegedly taking care of the orphans so that they can get food donations supplied by Ruvheneko Programme. Stigma and discrimination are however reported to be less nowadays given the increased awareness campaigns which castigate stigma and discrimination against the affected and PLWHA during events such as World AIDS Days. An example of such messaging is illustrated in Photograph 1 below.



**Photograph 1: ‘Behavioural change communication intervention messaging’ at St Theresa’s Ruvheneko Programme (Photo taken by author in December 2010)**

Orphans and Vulnerable Children are faced with a myriad of problems in their day to day experiences. These range from lack of food, clothes, school fees, stationery, and school uniforms to being victims of stigma and discrimination. As pointed out by VCGs, the existence of problems faced by OVC prompted Ruvheneko Programme to source funding to run various orphan programmes. According to Mr Garapo, five partners who mainly sponsor OVC programmes are the MoE’s BEAM, St Theresa’s CHBC Programme, Catholic Development Commission (CADEC) and CARE International. The OVC programme also adopts a holistic approach in catering for the needs of the children by offering ART to HIV positive OVC, ongoing care and counselling, nutritional support, payment of hospital bills as well as legal aid protection where OVC are assisted in accessing birth certificates and their parents’ death certificates. In some cases they source foster parents for the OVC from abroad.

Other OVC programmes include psycho-social camping where OVC are taken out of their homes over a weekend at the end of year to spend time with other children who experience the same dire circumstances. Children who go on these camps are normally eight years of age and older. OVCs interviewed in this study pointed out that they are afforded an opportunity to do introspection about their lives as orphans and discuss their emotions during psycho-social camping. Motivational speakers and a psychologist are invited to guide the children on how to accept their situations as well as to adopt certain coping mechanisms such as how to lead in a child headed household as well as how to withstand stigma at school and from relatives and friends in the community. Topics which are usually covered include the following: basic facts about HIV and AIDS, growing up, sex and sexuality and safer sex negotiation skills.

In addition to these discussions, the children are also spiritually guided by a Roman Catholic priest. During a retreat session, the children are given moments of silence and solitude, coming face to face with themselves and their problems. According to one of the Roman Catholic Church Elders at St Joseph's Hama Mission, Zebedia, 'the silence during retreats nurtures the children's listening skills and their ability to communicate with God's quiet voice'. One of the children said, 'after attending my first camp, I came back an empowered person, feeling that the sky is the limit as long as I trust in God and give it my best'. At the time of my research, he was studying law at the University of Zimbabwe. The RCC Church Elder further pointed out how beneficiaries of the OVC programme have become lawyers, policemen, teachers, nurses and soldiers. In his description of how the PSS camping benefits OVC, Mr. Garapo pointed out that in essence, the psycho-social camping is inspirational and motivational as it changes OVC's perceptions about themselves, that is from viewing themselves as passive victims to seeing themselves winning as survivors as they gather from the evaluation they conduct from OVC after the camping.

I attended the 2010 Christmas Party on the 17<sup>th</sup> of December 2010 at St. Theresa's Hospital and I observed how OVC shared experiences, challenges, and solutions. It is at this time that they reflect on their lives as orphans and compare it to the time when they lived with their parents. On this occasion, I managed to conduct a FGD with ten OVC and also conducted in-depth interviews with them. All ten were above the age of eighteen. Six of them were still in secondary school and four were at tertiary education institutions. They expressed their gratitude for the existence of voluntary care-givers (VCGs) because they eased them of the burden of

taking care of their sick parents, for those who are half orphans. Three girls who were part of the OVC focus group discussion pointed out how they had dropped out of school to take care of their sick parents only to be resume school after VCGs took over the care role for their parents.

Five of the OVC in the focus group indicated that they were living a better life during their orphan hood than their parents could afford especially those who Ruvheneko had sourced foster parents for from overseas. This illustrates the fact that Ruvheneko OVC programme restored OVC's respect and humanity which they had lost because due to extreme poverty, school dropout, stigma and discrimination. Most of these orphans are now giving back to Ruvheneko through involvement in other Ruvheneko spearheaded projects like gardening and peer education. They say that their engagement in these activities is their way of expressing appreciation to Ruvheneko Programme. Some of the OVCs are actively involved in prevention, treatment and care awareness campaigns, condom distribution and community drama, among other outreach projects meant to educate the community on HIV and AIDS.

For some OVC who come from a poor background where they lacked decent shelter and sanitation, Ruvheneko programme constructed two huts and one Blair toilet for five families in the Mahaso village by December 2010 (see Photograph 2 below). This home-stead belongs to one child-headed household in the Mahso Village. Both their parents died from HIV and AIDS related illnesses as evidenced by the two adult graveyards in front of their houses.



**Photograph 2: An example of newly built huts and a toilet for OVC in Mahaso Village (Photo taken by author in January 2011).**

#### **4.6 SUPPORT GROUPS**

In addition to Voluntary Counselling and Testing (VCT), Community Home-based care (CHBC), Treatment and OVC activities, Ruvheneko programme gives continuous support to PLWHA through its various support groups. Support groups were formed with the aim of facilitating the meeting of PLWHA in groups to share their experiences while supporting each other. Given the stigma and discrimination which PLWHA experience from family members, friends and the community, meeting with people who share the same burden gives them a chance to be share experiences and learn from each other. The Ruvheneko programme started various support groups like sewing, knitting, baking (bun making), weaving, (*zviseme* see photograph 3 below), music and drama, and gardening groups in order to create an enabling environment for PLWHA. The support group members range from eight to twenty members and they are composed of adults above the age of 18 years old. All the support groups are predominantly HIV positive women except the welding group which consists of unemployed male youth. Oxfam GB is the major funder of the support groups. Support groups are a source



of inspiration and encouragement to PLWHA who said they get a sense of common purpose and feel socially accepted as they engage and interact with people in the same situation as them. ‘Even if I am depressed, when I go to the support group I feel encouraged, motivated and confident to share my true feelings and emotions’, stated one widow who is HIV positive and part of the bun making group.

The gardening project at village levels involve the growing of vegetables and herbs such as moringa tree, mint, black jack, lemon grass, and aloe vera. These herbs are well known for boosting immune systems. The herbs are used for treating various conditions. STIs like herpes zoster are treated with a combination of black jack leaves and aloe vera; boiling of peach and avocado leaves is known for lowering blood pressure; while aloe vera is also used for treating thrush. The Sister in charge of the Out Patient Department (OPD) Sr Getrude at St Theresa’s Hospital explained how the use of traditional medicine has given hope in the treatment of HIV and AIDS. The use of local medicine, specifically the herbs in the Roman Catholic Church, is guided by the Chinhoyi Diocese project which was pioneered by Sr. Yulita Chirawu which led to the production of a booklet titled *Common Herbs and their uses manual* in 2003.

The use of herbs and traditional medicine in the treatment of HIV and AIDS related sickness for long has been resisted by western practitioners who described it as ‘primitive’ and ‘savage’ (Summerton 2006: 17 Hammond-Tooke 1989: 185; Mbereko and Mahlatini 2013: 137) As such, scientific knowledge systems have always taken a leading role in the bio-medical field at the expense of indigenous knowledge systems (IKS) (Summerton 2006:18). On the other hand, the Church was not at peace with African traditional medicine as it was regarded as ‘unscientific and some of its treatment methods were considered anti-Christian’ (Waitel 2000: 237; Chavhunduka 1999: 1). With the outbreak of the HIV and AIDS epidemic, both the church and biomedical practitioners had to loosen their muscles upon discovering that there is need to harmonise IKS and biomedical practices (Mbereko & Mahlatini 2013: 138; Kayombo, Uiso, Mbwambo, Mahunnah, Moshi & Mgonda 2007: 2). So, while traditional medicine has generally been looked down upon as a treatment method, the discovery of herbs like aloe vera, moringa and black jack has led to the acceptance of combination treatment. Most PLWHA take ART together with herbs which are known for boosting their immune systems. The church however does not condone the consultation of traditional healers for other

traditional herbs which are not recommended despite the appreciation that there is need to maximize positive synergies of both biomedical practices and IKS.

Commenting on the use of herbs by PLWHA in an in-depth interview, one of the Dominican sister who helps in the running of Ruvheneko Programme asserted that the church still does not condone the consultation of traditional healers (*n'angas*) for treatment but allows the use of herbs in conjunction with ARV treatment. The myth that sleeping with a virgin girl cures HIV and AIDS has been commonly known as traditional healers' prescription. It has been condemned nationally as it makes girl children vulnerable to HIV positive men wishing to be healed.

Literature demonstrates that there greater possibility of harmonizing bio-medical and traditional medicine in the treatment of HIV and AIDS and that such is accomplished by treating traditional healers as partners in development of vaccines and treatments for AIDS (UNAIDS 2006 & WHO 2003). In the case of Ruvheneko Programme, however collaboration is already presenting challenges. There has been non-adherence to treatment when some PLWHA believe they are healed and stop taking their ARVs which eventually leads to drug resistance and early deaths. Mr Garapo highlighted this as a major challenge in their fight against HIV and AIDS in the area as traditional healers would have claimed to have cured the disease. 'There is need for more workshops to raise awareness among traditional healers on this negative impact and how it is costing lives', he said. He added that traditional healers should be made to understand that there was no cure for AIDS and as such, the herbs can only lower the viral load and boost the immune system and that they should desist from telling their clients that they are healed for the repercussions were more devastating.

From my interaction with various support groups, I observed that the meetings give them a sense of belonging, a chance to debrief to share experiences and challenges. By so doing it fosters a culture of sharing and collective problem solving. During my two weeks participation in gardening in Mahaso Village, I could hear some freely boasting that '*Tarisai ndava kutakura mugomo wemvura, munopera mose muchindisiya*' (directly translated as, 'Look now I can carry a bucket of water, you will all die and leave me alive). What is significant about these gardening activities is that by mixing with others in a similar situation, hope is instilled in people and this keeps them strong. In addition, it has also become a source of financial aid and

economic self-sustenance. The group sells its produce locally and the proceeds are shared among group members. They are also supplied with fresh vegetables and herbs for daily consumption as pointed out by the support group leader. She further admitted that she looks forward to going to their gardening support group because it is the only place she can share her experiences without fear of being victimised or discriminated against. Others pointed out during the support group FGD on the 18<sup>th</sup> of March 2011, (which consisted of ten members representing five support groups namely; gardening, welding, mat making, bun making and sewing) that support groups were their sources of inspiration and encouragement and that they had helped them to be strong and bold, especially when it comes to their rights and responsibilities. A striking example comes from a widow who explained how she was being forced to be inherited (*kugarwa nhaka*) by her covetous husband's brother who wanted to inherit her possessions. She got advice from other widows who had faced the same problem at the support group and went to report the matter to *Msasa* Project, a women's NGO in Zimbabwe which helps women who experience family and other marital problems. They helped her resolve the matter because in the end she got all her possessions back and her husband's relatives were told by the court to stay away from her and her children.

Support groups have helped Chirumhanzu HIV positive women to overcome their various fears of disclosing their status to someone to get a treatment buddy and get initiated on ART. As pointed out by support group women in a focus group discussion with them, such fears range from fear of blame, rejection by loved ones, stigma, and isolation by family and community members. In the early days, lack of disclosure acted as a barrier to accessing treatment early, especially among women. The hospital personnel was faced with a dilemma: they saw how a person's CD4 count was deteriorating gradually but they could not initiate them on treatment without a treatment buddy as indicated by the OPD sister-in-charge. There were cases of patients who actually had to be referred to support groups to get the much needed support before they could be put on ART.

Another remarkable development as a result of the establishment of support groups was the formation of burial societies using the proceeds from the support groups. This has gone a long way in helping families have 'decent burials' in terms of both the purchasing of coffins and the provision of food at the funeral.



**Photograph 3: A show of finished products of *zviseme* (fibre mats) crafted by women of the support group (Photo taken by author in February 2011)**

The above mentioned support groups are specifically meant to benefit PLWHA. The Church run Budiro Training Centre (locally also known as KwaBhambamba) which offers specific support activities to youth who are out of school and unemployed. These include welding to manufacture window frames, door frames and burglar bars as well as conservation agriculture. With conservation agriculture, the youth grows vegetables with minimal or no mechanical soil disturbance to reduce top soil erosion and to keep minerals in the soil. The youth of Ruvheneko Programme are therefore cautious of the need for such sustainable farming which conserves natural resources like soil. One of the youth who also participated in the FDG explained to me that with conservation agriculture, they use today's resources with the future in mind, sustainable farming. The youth who take part in sustainable agriculture pointed out that they were trained by Oxfam GB delegates who also fund them with inputs as well as train them on conservation agriculture. Speaking to the youth in a focus group discussion, it emerged that the support groups are saving them from temptations and a lot of mischief such as taking drugs and alcohol at the Charandura Growth Point which is a kilometer from Ruvheneko since they keep themselves occupied with these self-help activities. They also appreciate them because they are a source of income. In the words of one of the youngsters: 'as the head of the family, I value the welding support group because it gives me money to buy food and clothes for my

young ones'. He is a 19 year old who runs a child headed household; being the eldest son in his family of four and both his parents died of HIV and AIDS.

The above discussion of Ruvheneko's activities has demonstrated that it is an integrated, comprehensive programme responding to HIV and AIDS in a holistic way. Ruvheneko Programme is also faced with challenges which will be outlined in detail below.

#### **4.7 CHALLENGES OF RUVHENEKO PROGRAMME**

Having given an account of the activities at Ruvheneko Centre, it is worth noting that the operations of the programme are not without challenges. The running of the programme depends heavily on donor funds and during my field research at the end of 2010, there were fears of donor fatigue (getting tired of funding HIV and AIDS projects). It emerged that most of the donors were withdrawing funds from direct HIV and AIDS activities which are not linked to medical male circumcision (MMC). MMC is believed to reduce chances of contracting HIV for men by 60% following randomized controlled trials which were carried out in Kenya, Uganda and South Africa (Auvert, Lissoba, Taljaard, Geffen, Fiamma & Heywood 2009). Zimbabwe as a country which is non-circumcising in general welcomed MMC as a preventive measure among men and donor funds were directed more to MMC. In addition, the Zimbabwean Government also indicated that the donors would no longer be allowed to fund HIV and AIDS programmes directly but through a regulating national body, the National AIDS Council (NAC), which was enacted through an Act of Parliament of 1999. NAC was a government initiative meant to coordinate all the multi-sectoral responses to the HIV and AIDS epidemic (NAC 1999). One of NAC's functions is to distribute funds as it deems fit, sparking fears that this may threaten the day to day operations of Ruvheneko programme as Mr. Garapo alluded to. These fears stem from alleged mismanagement and embezzlement of donor funds by government officials during the period of economic turbulence in Zimbabwe (PHR) apparently, most of the health related funds were also redirected for political party projects within ZANU-PF (Physicians for Human Rights 2009).

The National AIDS Trust Fund (NATF) was established soon after the formation of NAC in 1999 with the objective of funding all HIV and AIDS activities in Zimbabwe (NAC 1999).

Complementing this initiative was the introduction of AIDS Levy in 2000 with the objective of providing funding to HIV and AIDS interventions and also to complement external funding of HIV and AIDS in Zimbabwe (NAC 2000). In essence the GoZ aimed to reduce dependence on donor support in terms of funding HIV and AIDS intervention programs in the country (NAC 2011). According to Sections 14, subsections 14 and 15 of the Finance Act, Chapter 23:04, AIDS levy is to be raised through charging individuals, companies and trusts at a rate of 3% (NAC 2011). In addition to the formation of NAFT, there was a decentralization framework through Provincial and District AIDS Action Committees (PAAC and DAAC) that was established in a bid to coordinate the response to the epidemic (NAC 2011, Bird and Busse 2007).

The government driven funding of HIV and AIDS activities in Zimbabwe was allegedly characterized with political interference and there are also allegations of distributing funds along political party lines (Batsell 2005; Bird & Busse 2007; Garbus & Khumalo-Sakututwa 2003 and Price-Smith & Daly 2004). The perception that the AIDS Action Committees (which were created by the NAC at provincial and village levels) are partisan bodies was endorsed by Broom & O'Brien (2011). There were also allegations of misappropriation of ARV drugs by political elites accused of selling the donated drugs on the black market during this same period of economic turbulence between 2000 and 2009 (Mundawarara & Mapanda 2010; PHR 2009). One of the Ruvheneko Programme staff members pointed out how all this uncertainty triggered so many questions which remained unanswered: Will the NAC allocate enough funds to Ruvheneko to pay all the salaried staff? Will enough money be allocated to run all the activities without compromising quality? Will rural programmes like Ruvheneko be remembered given the usual neglect of rural areas? Will the provision of free ARV drugs continue as usual?

Duri *et al.* (2013) assert how the deterioration of the Zimbabwean economy led to acute shortages of foreign currency, food stuffs, liquid fuels, electricity, medical equipment and drugs. These national economic and political challenges in Zimbabwe also impacted negatively on the day to day operations at St Theresa's Ruvheneko Programme. Mr. Garapo pointed out how the erratic fuel supplies affected the outreach programmes as well as food distribution in the distant rural communities. Some of the HIV and AIDS patients who did not manage to get food became disgruntled and reneged from their uptake of ARVs while others started accusing programme staff members of being agents of the opposition party, the Movement for

Democratic Change (MDC). Following accusations by the Government that NGOs were supporting the opposition party, 2004 saw the promulgation of the NGO Bill. Clause (9) of the Bill prohibited the registration of local NGOs especially if their vision and mission included governance issues which aim at protecting human rights and political governance issues (NGO Bill Clause [9] 2004). In addition, such NGOs were forbidden from receiving donor funding (NGO Bill Clause [17]). The Bill impacted negatively on the operations of NGO financed programmes such as Ruvheneko.

All this made the running of Ruvheneko Programme heavily politicized. During food distributions, members of ZANU-PF, the ruling party, allegedly made slogans against the programme staff members responsible for food distribution. An example given to me was '*pasi neVanhu VeRuvheneko*' (literally, 'away with Ruvheneko staff members'). In most cases they could be heard swearing at a specific staff member saying, '*pasi na..... staff member's name*' (away with the mentioned staff member). The negative slogans against Ruvheneko staff were uttered by those who would not have received food donations. They blamed Ruvheneko staff for the food shortages and rumour had it that the staff members were stealing the food donations, hence, the shortage.

The Ruvheneko Programme staff I interviewed however explained that they had to screen PLWHA and OVC when the food supplies were in shortage. They used patients' weight as a criterion for food distribution. Those weighing more than 35 kilograms did not get any food aid while full orphans were given preference. People who fell outside these categories became disgruntled and started to make false accusations against the programme staff. Ruvheneko programme staff said they tried by all means to be non-partisan. This I observed during one of the food distribution sessions at Ruvheneko Centre where people who came wearing t/shirts branded any political party's name of people contesting for elections were sent back home to wear other clothes. In fact, the food shortages presented them with new challenges of drug resistance as some PLWHA abandon treatment to remain qualifying for aid at the expense of their own health.

Despite the challenges related to food distribution, the issue of confidentiality emerged as one of the major challenges confronting the Ruvheneko Programme. The VCGs were reported be violating confidentiality by divulging a person's status to spouses or relatives without the

person's consent. The senior counsellor Cephas referred to this as 'village gossip'. He narrated that lack of confidentiality, especially among volunteers, had been a stumbling block during the set up period especially before the formalisation of the programme when VCGs were not officially trained. By virtue of being unpaid, it was difficult to control or punish VCGs since they were not formally employed and did not have contractual obligations which bound them. This led to a loss of trust and confidence between the community and VCGs. Although the situation has recently improved due to training the CHBC- VCG received from Pact ZimAIDS, it is still a challenge which occasionally crops up.

With the introduction of ART, the OVC who are HIV positive are now living longer than in the past, often reaching adolescence. Due to the fact that no clinical signs may show in HIV positive people when they adhere to their ART properly, it is difficult to tell whether someone is positive or not by merely looking at them. As a result, it remains the prerogative of individuals to disclose their status to their sexual partners and if they do not, the positive uptake and response to ART poses the danger of transmitting the virus to their sexual partners deliberately. Mr. Garapo reported that this has already been happening and the counsellors are faced with a moral dilemma as to whether they should inform the partners of HIV positive adolescents or not. If they do, it would be a transgression of the ethical code of conduct. As a result, the community is faced with a new challenge which needs to be handled with caution. The power of ART is also witnessed among adults who recover to such an extent that they do not have any visible symptoms of HIV and AIDS infection. Some of these adults also engage in unprotected sex with multiple sexual partners who are not aware of their HIV status.

As the Ruvheneko Programme has gained in popularity for its good work, the hospital is receiving HIV and AIDS patients outside of its catchment area – some come as far as from Harare, Masvingo and Gweru. According to Mr. Tigere, one of the Senior Hospital Officials at St. Theresa's Hospital, resources were being depleted faster than anticipated and budgeted for since about 35% of their clients are now from outside their catchment area and they find it unethical to turn away the patients from these distant places.



## 4.8 CONCLUSION

This chapter has outlined the comprehensive activities of the Ruvheneko Programme which are integrated into the community's and church's response to HIV and AIDS in the Chirumhanzu District of the Midlands Province. Its responses offer a holistic approach by rendering prevention, testing, treatment, care and support services to the community. The success of the activities as reported on by informants and the local media point to the fact that the positive picture of Ruvheneko is not mere hearsay but a reality. Its success is what prompted Pact ZimAIDS to use it as a training ground for the establishment of other Ruvheneko centres in other provinces. The programme is however faced with challenges which have also been discussed in this chapter. The next chapter focuses on the analysis of the research findings which have been discussed in Chapters 3 and 4.

## CHAPTER 5: ANALYSIS OF FINDINGS AND CONCLUSION OF THE STUDY

### 5.1 INTRODUCTION

This chapter gives an analysis of the findings on the origin and structure of Ruvheneko Programme as discussed in chapter three as well as the findings on the activities run by Ruvheneko as discussed in chapter four. Findings from in-depth interviews, focus group discussions, observation and a review of secondary and primary sources of data (programme documents) have been presented. In this chapter, data is analysed qualitatively using a thematic approach where various responses from the key informants of the study are analysed against the objectives of the study. This chapter further provides conclusion of the study, highlighting the major findings and avenues for further research.

As noted by Smith and Firth (2011), qualitative research is invaluable for exploring complexities of healthcare and patient experiences and this is also the case in this study of Ruvheneko Programme, where HIV and AIDS patients' experiences were explored. As part of the analysis, this chapter explores whether the positive picture given about Ruvheneko programme by outsiders corresponds with views from beneficiaries of the programme. The chapter also examines how the programme managed to successfully engage community members despite the failure usually associated with most HIV and AIDS community engagement activities. Primacy is given to how Ruvheneko programme has managed to change the usual negative stigma associated with HIV and AIDS in Zimbabwe into positive attitudes in its catchment area. A critical analysis of the emerging themes from the collected data is done inductively. This includes the impact of HIV and AIDS on food security, the politics of partnerships in the running of Ruvheneko, the relationship between traditional and bio-medical approaches to HIV and AIDS, the role of support groups and motivations for volunteerism, among other emerging themes.

## 5.2 EMERGING THEMES

Below is a discussion of various themes which were derived from the analyses of findings of the research.

### 5.2.1 Community engagement in the context of Ruvheneko Programme

The preferred working definition of ‘community’ applicable to the study of the Ruvheneko Programme is that which makes reference to the collaborative participation of a community of people, rather than an individual citizen, for purposes of addressing issues affecting their wellbeing in their given geographical location, (see 1.3). In the case of Ruvheneko, the ‘community’ may at times include people who are infected by HIV and AIDS who volunteer to work as HBC voluntary care-givers (VCGs); people in various support groups; people who are on treatment whether pregnant (PMTCT) or on (ART); the affected who are related to the sick, orphans and vulnerable children (OVC); and various stakeholders such as traditional leaders, rural district councils, officials from the Ministry of Health and Child Welfare (MoHCW), the various churches and the different NGOs which are responsible for the funding of various programme activities.

One of the key findings of this study is that engagement in the context of Ruvheneko programme manifested in two forms, participation and partnerships. The community participated in Ruvheneko programme since its inception when the women of the St. Annah’s sect volunteered to help the hospital nurses and nuns in taking domicile visits to the sick and helping them both materially and spiritually. Participation is also seen when the community was tasked to choose representatives from their various villages whom they thought would better represent them to get CHBC training during the formalisation process. Another reflection of participation is in the naming of the programme from St Theresa’s CHBC Project to Ruvheneko Programme since the process was democratic by allowing various stakeholders to participate through a voting process in deciding on a name.

Partnerships manifested in the relationship between the community, church, hospital, and the donor community. It emerged that the donors found the church and the community already engaged in HIV and AIDS prevention and treatment activities and intervened financially. This

emanated from the fact that Ruvheneko lacked the financial muscle to expand and develop into a more comprehensive and integrated programme. It is in this context that Pact ZimAIDS, OXFAM, CARE International, World Food Programme (WFP), the Ministry of Education's BEAM programme, and the Ministry of Health and Child Welfare (MoHCW) became partners with Ruvheneko to ensure infrastructural and human capital development. The building of the Ruvheneko Centre, for instance, was made possible through the financial injection from PACT Zimbabwe and this necessitated the training of CHBC-VCGs and the employment of programme staff. In similar vein, CARE International and WFP chipped in with food donations, helping both the infected and affected with nutritious food. Funding from OXFAM necessitated the running of various support groups engaged in nutritional gardening, conservation agriculture, welding and bun making. The MoE's BEAM programme through partnership with Ruvheneko has been assisting OVC through the payment of school fees. All these activities are a reflection of how shared interests and authentic partnerships brought about capacity building, that is, development of sustainable skills, organisational structures, resources, as well as the commitment to health improvement to prolong and multiply health benefits over time (see 1.3.3).

From a holistic perspective, community involvement at Ruvheneko Programme transformed from a simple communication exchange through consultation to empowerment and mobilisation. It is this approach to community participation that has led to awareness raising on HIV prevention, transmission, and treatment in the community as well as changing community leaders' negative perceptions of HIV and AIDS. This observation concurs with the view that community involvement provokes behaviour change such as an increase in condom usage (Beeker, Guenther-Grey and Raj 1998, Ramirez-Valles and Brown 2003). In fact, the community engagement characterising the Ruvheneko Programme is in line with participatory rural appraisal (PRA) approaches where the community itself realizes its situation and takes the lead in trying to solve its problems (Chambers 1994). In like manner, the community of Chirumhanzu was confronted by the HIV and AIDS epidemic and took the initiative to form CHBC. It also emerged that the community's preparedness and willingness helped to sustain the partnership. This is also reflected by the revival of the *zunde ramambo* (chief's granary) in order to provide food for the OVC, CHH and PLWHA in need (see 4.2). The formation of the Chirumhanzu Church Leaders Association (CCLA) was another initiative the community took to engage all churches in the fight against HIV and AIDS. Another home

grown initiative by the community includes the formation of burial societies in order to accord a decent burial for those who die as a result of HIV and AIDS related diseases. All this reflects how participation and collaborative partnership are integral to the sustainability of the programme which in turn fosters community ownership of Ruvheneko Programme. Against this background, the next section provides a discussion on the internal and external portrayal of Ruvheneko Programme.

### **5.2.2 Positive portrayal of Ruvheneko Programme**

The discussion in the preceding chapters revealed that the activities being undertaken by the Ruvheneko Programme have indeed created a positive picture to the wider world as presented in local and international newspapers such as The Herald (2003), IRIN News (2003), The Tribune (2004) as well as its mention in academic studies like that of Lamptey and Gayle (2001). The popularity of the CHBC project has attracted donor funds which led to the expansion of the project into a programme.

The positive picture about Ruvheneko programme is shared by community members in general and OVCs and PLWHA specifically, as indicated in their responses during interviews and focus group discussions and in-depth interviews. Most of the OVCs and PLWHA revealed their delight which is generally derived from the tangible benefits they experience from their association with Ruvheneko Programme. Most informants cited the holistic nature of services provided at Ruvheneko as the source of their main motivation and gratitude. The accessibility as well as the availability of ART and PMTCT has seen many lives prolonged as compared to the period before the provision of treatment at St Theresa's Hospital. This has also reduced OVC as parents get well again and are able to fend for their families. Another important finding is the increased uptake of ARVs at Ruvheneko as well as opening up among those infected by HIV. During social gatherings like funerals, PLHWA who are on ART are heard saying, 'let us eat first and here is our bucket of water ...come guys lets drink.' Jokingly though, but encouraging others even those who might be hiding their HIV status; Mahaso Village CHBC-VCG Leader. Through reading and interpreting such testimonies by the beneficiaries, it can be argued that the positive portrayal of Ruvheneko is real and not merely journalistic reporting.

One other aspect that also substantiates the positive portrayal of Ruvheneko Programme is statistical evidence before and after the establishment of Ruvheneko. Evidence on the ground shows that the PMTCT infant positivity rate dropped from 25% in 2001 before PMTCT to 14% in 2011 and over 3200 people had been put on ART by October 2011. In addition to the decrease in infant mortality rate, the challenge of school drop-outs among the OVCs due the effects of HIV and AIDS in the catchment area was also mitigated through the formation of the Ruvheneko Programme. The introduction of the OVC project helped to cater for school fees for OVC especially after losing the breadwinner or both parents to HIV and AIDS. By 2010, the OVC project had helped 3 500 OVC and this has been made possible through donor partners like Pact ZimAIDS, BEAM and the Order of the Dominican Sisters who pay school fees for such OVC. From a gender perspective, it emerged that some girl children who had dropped out of school to take care of sick relatives were relieved of this burden since the trained CHBC-VCGs could take over the care role while they resumed schooling. All these add to the indicators of success for the Ruvheneko Programme.

The dividends of the Ruvheneko Programme have not only been realised in Chirumhanzu, but nationwide since it managed to set the standard for a comprehensive and integrated HIV and AIDS response in similar rural areas experiencing resource constraint (Anderson & Jackson 2001). This also served to mitigate the challenge of health professionals who resent working in the rural areas prefer urban areas because of poor infrastructure and living conditions. The establishment of six other rural based HIV and AIDS programmes in other provinces namely Manicaland, Mashonaland East and Midlands bearing the name Ruvheneko is evidence of the positive spill-over of the Ruvheneko Programme's success story (see 1.2).

The fact that Ruvheneko Programme is renowned for its comprehensive rural HIV and AIDS programme reveals that it a model and pace-setter for HIV and AIDS management in resource-constrained settings. This analysis concurs with Rau (2006) who points out how activities that have been institutionalised in national and global plans were actually pioneered at grassroots levels by churches and groups in infected and affected people. The same is reinforced by Epstein (2007), Low-beer and Stoneburner (2004) and Panos Institute (2003) who attest that some of the clearest achievements in confronting the challenges of HIV and AIDS have been linked to the crucial role played by local level actors.

In addition, guaranteed care from both the hospital personnel and community home-based care (CHBC) voluntary care-givers (VCGs) and support groups act as a catalyst in helping people make the decision to get tested. In fact, the support network is best explained in what Putman (2000, 1993) refers to as ‘social capital’. The notion of social capital provides insight into how social cohesion helps communities to address certain challenges. According to Putman (1993), social capital envisages networks, norms and social trust that facilitate cooperation and mutual benefit. It is further described as ‘bonds of community that in a myriad of ways enrich our lives’ (Putman 2001: vi). From this description definition it can be deduced that societies that foster mutual cooperation and reciprocity can achieve specific objectives with community members not anticipating any direct benefit in return. Central to the message of social capital is the notion of investing in transformation where people render their labour, skills, and available resources. In this case, people might not anticipate direct benefit or favour from whomever they help, but rather look forward to a culture of mutual survival where they might also be assisted in future.

By way of transplanting the wisdom of social capital to the Ruvheneko context, it can be inferred that the fact that HIV and AIDS has become ‘everyone’s problem’ meaning that people from the community and other discussed stakeholders see the opportunity of collectively standing up to the challenge of the epidemic. The notion of ‘community problem solving’ at Ruvheneko is reflected in the works of CHBC-VCGs who established burial societies and revived the (*zunde ramambo*). Furthermore, the latter is another model of social cohesion meant to alleviate food challenges for families of the affected (OVC and child headed households) as well as those infected who can no longer provide for themselves.

All PLWHA in support groups who participated in my research admitted to having been helped to disclose their status through the support, inspiration and encouragement they got in their support groups such as those engaged in bun making, gardening, music performance, welding and basket weaving. Some testified to the comfort they get from support groups highlighting that they can open up and share their experiences and give each other advice on how to tackle disclosure, negotiate safer sex through the correct and consistent use of condoms, and adhere to their treatment. At community level, another manifestation of social cohesion is in the reduction of stigma and social acceptance of PLWHA, open distribution of condoms which was a taboo in the past, use of real names instead of pseudo-names when accessing VCT and

the formation of burial societies. In retrospect, it is the holistic and integrated nature of the services provided by Ruvheneko Programme that makes its internal stakeholders view it with positive regard.

### **5.2.3 How Ruvheneko Programme managed to engage community members**

The sustainability of Ruvheneko Programme can be traced back to its establishment which allowed community participation and involvement. It developed in a continuum which fits well with Rodriguez-Garcia's (2009) theory of change which posits that community-based groups evolve in two dimensions, formal or informal. Rodriguez-Garcia (2009) looks at the social challenges that foster social collectivity where in an informal set up social support structures are pillars towards collectivity. With no external support structures, the community improvises certain self-help mechanisms in order to respond to social challenges such as HIV and AIDS and floods (Rodriguez-Garcia, 2009). The other dimension concerns formal community initiatives where proper institutions and structures are put in place. These may include legal formalization or registration, external support systems, and keeping of financial records (Rodriguez-Garcia 2009). This conceptualisation provides lenses through which one may understand the evolution and development of St Theresa's Ruvheneko Programme. Ruvheneko started running as a single service providing HBC informally as a community, hospital, and church response to the impact of HIV and AIDS in the catchment area. The formalisation and transition from project to programme which now offers HIV and AIDS education and awareness raising, VCT, treatment, care and OVC support was necessitated by partnering with NGOs and government departments. This saw the community responding more strongly to the fight against HIV and AIDS: more people accessing VCT, more HBC VCGs trained, more PLWHA getting treatment and more OVC getting supported leading to behavioural change. More and more people began to open up about their status and people's negative attitudes and perceptions towards PLWHA and OVC improved, leading to reduced stigma and discrimination. The desired impact of the programme, which is a reduction in mortality rates, was achieved and ART and PMTCT made PLWHA lead healthier and more productive lives than before the establishment of Ruvheneko Programme.



It emerged from the study that the cornerstone of the sustainability of Ruvheneko is the aspect of religiosity of the programme. The drive to serve God through serving others without expecting anything in return is what initially drove the women of the St Anne's Sect of the Roman Catholic Church to offer themselves for volunteering to take over from the hospital staff the load of visiting and helping the sick in their homes. They made home visits together with their usual hospital duties and were getting overwhelmed. In fact, today they act as foot soldiers in the fight against HIV and AIDS at community level. Coupled with religious motivations is the spirit of *ubuntu* which is drawn from African philosophy to help those in need voluntarily (Kaseke & Dhemba 2007:91; Mbiti 1969: 1). In essence, there was voluntary participation during the initiation of the community's response to the devastating impact of HIV and AIDS in the catchment area. The donors only came in to complement and expand the activities but were not the authors of the programme. It is for this reason that the community feels it owns the programme although it is now technically driven by external actors such as Pact ZimAIDS, WFP, Care International, Oxfam GB, BEAM, and MoHCW together with the Order of the Dominican Sisters' funders.

The community was involved in the implementation of the donor funded programme by identifying CHBC-VCGs in their various villages and it is this involvement that evoked a sense of community ownership of the programme. Again, the adoption of a participatory approach from various community stakeholders in the naming of the program as it evolved from being St. Theresa's HBC project to Ruvheneko Program instilled a sense of community ownership of the programme. It is this inclusion which has been a source of sustainability and effectiveness at Ruvheneko Programme.

The holistic approach of integrating HIV and AIDS education, counselling, testing, treatment, care and support adopted by Ruvheneko Programme in its response to the impact of HIV and AIDS gave the programme a human face. In the light of fears surrounding HIV and AIDS, what motivates people to get tested is the availability of treatment in the event of testing positive. In the case of Ruvheneko Programme, most people access VCT because of the guaranteed treatment and support services available which restore the hope of positive living.

#### 5.2.4 Reduction of HIV and AIDS related stigma

It emerged from the study that a high degree of HIV and AIDS mitigation was attained through various activities at Ruvheneko Programme such as community mobilisation, sensitisation workshops, condom distributions, dramas, poems, and information dissemination on HIV prevention, testing, treatment, care and support. This contributed to reduced stigma and prejudice (such as hiding the sick) which used to be associated with HIV and AIDS in the catchment area. An incisive deduction by the study is that most PLWHA in Chirumhanzu today actually prefer to be called by their real names and during my research I came across many informants who actually did not prefer any anonymity and use of pseudo-names (although I eventually used pseudo-names for all informants). This is unusual of many societies given the stigma and discrimination usually associated with HIV and AIDS. PLWHA now feel accepted as part of the community, hence, the disclosure of their real names without fear of being discriminated against or being rejected.

Another breakthrough that emerged from the study concerns the church's change in attitude towards HIV and AIDS. It emerged that unlike in the past where the church perceived HIV and AIDS as a punishment from God, the church leadership were capacitated through various awareness and campaigns by Ruvheneko Programme to accept the reality of HIV and AIDS. Traditional leaders and churches other than the Roman Catholic Church are now working hand in glove with Ruvheneko Programme in carrying out HIV and AIDS campaigns which was not the case during the inception of Ruvheneko. Such changes in perceptions and attitudes towards HIV and AIDS are a sure indication of how Ruvheneko programme has managed a successful change from the usual negative stigma associated with HIV and AIDS in Zimbabwe into a positive attitude.

The documentation, publication, and dissemination of programme success stories as well as personal testimonies have encouraged new clients to access VCT and they are a living testimony of the positive work the Ruvheneko programme is doing. It emerged that as people read case studies and hear real life stories of how various people have lived a positive life after testing positive, they feel motivated and have hope of survival, hence, the increase in VCT access by many without fear of victimisation. The dividends of the programme are made closer and real as they hear first-hand experiences from people they know, like the testimonies and

real life stories cited in Chapter 4. In addition, the employment of PLWHA helped especially the youth to participate in volunteer work as they hope for future employment should the programme expand further. Such positive benefits associated with Ruvheneko Programme erode the stigma associated with being HIV positive.

The integrated and comprehensive nature of Ruvheneko Programme's activities which range from prevention, testing, treatment and care and support is another aspect which has worked towards the reduction of stigma. These efforts have helped in making the community understand that testing HIV positive is not a death sentence since it is a manageable condition. The reduction of stigma is also attributed to continued behavioural change communication and messages. Such intervention messages like 'My friend with HIV is still my friend', 'Let's fight HIV and AIDS and not people with HIV and AIDS' and 'HIV and AIDS is everyone's child' displayed on T-shirts and flyers have helped in getting the message through to the community. The use of poems, dramas and music, referred to by Weiner et al. (2010) as 'edutainment' helped in stigma reduction. However, some elements of stigma still exist as is evidenced by slang labels which are still being used to describe PLWHA such as *akamedza acid* (someone swallowed acid) and *ari mudeparture lounge* (directly translated as 'someone is in the departure lounge', meaning the person is about to die of AIDS). In some instances, mothers who are HIV positive who are not supposed to be breast feeding end up ignoring PMTCT recommendations since it is now common knowledge in communities that if a mother is not breast feeding she is an HIV and AIDS patient. This illustrates that the issue of stigma is one challenge that Ruvheneko Programme is still grappling with regardless of the remarkable reduction in stigma.

### **5.2.5 HIV and AIDS and food security in the context of Ruvheneko Programme**

Food security can be defined as all year round access to sufficient food of appropriate nutritional value (see 2.7). One of the key facets of human security that has been threatened by the scourge of HIV and AIDS is food security. Given that farming in rural Zimbabwe, including Chirumhanzu District, is still highly dependent on human labour, the high prevalence of HIV and AIDS negatively impacts on food security. HIV and AIDS in Chirumhanzu District is compromising food security since most of the mothers who are conventionally producers fall

sick or spend the bulk of their time taking care of the sick. It is in this context that most PLWHA depend on Ruvheneko Programme food aid distributions for survival. Most of the PLWHA are not able to produce enough to feed their families since the children in most cases are left alone to do the farming. This explains why most households end up depending on food aid they get from Ruvheneko Programme. Not only does HIV and AIDS affect the ability of human labour to go to work and earn a wage or salary to buy food for families, it also negatively affects the ability of human labour to produce in the fields leading to food insecurity. Many households which had HIV positive breadwinners in the Mahaso Village pointed out how their families' ability to produce food had been hampered by HIV and AIDS.

One other emerging issue is that since women constitute 70% of the rural populace in Zimbabwe are the most affected by the HIV and AIDS pandemic (see 2.6). Not only has HIV and AIDS incapacitated women to produce enough for their families because of ill-health, it has also led them to be overburdened with farming and as well as primary care-givers role. As such, traditional safety nets like the chief's granary have been negatively affected as more people are unable to produce because of ill-health and those who are still able to produce cannot cope since they do not have spare time for the chief's field (*zunde ramambo*). The weakening of traditional safety nets means PLWHA who cannot produce for themselves and OVC have nowhere else to turn but the food aid initiatives of the Ruvheneko Programme.

Food insecurity increases people's vulnerability to HIV infection because poor nutrition contributes to poor health, low labour productivity, low household income and consequently, livelihood insecurity (see 2.7). Good nutrition for PLWHA delays the progression of HIV into AIDS thereby optimising the impact of ARVs, increasing compliance with treatment regimens and prolonging lives of PLWHA. In the case of Ruvheneko programme however, food insecurity has led to non-adherence to treatment as PLWHA prefer to default treatment so that their CD4 count remain below 200 and their weight below 35kgs and they thus remain eligible for food aid. Ruvheneko Programme staff narrated how non-adherence among PLWHA was at its peak during the period 2002-2009 due to economic and political meltdown where people 'preferred to die of HIV and AIDS than to die of hunger'. Despite continuous nutrition counselling given to PLWHA during food distributions, some deliberately stopped feeding themselves adequately in order to keep their weight below 35kgs, so that they will remain beneficiaries of the Ruvheneko feeding scheme. Such practices act as a hindrance to the fight

against HIV and AIDS and this leaves one wondering whether food aid does more harm than good as it has created a dependency syndrome to the extent that even when people were still fit did not want to work in their fields knowing that they will get food aid from Ruvheneko Programme.

### **5.2.6 The politics of partnerships in the running of Ruvheneko Programme**

Findings from the literature research showed that activities of NGOs and FBOs tend to be shaped by external donors and not necessarily the needs of the PLWHA. The NGOs are funded to provide stipulated intervention services managed by larger programmes and as recipients, they also do not have a say in determining the focus of such programmes (Kelly, Rau and Stern, 2010). Significant community involvement becomes a challenge as a result because funding agencies have requirements and they work on timelines which aim at saving costs and as such, true community consultation tends to take long and this works against cost effectiveness and adherence to given time lines. In the case of Ruvheneko Programme, as a result of partnering with NGOs, community ownership of the programme has been compromised. It emerged that as a result of partnership with the donor community, lack of consultation on key issues of the programme diminished their role as partners. It would seem like the community is more involved at the implementation of key decisions taken by the funders. For example, the needs assessment carried out before the training of CHBC-VCGs seemed to have been the work of the NGO partners and Ruvheneko staff. Some VCG respondents complained that they were not consulted on the length of the training and that even the training manual was designed by Pact ZimAIDS and in English only. Had they been fully consulted on all these matters, they would have highlighted the need for a longer training period as well as the language use. Another important finding from the study concerns power relations in the day to day running of Ruvheneko Programme. It seems there are unequal power relations in the whole partnership arrangement since the grass root members did not participate in the planning of training of HBC VCG for example, yet they are the beneficiaries of this training. Some VCG informants pointed out that the training workshops were intensive and felt they could have benefited more had it been done at a slower pace. In essence therefore, partnering with the funders puts the CHBC-VCGs on the receiving end in terms of content and execution. Interaction between the Ruvheneko programme administrators and the donors also shows unequal power relations

since the programme staff report to the donors and are thus not equal partners. Similarly, the loop-sidedness of this relationship has been reported by Mupindu, Muvandi, Changunda and Maphoshere (2003) who point out that the Pact ZimAIDS programme staff have been accused of treating Ruvheneko programme staff as desperate people who need assistance and are thus on the receiving end.

Crucial aspects of successful partnerships such as joint decision making and financial transparency (see Lister 2000:228) have not been achieved in the running of Ruvheneko programme. During my in-depth interviews, some informants expressed their disgruntlement over lack of transparency on the criteria for food distribution, when some get while others do not. Distribution decisions were made by the donors and Ruvheneko Programme personnel without communicating the criteria to PLWHA. As a result, there were accusations of embezzlement of food aid and corruption. In general, community involvement has been like what Brohman (cited in Crawford 2003:143) call 'instrumental' participation which was just for purposes of accomplishing the agency's objectives through limited consultation and involvement of locals. As alluded to earlier, Mupindu *et al.* (2003) contend that community members were not involved in the planning of programme activities but more in the implementation when they identified and selected CHBC-VCGs although the community members who participated in the research feel they own and lead the programme by virtue of this involvement.

In as much as there are challenges of power relations and limited consultation in the running of Ruvheneko Programme with the partnering with donors, the benefits of the partnership between the community, the programme personnel, the church and the donors have been realized. The expansion of a single service provider project, CHBC into a more comprehensive and integrated one through the provision of prevention, testing, treatment, care and support services in the community's fight against HIV and AIDS are tangible evidence of effective partnership and collaboration.

### 5.3 SUMMARY AND CONCLUSION OF THE STUDY

The main purpose of this study was to establish how community engagement and partnership in one of the most resource constrained rural settings in Zimbabwe resulted in one of the most vibrant rural initiatives in the fight against HIV and AIDS. This was discussed against the bedrock of the fact that rural settings are generally neglected in terms of health care provision in Zimbabwe. The study examined how the severity of the HIV and AIDS epidemic prompted partnership between the St. Theresa's Roman Catholic Mission Hospital, the RCC, the community in Chirumhanzu and the donor community in order to mitigate the impact of HIV and AIDS in the area. The study focused primarily on the Mahaso Village in Chirumhanzu as a test case for establishing the extent to which the partnership has succeeded in fighting the HIV and AIDS epidemic. As explained in the study, the aim was also to examine if the positive portrayal of Ruvheneko Programme by the media is shared by the programme staff and beneficiaries.

In chapter 1, I outlined how the pilot study I conducted on the Ruvheneko Programme triggered a need for further research on how community engagement resulted in the establishment of the programme as one of the rural initiatives in the fight against HIV and AIDS. In the chapter I presented an outline of the statement of the problem, the research questions, assumption and the objectives of the study. In this same chapter, key concepts such as 'community engagement', 'participation' and 'partnership' were defined (see 1.3.1, 1.3. 2 and 1.3.3). In addition, Chapter 1 gave an outline of the methods and methodologies that were utilised in data gathering and analysis as well as ethical considerations guiding the study.

Chapter 2 provided a conceptual discussion on the origins of HIV and AIDS in Zimbabwe using a historical approach. Various explanations of the origins of HIV and AIDS were proffered (see 2.2). In accounting for the HIV and AIDS trends in Africa, scholars have pointed out how sub-Saharan Africa hosts the largest share of the epidemic and this is believed to be caused by poverty, migration, gender imbalances which are perpetuated by patriarchal beliefs (see 2.3). Poor governance as well as socio-economic vulnerabilities also contribute to the high incidence of HIV and AIDS in Sub-Saharan Africa (see 2.3 and 2.9).

Since the discovery of HIV in Zimbabwe in 1985, it has impacted negatively on several aspects of human security ranging from food, education and health wise. (Price-Smith 2007; Rembe 2006; UNAIDS 2005 & ZNASP 2006.). More importantly, the perception of HIV and AIDS as a mere health issue resulted in slow government response which only started in 1987 with the establishment of The National AIDS Control Programme (NACP) which was followed by the National AIDS Council of 1999 (Fourie 2006 & Marais 2000 & Rembe 2006). Another remarkable development in the government's response to HIV and AIDS was the Criminal procedure and evidence Act as well as the Sexual Offences Act which saw the criminalization of the deliberate spread of HIV between couples. The Chapter also highlighted the multi-sectoral responses to HIV and AIDS by NGOs, the church and communities, (Chimhanda 2012; Maluleke 2004; Mupindu, *et al.* 2003; Pary 2002 & PHR 2009). The discussion on how the church (especially the Roman Catholic Church) has responded positively in the fight against HIV and AIDS was also given (see 3.2) and it is the RCC response to HIV and AIDS which forms the basis on which Ruvheneko was established. The multi-sectoral response to HIV and ADIS in Zimbabwe has seen a decline in the number of HIV infections and prevalence as of 2009 (Broom and O'Brien 2011) although the decline could also be attributed to the high incidence of HIV and AIDS related deaths as well as high levels of migration to neighbouring countries during the same period because of economic hardships.

Chapter 3 was built from the elaborate discussion of the impact of HIV and AIDS in rural Zimbabwe which resulted in the establishment of Ruvheneko Programme. It further outlined the historical background and rationale of the establishment Ruvheneko Programme, its expansion as well as the organogram of the personnel component of the Programme. The formation and existence of St. Theresa's Ruvheneko Programme is best understood as a grassroots non-governmental, governmental and community response to the impact of HIV and AIDS in Zimbabwe. Ruvheneko programme merits scholarly attention in light of the fact that it constitutes a modest and comprehensive rural based response to the scourge of HIV and AIDS. The community stood up to fight HIV and AIDS in their own community using locally available resources, especially voluntary labour. The pivotal role of the Church in the formation of Ruvheneko Programme is acknowledged since its establishment was in the broader scope of the Participatory Strategic Planning framework of the RCC. The religious backbone of the Ruvheneko Programme makes it a faith based organization (FBO). It has been demonstrated how the St Theresa's Ruvheneko Programme which initially started informally, later



metamorphosed into a comprehensive programme for the prevention, testing, treatment, care and support. The chapter also revealed how Ruvheneko was sustained and expanded through partnerships which resulted in financial support from the donor community.

It emerged that much of the funding for infrastructural development and training of staff among HBC-VCGs was mainly from Pact ZimAIDS. This was also reinforced by the Global Fund which provided ARVs and other logistical backups for running of the programme such as a vehicles for the outreach activities. Oxfam GB has financed the upkeep of support groups like gardening, sewing, bun making, mat making and knitting where PLWHA meet to share their experiences and encourage each other to adhere to treatment. WFP and Care International are responsible for the provision of food to both the infected (PLWHA) and affected (OVC) in a bid to curb food insecurity. The MoHCW has also assisted by paying salaries for two of Ruvheneko's counsellors and the MoE also helps the Dominican Sisters' Nuns in the OVC care through the payment of school fees and stationery for OVC through its BEAM programme.

In Chapter 4, a detailed discussion is given of all the Ruvheneko Programme activities namely provision of HIV and AIDS education, counselling, testing, treatment, care and support to PLWHA and OVC through CHBC. The success of the activities as reported by informants and the local media point to the fact that the positive picture given about Ruvheneko is not mere hearsay but a reality. Its success is what prompted Pact ZimAIDS to use it as a training ground for the establishment of three other Ruvheneko centres in three other provinces which are now run the same way as Ruvheneko (see 1.2).

Among the other success variables of Ruvheneko is the raised awareness and behaviour change which was a result of the CHBC-VCGSs advocacy, high uptake of VCT, treatment adherence as well as voluntary disclosure by those found positive. The high PMTCT uptake by pregnant mothers has also seen a reduction in the number of babies born HIV positive from HIV positive mothers. Stigma reduction was evidenced by the willingness of the community to participate in the research without fear of discrimination and prejudice. Another success variable is its effective management of the OVC programme which has seen many OVC attend school as well as the building of decent accommodation and Blair toilets for the poor households of OVC. To a large extent, stigma and discrimination were reduced as evidenced by the willingness of

informants to use their real names as well as giving their life testimonies to educate and encourage others who are in the same predicament as they are.

The chapter also discussed the challenges encountered in the establishment of Ruvheneko as well as its general running. It emerged that the Church and its perception of AIDS as a punishment from God is one of the challenges that nearly stalled the establishment of the Programme. Another challenge highlighted is the church's perception of condom distribution as encouraging promiscuity. Among the challenges, it emerged that traditional practices like *barika* (polygamy), *kugarwa nhaka* (wife inheritance) and *kuzvarira* (forced marriages) were also responsible for fuelling the spread of HIV (see 4.7). Stigma and discrimination were also other challenges since PLHWA were given various derogatory terms to describe their 'unfortunate' situation. More so, stigma resulted in hiding of sick people since there were fears that neighbours and friends would laugh at the affected families. The chapter revealed how community mobilisation helped to change people's attitude from negative to more positive.

While food distribution has also been a motivator for people to access VCT, food insecurity has also presented another challenge in the running of Ruvheneko Programme. Some PLHWA are reported to deliberately default taking their ARVs in order to keep their CD4 below 200 and keep their weight at 35kgs so that they remain eligible for food aid. In the long run this is leading to drug resistance and early deaths which could have been avoided. The chapter also revealed that the running of the programme was also negatively affected by the political situation in the country. Food shortages throughout the country forced the programme administrators to introduce new criteria where only those below 35kg and whose CD4 count was below 2000 were eligible for food aid. As a result, this earned the programme a negative political connotation where NGOs were described as supporters of the opposition (the MDC), (see 4.7).

In the final analysis, this study has pointed out that positive picture given of Ruvheneko externally is not mere representation but a reality to a larger extent as gathered from the informants' feedback, my own observations as well as reviewed literature in this study. Also, it was demonstrated that the source of Ruvheneko's success lies in the involvement and participation of the community as well as partnerships with various stakeholders. Furthermore, it was pointed out that the perceived partnership portrays unequal power relations where the

donor partners seem to use their financial muscle to dominate in the process. To a larger extent, stigma and discrimination are at their minimal as a result of the comprehensive approach by the Ruvheneko Programme, ranging from HIV and AIDS education and advocacy, provision of counselling, testing, treatment, care and support. Traces of discrimination are however still evident though outweighed by the dividends of Ruvheneko Programme.

Other emerging themes discussed in this chapter included the relationship between HIV and AIDS and food security as well as the use of traditional and bio-medical approaches in the treatment of HIV and AIDS. Food insecurity has been presented as a challenge in the fight against HIV and AIDS as it affects the uptake of treatment by some PLWHA as well as forcing others to deliberately default from taking their treatment so that they keep qualifying for food aid. HIV and AIDS has also undermined farming in the sense that the able bodied spend too much of their time taking care of the sick instead of tilling the land. Moreover, this has rendered the community helpless and dependent on donor aid. Breadwinners have been made incapable to work to provide money for food and farming equipment, often leaving their families without food. It is such insecurity that has led to increased vulnerability of women and young girls to engage in commercial sex thereby increasing their vulnerability to HIV infection.

In summation, based on the informants' views, my own observations, and the literature review, Ruvheneko Programme's success lies in the participation of the community as well as its partnership with various stakeholders, including the church. Ruvheneko Programme remains an example of how communities can effectively respond to the challenges which face them through utilising locally available networks and resources. I recommend that should there be more funding in future, the CHBC-VCGs need to be salaried since they contribute so much to the running of Ruvheneko Programme's, taking over the work which is meant to be done by health professionals. This will further motivate them to commit themselves to the work they are already engaged in. The programmes in place for OVC do not necessarily cater for HIV positive adolescents who are now sexually active. There is a probability that as most of them become sexually active without having been taught about their sexuality, they will infect others or re-infect themselves by engaging in unsafe sex, hence, the need to have a comprehensive programme which will target this population. As such, there is need to further explore the possibility of designing interventions to educate them on issues of sexual reproductive health, disclosure, deliberate spread of HIV, re-infection and viral loads.

It stands to reason that such a programme should be grounded in empirical research. In this regard, there is need for follow up visits to other Ruvheneko Programmes which were established in three other provinces and see how well they are doing as well as the impact they have had in their catchment areas. Since non-adherence to treatment is emerging as a challenge as PLWHA deliberately default taking their treatment to qualify for food aid, there is need to further explore the impact of incentives in general on HIV and AIDS intervention programmes. Further research should also focus on determining how Ruvheneko HIV and AIDS Programme may be self-sufficient financially amid fears of donor fatigue and centralisation of donor fund disbursement through the Zimbabwe National AIDS Council (NAC).

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