

**HIV and AIDS:
an epidemic of “pandemonium” amid denial and stigma by the
Roman Catholic, Anglican and United Methodist Churches in Manicaland, Zimbabwe (1985-
2002)**

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Abstract

The arrival of the HIV and AIDS epidemic in Zimbabwe in the early 1980s caused pandemonium in a young nation that was still basking in the glory of attaining political independence. With more than 75% of the population being Christian, churches were in a strong position to tolerate and support people infected and affected by the new disease. Initially Christians believed that HIV/AIDS was a curse from God for the sin of adultery and did not affect the “faithful”. Christians’ denial of the epidemic was also imbedded in the notion of AIDS as *runyoka*, a local sexually transmitted condition believed to attack males who had sexual intercourse with someone else’s wife. Christians’ blamed witchcraft for causing HIV/AIDS which enhanced the denial of the epidemic as a biomedical reality. While by the early 1990s church leaders declared that AIDS was not a punishment from God, the stigmatisation of people infected and affected by the epidemic took root among grassroots Christian communities. Using oral and archival sources this article argues that between 1985 and 2002 the reaction by churches to the epidemic was dominated by denial and stigma. Christian communities from the Roman Catholic Church, the Anglican and the United Methodist churches in Manicaland, Zimbabwe, failed to provide safe havens for people infected and affected by HIV/AIDS.

Introduction

During the period of post-independence euphoria from 1980 to 1985 Zimbabwe witnessed a silent HIV/AIDS epidemic. Whereas the first case of AIDS was identified and acknowledged in 1985, there was no publication of infection rates or illness.² Between 1983 and 1985, within medical circles, there were cases of people suffering from a strange disease that was later identified as AIDS.³ Zimbabwe’s population in 1982 was 7.5 million and it increased to 10.5 million in 1992.⁴ Christianity has been the dominant religion with 75% of Zimbabweans being Christians.⁵ The population of Manicaland province on which this article is largely based was 1.5 million in 1992.⁶ The Roman Catholic Church, the Anglican and the United Methodist churches are the largest “mainline” churches which between them share a large contingent of parishes, mission stations, schools and healthcare centres.

This article purports that there were different reactions to HIV/AIDS by the Roman Catholic Church, the Anglican and the United Methodist churches in Manicaland, Zimbabwe, between 1985 and 2000. Briefly, the Roman Catholic Church in Manicaland, institutionally known as the Catholic Diocese of Mutare, has a long history of presence among the Manyika people dating as far back as the 17th century.⁷ By 1955 the Roman Catholic Church in Rhodesia (now Zimbabwe) had attained the status of an ecclesiastical province with five dioceses including the Catholic Diocese of Mutare.⁸ The hierarchical and centralised nature of the Roman Catholic Church meant the diocesan bishops worked under the Zimbabwe Catholic Bishops’ Conference. In 1891 the Anglican Church in Manicaland

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² *Looking Back, Mapping Forwards: Research Findings on Home-based Care in Zimbabwe*, Irish Aid, SAFAIDS and HDN, (November 2007), 29.

³ Tendai Manyeza, interview by the author at Old Mutare Hospital on 24 August 2010.

⁴ Zimbabwe: Provinces, Major Cities and Urban Locations, Statistics and Maps on City Population, <http://www.citypopulation.de/Zimbabwe.html>, accessed on 28 July 2011.

⁵ *Zimbabwe: International Religious Freedom Report-2001*, US Bureau of Democracy, Human Rights and Labour, <http://www.state.gov/g/drl/irf/2001/5718.htm>, accessed on 15 March 2009.

⁶ Zimbabwe: Population Statistics, <http://www.geohive.com/cntry/zimbabwe.aspx>, accessed on 10 August 2009.

⁷ For this see Philippe Denis, *The Dominican Friars in Southern Africa: A Social History* (Leiden: Brill, 1998), 12-54. See also Philippe Denis, “South East Africa”, Philippe Denis (ed), *Dominicans in Africa: A History of the Dominican Friars in Sub-Saharan Africa* (Pietermaritzburg: Cluster Publications, 2003), 33, 36. See also John Weller and Jane Linden, *Mainstream Christianity to 1980 in Malawi, Zambia and Zimbabwe* (Gweru: Mambo Press, 1984), 2.

⁸ Weller and Linden, *Mainstream Christianity to 1980*, 62.

formed part of the Diocese of Mashonaland⁹ and in 1981 established the Diocese of Manicaland. Ecclesiastical authority resides in the office of the bishop acting in synod, which comprises the house of bishops, the house of clergy, and the house of laity.¹⁰ The United Methodist Church, formerly the Methodist Episcopal Church of America (MECA), set up the first mission station at Old Mutare in 1897¹¹ and was renamed the Zimbabwe Annual Conference in 1980.¹² An annual conference is the church’s highest decision-making body constituted by delegates comprising all the clergy including the bishop and laity representatives elected at circuit and district levels.

This article explores the levels of denial and stigma of people infected and affected by the HIV/AIDS epidemic shown by church bodies at the level of a denomination, as well as the local congregations or parishes. Philippe Denis correctly argued that historically each church level made a unique contribution either negatively or positively in their response to the epidemic.¹³ Ecclesiastical structures displayed varied responses to the epidemic, and there were situations of harmony and disharmony between the church hierarchy and grassroots Christians. At the bottom of each church structure was the laity who faced the menace of the epidemic in their localities. At the top of the hierarchy are bishops’ conferences, diocesan bishops, annual conferences and diocesan synods, all responsible for making binding decisions on matters affecting the church. There is always a difference between the grassroots and the church hierarchy’s experiences and perceptions of issues such as HIV/AIDS. This article seeks to illustrate that churches responded to the epidemic differently and it is argued that the actors at each level made specific inputs regarding denial, stigma and discrimination in terms of HIV/AIDS. The effectiveness of the church’s fight against the epidemic has a direct relationship with the realisation that people within the church community are infected and affected by HIV/AIDS.¹⁴

The historical context

The work of scholars such as Luc Montagnier, Elizabeth Bailes and others, Nathan Wolfe, William Switzer and others, Daniel Candotti, Claire Tareau and others trace the origins of AIDS on African soil.¹⁵ This is linked to the collapse of European rule in Africa especially Leopoldville, present-day Kinshasa in the Belgian Congo, dating as far back as 1959. Montagnier, whose laboratory work first identified HIV connected it to the death of an American man in 1952, a Japanese Canadian who died in 1958, an African woman who died in 1958, a Haitian American who died in 1959 and a sexually active American youth who died in 1969.¹⁶ The possibility of HIV originating from Cameroon and West Africa has been a contested issue in the AIDS debate. One view is that during hunting expeditions infected monkeys carrying simian immunodeficiency virus (IMV) transmitted it to human beings.¹⁷ Two theories explain the arrival of the HIV/AIDS epidemic in Zimbabwe. John Iliffe purports that the first HIV/AIDS epidemic reached Zimbabwe from the Karonga region of Malawi in 1982.¹⁸ Similarly, Helen Epstein states that AIDS reached Zimbabwe from the north in the Bukoba-Kagera region of Tanzania.¹⁹ The earliest possible data on HIV/AIDS in Zimbabwe showed that the first case of AIDS and aggressive Kaposi’s sarcoma was diagnosed in 1983.²⁰ In 1985, 3% of blood donors in the northern city of Harare were seropositive compared with 0,05% in the southern city of Bulawayo.²¹ At the district hospital at Hurungwe in Mashonaland West province the number of people who tested HIV positive between 1986 and 1988 escalated from 16 to 292. In Manicaland province all the seven districts, namely Buhera, Chimanmani, Chipinge, Makoni, Mutasa, Mutare and Nyanga, recorded

⁹ John Weller, *Anglican Centenary in Zimbabwe, 1891-1991* (Mutare: Manica Post, circa 1991), 5.

¹⁰ Michael Mbona private archives (MM), “Chapter 1: “The Diocesan Synod”, *Acts of the Diocese of Manicaland, Eighth Session* (December 1997), 1.

¹¹ Roger Peadar, “The Methodists in Zimbabwe”, Weller and Linden (ed), *Mainstream Christianity*, 85.

¹² Andrew Mhondoro, private archives, Rusape, (AM) *Official Journal of the third session of the Zimbabwe Annual Conference of the United Methodist Church*, 2 January 1983, 106-108.

¹³ For a detailed analysis of this see Philippe Denis, “The Church’s Impact on HIV Prevention and Mitigation in South Africa. Reflections of a Historian”, *Journal of Theology for Southern Africa* 134, (July 2009), 68.

¹⁴ Daniela Gennrich, *The Church in an HIV+ World: A Practical Handbook* (Pietermaritzburg: Cluster Publications, 2004), 56.

¹⁵ John Iliffe, *The African AIDS Epidemic: A History* (Oxford: James Currey Ltd, 2006).

¹⁶ *Ibid.*, 3, 4.

¹⁷ *Ibid.*, 4.

¹⁸ *Ibid.*, 33.

¹⁹ Helen Epstein, *The Invisible Cure: Africa, the West and the Fight Against AIDS* (New York: Farrar Straus and Giroux, 2007), 155.

²⁰ Iliffe, *The African AIDS Epidemic*, 38.

²¹ Mary T. Bassett and Marvellous Mhloyi, “Women and AIDS in Zimbabwe: The Making of an Epidemic”, *International Journal of Health Sciences* 21, 1, (1991), 148.

increased mortality from the late 1980s and the national antenatal (ANC) prevalence stood at 12,9% in 1990.²²

The HIV and AIDS surveillance report of 1989 issued by the state’s Ministry of Health and Child Welfare (MOHCW) revealed that between 1987 and 1989 the number of full-blown AIDS cases stood at 1 632 but the cumulative total escalated to 30 427 by March 1994.²³ The city of Mutare in Manicaland, located close to the eastern border with Mozambique, reached an HIV prevalence rate of 37% by 1997.²⁴ There are patterns of infection and oscillating labour migration in Zimbabwe and this relationship is traceable to the colonial period where “men maintained land rights and families in the communal reserves while working in mines and cities.”²⁵ Briefly, the second theory suggests that AIDS arrived in Zimbabwe from the south and there is evidence that AIDS was diagnosed in South Africa in 1982 in a white homosexual air steward.²⁶ The large movement of people between Zimbabwe and South Africa could have offered a possible conduit and is further supported by the perception of “associating AIDS with cross-border women.”²⁷

Denial

Ignorance and complacency lay behind the denial of HIV/AIDS, and the general perception among Christians that HIV and AIDS existed outside the community of the faithful delayed initiatives undertaken by the Roman Catholic, the Anglican and the United Methodist church followers. While the Zimbabwe Catholic Bishops’ Conference publicly admitted the existence of AIDS and made a statement as early as 1987,²⁸ ordinary lay Catholic Christians associated HIV/AIDS with *runyoka* and witchcraft.²⁹ HIV or simply AIDS as it was commonly known during the early days was a disease whose origins and mode of transmission was associated with *runyoka*, a local sexual transmitted infection that, according to traditional belief, attacked males who had sexual intercourse with someone else’s wife.³⁰ Due to being misinformed about the exact causes of AIDS and the mode of transmission, some Christians in Manicaland including Catholics, Anglicans and United Methodists also believed that AIDS was part of *runyoka*.

In the Shona culture sex is strictly protected and both premarital and extramarital sexual intercourse is forbidden through the use of taboos.³¹ Briefly, a man who suspected that his wife was being unfaithful sought the services of a *n’anga* (traditional health practitioner) and obtained a charm. The purpose of the charm was to ensure that any man who had extramarital sexual relations with a married woman was afflicted with a disease that wasted him away.³² The loss of weight common among people infected with HIV and AIDS strengthened the perception that the new “slimming” disease was as a result of *runyoka*. David Simons stated: “Not surprisingly, *runyoka* is often conflated with HIV/AIDS. *Runyoka* is, however, curable with a traditional healer’s intervention; HIV/AIDS is not.”³³ The main factor that caused a shift in the perception that AIDS was *runyoka* was that the “new disease” also infected the wife and unborn infant: *Takazoono kuti kwete iyi hoshwa haisiri runyoka nekuti yaibva yauraya zvese murume, mukadzi nemwana. Asi runyoka rwaingobata munhurume akapomba chete.*³⁴ (We realised later that AIDS was not synonymous with *runyoka* because the new disease claimed the life of the adulterous male, his wife as well as newly born infant). When people discovered this aspect of HIV, they concluded that there was a difference between AIDS and *runyoka*. However, limited changes in the Christians’ appreciation of the epidemic as a biomedical phenomenon continued to exist and thus failed to translate into immediate acceptance and openness about HIV and AIDS.

²² Iliffe, *The African AIDS Epidemic*, 38.

²³ Heads of Christian Denominations, *AIDS: The Christian Response* (Harare: Zimbabwe Council of Churches, 1989). Edward Ted Rogers accessed an electronic manuscript of the document to the author.

²⁴ Iliffe, *The African AIDS Epidemic*, 39.

²⁵ *Ibid.*, 41.

²⁶ *Ibid.*, 43.

²⁷ See also Theresa Matsika, interview by author at Rukweza, Makoni on 8 September 2010.

²⁸ Zimbabwe Catholic Bishops Conference archives (ZCBCH), Harare, ZCBC, “AIDS and Our Moral Responsibility”, Pastoral Statement issued by the Zimbabwe Catholic Bishops’ Conference, October 1987.

²⁹ Heads of Christian Denominations, *AIDS: The Christian Response*.

³⁰ George Maedze, interview by author at the cathedral of Holy Trinity, Mutare on 25 August 2010.

³¹ Cleopas Matenga, interview by author in Vengere, Rusape on 23 August 2010. See also Maedze, same interview.

³² Ralph P. Hatendi, *Shona Marriage and the Christian Churches*, in Michael F. C. Bourdillon (SJ) (ed), *Christianity South of the Zambezi, Volume 2* (Gweru, Mambo Press, 1977), 139.

³³ David Simmons, “African Witchcraft at the Millennium: Musings on a Modern Phenomenon in Zimbabwe”, unpublished paper, Michigan State University, (4 April 2000). See also Hatendi, “Shona Marriage and the Christian Churches”, 139.

³⁴ Simmons, “African Witchcraft at the Millennium”.

³⁵ Norman Mushawa, interview by author at St Matthew’s Anglican parish, Rusape on 12 September 2010.

Christians’ denial of HIV/AIDS was also fuelled by the perception that the epidemic was outside of the church.³⁵ Complacency “ruled the roost” as church followers claimed that they were “immune” to contracting HIV. Elisha Kabungaidze of Hilltop United Methodist circuit in Mutare mentioned that many church members including him thought that people in the church were safe from HIV infection and could not contract AIDS under the false sense of comfort that the new disease only attacked promiscuous people.³⁶ They were surprised later to realise that AIDS “did not know” that one is a Christian.³⁷ Kabungaidze further explained: “You know, the problem with us church people is that we practice self-righteousness. We get to a point where we do not see ourselves as part of this world. With a disease like AIDS many of our Christians never thought it might come to them but it did.”³⁸ That the scourge of HIV/AIDS also infected and affected members of the United Methodist Church was testimony to the fact that everyone was vulnerable. To their shock and consternation the ordained leadership of the church experienced the same fate.³⁹ Adulight Mapa, a retired nurse and member of the churchwomen’s fellowship, known locally as the Rukwadzano RweWadzimai weUnited Methodist Church, stated that HIV/AIDS was never talked about in the 1980s and the early 1990s. Christian churchwomen denied the reality that their families could also be infected or affected by the pandemic.⁴⁰ This attitude was not confined to Christians only since generally Muslims also denied that HIV/AIDS infected Muslims.⁴¹ Such perceptions illustrate the high levels of denial and which further fanned the spread of the pandemic.

The secrecy that surrounded AIDS influenced the public’s general reaction towards people infected and affected by the new disease. In Burundi in 1985 the Ministry of Health prohibited a research team from presenting results of the investigation on HIV/AIDS at a conference in Brussels and blocked publication of the findings in a medical journal.⁴² Marta Zaccagnini mentioned that African governments such as the Democratic Republic of Congo in 1983 and Zimbabwe in 1987 instructed doctors not to mention AIDS on death certificates.⁴³ In Zimbabwe HIV/AIDS was a source of discomfort for the government because the epidemic threatened the viability of the tourism industry at a time when the newly independent state was seeking to market itself. Dunmore Kusano, a medical doctor who trained in Zimbabwe in the late 1980s, mentioned that the government’s fear of losing potential tourist arrivals was a case of complicity in denying HIV/AIDS.⁴⁴ In fact pneumonia, TB2 or resistant malaria was often stated as the cause of death in people who died from AIDS-related diseases. Jessie Chimwaza, a female Anglican parishioner at Holy Name parish, Sakubva, mentioned that in the late 1980s members of the Anglican Church were secretive about the cause of a “slimming disease” that literally disfigured a person prior to its final conquest.⁴⁵ Consistent with this observation, Vuyelwa Chitimbire also mentioned that the church and the state were not angels in the way Zimbabweans in general responded to HIV and AIDS.⁴⁶ Chitimbire, who worked in the public health sector before joining the Zimbabwe Association of Church Hospitals, claimed that the church in general contributed heavily to denial and stigma as did the state.

At the institutional level there was either lack of engagement with the pandemic or negative reactions became the norm. At Holy Name parish, Sakubva, a handful of archival sources indicate that HIV/AIDS rarely featured in the official business of the parish meetings between 1985 and 1994.⁴⁷ Parishioners Chimwaza and Edgar Mbutsa in separate interviews concurred that from the time of the earliest appearance of HIV/AIDS in the 1980s and the surge in HIV infection between 1990 and 2000,

³⁵ Christinah Mombe, interview by author at the Catholic Diocese of Mutare Community Care Project Centre, St Joseph’s Mutare Mission on 19 August 2010.

³⁶ Elisha Kabungaidze, interview by author at Hilltop United Methodist Centre, Mutare on 13 August 2010.

³⁷ Kabungaidze, same interview.

³⁸ *Ibid.* See also Sophirina Sign, interview by author at the Zimbabwe East Annual Conference of the United Methodist Church office, Mutare on 23 September 2010. See also Andrew Mhondoro, interview by author in Rusape on 17 August 2010. See also Theresa Matsika, same interview.

³⁹ Kabungaidze, same interview. See also Sign, same interview. See also Mhondoro, same interview. See also Matsika, same interview.

⁴⁰ Adulight Mapa, interview by author at Dangare in Mutare on 13 August 2010.

⁴¹ Sindre Bangstad, “AIDS and the “Wrath of God”, Farid Esack and Sarah Chiddy (eds), *Islam and AIDS: Between Scorn, Pity and Justice* (Oxford: Oneworld Publications, 2009), 45.

⁴² Paul Kocheleff, “AIDS in Burundi and South Africa: A Day-To-Day Experience”, in Philippe Denis and Charles Becker (eds), *The HIV/AIDS Epidemic in Sub-Saharan Africa in a Historical Perspective*, Online Edition, October 2006, 146.

⁴³ Marta Zaccagnini, “History of HIV & AIDS in Africa”, May 2009, 5, <http://www.avert.org/history-aids-africa.htm>, accessed on 25 May 2009.

⁴⁴ Dunmore Kusano, interview by author at Makuma Medical Centre, Rusape on 21 September 2010. See also Kabungaidze, same interview.

⁴⁵ Jessie Chimwaza, interview by author at Holy Name Anglican parish, Sakubva, Mutare on 24 August 2010.

⁴⁶ Vuyelwa Chitimbire, interview by author at the Zimbabwe Association of Church Hospitals office, Harare on 5 October 2010.

⁴⁷ Holy Name archives, Sakubva (HNM), Minutes of Council Meeting, 6 August 1982, Minutes of Council Meeting, January 1990. Minutes of Council Meeting, January 1993, Minutes of Council Meeting, 30 June 1993.

the epidemic received minimum attention from the leadership of the parish. People simply moralised about the strange disease.⁴⁸ The same scenario took place at other Anglican Diocese of Manicaland parishes including St Cuthbert’s Denzva in Nyazura⁴⁹ and St Matthews in Vengere, Rusape.⁵⁰ The fact that at the local parish level HIV/AIDS was not a regular item on the agenda of council meetings is indicative of the negative attitude towards the pandemic.

HIV/AIDS rarely appeared on the agenda of St Simon Stock Roman Catholic Church parish council meetings between 1991 and 1994.⁵¹ Only at a meeting in June 1994 did the council discuss a proposed HIV/AIDS awareness youth seminar held at St Joseph’s, Vengere on 24-26 June 1994.⁵² The epidemic remained a peripheral issue in services led by the priest-in-charge at St Simon Stock. At the Roman Catholic cathedral of the Holy Trinity in Mutare denial of the existence of HIV/AIDS was noted from the parish council meetings held in 1987,⁵³ 1988,⁵⁴ and 1991.⁵⁵ Given the reality that lay members looked up to the clergy for guidance and leadership, low levels of awareness at the parish level may have caused possible harm. However, in Harare, Father Edward Rogers, a Jesuit priest, reportedly discussed HIV/AIDS at seminars with the clergy and laity of the Roman Catholic and the Anglican Churches since February 1988.⁵⁶ Rogers’ initiatives led to the establishment of the AIDS Counselling Trust in March 1988 and later the national inter-denominational HIV and AIDS forum in 1993.⁵⁷

HIV, AIDS and witchcraft

That witches, satanic spirits, and cannibals had always been associated with misfortune and death beyond natural causes was not new to Africa but the advent of HIV/AIDS brought these beliefs into the limelight. The Manyika people’s worldview that witchcraft accounted for illnesses associated with AIDS meant that reactions to the epidemic were generally characterised by denial. A study by Adam Ashforth showed that in the first years of the epidemic in Soweto, South Africa, black people used to see AIDS as *isidliso* or “Black poison”, an evil work done by witches.⁵⁸ The link between AIDS and witchcraft in South Africa as well as other places on the African continent affected the way in which people responded to the epidemic. Ashforth explained that witchcraft was associated with people’s ability to manipulate evil forces to harm others: “Witchcraft in the South African context typically means the manipulation by malicious individuals of powers inherent in persons, spiritual entities, and substances to cause harm to others.”⁵⁹ Furthermore, the witchcraft paradigm was particularly attractive because the HIV/AIDS epidemic singles out particular victims within intimate social networks and can readily lend plausibility to the suspicion that malicious individuals are pursuing secret evil work. Moreover, as the people so afflicted were not always the most virtuous members of the community, or those deemed most worthy of punishment it is easy to conclude that they are victims of malice rather than justice.⁶⁰

Efforts by the government and non-governmental organisations in Zimbabwe to medicalise HIV/AIDS failed to stop witchcraft accusations whereby witchcraft is taken not as the cause of the death or illness but is held responsible for allowing infection to occur. Being bewitched still has a place among the people of Manicaland and resembles the situation in western Uganda.⁶¹ While officially promoting the medicalised concept of AIDS, many of the Christian churches in practice use concepts of sickness and healing that are based on supernatural powers, the powers of the Christian God and his

⁴⁸ Edgar Mbutsa, interview by author at Holy Name Anglican parish, Sakubva, Mutare on 25 August 2010. See also Chimwaza, same interview.

⁴⁹ Benita Makoni, interview by author at St Cuthbert’s Denzva, Makoni on 15 August 2010.

⁵⁰ Jesmine Mavhima, interview by author in Rusape on 17 August 2010.

⁵¹ St Simon Stock Catholic parish archives (SSCPR), Rusape, Minutes of parish Council Meetings, 1991-1994.

⁵² SSCPR, Minutes of parish Council Meeting, 10 June 1994.

⁵³ The cathedral of the Holy Trinity archives, Mutare (CHT), Minutes of parish Council Meetings, 17 November 1987 and 15 December 1987.

⁵⁴ See CHT, Minutes of parish Council Meetings for 16 February 1988, 15 March 1988, 28 April 1988.

⁵⁵ See CHT, Minutes of parish Council Meeting, 30 March 1991.

⁵⁶ Ted Rogers, *Jesuit, Social Pioneer and AIDS Activist: A Memoir* (Pietermaritzburg: Cluster Publications, 2011), *Forthcoming*. See also T. Rogers, same interview.

⁵⁷ Edward Ted Rogers, interview by author at ARUPE College, Mount Pleasant Harare on 13 April 2011. See also Rogers, *Jesuit, Social Pioneer and AIDS Activist*.

⁵⁸ Adam Ashforth, “AIDS, Witchcraft, and the Problem of Power in Post-Apartheid South Africa”, unpublished paper number 10, (May 2001), 1.

⁵⁹ *Ibid.*, 5.

⁶⁰ *Ibid.*, 8.

⁶¹ Heike Behrend, “The Rise of Occult Powers, Aids and the Roman Catholic Church in Western Uganda” in Felicitas Becker and Paul W. Geissler (eds), *AIDS and Religious Practice in Africa* (Leiden: Brill, 2009), 35. See also Teresa Nyawera, interview by author at St Paul’s Catholic parish, Dangamvura on 5 September 2010.

adversary Satan.⁶² Even though such beliefs were not always expressed at the official level of the church, such as bishops and synods or annual conferences, they were widespread among the grassroots Christians. Local perceptions of AIDS go to the extreme of seeing the disease as a western conspiracy to destroy Africans: “As no cure has so far been found for AIDS, western medicine and aid organisations are accused of being producers of death more than life ... condoms were suspected of not preventing people from infection by HIV, but, instead, of being infected themselves and spreading the deadly disease.”⁶³ However, in Zimbabwe witchcraft is a controversial phenomenon. The laws of the state do not provide for the trial of people who are suspected of practising witchcraft even in cases where they are allegedly caught red-handed.

While modern Christianity stamped out witchcraft and the occult in Africa, Christian movements involved in the fight against the occult and witchcraft were actually reinstating and strengthening the “enemy”.⁶⁴ Christian anti-witchcraft movements strongly reinstated the occult powers they fought against and created a moral crisis for the church and the state by identifying a group of outsiders blamed for the misfortunes. In Zimbabwe the rising deaths from HIV were often blamed on witchcraft. To establish the cause of death a “gata” was organised at which the *n'anga* (traditional healer) identified the culprits responsible for the death of the deceased.⁶⁵ AIDS-related deaths were not an exception to this practice. Between 1985 and 2000 the Manyika people’s worldview that witchcraft was the underlying cause of the pandemic was part and parcel of the denial of HIV/AIDS.⁶⁶ The association of AIDS with witchcraft and occult forces by members of the Roman Catholic, the Anglican and the United Methodist churches in Manicaland had the negative effect of fuelling denial. AIDS was a new disease and ordinary people struggled to understand its origins and mode of transmission.

In the late 1980s the effects of the HIV/AIDS epidemic increased the belief in witchcraft and occult forces in the Anglican Diocese of Manicaland. Witchcraft assumed new status among Anglican Christians who further linked HIV/AIDS to it and thus weakened the church’s potential in combating denial. Generally, witchcraft was a phenomenon that parishioners and families did not speak about openly, especially to clergy, because the church officially discouraged it. The disclosure of one’s HIV/AIDS status was shrouded in secrecy. The failure by the leadership of the Anglican Dioceses of Manicaland to openly deal with HIV/AIDS from a biomedical perspective provided fertile soil for the association of AIDS with witchcraft and occult forces. Rarely did Anglican Christians openly admit to the fact that AIDS was responsible for the death of loved ones.⁶⁷

Within the Anglican Church in Manicaland, Reverend Livingstone Nerwande commenced spiritual healing at St Anne’s, Goto, in 1988 and continued with such activities at St Mary’s Magdalene, Nyanga, in the 1990s. Coincidentally, there were notable surges in HIV/AIDS cases and subsequent deaths and Nerwande’s claims to destroy witchcraft and occult forces that were believed to be the cause of sickness.⁶⁸ Some charismatic Anglicans from Manicaland teamed up with Nerwande to form *Chita cheMuchinjiko*, translated as the “Community of the Holy Cross”, in 1988. The identification of witches and the destruction of occult forces were common features at the healing gatherings. Nerwande with the aid of his supporters claimed possession of supernatural powers that destroyed snakes allegedly, used by witches to harm targeted victims. This had the effect of misleading people, including members of the Anglican Church, to wrongly believe that the HIV/AIDS pandemic was the product of witchcraft and occult forces. Elsewhere in Uganda, Behrend’s findings on the Roman Catholic Church concluded that the increase in the death rate through the AIDS epidemic was responsible for the dramatic activation and rise of occult forces in Africa. In the case of Uganda, like Manicaland, witches were allegedly responsible for the “death of today”.⁶⁹

The fact that Nerwande was in possession of Bishop Elijah Masuko’s licence to function as a priest, meant that the head of the diocese was in full support of the spiritual healing programme. Furthermore, the diocesan leadership and the local mission authorities at St Mary Magdalene permitted Nerwande to establish and construct a spiritual healing centre, which was later turned into a home-based care centre by Bishop Sebastian Bakare in 1999. In Uganda the Roman Catholic Church’s Uganda Martyrs Guild, established in the 1980s, instituted the practice of witch hunting in 1995.⁷⁰ The

⁶² Behrend, “The Rise of Occult Powers”, 35.

⁶³ *Ibid.*, 37.

⁶⁴ *Ibid.*, 32.

⁶⁵ Dennis Masaka and Agrippa Chingombe, “The Relevance of ‘Gata’ Among the Shona of Zimbabwe in the Context of the HIV/AIDS Pandemic”, *The Journal of Pan African Studies* 3, 1, (September 2009), 189-199.

⁶⁶ Maedze, same interview.

⁶⁷ Obert Murakwani, interview by author at St Bartholomew’s Anglican parish, Rusape on 4 May 2011.

⁶⁸ *Ibid.*

⁶⁹ Behrend, “The Rise of Occult Powers”, 43.

⁷⁰ *Ibid.*, 40.

fact that the Holy Cross Guild existed in Manicaland since the late 1980s has led to the conclusion that perhaps Nerwande influenced the developments in Uganda. The Uganda Martyrs Guild called for open confession and destruction of satanic forces in a similar style as did the Holy Cross Guild. This particular rise in the fight against occult forces coincided with the toll of AIDS-related deaths in Manicaland and suggests that Anglican Christians fanned the spread of the pandemic by not accepting the epidemic as a biomedical reality. Although having been formerly trained as a healthcare technician, Nerwande did not consult with medical staff and therefore undermined the services of medical institutions. The demise of Nerwande’s spiritual healing work was directly related to the realisation that his clients, including people living with HIV/AIDS, did not recuperate.⁷¹

“Divine healing” by Father Livingstone Nerwande was discontinued and Bishop Masuko dissolved the Community of the Holy Cross on 27 November 1996.⁷² The circumstances that led to the dissolution of the Community of the Holy Cross included the charging of exorbitant sums of money for healing services. Nerwande’s fame as a divine healer was phenomenal. Whereas Bishop Masuko believed that HIV/AIDS was strictly a consequence of moral failure⁷³ his support for Nerwande’s divine healing ministry for almost a decade misled Anglicans in Manicaland to associate AIDS with sin and the work of witchcraft. History thus repeated itself in Zimbabwe during the time of the HIV/AIDS epidemic. African responses to influenza in Southern Rhodesia in 1918 were similarly characterised by the rise of spiritual healers. Terence Ranger stated that in 1932 the influenza epidemic gave a powerful impetus to the emergence of indigenous prophetic churches led by Johane Marange and Johane Masowe. In their prophetic teachings healing came directly to the purified faithful through the descent of the Holy Spirit.⁷⁴

Unfortunately, the rise of spiritual healing by Nerwande delayed HIV/AIDS initiatives by the Anglican Church in Manicaland. At the Zimbabwe Anglican Church centenary celebrations held in 1991 only the Diocese of Harare acknowledged the devastation caused by HIV/AIDS.⁷⁵ The lack of mentioning of HIV/AIDS by the leadership of the Anglican Diocese of Manicaland showed that the pandemic was viewed to be of less importance compared to other issues.⁷⁶ This was despite the reality that church members and the general population were living in pain due to the effects of the pandemic. A mixture of denial and complacency might have prevented the leadership of the Anglican Church in Manicaland from acknowledging that ordinary Christians were being ravaged by the epidemic. The problem of the Anglican Church in Zimbabwe in general was deeper than what appeared on the surface. Michael Lapsley in 1988 stated: “It is possible to argue seven years after independence, that the Anglican Church [in Zimbabwe] still lacks a self-critical, analytical, or reflective, theological tradition. It still fails to analyse society and its role. There is no preferential option for liberation of the poor.”⁷⁷ The failure to adequately address the HIV/AIDS issue by the Anglican Church in Zimbabwe in general and in Manicaland in particular was attributed to two factors. First, the new leadership struggled to relate to the regime that had now achieved power, and second, the Anglican Church had to carry the “white” parishes with it resulting in racial tension.⁷⁸

In 2000 the denial of HIV/AIDS led to Christians at grassroots level to seek the services of *Tsikamutanda*, a prominent traditional health practitioner and magician. The claim by *Tsikamutanda* that he could destroy witchcraft and evil forces that caused ill health, including HIV/AIDS, ensured that he was regarded as the “person of the moment”. His activities closely resembled those of Nerwande as discussed above. In 2002 the United Methodist Church Zimbabwe East Annual Conference Council on Ministries provided an important illustration of denial of the epidemic when it stated: “Of late the whole country was taken by storm by the *Tsikamutanda* activities which caused havoc in many communities leaving behind trails of hatred, frustrations, accusations, and in some cases

⁷¹ Murakwani, same interview.

⁷² HNM, the Rt Revd Elijah Musekiwa Masuko, Bishop of Manicaland to the Members and supporters of the Community of the Holy Cross Re Dissolution of the Community of the Holy Cross, 27 November 1996. Letter was sent to all parishes and institution of the diocese and to all bishops of the Church of the Province of Central Africa. See also See HNM, Church of the Province of Central Africa, Standing Committee’s Report to Synod, Diocese of Manicaland Synod 1997, Agenda and Reports, 5-6 December 1997, 15.

⁷³ See HNM, Bishop’s charge to the eighth synod: “Unity in the Body of Christ”, 5 December 1997.

⁷⁴ Terence Ranger, “Plagues of beasts and men; prophetic responses to epidemic in Southern Africa” in Terence Ranger and Paul Slack (eds), *Epidemics and ideas: Essays on the historical perception of pestilence* (Cambridge: Cambridge University Press, 1992), 266-267.

⁷⁵ Weller, *Anglican Centenary in Zimbabwe 1891-1991*, 25-30.

⁷⁶ *Ibid.*, 25-26.

⁷⁷ Michael Lapsley, “Anglican Church and State from UDI in 1965 until the Independence of Zimbabwe in 1980”, in Carl F. Hallencreutz and Ambrose C. Moyo (eds), *Church and State in Zimbabwe* (Gweru: Mambo Press, 1988), 126.

⁷⁸ John Weller, “Anglican Integration”, in Carl F. Hallencreutz and Ambrose C. Moyo (eds), *Church and State in Zimbabwe* (Gweru: Mambo Press, 1988), 335.

closed churches.”⁷⁹ There was a perception that Christians infected and affected by HIV/AIDS visited *Tsikamutanda* because they lacked the courage to resist the “temptation” posed by the epidemic. The Conference Council on Ministries took the position that faith in Jesus Christ was the only source of strength amid the HIV/AIDS crisis by invoking the words of a song: *My hope is built on nothing less than Jesus’ blood and righteousness; I dare not trust the sweetest fame, but wholly lean on Jesus’ name.*⁸⁰ In a different guise, the church leadership also showed denial of the epidemic by offering spiritual solutions to the epidemic. This case serves to illustrate that grassroots Christians might have lacked the courage to accept HIV/AIDS as a biomedical reality and that HIV/AIDS was not necessarily the work of witchcraft and occult forces.

Stigma

Stigma, defined as a strong feeling in society that being in a particular situation or having a particular illness is something to be ashamed of,⁸¹ has been strongly associated with people’s reactions to HIV/AIDS. Though stigma might also be self-imposed it is largely related to the assumptions, stereotypes, generalisations and labelling of people as falling into a particular category on the basis of associations.⁸² In the early years of the epidemic the state healthcare system in Zimbabwe also stigmatised people infected with HIV. The author quotes a personal example of this when in 1986 a relative of his died of AIDS and the body was delivered from a provincial state hospital morgue in Mutare wrapped in black plastic and placed in a sealed coffin. The hospital dispatched a nurse who accompanied the corpse to the rural village and stayed there until a day after the burial. The family was ordered not to perform any traditional funeral rites which included washing and viewing of the body, and inheriting the deceased’s belongings such as clothes and utensils was prohibited. Mourners and family members were scared of breathing “polluted” air and this was accompanied by fear of contagion. Such incidents were common in Manicaland and widespread in Zimbabwe at that time. In another similar incident in 1988, a female interviewee mentioned that mourners at Triashill Mission were barred from viewing the body of her nephew who had died of AIDS. The deceased had served in the Zimbabwe military, and personnel from the army were dispatched with strict instructions prohibiting the performance of any traditional family funeral rituals including washing the body.⁸³

The late introduction of voluntary counselling and testing by the state in 1995⁸⁴ was symptomatic of the high levels of denial, stigma and discrimination of people living with HIV/AIDS in Zimbabwe. One of the main factors that contributed to the delayed reaction to HIV/AIDS by the Roman Catholic, the Anglican and the United Methodist churches in Manicaland was the failure by the churches to overcome the stigma associated with the disease. Ezra Chitando stated that when the HIV epidemic first broke out in Africa in the 1980s, the church in fact fuelled stigma and discrimination. The Bible was read in ways that condemned people living with HIV. The issue was reduced to one of individual or personal morality.⁸⁵ None of the three churches established voluntary counselling and testing services until after 2000 and in that way the churches indirectly supported a state of ignorance regarding people living with HIV/AIDS. The theology of divine retribution that perceived AIDS as a consequence of the sin of adultery and promiscuity inherently shaped the churches’ reaction to HIV/AIDS. This observation was not far-fetched as Ronald Nicolson stated: “Insisting, as we should, that the only totally reliable defence against AIDS is a lifestyle of fidelity, we must be very careful to make clear that having AIDS does not mean that one has been ‘promiscuous’. Many, even most, of those who contracted AIDS in South Africa [as well as elsewhere] are not promiscuous.”⁸⁶

Among the Manyika people of eastern Zimbabwe sexually transmitted infections could not be mentioned openly because they “exposed” a person’s infidelity.⁸⁷ Similarly, from the onset of the epidemic, AIDS was a disease associated with adultery and therefore was considered as a “trademark” of promiscuity. Those people who contracted HIV were stigmatised for having “loose” morals and

⁷⁹ Samson Muzengeza private archive (SM), Rusape, Conference Council on Ministries Report to the ZEAC of the UMC second session, 12-15 December 2002, 22.

⁸⁰ *Ibid.* The song was taken from the Wm. B. Bradbury, Seventh Day Adventist Hymn 39: “Dombo Rine Simba” (My hope is built in Jesus the Rock), in *Kristu Mundwiyo* (Bulawayo: Zambesi Union Publishing House, year not stated), 46.

⁸¹ Della Summers, *Longman Dictionary of Contemporary English*, 2003 edition (Essex: Pearson Education Limited, 2003), 1629.

⁸² Warren Parker and Karen Birdsall, *HIV/AIDS, Stigma and Faith-based Organisations: A Review* (Washington D C: DFID/Futures Group MSP, 2005), 5.

⁸³ Nyawera, same interview.

⁸⁴ *Looking Back, Mapping Forwards*, 31.

⁸⁵ Ezra Chitando, *Living with Hope: African Churches and HIV/AIDS 1* (Geneva: WCC Publications, 2007), 19.

⁸⁶ Ronald Nicolson, *AIDS, A Christian Response* (Pietermaritzburg: Cluster Publications, 1995), 24.

⁸⁷ Eugenia Tichawangana, interview by author at Triashill Mission on 9 September 2010. See also Augustine Dera, interview by author at Triashill Mission on 9 September 2010.

therefore “deserved” to suffer. Two elderly and widowed respondents mentioned that within Christian marriages women have always been victims of sexually transmitted infections such as syphilis or gonorrhoea.⁸⁸ When HIV/AIDS first appeared in Manicaland many people hoped that with regular treatment one could fully recover and this delayed the process of realising that this was a new disease.⁸⁹ Richard Chiome of St Simon Stock Catholic parish stated that the infected person tended to develop feelings of guilt and shame due to the association of AIDS with promiscuity.⁹⁰ At St Paul’s in Dangamvura there was a perception among lay people that talking about HIV/AIDS in the church was an embarrassment. Caston Nyemba, a male parishioner, mentioned that one could not discuss AIDS in the church without reference to sex and health.⁹¹ Nyemba’s opinion that matters of sex and health were private and personal, even though widely shared, led to the stigmatisation of people living with HIV, including Christians. Churches failed to become safe and open spaces for discussion on HIV/AIDS because in the Manyika cultural settings sex was a taboo subject. Beverley Haddad’s argument that human sexuality cannot be discussed in the public space including the church has relevance for the churches in Manicaland.⁹²

The Chalice as a “Cup of death”

By practice communicants in the Roman Catholic Church do not have to receive the elements of Holy Communion in two kinds. Within the United Methodist Church communicants are served with wine from individual containers. In both cases the chances of infection from sharing the same cup of the blood of Jesus Christ were non-existent. Until the late 1980s the Anglican communicants in Manicaland used to drink wine from the same chalice. The practice changed when messages from public health circles as well as myths started appearing suggesting that contact with the blood or saliva of HIV and AIDS-infected persons could lead to contracting the disease.⁹³ It became apparent to communicants that the chalice was no longer “the cup of salvation”, but one of “deadly poison” leading to death through contracting HIV from fellow members of the body of Christ. The first Anglican parish to discontinue drinking from the same chalice was the cathedral of St John the Baptist in Mutare. A new reality whereby communicants received the elements of communion by intinction since 1988 was a paradox to visitors.⁹⁴ The fact that members of the cathedral parish included whites, Indians, coloureds and blacks, and that the early cases of HIV/AIDS in Mutare were among blacks, might have caused this situation. At the time the relation between whites and blacks in the Anglican Church seems to have been antagonistic. Father Obert Murakwani mentioned that both the white clergy and parishioners were generally aware of HIV and AIDS but could not speak about it openly.⁹⁵ Within the Anglican Church in Manicaland the fear of HIV infection among the communicant church members gradually led to new relations in the life of the congregations.

The fact that the subject of AIDS and the chalice received formal attention at some meetings of the clergy and the diocesan standing committee from 1989 onwards is an indication of the seriousness given to this matter by the church leadership in Manicaland. Whereas the discussions were influential in shaping decisions regarding changes to the ritual of the chalice, no formal resolution was adopted on the matter. The bishop encouraged clergy and lay leaders to seek the “feelings of Anglican communicants at the parish level”.⁹⁶ Bishop Masuko’s perception of the changes in the ritual of chalice in response to communicant fears of contracting HIV was partly informed by deliberations that were going on in the Church of England on the same matter in 1986.⁹⁷ However, the Lambeth Conference of 1988 attended by Bishop Masuko did not address the issue of AIDS and the chalice save for acknowledging the pandemic and called on Anglicans to play a positive role in HIV/AIDS prevention and mitigation.⁹⁸ Despite the tolerant stance taken at the Lambeth Conference, the fear of contracting HIV from the chalice ranked high in the proceedings at a conference in Kenya in 1989. Father Murakwani attended the proceedings as a delegate of the Anglican Diocese of Manicaland and

⁸⁸ Matsika, same interview and Ellen Humure, interview by author at Watsomba, Mutasa on 13 September 2010.

⁸⁹ John Rukweza, interview by author at Rukweza Service Centre, Makoni on 8 September 2010. See also Humure, same interview.

⁹⁰ Richard Chiome, interview by author in Rusape on 28 August 2010.

⁹¹ Caston Nyemba, interview by author at Fern Valley, Mutare on 2 September 2010.

⁹² Beverley Haddad, “We pray but we Cannot Heal”: Theological Challenges Posed by the HIV/AIDS Crisis”, *Journal of Theology for Southern Africa* 125, (July 2006), 84.

⁹³ Kingston Nyazika, interview by author at the Anglican Diocese of Manicaland office, Mutare on 1 September 2010.

⁹⁴ Murakwani, same interview.

⁹⁵ Murakwani, same interview.

⁹⁶ Murakwani, same interview. See also Margaret Nyakani, interview by author at St David’s Bonda Mission on 22 September 2010.

⁹⁷ Murakwani, same interview.

⁹⁸ See Resolution 29, “Acquired Immune Deficiency Syndrome (AIDS)”, The Lambeth Conference, 1988.

therefore became an important resource on this issue.⁹⁹ Similarly, since 1985 the communicants in the Anglican Church of Uganda have discontinued the practice of drinking from the same chalice due to fear of contracting HIV.¹⁰⁰ Thus the links between the Anglican Church in Manicaland and its counterparts in East Africa might have strengthened the stigmatisation and discrimination of the church’s communicants who were living with HIV.

The changes introduced to the way communicants drink from the chalice as a consequence of HIV/AIDS among Anglican Christians in Manicaland were an indication of the pandemic’s trail of devastation on the faithful. Married communicant women faced a double tragedy. On the one hand the majority of them contracted HIV from their unfaithful spouses, and on the other hand the church failed to provide a safety net for them.¹⁰¹ While Anglican communicants believed in the healing power of the blood of Jesus Christ as received in the Holy Eucharist, the chalice became a death trap. In 1990 the Anglican Church in Manicaland had a total estimate of 46 000 members of which 28 000 were adult females, 8 000 were adult males and 10 000 were youth and children.¹⁰² Thus to a large extent the changes to the ritual of the chalice stigmatised and discriminated against women who were the majority followers. The Anglican Church leadership in Manicaland chose to protect the interests of those who were “well” at the expense of the “infirm”. This attitude was partly responsible for the low level of engagement that characterised the reaction to the HIV/AIDS epidemic by the leadership. Consequently, the division between “them” and “us” partly accounted for why there were hardly any initiatives by Anglican Church members to counter the effects of HIV/AIDS.

On a positive note, in 1989 churches under the Heads of Christian Denominations including the Roman Catholic, the Anglican Diocese of Manicaland and the United Methodist Churches started to confront the stigmatisation of people infected and affected by HIV/AIDS by declaring: “We do not maintain that AIDS is the punishment of a vengeful God.”¹⁰³ Though this issue will be treated elsewhere it is important to point out that the churches in Manicaland owe the Catholic Diocese of Mutare great respect for their courage in launching one of the most extensive home-based and orphan and vulnerable children care programmes in 1992.¹⁰⁴ This became a major step in acknowledging that people infected and affected by AIDS deserved respect, care and support and this also assisted in allaying stigma.

In June 1993 the United Methodist Church held a consultation on HIV/AIDS in Harare whose mandate was to dispel the notion that AIDS was a punishment from God. Leaders of the United Methodist Church from Southern Africa including Zimbabwe at which Manicaland was represented declared:

The origin of this virus is still in question in the medical community, we in the religious community are certain that it is not sent as a punishment from God upon those whose lifestyle is called into question. Humankind does indeed face a crisis in the wake of AIDS. We speak with hope that those who may not have taken seriously the impact and implications of AIDS will now do so.¹⁰⁵

However, the leadership of the Anglican Church in Manicaland trailed behind others and did little to denounce stigma and discrimination of people infected and affected by the epidemic until close to the end of the 1990s. In 1997 Bishop Masuko used his last “charge to synod” to show that the epidemic was not necessarily part of God’s plan of executing retributive justice for the sin of adultery. He went on to mention that HIV/AIDS had multi-faceted causes: “It should be understood that it [AIDS] is an economic, social, health and moral problem. The question is how are we going to invest in our children when these problems are destroying them?”¹⁰⁶ While there was a positive shift in the institutional response to HIV/AIDS in the 1990s, Christians at grassroots level showed little change in addressing denial and stigma of people infected and affected by the epidemic. Followers of the Roman Catholic, the Anglican and the United Methodist churches in Manicaland remained stuck in the notion that AIDS

⁹⁹ Murakwani, same interview.

¹⁰⁰ Rebecca Nyegenye, information supplied to author in 2011 in South Africa.

¹⁰¹ Ruth Mlambo, interview by author at Anglican Diocese of Manicaland office, Mutare on 16 August 2010.

¹⁰² Teddy Chigwanda, Anglican Diocese of Manicaland Secretary e-mail to author, 18 March 2011.

¹⁰³ Heads of Christian Denominations, *AIDS: The Christian Response*, 8.

¹⁰⁴ Joachim Nyamande, information supplied to author in June 2010 at the Diocese of Mutare Community Care Project Headquarters (DOMCCP), St Joseph’s Mission, Sakubva, Mutare. See also DOMCCP archives Rusape, Everisto Benyera, Tendayi Kureya and George Mutsoka, *Evaluation of CRS Zimbabwe’s Home-Based Care Programme*, January 2008, 18.

¹⁰⁵ SM, “HIV/AIDS Consultation Report”, *Official Journal of the fourteenth session of the Zimbabwe Annual Conference of the United Methodist Church*, 8-12 December 1993, 272. See also United Methodist Church Statement from the HIV and AIDS Consultation, Harare, 21-25 June 1993.

¹⁰⁶ HNM, Bishop’s charge to the eighth synod: “Unity in the Body of Christ”.

was inflicted on sexually unfaithful people by God, that the pandemic was related to *runyoka*, and was also caused by witchcraft and occult forces.

Conclusion

This article shows that the arrival of HIV/AIDS in the early 1980s caused significant pandemonium in Zimbabwe as it did in many other countries of sub-Saharan-Africa. The pandemic drew ambivalent and ambiguous responses from Christian communities because it challenged existing dogma, faith practice, and cultural and traditional notions of sexuality. In the first decade of the epidemic the reaction by the Roman Catholic, the Anglican and the United Methodist churches in Manicaland province in particular and in Zimbabwe in general appeared to be that of denial, stigmatisation and discrimination. Initially, ordinary Christians exacerbated denial and stigmatisation of people infected and affected by the epidemic by claiming that HIV/AIDS was a consequence of sin and therefore part of Yahweh’s curse upon an adulterous people. The complacency shown by the members of the Roman Catholic, the Anglican and the United Methodist churches exacerbated the spread of the epidemic. Although church leaders’ perception of the epidemic changed from denial and stigmatisation in the late 1980s to the early 1990s, church followers were slow in accepting and tolerating fellow Christians and community members who fell prey to the pandemic. Generally, theological discussions remained moralistic in tone “as if the areas of prevention on the one side and of support and care on the other were totally disconnected.”¹⁰⁷

The perception of HIV/AIDS as *runyoka* and the general worldview that associated the epidemic with witchcraft common among indigenous communities in sub-Saharan Africa, including the people of Manicaland, did little to alter the state of denial and stigmatisation. Within the Anglican Church in Manicaland denial of the HIV/AIDS epidemic as a biomedical reality led to the emergence of spiritual healing and witchcraft hunting. Similarly, the fear of contagion led to permanent changes in the ritual of the chalice and thus fuelled stigmatisation and discrimination of HIV-positive Anglican communicants. While this development was welcome to many people, generally the denial and stigmatisation of people infected and affected by the epidemic was a hallmark of the longest serving churches in Manicaland and turned them into liabilities and not assets in the fight against this disease. Perhaps HIV/AIDS-related denial and stigma could have been reduced early through the collaborative response of church leaders and Christians at grassroots level.

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