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A HOLISTIC PASTORAL APPROACH TO HIV/AIDS SUFFERERS: REDUCTION OF STIGMATISATION IN ZIMBABWE

A dissertation submitted to the University of Dublin
for the Degree of Doctor of Philosophy

Annah Nyadombo

2012

Declaration

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Summary

This thesis was written as a research project on *A Holistic Pastoral Approach to HIV/AIDS Sufferers: Reduction of Stigmatisation in the Diocese of Mutare, Zimbabwe.* The purpose of the research was to explore the connection between HIV/AIDS and stigmatisation, in order to develop a vision and a strategic policy and plan of action for the Diocese of Mutare, which can best assist sufferers to rediscover their own sense of dignity and worth, agency and empowerment. The structure and elements of a comprehensive pastoral approach was designed to take account of and bring together, suffering people, expressed experience, stated needs, and relevant research on the understanding of HIV-AIDS and on stigmatisation. Moreover, bringing these elements together into dialogue and interaction is necessary in order to develop a holistic and strategic vision and practice of pastoral care that embraces a person in their totality. The physical, spiritual, emotional, social, intellectual and environmental needs were key aspects of life identified as central to such a pastoral care vision and strategy; With such core components as healing, hospitality, compassion, empathy, peace and justice kept in view, and fundamentally, the subjective agency, capabilities and participation of sufferers in deliberation and decisions about their treatment and care, if stigmatisation is ever to be overcome.

The research methodology of this thesis consisted of a descriptive survey method in which, through questionnaires, the respondents were asked to provide information. This method helped to deal with both qualitative and quantitative data. Snowball sampling was used to get the total respondents for the case study. In addition, the researcher drew together information and analysis through literature review – books journals, articles, newspapers, magazines and documents of the Roman Catholic Church and World Council of Churches. Interviews, observations, onsite research in the Diocese of Mutare also provided valuable data on what has been written and said about HIV/AIDS and stigmatisation. The onsite research yielded valuable qualitative data resulting from questionnaires completed by 10 Church leaders, 30 Church members, 20 caregivers and 30 sufferers. Although the sample was small, a 100% response to the questionnaires

was evoked. Further valuable quantitative data resulted from interviews and discussions with 10 members of the study group and also general observations of encounters between sufferers and others.

Poverty, lack of education, economically necessary prolonged separation of husbands and wives and female servility has all helped the spread of HIV/AIDS in sub-Saharan Africa. Stigmatisation, on the other hand, was shown to be fostered by long-held cultural, social and religious practices. Sufferers endure intense stigmatisation since this is demonstrably one of the ways that 'in-groups' set out to protect themselves from 'out-groups' and maintain the "safety" of the status quo. The theory of Structural Violence (Galtung) highlighted that need for the Church, governments, and citizens to work together for justice, solidarity, participation and the common good. The case study revealed sharp differences between what sufferers said they needed – e.g., regular visits, love, health care, food, education, choice and involvement; and what care-givers, Church leaders and members actually offered in practice. By bringing this disjunction under scrutiny and into critical correlation ship, a way can be opened towards change. A potential dismantling of the apparatus of stigmatisation and the crisis is possible in this way.

Based on all the research and most particularly, on the results of the case study, the author developed and recommended a new paradigm of Holistic Pastoral Care by the Catholic Church in the Diocese of Mutare – one that is relevant for community-based organisations and for other Churches and faith communities. This approach is premised fundamentally upon a community basis rather than an individual basis merely – though never losing sight of the unique needs of each person. The approach has to provide for the physical, mental, psychological needs of sufferers, and to treat a person in their wholeness as participants in a wider community of life and being. The model showed that all aspects of life are to be addressed in order to reduce factors that embed and consolidate the stigmatisation process. Finally, the Catholic Church was challenged to be prepared to work with other Church denominations and agencies in Mutare, both in ministry of common witness and care, and to pool and maximise resources to make the 'all-embracing' holistic pastoral care approach effective and successful.

Dedication

I dedicate this work to my late parents William and Theresa (Magudura) Nyadombo, my relatives and friends, Martin and Catherine Wall Family, Fr. Ray Flaherty, Flaherty Family, Sr. Anne Marie, Margaret O' Shaughnessey and family, Eilish and Liam Bracken Family, Una and Micheal Crean Family, and to all who supported me during my studies.

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I would like to thank the Irish School of Ecumenics and Trinity College Staff at all levels who have helped me since my arrival in Dublin. I thank in a special way, Christine, Mary, and Aideen of the Irish School of Ecumenics for their outstanding administrative work. I offer my sincere gratitude to the Library Staff in the Irish School of Ecumenics and Trinity Campus for their assistance in my search for relevant information.

I wish to express my deep gratitude to all the Academic Staff of the Irish School of Ecumenics for their dedication and knowledge. Thanks to all Professors who contributed to my studies from other faculties. My sincere gratitude goes to Professor Gillian Wayne for her guidance and encouragement. And of course, most of all, I would like to thank my Supervisor Professor Geraldine Smyth for her patience and intelligence in deciphering my obscure drafts, and, above all, her constant efforts and help over the years. My sincere gratitude goes to the examiners Professor Suzanne Mulligan and Professor Linda Hogan for their amazing knowledge and expertise which have helped to shape the final copy of this thesis. Their contribution will ever be valued in life.

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And of course, I wish to thank my relatives, nephews, nieces, cousins, my brothers, sisters, and all my friends for their love and support. Last but not least, I express my profound gratitude to those I would have liked to be by my side but unfortunately departed too early, my father William, my mother Theresa, my sister Christine and my brothers Patson and Noah, Sr. Martha O.P., May they Rest In Peace.

May God bless each and every one of you, I remain united in prayers.

"Let us concern ourselves with things divine, and as pilgrims ever sigh for and desire our homeland; for the end of the road is the traveller's hopes and desires, and thus, since we are travellers and pilgrims in the world, let us ever ponder on the end of the road in our homes." St. Columbanus, seventh-century Irish Saint.

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
CAFOD	Catholic Agency For Overseas Development
CRS	Catholic Relief Services
DH	*Dignitatis Humanae*
DHS	Demographic Health Survey
DNA	Deoxyribonucleic acid
DOMCCP	Diocese of Mutare Community Care Programme
DRAW	Die, Recognise, Acknowledge, Welcome
FACT	Family AIDS Caring Trust Family Action Counselling and Testing
GNP	Gross National Product
HIV	Human Immune-Deficiency Virus
IEC	Information Education and Communication
MOHCW	Ministry of Health and Child Welfare
NAC	National Aids Council
NGO	Non-Governmental Organisation
NHISU	National Health Information and Surveillance Unit
PACSA	Peace and Conflict Studies in Anthropology
PEN – 3	Perceptions, Enablers, Nurturers
PLWHA	People Living with HIV/AIDS
RAW	Recognise, Acknowledge, Welcome
RC	Roman Catholic
STD	Sexually Transmitted Disease
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International development
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
ZCBC	Zimbabwean Catholic Bishops' Conference

Chapter 1 INTRODUCTION

1.1 Background to the Thesis

The dual aims of this thesis are to examine the current factual situation regarding the personal and family situation of people suffering from stigmatisation due to being diagnosed as HIV-AIDS positive and to develop a holistic pastoral care model to alleviate their sufferings. There is a substantial amount of readily available knowledge on this disease subject but very little research has been done on the effects of stigmatisation on those who are suffering.

The thesis is not focused on HIV (Human Immunodeficiency Virus) which can lead to full blown AIDS (Acquired Immunodeficiency Syndrome).[1] The focus concentrates rather on the fact that HIV-AIDS related stigmatisation. Stigmatisation, one could say, is the disease underlying the disease. Stigmatisation' in this context, can be seen as a social, cultural, and religious reaction to HIV-AIDS. Worldwide reaction to HIV-AIDS has a parallel in how people regarded, and probably regard the disease of leprosy. The thesis is very much focused on the people of the Catholic Diocese of Mutare, Manicaland Province, Zimbabwe.

The thesis emphasises that one cannot fully understand the basis of stigmatisation without grasping the deep and complex roots of the cultural, social, and religious norms of communities. Thus each chapter elucidates and highlights core stigmatisation concepts developed through research, which contribute in turn to the key building blocks of a holistic pastoral care approach.

The thesis also seeks to contribute solutions for the Churches in the 21st century, and particularly for the Roman Catholic Church in the Diocese of Mutare. The author also proposes possible future research areas which lay beyond the limited scope of this thesis.

It is hoped that this thesis will facilitate and challenge the Church's pastoral approach to sufferers and promote the need for an approach to pastoral care that is personal, communally focused, and comprehensive. The results can help

[1] Helen Jackson, Russell Kerkhoven, Diane Lindsey, Gladys Mutangadura, Fungayi Nhara, *HIV/AIDS in Southern Africa: A Threat to Development*, (Harare: Southern Africa AIDS Information Dissemination Service 1999), p. 7.

promote and strengthen a sustainable primary health care response to the health care needs of both the infected and wider community

1.2 Sub-Saharan Africa

In sub-Saharan Africa, the exponential spread of HIV-AIDS and its devastating social impacts have proved overwhelming for the people already impacted by poverty, war, infant mortality, gender injustice, and unemployment. Many die for want of access to relatively inexpensive medicines. Other people have died through lack of disclosure and for fear of losing support from their family members, friends, community, and society at large.[2] But many others have suffered silently and differently because of the destructive effects of the stigma attached to the disease as well as the process of stigmatisation which plays out inexorably and all pervasively in the lives of those who are infected. The process of stigmatisation is a vicious cycle which spirals downwards and outwards, damaging the sufferer, family members, local community, and wider society[3]. Each negative manifestation of stigmatisation reinforces one another, thus fuelling and embedding stigmatisation in cultural, social, and religious institutions.

In Zimbabwe, the disease of HIV-AIDS and its stigmatisation has increased and intensified with many of the current disadvantages and hardships related to economic poverty, political upheaval, social uprooting, cultural alienation, religious disapproval and environmental loss.[4] The lack of equilibrium in these elements of life exacerbates social divisions, personal isolation, poverty, and power imbalances.[5] Taking all of the above into account, the disease of HIV-AIDS and related stigmatisation is not perceived to be a manageable disease. Rather, it is blown out of proportion and in effect takes on a life of its own whereby it is described in frightening terms with death as the only ultimate result. This causes even more problems for the infected and leads to even more stigmatisation. As Zimbabwe is one of the most seriously HIV-AIDS impacted countries, it is hoped

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[2] Ann Smith and Enda McDonagh, eds., *Christian Perspectives on Development Issues: The Reality of HIV/AIDS,* (Kildare: TRÓCAIRE Catholic Agency for World Development, 2003), p. 13.
[3]Ann Smith and Enda McDonagh, eds., (2003), p. 26.
[4] Linda Hogan, "Cross-cultural Conversations: Applied Ethics in a World Church," in Linda Hogan, ed. *Applied Ethics in a World Church: The Padua Conference,* (Maryknoll, New York: Orbis Books, 2008), p. 3.
[5] Helen Jackson *et al.,* 1999, pp. 14-17.

that this thesis will bring enlightenment to all parties concerned in the welfare and wellbeing of HIV/AIDS sufferers, especially on how to reduce stigmatisation and promote health, social inclusion and vitality.

1.3 Research into the Causes of Stigmatisation

Stigmatisation manifests itself in various guises; a number of such manifestations are explored in Chapter 2. The American psychologist, Erving Goffman emphasizes in his theory of stigma, that the stigma relationship is one between an individual and a social setting with an ascribed set of expectations. Thus, everyone at different times plays both roles of stigmatised and stigmatiser (this latter, he terms "normal"). Developing his language of "insiders" and "outsiders" and the normalization dynamics of stigmatisation (at a time in the USA when segregation was the norm in the Southern States of America), he analyses the lengths that some people went through in order to conceal the realities that are deemed abnormal by society, for fear of being marked as failures and outsiders.[6] This theory is helpful towards understanding such socially constructed and culturally controlled attitudes of one person or group towards another as all too normal in its recurrence.

Another sociologist, Falk, likewise concludes that "we and all societies will always stigmatise some condition and some behaviour because doing so provides for group solidarity by delineating "outsiders" from "insiders" (Falk, 2001: 24). This is an important claim because, paradoxically, it reminds us that stigmatisation practices are not confined to extreme cases, but are frequent in human behaviour. At the same time, stigmatisation is a challenge to the humanity of both the *stigmatised* person or group and the *stigmatising* person or group.

Furthermore, the majority of research into stigma has found the process of stigmatisation has a long history and is cross-culturally ubiquitous.[7] Research shows that culture plays a crucial role in the process of stigmatisation. People are

---

[6]Erving Goffman, *Stigma: Notes on the Management of Spoiled Identity.* (London: Prentice-Hall, 1963), p. 13.
[7]Kleck Heatherton, *The Social Psychology of Stigma*, (Hebl and Hull: The Guilford Press, 2000), p. 14.

influenced, shaped, and even conditioned by their culture and it is inherited thought patterns and behaviour (Bate 2009:9). Of course, individuals react to or

Actively cope with stigma in a variety of ways across stigmatised groups, and according to different times and situations.[8] Human behaviour is not necessarily predictable.

And so, the argument of the thesis develops through six chapters. Each building up and testing the argument that one cannot fully understand HIV-AIDS sufferers and their needs without a wide-ranging grasp of the stigmatisation that persistently attaches to the disease.

1.4 Definitions and Root Causes of Stigmatisation

Chapter 2 provides the background to the study and includes definitions – of stigma and stigmatisation and its root causes, with a particular emphasis on the effects of religion, culture (including the media), and social order. This is followed by an explanation of such pivotal terms as attitude, prejudice, stereotyping, myth, deviance, stigma, and how these realities impact on stigmatisation.[9] The thesis aims to provide a sociological definition of stigma and stigmatisation, drawing upon cultural and theological factors, as crucial to a proper understanding of the concepts and meaning in the context in which they are used. For example, sociological factors are taken to include socio-economic realities such as poverty, power in all its forms, policies, politics, gender, and sexuality (Kusumalayam 2008:89). The existence and operation of these factors are shown to re-inscribe and intensify existing stigmatisation. Cultural aspects are probed to demonstrate how mentalities and practices engrained in traditional beliefs, values, customs, social forms, norms relating to marriage, inheritance, and work, all serve to aid the perpetuation of a stigmatisation system in multiple ways.[10] Some of the important forces in society are organisations like the following: the media, the business

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[8]Alec Irwin, and Elena Scali, "Action on the Social Determinants of Health: A Historical Perspective," *Global Public Health,* Vol. 2, no. 3. (2007), pp. 235-256.

[9] Stuart C. Bate, *Understanding Human Society,* (Nairobi: Paulines Publications in Africa, 2009), p. 12.

[10] Rose N. Uchem, *Overcoming Women's Subordination: An Igbo African and Christian Perspective: Envisioning an Inclusive Theology with Reference to Women,* (Parkland: Dissertation.com, 2001), p. 72.

community, the military, the government, trade unions, Churches, religious groups, educational institutions and so forth.[11] The understanding and elucidation of negative impacts of stigmatisation will become crucial later in the thesis in the identification of key pathways to reduce stigmatisation and the disempowerment that typically accompanies it.

1.5 HIV-AIDS and its Relationship to Stigmatisation

In Chapter 3, the disease HIV/AIDS is discussed in detail following the same substantive sociological, cultural, and religious factors as discussed in the previous Chapters. Structurally, the chapter sets out to provide with simple non-technical language, a description of the disease, the social aspects of the disease and the suffering of the infected.[12]

This Chapter also outlines how the disease, particularly in a number of African regions, is aggravated by such prevailing realities as poverty, hunger, economic inequality in the workplace, disruption of supportive family processes, gender-based oppression, class discrimination and such cultural practices as polygamy. Sub-Saharan Africa is shown to be more heavily affected by HIV and AIDS than any other region of the world. Since the beginning of the epidemic in the early 1980s, 14.8 million children had lost one or both parents to HIV/AIDS.[13]

Currently one in ten of the Zimbabwe population is living with HIV.[14] The country is caught up in one of the harshest AIDS epidemics in the world. In a country with such a tense and troubled political and social climate, an effective response is even more difficult. The government has been widely and vigorously criticised by the international community, and Zimbabwe has become increasingly isolated politically and economically from the nation community. Zimbabwe has had to confront successive severe crises in recent years, including an unprecedented rise in inflation (in January 2008 it reached 100% plus). The social and economic consequences of the HIV epidemic are widely felt, not only in the health sector, but

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[11] Bate 2009, p. 15.
[12] Helen Epstein, "The Global Health Crisis", in Kurt M., Campbell and Philip Zelikow, eds., Biological Security and public Health: In Search of a Global Treatment, (Queenstown: The Aspen Institute, 2003), p. 5.
[13] UNAIDS A Report on the Global AIDS Epidemic, Geneva: UNAIDS, 2010, p. 9
[14] UNAIDS (2010), p.10.

also in education, industry, agriculture, transport, human resources, and the economy in its local and global dimensions (Jackson et al., 1999: 26-28).

The Chapter further develops an understanding of stigmatisation as a spiralling process whereby the individual is initially marked out and ultimately excluded, undermining bonds with family, friends, community, and society at large. Light is also shed on patterns whereby the community and even family of the stigmatised person are pressured to act negatively due to the heightening of fear of the disease and its imputed endangerment to all. The theory of Johan Galtung on structural violence[15] is also introduced as a determining concept to highlight the indirect, covert, yet "devastating patterns of stigmatisation on all aspects of a person's life leaving them with virtually no socio-economic, cultural, familial resource, and support systems," (Kelly, 2010: 120-21, 188).

This chapter argues and advances evidence that stigmatisation is not identifiable by straightforward means; not so much because of fear of disclosure on the part of sufferers and because the stigmatising and shunning comes to be regarded as normative and socially valued. Rather a more blameworthy and socially destructive root of stigmatisation comes when almost all blame, accusation, cursing and condemnation are directed at sufferers, leaving them shorn of human dignity and respect. The chapter thus demonstrates that it will require systemic engagement and an inclusive approach if stigmatisation is to be challenged and reduced.

1.6 The Role of the Church

Chapter 4 is a critical discussion of the realities of stigmatisation in the Church and its agencies in Zimbabwe. The chapter seeks to identify the role the Churches – specifically the Roman Catholic Church – have played through ignoring, colluding or actively contributing to attitudes and behaviours that stigmatise those suffering from HIV/AIDS. For example, the Church stands accused of using judgemental language in preaching. Churches have historically, up to the current day remained

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[15]Ian Attack, "Peace Studies and Social Change: The Role of Ethics and Human Agency," in *Policy and Practice: A Development Education Review.* Vol. (9), (2009), pp. 39-51.

silent, not acting to raise awareness about the disease and the actual and multiple factors which render people more vulnerable to the disease (Khathide 2003:1). Relevant documents of the Zimbabwean Catholic Bishops are adduced to in this respect. Initially, the Church's focus was – unhelpfully – on a single line of causal analysis and approach (sexual behaviour, calls for sexual fidelity or abstinence, for example). Only later were socio-economic factors acknowledged as were issues of health justice and social justice. Following this, came a focus on the pastoral and ecclesial challenge of addressing what might be needed in terms of God's mercy at work. The Church is now challenged to reassess priorities of justice, relationship, and pastoral care on a relational basis, showing empathy with those who suffer, preaching compassion, hope and welcome to all.[16] The primary focus of the Old Testament thinking on health and illness is on God as the one who can give or take health and life away. Good health was looked on as the result of living an unblemished life and vice versa, "good health is directly connected to holy living."[17] As stated in Deuteronomy, "I wound and I heal; and no one can deliver from my hand."[18] Hence, the worldly aspect of Israel's relationship with Yahweh emphasises life with the result that immediate rewards and punishments in terms of health and wealth, sickness and misfortune, play a dominant role.[19] In the book of Leviticus (26:16), the view of leprosy was based on ethical considerations and was largely regarded as a punishment from God. Sickness as a punishment and taint was also considered a breach of the covenant between God and his people in the Book of Psalms and in the Book of Proverbs.

In some Episcopal teaching, however, sickness is even presented as a grace and as a path for transformation for the Church. However, there is a failure here to keep the sick as persons at the centre of the leadership and teaching focus. The reality is that few sufferers accept such a ravaging sickness as grace and often struggle in doubt, searching for the truth about God's will in the midst of their affliction, or a word of comfort and assurance. Examination of later Zimbabwean Bishops'

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[16] Ezra Chitando, *Living with Hope: African Churches and HIV/AIDS,* Geneva: World Council of Churches, 2007, pp. 40-41.
[17] John A. Sandford, *Healing Body and Soul: The Meaning of Illness in the New Testament and in Psychotherapy,* (Leominster: Gracewing, 1992), p.13.
[18] Deut. 32:39; Ex 4: 11; Am 3:6; Isa 45:7.
[19] Morton Kelsey, (1976), pp. 34-35.
John Wensing, *Health and Healing – Studies in New testament Principles and Practice,* (Edinburgh: The Handsel Press, 1980), p. 30.

Letters reveals some change of direction, for example the letter written in 1998 calls the whole nation to genuine unity through faith and conscience. The Roman Catholic Church is shown as needing to step into a wider and more focused public role with regards to the great importance of justice and the pastoral care of a suffering people.

1.7 Case Study Diocese of Mutare

Chapter 5 presents a case study actually carried out in the Diocese of Mutare, one of eight Catholic dioceses in Zimbabwe. The case study was aimed at getting first-hand information from the sufferers, care-givers, Church leaders and Church members. The Diocese of Mutare is to be used as a pilot study, with the intention that the research findings can be studied and used by other Dioceses in the country, and by other organisations and denominations who are also engaged in the pastoral care of HIV/AIDS patients.

The study draws upon theoretical and research insights outlined in the first 2 chapters of this thesis particularly relating to factors identified as catalysts that fuel stigmatisation. The respondents are from four key categories namely, sufferers, caregivers, Church members and Church leaders.

People with an involvement in HIV/AIDS care were identified, who then recommended others to be contacted. The researcher contacted the respondents by email, letter, telephone and personal visits to ask for their consent before commencing the field work. The respondents gave their written consent to take part in the study. Ethical research guidelines were observed dealing with matters of respect for human dignity, confidentiality, and communication. The researcher requested assistance from members of her religious congregation to distribute and collect questionnaires – all in sealed and tamper proof envelopes.

The result of the case study demonstrates that the knowledge of the disease is uneven and points towards a more soundly based understanding of the realities of HIV/AIDS. It also indicates a clear need for informed understanding of the contributory factors and dynamics of stigmatisation and its operation as a vicious cycle, which all variously and to different degrees play a part in maintaining and intensifying the problem. The chapter presents the data descriptively,

diagrammatically and analytically. The case study is effective in highlighting how the dynamics and definitions derived from studies of stigmatisation in other spheres, are actually played out dramatically in the sphere of HIV/AIDS. It is also useful in highlighting specific areas of good work and cooperation, but also points to those roles, policy and provision which need urgent attention and better coordination. The latter are especially important to the development of a holistic pastoral approach that is centred on the experience, voice and holistic needs of those who are suffering from the illness. The case study shows that there is a lot of good work currently going on but the approaches are not holistic, in fact they are disjointed and not always relevant.

1.8 A Holistic Pastoral Approach

Chapter 6 deals with the holistic pastoral approach to HIV/AIDS sufferers in the Diocese of Mutare. The chapter focuses on the Church as the Body of Christ, its ministry, and its role in pastoral care. The chapter emphasises the need for community involvement in pastoral care. The involvement focuses on an ecosystem approach where everyone in engaged universally for the common good. The ecosystem approach is recommended because it is not size dependent. It means that expertise is concentrated and all facts of life are taken into consideration. Thus the wholeness of the person is respected with dignity restored. A holistic approach does not ignore the person's physical, emotional, spiritual, economic, and intellectual needs. Policies and laws should be framed through considering the human dignity and promotion of development with the aim of addressing injustices in society (Chitando 2003: 25). All aspects are to be addressed to have a comprehensive approach. Thus the sociological, cultural and religious aspects of stigmatisation can be reduced.

The chapter makes reference to the Vatican II documents which give instructions on the mission of the Church and the calling for evangelisation. The reality of God is discussed to provide meaning on the work of salvation. Jesus is the model of healing and of hope in the chapter. The understanding of healing was developed as far back to the Old Testament. The chapter is fashioned in a way that reminds the Church to take an active role in the ministry of healing and the use of the sacraments in the process to transformation to a more caring body.

A method to reach-out to people who are stigmatised was developed called the 'Justice Model' approach. This has 3 stages. First, an Approach, which means Recognising, Acknowledging, and Welcoming the individual. Second, Accomplishment, which includes Reciprocity, Affirmation and Win-Win for the individual. Third, Announcement, which means Relationship, Added Value and Well-being for the individual. This MODEL can make a vital contribution to reducing stigma and restoration of the health and dignity of a person. This method is rooted in the embracing of the person in their wholeness.

In addition, the author feels that future work could be undertaken on attitudes, and on the cultural beliefs that make people act and see things as they do. Society could benefit from these studies for they will expand our understanding of stigmatisation.

1.9 Conclusion and Recommendations

The final chapter draws all the major points of previous chapters together and develops recommendations for informing the vision, policy and practice of the Roman Catholic Diocese of Mutare and the wider caring community with the aim of reducing HIV/AIDS related stigmatisation by education, the use of the media, other programmes and community holistic care. Education is required to show that people with the disease are not pariahs and are not being punished by God for sinful transgressions. This stage involves action at different levels, local and regional, pastoral and public; taking into account both personally oriented and wider strategic and policy approaches.

Chapter 2 STIGMATISATION

> We can fight stigma. Enlightened laws and policies are keys - but it begins with openness, the course Schools should teach respect and understanding. Religious leaders should preach tolerance. The media should condemn prejudice and use its influence to advance social change, from securing legal protections to ensuring access to health care.[20]

2.1 Introduction

Stigmatisation is not new; it has existed for as long as man has lived on this earth. The Hebrew and Christian Scriptures abound with examples such as tax collectors, the lepers, and the sick. Even literature old and new exemplifies this point. A good example is the story of Jude the Obscure written by Thomas Hardy published in 1895. Jude is a highly intelligent working class man who finds that his path to a university education, his passport out of poverty, is prohibited by class and lack of money. He experienced exclusion and isolation. The story of Jude ends in sadness which has many parallels with the tragic situation of how many suffer due to stigmatisation in today's world (Hardy, 1895).

While this thesis deals with the problem of HIV/AIDS related stigma in Zimbabwe, the developed world is not immune to the problem. Indeed, Gerhard Falk (2001)[21] remarked "The lesson learned from a review of stigmatised people in American life is, that we and all societies will always stigmatise some condition and some behaviour because doing so provides for group solidarity by delineating "outsiders" from "insiders."[22] So, while the problem may be more prevalent in the developing world, the developed world also has its own problems. The purpose of this chapter is to define stigma and stigmatisation, identify the social, religious and cultural underpinnings of stigmatisation, and identify the consequences of stigmatisation for those considered to bear a stigma. Faulker et al., (1994) in their study, *Robert Burton in the Anatomy of Melancholy*[23] uses "melancholy" as the

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[20] Ban Ki-moon, "The Stigma Factor," *The Washington Times* (6 August 2008).
[21] Gerhard Falk, Stigma: *How We Treat Outsiders*, (New York: Prometheus Books, 2001), p. 13.
[22] Ibid. (2001), p. 10.
[23] Thomas C. Nicholas, K. Faulker, Kiessling and Rhonda L. Blair, Robert *Burton the Anatomy of Melancholy* Vol. III, (New York: Oxford University Press, 1994), p. 14-16.

means through which all human emotion and thought may be viewed and dissected. Thus the process of stigmatisation contributes to the human emotions that in turn contribute to misery.

2.2 Definitions

2.2.1 Stigma and Stigmatisation

Throughout history, stigma and stigmatisation have been experienced by many people as a result of illness, social, cultural and religious practices. The word "stigma" is of Greek origin and means "to pierce, to make a hole." This association with piercing has led to "other meanings of the word stigma, with particular reference to stigmata (wounds similar to those of Christ indicating that a person has lived a life of extraordinary sanctity)," like Saints Francis of Assisi and Saint Padre Pio. However, this sense of stigma marking someone as special is not very common. More often the word has negative connotations. For example, the word was used to mean branding a criminal with a hot iron to mark infamy. Faulker (1994: 15) spoke of being "stigmatised with hot iron."[24] It was in the late Middle Ages that the word stigmatisation came to mean the public defaming and branding of a criminal so that all could recognize him.[25] Apart from the physical branding, not much has changed since the Middle Ages, except that today stigmatisation is applied to many conditions, such as, socio-economic status, health, religion, language and cultural beliefs. For example, people who suffer from different illnesses such as leprosy, cancer, mental illness and similar illnesses may bear a stigma because these types of illness are often deemed unacceptable in society and hence can stimulate prejudice, discrimination and stigmatisation against the afflicted.

A renowned sociologist, Erving Goffman (1963)[26] defined stigma as having or being branded with an outward recognisable sign that leads to the process of an individual being stigmatised by others. This process is called stigmatisation. This dynamic process of stigmatisation arises from a perception that, there is a

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[24] Thomas C. Faulker, (1994), p. 24.

[25] Norman Sartorious and Hugh Schulze, *Reducing the Stigma of Mental Illness: A Report of a Global Programme of the World Psychiatric Association,* (Cambridge: Cambridge University Press, 2005), p. 215.

[26] Erving Goffman, *STIGMA: Notes on the Management of Spoiled Identity*, (London: Prentice Hall 1963), p. 11.

violation of social norms (Cameron, 1993). Typically, this leads "to prejudicial thoughts, behaviours and actions and institutional patterns of behaviour, on the part of governments, employers, healthcare providers, co-workers, friends, and families" (Cameron, 1993; Jayaraman, 1998 and Ziegler et al 2000).[27] People are stigmatised because of attributes or blemishes, i.e. prostitutes. For example, members of society with disabilities may experience stigma as a result of their specific disability.

According to Goffman in his book *Stigma: Notes on the Management of Spoiled Identity*, "Stigma refers to signs designed to expose something unusual and bad about the moral status of the signifier."[28] This implies that, stigmatisation is a phenomenon whereby an individual is deeply discredited by his or her society and is rejected as a result of such an attribute and this also involves a process by which the reaction of others spoils a person's normal identity. This demonstrates that it is a dynamic process that discredits and demeans an individual in the eyes of others.[29] It is ingrained in society, whose purpose is to distinguish the ideal people "insiders" from the rejected ones "outsiders" (Goffman, 1963: 20). "These threats call into question one's basic worth as a human being and can thus pose threats to psychological well-being" (Baker, 2002; Grandall, 1995). As a result in societies or communities,

> ... Some social groups are valued, treated respectfully, and can easily access important material and social resources whereas other groups are stigmatised they are devalued, treated disrespectfully and often have difficulty obtaining even basic resources (Tiedens and Wayne: 2004).

The difference of unjust treatment is often realized when stigmatised groups face prejudice in economic, interpersonal and political domains (Snowden and Thomas, 2000:19). In addition, several authors helpfully divide stigma into *felt* or *perceived stigma* and *enacted stigma* (Jacoby, 1994; Malcolm, 1998; Scrambler, 1998; Scrambler and Hopkins, 1986). Felt or perceived stigma refers to real or imagined fear of society's attitudes and potential discrimination arising from a particular group or groups. This motivates a person to deny his or her condition for fear of possible negative reactions of family, friends and community. On the other hand,

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[27] Lisanne Brown, Lea Trujillo and Kate Macintyre, *Interventions to Reduce HIV/AIDS Stigma: What Have We Learned?* (New York: the Horizons Program and Tulane University, 2001), p. 4.
[28] Erving Goffman, *STIGMA: Notes on the Management of Spoiled Identity*, (London: Prentice Hall, 1963), 11.
[29] Erving Goffman, (1963) p. 16.

enacted stigma refers to the real experience of discrimination (Malcolm, 1998: 16). It is the action which has been constituted or passed on to an individual, for example, "discrimination in housing and employment."[30] Hence, "the stigma ...extends beyond the individual... to encompass everything and everyone associated with him or her."[31] According to Goffman (1963: 15), "Stigmatisation is the societal labelling of an individual or group as different or deviant."[32] From a sociological perspective, a stigma is an attribute, mark or blemish, or behaviour or reputation which is socially discrediting in a particular way. It causes an individual to be mentally classified by others in an undesirable, rejected and stereotyped way, rather than being accepted in a normal acceptable manner. Thus, "stigmatisation can result in negative discrimination which leads to numerous disadvantages in terms of access to care, poor health service, and frequent setbacks that can damage the self-esteem of an individual."[33]

Stigmatisation is, therefore, concerned with social life, "... by social behavioural patterns with essential religious-cultural dimensions."[34] This means that stigmatisation cannot be automatically determined, since its sources are deeply embedded in societal, cultural, religious values, attitudes, prejudices and, myths.[35] The sources of stigmatisation as outlined in the following paragraphs are some of the most important in relation to whom, how and at what level individuals are stigmatised. The problem of stigmatisation begins with how people see, judge and act with one another in a dilemma producing situation. Arguably, a person's attitude is a prime mover in the stigmatisation process. Once a negative attitude is adopted, fear takes over and a whole range of factors arise, such as the following, attitude, fear, social control, stereotyping, labelling, discrimination, myth, prejudice, scapegoating, and deviance. In this way, a vicious process or cycle develops. The result of the latter is stigmatisation. Most significantly, I will argue that this vicious cycle impacts on the person thus stigmatised, but also has

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[30] Frank Nubuasah, SVD. "Stigma and Discrimination" in Michael F. Czerny, S.J. (ed) *AIDS and the African Church: To Shepherd the Church, Family of God in Africa, in the Age of AIDS,* (Nairobi: Paulines Publications, 2005), pp. 35,37.

[31] Norman Sartorious and Hugh Schulze, *Reducing the Stigma of Mental Illness: A Report from a Global Programme of the World Psychiatric Association*, (Cambridge, Cambridge University Press, 2005), p. 216.

[32] Goffman (1963), p. 28.

[33] Norman Sartorious and Hugh Schulze, (2005), p. 2-5.

[34] Saayman, *Journal of Pastoral Care and Counselling* 57, (2) (2003), pp. 197-210.

[35] Stuart C Bate, *Understanding: Human Society,* (Nairobi: Paulines Publications Africa, 2009), p. 20.

destructive impacts on all the actors involved – those stigmatising, families, communities, Church and society. It will therefore be essential to understand the complexity and mutually interactive reinforcing dynamics of this vicious cycle and ultimately for those seeking to tackle and end stigmatisation; to take such factors into account in developing a totally holistic response. How people's attitudes are formed however, relates to their cultural, religious and socio-political context. The relationship between these factors and stigmatisation will be discussed in the following sections.

2.2.2 Cultural Causes of Stigmatisation

Culture is a complex whole that includes all physical and non-physical aspects of society, such as, language, knowledge, laws and customs. Culture influences the way people behave and belong in society and how they interact with each other.[36] Otieno (2002: 25) demonstrates that learned cultural beliefs, values, and customs serve to direct the behaviour of members of a particular society, giving that society a distinctive character and personality. Both values and beliefs are mental images that affect a wide range of attitudes which in turn influence the way a person is likely to respond to a specific situation.[37] This denotes the cultural matrix and dynamics of stigmatisation.

Customs constitute culturally approved or accepted ways of behaving in specific situations. Clearly, in an African context, one must take close account of the cultural aspects that cement African tribal practices. However, African customs vary from country to country; cultural practices are influenced by the beliefs of a particular tribe.[38] Even if women appear to be satisfied with such customs there is still need to probe more deeply to make change within the cultures.[39] Many of these differences are shown in leadership and gender roles. Thus, stigmatisation is woven into the fabric of society and is reinforced by cultural and religious taboos. The function of taboos is mainly for the preservation of social order, that is, an

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[36] Nicholas Otieno, *Human Rights and Social Justice in Africa: Cultural, Ethical and Spiritual Imperatives,* (Nairobi: All Africa Conference of Churches, 2002), p. 23.
[37] Ibid. (2002), p. 9.
[38] Stuart C Bate, (2009), p. 96. See also Nicholas Otieno, (1995), p. 13.
[39] Martha C. Nussbaum, *Women and Human Development: The Capabilities Approach,* (Cambridge: Cambridge University Press, 2000), p. 42.

"ordered" system of values, beliefs and relationships that govern life and death.[40] Taboos determine meaning in society. This implies that taboo is deeply embedded in communal and individual consciousness, to protect life as we know it and to protect itself from disintegration. Social groups protect themselves from harm, danger and destructive influence of the "different" or the "other."[41] The meanings attached to taboos are not governed by reasoning, respect for and upholding customs, but by the status quo.

Millions of girls and women, especially in Africa, remain embedded in a culture that maintains cultural exclusion, abject poverty, systemic violence and discrimination as well as other fundamental violations of their human rights.[42] Some customs are a danger to girls and women, for example, the traditional customs of marriage. Some tribes allow men to have more than one wife. When a girl refuses to comply with the arrangements, in many cases, she is excluded from the family and even from the community where these customs are practised.[43] In order to perpetuate these customs, in many cases, girls are deprived of education. Sometimes the women are treated badly and are subject to domestic violence. It is in this sense that culture forms the matrix, which gives particular shape to the patterns and practices of stigmatisation that affect women and girls. Yet, in the 'Millennium Declaration' the world's leaders have affirmed that "men and women have the right to live their lives and raise their children in dignity, free from hunger and from the fear of violence, oppression or injustice."[44] The massive difference in the African culture is also a result of too many dialects and different languages of tribes and nationalities. The multitude of languages and dialects is a pertinent issue in Africa because of the sheer size of the continent. Language is a "vehicle for the technical and cultural development of people."[45] The different language people use to communicate gives them a cultural map and reference points. However, language structures can be clear or unclear, understated or

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[40] World Council of Churches, *the Ecumenical Response to HIV/AIDS in Africa*, (Geneva: WCC, 2001) p. 8.
[41] Ibid. (2001), p. 8.
[42] Nicholas Otieno, *Human Rights and Social Justice in Africa: Cultural, Ethical and Spiritual Imperatives*, (Nairobi: All Africa Conference of Churches, 2002), 13.
[43] Martha C. Nussbaum, *Women and Human Development: The Capabilities Approach*, Cambridge: (Cambridge University Press, 2000), p. 42-43.
[44] Nicholas Otieno, (1995), pp. 50-51.
[45] Harriet Deacon, Sandra, Prosalendis and Irene Stephney, *Understanding HIV/AIDS Stigma: A Theoretical and Methodological Analysis*, (Cape Town: HSRC Press, 2005), pp. 24-26.

overstated and obvious or misleading.[46] Language with its explicit and implicit codes can cement or hinder good relations: cultivate good, accommodative feelings about personal, political and social sentiments and realities of togetherness. All in all, language can be an agent of stereotyping or social change. Language in multimedia communication can reinforce social behaviour and establish and maintain social values and beliefs.[47] For example, language can be deployed in a fearsome manner to describe a disease as being caused by the anger of the ancestral spirit's; alienating and intensifying the strength of cultural belief to frighten the listeners (Bate 2009: 96-97). This type of dramatic language is being used as a form of social control to maintain the authority of those in power. It can also serve to render hearers passive in the face of the transcendent power of the ancestors.

On the other hand, language can be used to engender good relations and goodwill, cultivate good, accommodative feelings about personal, political and social sentiments and the supportive realities of community. The positive aspects of communication and media can be used to reduce the further demeaning of people. This will be the consequence, as will be addressed later in the thesis, of the constructive and creative focus of communication to be called into play in regard to the understanding of HIV-AIDS and in evoking human social responsibility and agency in confronting it. Culture and socialisation play an important role in gender development. Gender development is related to both men and women or to both boys and girls, shaping their respective roles in society. For example, type of work that can be influenced by the particular environment, could be fighting in a war, or being a long distance driver (trucks). Although the latter work can be done by both men and women, there is significant difference in the work which attracts men more than women. Maccoby and Jacklin identified a few differences between boys and girls in their study of sex differences.[48] However, when they examined the behaviour of boys and girls in interactive situations, important patterns of

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[46] Lev Semenovich, Vygotsky, *the* Collected Works of Lev S., Vygotsky. Vol.2. *The Fundamentals of Defectology Abnormal Psychology and learning Disabilities.* Translated and with an introduction of Jane E. Knox and Carol B. Stevens, *et al.*, eds., (New York: Plenum Press,. 1993), p. 90.

[47] Lev S. Vygotsky, (1978), p. 90.

[48] Eleanor E, Maccoby, and Carol N. Jacklin, *The Psychology of Sex Differences*, (Stanford: Stanford University Press, 1974), p. 26

difference became evident. What they demonstrated was, how gender is "framed' and taught in an overall cultural context, and is best understood as being embedded in a particular culture."[49] Culture has a significant influence in shaping the perceptions and judgements of people. The culture poses some conditions that limit the roles of both men and women and cause them to act differently. In many African countries including Zimbabwe, patriarchal systems of authority are replicated through cultural legitimised structures of power which can side line the role of women.[50] "All culture is learned."[51] Genders stereotypes have negative impact on men who are in most cases are blamed for imbalances of power and social justice.

As a result of cultural structural boundaries, stigmatisation can come to be regarded as normal within a society. But this thesis will argue that since stigmatisation is culturally constructed, it can be culturally reframed and dismantled. Environmental changes and globalisation have, for example, influenced the way of living for various societies. The stigmatised can take advantage of changes to fight against stigmatisation. For example, today increasingly educated African women are talking openly about cultural practices, which were taboo just a few years ago. This makes stigma reduction possible through critical reflection and open debate on cultural values, norms and practices.

2.2.3 Religious Factors in Stigmatisation

There can be no true understanding of the reality of stigmatisation without an understanding of society's religious values and beliefs and the interpretations of those values and beliefs. Religion can be described as a body of religious beliefs, moral values and social norms of culture. Religion in turn plays a critical role in sanctifying the social order and meeting the needs of society, for it is often through the symbolic-sacramental values that human life can find expression. "We experience the world through seeing, hearing, feeling, touching and using all our

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[49]Lawrence Kohlberg, 'From Is to Ought: How to Commit the Naturalistic Fallacy and Get Away with It' in T. Mischel ed., *Cognitive Development and Epistemology,* (New York: Academic Press, 1971),pp 14. 151-235.
[50] Nicholas Otieno, *Human Rights and Social Justice in Africa: Cultural, Ethical and Spiritual Imperatives,* (Nairobi, All Africa Conference of Churches, 2002), p. 10
[51] Bate (2009), p. 96.

human senses. In this way we relate to the world around us."[52] Religious values provide a protective and meaningful role to life. Those that do not comply with traditional values, beliefs and norms may be stigmatised if they offend or are perceived to offend against the values at the core of the religious community and the taboos which have over time been constructed to protect the country and its values against threat or danger.[53] This is a well observed feature of all society but no more so than in Zimbabwe. The social and hierarchical structures of authority have a recognised power within this culture. Another pertinent factor here is the role of religion in conflict, war and peace. Frequently in the past, religion has also been used to justify conflicts, religious wars and ideological violence, for example, during the period of the Roman Empire and the Crusades. The latter is also is true of Zimbabwe (Rhodesia) when the early Missionaries settled in the Zimbabwe; they had to establish different mission stations according to denominations such as the Dutch, Methodists, Anglicans and the Roman Catholic.

According to typical patterns of stigmatisation, stigmatisers often appealed to religious and cultural norms to justify violence, to instil fear or to enforce conformity using threat or even violence in the process. For example, violence is considered to be culturally against women, if they refuse to accede to traditional marriages in the African context.[54] The influence of alternative cultural consolidators such as, participation, involvement, inclusion, proximity and engagement, would be overruled in this enforcement. Coercion and violence have been the acceptable punishment reinforcing earlier moves of threat, isolation, distancing, exclusion and silencing.[55]

Historically, religious authorities have cited biblical texts (Gen. 3:16; 1 Tim. 3:14) wrenched from the biblical circumstances with its hermeneutical qualifications, and applied them uncritically into a context, where the husband may have gone afar to find work and failed to return, in order to justify this punitive shunning

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[52] Bate (2009), p. 101.
[53] Richard N. Rwiza, *Formation of Christian Conscience: in Modern Africa*, (Nairobi: Paulines Publications Africa, 2001), pp. 25.-27.
[54] Ibid. (2001), pp. 19-20.
[55]UNAIDS A *Report of a Theological Workshop Focusing on HIV and AIDS- Related Stigma,* (Geneva: UNAIDS 2005), p. 5.

and violence. In the context of stigmatisation, Church leaders and biblical teachers need to do much more to challenge the unchristian basis of such literalist readings, and at the same time reclaim texts that foster freedom, equality, compassion and social justice. Within the Biblical tradition there are many examples that point the way in which the stigmatised of the day were treated. One thinks of the universal appeal of the Parable of the Good Samaritan (Lk. 10:25-37) which Jesus taught explicitly in response to a question about what was necessary to inherit eternal life. The story centres on the breaking of an ethnic-religious taboo in the face of a transcending human need. The Good Samaritan did not shun his enemy who was in trouble, but broke with cultural norms and took care of his needs.

Examples are to hand from the Gospel portrayal of Jesus and the open welcoming way Jesus related to women as equals (Jn. 12), and to those deemed to be outcasts, for example lepers and women and men who had transgressed (Lk. 5:12-16). Jesus mixed with those on the margins of society and included outcasts (Lk. 7:36-50) included them, invited them into his circle of friends, touched them and, in turn, allowed himself to be touched by them. In the end, and at the very centre of the Christian mystery, Jesus is portrayed as submitting himself to the ultimate humiliation of public crucifixion outside the city walls (Mk. 15:21). Such a critical biblical reappraisal is a critical need in Christian contexts where texts are used as weapons of stigmatisation. This theme will be returned to later in highlighting the spiritual role of biblical teaching and liturgical practice focussing on the needs of those suffering from HIV/AIDS and in the stigma that so often accompanies it, even from religious agents and leaders, even though it goes against the message of the Gospel. Having dealt briefly, with the cultural and religious aspects of stigmatisation, this section will focus on the social and sociological aspects of stigmatisation. All spheres of social activity are affected by the interplay between these constituent parts, social, cultural and religious. The legal aspects must be examined for reinforcement of stigmatisation, or as a means of its reduction and redress.

2.2.4 The Legal Framework of Stigmatisation

National, regional and international legal frameworks have been agreed upon to reduce stigmatisation.[56] However, despite the existence of an internationally agreed legal framework, governments are sometimes the worst violators, for example, in carrying out signed agreements on policies promoting human life, by their inconsistent interpretation of the legal framework. Harmful civil laws have been enacted which allow or collude in demeaning people. Stigmatisation operates within the family, community, and at national and international level in the form of punitive or exclusive laws, policies and administrative procedures, which are often justified as necessary to protect the 'general' population.[57] Laws consistent with internationally agreed legal frameworks are required to be enacted to protect citizens from stigmatisation.[58] So too, monitoring and accountability measures need to be enacted.

2.2.5 Human Differences and Stigmatisation

In an African context, gender roles are structurally unequal. Women are seen as inferior, and even as objects that can be bought and sold. Men exercise power over women. Women are not viewed as free agents in most spheres of influence, particularly, culturally, socially, and religiously. Gender inequality, rights of women and gender mainstreaming are not not new terms nor are the international laws, declarations, platforms and mechanisms enacted to protect the rights of women worldwide.[59] The lack of enforcement of these laws, platforms and mechanisms encourages structures and practices that perpetuate female disempowerment and punitive isolation. "But we can say that negative labels, rejection, exclusion, termination of employment, eviction, devaluation, refusal of service, shame and embracement are some of the indicators of the presence of stigma."[60]

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[56] Richard N. Rwiza, *Formation of Christian Conscience: in Modern Africa*, (Nairobi: Paulines Publications Africa, 2001), p. 26-27.
[57] Julius K. Nyerere, *Man and Development,* (Dar es Salaam: Uhuru Na Maendeleo, 1974), p. 82.
[58] Richard N. Rwiza, (2001), pp. 40-41.
[59] Nicholas Otieno, (2002), p.13.
[60] Michael F. Czerny, S.J. (Ed) *AIDS and the African Church: To Shepherd the Church, Family of God in Africa, in the Age of AIDS,* (Nairobi: Paulines Publications, 2005), p. 41.

Marginalisation of women is further reinforced by accepted cultural and social norms of economic, educational, cultural and societal disadvantage and unequal access to information (Aggleton and Warwick, 1999; Chiremba and Makore-Rukuni, 2002). It is easier to marginalise women who are already at the fringes of society. The truth of the actual situation is obscured or even denied even against available evidence and rational observance. This can also be seen at work in such areas as ethnic and cultural structures of hierarchy, social division and disposition of power and influence which can easily become force fields where, stigmatising ideas, norms and practices are fuelled.

2.2.6 Race and Ethnicity and their Relation to Stigmatisation

In Africa, as elsewhere in the world, racial and ethnic assumptions are embedded in a community's values and beliefs which regard certain other races or ethnic groups as inferior. For example, it might be assumed that African "immorality behaviour" meaning the lifestyle and actions of some people in a given environment is more pronounced than the West's "immorality behaviour"[61] (Parker, Easton and Klein, 2000: 34; Chiremba and Makore-Rukuni, 2003:243). The same could be said about some diseases, "African diseases" or "Western diseases." This ignores the fact that certain countries due to their physical location say jungle areas, are by definition going to have different diseases than developed urban areas. Once again, it is easier to ignore differences than to examine the contexts and the causes of such differences and engage them in their particularity and inter-connectedness.

Targeting and labelling small, racial, ethnic groups as "spreaders of disease" exacerbates sex and sexuality as sources of stigma and stigmatisation. In reality, with migration and global social dynamics, diseases have no respect for racial or ethnic boundaries. Movement of people from one racial ethnic group to another or from one country to another in search of work can be a key factor in the spreading

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[61] Makore-Rukuni, "Back Then and Right Now in the History of Psychology: a History of Human Psychology in African Perspectives for the New Millennium" *Journal of Psychology in Africa,* Vol 15 No. 1, (South Africa: Sage Publications, 2005), p. 243.

of a disease, regardless of race or ethnicity. The situation can be exacerbated by hazy views regarding different levels of poverty assumed in different racial and ethnic groups, which regard their own group as normative.

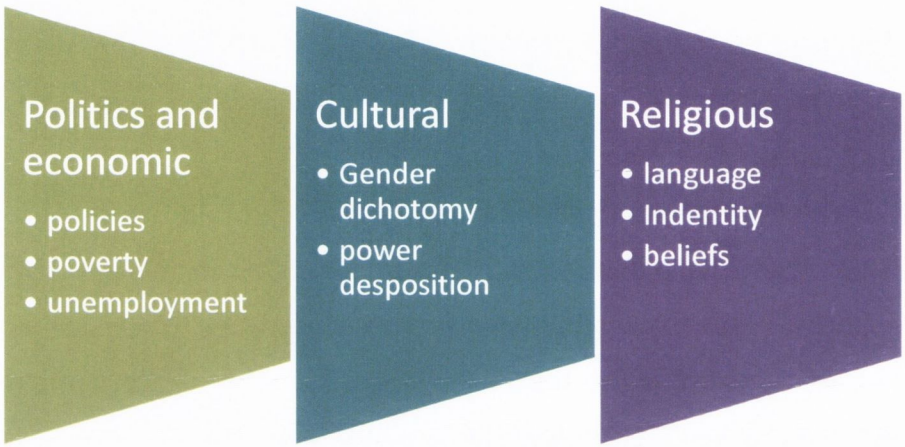
The wealth of one racial or ethnic group can be used as a correlative of demeaning behaviour towards other people. The spread of a disease can be seen as a result of this mobility. Thus, it becomes a short step to blaming "outsiders" as the source of danger and disease, shunning, denouncing and scapegoating them. New forms of social exclusion such as, exclusion as a result of assumptions about the rich (lifestyles, affluence), or the poor (stealing), are associated with global changes for example, perceived outsiders become easy targets. There is evidence that, social exclusion marginalises the poor and makes them, homeless, landless and most likely jobless. The world has experienced a period of rapid globalisation and brought with it a growing polarization between the rich and the poor (Castells, 1996; 1997 and 1998). Poverty, powerlessness and lack of social standing increase vulnerability to stigmatisation. Stigmatisation in turn exacerbates poverty and powerlessness (Parker, Easton, and Klein, 2000).

2.2.7 Violence and Conflicts as Reinforcers of Stigmatisation

Societies, individuals and even governments have used violence or coercion to mobilise the majority to reinforce stigmatisation. For example, in these situations, society, in its broadest understanding, choose not to exercise a wider perspective and approach to provide participation, involvement, inclusion, belongingness, proximity, and engagement. Thus, violence is often presented and justified as a way of protecting the group from what is perceived as a threat to the group's survival. The political, economic, cultural, religious, and environmental characteristics all come into play in reinforcing patterns of the influence of Structural Violence. These characteristics are the foundation in which individuals or groups become vulnerable in society and then become victimised and scapegoated as responsible for the ills of that society. For example, economic features such as chronic poverty and unemployment can result in structural injustice and violence. Figure 1.0 summarises these realities of structural violence.

To develop a better understanding of structural violence and its impacts, an examination of how political economic, cultural and religious aspects maintain structural violence will be discussed as highlighted in the light of Galtung's theory. Barnett and Blackwell (2004:4) say, "As poverty increases so usually do income and class inequality. Mobility increases as people seek to escape poverty and work away from their homes."[62]

Figure 2.0 Structural Violence in Politics, Culture and Religion



According to Johan Galtung (1969), he observed that Structural Violence is a form of violence where some social structure or social institution purportedly harms people by preventing them from meeting their basic needs.[63] Examples of such forms of violence are categorised as; institutionalised elitism, ethnocentrism, classism, racism, sexism, adultism, nationalism, heterosexism and ageism. Structural violence and direct violence are viewed as interdependent. Direct violence includes family violence which is commonly referred to as domestic violence, racial violence which is a failure to accept other nationalities and hate crimes where past evils are never forgiven. Furthermore, terrorism brings insecurity to nations. Also, genocide is an unjust cause for killings and war, which is the last thing expected of any peaceful nation.[64] Security forces in some instances have demonstrated direct violence where they sometimes fight for land.

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[62] Tony Barnett and Michael Blackwell, *Structural Adjustment and the Spread of HIV/AIDS.* Working Paper, (London: Christian AiD 2004), p. 4.
[63] Johan Galtung, "Violence, Peace, and Peace Research" Journal of Peace Research, Vol. 6, No. 3 (1969), pp. 167-191.
[64]Johan Galtung, (1969), p.172.

From this, it follows that direct violence cannot be treated or prevented unless the structural violence that engenders it is removed.[65] Galtung's Theory of Structural Violence is connected with both the negative and positive aspects of peace. These aspects are intertwined and are connected with the kind of direct violence and social injustice, or structural violence, of or associated with structures and dynamics of stigmatisation towards those already on the periphery or excluded. [66] For Galtung, "the distinction between direct (or personal) violence and structural violence revolves around the issue of deliberate or intentional action."[67] This includes such matters as globalisation and development. In some countries people are adversely affected by some general rules and regulations in areas that militate against human development, education, health and provision of food. This is more harmful since structural violence is most often more invisible. Those most implicated in such violence need education on the root causes and deep structures of such multi-faceted violence.[68] So it is not sufficient to focus solely on the individual reasons of perpetrators and victims. Social analysis on the structural and institutional causes and impacts of violence is also essential.

The theory of Galtung describes that conflict and violence are entrenched in the whole society, as individuals or as members of the community. Galtung (1969) further describes violence as the absence of peace.[69] Galtung asserts that violence can be a cause of many disagreements and has the potential of dividing people. This division can lead to categorising people and creates a gap which distances people from each other. Thus ordinary people are used as consumers, who participate or perpetuate unjust social or economic structures that hinder progress or development. Galtung (1969) also highlighted the issues of gender and how women suffer from violence. Structural violence can also be related to symbolic violence, and domestic violence For example, "when one husband beats his wife there is a clear case of *personal* violence, but when one million husbands keep one

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[65] Ian Attack, 'Peace studies and social change: The role of ethics and human agency' in Policy & Practice: A DevelopmentEducationReviewVol.(Autumn2009),pp.39-51.
available:http://www.developmenteducationreview.com/issue9-
[66]Ian Attack, (2009), p. 2.
[67]Ian Attack, , 2009, pp. 39-51,
[68] Johan Galtung, 'Violence, Peace and Peace Research' in *Journal of Peace Research,* Vol. 6, 3, (1969), p. 170.
[69]Johan Galtung, 'Violence, Peace and Peace Research' in *Journal of Peace Research,* Vol. 6, 3, (1969), p. 170.

million wives in ignorance there is *structural* violence."[70] The same can be true of the behaviour of a particular community. If certain behaviour is relates to one person the community is quick to act, but if the same behaviour involves many members of the community it takes time for the community to act. This can be true of structural violence since it is hidden in the attitudes, beliefs, practices, social status and even in the welfare practices of the culture. Clearly, structural violence also affects sufferers of HIV/AIDS and their families particularly where poverty and injustice or social stigma militate against their access to medical treatment and social inclusion. Women are especially vulnerable because of structures of gender and discrimination and inequality as maintained by cultural and religious prejudice.[71] Correspondingly, in a society where life expectancy is twice as high in the upper as in the lower socio-economic groupings, violence is experienced even if there are no actual physical attacks, as when one person kills another."[72]

Culture is the interrelated set (configuration) of learned, created and borrowed beliefs, ideas, values, norms and symbolic meaningful systems, which characterise and influence the human behaviour of a people" (Mac Gréil, 1996:33, Bate 2009: 21). Thus in the next Chapter there is a detailed explanation of the role of culture in society. It shapes and defines the ethos of any given society. It shapes the behaviour of the people in the family, community and society at large.[73] "It donates a historically transmitted pattern of meanings embodied in symbols, a system of inherited conceptions expressed in symbolic forms by means of which men communicate, perpetuate, and develop their knowledge about and attitudes toward life (Clifford Geertz 1973:89). Hence, the values are limited due to different dimension that controls society namely, political, economic, social, cultural, religious and psychological.[74] The values are formed from the beliefs and ideas shared rituals performed and language used (Tylor, 1871: 1; Harris, 1988:122). Galtung is clear that structural violence is socially constructed and also

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[70] http://www.scienceforpeace.ca/0602-structural-violence accessed 04/06/2012, 1-3.
[71] Feachem Richard and Oliver Sabot. "The Global Fund 2001-2001: A Review of the Evidence. Global Public Health 2, no. 4 (2007):pp. 325-341.
[72]http://www.scienceforpeace.ca/0602-structural-violence accessed 04/06/2012.
[73] Stuart C Bate, *Understanding Human Society,* (Nairobi: Paulines Publications Africa, 2003), pp. 25
[74]Nicholas Bate, (2009), p. 21.

indicates that in order not to "overwork" the term structural violence, it is better to resort to the more common usage of structural justice.[75] Galtung's claims have provided further studies which endorse his theory. The results from a study by James Gilligan, a psychiatrist from the United States, affirms that structural violence is embedded in unjust social issues. His model presented examples that showed that power and classes in society lead to the injustices and disparities in society. There are gaps between those who "have and have not". For example, in health care, the rate of deaths correspond to the different socio-economic sectors, where the wealthy and the poor experience ease or struggle respectively in accessing medical help, linked also to employment opportunity or social power.[76] Gilligan (1996) describes these "excess deaths" as "non-natural" and attributes them to the stress, shame, discrimination and denigration that results from a lower social status. Gilligan's thesis is demonstrably borne out in relation to HIV-AIDS sufferers with evidence of "increased rates of death and disability suffered by those who occupy the bottom rungs of society, as contrasted with the relatively lower death rates experienced by those who are above them."[77]

Structural violence is attributable to specific embedded and structural patterns that injure or harm individuals or masses of individuals. In many cases, policies and social structures fuel structural violence. Clearly in such settings, personal existence is reduced and women are rendered more invisible and relegated to ideas of passive submission in areas of life pertaining to, for example, sexuality work and freedom of movement. Furthermore, such non-conformity, where familial and gender roles are highly conformist in expectation and practice, is liable to provoke blame, disapproval and isolation. In such a cultural and emotional ethos, exposure to stigmatisation is greatly increased. In the next chapter, structural violence is shown by how people are stigmatised particularly those who are suffering from HIV/AIDS. Some policies and social settings affect these people and sometimes they lose their dignity.[78] In Chapter 4, additional examples of structural violence will be highlighted and further discussion on cultural violence

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[75]http://www.scienceforpeace.ca/0602-structural-violence accessed 04/06/2012, 1-3.
[76] James Gilligan, *Violence: Reflections on a National Epidemic*, (USA: Vintage Books, 1996), p. 16.
[77] James Gilligan, (1996), p. 4.
[78]Paul Farmer, Bruce, Nizeye Sara, Stulac and Salmaan Keshavjee. Structural Violence and Clinical Medicine', *PLoS Medicine* Vol 3, no. 10 (2006), pp. 1686-1691.

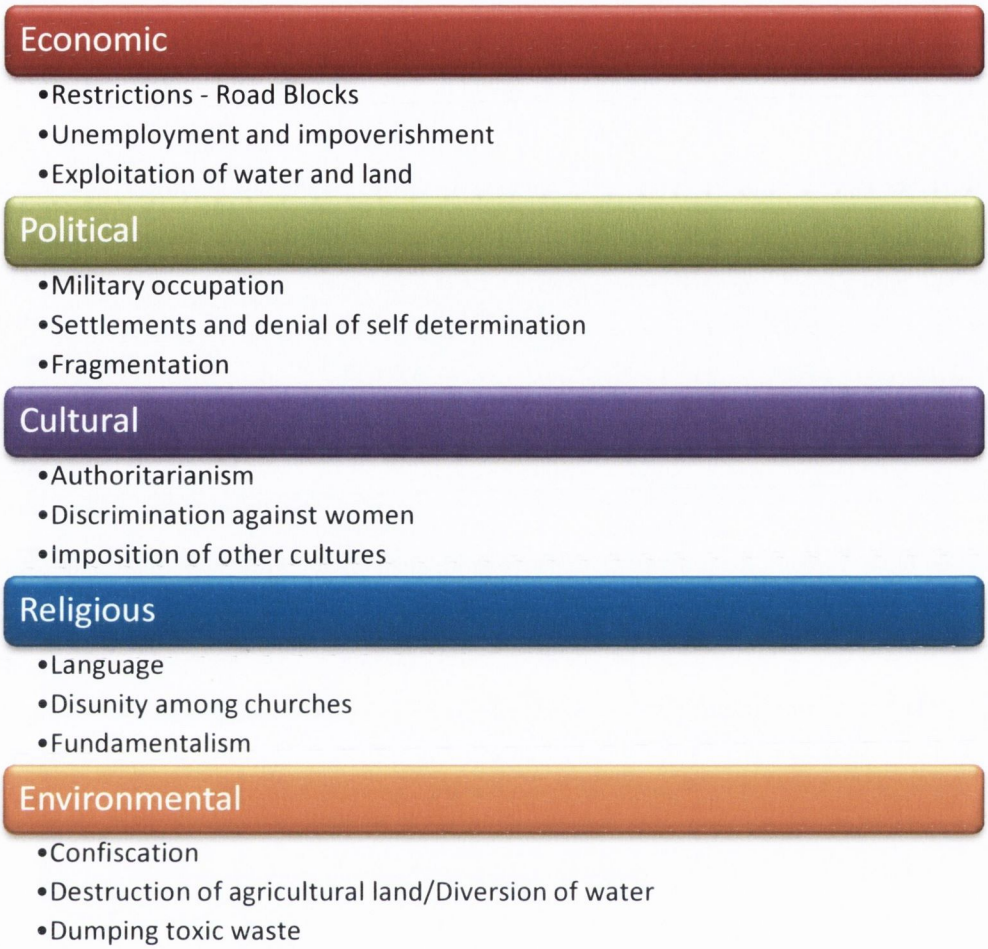
will be dealt with in Chapter 5. Furthermore, in Chapter 5, the claim will be developed that "structural interventions" are possible solutions to structural violence, specifically in relation to HIV/AIDS and stigmatisation.[79] These issues affect the individual or group since they are hidden in the beliefs and values of the perpetuator.

Several examples of such practices are listed below under their respective heading. For instance, under the heading *economic,* some rules, restrictions and regulations which are applied to road users, especially during road blocks, are some of the causes of structural violence.[80] The same can be said about the political issues, *displacements* can also be a source of violence for people who lose their sense of belonging.[81]

Table 1.1 below highlights some aspects of structural violence that can contribute to stigmatisation as causes and consequences from Economic, Political, Cultural, Religious and Environmental factors. These aspects can be obstacles to development in education, health care and access to basic needs which can curb poverty. Pope, (2009: 271) says, that the "income and investment" gaps in the economy makes it difficult for poor countries to invest in development and be able to provide social services. "Macroeconomic policy impacts on the economic viability of development because they alter absolute poverty and distribution of wealth." This has direct impact on "both households and health systems" (Federici, 2002; Gostin 2004; Poundstone, Strathdee and Celentano, 2004).

[79]Paul E. Farmer, Bruce, Nizeye, Sara, Stulac, and Salmaan, Keshvjee, (2006), pp. 1686-1691.
[80] Paul Farmer, *Pathologies of Power: Health, Human Rights, and the New War on the Poor*, Berkeley and Los Angeles: University of California Press, (2003) p. 8.
[81] Paul Farmer, Bruce Nizeye, Sara Stulac, and Salmaan Keshvjee, (2006), pp. 1689-1691.

Table 2.1 Structural Violence Factors



Source: Summary of Galtung's Theory of Structural Violence (1969:110-170).

2.3 Cause and Consequences of Stigmatisation

Stigmatisation is a multi-faceted social, cultural and religious problem which operates in a vicious cycle to demean[82] the stigmatised but there is no doubt that the following factors play an important role in what can be called the phenomenon of stigmatisation. A person's perception or behaviour is in most cases influenced by the attitude of others, as prescribed by society's values. According to Micheál Mac Gréil, (1977:7) in his book titled *Prejudice and Tolerance in Ireland,* "an attitude is a mental and neutral state of readiness, organised through experience, exerting a directive, or dynamic influence upon the individual's response to all

[82] Federici Silvia. "War, Globalization and Reproduction," *Alternatives: Turkish Journal of International Relations* 1, no. 4 (2002), pp.254-267.

objects and situations with which it is related."[83] People's attitudes are conditioned in part by their parents, homes and wider social environment. This shapes the behaviour of the individual. While Robert Brown (1965:240) says that an attitude is always focused on the individual, others, and in some cases society at large. It is sometimes an influence on how the individual behaves and relates to others. It shapes one's behaviour in most cases.[84]

According to Mac Gréil, the stigmatised are central in the process because they have distinguishing differences. The greater the contrast or negative comparability, the greater is the stigmatisation or exclusion. The negative comparability can be in the form of a certain behaviour or physical aspect. In addition Falk's (2001) comments regarding delineating "outsiders" from "insiders" is in agreement with Mac Gréil's findings on how certain people are treated differently in society. Mac Gréil's (1977:11-28) and Falk's (2001) findings are very different to "Article 1 of the Universal Declaration of Human Rights," (UDHR) 1948, which states that, "All men are born free and equal in rights and dignity." For example, "in the case of more extreme attitudes, that is, when evaluations of the focus were 'bad', feeling towards it tended towards 'dislike' of the object of the attitudes and there was a behavioural tendency to 'hinder' or 'attack' the focus" (Mac Gréil, 1996:22). This creates different levels of social distance and closeness to the 'other' from 'ethnic, social, religious, political or racial groups' Mac Gréil, 1996:22). They are endowed with reason and conscience and should meet each other in a spirit of brotherliness."[85] Article 1 of the Universal Declaration of Human Rights may very well be an unattainable goal. Men women and children appear to be born to differ.

Moreover, a wider knowledge of any attitude is the basis for spreading the attitude to a wider segment of society. The degree of differentiation depends upon the

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[83] Micheál Mac Gréil, in his book titled *Prejudice and Tolerance in Ireland,* Co. Kildare: The Survey and Research Unit, (Maynooth: Department of Social Studies, St. Patrick's College, 1996), p. 7.

[84] Roger Brown, in Micheál Mac Gréil *Prejudice and Tolerance in Ireland: Based on a survey of intergroup attitude of Dublin adults and other sources,* (Dublin, Research Section, College of Industrial Relations, 1977), p. 11.

[85] John Kusumalayam, *Human Rights individual or/and Group Rights? An Attempt towards A Holistic Understanding of Human Rights Based on The Christian Concept of the Human person as the Imago Trinitatis,* (Mumbai: St. Pauls, 2008), p.187.

positions held by different people in society, community or family. The intensity of the stigmatisation depends on the position held by the stigmatiser or stigmatised, varying from positivity (high position) to negativity (low position), with neutrality somewhere in between.

2.3.1 Fear as a Cause and Consequence of Stigmatisation

Recent efforts to synthesise the dynamics of stigmatisation suggest that, it is a set of responses to what Coleman (1986) terms "the dilemma of difference". Coleman (1986) suggests 3 main causes and consequences of stigmatisation, namely, fear social control and stereotyping. Analysing Coleman's 3 causes, results in fear being identified as a primary cause of stigmatisation. As human beings we tend to fear differences, fear the future, and fear the unknown.[86] From experience, children tend to fear the dark. But what is it that they actually fear? The author believes that it is really fear of the unknown. This fear of the unknown follows through to the adult life of the individual. Consequently, we as adults, remembering our earlier fears, stigmatise that which we fear, in other words, that which is different or unknown. Fear drives our negative attitude and all of the other stigmatisation factors outlined in this chapter follow in tandem. In Coleman's view, another factor in the stigmatisation process is social control.

2.3.2 Social Control as Cause and Consequence of Stigmatisation

Social control is the behavioural impetus for stereotyping, blaming and demeaning. The social control process serves to preserve the existing social hierarchy, maintaining marginalised groups in their inferior social positions. Social control is associated with the way people are regulated in society be it political or societal. Particularly when discriminatory laws that relate to disease notification are passed, people in inferior positions often tend to feel afraid of the consequences of being shamed in public.

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[86] John A., Coleman, William F. Ryan, eds, Globalization *and Catholic Social Thought: Present Crisis, Future Hope,* (New York: Orbis Books, 2005), p. 24.

There are different mechanisms which act as the powerful forces to make this happen within a group. For example, an individual's behaviour can be influenced and even regulated by peers, family or group behaviour sometimes positively but sometimes negatively. Emile Durkheim referred to such control as "regulations". These are rules and regulations that effectively operate towards control in a given society, state or social group. Operating internally by control is an informal unwritten pressure within the family or other groupings to protect and perpetuate the internal norms and values of family or grouping. External control, such as that which operates in the workplace or educational establishments is associated with rewards, such as bonuses or promotion; or punishment such as demotion or loss of position. Thus, in Herzberg's (1959), Two Factor Theories, showed that a person's behaviour is determined by the forces of the external environment and that the behaviour is shaped in most cases by peer pressure. Social control relates mainly to the way people live together in the community. If one fails to be compliant then they risk being excluded and ultimately stigmatised.

Abraham Maslow's (1970: 20-23) Theory of the Hierarchy of Needs focuses on a person's needs from the lowest level to the highest level. The lowest level is comprised of, for example, the basic needs for water, air, sleep and food.[87] The highest level of needs includes among others, self-actualisation, which is acceptance of facts, freedom from prejudice, and the ability to solve problems, being creative and acting morally (Bate 2009: 63). The theories of Herzberg and Maslow lead to the conclusion that if one is on the bottom rung of the social ladder, it is much easier to be stigmatised (Palmer and McMahon 1997). The latter is true because being at the bottom is also associated with poverty and lack of education and hence leaves you at the mercy of the stigmatisers and being stereotyped. One can see a definite pattern emerging for those affected by the HIV/AIDS virus who also happen to be culturally inferior, powerless and whose basic physiological and health needs are left unfulfilled in other words, the poor and the uneducated. "Abraham Maslow and others identified people's needs as failing into five broad categories: social, emotional, intellectual, physical and spiritual", (Ward and Rose

[87] Abraham Maslow, *Motivation and Personality,* (New York: Harper and Row, 1970), pp. 20-23.

2002: 30).[88] In trying to provide care to people it is important to know that "wherever possible, care plans aim to enable/empower people to help themselves."[89] "Human needs are not all of the same weight and value. Some are more basic than others," (Bate 2003: 63). This idea is going to be developed in detail in Chapter 5 of the thesis. The main focus is of enabling the person in need is not to stereotype but to "enhance dignity, confidence, self-respect and independence for the service user."[90] The next section is describing how stereotyping can be a cause and the consequence of stigmatisation.

2.3.3 Stereotyping as a Cause and the Consequence of Stigmatisation

Stereotyping results from the human tendency to categorise and is primarily a cognitive process. An important factor to note is that the stereotyping process distorts the mind of the marginalised to the extent that they become confused and disorientated.[91] The result is that the marginalised person or group begins to lose confidence in their dignity. Media representation of people and groups may often operate as a form of stereotyping, especially in the advertising, entertainment and news industries. The Media's aim is to give audiences a quick, simplistic common understanding of a person or group, usually relating to their class, ethnicity or race, gender, sexual orientation, social role or occupation (Rwiza: 2001:34). Sometimes media is interested in its own publicity and lack evaluation of its impact to the public.[92] The media mirrors styles, attitudes and aspects of what is socially desirable and successful and also the opposite, often portrayed by stereotypical coding, bad or overhyped news sells papers. O'Sullivan et al (1994: 38) describe stereotyping as the social classification of particular groups of people, often by highly simplified and generalised signs, which implicitly or explicitly represent a set of values, judgements and assumptions, concerning their behaviour

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[88] Perry Share and Kevin, Lalor, ed., *Applied Social Care: An Introduction for Students in Ireland* 2nd Edition, (Dublin: Gill and Macmillan 2009), p. 28.
[89] Ibid. (2009), p. 12.
[90] Ibid. (2009), 44.
[91] Aaron Beck, Depression*: Causes and Treatment*, (Philadelphia: University of Pennsylvania Press, 1967; 1976), p. 30.
[92] Cynthia Pope, Renée T. White, and Robert Malow, *HIV/AIDS: Global Frontiers in Prevention/Intervention*, (New York: Routledge 2009), p. 345.

characteristics or history.[93] Hummert et al. (1995: 26) agrees with O'Sullivan et al (1994: 16) and defines stereotypes as sets of "generalized beliefs about a group that are widely held within a particular culture."[94] These beliefs reinforce "truths" or "myths" about a group or community. More often than not, the groups being stereotyped have little to say about how they are represented, and are usually not asked. Thus, stereotyping perpetuates social prejudice and inequality.

The difference between groups is then emphasised on the basis of the negative characteristics of a group. The stigmatiser and the stigmatised are both taught and learn the beliefs in their environment, amounting to positive views about the stigmatiser and negative views about the stigmatised, respectively. Both may be guilty of faulty perception and interpretation the stigmatised may find it difficult to create new ways of thinking, necessary to disassociate them from being stigmatised and reject the stereotype. In summary, from the research of O'Sullivan et al; Hummert et al and Coleman's theory of the Dilemma of Difference, it is clear that fear, social control and stereotyping all play a vital role in the vicious cycle of stigmatisation operating in a causal way, and also producing further consequences which serve to strengthen the idea of the stereotype and being in it. The figure below summarises Coleman's Dilemma of Difference theory.

Figure 2.1 Dilemma of Difference

Source: Diagram own: Details Coleman (1986)

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[93]John Hartley, Tim O'Sullivan, Danny Saunders, Martin Montgomery and John Fiske, *Key Concepts in Communication and Cultural Studies.* 2nd Edition, (London: Routledge, 1994), pp 34-36.

[94]Mary L. Hummert, Teri A. Garstka, Jaye L. Shaner & Sharon Strahm, 'Judgments about Stereotypes of the Elderly: Attitudes, Age Associations, and Typicality Ratings. Research on Aging, 17', Vol., 49, (5), *The Journal of Gerontology*, (Oxford: The Deontological Society of America, 1995), pp. 168-189, 240-249.

While Coleman did not list the factors in his theory of the Dilemma of Difference in any particular order of priority, I believe that after social control fear is the next important factor in driving stigmatisation. Coleman also considered stereotyping as a major factor in his Dilemma of Difference, labelling which follows is another element of stereotyping.

2.3.4 Labelling as a Cause and Consequence of Stigmatisation

The labelling theory infers that stigmatisation is the societal labelling of an individual or group as different and deviant (Goffman, 1963). The stigmatised individual or group is seen as having violated a set of shared attitudes, beliefs and values. According to Schur (1971), "the central tenet of labelling orientation is quite straightforward: Deviance and Social Control always involves processes of social definition", that is labelling. "Social groups create deviance by making rules, whose infraction constitutes deviance, then applying those rules to particular people and labelling them as outsiders" (Howard Becker in Schur 1984: 35). In this context, deviance is not related to the type of act that has been committed; rather it refers to the fact that the offender has broken an established rule or rules of a particular grouping. Breaking the rule is considered a form of deviant behaviour and leads to labelling the offender as a deviant.[95] As a result, social interaction between the offender and the group is strained to breaking point. The processes of social definition, or labelling, that contribute to deviance outcomes are actually found on at least three levels of social action, i.e. collective rule making, interpersonal reaction, and organisational process. This means that in a particular group setting, there are rules and regulations which govern the working, interpersonal reaction and organisation of the group. Each member is expected to conform to those rules and regulations. Collectively the rules and regulations achieve the cohesion and survival of the group. This is going to help in the latter parts of the thesis to focus on the need of engaging the community to work together reaching out to HIV/AIDS sufferers.

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[95] E. M. Schur, *Labelling Women Deviant: Gender, Stigma and Social Control,* (Philadelphia: Temple University Press, 1984) p. 20, 35. See also Schur, E. Reactions to deviance: A critical assessment. *American Journal of Sociology*, 75, (1969), pp.. 309-322.

2.3.5 Discrimination as a Cause and Consequence of Stigmatisation

Since the discovery of the causes and consequences of HIV/AIDS, many people have been discriminated against by friends, family and Church, for fear of being infected by the disease. Discrimination may be defined as, "the unjust or prejudicial treatment of different categories of people, especially on the grounds of race, age or sex."[96] Discrimination undermines equality in society, and exacerbates social differences and social solidarity. Discrimination can also be used at the work place, where people are grouped according to special needs, qualifications, skills and interest. This in a sense can be seen as positive discrimination. However, in the context of employment, it can undermine labour standards and lead to an inefficient use of skills. Yet, discrimination is often difficult to detect and measure, as discriminatory behaviour is rarely observed directly.[97] Furthermore, this can be related to Ireland, although it is remote from Zimbabwe, nevertheless, these points are helpful in elucidating discrimination in any multi-cultural society. The first national survey of the experiences of discrimination in Ireland was carried out by the Central Statistics Office (CSO) in 2004 (CSO, 2005a).[98] Drawing on the nine grounds covered by Irish Equality legislation, discrimination was defined as follows for the benefit of those participating in the survey:

> Discrimination takes place when one person or a group of persons are treated less favourably than others because of their gender, marital status, family status, age, disability, 'race' – skin colour or ethnic group, sexual orientation, religious belief, and/or membership of the Traveller community. Discrimination can occur in situations such as where a person or persons is/are refused access to a service, to a job, or is/are treated less favourably at work. In other words, discrimination means treating people differently, negatively or adversely.[99]

While the survey and its findings were particular to Ireland, the actual definition provides a good working model for the purpose of this thesis. In discussing the process of stigmatisation there is no way that one could talk about stigmatisation

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[96] Catherine Soanes and Angus Stevenson, eds., *Oxford Dictionary of English* 2nd edition, (Oxford: Oxford University Press, 2003), p. 497.
[97] Gandy Matthew. "Deadly Alliances: Death, Disease and the Global Politics of Public Health." PLoS Medicine 2, no. 1 (2005), p. e4.
[98] Helen Quinn, Emma Russel and others, *The Experience of Discrimination in Ireland,* The Equality Authority and The Economic and Social Research Institute, (Dublin: The Brunswick Press, 2008), p. 8.
[99] Ibid.

without making reference to discrimination. Discrimination in this sense is the way people are marked out and how they are excluded from society, community and family. As the theme of the thesis unfolds, the definition above will become more meaningful. Discrimination can be engrained in societal beliefs, both cultural and religious. Thus, "discrimination is a particular consequence of stigma and prejudice."[100] In society these consequences may be a result of myths failing to grasp the meaning of an event.

2.3.6 Myth as a Cause and Consequence of Stigmatisation

One definition of myth is, "any idea or fictional story, recurring theme, or character type that appeals to the consciousness of a people by embodying its cultural ideas or by giving expression to deep, commonly felt emotions."[101] This definition shows both the anthropological sense of the term as the fundamental symbolic narratives of society, together with its more general usage.

The major point about myth is that for certain members of society it may be understood or misunderstood as an actual fact. Myths can appear to be sacred, exemplary and significant since they have serious consequences in terms of prejudices and social exclusion for individuals and members of society. Myths are commonly related to health issues that can lead to social exclusion and rejection. In addition, myths can lead to individual suffering as a result of society's negative attitudes or prejudices. As one example, one could look at myths of gender disparity, (the male and female dichotomy). This thinking probably has its origin in the early years of mankind when the more muscular man was needed to provide protection against marauding tribes and wild animals. Man was also considered the hunter gatherer for the family. As a result man was considered to be strong, and was able to provide security for the family. Women on the other hand were considered as the family carers in the home. Both women and children depended on man for survival. This concept has long since been overturned. But, the

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[100] Norman Sartorius, and Hugh Schulze, *Reducing the Stigma of Mental Illness: A Report from a Global Programme of the World Psychiatric Association*, (2005), p.215.

[101] Lawrence E. Hewitt,& H. T. Blane, *Prevention through Mass Media Communication* in P. Miller & T. Nirenberg (Eds) 'Prevention of Alcohol, Abuse,' (New York: Plenum Press ,1984), pp. 127-131.

inequalities of power which the myth has produced are still with us. Myth can lead to imbalances, prejudices and injustices in life, particularly, in families and community who continue to make people suffer and remain stigmatised.

2.3.7 Prejudice as a Cause and Consequence of Stigmatisation

Prejudice looks to the heart of stigmatisation,[102] and is a result of how people perceive and pre-judge the world about them. Prejudices based on pre-existing, long-standing beliefs, without any real basis in fact, can easily lead to acts of stigmatisation. The term is derived from the Latin word *prae-iudicium,*[103] "a preceding judgement."[104] A prejudice is an attitude towards an object, person, group, idea, place or thing.[105] "Prejudice is an attitude reflecting the readiness of people to act in a positive or negative way."[106] As will emerge in later chapters of this thesis, prejudice plays an important role in the process of stigmatisation. American psychologist, Gordon Allport, a leading authority on social prejudice[107] in his book, *The Nature of Prejudice,* points to a similar set of descriptors, defining prejudice as: "An avertible or hostile attitude towards a person who belongs to a group, simply because he or she belongs to that group, and is therefore presumed to have the objectionable qualities ascribed to that group. It is an antipathy based on a faulty and inflexible generalisation."[108]

The study of Mac Gréil, (1996: 44) asserts that prejudice can be referred to "hate attitude,"[109] "Antipathy" is actually a more accurate term to describe the phenomenon with regard to "negative intergroup attitudes" Mac Gréil (1977: 31). For example, Aronson (1980:195-197) likewise, defines prejudice as "a hostile

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[102] Sally Zierler, et al., *"Violence victimisation after HIV infection in a bus probability sample of adult patients in primary care".* American Journal of Public Health 90 (2), (2000), p. 10.
[103] Charlton T. Lewis, *Elementary Latin Dictionary,* , (Oxford: Oxford University Press 1985),p. 637
[104] Ibid. (1985), p. 637.
[105] Micheál Mac Gréil, Prejudice *and Tolerance in Ireland: Based on a Survey of Intergroup Attitudes of Dublin Adult and Other Sources,* (Dublin: Research Station, College of Industrial Relations), 1977) p. 7.
[106] Norman Sartorious and Hugh Schulze, *Reducing the Stigma of Mental Illness: A Report from a Global Programme of the World Psychiatric Association,* (Cambridge: Cambridge University Press, 2005), p. 215.
[107] Micheál Mac Gréil *Prejudice and Tolerance in Ireland: Based on a Survey of Intergroup* Attitudes *of Dublin Adult and Other Sources* (Dublin, Research Station, College of Industrial Relations, 1977), p.19.
[108]Gordon W. Allport, *The Nature of Prejudice,* (Cambridge, Mass: Addison- Wesley Publishing Company 1954), p. xviii, 537.
Mazafer Sherif, *The Annals of the American Academy of Political and Social Science,* (Jan 1954 vol.295, 1954: 171-172.), p.1-10.
[109]Micheál Mac Gréil,(1996), p. 30-32.

and negative attitude toward a distinguishable group based on generalisations derived from faulty or incomplete information." Mac Gréil's definition is both comprehensive and operational and one which I shall follow. Social prejudice is a hostile, antipathetic, rigid and negative attitude towards a person, group, collectively or category, because of the negative qualities ascribed to the group, collectively or category based on faulty and stereotypical information and inflexible generalisations.[110] The main addition is that of the 'group, collectively or category' as focus of the prejudice. Allport (1954) emphasises that the focus of prejudice does not come into the reckoning in the situation, but is founded in the "faulty and stereotypical information."[111]

2.3.8 Scapegoating as a Cause and Consequence of Stigmatisation

A scapegoat may be defined as "a person who is blamed for the wrongdoings, mistakes or faults of others, especially for reasons of expediency."[112] From a psychological perspective, unwanted thoughts and feelings can be unconsciously projected onto another who becomes a scapegoat for one's own negative energy or indeed prejudice. A whipping boy or "fall guy" are a modern terms for scapegoats. A scapegoat may be a child, employee, peer, small ethnic or religious group, or country.

Scapegoating distances the "moral majority" from a sense that, they themselves may be at risk, and therefore reduces anxiety, fear and ignorance of the unknown in the "general population."[113] Scapegoating is a way of magnifying the patterns of marginalisation and prejudice that already exist in society, so as to avoid being employed to characterise an entire group of individuals according to the unethical or immoral conduct of a small number of individuals belonging to that group, also known as guilt by association. If we have learned anything from history, it is that almost every imaginable group of people, whether by gender, colour, race, creed, political belief, or just plain differences from the majority, have been treated like

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[110] Micheál Mac Gréil, (1996), p. 20.
[111] Micheál Mac Gréil, (1977), pp. 11-21.
[112] Catherine Soanes and Angus Stevenson, (editors) *Oxford Dictionary of English* (Second edition), (Oxford, Oxford University Press, 2003), p. 1574.
[113] Ibid. (2003), p. 1574.

scapegoats. Hence, some people isolate themselves while others develop deviant behaviour.

2.3.9 Deviance as a Cause and Consequence of Stigmatisation

In society some people look on themselves as different to others and there are some who actually make life difficult for others. Deviant behaviour which is hostile makes it difficult for some people to be able to connect with particular groups or individuals. Gerhard Falk (2001:15) in his book, *Stigma: How We Treat Others* expanded on Goffman's work by redefining deviant as, 'others' who deviate from the expectations of a group."[114] He further categorised deviance as societal deviance and situational deviance. Societal deviance refers to a condition widely perceived, in advance and in general, as being deviant or departing from usual or accepted standards, especially in social or sexual behaviour. "Homosexuality is therefore an example of societal deviance because there is such a high degree of consensus to the effect that homosexuality is different, and a violation of the norms of social expectation" (Falk, 2001:30).[115]

While Falk made his observation linking homosexuality to deviance in 2001, this is still a valid observation in the world of today. Situational deviance refers to a deviant act that is labelled as deviant in a specific situation, and may not be labelled deviant by society. Similarly, a socially deviant action might not be considered deviant in specific situations. "A robber or other street criminal is an excellent example. It is the crime which leads to the stigmatisation of the person so affected." (Falk, 2001: 25). The following figure summaries all of the factors discussed above which have an input into the stigmatisation of individuals, groups or whole communities. The factors have been discussed in detail in the chapter. What is certain is that stigmatisation is a multifaceted, vicious circle of human negative actions. The negative actions result in the individual or group distancing, excluding, shunning and isolating others. The diagram below shows some of the negative outcomes. The effects of the vicious circle will be further discussed in the

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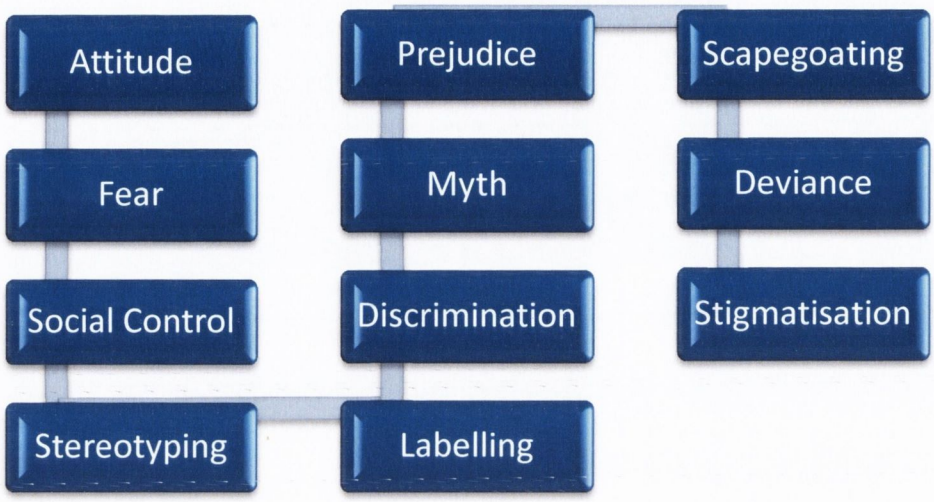
[114] Gerhard Falk, (2001), p. 15
[115] Ibid. (2001), p. 30.

next chapter and the chapters to follow. Below are some of the aspects discussed in this Chapter to give background knowledge of causes and consequences of stigmatisation.

Figure 2.2 From Attitude to Stigmatisation – A Vicious Circle



Source: Own

The factors in the above figure are embedded in the psyche of society. They are linked to the social, cultural and religious aspects of life that contribute to the vicious cycle stigmatisation. Therefore this section of the chapter is going to highlight the complexity of human behaviour, customs, beliefs and norms. The human rights of the whole person will also be discussed. There are several re-enforcers of stigmatisation, such as, power, policies, sexuality, laws, customs, race and poverty. These will be further elaborated on, showing different pressures and practices which lead to stigmatisation and discrimination. The section commences with a discussion of the cultural aspects of stigmatisation.

2.3.10Organisations and Institutions as a Consequence of Stigmatisation

The fabric of institutions is based on pre-existing values in society. Institutions stigmatise people whose family members have been stigmatised. In educational institutions, children from poor families and marginalised families are stigmatised and made scapegoats. For example, they are teased by classmates from the stigmatisers or shunned from collective activities or even expelled by the

authorities from school, or subjected to violence.[116] The above beliefs imply that, the stigmatiser, when he/she uses pre-ordained organisational/institutional norms to achieve an intended objective, feels satisfied to enjoy the fruits of the labour of the stigmatised and excluded person. Surprisingly, the younger generation is still being indoctrinated into accepting stigmatising attitudes and practices (Kirp et al., 1989) this is an example of the vicious cycle of stigmatisation, the grandparents were stigmatised, their children and their children's children were also stigmatised and so it goes on *ad infinitum*. In the workplace stigmatisation is reinforced by organisational structures. The hierarchical structures of an organisation can, typically, make some employees feel isolated and not part and parcel of the organisation. This effect can be further compounded by the inequitable treatment of employees. Thus stigmatisation is expected at the workplace.

2.3.11 Communication and Media as Agents of Stereotyping

The mass media can be greatly influenced by ideology (political beliefs), which are the roots of stigmatisation. Ideology emphasises differences between people and groups and counts deviations from the norm as threats to personal and social security.

Media can be an agent of socialisation and cultural norm, enforcing stigmatisation exposed in feature films, news reports and advertising or stigmatising social problems caused by racism, poverty, drug abuse and mental illness.[117] The Media usually transmits what society expects, as already noted, bad news sells. So the media usually describes patterns, expectations and norms of the community life of specific groups. This aggravates stigmatisation, since this reinforces what society has come to expect, (Malcolm, 1994). Media can cause violence which has both short-term and long-term effects to the lives of people. Different games on television which are violent can shape the lives of the young to become hostile in community and society at large. Expectations will become the general knowledge

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[116]D. Kirp, et al., *Learning by Heart: AIDS and Schoolchildren in American Communities*, (New Brunsurick, N.J: Rutgers University Press, 1989), p. 22.

[117] Michael Cummings, Public Media Centre *The Impact of Homophobia and other Social Biases on AIDS. A Special Report by the Public Media Centre,* (San Francisco, California, 1995), p. 3-5.

of social order and become the guides of action, reinforcing pre-existing stigmatisation.

The pre-existing political, social, cultural religious and economical values of society that support stigmatisation can be reinforced by media, through using technologies such as text, graphics, sound and video that are effective modes of communication.[118] There can be a lack of trust and truth in the media if it is controlled by the political system.[119] However, media cannot be singled out as a sole cause of anti-social behaviour in society. Media has different effects on different segments of society.[120] This implies that, social stereotypes and ideological views can also be changed by the media by being positive towards the stigmatised. Media can influence and change cultural attitudes through dissemination of anti-discrimination information and by using celebrities to mix with the stigmatised, thus, reducing stigmatisation. Media can promote sub-cultures that are anti-stigmatisation thus influencing societal values for the good of all. The media communication revolution can be used to break the culture of silence such as, denial, exclusion, stereotyping and stigmatisation.

Radio and television are part of the mass media that can transform the attitudes of the stigmatisers. There are different ways media can change the mind set of people. For example, local forms of dance, song and storytelling can be used to get the message of non-stigmatisation or resistance to stigmatisation across to a wide body of the population. Local culture can be used as a tool of life by the people. Indigenous culture provides a basis for teaching, ethnical, cultural, and religious values. All in all, communication and media can either be used as agents of stigmatisation or social change.

2.4 Summary

The aim of this chapter was to develop an understanding of stigmatisation, and to discuss the sociological, cultural and religious causes of stigmatisation, to achieve a

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[118]L. Rowell, Huessmann, "Psychological processes promoting the relation between exposure to media violence and aggressive behaviour by the viewer" *Journal of Social Issues*, Vol. 42, (1986), pp. 125-139.
[119] Shirley Biagi, *Media Impact with Infotrac*, (Paperback, Thompson Learning, 2000), p. 7.
[120]Cynthia Pope, (2009), pp. 344-345.

better understanding of stigmatisation as a social process embedded in the core values of society. To make such a discussion possible certain terms such as, stigma and stigmatisation, attitude, fear, social control, labelling, discrimination, myth, prejudice, scapegoating and deviance, were examined and explained. Other related terms were also defined as encountered in the discussion.

This chapter has clearly established that, stigmatisation is a vicious cycle and is deeply rooted in societal, cultural and religious values, as a form of social control. The practice of stigmatisation is ingrained in society, the purpose of which is to distinguish the ideal people "insiders" or "in-groups" from the rejected ones "outsiders" or "out-groups" (Allport, 1954). "In-groups" are seen as acceptable as they conform to the accepted norms of a particular society, social order or grouping," (Allport, 1954: 24; Bate, 2009: 59). "Out-groups", on the other hand, are labelled as deviants because they are seen as having attributes that disturb and threaten the existence of the existing social order (Goffman, 1963). Those who consider themselves the "in-group" or "normal" will go to enormous lengths to maintain the status quo, which is achieved by keeping those considered as different under control, regardless of the personal cost to the effected party.

Attitude, fear and social control were seen to be key factors in the vicious cycle of stigmatisation. Attitudes are shaped and formed by people's social standing, their parents and peers, and the environment in which they grow up. Attitudes develop over time and once developed, whether rightly or wrongly, can be very hard to change. Fear, on the other hand, is something which can change over time and is related to the unknown. Fear is a powerful emotion as it will drive people to take illogical action just to preserve an ideal, even if the fear is unfounded and based on faulty information. Fear of what is considered a contagious disease is a perfect example, even though the disease may not be contagious. Social control is the most insidious of the lot as this is imposing the will of the group without consideration for its effects on the individual. What is good for the group may not be good for the individual.

The chapter opened with a discussion of the cultural, religious and sociological aspects of stigmatisation. This discussion covered how the law can perpetuate and prolong stigmatisation. Particularly, when discriminatory laws, such as, disease notification are passed. The discussion on the law also highlighted the fact that international protocols on human rights are not always included in local law. Galtung's theory of structural violence was discussed at length in order to bring an understanding of some of the concepts embedded in structural violence. Violence has been seen as a tool to other injustices and cause of harm to society. The political, economic, cultural, religious, and social environments of society are strongly rooted in structural violence that leads to creating imbalances in society. Galtung's theory helped to shows some aspects which are causes and consequences of stigmatisation. The discussion on human differences included gender inequality which is a serious issue in an African context, where men are seen as powerful and women are seen as subservient. Language was also seen a discriminating factor. Language can be a pointer to social status and level of education. Only speaking the local language can lead to difficulties in life and hence to stigmatisation. Race and ethnic background were also seen as stigmatising factors. Movement of people from one racial ethnic group to another or from one country to another in search of work can be a source of spreading disease, regardless of race or ethnicity.

Organisations (the workplace), communication and the media rounded out this chapter. Stigmatisation is reinforced in the workplace by organisational structures. The hierarchical structures of an organisation can, typically, make some employees feel isolated and not part and parcel of the organisation. The pre-existing political, social, cultural religious and economic values of society that support stigmatisation can be reinforced by media. On the other hand, media can be a force for good and can take a stand against stigmatisation. The mass media can transform the attitudes of the stigmatisers by presenting regular features about the devastating effects of stigmatisation on individuals and its damaging effect on society and the country as a whole. The above was a prelude to chapter 2 which will discuss HIV/AIDS stigmatisation from a sociological, cultural and religious perspective.

Chapter 3 STIGMATISATION: HIV/AIDS

> Informing young people about HIV is essential to stopping the spread of the disease. Engaging young people to share their experiences with HIV to help inform their peer is a powerful way to build understanding and breakdown the stigma that surrounds HIV/AIDS.[121]

3.1 Introduction

Almost everywhere in the world, the HIV/AIDS epidemic continues to be associated with stigmatisation. Attitudes and behaviours concerning the epidemic are based on "half-truths" informed by prevailing urban myths.[122] The misunderstanding surrounding HIV/AIDS-related stigmatisation is the result of associating it with individual behaviour, rather than considering it from sociological, cultural and religious perspectives. This stigmatisation can be understood within social behavioural patterns, with essential religious-cultural dimensions that pre-existed and are still in existence in the family, community, society, the national and international community. The nature of the stigmatisation cannot be automatically determined, since its sources are deeply ingrained in societal, cultural and religious values. Emile Durkheim was the first psychologist in 1895 to explore stigmatisation as "a social phenomenon."[123] He referred to its association with the power to be able to judge and punish deviant behaviour in society.

To understand that stigmatisation is a social process, this chapter analyses it in its sociological, cultural and religious contexts as related to HIV/AIDS. It is a central argument of this thesis that one cannot fully understand the situation of HIV and AIDS sufferers without a full grasp of the stigmatisation that surrounds the disease. Moreover, this understanding can help to alleviate the plight and feelings

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[121] Tina Hoff, Senior Vice President & Director, Health Communication & Media Partnerships Program at Kaiser Family Foundation Scenarios USA is a non-profit organization that uses writing and filmmaking to foster youth leadership advocacy and self-expression in under-served teens. Scenarios USA asks young people to write about the issues that shape their lives for the annual "What's the REAL DEAL?" writing contest, and thousands have responded with their raw and revealing insights, 17 April (2006).

[122] Tony Barnett and Michael Blachwell, "Structural Adjustment and the Spread of HIV/AIDS. Working Paper, (London: Christian AID, 2004), p. 4.

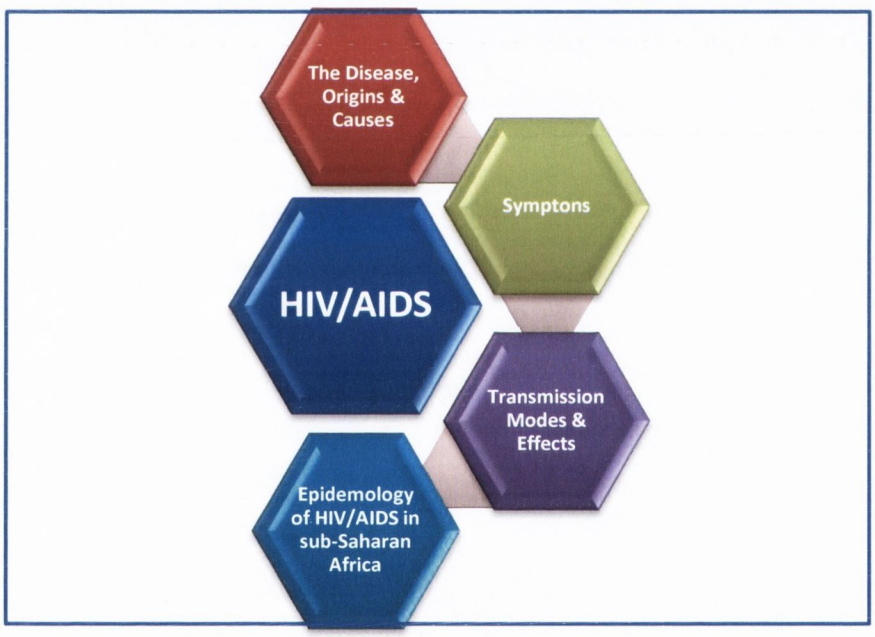
[123] Emile Durkheim, *the Rules of Sociological Method,* (New York, the Free Press (1895/ 1964) p. 14.

of the infected and affected people, through devising appropriate strategies, programmes and interventions – which will be discussed in detail in chapter 5.

This chapter opens with some essential background material on HIV/AIDS. The disease, its origins, causes, effects and modes of transmission, will be explained. Thereafter the stigmatisation of AIDS sufferers will be outlined with reference to the social, religious and cultural contexts which lead to their stigmatisation.

To enhance the understanding of the reader, the next section of the chapter is arranged according to the following themes - the disease, its origin and causes, symptoms, transmission modes and effects, and finally the epidemiology of HIV/AIDS in sub-Saharan Africa. The following figure shows the sequence of the above themes.

Figure 3.1 Understanding HIV/AIDS



Source: Own

The causes, symptoms and modes of transmission can vary from country to country and from person to person. The trend of the spread of the disease varies, sometimes increasing and sometimes reducing.

3.2 Description of the Disease, Origins and Causes

HIV is a syndrome that is caused (in the scientific sense of the word) by a virus (HIV, a retrovirus) that infects and causes a biological change in the human body

that leads to Acquired Immune Deficiency Syndrome otherwise known as AIDS. [124] The retro-virus shows an unprecedented ability to undermine the human body's immune system.[125] The human immune-deficiency virus can insert itself into the host cell nucleus. Since it contains an enzyme, known as reverse transcriptase, it is the mechanism that enables the cell nucleus to force the cell to make a DNA copy of viral genetic material. This gives it the power to be incorporated into the host cell. It therefore leads to a take-over of the T4 lymphocytes, which accounts for the immunodeficiency effect of the virus.[126] The virus attacks, insidiously and secretly, the defences of the immune system. By so doing, the HIV virus progressively leaves the sick person more and more unable to resist the aggressiveness of the disease and disease opportunistic infections.[127]

The human body is weakened and progressively deprived of the possibility of living a normal life, and ultimately surviving. HIV reduces the capacity for resistance in the immune system leaving the infected more prone to other infectious diseases. HIV is a result of the weakened cells that exist to provide protection to the body. The body is protected by the immune system which fights against any infection. If that immune system is compromised it is like leaving the body without protective support. Thus HIV slowly weakens the ability of the body to protect itself. As a result the body is open to many chances of being destroyed by the virus and other opportunistic diseases. Thus antiretroviral drugs were developed to help the cells fight against the virus and reduce the amount of cells being attacked in the system.[128] Full blown AIDS is a series of opportunistic infections and/or tumours[129] (Hall and O'Grady, 1989). This makes it apparent that eradicating HIV/AIDS is going to require more than restoring a patient's competent immune system, since the antibodies, the defensive mechanisms of the

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[124] Helen Jackson *et al.*, (1999), p. 7-11.

[125] Sonja Weinreich and Christoph Benn, *AIDS-Meeting the Challenge Data, Facts, Background*, (Geneva: WCC Publications, 2004)1-2.

[126] Michael J. Kelly, "The Response of the Christian Churches to HIV/AIDS in Zambia," in J. N. Amanze F. Nkomazana, and O.N. Kealotswe (eds) *Christian Ethics and HIV/AIDS in Africa*, (Gaborone: Bay Publishing, 2007), 27. See also, Vicky Cosstick, ed., *AIDS Meeting the Community Challenge* (England: St Paul Paulications, 1987), p. 34.

[127] Lawrence O. Gostin, *the AIDS Pandemic: Complacency, Injustice, and Unfulfilled Expectations*, (Chapel Hill: University of North Carolina Press, 2004), p. 16.

[128] Vicky Cosstick, (ed.) *AIDS Meeting the Community Challenge* (England: St Paul Paulications, 1987), pp. 16-17.

[129] Judith A. Hall, *Non-Verbal Sex Differences: communication Accuracy and Expressive Style*, (Baltimore: Johns Hopkins University Press, 1984), p. 27.

body, would have been overwhelmed or destroyed. As a result, the body becomes weak and in certain cases the infected person loses weight and becomes thin. [130] HIV/AIDS was first discovered in United States of America, in California and New York City within the gay community.[131] Many countries including Britain started to record symptoms of the disease in the early 1980s. Then the wider international community became aware of this deadly disease.[132] However, it was strongly associated in the public imagination with a particular group and lifestyle.[133] As a result, the disease was considered to be a disease of the West. However some countries in Central Africa had already been suffering from the disease (Gilmore and Somerville, 1994). Due to mobility, the disease quickly spread to Southern Africa and countries like Botswana, South Africa, Tanzania and Zimbabwe had the highest infected population. In 1981 it was officially recognised that a "new disease" known as Acquired Immune Deficiency Syndrome (AIDS) had appeared.[134]

3.3 Symptoms of HIV/AIDS

The outward symptoms of HIV/AIDS are many and varied. The following are some of the known symptoms of the disease. However, certain symptoms are not obvious and can only be detected by medical means. Depending on the level of HIV/AIDS, the symptoms include: loss of body weight, irrespective of amount eaten, loss of appetite and vomiting, coughing related to TB, diarrhoea, sores in the mouth and throat, ear and eye infections, and changing of skin pigmentation Cosstick, 1987:26-3). The more advanced the disease, the greater the effects.

The search for a vaccine which will cure HIV/AIDS has been lengthy and difficult. But new research into how the virus functions and its structure is helping advances towards a vaccine. However, it is fortunate that it is not efficient in transmission from an infected person to an uninfected person. In most cases or

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[130] Helen Epstein, "The Global Health Crisis" in Kurt M. Campbell and Philip Zelikow eds., *Biological Security and Public Health: in Search of a Global treatment,* (Queenstown: The Aspen Institute, 2003), pp. 22-25.
[131] Sonja Weinreich and Christoph Benn *AIDS-Meeting the Challenge Data, Facts, Background*, (Geneva: WCC Publications, 2004), p.1.
[132] Vicky Cosstick, (ed.) *AIDS Meeting the Community Challenge*, (England: St Paul Publications, 1987), pp. 14-15.
[133] Gregory M. Herek and John P. Capitano, "Public Reactions to AIDS in the United States, a Second Decade of Stigma." *American Journal of Public Health,* (1993), pp. 83:74-577.
[134] Vicky Cosstick, (1987), p. 11.

instances, it can take frequent contact with an HIV infected person for infection to be transmitted. The virus appears in many forms; it mutates rapidly, invades immune cells and turns infected cells into producers of more viruses. It may remain latent for long periods. Antibodies to HIV (currently the only way to diagnose infection) only appear weeks or months after exposure. This is called the window period. At the time of acute infection stimulation of antibodies against the virus occurs. This leads to an acute seroconversion illness similar to glandular fever with muscle aches, joint pains, swollen lymph glands and a sore throat.[135] Thus, the virus attacks insidiously the defences of the immune system. This leaves a person weak and progressively deprived of the possibility of living a normal life, and ultimately of surviving.

3.4 Transmission Modes and Effects of HIV/AIDS

HIV can be transmitted through contaminated body fluids entering the body in sufficient quantities through the skin. The main modes of transmission are; "multiple and concurrent sexual partners, early debut, cross generational sex, transactional (sex workers) sex and casual sex."[136] In addition, HIV is transmitted through infected blood, by intra-venous drug use with contaminated needles and other modes, for example, open wounds[137] (United Nations Report 2005). Studies have also shown that another form of transmission is mother to child, both pre- and post-natal.[138]

It is important to stress that HIV/AIDS is not transmitted by the following:

- being bitten by mosquitos, other insects or animals
- eating food handled, prepared and served by somebody with the HIV infection
- sharing toilets, telephones or clothes, forks, knives or drinking glasses with an HIV/AIDS sufferer

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[135] Ibid. (1987), p. 14.

[136] TACAIDS "National Multisectoral HIV Prevention Strategy", *Tanzania National Multisectoral HIV* and AIDS M &E Plan Tanzania Commission for AIDS Second Edition, Dal es Salam: *TACAIDS*, (2011 to 2012), p. 12-16.

[137] UNAIDS (2005), p. 4.

[138] Sonja Weinreich and Christoph Benn *AIDS-Meeting the Challenge Data, Facts, Background*, (Geneva: WCC Publications, 2004), p. 32.

- touching, kissing a person with HIV infection without open wounds on the lips or mouth; attending school, Church, shopping malls or other public places with HIV-infected persons
- Participating in sport together, nor will sweat from HIV-infected person transmit the HIV virus.

There is however, a warning that, when lips are bleeding one should avoid contact with open wounds. In addition, deep kissing may also hold a small amount of risk of transmitting the HIV virus. The probability of transmitting HIV via unprotected sex rises dramatically if either partner has another Sexually Transmitted Disease ("STD"), such as syphilis or cancroid. The latter sexually transmitted infections result in ulcers and sores that facilitate the transfer of the virus (UNAIDS, 2006).

3.5 Epidemiology of HIV/AIDS in Sub- Saharan Africa

Africa, as already noted in Chapter 2, is a large diverse continent. The HIV/AIDS data given below relates only to sub-Saharan Africa. The source of the data is a 2007 UNAIDS update on the trends and spread of the disease. This data will helpfully convey the sheer magnitude of the HIV/AIDS problem in sub-Saharan Africa.[139]

Out of an estimated world total of 33.2 million in (2006: 40 million people) living with HIV:

- About 68% (2006: 62%) of the world's HIV and AIDS population are located in sub-Saharan Africa.
- Sub-Saharan Africa accounts for about 68% of all new annual global infections.
- Of all AIDS-related deaths (2.1 million) about 76% (2006: 72) are reported in sub-Saharan Africa.
- More than half of people living with HIV/AIDS in sub-Saharan Africa are women (the world average is 45% (2006: 59%).
- The adult prevalence rate in sub-Saharan Africa is 5.0% (2006:5.9%) (The world average is 8.0%).
- More than 80% of the global number of children living with HIV/AIDS lives in sub-Saharan Africa.[140]

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[139] UNAIDS (2007), p 6.
[140] Ibid. (2007).

The above data reveals that HIV/AIDS has "become a development issue that within the statistics given above more and more people are seeking help in the health sector."[141] This is not easy, however, especially in developing countries where health, education and public sectors are struggling to provide the basic services, and where travel to medical facilities is often hazardous and prohibitively expensive.[142] Given this context the number of infections may actually be much higher because some people never seek hospital care for AIDS, some physicians or nurses may not want to record a diagnosis of AIDS, because of the stigma attached to the disease, and because some people with HIV infection may actually be afflicted by other diseases because they never have health checks even when unwell with other illnesses.

According to Ezra Chitando[143] research indicates that HIV/AIDS was already an African problem pre 1980. However, it was only acknowledged in the 1980s and this failure to acknowledge earlier can be explained by a complex set of factors including fear of a backlash against Africa and Africans in general and no doubt also because of economic considerations, not least of which was the tourism industry. Since disclosure, the disease has posed a serious challenge to various African governments. The disease poses challenges in the medical, social, economic cultural and educational fields.[144] It also acts like a sponge absorbing large amounts of scarce resources and time. Worth emphasising is that amongst the number of infected people in sub Saharan Africa, women and children are by far the most impacted group.[145] The number of widows and orphans is therefore very large. Moreover the working population of young men is also seriously impacted. All in all, HIV has created a disaster of huge proportions for countries still struggling to rise above the poverty line (Kelly, 2008)

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[141] Ann Smith and Enda, McDonagh (Eds.), *The Reality of HIV/AIDS Christian Perspectives on Development Issues*, (Dublin: TROCAIRE, VERITAS and CAFOD, 2003), pp .1- 15.
[142] Helen Epstein, (2003), p 45.
[143] Ezra Chitando, *Mainstreaming HIV/AIDS in Theological Education: Experiences and Explorations*, Ehaia Series, (Geneva: WCC Publications, 2008), p. 15.
[144] Ibid. (2008), p. 28.
[145] Ann Smith, and Enda McDonagh, eds., *the Reality of HIV/AIDS Christian Perspectives on Development Issues* (Dublin: TROCAIRE, VERITAS and CAFOD, 2003), p. 14.

3.6 A Discussion of the Social Production of the Disease

Thus far in this chapter the emphasis has been on explaining the biology of the virus and its medical consequences and manner of transition. However, it is important to understand that this disease, as with others, cannot be understood solely through this biological lens. Ultimately, the biological model embodies an approach to analysing disease that is fundamentally individualistic. Profoundly ahistorical, it contains within itself a dichotomy between the biological individualist and the social community. (Kusumalayam 2008: 49-50). It also ignores the latter... reflecting an ideological commitment to individualism, the only preventive actions seriously suggested are those that can be implemented by solo individuals. Little attention is accorded to situations in which negotiation is required between persons (or communities) with unequal power. Intended or not, these attitudes implicitly accept social inequalities in health (education and warfare) fail to challenge the social production of disease.[146]

The above statement certainly applies to the African context in the way health is perceived in the family, community and society. In many cases, a curse is regularly associated with prolonged disease which is not common within the culture, and drastically shapes a person's life. A person can be considered healthy only if he/she belongs within the context of a healthy community. The fact that a deep spiritual and religious perception of the universe generally characterizes life in Africa also means that health and sickness in Africa are never regarded as merely physical or biological. As previously noted, health and sickness are at once social, somatic, religious, and spiritual phenomena. It is this comprehensive background that explains both "the constant quest for healing and well-being and the fact that healing can never be viewed as merely the healing of an individual beset by illness"[147] (Hogan, 2008:141). For example in Tanzania, the HIV epidemic is driven by "a complex set of intertwining biological, behavioural, and underlying socio-cultural and socio-economic factors."

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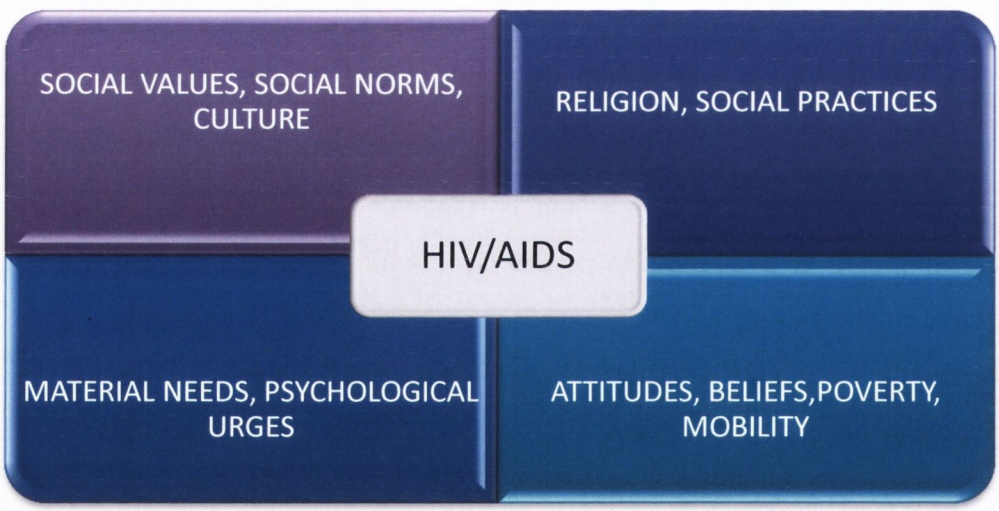
[146] American Journal of Public Health, vol: 92, Issue: 7, *American Journal of Public Health,* (2002), pp. 1073-1076.

[147] Linda Hogan (ed.) *Applied Ethics in a World Church the Padua Conference,* (Maryknoll, New York: Orbis Books 2008), p. 141.

The factors that intensify the spread of HIV/AIDS include, among others, social values and norms, religious and social practices, attitudes, beliefs, poverty and mobility and material and psychological needs. Each of these factors is complex in itself, for example, the mobility factor has a number of variables which repay further analysis, such as the distance travelled, the duration of time away from home, whether a person is traveling alone or with a spouse, whether the person traveling is male or female and whether the travel is rural or urban. It is not mobility per se that is a determinant in the contracting of HIV/AIDS, but the breadth of exposure to the range of chances of infection (Aliber, 2002). The following figure details the factors noted above which can assist in the spread of HIV/AIDS. The paragraphs which follow describe how each particular factor impacts the spread of the disease.

Figure 3.2 Factors which Can Assist the Spread of AIDS



Source: Own

All of the above are complex inter-connected social phenomena that must be well understood as such, before anyone can start thinking in terms of a solution against the spread of the disease.

3.7 Vulnerability among Different Groups of People

It is necessary to emphasise that while all strata of society are at risk, the degree differs among different groups. Poorer people are more vulnerable to the disease.

"While poverty does not cause HIV/AIDS, it facilitates transmission, makes adequate treatment impossible to afford, accelerates death from AIDS-related illnesses and multiplies the social impact of the epidemic[148]." Unfortunately, vulnerability already constitutes a too-common experience for many people. It is in situations of chronic poverty, hunger, civil wars, forced immigration, oppression or discrimination, that life becomes dangerously precarious for a larger and larger part of humanity. The list of situations can be almost endless because more and more persons experience situations of vulnerability, nourished by many forms of instability all over the world, an example being, human trafficking. The French theologian Philippe Borden rightly states that, 'vulnerability starts at a physical and bodily level.[149]

3.8 Patterns of Infection by Age and Gender

Contrary to popular assumption, most new infections are transmitted by heterosexual contact. This means that people at risk are liable to become infected as soon as they become sexually active. In a study by Mposhi in Zambia it was found that, the infection levels were extremely high for girls and young women. The highest infection levels for women were in the age group 20 to 24. While for men, the highest infection levels were found in the age group 30 to 39. Overall, the prevalence for a female was markedly higher than for males among the age group 15 to 24, because women mature earlier than men and are more vulnerable at an earlier age. The male prevalence was higher in the age group 23 to 39 because it is in this period that so many leave their families to work in the cities. As will be argued later in this thesis this factor needs to be taken into account when shaping educational and awareness programmes as part of an appropriate strategy of preventative and pastoral care for HIV/AIDS sufferers and their families.

Women are often powerless and culturally disempowered in their struggle with the infection or the disease. When men are infected they usually must relinquish their responsibility of caring for their families, since in most cases once AIDS is

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[148] Ann Smith and Enda McDonagh eds., *the reality of HIV/AIDS Christian Perspectives on Development Issues,* (Dublin: TROCAIRE, VERITAS and CAFOD, 2003), pp. 26-27.
[149] Ibid. (2003), pp. 26-27.

diagnosed they may become unemployed and unemployable. The virus of AIDS has impoverished innumerable families in Africa, (Bate 2009: 35). Many cultural practices render women and young girls vulnerable to HIV infection. These practices include early marriages and wife inheritance (despite the legal minimum age for marriage being 18 years). Marriage is highly valued within African society, even where it is not monogamous. In the past, African culture in some countries expected parents to arrange marriages for their family. The parents would recommend families who were hard working, were rich and could afford to provide food. Livestock was also important in assessing the status of a particular family. Having many cows, goats, sheep and pigs meant a lot in the setup of the family. In countries where people were allowed to hunt, the family whose father was able to bring meat was also considered to be rich. In some cases, farming was also highly respected in that more food was provided. Due to the above factors, men were also allowed to have more than one wife. The practice of a man having more than one wife (polygamy), with a formal payment of lobola (bride price or dowry), with full social acknowledgement and support, is mostly found in rural areas. "Society is made up of many different classes and groups which experience power and powerlessness." Thus, groups compete to influence social policies and social change.[150]

However, polygamy is also practised by religious groups, like the Apostolic Church. The idea of having many wives is respected in the Church as a result of certain legitimising claims attributed to prophets. Women in this context have no choice but to abide with these claims with their purported transcendent source. Hence, women have limited choice about whom to marry and are not allowed to refuse the men (the prophets) have selected and pointed out. There are some chiefs and kings, who are given wives free of charge by the community. In practice, some families show respect to their chief by giving a young woman to be one of his many wives. However, modern chiefs and religious chiefs do not always accept the women as wives, but instead give the woman to their relatives in the clan. This practice has disempowered and caused problems for many young girls and women, depriving them of freedom of choice and vulnerable. When married, these

[150]Nicholas Bate, (2009), p. 36.

women live in one household and in certain places they are in one compound divided into small house units. There is now a risk of, this otherwise closed marriage system, being exposed to HIV through infections, resulting from earlier sexual experience of some of the members (NAC & UNFPA, 2006). Furthermore, as a man ages but continues to take on very young wives, younger women not being contented by such marriage arrangements may seek relationships outside the polygamous system with a risk of infection for those within that system.

It can be seen therefore that this cultural practice can contribute to and exacerbate intra family viral transmission. Evidence shows also that women tend to be slow to seek medical advice when they are not feeling well. This can be due to ignorance, fear, poverty and inability to take a stance of independence. In the 1999 Demographic Health Survey ("DHS"), 15.5% of all currently married women and 9.4% of all currently married men were reported to be living in a polygamous union. This was notably higher among married women without an education (30.2%) and in the 15 to 19 age groups (54.6%) of currently married young people without an education. In Zimbabwe – the main focus of this study – polygamy has long been recognized as posing an epidemiological risk. The recent rejection of polygamous relationships may have varying positive repercussions by the National AIDS Council in Zimbabwe. Even where it is illegal, the tacit social endorsement of polygamy may persist through its risky urban derivation, for men to have an unregistered marriage commonly referred to as "small houses" (National AIDS Council (NAC), 2006). UNAIDS (2004) identified three key factors that contribute to the greater vulnerability of women and girls to HIV infection. The first one is the culture of silence surrounding sexuality. Good women are expected to be ignorant about sex and passive towards men in sexual interactions, despite the reality that women begin their sexual activities at an earlier age than men.[151] Secondly, exploitative transactional and intergenerational sex is common in some parts of Africa, including Zimbabwe. In a study, LeClere-Madlala (2004) found out that, the motivation and meanings of sexual exchange for material gain could be motivated by consumption and subsistence. The research found out that,

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[151] Paul Farmer, *Pathologies of Power: Health, Human Rights, and the New War on the Poor,* (Barkeley, Los Angeles: University of California Press, 2003), p. 28.

contemporary forms of sexual exchange are more intergenerational and are a means used by women to pursue images of modernity created by the media and globalization. In practice, for biological reasons there is a greater probability of male-to-female transmission than female-to-male. Thirdly, it should be noted that the probability of female to male transmission is influenced by the circumcision status of the man; female to male transmission probability is increased if the man is not circumcised.

Furthermore, it is worth emphasizing that, the women, especially rural women are poorer than their male counterparts and poorer than those in towns or cities. Women typically lack money for medication. Female-headed households are poorer than male-headed households. Women are more impoverished than men with respect to either ownership of assets or activities, or access to credit (World Bank, 1999 Jazzely, 1990). There is an assumption that HIV is widespread in heterosexual and drug abusing populations worldwide (as well as in the homosexual population). Though this can be a fact, it should also be noted that, this scenario can be made worse by poverty. The human immune system can be weakened by a host of factors, including, but not limited to the effects of poverty and epidemiological co-factors in disease transmission (malnutrition, parasite load or poor access to health care).

Unequal distribution of agricultural income leaves women without adequate income for medical treatment. Economically, most of the agricultural activities in Zimbabwe are done by women who in the end do not enjoy the fruits of their labour, because the end products are controlled by their husbands, other men and economic systems in which they have no part. Thus, because of cultural practices, the benefits accrue to men rather than to women. Besides poverty, gender inequalities leave women without adequate resources to visit health clinics or hospitals for medication. Such disempowerment and marginalisation render women more open to physical infection and emotionally and socially liable to isolation and to being blamed and stigmatised. The inequality in the distribution of farming income is, however, not the only cause for the spread of the disease.

3.9 Labour Markets, Migration and Gender in Relation to Stigmatisation

Social norms and expectations perpetuate the spread of the disease and its related stigmatisation. Job segregation along gender lines remains deeply entrenched in African social norms and practices. Because of the lack of lucrative jobs, for example, in rural/urban areas, some women resort to prostitution, which can be a source of the disease. Women have a narrower range of occupational choices as compared to men (Milward, 1995). Men can work in underground mines which is labour intensive hard work and where in such places women are a minority. Promiscuity was endemic in mining villages where men lived, separated from their families and where prostitutes were readily available for financial gain. Similar situations existed on trucking routes. Long distance drivers spend several weeks on the road and opportunities of unfaithfulness were readily available. Women earn less than men in the full time employment sector – assuming in the first place that they can even find paying work in rural areas. In the permanent employment sector, such as working on farms, gender greatly affects the workplace because of different categories and divisions to suit the job in question. Very often the workplace mirrors and sometimes exacerbates the gender inequality and discrimination present in the wider society. Economic pressure and poverty force women mostly to accept work that is unpleasant, often leading them to being viewed as unclean and in turn being stigmatised, all the more so if they are known to suffer from the disease.

The section above demonstrates clearly the manner in which HIV/AIDS is 'socially produced' and how it's transmission is facilitated by cultural assumptions and practices (in particular gender inequality), social norms and economic circumstances and systems. It will remain in the next section to explain and discuss the process of the social dimensions and scope of stigmatisation.

3.10 A Discussion of the Social Production of the Stigmatisation of Sufferers

There is much evidence and no doubt that people living with HIV/AIDS are stigmatised in the African context. As will be elucidated, there are many sites of this stigmatisation, from the individual to the family, to the community. Having established the significance of these sites of stigmatisation, this chapter will then suggest, in line with Chapter 2, that stigma arises from the social, cultural and religious contexts. Culture can involve and promote both positive and negative behavioural outcomes. The influence of culture shapes human behaviours which are either harmful or beneficial at the time. In the case of HIV/AIDS, culture can spearhead harmful attitudes and behaviour with a damaging impact on individuals, communities and indeed on the African population as a whole. The beliefs and values of the African population regarding sexuality need to be rethought and adapted to changes in the social context. (Shisana & Simbayi, 2002: 16).

As regards to HIV/AIDS-related stigma, a new approach to prevention, knowledge and empowerment needs to be developed. Mazrui (1986:239) defines culture as, 'a system of interrelated values active enough to influence and condition perception, judgement, communication, and behaviour in a given society.' This means that culture plays a crucially important role in influencing behaviour in family life, community and society. Furthermore, Hahn (1995:23), accentuates the 'role of culture and society in relation to sickness and healing, and highlights the use of language in the understanding of illness concepts.' Thus, 'one's cultural belief system influences one's self-understanding, and social roles and relationships when one is ill (Brody, 1987: 10). Here it is necessary to take account of the understanding and practice of medicine as also a cultural outcome, particularly with respect to the focus on the body rather than the contexts that define and shape the body (Farmer, 2006: 1689).

Regardless of the disciplinary basis on which the definition is advanced, it is generally understood that culture is the foundation on which health behaviour in general and HIV/AIDS in particular is expressed and through which health must be

defined and understood. This realisation of cultural centrality to health has resulted from the need to question and examine critically the assumption inherent in Western-based conventional theories and models, which postulate that health behaviour is a-cultural.[152] This is not to deny the fact that the study of culture as well as its contribution to the understanding of health behaviour in recent times is altogether new. Culture and its impact, nonetheless, are hugely significant for the understanding of Africa and its people. Another definition by Sarpong (2002:40) brings this out, explaining culture as "the complex whole which includes knowledge, belief, art, morals, law, custom and any other capabilities and habit's acquired by man as a member of society."[153] If this is true, then the different culturally based models provided by Western scholars in their very different cultural contexts, need to be scrutinised and proofed before being applied without question to the African contexts. They provide a background that has limitations in attempting to anchor a one-culture-fits-all model for understanding health behaviour.[154]

Thus, HIV in Africa has been most devastating because of its embeddedness in certain African cultural norms and practice. For example in the area of mental health, culture and language are demonstrated to be the key to providing effective mental health services. The same can be true when trying to address the problems of HIV. Failures to adopt new practices and new behaviours are often seen as cultural retrogression. According to Webb, (2001:21) who compares culture to the air we breathe: asserts that, "We live and move about in the culture with which we are closely and invisibly enmeshed." However, human achievements and endeavours are aimed at "cultivating" the cosmos into a human space that creates space for living through symbols, metaphors, language, instruments *(techné)*. The human life is centred on networking and connecting with one another. The culture of individualism has led to lack of care of the sick in community and society. The

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[152] *Journal of Social Aspects of HIV/AIDS Research Alliance*, Vol. 1 No.1 May (2004).

[153] Kenneth S. Sarpong, *Peoples Differ. An Approach to Inculturation in Evangelisation.* (Accra, Ghana: Sub-Saharan Publishers, 2002), p. 40.
Johan Cilliers African Spirituality, "Formations and Movements of Christian Spirituality in Urban African Contexts", (South Africa: University of Stevensbosch, 2009), p. 4.

[154] Nehemiah Nyaundi, "The Phenomenon of Violence in Eastern Africa", in Laurenti Magesa, ed. *African Theology comes of Age: Revisiting Twenty years of the Theology of Ecumenical Symposium of Eastern Africa Theologians (ESEAT)* (Nairobi: Paulines Publications Africa, 2010), pp. 123-131.

practice of isolating the sick because they are viewed as a source of endangerment, in a culture where the sick are traditionally cared for by family and community, is one obvious example of isolation taking on the cultural character of stigma the HIV infected persons and their immediate family (Hoffman 1995: 56).

This reality makes it even more critical that a more in depth account is taken of the role of culture in its specific forms, in defining, regulating or maintaining behaviour in the context of health in general and HIV in particular. Parker and Aggleton (2003: 28) examined the influence of the broader contexts of culture in AIDS related stigma and accompanying denial and concluded that stigma could not be fully examined outside the cultural contexts that give it meaning.[155] Language offers some clues. In this African context, if there is a lack of "*ubuntu*" referring to community participation in joys and sorrows, meaning community in its fullest sense, a person cannot thrive or become well.[156] Then, "*ubunye*" that is "holism" a Greek word meaning "all entire, total" is related to the interconnectedness of people in a particular environment and wider society while, "*amandla*' meaning (power) is vitality."[157] The Africa culture is expressed through hospitality and living in unity and solidarity. In African culture there is a strong sense of family and caring. Thus the notion of extended family is a common element of the family structure. This understanding of living together in community is the heart and core of African family, whereby a person does not only belong to a family but also to the community. This is the essence of solidarity.

People need strength or energy to carry on different tasks and this comes through acting collectively and through collective solidarity. Thus, "biological, chemical, social or economic conditions" are viewed as all properties of a given system and linked together to make a whole, like a tree with many branches.[158] The movement is always towards greater inclusiveness, "from solitary to solidarity, from independent to interdependence, from individuality vis á-vis community to

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[155] Kenneth S. Sarpong, (2002), p. 5.
[156] Bate (2007) pp.35-7.
[157] Ibid. (2007), p. 7.
[158] Johan Cilliers African Spirituality, 'Formations and Movements of Christian Spirituality in Urban African Contexts' (South Africa: University of Stevensbosch, 2009), pp. 4-5.

individuality á la community" Louw (2002:15).[159] In focussing in this chapter on African culture in its interdependent and inclusive depth, the purpose is to highlight the kind of gaps and misconceptions that will need to be addressed in dealing with the whole reality of stigmatisation for HIV/AIDS sufferers. The underlying reality is the disease. Preventing the disease and treating it when it occurs is the original or primary concern of most groups dealing with the phenomenon of AIDS. Awareness of stigmatisation of victims of AIDS is a consequence or result of the AIDS pandemic. Preventing stigmatisation and making people aware of its evil effects and its injustice is essential. In the next section attention will be turned to key social locations or 'sites' of stigmatisation.

3.11 Sites of Stigmatisation - Individual, Family and Community

The individual person is challenged by the disease in many ways. In the process of stigmatisation the individual person is vulnerable in that due to suffering from the disease there are other forces that make it difficult to cope with the related hardships. How a person copes with stigmatisation depends on family and social support and the degree to which that person is able to be open about her or his health situation and lifestyle.[160] An individual can internalize stigmatisation, self-stigmatisation, and isolate himself/herself.[161] Where there is a lack of food and money, the sick person is likely to experience heightened anxiety, and withdraw in fear and shame. "HIV-related stigma serves to deprive people with AIDS of confidence and agency, and moral freedom they need to access treatment, participate in programs and increase self-efficacy, all of which have positive health outcomes."[162] There is a need to stamp out stigma. But this cannot be done only through "legislation against overt manifestations of discrimination", because "no public measures or legislation can reach into the heart, into those depths where prejudice and stigma originate" (Kelly, 2010:139). This is an understanding that

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[159] David J. Louw, Pastoral Hermeneutics and the Challenge of a Global Economy: Care to the living Human Web. *In The Journal of Pastoral Care and Counseling.* Vol. 56/4, (2002), pp. 339-50.
[160] Norbert Gilmore and Margaret A. Somerville, 'Stigmatisation, scapegoating and discrimination in sexually transmitted diseases, overcoming "them" and "us".' *Social Science and Medicine,* 39, (1994), pp. 1339-135.
[161] Norbert Gilmore and Margaret A Somerville, (1994), pp. 1339-135.
[162] Cathrine Campbell and Andrew Gibbs, "Stigma, Gender and HIV: Case Studies of Inter-Sectionality in Boesten Jelke and Nana K. Poku eds. *Gender and HIV/AIDS: Critical Perspectives from the Developing World,* (Surrey, UK: Ashgate, 2009), p. 29.

"change can only come about through a massive emphasis on universal human rights and justice, especially in relation to women and to people living with the disease in any of its stages"(Kelly, 2010: 138-9). Therefore, governments are called upon to review their legal systems so that the systems are able to protect and respect all those who are marginalised because of the disease (Babbie 1989:112). The Universal Declaration for Human Rights' first principle is that, "All human beings are born free and equal in dignity and rights." This calls for all nations to take care of their people but in a more practical way for those who are stigmatised. (Kelly 2010: 140.)

So too, other family members can reinforce the social isolation of the relative affected by the disease. Individuals need great support from the family especially when they are first told that they are HIV positive. This holds true also if they adopt a stance of concealment and denial. Although one might expect the family to be the main source of care and support (World Bank, 1997; Leach and Machakonya, 2000, and Kelly 2010), propose that the behaviour of the family towards relatives suffering from HIV/AIDS can be an indicator of how they are stigmatised *within* their own families.[163] They point to evidence that infected persons often experience ill-treatment. This is particularly so in the case of women. The ill-treatment includes blame, rejection and loss of children and home (Parker and Galvao, 1996; Bharat and Aggleton, 1999; Krifek, 1976). The family cannot bear the shame that is coupled with the expenses to be incurred because of the disease. This complexity of stigmatising and being stigmatised within one person, and within one family will be a matter of attention in a later chapter, towards developing a holistic and systemic pastoral care strategy – person, family, and also – communities. This has failed the "approach to HIV prevention to address the social, cultural and economic factors that shape behaviour. Instead it places responsibility for the transmission of the virus squarely on the shoulders of individuals, overlooking the reality that they are not always in full control of their choices" (Kelly 2010: 136). This has left individuals with fear because the emphasis is placed on their behaviour. A better understanding of this human state

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[163] Norman Sartorious and Hugh Schulze, *Reducing the Stigma of Mental Illness: A Report from a Global Programme of the World Psychiatric Association*, (Cambridge: Cambridge University Press , 2005),p. 3.

needs to be understood by agencies and who must also have respect for the plight of the individual on the grounds of moral constraints and freedom. They are warned, "behave in this way and you will not contract HIV; behave in that way and you run the risk of becoming infected, but if you do become infected, it is because of your behaviour. It is your choice, your responsibility" (Kelly 2010:136, 140). This has made it difficult to engage the sufferer to talk about their condition as well as those who are reaching out to solve the problem of HIV. There is always an element of fear, blame, shame and denial. Therefore there is need for other "approaches to embody a justice perspective," (Kelly 2010:141).

Community is a group of people with similar characteristics who share the same beliefs, bonds and values. The individual belonging to a community is expected to participate in community activities, since a community is a group with shared characteristics, beliefs, bonds and values.[164] From this perspective, the failure of the individual also affects all member of the community and becomes their failure. Hence, the individual infected with HIV/AIDS brings shame to the whole community. He or she might face rejection or punishment directly and or indirectly. The isolation of people living with HIV/AIDS in the community can be extended to partners, or spouses, and other families connected with the sufferer such as neighbours and friends. The stigmatised often fail to mobilize themselves to fight the stigmatisation because they lack resources, knowledge and understanding that stigmatisation is a social process – which can be resisted by social means.

The practice of mutual blaming can act to intensify feelings of separateness and the experience of stigmatisation. It is not unusual for a community to blame individuals and families for contracting the disease, (Kelly 2010: 13). This totally disregards the fact that, anybody can contract the disease. This of course links back to what was said above about the persistent and deep ignorance of many people as to how the disease is actually contracted in the first instance. Similarly, as seen already, when such a label is applied it attracts negative attention and

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[164] Adam K arap Chepkwony, "Development and Challenges of Pastoral Care in Africa" in Laurenti Magesa, ed. *African Theology comes of Age: Revisiting Twenty years of the Theology of Ecumenical Symposium of Eastern Africa Theologians (ESEAT)* (Nairobi: Paulines Publications Africa, 2010), pp. 71-83.

carries a negative judgement (Tischler et al, 1983:46). The community via its cultural system comes to perceive the disease as abnormal and as something which brings shame and danger to the community. This collective response to the disease upholds or reinforces patterns of stigmatisation in the community. The community's collective local cultural beliefs, explanations and interpretations are used to reinforce pre-existing stigmatisation for those in the community whose behaviour is considered deviant through breaking of taboos and norms (Warwick et al 1998). For example, a community which regards the disease as the result of "immoral" behaviour reinforces the pre-existing application of stigmatisation to sufferers.[165] This implies that HIV-AIDS stigmatisation in communities can be better understood in the context in which these communities perceive the reality of the disease.

The community's interpretation of the realities of the disease is often misguided. This interpretation is manifested in the form of allocating blame, shunning or gossiping about those perceived to carry the disease, and also involves scapegoating mechanisms and punishment. Such behaviour can also take the form of violence being inflicted on those stigmatised so as to punish them for no apparent reasons other than the stigmatisers justifying themselves (Daniel and Parker, 1993: 38; PANOS, 1990:6). At times, members of the community find satisfaction in ignoring sufferers who have no hope and no one to help them. While feeling justified that their punitive actions uphold the health of the community, such scapegoating actually weakens not only the health and well-being of the sufferer, but also that of the family and whole community.

3.12 The Cultural Causes of HIV/AIDS Stigmatisation

Society is cemented by cultural values and traditions that are handed down and practiced within a given cultural context. Typical of such cultural values are rigid forms of building the communities' assumptions and cognitive structures. These are not easily modified by experience, such as, the view that it is the mandatory

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[165]Laurenti Magesa, "Appraising 20 Years of Christian Ethical Thought in Eastern Africa: Moral and Ethical Issues in African Christianity" in Laurenti Magesa, ed. *African Theology comes of Age: Revisiting Twenty years of the Theology of Ecumenical Symposium of Eastern Africa Theologians (ESEAT)* (Nairobi: Paulines Publications Africa, 2010, pp. 45-56.

duty of an African woman to cook food for the family. This was formerly the cognitive structure within Irish culture, for example, though that is no longer so rigidly held. Culture plays a vital role in determining the level of health of the individual, the family and the community. This is particularly relevant in the context of Africa, where the values of extended family and community significantly influence the behaviour of the individual. Hence the extended family has a say in the way women, in a particular household, are committed to their daily chores.

Thus, women are often controlled by the family and are vulnerable to exclusion if they fail to comply with set rules and regulations. Such powerful behaviour in relation to family and community is one major cultural factor that has implications for HIV/AIDS stigmatisation. As the impact of HIV/AIDS in Africa remains unabated, a culture-cantered approach to prevention, care and support is increasingly recognised as a critical strategy. Different interventions have been carried out including mode PEN-3, a model which was developed to centralise the importance of culture in health promotion interventions, which is presented as a framework to be used in HIV/AIDS prevention, care and support in Africa. "The role of HIV-related stigma is supporting gender inequality is under theorized. Understanding the relationships between stigma, gender inequality and the continuing HIV/AIDS pandemic is crucial if this cycle it is to be broken" Campbell and Gibbs 2009:29).

Still there is need for education and participation to understand the application of this model. This will be discussed further in Chapters 5 and 6. It is sufficient at this stage to note that the 3 domains of the PEN-3 model incorporate specific constructs: relationships and expectations, cultural empowerment, and cultural identity that taken together can form a comprehensive pastoral approach. The cultural empowerment, relationships and expectations domains are "assessment/appraisal" domains that are used for cultural assessment. Community identity is the "application/transformation" domain that helps the public health practitioner assists the community to identify the point of entry of the intervention. In this chapter the author describes PEN-3 and how the assessment/appraisal domains can be utilised to frame HIV/AIDS-related concerns

in the context of Africa.[166] The PEN -3 models will be used in Chapter 5 to address strategies to reduce stigmatisation caused by cultural taboos, beliefs and practices.

Also together with cultural taboos, illness, death and punishment, cultural and traditional beliefs can point to sufferers as inferior. These cultural values and beliefs are taught and passed on within society when children are growing up, hence the need to address these issues even at an early stage of life. Negative attitudes and behaviour are engrained in some cultural practices that form the person and society at large. In Chapters 5 and 6 these factors will be discussed especially when explaining about the factors that affect human development. There are also social determinants of health that are varied and involve interplay. Bronfenbrenner, a psychologist, proposed an ecological approach that shows factors which influence the health of a person. For example, the individual life style is influenced by age, sex and constitutional factors as well as social and community networks.

Furthermore, there are general socioeconomic, cultural and environmental conditions that can be linked to such factors as agriculture and food production, education, work environment, unemployment, living and working conditions, water and sanitation, health care services and housing problems.[167] "Factors such as food, poverty, low income and other social variations contribute to health outcomes and point to the diverse influences on health that exist within society,"[168] both for sufferers, the affected and the infected. This means that, in the context of stigmatisation, rather than looking at the scientific or medical realities of the disease, a given society looks to its cultural values and norms for an explanation and a prescribed course of action. Since, society is held together by cultural values and traditions that are handed down and practiced within a given cultural context and since cultural beliefs, values and customs learned from birth and gradually adapted to apply to new situations, HIV/AIDS as a grave epidemic disease creates

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[166] James F. Keenan, S. J. (ed) *Catholic Ethicists on HIV/AIDS* Prevention, (New York: The Continuum International Publishing Group Inc., 2002), pp. 14-19.

[167] Emma O'Brien, *Psychology for Social Care: an Irish perspective*, (Dublin: Gill & Macmillan, 2011) p. 187, "Bronfenbrenner's ecological model shows that different influences on an individual and how they interact to shape the developmental pathways", 1994, p. 186.

[168] Emma O'Brien, *Psychology for Social Care: an Irish Perspective*, (Dublin: Gill & Macmillan, 2011), p.187.

major instability for the members of the community. The ultimate aim is to understand how to deal with the incidence of disease-related stigmatisation in the light of pre-existing cultural beliefs. When children are growing they are taught to behave in a certain manner and values are promoted. Parents look at the future of their children as an investment for good life. As the children grow up they are not only influenced by their parents but they are open to the influence of their peers and external influences. Hence behaviour patterns change and the cultural values and norms are compromised. Thus, when addressing the problems of stigmatisation relating to HIV/AIDS, peer support will also need to be addressed. For the sufferer, meeting such a negative condemnation or punitive range of interpretations of her or his own situation is often to provoke the depressive triggers already noted, such as isolation, withdrawal and mutual blame. A link lies between patients' negative fears and beliefs, and actual anxiety disorders. However, the level of stigmatisation may change and modify over time as new situations are confronted and rival interpretations challenge cultural conditioning, making the attempts at stigmatisation reduction possible.

Over recent decades traditional communities have learned to adapt to their environments, through formal and informal methods. The means to adapt are communicated through a common language and shared symbols, influencing people's decisions as they impact on the social, cultural and economic contexts of society. As suggested above, sufferers are culturally socialized to over-respect the unaffected and uninfected and because of this, they act submissively towards them. Culturally and therefore morally, inferiority is given legitimacy by society. Society operates through traditional laws, as a form of social control, to deny sufferers equal rights. The individual, family, organisation, society and community all have common factors across all the domains of cultural competence.[169] Chapter 5 and 6 will describe some of the domains in detail. For example, infected people can be forbidden to use the same plates as those who are uninfected. Different values and beliefs affect the relationships of people in the community and family. This makes sufferers feel abnormal and insecure. The traditionalists hold on to their rules and

[169] Manoj Pordasani, Claudia, Lucia, Moreno, and Nicholas Roberton Forge, "Cultural Competence and HIV," in Cynthia Cannon Poindexter ed., *Handbook of HIV and Social Work: Principles, Practice, and Populations,* (Hoboken, New Jersey: John Wiley and Sons Inc., 2010), pp. 52-56.

challenge any constitutional challenges or moves that they think will threaten their customary position.

3.13 The Religious Causes of Stigmatisation

The religious context of stigmatisation cannot be fully grasped without understanding both Church and traditional values of various groups in African society. Neither traditional nor Church values accommodate the sufferers who are regarded as people who have committed offences against their religion. Sociologically, religion preserves the values of society and serves the cohesion of communities. Just like cultural values, religious values are taught and absorbed though many unconscious processes and practices. One cannot understand the reality of sufferers without considering society's religious values. One must seek to understand and work with these religious traditions and Church values if one wishes to be sensitive to the sufferers. At the same time, ways need to be found from within and without that religious ethos, which can be deployed towards the alleviation of the suffering and towards talking about the illness, and promoting the well-being of the individual in society.

Society protects those who conform to its values and norms, endeavouring to avoid the perceived social threats posed by the disease. Society usually sanctifies the social order as it meets the needs of society for rituals that bind people together. By using the official prescribed religious rules at the expense of realistic rules, people are often taught certain religious values, that lead to sufferers being regarded as 'abnormal' and blameworthy. In the face of AIDS in Africa, religion has become highly controversial in the past twenty years, primarily because many prominent religious leaders have publicly declared their opposition to the use of condoms. Some problems also emanated from the approaches to prevent the spread of the disease and also on the issues of fidelity within marriage and sexual abstinence outside of it.[170] In other parts of the world too, different people have come up with different interpretations and meanings of marriage in a religious context. Most if not all Churches believe that there are core values in society which

[170]Vincent Leclercq, *Blessed are the Vulnerable: Reaching out to those with* AIDS, (New London: Twenty Third Publications, 2010), pp. 20-23.,

need to be understood and adhered to. Thus in this thesis the writer focuses on the Church's thinking and the teaching that helps to form the dignity of the human person, not exclusively but mainly emanating from the Roman Catholic Church.
All of what has been argued so far indicates that there are interlocking societal, cultural, religious and psychological values that fuel stigmatisation in Africa. The gap is widened by the use of symbolic stigmatisation to classify religious, moral, cultural, and social diseases with negative or positive meanings. Contrary to what may be inferred from the above, it is possible that a society which bases its attitudes on religious values can reduce the impact of taboos and prejudices embedded in the community. It is important to "assess the traditional power structures and hierarchies within the community."[171]

Since communities are composed of both the "dominant" and "minority" groups, it is very "essential to understand the leadership profile."[172] As will be argued later in the thesis this possibility makes it easier for society and the Church to provide social support services and the facilities to strengthen service delivery and outreach to sufferers. In some circumstances religion had been an obstacle to prevention and treatment of AIDS. Some pastors have preached and have made their sick members refuse treatment and stop taking medicine because they are going to rely on supernatural power. Some sick people suffering from the pandemic have listened to such false advice from their pastors and this has resulted in many deaths which are not even recorded.

Many people in Africa are still ignorant of how the disease is transmitted. Because of their religious beliefs, some infected people are condemned because of their illness and are judged as a result of their physical appearance. Yet, some do not disclose their illness for fear of breaking the relationship with their family, community and society at large. Sometimes they are afraid to seek treatment for fear of making their illness known to other Church members. Many people who could have benefited from accessing treatment did not, due to the shame attaching to the disease. There is still a big challenge for the Church in its teaching capacity

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[171] Cynthia Cannon Poindexter ed., *Handbook of HIV and Social Work: Principles, Practice, and Populations,* (Hoboken, New Jersey: John Wiley and Sons Inc., 2010), p. 48.
[172] Ibid. (2010), p. 50.

not to be afraid to speak out about the truth, to provide education and also to continue providing facilities to the sick and the marginalised. This will be further discussed in Chapters 4, 5 and 6.

In addition, in recent years, people have been deceived by those claiming to be able to perform miracles using oil or water, for example. Sufferers are made to believe that they are cured. Some poor people have become even poorer due to the demands of the person performing such bogus healing. Furthermore, some poor people have been made to sell property in order to belong to a Church. In some parts of Africa there are stories of different Churches and religious groups fighting each other, with boundaries imposed that make it more difficult for Churches to come together to fight the disease. Where boundaries and exclusion come into the power play in rival religious groups, it is no wonder that stigmatisation becomes even more pronounced there. Competition breathes hatred and stigmatisation is easily normalised in those situations.

Furthermore, religious beliefs, attitudes and practices still fuel stigmatisation, as for example, in judgemental attitudes to those who are sufferers. Some actions affect people directly. Other types of action operate and affect people indirectly as Johan Galtung (1969) puts it clearly in his theory of Structural Violence, religion can become part and parcel of a structural violence not least in the destructive causes and effects of stigmatisation. Some rules and regulations can actually promote violence and exclude people. Gillian Peterson (2001) identifies the steps taken in stigmatisation. The first step in the process relates to the stigmatiser distancing the victim from others in society. "The shame, guilt and worry that family members can feel adds to stress on the group. The increased stress may reduce the individual's or group's reserves – in terms of emotional and often financial resources, and in terms of time that can be spent with members of the family who are not suffering from the illness."[173] The religious practice of shunning/avoiding operates in this way.

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[173]Norman Sartorious and Hugh Schulze, *Reducing the Stigma of Mental Illness: A Report from a Global Programme of the World Psychiatric Association*, (Cambridge: Cambridge University Press, 2005), p. 3.

3.14 The Stigmatisation Process

The stigmatised are individuals or groups of people, such as sufferers who are ostracized, rejected, scorned and shunned for whatever reason. Such marginalized people may experience discrimination, insults, attacks and even murderous acts. Although the experience of being stigmatised may take a toll on self-esteem, academic achievement, and other outcomes, it can also be said that, many people with stigmatised attributes have self-esteem and can display high levels of resilience to their negative experiences (Heatherton et al, 2000). The stigmatiser, on the other hand, tends to see nothing wrong with the vicious cycle of stigmatisation. It is rather a process that is interpreted as part of his or her cultural values or religious beliefs. For instance, sufferers may be subjected to prejudice, discrimination and oppression, through behaviour enshrined in religious and cultural values. Figure 2.3 shows how the stigmatisation process grows in a vicious circle and a multiplier effect from the stigmatiser to the victim to the community to society at large.

Figure 3.3 Stigmatisation Process

Source: Own

The stigmatisation process can take the form of overlooking the victim, the family, and the community at large including friends. The victim of stigmatisation suffers loss of self-esteem and confidence losing a sense of belonging. In being labelled, the victim is shown to have fallen short of the expected norm, even though founded on

misunderstandings about the illness, its course or possible treatments.[174] This leads to de-lineation, excluding the victim from the rest of society. This follows what Gordon Allport describes as the "five progressive severe stages of behaviour." Social prejudice can be acted out in these negative stages and can develop from one stage to the next if not corrected (Allport, 1954:15). For example, stage one *"Antilocution or Ridicule,"* behaviour is expressed by hostile feelings towards the object, be it family, friends or any group of people.[175]" If this is not corrected then it leads to another stage *"Avoidance' or Shunning."*[176] Prejudiced people at this stage seek to avoid the company of the minority as far as possible.

Furthermore, *"Discrimination stage"* is a stage that the prejudices person makes detrimental distinctions in an active way.[177] For example, seeks separation which is supported by law and customs. The fourth stage is called *"Physical Attack."* Usually at this stage the behaviour is seen to develop towards attacks of persons as well as attacks of property. An example of this is seen sometimes where there are a 'Traveller' camps or different tribes in the case of Africa. The fifth is the *"Extermination or* the *Expulsion;"* this is related to the "ultimate degree of violent expression of prejudice."[178] Regrettably it has not been that rare a phenomenon in history. In the case of HIV/AIDS, the victim is made to feel without dignity, and if weak is unable to resist being subjectively drawn into the next stage of the process. Thus, the individual is affected psychologically by being labelled with undesirable characteristics as stigmatised (Wolfgard, Savitx and Johnson, 1962).

The stigmatised person under the pressure of being excluded the more easily becomes a victim of the situation. Usually, the damaging implications can be seen as a process developing from one stage to the next, from a minor impact mounting to a more destructive impact and a situation with consequences that are difficult to reverse. This social dimension enables the victimizer to get support from the community or society, which is engrained in active tendencies and patterns of stigmatisation. There is enough justification available for negative actions in this

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[174]Norman Sartorious and Hugh Schulze, (2005), p. 5.
[175] Ibid. (2005), p. 5.
[176]Gordon Allport, (1954), p. 15.
[177] Norman Sartorious and Hugh Schulze, (2005), p. 5.
[178] Ibid. (1954), pp. 15-16.

situation. Hence, the community remains quiet rather than challenging the destructive attitudes or behaviour. Even where the minority may disagree with what is happening, the majority team up in silence effectively promoting the destructive practices. This pattern is strengthened by the dynamics of power operating by social control and manipulation.

Sufferers can be enabled to build skills for the reduction of the risk of HIV and promote a holistic approach to care through opposing stigmatisation. The response of the stigmatiser and stigmatised can be used as a basis to resist or oppose the stages of the stigmatisation process from the outset. This is possible if those liable to be stigmatised are equipped with the necessary skills (PACSA, 2004). Escalatory spirals can be demolished or broken through dismantling unacceptable behaviours and perceptions that operate between the stigmatiser and the stigmatised. This makes visible the active responsibility of the stigmatiser and it restores a sense of effective agency to the stigmatised person within the stigmatisation process (Large, 1993). With political will, commitment, openness, appropriate programmes and policies all can be involved in eradicating stigmatisation, since all involved will have one goal, an understanding and eradication of the stigmatisation process (UNICEF, 2006; USAID, 2006). Such a holistic approach is the answer to the vicious cycle and structural violence of stigmatisation.

3.15 Summary

Chapter 2 dealt with the problem of HIV/AIDS related stigmatisation from a sociological, cultural and religious perspective. The chapter used definitions and material developed in chapter 1 to enhance the readers' understanding of the background to stigmatisation. It has been argued that stigmatisation is a complex problem and has its origins in societal, cultural and religious values and concepts. Chapter 1 discussed the part that attitude, fear, social control, stereotyping, labelling, discrimination, myths, prejudice, scapegoating and deviance play in the stigmatisation process. In the current chapter it was demonstrated that all of the latter will be even easier to apply in the case of people already weakened by the debilitating disease of HIV/AIDS especially in the process of the vicious cycle of

stigmatisation. The chapter opened with a relatively brief discussion on the origins, causes, symptoms and modes of transmission of HIV/AIDS. Human Immunodeficiency Virus (HIV) is retrovirus that was isolated as the cause of the infection known as AIDS. Acquired Immune Deficiency Syndrome (AIDS) is the disease caused by the virus HIV. The virus attacks the immune system leaving the body weak and vulnerable to other opportunistic infections.

The modes of transmission cause people with the disease to be marginalised. They are seen as people who have brought shame to their family and community and to society at large. The second part of this chapter dealt with the social and cultural practices and norms, religious practices and beliefs, attitudes to poverty, mobility of labour and material needs and psychological impulses which intensify HIV/AIDS related stigmatisation. People's behaviour is controlled by beliefs and practices in the family, community and society at large. Thus it was shown that, as the family, community and society exist by certain values that they expect the individual to observe, stigmatisation becomes embedded in cultural, religious and social beliefs. The sufferers of HIV/AIDS are easily stigmatised through the way society perceive events in people's lives, negatively judging these according to the controlling beliefs and norms. Society is held together by cultural values and traditions that are handed down and practised within a given cultural context. Typical of such cultural values are rigid forms of building the communities' working relationships, which once they are established, are not easily modified by experience. Cultural beliefs, values and customs which are learned from birth are gradually modified to apply to any new situation within the community. The social prejudice as highlighted by Gordon Allport has showed that negative behaviour if not corrected can develop from one stage to another to the extent that it results in violent behaviour. Allport developed five stages that showed the intensity of negative growth of behaviour that is still a fact today in relation to HIV/AIDS sufferers. But the enormity of HIV/AIDS as a pandemic disease is such as to create more instability for the members of the community than it can simply accommodate within the existing framework of values, because it is seen as a threat to the survival, safety and norms of the community. Stigmatisation has been highlighted

in this chapter as a vicious cycle. The vicious cycle is fuelled by other factors such as poverty, power, socio-economic status, and inequalities.

The inequalities have affected the position of women in the community and society at large. However, poverty in this case is not only related to a lack of material resources. The inequality in the distribution of income is not the only causal factor in the spread of the disease. It is not the presence or absence of money that counts, but the poverty of knowledge about the disease. There is a need to educate and convince sufferers of risky practices that can worsen the disease and the practical steps they can take to safeguard themselves against isolation, scapegoating and other stigmatising actions of others. The understanding of the key factors and dynamics of HIV/AIDS-related stigmatisation will be key focus in this research towards identifying the parallel key factors that will contribute to building ideas and practices in the development of a holistic pastoral approach (chapter Methodologically, this will also keep to the fore the necessity of research focus on the cultural, social and religious dimensions and dynamics that shape the actual ways that people are stigmatised in community. The purpose of the next chapter will be to connect the central ideas developed in chapters one and 2 and discuss the realities of stigmatisation in an African and Zimbabwean context. A case study carried out in the Diocese of Mutare in Zimbabwe and discussed in chapter 4 will give further answers to some of the questions raised about the level of stigmatisation in Zimbabwe. The unlocking of these factors will pave the way for an appropriate approach to develop strategies, initiatives, programmes and interventions towards a holistic pastoral approach which will be discussed in Chapters 5 and 6.

Chapter 4 THE REALITIES OF STIGMATISATION IN AFRICA

4.1 Introduction

Chapter 2 of this thesis focused on research findings and theories of stigmatisation in general terms, while Chapter 3 focused specifically on HIV/AIDS-related stigmatisation. Such background knowledge and understanding was necessary to fully understand and appreciate the realities of HIV/AIDS stigmatisation in Africa and particularly in Zimbabwe. A thorough understanding of stigmatisation can form a basis upon which to find appropriate approaches for the liberation of people who are stigmatised. Various organisations at local, national, and international level are trying to deal with stigmatisation issues in Africa. These organisations carry out various programmes that may not necessarily address the root causes of stigmatisation, rendering their efforts and energies, therefore, less productive. The Roman Catholic Church is just one of the organisations fighting against stigmatisation of those suffering from AIDS related illness, but may not be doing as effectively, in so far as it is failing to probe for the root causes, and particularly through failing to recognise its own role in producing and reinforcing stigma.[179]

In this chapter, I shall start by giving background information regarding Africa and Zimbabwe. Following this is a section on HIV/AIDS prevalence and then a further section on the stigma endured by AIDS sufferers. This will be followed by a discussion of the cultural and religious roots of stigmatisation - with a particular focus on the RC Church and finally the reactions of the Church to HIV/AIDS. The chapter ends with a summary of the key points raised in the discussion. The main points raised in this chapter formed a major part of the onsite case study performed in spring 2011 in the Roman Catholic Diocese of Mutare, Zimbabwe, which will be discussed in the next chapter.

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[179] "Church", this means the whole Church going back to the apostolic tradition, the title of a Church will always be capital letter "C". "Church" with a small "c" this means a particular church in a given place or a general reference to the combined denominations.

4.2 Background of Africa and Zimbabwe

Africa is the world's second-largest and second-most-populous continent, after Asia. The surface area of Africa, including adjacent islands, is approximately 30.2 million square kilometres (Sayre, 1999: 26). As of 2009, Africa has a population of about 1.0 billion people or approximately 14.72% of the world's population. Africa is almost divided in two by the equator. There are numerous climatic zones, including the Sahara desert, the largest desert in the world. Because of the different climatic zones, Africa is home to many diseases, such as malaria. Though Africa is endowed with major natural resources, some parts are still steeped in dire poverty.

Zimbabwe's independence coincided with the introduction of structural adjustment programmes in Africa. This was in accordance with the expectations of the International Monetary Fund and the World Bank, of which Zimbabwe had become a member in 1980. Thus, the government adopted the "Growth with Equity" policy based on the establishment of a socialist and egalitarian society. According to Chakodza (1993:12), Zimbabwe's economic performance improved slightly due to an economic upturn, which had started in late 1984. Between 1980 and 1985 the economic performance was characterised by 3 distinct phases (Kadenge et al, 1993:24). There was a period of high economic growth as a result of the adoption of policies on land redistribution from 1980 to 1981. The next phase was between 1982 and 1983 which saw the economy decline up to first half of 1984. There was a need to redress structural weaknesses in the economy, including inequalities in social service provision (UNICEF, 1994). Therefore, the new government was under pressure from international agencies to allow market forces more freedom in the economy. However, the government decided not to alter the inherited political and economic structures (Kadenge, 1993:16). Then economic growth was witnessed in the second half of 1984 through the liberalization of the post-independence economy. According to Gibbon (1995:34) during the period of 1986 to 1990, the third phase, there was a negative impact on the economy when the government envisaged a national programme that affected the white-owned commercial farmland, that is, distribution of land to native Zimbabweans. This also hastened the decline of the economy and by the late 1980s Zimbabwe's economic strategies were no longer sustainable. The

subsequent devaluation of the Zimbabwean dollar hindered local markets in their attempts to link with other markets outside the country. This resulted in high inflation which was an obstacle to economic growth and increased unemployment and poverty (Government of Zimbabwe, 1998:8). This socio-economic situation of Zimbabwe had had adverse effects on the marginalised and created national upheavals that affected sufferers of HIV/AIDS (Mupedziswa, 1997:16). HIV/AIDS was discovered in Central Africa in 1981. However, the potency of the disease in Africa was not fully appreciated until some years later. Zimbabwe, a major country in Southern Africa, and the main focus of this thesis, acknowledged the existence of the disease for the first time in 1983.

4.3 Zimbabwe: A Divided and Fragmented Society

Zimbabwe is one of the landlocked countries in sub-Saharan Africa. The country shares boundaries with Zambia at the north, South Africa at the south, Mozambique at the east and Botswana at the west. Zimbabwe, previously Rhodesia, was a colony of Great Britain from 1890 to 1980, when it won its independence. During this period, local Zimbabweans suffered stigmatisation, being deemed lesser creatures than their colonial masters, and denied equal entitlement to land ownership and to educational access. A Pastoral Letter issued by the Rhodesian Catholic Bishops Conference 6th December 1977 stated that "Rhodesia is living in a state of conflict". It further commented that it was "imperative for all races to examine what they can contribute towards peace and justice for all."[180] The Bishops observed that racial prejudices and egoism were hindrances towards promoting a multiracial society in Rhodesia. However, independence from Great Britain did not usher in the expected positive change for the poor people of Zimbabwe. They were and are still at the lower end of the land ownership and educational platform.[181] Non-access to land and all that it brings, such as food and a source of money for education and health, results in poverty; and as in many cultures, lack of status, wealth, and education leads to marginalisation, forms of segregation, and stigmatisation. As discussed in chapters

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[180] Rhodesia Bishops Conference *Pastoral Letter: A Study Document Issued by the Rhodesia Catholic Bishops' Conference*, 6 December (1977), p. 4.
[181] Adrian Hastings, *African Catholicism: Essays in Discovery*, (London, SCM 1981), p. 46.

2 and 3, poverty and stigmatisation frequently go together. Thus, while stigmatisation, discrimination and abuse of human rights are not new, being long engrained in the culture and structures of recent decades, they have left gaping differences in health, education, politics and social strata in Zimbabwean society. Thus dramatically separating rich and poor, rural and urban dwellers, political affiliations, the ruling and the opposition parties. For example, the education system was organised into different categories. In urban areas, schools were segregated in order to serve rich and the poor classes. In rural areas, there were mission and community schools. Almost on an equal note the same racial divisions applied to Churches and to all aspects of life in the country – with Church structures replicating the segregations in society. For example, in the past, mission schools did not accept pupils who were not Christians. This has now changed and such schools accept all pupils, regardless of beliefs. In some wealthier schools the fees were determined by the parent's economic background. For example, to send a child to a liberal European school, one had to have a horse or similar indicators of wealth. The above are just some examples of the more subtle and nuanced causes, which have led to social injustice and institutional discrimination between differently categorised social and religious groups. Persons, in this paradigm were valued as a matter of course according to their wealth and standing in the community rather than according to their need or actual ability.

The majority of Zimbabwean people live in rural areas and are very poor, in comparison to their urban counterparts, as far as regular work and receipt of a salary is concerned. Those who live in towns are viewed according to social classes that are moulded along residential lines. Previously, separate European and African residential areas existed. Although, nowadays there is freedom to choose where one lives, this is still determined by wealth. Those living in high density suburbs, formerly referred to as Black Townships, were and are perceived according to prejudice as violent and uncivilized by those living in low density suburbs, formerly structured as white residential areas. Living in townships carried a social stigma, carrying negative economic, social, and political repercussions. There is also a significant gender dimension to such discrimination and stigmatisation. Urbanisation resulted in the jobs market being dominated by

men. This has led to the consequential marginalization of women and families who were rendered economically dependent and isolated and had to live separate from their husbands, sons, and brothers for months or even years. Male workers typically lived in large overcrowded hostels, leading to a host of social problems. The hostel conditions also led to workers taking other "wives", fathering children and forming "bed-holds" in place of traditional households. This large scale movement of manpower has changed the terms of family life and gender relations, undermining the chances of equality under the law, and relegating many women to poverty and invisibility. A further result of this large scale uprooting of male workers was that the ratio of male to female in the towns was quite unbalanced. This socially constructed pattern, a legacy from the colonial period, with its legacy of sexual separation, family rupture and an imbalance of males and females in urban and rural settings, respectively, remains engrained. So too, single women urban dwellers were often automatically associated with the exchange of sex for money, while the male segregation heightened the frequency of homosexuality.

All such behaviour violated strong cultural taboos, which was interlocked in its dynamics and has in turn deepened the sense of social alienation and cultural displacement. As well as movement to urban areas, people often came to seek economic betterment by trade across Zimbabwe's many borders. Men, but mainly women, cross back and forth between Zimbabwe and adjacent countries on a regular basis.[182] Men tend to find work in neighbouring countries and only return home at intervals. Historically, many Zimbabweans were displaced and in order to survive had to travel to other countries, such as South Africa, to find work in factories, mines, and plantations. Those who crossed the borders on a regular basis, increasingly, have been regarded with hostility, labelled as migrant and stigmatised as people who spread diseases, such as HIV/AIDS. The high prevalence rates of HIV/AIDS at border settlements and Zimbabwean villages such as, Plumtree or Beitbridge is a prime example. As it is women who more regularly cross the borders for ad hoc trade (in a bid to resist the worst levels of poverty and ill-health), they are seen as economically precarious and become still more vulnerable to exploitation and stigmatisation as disease bearers. From the above it

[182] *Central Statistical Office, Zimbabwe*, Government Printers, (2006).

can be seen that the sociological, cultural and religious environment in Zimbabwe was and is too weak to analyse and prevent such social patterns of stigmatisation. Social class divisions lead to further violence and social injustice towards those who are depicted as low class, uprooted, violent, unstable and dangerous.[183] Zimbabwean society is fractured by the kind of structural violence as posited by Galtung and presented in the previous chapter. Zimbabwean structures of politics, education, and health are still perpetuating stigmatisation in family, community, and the nation as a whole. The issue of HIV/AIDS related stigmatisation has led to high prevalence rates in different communities in Zimbabwe.

4.3.1 Current Strategy of Government Approach

Over the years, Zimbabwe adopted a multi-sectoral approach in its fight against HIV and AIDS. Working with a spirit of cooperation and partnership various organisations such as international partners, non-governmental organisations, faith based organisations, community based organisations, community leaders and the communities themselves united in the fight against HIV and AIDS. The current aim is "to achieve zero new HIV infections; zero discrimination; and zero AIDS-related deaths by 2015."[184] In order to achieve this goal the organisations mentioned must adapt and adhere to various approaches. In order to fulfil international and regional obligations, including Millennium Development Goals, the United Nations Declaration of Commitment and the 2011 Political Declaration on HIV and AIDS was the Global Plan adopted by the government. This was aimed the elimination of new HIV infections in children and keeping mothers alive. The Maseru and Brazzaville Declarations, and the Maputo Plan of Action, must also be considered. This can be done in a coordinated and collaborative way. Through the National AIDS Council the government will initiate relationships with other organisations both at a national and international level. The plan for government is to have an AIDS free generation; as a result of the increased effort this will be achieved. Guided by the new Zimbabwean National HIV and AIDS Strategic Plan II 2011-2015, there is a focus on specific measurable and an achievable set of results. This demands concerted efforts and strong commitment from all at the various

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[183] A. Hastings, *African Catholicism: Essays in Discovery*, (London: SCM, 1981).
[184] National AIDS Council Plan Zimbabwe (2011).

levels including those at policy and operational levels. It is vital that all levels work together in a complementary fashion.

4.4 Prevalence of HIV/AIDS in Zimbabwe

To provide the relevant context for the magnitude and complexity of HIV/AIDS in Zimbabwe, the following statistics should be highlighted, and by association the reason why stigmatisation exacerbates the suffering that accompanies this already desperate pandemic. With so many people infected by the disease, stigmatisation functions to some extent as a defence mechanism according to a degenerating pattern of overlooking, social distancing, and shunning, blaming, demonising and physical attack. All the factors as outlined in Chapter 3 such as negative attitudinal stances, (namely fear, and prejudice denouncing sufferers as an endangerment to the community) rise to the fore in concrete and interlocking patterns that leave sufferers and their families physically weak, emotionally cut off and socially powerless. All these negative indicators militate against the likelihood of access to medical care and undermine an ethical approach based on dignity and care, human rights and justice. In a vicious systemic dynamic, those focally affected are further stigmatised, but indeed, everyone is damaged in the social system, since this vicious cycle intensifies the fragmentation in a society already torn apart by internal violence, economic collapse and political corruption.

Reliable statistical estimates from bodies such as the UN for those suffering from HIV/AIDS in Zimbabwe are among the worst on the African continent. Significant financial and human resources are required just to deal effectively with this one health issue alone, for, as has been demonstrated, the disease cannot be understood in a "stand alone" way, but rather as embedded within a range of multi-faceted and interlocking social, cultural, economic and religious settings, involving different sectors that are local, national and international in reach. The following sets out the stark realities already noted in summary at the opening of the chapter. The first reported case of AIDS in Zimbabwe occurred in 1985. By the end of the 1980s, approximately 10 per cent of the adult population was infected with HIV. The figure rose dramatically in the first half of the 1990s, peaking at

more than 36 per cent between 1995 and 1997. Since the late 1990s, prevalence has been consistently declining. I have tabulated these for the sake of clarity.

Table 4.1 HIV/AIDS Estimates Zimbabwe

HIV AND AIDS ESTIMATES IN ZIMBABWE (UNAIDS 2008)	
Total Population*	**11.7 million (mid-2010)**
Estimated population living with HIV/AIDS**	**1.02 million [930,000 - 1,150,000] (2010)**
Adult HIV Prevalence**	**13.6% [12.7 - 14.7%] (2010)**
HIV Prevalence in Most at Risk Populations***	**56% (2005)**
Percentage of HIV- Infected people receiving Antiretroviral Therapy******	**17% (end 2007)**

Source: *U.S. Census Bureau **Zimbabwe National EPP-Spectrum Estimates 2009*** UNAIDS/ WHO/UNAIDS/UNICEF *towards Universal Access,* 2008.

Examining these statistics, there is little doubt that in Zimbabwe HIV/AIDS has assumed epidemic proportions. At the very least, in order to survive, infected people need critical medical and physical care. Those affected, however, are also in dire need of moral and emotional support, and the same applies to those close to them who carry the immediate responsibility and often the burden of care for their infected loved ones. Both groups need a comprehensive system of support from the wider body of carers and from their religious communities - in this instance, from their Church.

The 2005 surveillance data show that HIV prevalence among women 15-49 constitutes more than 56% of the adult prevalence.[185] HIV prevalence surveys have also shown very high levels of infection in border areas, growth points, and

[185] Zimbabwe National HIV/AIDS Estimates, 2005; Preliminary Report (Health Information and Surveillance Unit Dept. of Disease and Prevention
and Control, AIDS and TB programme (http://www.unaids.org.zw)

mining towns and on commercial farms,[186] suggesting mobility and spousal separation are major vulnerability factors. Mobile populations are also highly vulnerable to the epidemic, and key populations at higher risk include sex workers, seasonal agricultural workers, and long-distance truck drivers, mine workers, cross border traders, uniformed personnel and employees of the transport sector.[187] High population mobility has been identified as one of the key drivers of the HIV epidemic in Zimbabwe. Recent surveillance data show an estimated 20.1% prevalence in the 15-49 age groups, and an estimated 1,610, 000 Zimbabweans infected with HIV at the end of 2005.[188] With a national adult prevalence of 15.3 per cent at the end of 2007, Zimbabwe was one of the 10 highest-prevalence countries in sub-Saharan Africa. According to national estimates, prevalence decreased to 13.6 per cent in 2010.[189] The reasons for the decrease are due to migration, isolation of some people in rural areas and inadequate recording across the health sector and also due to programmes initiated by church groups, government and foreign agencies.

Although the AIDS epidemic in Zimbabwe is generalised, women and girls are particularly vulnerable to infection. Surveillance survey reports show that women and girls are twice as affected by HIV compared to the general population. Although HIV prevalence is high, the 2005 rate is an improvement from the 24.1% recorded in 2003 indicating that Zimbabwe has made some progress in controlling the spread of the epidemic.

> Global rates of new HIV infections have steadily declined over the past years, with the annual rate falling by nearly 25% between 2001 and 2009. Southern Africa remains the epicentre of the global HIV epidemic. I am heartened by the fact that Zimbabwe is among the first countries in the region to have recorded such a decline. HIV prevalence declined from 20.1% (2005) to 14.26% in 2009. The annual HIV incidence has also declined from a peak of 1.14% in 2006 to 0.85 in 2009.[190]

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[186] 2003 Zimbabwe Antenatal Surveillance Survey
[187] United Nations, 2005.
[188] Ibid. 2005, also Zimbabwe National HIV/AIDS Estimates, 2005; Preliminary Report (Health Information and Surveillance Unit Dept of Disease and Prevention and Control, AIDS and TB programme (http://www.unaids.org.zw)
[189] Ibid. (2005), p. 4.
[190] His Excellency President of Zimbabwe Robert Mugabe, (2012), p. 1.

The epidemic has reduced life expectancy, deepened pervasive poverty among vulnerable households and communities, skewed the size of populations, undermined national systems, and weakened institutional structures. However, it can be difficult to disentangle the epidemic's effects from other social and economic changes that occurred over the last two decades.[191]

Females and infants are seriously affected by the disease, in many cases without their knowledge or active complicity, as the following illustrates:

Table 4.2 Infant Mortality and Average Female Life Expectancy

Zimbabwe	1990
Infant Mortality	Up 2 times
Average life expectancy for women particularly affected by AIDS	47 years

The National Health Information and Surveillance Unit in Zimbabwe have shown that HIV prevalence rates vary with location across the country. A recent survey showed that, there is generally little difference between urban and rural HIV/AIDS – (18.9%) and (17.6%) respectively.[192] However, prevalence rates can be over 35% in areas of high population concentrations such as large-scale commercial farms, administrative centres and border settlements.[193] Significantly, the United Nations Development Program (UNDP) reported that "in 2007, 94% of the population was without a job and almost 50% were in need of food aid."[194] The report continued, "Food shortages, impoverishment, forced removals, and drought have compelled hundreds of thousands of Zimbabweans to migrate in search of livelihood opportunities."[195] Such conditions are fertile ground for the HIV virus. Neither is it surprising that the findings by UNICEF indicated accompanying high rates of stigma (52%) compared to disclosure (3%) which was worse in border

[191] USAID/Zimbabwe, (2008), http://www.usaid.gov/zw/ accessed September 2010.
[192] *National Health Information and Surveillance Unit*, (2006).
[193] *National Health Information and Surveillance Unit*, (2006).
[194] United Nations Development Program, (2007).
[195] Zimbabwe National AIDS Council, (2010).

areas. All this is evidence of the systemic conditions in which the HIV virus thrives and disease and stigmatisation increases apace. "My government, through the National AIDS Council (NAC) in collaboration with local and international partners is providing effective leadership for the national multi-sectoral HIV and AIDS response, despite significant funding, human resource, and material challenges." [196] However, many of the poor are still voiceless, therefore the relationship between poverty and stigma continues. This is a vicious cycle that needs to be challenged and changed.

4.5 HIV/AIDS and Stigma

Stigma perpetrated against HIV sufferers takes different forms. For example, the blame and judgemental attitudes from their community or even friends and family members can provoke sufferers to distance or isolate themselves or be silent about their health condition. The case study also shows that children in Zimbabwe are also affected by the epidemic, with many orphaned because of the disease. According to Ministry of Health and Child welfare (MOHCW 2009) estimates, approximately 1 million children under the age of 18 had been orphaned by AIDS.[197] Hence, the traditional extended family and other support systems are overwhelmed by this situation. The next section deals with how cultural practices have influenced the spread of the disease as well as fuelling stigmatisation. Some aspects of the involvement of culture have been highlighted already in the previous Chapter. I shall now dwell on cultural beliefs specifically in relation to stigma and stigmatisation of the sufferers of the disease.

In Zimbabwe, as in other African countries the reported causes of death from different diseases can sometimes lead to incorrect reports as to the actual cause of death. This misinformation is often related to long held beliefs based on tales, myths and superstition. The mislabelling of the actual cause of death can be an attempt to cover up the real cause, because of the shame factor, or for fear of the accompanying stigmatisation. Stigmatisation is not a new phenomenon either in Zimbabwe or in any other country; it has existed throughout history, especially in

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[196] His Excellency President of Zimbabwe Robert Mugabe, 19 January, (2012), p.1.
[197] Ministry of Health and Child Welfare, (2009).

relation to diseases which are disfiguring, infectious or terminal, such as, leprosy, tuberculosis (TB) and syphilis. Such diseases have an outward physical manifestation, obvious to onlookers. Typically, people suffering from such diseases are stigmatised and discriminated against by the general community – given unjust and unjustifiable treatment, based on their perceived misdoing and status.

At various stages of life the issue of sexuality and consideration of prevailing taboos is not an easy topic of conversation in African society. "Sexuality refers to the 'spiritual, emotional, physical, psychological, social, and cultural aspects of relating to one another as embodied in male and female persons."[198] Sexuality in this sense is the totality of the human person. The difference comes about when sex and sexuality are discussed separately.[199] This has left women and girls more vulnerable to domestic violence.[200] There is very little education passed on to young people on the issues of sexuality and how it builds a person as a whole. The culture forgets that, "young people have a right to know about sex, sexual practices, HIV-related sexual risks, reducing risk-taking behaviour and how to protect themselves against infection."[201] "Among adults, educators, community leaders and religious personnel," this is not an easy task. They fear that whatever knowledge impacted might lead to 'promiscuous behaviour."[202] It is this education that can "promote respect for every person on the basis of a common humanity, being all-inclusive, combating prejudices, affirming gender equity, recognising common objectives and shared purposes, acknowledging the right of every individual."[203] Education is a social tool which helps to learn more about diseases and improve attitudes and behaviour. "Stigma, silence, discrimination and denial, as well as lack of confidentiality, undermine prevention, care and treatment efforts and increase the impact of the epidemic on individuals, families, communities and nations," (UNGASS, 2001: 4).

> Through the decentralized NAC structures, we are able to ensure that services reach all people. Our vigorous national behaviour change campaign

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[198] Michael J. Kelly, *HIV and AIDS: A Social Justice Perspective,* (Nairobi: Paulines Publications Africa, 2010), p. 28.
[199] Michael J. Kelly, (2010), p. 28.
[200] Michael J. Kelly, (2010), p. 121.
[201] Michael J. Kelly, (2010), p. 28.
[202] Michael J. Kelly, (2010), p. 33.
[203] Michael J. Kelly, (2010), p. 211.

> and the employment of several prevention strategies must be hailed. However, let me hasten to say that if we have to achieve an AIDS free generation, we should aim to reduce the annual HIV incidence by more than fifty per cent by 2015.[204]

The traditional Zimbabwean explanations for disease and therefore death fall into different categories.[205] The dominant cause of disease is the anger of "Mwari" the Supreme Being who is spited. Also offences to the tutelary spirit's otherwise known as the "Vadzimu" "gods" or the "divinities" are commonly believed to cause ailments. The overlooking of or disrespect towards these ancestral spirits can, according to popular belief, result in disease.[206] So too, it is thought that a person's own immoral or "evil" behaviour can result in physical, and mental disease.

"Ngozi" commonly refers to a spirit of a dead person who haunts the living for a particular reason. Therefore, relatives of a person who has killed someone live in fear that the spirit of the dead person will return to haunt them. It is also a belief among those given to certain superstitions that a person afflicted with certain diseases, is actually under the control of an evil spirit. Some believe that since HIV/AIDS is a devastating pandemic, it must be caused by human sinfulness on a monstrous scale.

These beliefs give an underpinning to stigmatisation practices as a way for others to possibly appease the spirits. Moreover, such beliefs facilitate the stigmatisation process so that the healthy can distance themselves from the person carrying the disease and its perceived threat to the health of the community (Herek and Glunt 1988:887). Some Zimbabweans refer to the disease as "*Mukondombera*", a disease without reverse or "*kurumwane chekuchera*", a disease of one's wrongdoing. Certain diseases in Zimbabwe are regarded as particularly unclean and shameful, and HIV/AIDS falls into this category. Because of this, relatives often tend to conceal the condition of those close to them, to such an extent that, there is a lot of

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[204] His Excellency President of Zimbabwe Robert Mugabe, 19 January (2012), p. 1.
[205] Ezra Chitando, *Mainstreaming HIV/AIDS in Theological Education: Experiences and Explorations* Ehaia Series, (Geneva: WCC Publications, 2008), p. 12.
[206] Ibid. (2008), p. 20.

silence about the disease, until a person dies.[207] Often then it is explained as pneumonia or TB. The majority of Africans have not yet forgotten or ignored their native cultural roots, despite the encroachment of modernity.[208] Some African cultural practices include polygamy and "small houses", or wife replacement/inheritance and uncontrolled playing with a wife's younger sisters. In such contexts, polygamy is the practice of men having more than one wife with formal payment of *lobola* (bride price or dowry) and full social acknowledgement and support. This practice heightens the risk of contracting HIV, if even one of the partners is unfaithful or promiscuous. Wife inheritance is the practice of a younger brother adopting his dead brother's wife and bringing her and her children under the roof of a protective household. There is a risk of the younger brother contracting HIV if the deceased brother died of HIV/AIDS. "*Chigara mapfiwa*", known as wife replacement is the practice whereby the younger sister or cousin replaces the dead sister. "Small houses" refer to hidden marriages.

Such cultural practices have further spread incidences of HIV/AIDS in Zimbabwe,[209] leading to those suffering from the disease being stigmatised when it comes to light. According to Machyo[210] an educationalist, exploring issues of the Church and HIV/AIDS in the Kenyan context, cultural practices vary, some proved beneficial in AIDS prevention, while others perpetuated its spread. He argues that the beneficial ones need to be enhanced and others modified.[211] Because of its nature, culture is so integrated into everyday life and beliefs; it is often difficult to separate the beneficial practices from harmful ones. Some practices like faithfulness in marriage and sound instruction on sexuality to the youth during initiation are practices that can be encouraged since they can contribute to solid relationships, good health and family preservation. However, some practices, for example, wife inheritance and (male/female) circumcision, may facilitate transmission of the HIV virus. Applied to the sphere of HIV-AIDS, this implies "a

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[207] Ezra Chitando, *Living with Hope: African Churches and HIV/AIDS 1:* (Geneva, WCC Publications, 2007) pp. 32-37.
[208] Nicholas Otieno, *Human Rights and Social Justice in Africa: Cultural, Ethical and Spiritual Imperatives,* (Nairobi: All Africa conference of Churches 2007), pp. 81-109.
[209]Nicholas Otieno, (2007), pp. 81-109.
[210] Cathrine N. Machyo, "The Catholic Church and the HIV/AIDS Pandemic in Kenya: an Exploration of Issues", *African Education Journals and Magazines,* (Nairobi, 2011), p. 4.
[211] Ibid. (2011), p. 4.

radical re-orientation of economic attitudes, practices and structures [that] can really address poverty and ... seriously reduce the spread of the pandemic and. assist those that are infected."[212] In the development of any holistic pastoral approach the influences of family, community and environment are paramount because they encompass the natural development of the individual. The microsystem, exosystem and macrosystem approach of Bronfenbrenner amount in total to an ecosystemic approach. Nothing less is adequate to the scope and complexity of the challenge confronting pastoral work, because it connects the human and interpersonal element of caring for each other. An ecosystemic approach means that the whole person-in-community within a wider systemic relation gets attention. Thus, from the Christian perspective, any pastoral response to HIV/AIDS," according to Smith and McDonagh, "must return again and again to, awareness-raising, education, social, cultural and political reform and economics."[213]

In other communities AIDS is seen as a curse or as a result of witchcraft/ sangoma. Such false beliefs and practices clearly need to be changed. Thus, in order for change to occur, when a crisis such as HIV challenges culture, there is need to understand the underlying traditions, current issues and changing social contexts, to enable people to think about and provide alternatives, for example, to wife sharing and wife inheritance and the sexual or economic subordination of women. There are inherent risks and dangers in such traditional practices and customs, which may have provided succour or family structure in earlier times in a different cultural setting, but have now lost any protective function and need to be challenged. According to Baitu (2000: 23) "apart from emphasizing sexual abstinence before marriage and chaste living in marriage, the Catholic Church can assist in stressing African traditional structures," such as the family, the neighbourhood and the village community, which used to uphold moral values, encourage, and support such customs in their difficult task of serving as

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[212] Ann Smith and Enda McDonagh, (2003), p. 49.
[213] Ann Smith and Enda McDonagh, (2003), p. 49.
See also Francis Cardinal George, O.M.I., *The Difference God Makes: A Catholic Vision of Faith, Communion, and Culture,* (New York: The Crossroad Publishing Company, 2009), pp. 245-247.

instruments of behaviour change[214] which are essential for arresting the spread of HIV/AIDS.[215]

According to Machyo, "there is also a need to interpret cultural traditions in the light of Scripture (Gospels)."[216] But there is also a need for care here, as some scriptural texts, as noted in the previous chapter, have been used to legitimate scapegoating and stigmatisation. This will be addressed more fully later in relation to the proper training of culturally sensitive and gender-aware pastoral ministers including the clergy, who are faced with this overwhelming task of relating to the HIV/AIDS pandemic and the suffering of many in their care. From the report on the conference at the Vatican on HIV/AIDS in December 1999, Bishops in their group sessions acknowledged that "the religious lacked the skills,"[217] that the pandemic required.[218] They did not, however, acknowledge that they also lacked the critical capacity to examine how religion has often colluded in patriarchal attitudes and practices that have left women sexually vulnerable to violence, subordination and without a voice. Religion and the Church need to be brought under scrutiny in this regard. Thankfully, this situation has now changed through training, capacity building, self-development and education.

4.6 The Church and the Root Causes of Stigma

It should be remembered that the Catholic Church has been foremost in the dedication of resources, services and in advocacy towards eradicating HIV-AIDS and caring for its victims. But neither should it be denied that certain religious practices have supported beliefs and conditions that fostered the spread of HIV-AIDS and given legitimacy to attitudes and practices of stigmatisation in Zimbabwe. For example, there are rules and regulations concerning marriage and baptism which are used to obstruct persons, both rich and poor, wanting to receive

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[214] J. Baitu, "The church and HIV/AIDS in Africa South of the Sahara", paper presented at the Interdisciplinary Session of the Faculty of theology, (1998).
[215]Ibid. (1999), p. 3..
[216] Catherine N. Machyo (Article) 'the Catholic Church and the HIV/AIDS Pandemic in Kenya, (Nairobi: An Exploration of Issues, 1989).
[217]G Ngumi "Baseline Data Analysis: Development of HIV and AIDS Curriculum for Eastern and Southern Africa", paper presented at the HIV/AIDS Curriculum Development Consultation for Theological Institutions in Eastern and Southern Africa 26-30 June, (2000).
[218] Pontifical Council for Health Pastorate, Report on the AIDS Conference: "The Catholic Church and the Challenge of HIV/AIDS", Medicus Mundi International Newsletter No. 65, (2000).

those sacraments. Those suffering from HIV/AIDS are regarded as "abnormal" or deviants since they are considered to have failed to abide by religious values. The latter is a spiritual form of distancing and stigmatisation that undermines religious belonging and withdraws the consolation of spiritual assistance. This is at a time of most desperate need, and flies in the face of the Gospel message of liberation of the oppressed, healing for the sick and comfort for those who mourn. Within African traditional religion there is also an emphasis on ancestral spirit's, which influence the mentalities and practices of the ordinary African individual. Such mentalities and practices ignore Christian moral values, as embodied in the teaching and example of Jesus as portrayed in the Gospels. Jesus' teaching about the Kingdom of heaven, teachings on the Father, and the beatitudes were lessons to make people understand the existence of God. God as Creator cares for his people and has unconditional love. Therefore the Church as the follower of Jesus can live in hope for the Kingdom.

The ancestral spirit's (*vadzimu)* sometimes takes precedence in the day to day lives of the faithful. A paper from the Zimbabwean Catholic Bishops' Conference brought to light the irrevocable fact that African Christians "are puzzled, bewildered, and confused by the conflict they experience between the loyalty to their ancestors and their loyalty to Christ."[219] Thus the Church in Zimbabwe still has to work towards a "genuine formation of Christian conscience," bringing the mentalities and practices of both ancestral culture and of Christianity into this process.[220] Sometimes, the language used in the Church and media is full of phrases and messages that knowingly or unknowingly, stigmatise people. For example, the language used may not accommodate respect for the innate dignity of the individual person or norms of human rights. The language of "us and them" used in the Church disregards the respect, consideration and involvement of the people infected with the disease, in reflecting on their condition and experience. In the words of Pope Paul VI, "Evangelisation loses much of its force and effectiveness if it does not take into consideration the actual people, to whom it is addressed, if it does not use their language, their signs, their symbols, it does not have an impact

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[219] Richard N. Rwiza, *Formation of Christian Conscience: in Modern Africa.* (Nairobi: Paulines Publications Africa. 2001), pp. 106-107.
[220] Ibid. (2001), p. 105.

on their concrete life."[221] Inclusiveness and participation are needed, not distancing and exclusiveness. Language is an important vehicle to foster understanding and changes in behaviour. The language used by the New Testament authors has a role to play in explaining the broad spectrum of understanding the work of salvation, as set out by the different authors and redactors of the New Testament. The issues of life, wholeness, healing and salvation demonstrably reinforce and balance each other and overlap in terms of meaning, image and process. Healing was a definite part of Christ's ministry and he commissioned his disciples to go out and heal the sick. Jesus himself described his mission in terms of Isaiah's words: Go and tell John what you see and hear: the blind see, the deaf hear.[222]

So too, the Early Christian community was strengthened by the miracles the Apostles worked (Acts 4:29-30). The evidence is clear that healing was an integral part of Jesus' ministry and of the commission he gave to the Church.[223] "Jesus and his followers clearly understood salvation holistically, inclusive of body, mind, emotions and relationships"[224] and they also understood the essential relational and social nature of the person.[225] This sheds light on why the eradication of stigmatisation and the healing of its destructive effects must be seen as integral to the ministry of healing among sufferers of HIV/AIDS and their families and communities. No one can exist healthily or happily if rendered excluded and isolated. However, when it comes to the issue of HIV/AIDS prevention, the Catholic Church differs on this with other development agencies and their policies, mainly arguing that the use of condoms is unacceptable. Although in certain circumstances the ethical use of condoms in marriage is more compassionate, considered and encourage. Therefore the churches recent leaders of the church are more understanding on the issue of preserving life in marriage.

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[221] Paul VI, *Evangelii Nuntiandi* (Evangelization in the Modern World), article 63, 8 December 1975. In Austin Flannery, O.P. ed. *Vatican II Documents* Vol. 2 Northport, New York: Costello Publishing Company (1982).
[222] William J. Bausch, *The Parish of the Next Millennium Mystic* (CT: Twenty-Third Publications, 1998), p.177
[223] Albert Nolan, (2006), 143-147.
[224] William J. Bausch, (1998), p.177.
[225] Avery Cardinal Dulles, *Models of the Church* Expanded Edition, (New York: Doubleday, 2002), pp. 7, 26-86.

The debate about the religious acceptability or unacceptability of the use of condoms leaves an open space for discussion about adequacy, root causes, the right to protection, and the obligation to do everything possible to save life. But the Church must also confront the reality that it too may have to realise that its structures and its application of power, politics, policies and taboos are greatly influenced by the sociological, cultural and religious values of society, or indeed distorted or culturally-bound by theology and ethics. This also has relevance to how the Church deals or resists dealing with gender issues, sex and sexuality, race and ethnicity, class and poverty in personal, inter-relational, and structural ways. The thinking of Church leaders can reveal the interlocking sociological, cultural, and religious constraints in its own responses to those who experience stigmatisation directly and structurally. According to *Lumen Gentium* (No.1) of the Second Vatican Council, "the mission of the Church is both the spiritual and social: the Church is to be both a sign and an instrument of our union with God, and of the unity of all humankind."[226] Responding to this challenge of stigmatisation in its own life and ministry is urgent, and the Church in developing different strategies from theological, spiritual, moral and pastoral perspectives, needs to focus critical attention on its own failure and complicity. The ministers are challenged to address the needs of the Church. Therefore, leaders and Church members are called to act as representatives of the Church so that people can draw from them special authority and competence to meet religious need and in their role serving as supervisors for others.[227]

The Church can also be a healing agent and can help effectively in the reduction of stigmatisation, by addressing fundamental theological mentalities and religious practices – at the very least the of images of God that are presented, such as, punitive, just, healing, welcoming. The picture of God put forward by the Catholic Bishops in Zimbabwe in 1983, just as HIV/AIDS was recognised in Zimbabwe, varied according to the situations being addressed. Reading the Pastoral Letters which were published at that time, one can see that their combined approaches only focused on issues of morality. More emphasis was put on the need for careful

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[226] Richard M. Gula, S.S. *Ethics in Pastoral Ministry*, (New York: Paulist Press, 1996), p. 57.
[227] Ibid. (1996), p. 66.

behaviour, with an emphasis on warnings and judgment by God (Atonement Theology). God was seen as a condemning God rather than as a God of forgiveness and love. Thus people in the community who were already suffering from HIV/AIDS felt even more condemned and excluded, with nowhere to turn for help. The experience of the Church as a welcoming loving body was denied them in their daily lives. So too, the Church as advocate, drawing attention to the structural injustice of poverty and powerlessness, does not figure in these early Pastoral Letters (Gerkin 1997: 82). The Bishops urged that those afflicted should be treated with respect according to their God-given dignity. All are to respond with compassion, love, best care, and attention, without any moral judgment, as the models of Christ.[228] Further, examples are given in section 4.8 under the Bishops pastoral statements.

The Church, as the defender of the moral and social norms of culture, thus functioned within a narrow moral framework to reinforce and ritualise symbolic stigmatisation rooted in negative moral judgment and blame. The Church's pastoral thinking from mid-1980s was that of condemning HIV/AIDS sufferers, challenging their behaviour and stigmatizing others. In present-day society, human dignity demands that each person's right to life be guaranteed and sustained. It includes the right to ownership, to food, to clothing, to physical and spiritual education, to religion and religious practice, to health care, to freedom and to respect. It includes also the right to participate in decisions, and to take initiatives.[229] If the Church preaches on justice it must be perceived to be just itself in its policies and actions. Lartey (2003: 61). Symbolic stigmatisation was used to reinforce social, cultural, religious, and moral values associated with HIV/AIDS stigmatisation. Members who were so labelled were deemed to have "sinned" and excluded on the grounds that, exclusion was necessary for the preservation of the Church's identity and for the protection of the welfare of the majority of the members of the Church. It seems strange now to remark that this was and is contrary to Jesus' actions of inclusion of the poor and the weak. Symbolic stigmatisation was used to classify religious, moral, cultural, and social diseases

[228] Pastoral Statement issued by Zimbabwe Catholic Bishops Conference, (October, 1992), 1.
[229] Bishops of Rhodesia, (1977).

with negative or positive meanings. HIV/AIDS disease was negatively signified because it was associated with "sin" and taboos. The Church used prevailing uncritical metaphors such as, "a gay disease", "the disease of the unholy", "HIV/AIDS kills" fuelling the climate of condemnation rather than calling for deeper social analysis of structural causes and initially failing to fully embrace HIV/AIDS sufferers, thus reinforcing with its complicity the cold silence of stigmatisation. Religious doctrines and moral and ethical positions regarding sexual behaviour, sexism and homophobia helped to create the perception that those infected had sinned and deserved their punishment.[230] One can legitimately read the record of the closing sessions of early meetings, workshops and conferences on issues related to HIV/AIDS as filled with rigid, fossilised, judgmental, patriarchal and exclusive comments.[231] This shows that the Church, as a social institution, was reinforcing wholly uncharitable attitudes and practices, by its own cultural and religious narrowness of vision and analysis. Before the spread of AIDS, the teaching emphasis of the various Christian Churches, including the Roman Catholic Church, heavily emphasised the purity and holiness expected of those who joined the Christian and Catholic Churches in Zimbabwe.

It is also important to note that the knowledge of the disease was not well known even at the highest level of the Catholic Church. But researches were being carried out to understand the disease and its implications on the lives of the people. The Church at the institutional level supported local programmes financially. The Church at local level provided the manpower and facilities to facilitate the programmes. Also the hierarchy helped with instructions, teaching and preaching about the disease according to values in family, community and society at large. Theological dialogue was insufficiently focused on contextual issues and was protected by cultural or religious taboos when dialogue strayed into areas of human experience. This did not stop the spreading of HIV/AIDS stigmatisation. However, it must also be acknowledged that the pastoral response of the Catholic Church, when the epidemic first came out of the shadows in the 1980s, was that of opening their mission hospitals to patients whom other hospitals had rejected.

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[230] WCC Ecumenical Advocacy Alliance, (2001).
[231] Pastoral Statement issued by Zimbabwe Catholic Bishops Conference, October, (1992) p.1.

This was also done by adopting community-based programmes or by finding ways of assisting orphaned children or their careers. The Church finally began to realise the real realities of HIV/AIDS when the mission hospitals began taking in sufferers. The call for priestly and pastoral care now came to the forefront.

4.7 The Necessity of a Pastoral Approach

It is now fifty years since Vatican II revised the way the Church was developing in the world, particularly in the document, *Gaudium et spes* on the Church in the Modern World.[232] Different, more context-sensitive views followed calls for the Church to open its doors and to continue to care for the sufferers. Today the Church has realised the need to live by the gospel teachings especially for the poor, the marginalised, the sick and those treated unjustly. Furthermore the Catholic Church in today's era is faced with the challenge of addressing the consequences of HIV/AIDS for children and parents. In addition, the Church has realised that it has to intensify its apostolate to the sick and also to train personnel to reach out to those in need of spiritual, physical, emotional, social, and intellectual help.

The Church has realised that the disease has touched the lives of its members at all levels. The voice and scope of faith-based organisations has not yet been fully recognized by the Roman Catholic Church, despite efforts made by some of the organisations, including the International AIDS Society to include the voices of many religious and secular leaders. It will be mainly through collaboration that solutions and mobilization of resources towards combating the disease can be achieved. Catholic teaching is rooted in faith and the social doctrines of the Church. Therefore, the Church's teaching, serving and pastoral caring can bring people a vision of the whole person created in the image of God, gifted with a God-given unique and irrevocable dignity.[233] The Church, as a community, can act as a leaven to help the sufferers help and develop themselves. One African text puts it succinctly in a broadly based view of Church responsibilities:

> We can, as people of faith, journey with others so as to challenge beliefs and attitudes in individuals and in society that help to generate ignorance, fear, stigma and discrimination. We can encourage people to choose life. We can

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[232] Austin Flannery, O.P. General ed. *Vatican Council II: The Conciliar and Post Conciliar Documents.* Gaudium et spes 7 December 1965, (Northport, New York: Costello Publishing Company, 1988), pp. 903-911.
[233] Ibid. (1988), pp. 813-824.

> vigorously promote human rights and dignity helping to break the silence and denial. We can use our spiritual resources of prayer and reflection on scripture to bring hope, healing and reconciliation to those infected and affected. We can above all, learn to listen to those living with HIV/AIDS (stigma) and create in our communities of faith places of welcome.[234]

There is a clear recognition that through shared faith and in working together, stigmatisation can be reduced, but rooted in acknowledgment of past failure. "Who can deny the bitterness and misunderstanding which characterizes and disgraces so much of life in Zimbabwe today."[235] Urgently called for is that Church leaders and membership show willingness to love, share ideas and respect for each other as people of God, and to empower those suffering from stigmatisation, by walking with them, and challenging the negative societal, cultural and religious values of society. What can be derived from this is that there are socio-religious cultural practices in Zimbabwe that can be critically evaluated, and if necessary discarded, because they expose both men and women to the possibility of being stigmatised (Jackson 1992:26-28). Some of these practices, following from economic and social inequalities, breach human rights and abuse other people physically, emotionally and socially especially women within patriarchal communities due to economic and social inequalities. In working to bring about a sense of solidarity, obsolete concepts of human dignity can no longer be espoused.

The workings of the Christian Church and other organisations/institutions in Zimbabwe, with particular reference to understanding and responding to stigmatisation, cannot be fully grasped without the corresponding understanding that the Church and other organisations are the champions of social, cultural and religious values of society. In its own self-understanding and speaking within a theological and pastoral discourse, the Church continues to respond to its prophetic calling, expressing the fact of Christ in her whole life. The call is to respond to the preferential option for the poor, Christ's serving, Christ's healing, Christ's suffering, and Christ's dying. It must also be stressed, of course, that in public life there must always be scope for the religious dimension in people's lives and for pastoral care of HIV/AIDS sufferers. Rosemary Haughton, although writing

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[234] Churches in Manicaland, *The Truth Will Make You Free: A Compendium of Christian Social Teaching* (Churches in Manicaland: Mutare, 2006), p. 147.
[235] Ibid. (2006), p.147.

more than a decade before AIDS, warned that the side-lining of religious discourse in the public sphere undermines social vitality and coherence.[236] In situations like Zimbabwe and from a theological perspective, the shared language of Christ's death, Christ raised and Christ glorified assists people in their understanding of the meaning and purpose of their lives within the community of the Church.[237] The creation of community provides a shared structure which supports and helps every person and group (Otieno 1995:53). The community is part and parcel of society, moulded and controlled by societal values, beliefs and prejudices. Therefore the whole community is involved in creating a conscience for transformation. Thus the Church has an active responsibility in guiding their members on moral issues.

The Church's social and institutional structure and agents such as the Dioceses, Parishes, Small Christian Communities, and Guilds provide key channels of formation, transformation and service. Thus the social mission of the Church belongs to the whole community of the society. "The Church must engage in the discernment of societal problems from the perspective of the marginalised groups" (Bate 2009: 53). The interlocking historical, social, global, and service factors in the Church's pastoral tackling of stigmatisation of HIV-AIDS sufferers will be taken up more fully in chapters 5 and 6. "The Church and other civil society actors have a duty to facilitate the right to be heard of the ordinary citizens, marginalized and excluded" (Bate 2009:53). Suffice to note here that the Church is strategically placed to facilitate and help conscientise and put structures in place for an adequate and dynamic response. However, its approaches do not appear to be effective enough because of its traditional and static, hierarchical, institutional forms of ministry. The Conference of the Catholic Bishops in Zimbabwe has been responding to changing and different situations.

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[237]Rosemary Haughton, *The Transformation of Man: A Study of Conversion and Community* (Illinois: Temlegate Publishers, 1980), p. 256.

4.8 ZCBC Summary of Pastoral Letters 1980 to 1991

4.8.1 Building a New Nation -1980

Independence from the United Kingdom on 18 April 1980 ushered in the birth of the new nation of Zimbabwe. It was time to put down arms and bring people together in unity. Therefore, this pastoral letter which was written after independence was addressed to the government and to Christians asking them to focus on building a new nation, where human rights and duties were to be respected at all levels.[238] People were asked to forgive one other and the resources of the country were to be used to benefit all citizens and public services were to be made available without discrimination.

All Zimbabweans were urged to work for justice and peace, to love one another and all Christians were encouraged to pray for the future prosperity and peace of the country.[239] It is important to note that as far back as 1980, the bishops were conscious of their role in pastoral public ministry in urging the government to be responsible for its citizens as well as promoting a just nation where human rights were observed and respected. The main emphasis, however, in the pastoral letter, was on the need for justice and peace and raising awareness of some of the political ills that might affect the nation's reconciliation process.[240] Thus, some social problems in the transitional period from the war of independence to actual independence were not foregrounded in detail. Factors such as fear, power, social control, gender dichotomy, and cultural discrimination were not confronted as urgent.

4.8.2 Our Way Forward – Pastoral Statement 1982[241]

The Bishops in this next pastoral letter were trying to make the nation realise that it was the responsibility of everybody to promote life and to ensure that no one

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[238] Zimbabwe Catholic Bishops Conference, *a Statement of the Roman Catholic Bishops of Zimbabwe,* 17 April, (Harare: ZCBC, 1980), p. 2.
[239] Ibid. (1980), p. 3.
[240] Ibid. (1980), pp. 2- 3.
[241] Zimbabwe Catholic Bishops Conference, *Pastoral Statement Issued by the Zimbabwe Catholic Bishops Conference,* 'Our Way Forward', 28 November, (Harare: ZCBC, 1982), p. 1.

remained victim of post-war violence and conflict in the country.[242] Hence, the bishops emphasised that justice in practice and policy was a fundamental issue which the government could promote. The government was to protect its entire people and to remove all structures that reinforced divisions and unjust discrimination whether based on race, tribe, sex or creed. The government was also to promote equitable distribution of wealth, land and provide for basic human rights in the areas of education, health and work conditions including better pay. In addition, the Pastoral Letter emphasised the need for unity for the common good. Christians were to be guided by conscience and the social teachings of the church which emphasise the need to work for the development and betterment of the poor, and respect for all human beings as created in the image of God. The nation's people were reminded to care for each other in brotherly/sisterly love.[243] Furthermore, the pastoral letter noted the intention to help both the government and the local church to have a vision that would enhance the solidarity of the nation, and introduce a collaborative approach, including cooperation from the citizens.[244] The State and Church were to work together by showing leadership and support for its citizens.

The bishops at this stage were conscious of the political disturbances in the country. Thus, the Letter was written to promote justice, equality and the idea of working for the common good.[245] The Bishops did not go into detail on the causes of social injustice and its effects as a vicious cycle with some important pre and post-independence human factors such as exclusion, discriminatory laws which grouped people in different categories in regard to access to education, health, and even separating people of different races to live in the same neighbourhood. There is surprisingly little mention of these economic, political, social, religious and cultural interlocking factors of social injustice. Furthermore, the impacts of violence on vulnerable and consequences on people such as women and children might have been highlighted in the pastoral letter. All these were soon to prove highly significant in the understanding of the spread of HIV/AIDS: poor people

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[242] Ibid. (1982), p. 2.
[243] Ibid. (1982), p. 5.
[244] Ibid. (1982), pp. 2-3.
[245] Ibid. (1982), pp. 4-6.

more vulnerable socially and structurally to disease in general, and to HIV/AIDS in particular.

4.8.3 Reconciliation is Still Possible – Pastoral Statement (Easter 1983)[246]

In 1983, the Pastoral letter continued with the same subject of violence in some pockets of the country that was so intense resulting in many deaths, some people lost their lives and their property destroyed.[247] The government was urged to maintain law and order as well as not to participate in the violence. The use of arms against innocent people and anti-social behaviour was challenged as disruptive to unity and peace.[248] Therefore, the Bishops in this letter called for reconciliation. Reconciliation was to be the responsibility of everyone in the country.[249] The Bishops named structural violence but they did not mention the causes of structural violence, such as poverty, unequal distribution of land, economic hardships such as employment, lack of education, ignorance and poor public services in both the education and health sectors as part of provoking to the unrest in the country.[250] To the date of this letter, the Bishops had not mentioned HIV/AIDS a sinister, new threat besetting the country and on which the church and the government would need to co-operate if the disease were not to become the pandemic that lay ahead.

4.8.4 Socialism and the Gospel of Christ - Pastoral Statement[251]

This pastoral statement was aimed at halting the ideology of socialism which it was feared might lead to communism. The bishops invited people to work for the development of the country and also to realise that the country had many resources which if equally distributed could make every citizen enjoy the wealth of the nation.[252] The model is clearly one of distributive justice rather than social and

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[246] ZCBC, *Pastoral Statement,* "Reconciliation is Still Possible," Easter, (Harare: ZCBC, 1983), p. 1.
[247]Ibid. (1983), p. 1.
[248] Ibid. (1983), pp. 1-2
[249] Ibid. (1983), p. 2.
[250] Ibid. (1983), p. 2.
[251] ZCBC, *Pastoral Statement* 'Socialism and the Gospel of Christ', 1 January, (Harare: ZCBC 1984), p. 1.
[252] Ibid. (1984), p. 1.

structural justice. This statement spoke about the choice of different political ideologies that might be followed by the government and how they might affect the livelihood of the people.[253] For example, the statement included such issues as, minimum wages, working conditions; reintegrate displaced people, through policies and laws, as well as Christian values of life, respect for human life, compassion and love.[254] It was important for the nation to learn from other countries in the world that were democratic. This would enable people to develop as individuals and as a nation, thus promoting the goodness and worthiness of the human life. In addition it was time to give people hope and build attitudes and behaviours that builds unity in the country.

4.8.5 Christian Marriage and Family Life - Pastoral Letter -1984 [255]

In 1984 the Bishops issued a pastoral letter to challenge the "domestic church".[256] In this language the Bishops upheld the family as a unit of development and of spiritual formation. The family was seen as the place where character, behaviour and values were developed and the individual formed in society. The language and issues reflected as ideal model of family and of marriage as a sacrament, Divorce and the issues of single mothers were also addressed urging family members to give mutual support to those affected.[257] This Pastoral letter did not discuss the problems for women and young girls caused by men as their counterparts nor did it raise questions of gender, power, inheritance and ownership. Such areas would have needed the attention of the bishops as teachers to provide instruction to stable marriage that empowers married life and life-giving social values and the hope for a better future.[258]

The use of the Bible in the home was seen as vital to form the Christian family.[259] With this focus, Christian Families are presented as the domestic church.[260] The

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[253] Ibid. (1984), p. 1.
[254] Ibid. (1984), p. 1.
[255] Ibid. 1984), p.1.
[256] Ibid. (1984), p. 1.
[257] Ibid 1984), p. 3.
[258] Ibid. (19840, p. 3-4.
[259] Ibid. (1984), p. 2.
[260] Ibid. (1984), p. 1.

future of the church depends on the families that are able to provide support, dialogue, care and forgiveness of one another.[261] One can raise the question, why this pastoral letter did not highlight the problems faced in the family not only from a moral and spiritual point of view but also from the social, political and physical perspectives on the imbalances of power. The position of power was not addressed nor the lack of equality and freedom for women. Cultural practices which include elements that might have been addressed, such as respect for female children, the whole practice of lobola (the bride price) make such factors. Failure to address these issues, have been seen to contribute to abusive behaviour and to gender based violence in family life. People needed to be made aware of the cultural practices that destroy family life rather than of building families based on equality, dignity and genuine love.[262] The Bishops did however remark on the need for Christian parents to witness to their Christian beliefs and to stand out against the high-price lobola that is so common."[263] The cultural practice in itself was not sufficiently probed. Gender was still not on the radar. This would remain a lack and a hazard later when HIV/AIDS came onto that radar.

4.8.6 AIDS and Our Moral Responsibility - Pastoral Statement 1987

Notwithstanding the discovery of HIV/AIDS in Africa during the 1980s, the Bishops Conferences in Zimbabwe was preoccupied by political issues subsequent to the gaining of Independence in April 1980. Since the whole of the African Church was slow to acknowledge the existence of the disease it was no different in Zimbabwe. In 1987 the Bishops issued a pastoral statement on the purpose of their mission to teach. The focus also drew on the Vatican II teaching e on the importance of education and also used language of human rights and made reference to the UN Declaration on human rights.[264] Such a framework of reference is not to the fore; however, when later in 1987 the Bishops for the first time issued a pastoral message that focused on AIDS as a moral issue.[265] The document looked at the disease in the context of sexuality in an interpersonal behavioural frame of

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[261] Ibid. (1984), pp .4-5.
[262] Ibid. (1984), pp. 3-4.
[263] Ibid. (1984), p. 5.
[264] ZCBC *Pastoral Statement* 'AIDS and Our Moral Responsibility October, (Harare: ZCBC, 1987), p. 1.
[265] Ibid. (1987), p. 1.

reference, with regard to contributing factors in the spread of the disease. For example, a person's misuse of alcohol and drugs, are named and there are relevant warnings against promiscuity.[266] Other contributory causes were also mentioned such as the use of unsterilized needles and blades.

The tone of the pastoral letter was full of compassion and respect for the sufferers. The Bishops said, "First of all we state that our primary concern is for AIDS' sufferers, their families and friends who also suffer much distress."[267] The bishops therefore urged the nation in the need to be caring and uphold the dignity of the person; in home, hospital or community at large. So also, the pastoral letter shows that the bishops were aware of and highlighted some causal factors and were concerned to encourage behaviour change.[268]

4.8.7 The Pastoral Letter of the Bishops 1987

The pastoral statement issued by the Zimbabwean Catholic Bishops Conference, (October 1987:1), states that "AIDS... is spreading in our society and we would be lacking in our pastoral duty if we did not lend our voice to those helping to counteract the spread of this disease."[269] This acknowledges the silence attached to the disease. The Bishops went on to say that in order to face this serious health and moral challenge "we have to return to the source of morality and consider our attitude to human relationships and to sexuality within this context."[270] The Bishops suggested that chastity and honesty before marriage and fidelity to one's partner after marriage were crucial values. They suggested that people reaffirm their moral standards. People, besides fear of the disease, have to set their moral standards in the knowledge of God's love for them and to respond to His love by keeping His law. The Bishops acknowledged African traditional values that reinforced the Christian law that upheld virginity of both bride and bridegroom before marriage. Both the Christian law and traditional values condemn both pre-marital and extra-marital sex. This is in keeping with the widely accepted norm that behavioural change holds the key to transformation of the pandemic. Thus, the

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[266] Ibid. (1987), p. 1.
[267] Ibid. (198)7, p. 1.
[268] Ibid. (1987), p. 2.
[269] ZCBC Pastoral Statement October, (1987), p. 1.
[270] Pastoral Statement issued by Zimbabwe Catholic Bishops Conference, October, (1992), p.1.

Church called for all stakeholders to be involved in seeking solutions to HIV/AIDS stigmatisation. As a teacher, the Church can take the opportunity of the presence of the disease to reinforce traditional moral teachings and values especially with regard to human development.

The following principles can be factored into the holistic pastoral approach, for the reduction of HIV/AIDS stigmatisation, which are currently lacking in the Church's response.[271]

1. The dignity of the human person *Humanae Vitae* must be preserved from conception to natural death.

2. The basic human rights of a person need to be recognised. The offshoots of God-given dignity such as, the right to life, shelter, clothing, food, education, health care, and employment must be observed.

3. The promotion of the common good is paramount. All people should have environments conducive to share in the goods of the earth. Public policies should protect all people regardless of their status or state (Catechism of the Catholic Church, 1992 par. 1909)

4. The Church can show concern for those who remain poor through examining public policy and decisions on the needs of the poor. To the Church the poor are a treasure. When you hold a banquet, invite the poor, the crippled, the lame, and the blind". (Luke 14:13).

5. Subordination of private interests in the interests of the common good is vitally important. There is need for empowerment of those suffering stigmatisation.[272]

The Church continues with the mission of Christ guided by the Holy Spirit. The Church does not work in isolation and also engages other organisations that are able to provide the required services. The Church can influence political and economic plans of the states especially in its response to the above listed factors affecting human life. "Great numbers of people are acutely conscious of being deprived of the world's goods through injustice and unfair distribution and are vehemently demanding their share of them."[273] The Church is called to reflect and

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[271] Catholic Bishops Conference (ZCBC), June (1987, 1991, 2003, 2005, 2007)

[272] In Zimbabwe activities are based and guided by the National Policy on HIV/AIDS, drawn from the Statutory Instrument 2002 of 1998 (Labour Relations HIV/AIDS) Regulations (1998), the Public Service Act, 1996 (Chapter 16:04) and Regulations on the Public Service HIV/AIDS Policy (2005), the Public Service Strategic Plan (2006), and the Zimbabwe National HIV/AIDS Strategic Plan (2006-2010).

[273] Austin Flannery, O.P. General Ed. *Vatican Council II: The Conciliar and Post Conciliar Documents.* Gaudium et Spes 7 December 1965, (Northport, New York: Costello Publishing Company, 1988), pp. 909-911.

act on such injustices on behalf of the voiceless. Human beings want to live a life that is "full, autonomous, and worthy of his/her nature as a human being."[274]

However, it is questionable why the bishops did not make explicit connections between the pre- disposing social factors in the spread of the disease – such as poverty and poor nutrition, failures in human rights and gender equality, economic marginalisation and uprooting. Such factors are well known to render people more vulnerable particularly women and girls to being infected and affected. Neither is there direct attention to the need for people to have access to knowledge and all round information about the disease and its destabilising effects on family and community life; such as the pressures of medical costs, loss of employment and stigmatisation.

4.8.8 Marriage, Family, Sexuality and the AIDS Epidemic 1991[275]

The first pastoral letter which directly addressed the problem of AIDS in 1987 did refer to the pandemic as a social concern as well as a moral concern, but its main emphasis was on the family unit.[276] The family was seen as the key structure in the building of values and relationships of support and care for one another. This in turn was argued as having a constructive influence on the wellbeing and values of the community at large.[277] From a theological point of view, the family foundation was shown to be based on the Christian understanding of God's love to his people. [278]However, due to the disease many families were fragmenting and children were left without anyone to care. The bishops expressed sorrow for suffering people, but also grieved that many people in the country were disregarding both the law of nature, biblical precepts, and their own cultural values. Fidelity in marriage was no longer cherished.[279] The tone of language was personal and valuing of mutual care,

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[274] Austin Flannery, O.P. (1988), p. 909.
[275] ZCBC *Pastoral Letter on Marriage, Family, Sexuality and the AIDS Epidemic*, 'Save Our Families' March, (Harare: ZCBC, 1991), p. 1.
[276] Ibid. (199)1, p. 2.
[277] Ibid. (1991), p. 3.
[278] Ibid. (1991), pp. 2-3
[279] Ibid. (199)1, p. 5.

tenderness and marital love and dignity. There was an important allusion to the prevailing existence of violence, pain and incest: [280]

> What was meant to foster lifelong fidelity has become a means of monetary intoxication and excitement. What was meant to instil tenderness and gentleness in couples, and bring them comfort and joy, has been turned into a brutalising and dehumanising experience of violence and pain for victims of rape and incest.[281]

This teaching perspective comes across as focussed on moral values and norms that were being compromised in the behaviour of individuals, couples, and in the community, and change was called for.[282] In retrospect, one might raise the question about the lack of reference to such relevant factors as prejudice against sufferers and their families, lack of information and ignorance, and the socio-economic injustices that also played a part in the spread of the disease. Absent also was a significant reference to the provision of a comprehensive education for family, cultural, social and spiritual life, as if moral constraint were the only key to change; rather than a more holistic pastoral approach regarding the challenges of capacity building in proactive health care and social education. The need for a more comprehensively tackling of environmental issues such as drought, lack of clean water, malnutrition as part of the causes of poor health factors at a structural level is vital.

4.8.9 The Bishops' Pastoral Focus on Violence

A Church seeking reconciliation and peace in the document 'The Decade to Overcome Violence' (Janice Love: 2001:145), set out its aims clearly. Giving Churches and the ecumenical family ten years of concentrated opportunities to uncover our complicity as Christians in violence and to discover and advocate contrite models for promoting justice and right relations within congregations, families, neighbourhoods, nations, and among the people of the world.[283]

The Church had to discover that HIV/AIDS-related stigma is not a straightforward phenomenon as attitudes towards the epidemic and those affected vary massively.

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[280] Ibid. (1991), p. 6.
[281] Ibid. (1991) p. 2, no. 3.
[282] Ibid. (1991), p. 5.
[283] Janice Love, "The Decade to Overcome Violence", *Harvest from an Ecumenical Journey*, in ER 53.2, (April 2001), p. 145. See also, René Girard., *Violence and the Sacred*, P. Gregory, trans. (Baltimore, MD: The Johns Hopkins University Press 1977) p. 2.

According to Alonso and Reynolds, (1995:303) stigma is not limited to a single thing. It is a multidimensional concept that includes the entire field of people that have a deviant behaviour. For instance, people who have violated the rules and are causing harm to society. Even within one country reactions to HIV/AIDS will vary between individuals and groups of people. Religion, gender, sexuality, age and levels of AIDS education can all affect how somebody perceives, feels and responds to HIV/ AIDS. Therefore AIDS-related stigma is not static. It changes over time as infection levels, knowledge of the disease and treatment availability vary. From early in the AIDS epidemic a series of powerful images were used that reinforced and legitimised stigmatisation;

- HIV/AIDS as punishment (e.g. for immoral behaviour)
- HIV/AIDS as a crime (e.g. in relation to innocent and guilty victims)
- HIV/AIDS as war (e.g. in relation to a virus which must be fought)
- HIV/AIDS as horror (e.g. in which infected people are demolished and feared)
- HIV/AIDS as otherness (in which the disease is an affliction of those set apart)[284]

These images have left some challenges for the Church to address. Many people have been stigmatised in one way or the other because of falling into different categories of the images displayed above. There are some negative enablers that refer to lack of available, accessible, acceptable and affordable resources needed to promote positive preventive health decisions and actions. Religious leader's reluctance to discuss HIV openly can promote stigma or blaming HIV/AIDS on other groups.[285] Another example similar to the above is when the governments do not provide free ARV (antiretroviral) treatment to persons living with HIV/AIDS; thereby presenting a disenabling environment for effectively addressing the disease. The lack of free ARV treatment can be linked to the shortage of funds and facilities in the health care system. Failing to provide free ARV treatment has contributed to some people refusing to be tested. There is an urgent need to address short comings in the provision of health care and treatment. Therefore, an enabling environment is critical to effectively reduce and

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[284] HIV/AIDS Stigma and Discrimination (website): http:// www.avert.org/hiv-aids-stigma.htm accessed 10/04/2012.

[285] *Journal of Social Aspects of HIV/AIDS Research Alliance*, Vol. 1 No. May (2004), p. 10.

eliminate stigma'.[286] In the Pastoral Letters provided by the ZCBC, in 1987, the contents lacked contrite reference to the disease and it impacts on the lives of people.

4.9 Church and its Instruments of Change in Reducing Stigmatisation

The acknowledgement and understanding by the Church and it's agents of change on the impact of stigmatisation has certainly increased over the past few years. Several pronouncements have been made by the Church and other organisations on the relationship between sexual or drug-related practice and the impact on sufferers in contracting HIV/AIDS, as well as the moral and social impact on society as a whole. However, many countries in the world have been advocating for a change of attitudes and behaviour that takes a fuller account of the complexities involved. Many too have since been engaged in responding constructively via various groupings, forums, workshops, and conferences. In the context of stigmatisation, the whole purpose of pastoral work is to have a comprehensive approach to the complexity of the problems of the stigmatised person or group. This calls for a pastoral approach which encompasses the Microsystem, the Ecosystem and the Macrosystem of Bronfenbrenner's Ecological Model.[287] The microsystem concept developed in the Irish context, refers to the influence of family, religious setting, classroom or peer group in the development and transformation of the individual character. The ecosystem includes the broader settings of school, community, health agencies and mass media, which have a greater influence on the external development of human character. Still more broadly, the macrosysytem includes political systems, culture, normality, society and economics.[288] These determine the timeframe and scope of the development of values point up the challenge of addressing the imbalances of "structural injustices... [which] need to be re-oriented."[289]?

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[286] Ibid. (2004), p.11.
[287] Perry Share & Kevin Lalor eds., *Applied Social Care: An Introduction for Students in Ireland*, 2nd Edition, (Dublin, Gill Macmillan, (2009),p. 98.
[288] Ibid. (2009), pp .97-98.
[289]Ann Smith and Enda McDonagh, (2003) p. 49.

While not denying the fact that much has been done to address the disease and to help suffers, there has still not been actual comprehensive initiatives specifically aimed at combatting stigmatisation. The initiatives did involve many other components, such as, increasing awareness, empathy and altruism, reduction of anxiety or fear, and improving attitudes. Stigmatisation – incredibly – is not yet taken seriously as being a social process embedded in family, community, culture, religion and society. Hence, there is a need for the Church to advocate for this nationally and internationally, and also to focus on ensuring a holistic approach within its own pastoral care.

Cognisant of the fact that Zimbabwe is now faced with challenges in relation to the pandemic; more money is being spent on health, education and social welfare issues. Due to the demand for health services, there is always the possibility for a collapse in these services. There are changes in consumption patterns and demographic profiles. There is an increase in the number of female-headed families, orphans and child-headed households. Families have less disposable income. All these challenges are forcing the Church and its agents to try to reduce stigmatisation. The Church in its pastoral ministry can identify the gaps in people's needs for education, health, employment opportunities and sharing of resources.[290] In Zimbabwe the Church has to find ways and means to address the needs of the poor people. "HIV/AIDS has a profound impact on growth, income and poverty."[291] As has already been highlighted in Chapter 4, there are different factors that lead to poverty cultural, religious and social factors need special attention from the Churches pastoral ministry. To reduce poverty among the unemployed and others there is a need for bottom up empowerment of those caught up in the vicious cycle of poverty and HIV/AIDS. Empowering those at the bottom of the economic ladder can stimulate them to better themselves, if they perceive themselves to be in charge of their own future.

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[290] Ann Smith and Enda McDonagh, Series eds. *Christian Perspectives on Development Issues: The Reality of HIV/AIDS,* (Maynooth: TROCAIRE, VERITAS, CAFOD, 2003), pp. 26-27.
[291] Ibid. (2003), p. 29.

The HIV/AIDS-related stigmatisation is going to be approached based on a number of principles distilled into 3 strategic areas of, prevention, care and treatment, and mitigation. These will be discussed in detail in the next chapter.

The key principles are:

(1) HIV/AIDS is an emergency;

(2) Provision of health and safety;

(3) Openness, non-stigmatisation and non-discrimination on the basis of HIV/AIDS;

(4) A multi-sectorial approach to the fight against HIV/AIDS;

(5) Mainstreaming gender in all programmes and activities;

(6) Addressing needs of vulnerable groups, such as, orphans, child-headed households, grandparent-headed households and female-headed households;

(7) Meaningful involvement of people living with HIV/AIDS;

(8) Equitable access to prevention, treatment and support services;

(9) Evidence-based treatment; and

(10) Adherence to international goals and principles.

The intervention programmes remain aimed at minimizing and managing infection rates. The main programmes are prevention, voluntary testing, voluntary counselling, ARV treatment and behaviour change. Unclear in the intervention programme are recommendations on how to reduce poverty and vulnerability to stigmatisation. Also, the programmes that have been introduced are not working satisfactorily due to, lack of finance and knowledge and lack of health status disclosure. Another major factor in the lack of success of intervention programmes is due to fear of disclosure of HIV/AIDS status. But overall, it is the lack of programmes on poverty reduction, gender equalisation and equal employment opportunities for males and females.

Stigmatisation agents remain omnipresent.[292] The poverty issue is neglected, overlooked and not given the importance which it requires. Church policies which are formulated at Conference level are passed down to Diocesan level, parish level

[292] Zimbabwe National HIV and AIDS Strategic Plan (ZNASP) (2006-2010).

and then prayer groups. The lower levels depend on the top echelons of the Church hierarchy. This perspective or structural functionalism assumes that, the Church structures are fully capable of bringing about change and that the Church itself is a stable, harmonious and continuing flexible body. The changes promulgated by the Church in this context come from external pressures, for example, stigmatisation. This ignores the fact that many Church members are themselves being stigmatised. As long as the Church regards stigmatisation as an external force, its values will continue to be incompatible with some societal values. Something more radical and prophetic is called for, as will be discussed in chapter 5.[293]

In society, conflict is a normal feature of life as a result of unequal distribution of power, privileges, prestige and preference. There is a permanent struggle between the stigmatisers and stigmatised. The Church should respond by empowering those stigmatised in the combating of stigmatisation. Also, the Church should educate and challenge the stigmatisers against trespass on another's inalienable human dignity. Stakeholders at all levels need to be facilitated to reflect critically and self-critically on their experiences and on the real evidence that has been garnered. The greatest empowerment should be at the grass-roots level and at the lower echelons of the Church organisation, namely, the parishes and local community Churches, since that is where the capacity for transformation is actually strongest. It is only recently that the Church has begun to devolve power to the parishes to make decisions important to them. However, it should be pointed out at the onset that local resources are inadequate for this trend, hence the need for partnerships. The Church is beginning to realise that in small communities, there is unity in diversity and the Church's unity can never be totally uniform, but rather harmony in diversity.[294] There is more actual bonding, spiritual support, liturgical practice, and community participation in small communities than in the larger Church, because of, proximity, similar experiences,

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[293] Ibid. (2006).
[294] James O' Halloran, SDB, *Small Communities A Pastoral Companion,* (Maryknoll NY: Orbis Books, 1996), p. 1.

and local leadership.[295] People cannot be developed but must develop themselves; at most, outsiders can only facilitate and support change. The theological vision of a small community springs from the depths of the Trinity (The Father, Son and the Holy Spirit). People in the cities and towns have suffered in many ways. There is lack of suitable accommodation. In some high density areas people receive very little public care provision, and suffer a lack of paid employment and reliable income for food, heat and other basic human needs. This creates an environment conducive to sickness and vulnerability to the pandemic. Liberation theology can be thus highlighted in a pastoral context to reinforce the preferential option for the poor and elevated the innate dignity of each human person.

4.10 Summary

In conclusion, the Pastoral letters for the ZCBC from 1980 to 1987 were more attuned to the political unrest and the role of politics and in the country post-independence, than to confronting the realities of HIV/AIDS. It should be noted that these were trying times for the bishops who tried to reflect on one particular theme in each pastoral letter. In order not to totally ignore some of the more pressing issues, the bishops tackled numerous issues in the context of the pastoral letter on "Our Mission to Teach, Save Our Families, and Our Way Forward" (1991). The themes of the pastoral letters reflect the contextual realities and the pressures the bishops were responding to at a particular time.

Clearly under such conditions, some pastoral concerns did not get enough attention. Other facets of the HIV-AIDS reality that were not addressed include the whole attendant patterns of social and religious stigmatisation, the language of blame and punishment not uncommon in sermons, and, cultural practices and public policies which are oppressive and unjust in regard to gender equality cultural exclusion and the need for a comprehensive revision of pastoral ministry in afflicted communities and families. Some important direct HIV/AIDS matters were raised in two pastoral letters of 1987 and 1991. It is unfortunate that these pastoral letters were not taken further at diocesan and parish levels through the

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[295]James O' Halloran, Living *Cells: Vision and Practicalities of Small Christian Communities and Groups, (*Dublin: the Columba Press, 2010), pp. 13-66.

devising and implementing of a pastoral plan and programmes of education and capacity building that would empower people and priests in their diocesan, parish and community settings to participate and collaborate with the bishops in an effective pastoral response to a disease that was clearly on the map since the early 1980s.

The bishops do in various ways take responsibility nationally and globally to be the voice of the voiceless and to stand up for the truth. Christians as mentioned in different pastoral letters have also to endeavour to engage themselves in prayer for unity in the country, in actions of justice, and in solidarity with each other, with all who are suffering and indeed with the wider church[296]. It is also important that the bishops in their pastoral teaching do not appeal only to the need only for personal and behavioural change, while leaving out the appeal to human rights and social justice which promote or take account of the dignity of the person, the right to life, food, education, healthcare, property and land. Pastoral teaching and pastoral letters specifically have a role to play in contributing to the transformation of social values, religious practice and cultural exclusions[297] by promoting action for justice, inclusion, and respect for all those whose lives are diminished and made close to unbearable as a result of HIV/AIDS and its attendant patterns of stigmatisation.

In Zimbabwe, the process of stigmatisation still challenges the Church today to put into consideration the holistic approach to pastoral care. The whole of a person's life is to be considered such as those aspects which affect the conscience and the growth in faith. Thus the reality of life has to be challenged, taking into account the capacity and the vulnerability of human beings in their particular contexts. There is a need for the development of the individual and the community at large. The Church is uniquely placed to do this because it has a sophisticated nark of structures and agents to reach out to people. The Churches and organisations are facing challenges in promoting and providing services that can change the social

[296] ZCBC (1991), p. 2.
[297] Ibid. (1991), p. 6.

mind set, according to the *Zimbabwe Human Development Report*, 2003,[298] which also asserts that stigmatisation is greatly enforced by a socially disadvantaged, unstable and poor health environment.[299] The Church and other agents are challenged to design and implement a new approach for combatting stigmatisation. Both males and females are vulnerable to stigmatisation.

Therefore, a holistic pastoral approach should address all aspects of life, namely, spiritual, physical, social, economic, intellectual and emotional. The Church has the ability to reach out to the whole country through its countrywide dioceses' organisation. The Dioceses are rich with human resources, professional and otherwise who could be involved in policy making, policy implementation, communication, health, and education.[300] The services provided by the Catholic Church are still very crucial to the development of social and spiritual structures in Zimbabwe. The Catholic Church in the Mutare Diocese, with its role in developing and sustaining a holistic pastoral strategy aimed at prevention and care and very particularly in combatting and reducing stigmatisation, is of paramount importance. In the next chapter the findings of the case study will help, both by exposing and dismantling the underpinning and interlocking mechanisms that hold stigmatisation in place as a vicious spiral, and also by positively promoting the countervailing conditions and processes that will replace stigmatisation with participation, hospitality and communities of empowerment and care. The information is going to help in the development of a holistic pastoral approach model in Chapter 5.

The Bishops Pastoral Letters have shone some light on how the Church reacted to different situations that affected people's lives. People still have a strong faith and the Church is still seen as the agent of hope. Transformation is still needed as a form of creating a community of people where the community has respect for each other and care for each other. The findings in Chapter 4 will be a great tool to develop a model which will engage the community in a comprehensive pastoral

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[298] Zimbabwe Human Development Report (2003), pp. 7-13.
[299] Ibid. (2003) p. 220.
[300] Ibid. (2003) p. 220.

care programme. From all indications the Church leaders in collaboration with other professionals are concerned in seeking ways to find solutions for the care of people and to promote human dignity. They have been regularly addressing and seeking solutions for the well- being of all concerned but more in depth study of stigmatisation and its long effects on society at large is needed.

Chapter 5 REALITIES OF HIV/AIDS STIGMATISATION - CASE STUDY

> The stigma is something that kills human beings - sometimes far more than the disease.[301]

5.1 Introduction and purpose of this case study

Some would claim it is little wonder that people infected with the HIV/AIDS virus are stigmatised. In the scheme of things, HIV/AIDS is a relatively new disease, say compared with leprosy. It should be remembered that at its peak, leprosy probably had the same stigmatisation factor as HIV/AIDS. Indeed, even though leprosy is now controlled by drugs, and might be described as a controlled disease, the very mention of it can still strike fear. Within this perspective the realities of stigmatisation among sufferers of HIV/AIDS residing in the Roman Catholic Diocese of Mutare, must be approached, as discussed in the previous 3 chapters, with careful reference to the sociological, cultural, and religious contexts of stigmatisation.

This chapter presents the findings of a case study carried out in the Diocese of Mutare, which aimed to reveal the practical realities that HIV/AIDS sufferers, in that context, experience and endure as a result of being stigmatised. These realities will form the basis upon which the thesis will then build an argument and a model for a pastoral holistic care approach that can be used to combat stigmatisation among sufferers and to empower them in the recovery of their human rights and freedom (Gerkin 1997:84) The purpose of this case study was to hear and discuss, on a first-hand basis, the concerns of sufferers, care givers, Church leaders and members as to how they view and experience stigmatisation.

The author is of the opinion that close evaluation of the case study results will form the basis for a workable and improved approach by the Church for the reduction of HIV/AIDS stigmatisation. It is hoped that the knowledge of the practical realities of stigmatisation will assist the Church and its agencies with an

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[301] London's Independent, "Mandela at 85 -- The man, the myth" (Whitaker, *Independent*, 7/18).

on-the-ground understanding of the issues of the impact of stigma; thus leading to the development of a holistic pastoral approach to countermanding stigmatisation in the Diocese of Mutare. While an understanding of the disease of "stigmatisation" is fundamental, what is further required, building upon this knowledge, is action on the ground.

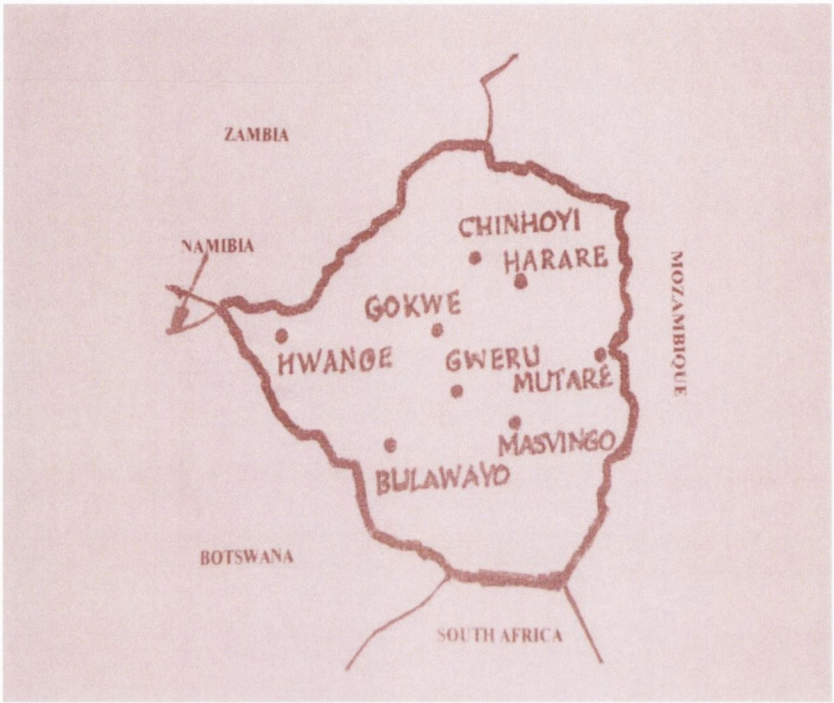
5.2 The Case Study in Context: The Diocese of Mutare

The Roman Catholic Diocese of Mutare is located on the Eastern side of Zimbabwe bordering Mozambique. It covers an area of 32,202 square kilometres. The Diocese is one of eight in Zimbabwe following the Roman Rite. There are 2 Archdioceses Harare and Bulawayo. There are six Dioceses in the country namely Gokwe, Masvingo, Gweru, Chinhoyi, Hwange, and Mutare. The map of Zimbabwe below shows the geographic location of these respective Dioceses in the country. This case study particularly focused on the Diocese of Mutare. In the previous chapter additional information was included about the local Catholic Church in Zimbabwe including the establishment of the dioceses.

The population of Catholics in the Diocese of Mutare using statistics of 2008 was approximately 128,120 (6.7%) of the total population of 1, 925,455 within the region. It is divided into 5 deaneries. Each deanery is subdivided into parishes. Each parish is subdivided into small communities. It is mainly in the small Christian communities that families find their identity and feel they belong to the Church and have a meaning in life.

The following map shows the number of mission stations in the Diocese of Mutare. The mission stations cover the entire diocese. The introduction of a well organised, staffed and funded Holistic Pastoral Approach in the Diocese can in time lead to a reduction of stigmatisation regardless of the form that it adopts. What is required for maximum effectiveness is commitment from the Church, the community and sufferers.

Figure 5.1: The Catholic Arch-Dioceses and Dioceses in Zimbabwe



Source: Zimbabwe Catholic Directory 2008-2010:

It should be noted that there are a number of organisations within the diocesan structure already engaged in work with sufferers of HIV/AIDS. Because of the prevalence and effects of HIV/AIDS stigmatisation in Diocese of Mutare, the Diocese of Mutare Community Care Programme (DOMCCP), Catholic Relief Services (CRS), Family Action Counselling and Testing (FACT) and Youth Alive organizations were established, to engage in various activities with the aim of reducing stigmatisation in families, schools, work place, Church and community.

The mission statement of the DOMCCP declares, "Our aim is to facilitate, capacitate and support community driven initiatives in preventing and combating the impact of HIV/AIDS in the Catholic Diocese of Mutare."[302] Alongside the Diocese Community Care Programme are the Youth Alive and FACT programmes, now well-established, credible and growing HIV/AIDS service organisation based in Mutare.

[302]Diocese of Mutare, 'Vision of DOMCCP' (art), (Mutare: Diocese of Mutare, 2005),pp. 2-3.

Figure 5.2: Map of the Diocese of Mutare and Mission Stations.

Each of these organisations is involved in behaviour change strategies, educational programmes, the encouragement of HIV testing, commemoration of World AIDS Day, capacity building for service and advocacy organisations, and anti-stigmatisation work and empowerment. In 2010, there were over 1,000 volunteers working in all the implementation sites in the Diocese of Mutare. One aspect of this case study is to assess the efficacy of these responses from within the Church and question what more needs to be developed in the pastoral approach to overcoming HIV stigmatisation.

Despite the work of the different organisations, a holistic pastoral approach is of paramount importance in that it addresses the needs of the person in a

comprehensive way, within their families and their community structures. For example, emphasis will be directed to all aspects that affect the individual's life. The cultural, political, economic, social and spiritual environments are all challenged and the Church takes an active role in evangelisation, education, health care, spiritual development and care for the environment. These various organisations through their narking and sharing responsibilities are well positioned to make a greater combined impact.

5.3 Case Study Objectives, Research Questions and Methodology

5.3.1 Research Objectives

The research was carried out in the Diocese, by issuing questionnaires to 90 consenting participants, with the aim of meeting the following objectives:

(a) To establish the present situation of stigmatisation in the Roman Catholic Diocese of Mutare;

(b) To reveal where possible the actual methods of stigmatisation;

(c) To reveal the feelings of sufferers;

(d) To assess the feelings of caregivers;

(e) To assess the extent to which pastoral care is reducing stigmatisation among sufferers;

(f) To establish what further initiatives, programs, interventions are required to reduce stigmatisation in the Diocese;

5.3.2 Research Questions

The case study was designed, in particular, to obtain answers to the following questions.

(a) What are the most prominent aspects of stigmatisation experienced by sufferers in the Diocese of Mutare?

(b) What are the realities of stigmatisation experienced by sufferers and what are their feelings?

(c) What are the activities being carried out in relation to HIV/AIDS by the Diocese of Mutare?

(d) What aspects of pastoral care are the Church and its agents offering sufferers of stigmatisation in the Diocese?

A full list of the questions asked of the participants is available at Appendix 1. Having decided on the objectives and the actual questions, the author then decided on the number, gender and background of the case study. The sample taken from the entire population was 90.

5.3.3 Research Methodology

To evoke responses to case study questions, the researcher used both narrative and descriptive designs as research methodologies, involving both qualitative and quantitative methods. The author took care to ensure that the norms of confidentiality, objectivity and economy were met in performing the study.
The researcher had to specify how participants were to be identified and contacted, how data was to be collected, presented and analysed. The descriptive design assisted the researcher to obtain complete and accurate descriptions of situations from first-hand information. Using sampling techniques, questionnaires, interviews and observations as research instruments was deemed the most time and cost effective method of carrying out the study. The methods used were also the most efficient way of collecting study data.

The quantitative method enabled the researcher to collect numeric, original data which was then compared, as a control mechanism, with secondary data from existing surveys and other external data. Most of the research depended on the completed questionnaires but was followed up with interviews with open-ended questions. The respondents were selected from the different categories – Church leaders, Church members, carers – taking 2 from each category, and four from the category of sufferers. The qualitative methods, based on the sample interviews, enabled the researcher to obtain non-numeric (illustrative) data, which encompassed attitudes, feelings, perceptions, aspirations and preferences. The interviews helped the researcher to further clarify and understand the responses to certain questions included in the questionnaire. The interviews followed a pre-set series of questions on areas such as, isolation, disempowerment, gender,

ostracism, poverty and stereotyping. The interview questions were independent of the questions in the questionnaire. Quantitative and qualitative methods have their respective shortfalls. For example, qualitative data cannot be easily quantified to show relationships and the reality of, say, implied verbal abuse or respondents giving information for self-fulfilling reasons. Quantitative data cannot express the inner feelings of sufferers. For such reasons both quantitative and qualitative methods were adopted to complement each other.

5.3.4 Sample Size Selection

The author decided that a sample of 90 persons would give a good indication of the problems and possible solutions to stigmatisation in the Diocese of Mutare.

The researcher used stratification to select the study sample which included, 10 Church leaders, 20 caregivers who were close to sufferers and working with support groups; 30 Church members both male and female who represented the community; and 30 sufferers willing to take part in the study. The selection of the respondents was based on persons holding senior positions, experience and length of service, and sufferers, who were more than willing to participate; indeed these tended to be the first to volunteer. The sample was considered to be reasonably representative of the study population to give the required information to answer the questions as outlined in 5.3.2 above.

5.3.5 Identification and Contact of Participants

The respondents were identified and contacted as follows:

1. Church leaders were identified by contacting senior members in the Church and ascertaining their willingness to be involved in the case study, their knowledge of HIV/AIDS and their involvement in providing pastoral care. Once Church leaders with relevant experience were identified they were contacted by letter, e-mail, telephone and personal visits.

2. Church members were identified following discussion and correspondence with the parish council. Those Church members selected for follow up were contacted by letters and visit's when the researcher returned to Zimbabwe to conduct the study.

3. Care givers were identified by contacting the chairperson of the caregiver's association. Once a list of suitable caregivers was identified, they were contacted by letter. A suitable caregiver was one with wide

experience and not less than five years' experience in caring for persons who were infected.

4. Infected persons were identified by the researcher's personal knowledge or contacts. These in turn introduced the author to other further infected persons. Once identified, these infected persons were contacted by letter.

Overall, the snowball technique was utilised to identify the participants for the case study. In addition, viva voce played a role in informing people that a case study on HIV/AIDS stigmatisation was in the process of being established. The author did not have any real problems in identifying and contacting individuals for inclusion in the case study.

5.3.6 Data Collection Procedures

Questionnaires, interviews, and observation were the methods used to collect the data. The author discussed the questions on the questionnaire with the participants and recorded their responses, for those persons who could neither read nor write. These sessions, by necessity, also included an element of discussion of the questions to clarify them for the participants. The actual methods used, for those who could neither read nor write were determined by the nature of the topic under discussion, for example, attitudes, feelings, perceptions and aspirations of people are all qualitative questions, more suitable to discussion. Questionnaires were given to all participants including sufferers who could read English. Those who could neither read nor write English were interviewed and the researcher recorded and translated their response into English. The questionnaire contained multiple choice questions requiring short answers, as well as open ended questions for respondents to express themselves freely. The questions were carefully planned and written in unambiguous plain English.

A questionnaire allowed the researcher to achieve anonymity and confidentiality, particularly important since the topic is sensitive. This was considered as likely to motivate the respondents to answer questions more freely. The respondents were kept focussed on the subject matter by the posing of relevant questions concerning the study. The questionnaire also facilitated the process of tabulation and analysis of data because the questionnaire was self-delivered. The respondents were at liberty to ask the researcher for clarification concerning questions they did not

understand. The researcher could not have received all completed questionnaires without the help of assistants, who delivered and collected some of them. The assistants were members of the author's congregation who were involved directly with sufferers, and were responsible and reliable in their role. The researcher engaged them after assessing their level of understanding in relation to certain crucial ethical research norms to be observed in carrying out the research. For example, the researcher was assured that these assistants had gone through training and had knowledge of the importance of confidentiality, respect, privacy, freedom, confidentiality harm, consent, and communication. Because of the critical importance of these ethical research norms, the researcher also provided additional training to the assistants in advance. This was done online because of distance. Accompanying the questionnaires were clear instructions which guided and assisted the respondents. Some questionnaires were posted while others were hand-delivered.

5.3.7 Ethical Norms and Issues

Ethical issues and concerns were uppermost in the mind of the author when drafting the questionnaires and performing the study. In particular, issues of confidentiality, privacy, dignity of the whole person and methods of communication were observed during the case study process. The respondents gave their permission to take part in the case study and to complete a questionnaire, to be interviewed and to be involved in the group discussions. To maintain confidentiality, the completed questionnaires were put into sealed envelopes for collection by the researcher or her assistants. Furthermore, prior to their involvement, the researcher gave instructions to her assistants on the importance of the ethical norms noted above. For ethical and legal reasons, the researcher also obtained permission for the case study from the respondents and from the diocesan authority.

5.3.8 The Interview Process

Interviews on a one to one basis were held with 10 out of the 90 respondents. This included 2 Church members, 2 Church leaders, 2 caregivers and 4 HIV-AIDS infected persons. Interviewing the above helped to clarify some questions and also

got further qualitative information. The interviews consisted of a series of pre-set questions (on isolation, disempowerment, gender, ostracism, poverty and stereotyping), the researcher clarified points as the interviews progressed. The semi-structured nature of the interviews allowed the interviewer to probe for more information from the respondents continually encouraging respondents to give fuller information using a common language or "*lingua franca*" (Shona). The researcher sought to avoid interview bias, which could have been caused by verbal cues or personal views, by remaining objective and adhering to the interview guide and standardized, structured questions.

The researcher took all precautions to make the interviews successful. The respondents were encouraged to express themselves freely. Appointments were arranged with leaders where the respondents were located, so that they could consult and organize meetings with the respondents. The presence of the researcher during the actual interviews gave her the opportunity to explain the purpose and importance of the study to the respondents, as well as re-affirming the respondents' confidentiality. Interviews were conducted during the same weeks as the questionnaires were completed. The interviewees gave full permission to the researcher to make notes of the interviews. Personal observations were made as the researcher toured the places where the respondents resided.

5.3.9 Group Discussions

As well as the ten individual interviews, the author also used group discussions as a method of collecting data. Both format that is, guided discussions and informal freeform, i.e. no agenda, discussions were held with forty respondents, comprised of 10 caregivers and thirty HIV-AIDS infected persons. The participants in the group discussions were divided into four groups. In each of the four groups there were 10 participants comprised of 5 females and 5 males. The members of the group discussions volunteered to take part, once the purpose of the exercise was explained. It was through interviews and the group discussions that the nature and extent of issues of isolation, empowerment, gender relations, seclusion, verbal abuse and harassment were fully established. For example, it emerged from the

group discussions that, sufferers felt that they were considered to be burdens to their families.

5.3.10 Observation as a Research Tool

The researcher also used observation as a research tool. Observations took place at one of the centres that cared for sufferers. The researcher made some direct observations of the behaviour of HIV/AIDS infected people, such as, how they interacted with carers, uninfected persons and interaction among themselves. This was done on a nonspecific, no names no consent and non-intrusive basis. These observations were made to give the researcher a foundation to assist her in interpreting the actual results of the questionnaires, the interviews and the group discussions. Wherever possible, the researcher also observed and recorded how relatives of the infected persons reacted. While ethically it would have been preferable to obtain consent for the observations, had they known, those being observed might not have acted in an unselfconscious manner.

5.3.11 Ethical Considerations Using Observation

At all stages of this case study the researcher observed best ethical guidelines to obtain, analyse and report the results of the case study. The physical and mental health of the participants was uppermost in the mind of the researcher and her assistants, who collected some of the sealed survey questionnaires. All of the participants, who were over 15 years of age, gave their consent in writing to take part in the survey. The main part of the survey comprised of a detailed questionnaire. However, the researcher felt that a small amount of interviews allied with some minimal actual observation would benefit the study. On the basis that the participants had given their written consent to take part in the survey and did not object to the interview process, the researcher was of the opinion that a small amount of non-intrusive observation would also be acceptable to the participants, as it gave the researcher the opportunity to observe the participants

in a natural environment.[303] The observations took place in locations where material resources were being distributed to HIV/AIDS sufferers. No one objected to the presence of the researcher at these locations. The observation posed zero physical or mental risk to those being observed. (Alston and Bowles 1998:15). According to Baker et al (1993: 45), it is important for the researcher to "spend time with members of the group being studied and observes daily routines and unusual events as a participant in action and at the same time as someone removed from it."

In fact, the researcher was firmly of the view that taking the three forms of research, namely, questionnaires, interviews and observations would make for a more rounded report. It was also hoped that a more rounded report would benefit HIV/AIDS sufferers in the longer term as it would bring additional information to the notice of the relevant authorities. Obviously the observations cannot be tracked to any individual or location as it was done on a completely anonymous basis. The researcher was aware that indirect observation was not acceptable on ethical grounds. "Just as research is never value free, ethics is a vital part of every research project."[304] Ethical criteria for research includes, "autonomy or self-determination" that is "informed consent and confidentiality," "non-maleficence" that is "not doing harm," "beneficence" that is doing good" and "justice" that means the purpose is "just," (Hardwick and Worsley 2011). Participants are entitled to know exactly the motive and data to be collected and where possible all the questions surrounding the method being used. "Qualitative research is not removed from the respondent-the researcher maintains that it is impossible to separate from those being researched."[305] More so, the participants can be used by the researcher to take an active role in the process of observation that is making them record their own behaviour and outcomes and share the information with the researcher. But such an approach is possible where there is quantitative data involved using figures to analyse the data collected. The observations were purely used as a yardstick for comparison with the actual results of the case study. The

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[303] Paul J. Baker, Louis E. Anderson and Dean S. Dorn, *Social Problems A Critical Thinking Approach* 2nd Edition, (Belmont, California: Wadswoth Publishing Company, 1993), p. 45.
[304] Margaret Alston and Wendy Bowles, *Research for Social Workers Introduction to Methods* 3rd Edition (Oxon: Routledge, 1998), p. 13.
[305] Ibid. (1998), p. 13.

researcher recorded events as they occurred and was able to observe the realities of the situation which the sufferers were taking for granted. For example, it was clarified that the interviewers were not interested in snooping and that those being interviewed should not use the interview to complain about the type of food they were given or tell the authorities about what they disliked (hospitals, support groups, or to their families).

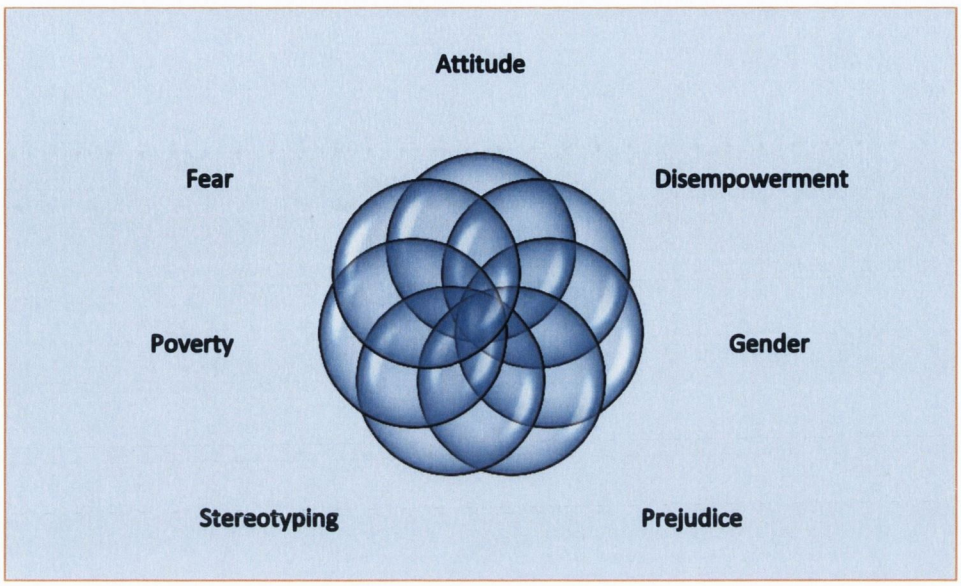
5.3.12 Data Presentation and Analysis Procedures

The researcher summarised the responses to the questionnaires using pre-set headings. Frequency distribution tables, bar charts and pie charts were produced to facilitate an analysis of the information. Graphing the data permitted the researcher to appreciate and interpret more readily the results of the survey. The statistical data then assisted the researcher to fully describe the factual situation.

5.3.13 Limitations and Caveats Concerning the Study

Stigmatisation as has been reiterated is a broad, multi-faceted and systemically interconnected problem. Hence, the case study concentrated only on, and is limited by, those areas, set out in the diagram "Important Stigmatisation Factors" at 5.3 below, and considered by the author to be of the greatest concern. The multiple inter connected circles were chosen to show the complicated interconnections between the areas. For example, sufferers can be stigmatised based on poverty, lack of education and even the language one speaks – English is viewed as sign of a good education, while only speaking the local language is often deemed a sign of ignorance and a poor education. As for further caveats, as with all studies, the accuracy of a study is only as relevant as the honesty of the respondents and the relevance of the questions asked. It is also acknowledged that this was a small study and so care is needed in interpreting the results and not extrapolating them across the whole of Zimbabwe. For example, the study was carried out in the Diocese of Mutare, a relatively small rural diocese and so the results may not be directly representative of the diocese of Harare, a large city diocese

Figure 5.3 Important Stigmatisation Factors



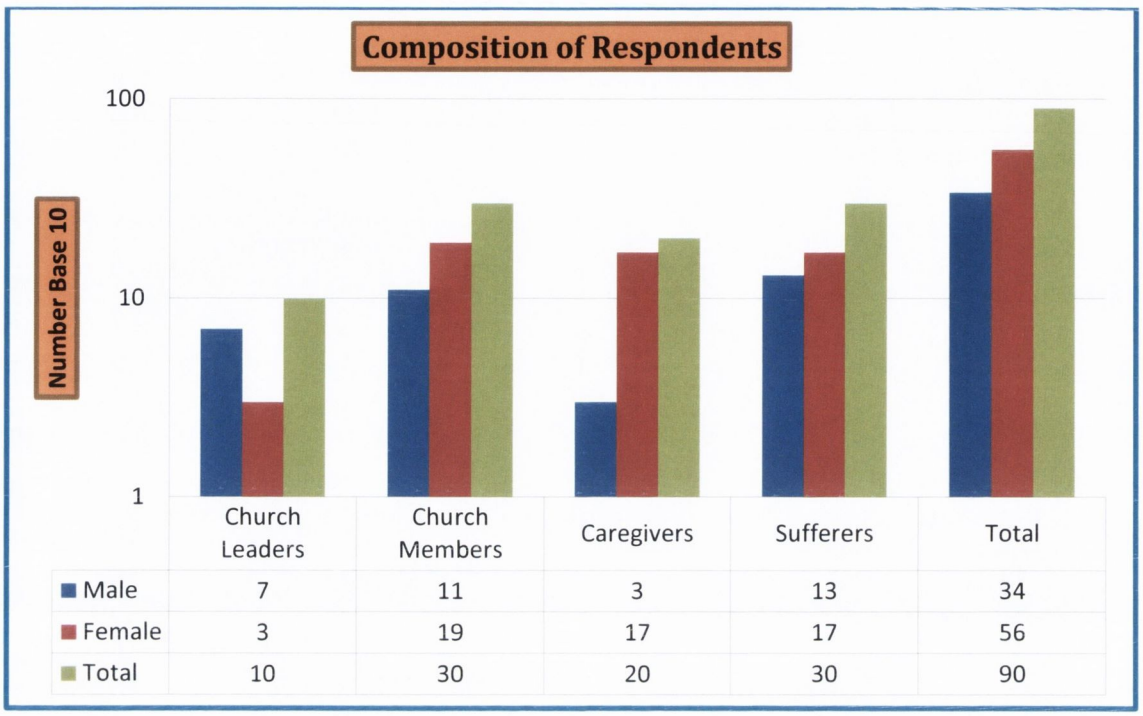
Source: Author

5.4 Case Study Findings – Qualitative and Quantitative Data

This next section of the chapter presents the qualitative and quantitative data resulting from the case study, the aim of which was to reveal the practical realities experienced by HIV/AIDS sufferers in the Diocese and which endure as a result of being stigmatised. Ninety respondents took part in the case study. Table 5.1 sets out the composition of the respondents.

The age range of Church leaders, (ordained and non-ordained that is male and female leaders), members and care givers was 15 to 49 years and that of sufferers was 19 to 25 years of age. The group was representative enough of those who could contribute meaningfully to suggesting ways and means of eradicating stigmatisation.

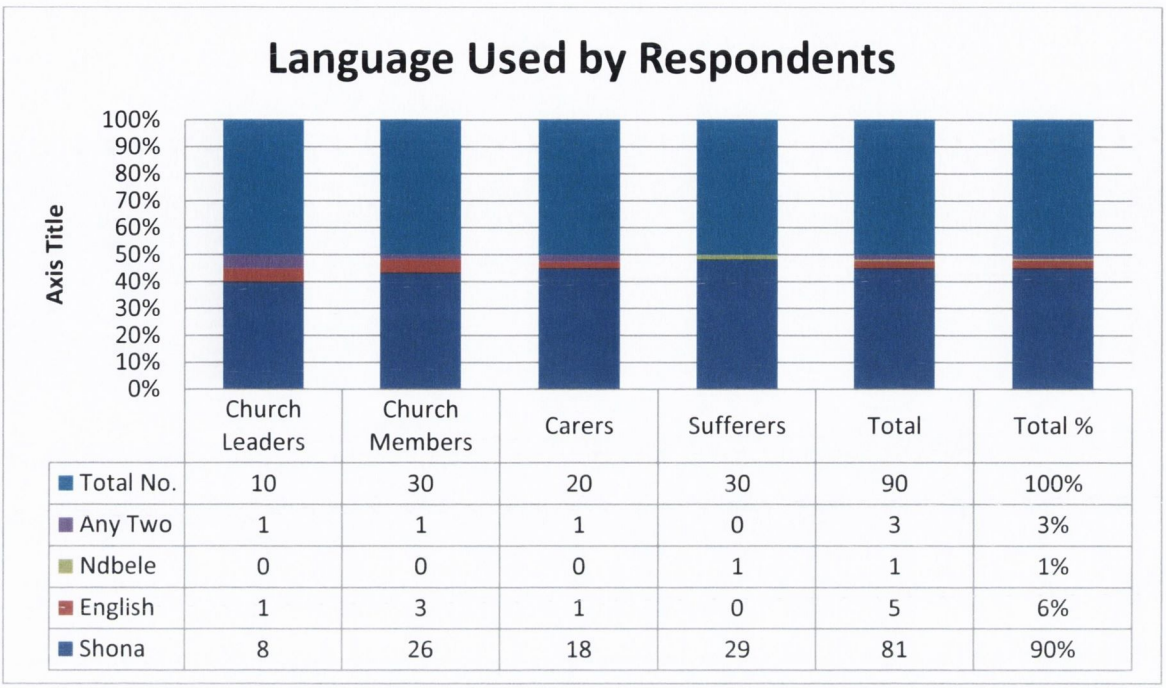
Table 5.1 Composition of the Respondents (Number of respondents 90)



	Church Leaders	Church Members	Caregivers	Sufferers	Total
Male	7	11	3	13	34
Female	3	19	17	17	56
Total	10	30	20	30	90

Table 5.1 shows that, there were more male Church leaders 7 (CL) than female leaders 3 (FL), while there were more female Church members 19(CM) than male Church members 11 among the respondents. This could indicate that, women are marginalized or less represented in Church leadership. Asked about this state of affairs, during the interviews, one Church leader said that, "Considering our African culture, women are not considered to be leaders over men" (interviewee CL1). On the other hand 2 female Church members and one Church leader in interviews and discussions challenged Church rules that reinforced the exclusion of women from leadership on the basis that this could be erroneous as many women would be as good if not better than men (interviews CL 2). The above table 5.1 also shows that there were more female caregivers 17 (men: 3) and sufferers 17 (men: 13) than male, which may in part reflect the fact that more females reside in the rural areas. In an interview and discussion, five of the female sufferers pointed out that, although they were in the majority, men in general were treated better than women in terms of "possessions, education and welfare in the home". During the interviews, caregivers emphasized that caring for the sick was mostly the role of women "as women were more caring and loving than men" (interviewee CG 1).

Table 5.2 Language Used by Respondents (Number of respondents 90)

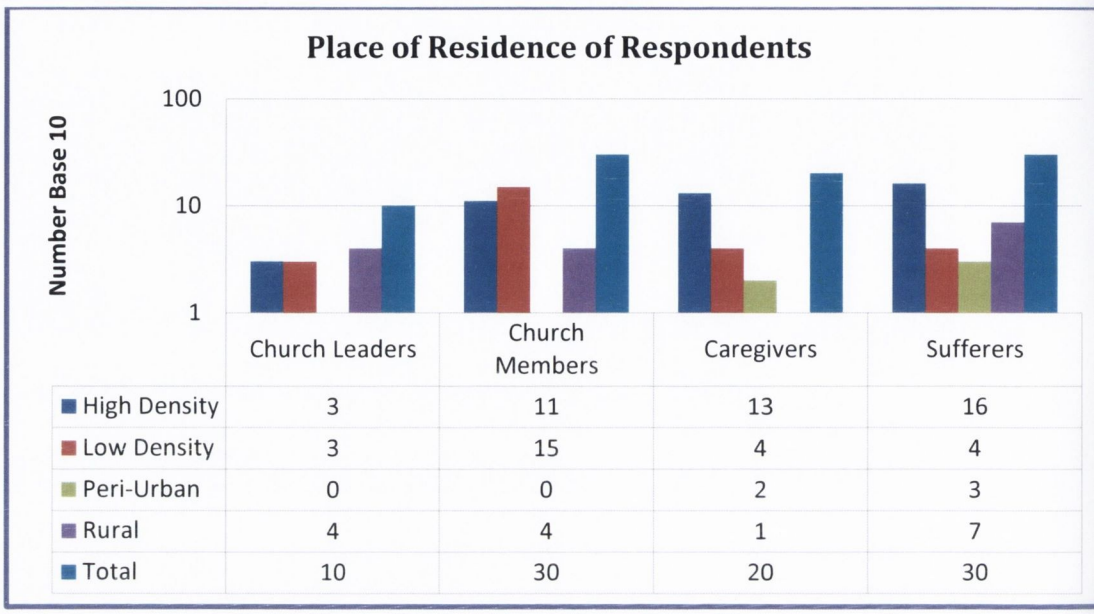


	Church Leaders	Church Members	Carers	Sufferers	Total	Total %
Total No.	10	30	20	30	90	100%
Any Two	1	1	1	0	3	3%
Ndbele	0	0	0	1	1	1%
English	1	3	1	0	5	6%
Shona	8	26	18	29	81	90%

Eighty one of the participants spoke and understood the local language Shona; five were comfortable with English; one was comfortable with Ndebele, another local language in Zimbabwe, mostly used in the southern part of the country; and 3 were comfortable using any of the 2 languages. The preponderance of those comfortable with the local language, particularly amongst the sufferers and care-givers, might imply that, most participants had a low level of education, since English is the official language of education and communication in Zimbabwe. The situation regarding the use of Shona and Ndebele has improved with an increased realisation that even some Church members were also stigmatised.

From the group discussions, interviews and questionnaires, English and Shona were the main languages used. Asked what language was mostly used in writing books, newspapers and preaching in the Church, 100% of the respondents agreed that English was the language mainly used for communication. It is only in recent times that there are now separate preaching hours for those understanding English and those understanding Shona or Ndebele, depending on which part of the country is involved.

Table 5.3 Place of Residence of Respondents (Number of respondents 90)



	Church Leaders	Church Members	Caregivers	Sufferers
High Density	3	11	13	16
Low Density	3	15	4	4
Peri-Urban	0	0	2	3
Rural	4	4	1	7
Total	10	30	20	30

Table 5.3 shows that 48% (43 out of 90) of the participants lived in high density suburbs, 29% (26 out of 90) lived in low density suburbs, 6% (5 out of 90) lived in the peri-urban area, and 17% (16 out of 90) lived in rural areas. Bearing in mind the size of the sample and the distribution between the different residential areas the following observations can be made:

Table 5.4 Residence of Sufferers

Peri-Urban Area	• Number in sample - 5 • 60% HIV/AIDS sufferers
Rural Area	• Number in sample - 16 • 43% HIV/AIDS sufferers
High Density Area	• Number in sample - 43 • 39% HIV/AIDS sufferers

What can we learn from the findings in the above table?

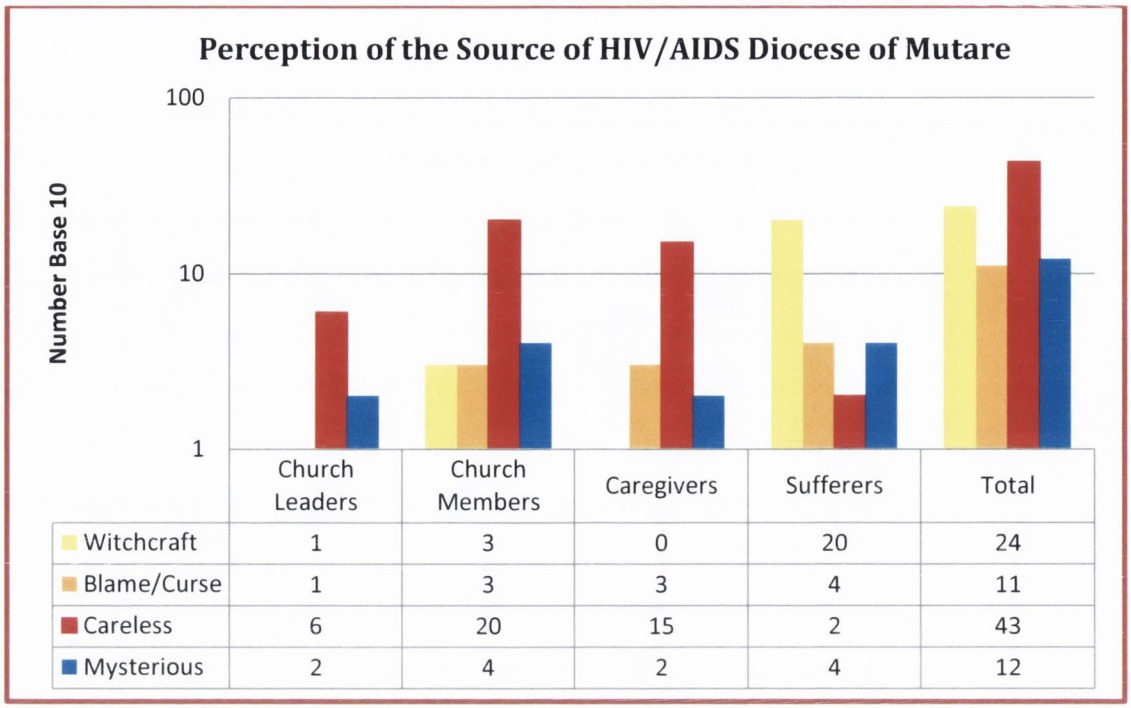
1. It could be surmised that those who live in low density suburbs are better off, better educated and live more comfortable secure lives, free from the disease.
2. As might be expected peri-urban dwellers are faced with more exposure to social pressures of various sorts and so there is a high % of sufferers in the peri-urban area. In this instance, the smallness of the sample needs to be factored into the equation. But overall city/urban life is lived at a faster pace than rural life. Also, African urban areas can have a transient working population and this is also an issue with the spread of the disease.
3. High density areas have their own problems of poverty and people living in close proximity, so it is not at all unexpected to find a high % of the disease in this area.
4. As for the rural %, this can be at least related to poverty, lack of education and lack of rights, particularly for females. Furthermore, rural members returning from working in the cities can also be a source of the disease in rural areas.

5.4.1 Current Perception - Source of HIV/AID

Referring to table 5.4 below:

- 43 (48%) out of 90 said that, HIV/AIDS resulted from the sufferers' own carelessness, analysed as 6 Church leaders, 20 Church members, 15 caregivers and 2 sufferers.
- 24 (28%) out of 90 said that it was a result of having been bewitched, analysed as 20 sufferers, 1 Church leader and 3 Church members.
- 11(12%) out of 90 said that, it was a result of blame/curse, analysed as 1 Church leader, 3 Church members, 3 caregivers and 4 sufferers.
- 12 (13%) out of 90 said that it was a mysterious phenomenon, analysed as 2 Church leaders, 4 Church members, 2 caregivers and 4 sufferers.

Table 5.5 Perception of the Source of HIV/AIDS



	Church Leaders	Church Members	Caregivers	Sufferers	Total
Witchcraft	1	3	0	20	24
Blame/Curse	1	3	3	4	11
Careless	6	20	15	2	43
Mysterious	2	4	2	4	12

Source: Case Study of 90 participants

Table 5.5 below, summarises the information in table 5.4 above in overall numbers and percentages. Indisputably, it can be claimed that the nature, causes and dynamics of stigmatisation are not well understood by the survey participants – a significant matter for practical and pastoral education, which will need to be engaged. The respondents emphasized the experience, effects and prevalence of stigma. This admission of the prevalence of the disease could be a key starting point in developing a new pastoral approach to halt and ultimately permanently stop the spread of stigmatisation in the Diocese of Mutare. Contributions on potential means and ways to stop the disease can come from all interested parties.

Table 5.6 Summary of Alleged Source of HIV/AIDS Diocese of Mutare

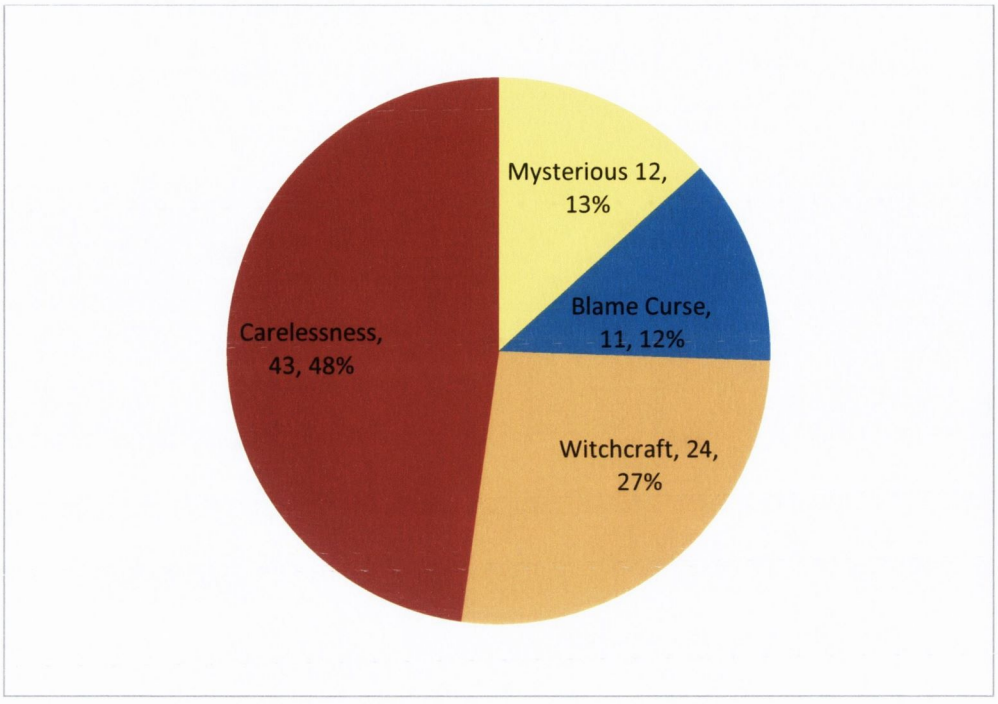


Chart: Own: **-90 Participants**

From the above information, it is obvious that there is a lack of comprehensive knowledge about the disease of HIV/AIDS, its sources, causal factors and modes of transmission. According to the findings above about 43% the alleged source of HIV/AIDS was due to carelessness. This is thought to be due to inappropriate life style, such as, promiscuity, multiple partners, and irresponsibility. However, there may also be a link between carelessness, lack of education and general ignorance. The sufferers were regarded as "spreaders of HIV/AIDS," because of fear by others who thought that they might get infected by the illness through contagion. This manifested an "us and them" perception and approach to the issue.

5.4.2 Modes and Methods of Stigmatisation

From the discussions and interviews, fifty four of the respondents said that the sufferers were stigmatised because they had in some way angered their ancestral spirit's, leading them to be bewitched and hence isolated. This led the researcher to conclude that the respondents recognised the experience (subjective) and act (objective) of stigmatisation, but did not understand the process and interactive steps which caused stigmatisation. As demonstrated in chapters 1 and 2, all steps

in the stigmatisation process are upheld by society for its survival and to maintain its sociological, cultural and religious values and customs. Twenty four of the Church members and leaders said that, previously the preaching regarded sufferers as sinners and the words used were those which discouraged sufferers from believing that they were accepted and belonged.

5.4.3 The Expressed Views of Respondents on Mixing with each Other

From the discussions and interviews, fifteen of the sufferers admitted that, they were not fully aware of some of the risky situations that could have led them into the situation in which they now found themselves. Nine of the sufferers interviewed admitted engaging or being forced or coerced to engage in sexual activities.

5.4.4 Expressed Views and Feelings of Sufferers

According to Table 5.6, 27 of the sufferers claimed that other people were not easily mixing with them. I as researcher in the actual context indeed made the following noteworthy observations: when other people visited the sufferers, they kept at some distance from the sufferers; they were not at ease in shaking hands with sufferers; they rarely used the same toilets; one member of the Church whispered to her sufferers, "Be careful, and do not go nearer the visitor". All of these reveal aspects of ignorance about the nature of the disease and infection and lead directly to the sufferers being marked out and stigmatised as a source of disease, further excluding them from normal social interaction and making them feel unwanted in society.

The above findings show that, the sufferers were isolated, distanced from the rest of the people because they were feared, seen a danger, regarded as sinners or spreaders of diseases. Clearly, stigmatisation was not understood. Twenty one of the sufferers, who had experienced stigma, in the past, also deemed that the stigmatised persons had to be kept apart and left out of what is considered to be a "normal" society. The questionnaire responses about how sufferers felt about their condition and others' relationships with them revealed a further range of practical

difficulties associated with their experience of social exclusion. They verbalised the following:

- Sufferers experienced a lack of basic foodstuffs and finance for their daily needs, which resulted in a very unbalanced diet, at a time when they needed more rather than less help.
- They lacked clothes and bed linen.
- Because of the lack of finance they suffered from trauma and deterioration in their health; they also suffered from lack of appetite (in the opinion of the researcher), most likely related to money and health worries.
- They felt excluded from meetings addressing health and general educational and community programmes.
- The spiritual and psychological aspects of their life were diminished. They spoke of feeling unloved, not listened to, subject to sexual and verbal abuse, and a lack of professional parish care.
- They felt harassed, and exploited by caregivers and others and were stereotyped, demeaned, unwelcome and ostracised.

The above summary suggests a consistent indication of the actual realities that sufferers said made their lives miserable, isolated and rejected. This summary categorization shows a worrying picture of a lack of adequate physical, psychological, moral and spiritual care, caused by social distancing even of carers that adds to the existing burden of suffering of those affected. Most of the "complaints" seem to pertain to lack of an overall or holistic approach to their needs. But basic needs and the lack of spiritual and psychological guidance was also a particular point of concern. (Magesa, 2010: 137). A person who is subjected to sexual abuse, verbal abuse, rape and harassment loses his/her dignity as a result of being exploited. The sufferers feel that they are worthless and are objects rather than agents, barely human beings at all. If a person is not allowed to mix with others, and is rarely visited, that person can feel loss of dignity, ostracized and isolated. These negative attitudes towards sufferers spread stigmatisation and reinforce the stigmatisation process of separation, isolation and alienation, which

the sufferers are prone to internalise in anger, depression or self-blame, all with an impact of deteriorating health.

5.4.5 Expressed Views and Feelings of Caregivers

It is important also to take account of the perspectives and feelings of caregivers. Table 5.6 caregivers tell us that, 18 out of 20 caregivers mixed with sufferers. Asked whether they were not afraid to mix with sufferers, 12 of the caregivers observed that it was "part of their work" with 8 making such observations as, "We have to love those suffering and make them feel they are part of us." These replies do not show spontaneous compassion, love and empathy for those who are suffering, but more like a "job description". From the interviews the sense was that caregivers do what they do with caution. This could be interpreted as doing what they do as it is part of their work. The sense of love and caring may not be prescribed, particularly when there is ignorance about the actualities of cause or risk of contagion, and about the harmful impact of stigmatisation for the sufferers and all of those around them.

5.4.6 Expressed Views and Feelings of Leaders

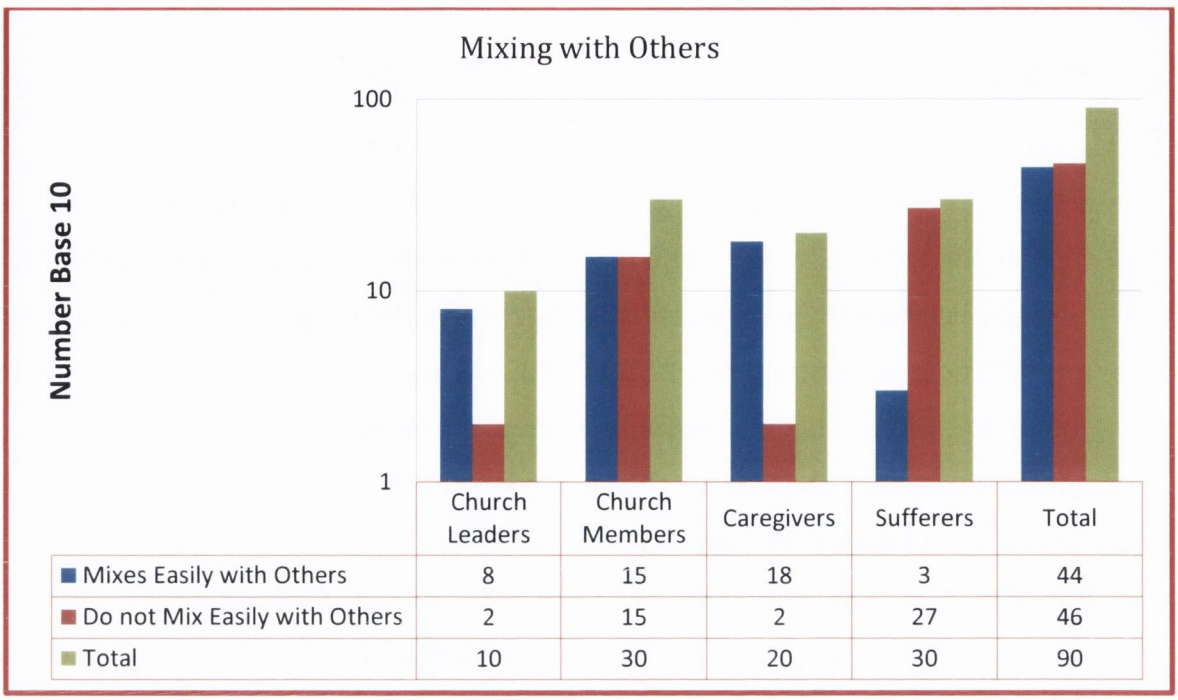
Table 5.6 leaders, shows that, 80% (8 out of 10) of the Church leaders easily mixed with sufferers. 2 out of 10 (20%) leaders did not easily mix with sufferers. If this was a reality, and could be extrapolated across the entire country, this could mean that, there was less stigmatisation of sufferers by Church leaders. This may seem a hopeful starting point in the process of de-stigmatising sufferers in Church communities and challenging the whole stigmatisation process. But, here it must be remembered that contact between Church leaders and sufferers is infrequent and out of touch with daily survival. In fact, 3 of the Church leaders perceived sufferers as threatening, dangerous, fearful, and unfriendly and spreaders of the disease. This was the fact that when the disease was known in the country the 'Motto' used to make people aware was that, "AIDS kills" as well explained in Chapter 3. So there was great fear of the disease and worse still for the infected person was seen dangerous. From a Church point of view, education processes towards de-stigmatisation will need to be comprehensive and systemic across the organisations of the Church at every diocesan and Church level.

5.4.7 Expressed Views and Feelings of Church Members

Table 5.6 shows that, 15 out of 30 Church members mixed easily with the sufferers, while 15 did not easily mix: "Why mix? We have enough of these people in our homes", some Church members said. This indicates a discomfort and dislike of mixing with sufferers. In an interview and discussion, 2 of the Church members were uncomfortable about social gatherings and mixing with the infected; fearing that to be associated with sufferers would increase the risk of contracting the disease. Some Church members "labelled" sufferers as prostitutes or people of immoral behaviour. Clearly, this would have caused sufferers to feel isolated from members of their own Church community.

The expressed views and feelings of Church leaders, Church members, caregivers and sufferers are summarised in Table 5.6. In summary, the split is almost 50/50 between those who felt free to mix easily with sufferers and those who did not. However, at a very basic level 27 sufferers out of 30 (90%) in the sample do not believe that Church Leaders, Church Members and Caregivers mix easily with sufferers. This might explain the feelings of abandonment and lack of physical resources detailed above. It also indicates the scope of the ethical pastoral challenge that needs to be tackled across the Catholic Church in the Mutare Diocese.

Table 5.7 Social Mixing With Others



	Church Leaders	Church Members	Caregivers	Sufferers	Total
Mixes Easily with Others	8	15	18	3	44
Do not Mix Easily with Others	2	15	2	27	46
Total	10	30	20	30	90

5.4.8 Current Pastoral Care and Extent of Reduction of Stigmatisation

According to the responses to the questionnaires (Table 5.6), 8 out of 10 Church Leaders mixed easily with sufferers. However, we also know that 90% of the sufferers surveyed (27 out of 30) were of the opinion the Church Leaders and others did not in fact mix easily. So immediately we are confronted with a difference of opinion in terms of how Church Leaders, Church Members and Caregivers are perceived by Sufferers. The interview process also disclosed that 2 of the Church leaders acknowledged that there was less mixing between Church leaders and sufferers than should be the case. It has already been noted, furthermore that the irregularity of likely social interaction between Church leaders would be an additional qualifier to positive comment about willingness to socially mix with sufferers. 3 of the Church leaders perceived sufferers as threatening, dangerous, fearsome, and unfriendly, and – the bottom line of false perception – spreaders of the disease. One cannot therefore presume that positive attitude and example from Church leaders will provide a good and reliable starting point to work towards de-stigmatisation and to provide pastoral education and

care towards ensuring de-stigmatisation. To promote pastoral care that builds "integrity, transparency and good governance"[306].

The evidence – summarised in Table 5.7 below – rather points to the current quality and level of pastoral care as totally inadequate. Of the 20 caregivers who took part in the survey, 8 cared for 15 to 30 sufferers daily, and each of the other 7 caregivers cared for 21 sufferers daily. As for supervisors, each of the 3 of these supervised the caring of 240 to 590 sufferers twice weekly, and each of the other 2 supervisors oversaw the care of over 590 sufferers once per week. It is likely that caregivers' negative attitude and outlook is influenced by a clear lack of adequate training, resources and time allocation for each sufferer being so short as to make meaningful personal interaction almost impossible. The likelihood would be that carers would feel overwhelmed by the extent of their task. The caregivers were all Church members and supervisors were Church pastors. The above ratio of caregivers to sufferers was too high for effective caring and supervising.

From observations, the caregivers were not able to give individual attention to all sufferers, especially those who were in a critical situation, such as, those who needed assistance in basic feeding or visiting toilets. Obvious questions arise about the gap in thought and action between the Gospel vision of care, inclusiveness, empathy and hospitality.[307] But one must not neglect the structural and training dimensions of the task, and whether within the wider Church community are people and resources that could be called upon to contribute in other diverse informal ways of social interaction that would go some way to mitigating the stigmatisation system that is in evidence and promoting a more effective and better resourced system of pastoral care. Examination of the Table 5.7 reinforces these impressions.

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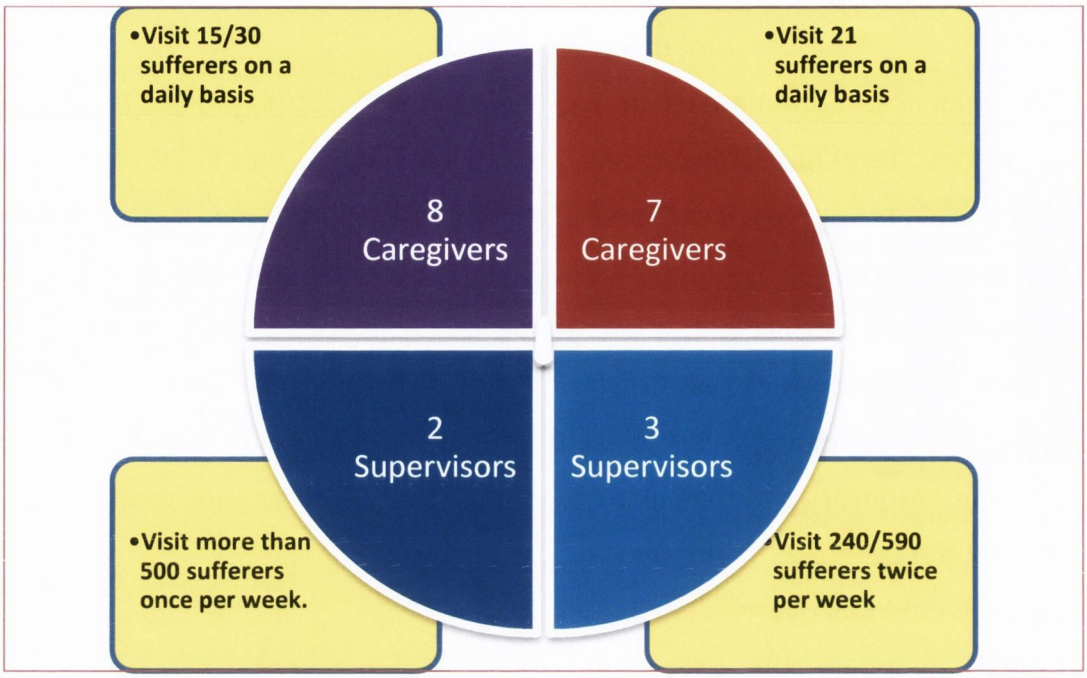
[306] Therese Tinkasiimire, "Moral and Ethical issues in African Christianity: Integrity, Transparency and Good Governance", in Laurenti Magesa, ed. *African Theology comes of Age: Revisiting Twenty Years of the Theology of the Ecumenical Symposium of Eastern Africa Theologians (ESEAT)*, (Nairobi: Paulines Publications Africa, 2010), pp. 57-66.

[307] Richard M. Gula, S.S., *Ethics in Pastoral Ministry,* (New York: Paulist Press, 1996), pp. 9-12.

Table 5.8 Caring for Sufferers (Participants 90, Carers 20)



Source: Own

Asked whether they were managing adequately, all 5 supervisors and 15 caregivers said that, they were finding it difficult to offer adequate care due to the large numbers of sufferers. The carers were expecting the relatives of sufferers to assist them. "Most of the relatives just dumped the sufferers and never came back," the supervisors complained. As for the level of training of the few caregivers and supervisors, the Church leaders said that there were a few caretakers and pastors who were trained and most of these were doing a splendid job in caregiving. Some caregivers and pastors have served in their capacities for 6 to 15 years and showed signs of dedication and commitment in deeply difficult times and conditions. The Church leaders did comment that some caregivers needed more counselling and training, and some said that they were not pleased with the work of some caregivers, especially with those who were not trained, especially where they neglected the sick and distanced themselves from the sufferers.

Again the socio-economic realities must also be kept in view. Most of the sufferers were poor, without basic necessities of life. It must also be recalled that poverty as caused by economic exploitation and unequal distribution or sharing of resources is a pre-determining source of stigmatisation, leaving the poor even more

marginalized. Wider community-based programmes aimed at educating the sufferers, carers and the wider community on how to survive in conditions of dire poverty are a fundamental key in the process of social change.

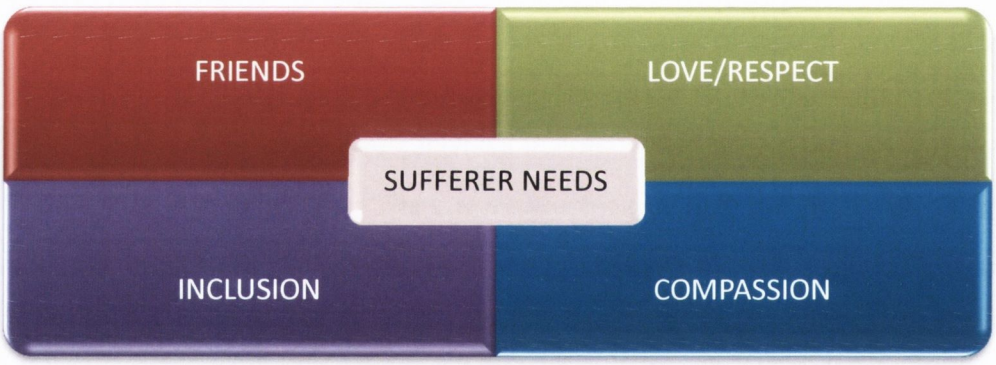
When questioned regarding the adequacy and availability of the assistance, 100% of the respondents admitted the inadequacy and sometimes unavailability of assistance. This reality is likely to play into and intensify the sense of stigmatisation among sufferers. More than one sufferer made the following type of complaint: "We can go some days without treatment and enough food." Without attributing moral blame, this, doubtless, implies that the organizations were not able to provide enough assistance. When asked what the Church leaders and caregivers do when there was a shortage of personnel and commodities, the Church leaders said that, they often ask for the assistance from their development partners in the Catholic Development sector, which include Misereor, CAFOD, Catholic Relief Services, Global Funds, and from the UN and other aid organisations. It was in working through such charitable partnerships that they were able to secure short term assistance for the sufferers and to involve them in longer term advocacy.

From the point of view of the caregivers, they too complained about the conditions and about being harassed by the sufferers. The Church leaders and members also commented upon the resistant attitudes of suffers towards advice, and lack of understanding about their health condition. They ascribed this to a lack of education leading to deterioration in the health and in the ability to take responsibility. It appears, however, that these expressions do not quite address the deeper roots of complaints regarding their desire for pastoral and spiritual care from their parish and professional care from doctors and nurses. Although the Church leaders claimed that approximately 12,000 people benefited from the assistance, the assistance was not effective enough in terms of medical provision or to find ways of dismantling the mind sets and structures of stigmatisation among the sufferers and carers. This poses questions about the underlying vision and resourcing of pastoral care as expressed in diocesan or parish mission statements, and shows that the objectives of these organizations are still not being

achieved. For example, the frequency of visiting the sick and provision of counselling services.

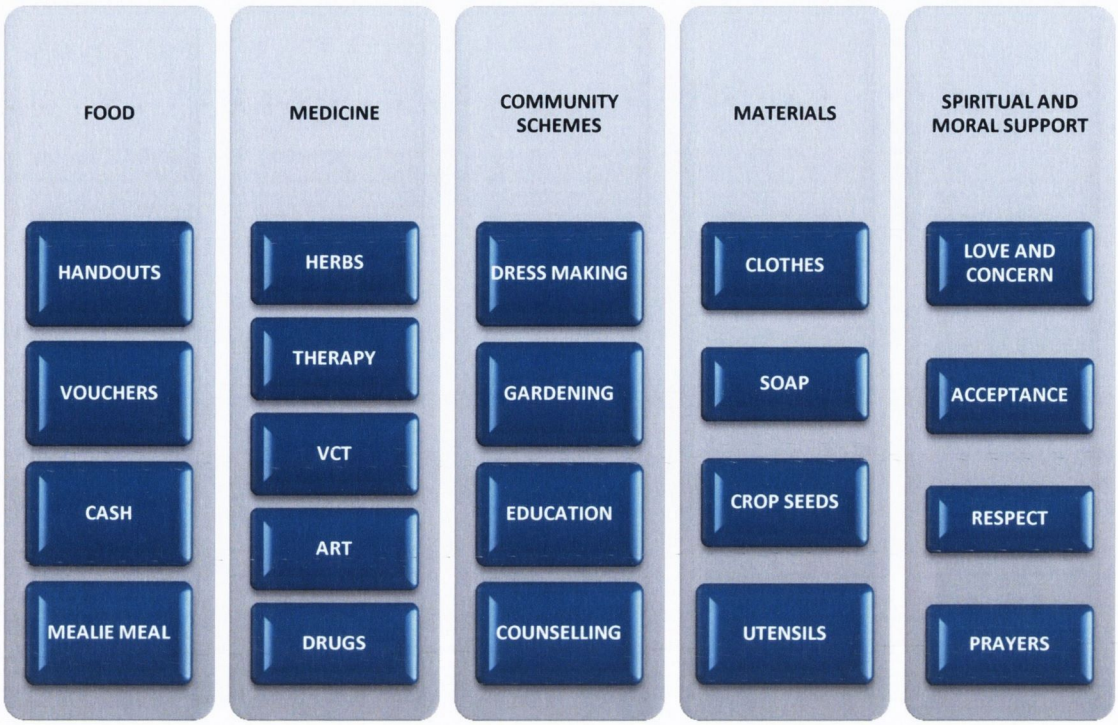
The negative picture emerging is worsened if one builds in the irregular basis of visit's by Church leaders and members, to sufferers in hospitals, clinics, community and home settings The frequency was on average once per week by 21 Church leaders and 4 of the Church members. This could be considered low, given the depth and extent of basic human need and plight of sufferers. In Figure 5.4 below shows the areas where basic needs of sufferers must be addressed in order to reduce stigmatisation. (Maslow, 1977: 20) These basic needs such as food, education, self -esteem, are going to be discussed in detail in the next chapter on developing a comprehensive pastoral approach.

Figure 5.4: The Basic Needs of Sufferers



The questionnaires and interviews have helped the researcher to build crucial information on the areas lacking towards a holistic pastoral approach as set out in the following table.

Table 5.9: Assistance by Type Given to Sufferers



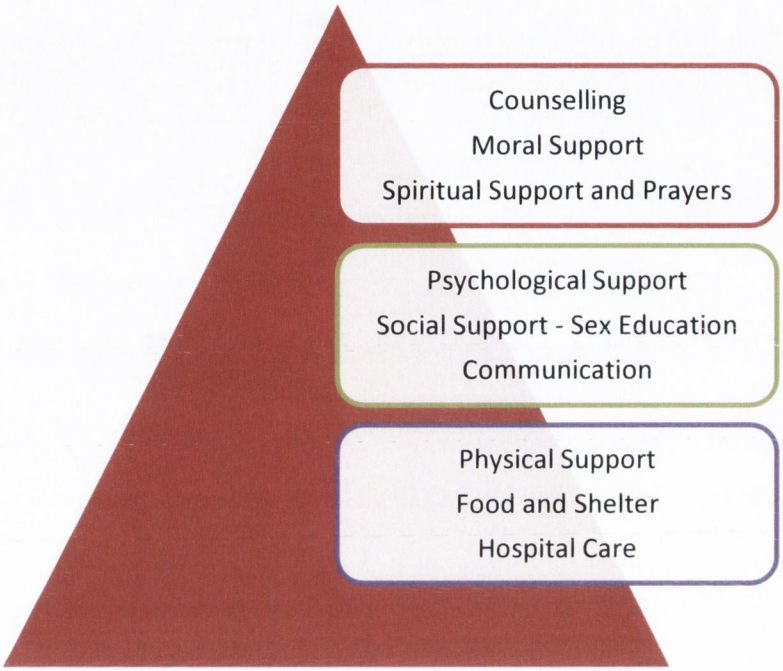
To enable the sufferers to live with dignity and promote self-reliance, strategies need to be worked out in collaboration with the community. For example, the community can develop useful employment in profit making projects such as sewing, gardening, advanced education classes and updating in counselling skills. The Church is superbly positioned to help with all the latter employment projects because of its long standing experience in education. They in turn can become wounded healers in community. The person is supposed to be taken as a whole dealing with all the elements of life situation such as the physical, spiritual, emotional, social and intellectual aspects. This helps to evaluate the pressing needs of the sufferers and be able to address the needs in a just manner. The table below shows the different aspects of human needs that will help to develop a comprehensive approach to satisfy those needs.

Thus, listening to the complaints of the sufferers, the researcher was of the opinion that indeed the sufferers felt isolated, hurt, distanced, demonized, stereotyped, labelled, blamed and rejected. The Church leaders and members, although they realized the need to visit the sufferers, were unable to visit them regularly. Thus, sufferers are often shunned or stigmatised due to lack of resources and the threat of disease. One hundred per cent of the sufferers wanted very much to visit their relatives and friends, but they were themselves reluctant, because of anxiety and fear of being stigmatised. They wanted to be treated as "ordinary" sick human beings. With tears, one sufferer confessed, "One day those who shun me will also become ill and die and I will meet them in the presence of God." The remark showed that the sufferers realise that they are very sick and may only have a short time to live, but that they are hopeful of a life hereafter when all will be revealed in its fullness and truth. From the interviews, discussions and questionnaires 7 out of 10 Church leaders, 20 out of 30 Church members, 15 out of 20 caregivers and 30 (100%) of the sufferers came up with the following suggestions to combat stigmatisation as tabulated in Figure 5.9:

Table 5.10: Further Initiatives and Programmes

Figure 5.5: Other Specific Needs

Besides these provisions, 3 Church leaders, 14 Church members, 5 of caregivers and 12 sufferers emphasized the need for



These recommendations would appear to be comprehensive and include many aspects of human life. However, the suggestions do not pinpoint the negative structural sociological, cultural and religious values, beliefs and attitudes that perpetuate stigmatisation often in concealed ways. Partnership and systemic approaches are needed in the fight against stigma at personal, organisational and institutional level. Any effective approach to combating the disease and the vicious cycle of stigmatisation needs to be value-based, multi-levelled, time-phased and comprehensive in approach – local, diocesan, national and global in scope if stigmatisation is to be removed from the equation of HIV-AIDS.

5.5 Lessons to Learn from the Case Study

My research has shown that the stigmatisation at the heart of the HIV-AIDS pandemic is complex and requires a deep and a nuanced approach to understanding and develops a strategic plan of intervention. In this section, I have highlighted some of the crucial findings that emerged from this case study, to include: isolation, social alienation, stereotyped relationships, gender-based inequality and disempowerment, and ostracism as punishment for perceived deviance. Other areas such as causes and patterns of poverty and social deviance have been well-researched but need to be more specifically correlated to the issue of stigmatisation. So too, the roles of leadership, relevant information and education are also important to explore in future case studies.

The findings of the case study support Coleman's (1988: 26)[308] assertion that those who are different are marked out very definitely as different. In the case study the sufferers were under no illusion, but that they were different.

Within all of the above differences between the insiders and outsiders, the "haves" and the "have not's", we can better understand the nature and interlocking causes of isolation, disempowerment, gender, ostracism and stereotyping which we have seen at work in the case study. Basically, the value judgements by the insiders and "haves" are all positive in their own favour. While the value judgements the "haves" hold in relation to the "have not's" are all negative in relation to the latter. Perhaps a parallel can be drawn, in this instance, with the phrase "power corrupts and absolute power corrupts absolutely".[309] Self-righteousness blinds oneself, uncritical self-righteousness blinds everyone.

Having set the scene, we will now discuss some of the findings which emerged from the case study.

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[308] James S. Coleman. *The American Journal of Sociology*, AJS Volume 91 Number 9 May (1980), (Illinois: University of Chicago, 1986), pp. 1309 -35, 228.

[309]John Emerich Edward Dalberg, Lord Acton (1834–1902) in a letter to Mandell Creighton, April 5, (1887), "Power tends to corrupt and absolute power corrupts absolutely. Great men are almost always bad men, even when they exercise influence and not authority: still more when you super add the tendency or the certainty of corruption by authority." Acton, *Essays on Freedom and Power,* (ed), Gertrude Himmelfarb, (1972) pp. 335–36.

5.5.1 Feeling of Isolation

Sufferers reported feeling isolated because they were regarded as people who had "sinned" (Table 5.4) and who in turn could then corrupt those who had not. Moreover, they felt isolated because many of the people did not understand the "mysterious" disease they were suffering from and thus were in fear that the disease would spread to those not infected. The isolation of sufferers was also pronounced in places where sufferers were residing in high density areas and rural areas, while the Church leaders and members mostly resided in low density areas. As a result of the different place of residence, group mixing was difficult and sufferers were also regarded as dangerous and spreaders of the disease.

So too, evidence points to the reality of the isolation of sufferers as directly linked to lack of solid information and the resulting ignorance and urban myths about the disease. Others' misplaced perceptions and fear of the disease further deepens the isolation of sufferers and the prevailing ignorance as to the facts and realities of the disease.

5.5.2 Empowering the Stigmatised

The findings show that the sufferers were not adequately empowered to deal with being stigmatised. The lack of empowerment was more on the receiving end, with patterns of constructed dependency amongst the sufferers in relation to provision of foodstuffs, medicine, community programmes, and materials and indeed around the area of spiritual and psychological support (Table 5.8). The sufferers also expressed a desire to be empowered to exercise their own initiative in dealing with their illness, and in combating or reducing the vicious cycle of stigmatisation (Tables 5.8 and 5.9). Many existing studies in various areas of development, health and well-being make it clear that rendering people dependent without enabling them to participate, is counterproductive. (Kelly, 2010: 223-225). Empowerment should enable the sufferers to make decisions and choices on those aspects of life that concern them, such as:

- decisions on self-sustaining projects that would assist them;

- decisions made by service providers and partners regarding the adequacy and availability of assistance,
- decisions about spiritual and psychological aspects that concern their lives, and
- decisions on treatment options and care planning
- decisions on how they might alleviate the impacts of unemployment and poverty

Empowering sufferers is about instilling confidence and a sense of agency, doing constructive things to aid their quality of life and freedom in exercising their own initiative.[310]

5.5.3 Gender, Suffering and Empowerment

Historically, women were seen as inferior to men in many aspects of life, particularly in public leadership roles. Although the sufferers and caregivers did not quite elaborate their answers, it can be inferred that there is unequal treatment and role expectations between men and women in Zimbabwean society. The unequal treatment of women is another form of female stigmatisation. For example, "traditionally, women have done the work at home, which is regarded to have a lower status and esteem."[311] "Women also have not been given equal opportunities in education or work outside the home."[312] Women are increasingly advocating for an end to gender-based injustices and are addressing unequal power relations at each stage of the stigmatisation process (Allport, 1954:15). Women can be a powerful agency for development.[313] The institutionalised structures of stigmatisation are failing to silence these voices. Education and participation are key ways to demonstrate that the reduction of stigma and stigmatisation is possible through open debate and the exposure of constricting cultural values and practices. These injustices towards females need to be more consistently tackled by Bishops, Bishops' Conferences, at regional and parish levels. There is need for education to give people knowledge of the value of the other person to avoid stereotyping.

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[310] Kelly (2010), p. 219.
[311] Martha C. Nussbaum(1992) pp. 140-143.
[312] Ibid. (1992), p. 142.
[313] Martha C. Nussbaum, *Women and Human Development: The Capabilities Approach* Cambridge: Cambridge university Press 2000, pp. 42-44.

5.5.4 Stereotyping & Scapegoating

In the case study, Tables 5.4, 5.5 of the respondents said that, sufferers have done something wrong to annoy their ancestral spirit's (table 5.5) and had to be punished for their carelessness. In other words, the wrong doers were treated as scapegoats. This was accusatory and judgmental, seeing the other side as wrong to justify one's position. The Church leaders, members and caregivers accused sufferers of harassing them, of having a lack of understanding of their health status and of having negative attitudes towards accepting advice on their health status. All of these accusations only made the stigmatising and scapegoating worse.

Church leaders, members and caregivers and sufferers stereotyped each other as a defensive mechanism, both sides therefore suffered as a consequence of the stereotyping. This illustrates the systemic nature of stigmatisation which damages all concerned and increases the human tendency to over-rely on third parties to solve one's own problems. A more interdependent approach to care planning, in which sufferers and carers and families all contribute ideas and solutions, would be an enhancement for all concerned (Chitando 2007:19). Moreover, re-education on atonement theology will be vital to combating traditional beliefs and myths, with more emphasis on an all-encompassing, all-embracing God of love and compassion.

5.5.5 Ostracism

Sufferers complained that they were, prevented from attending functions and recreational activities with others, starved of professional and pastoral care, harassed, isolated, not listened to and not welcomed, even demonized and not regularly visited and as such they felt ostracised (Table 5.4 and 5.6). In this thesis, to ostracise refers to the exclusion of a person by general consent from the community or society.[314]

5.5.6 Love and Compassion

The sufferers complained of not being loved, not being taken care of properly (Figure 5.4) and some complained of violation of their human rights. They related

[314] The Penguin Group Clays Ltd. St Ives pl. England, page 623.

these complaints specifically to the attitudes and behaviour deemed lacking in Church members, leaders and caregivers. Surprisingly, at a macro level, the Church agents were spearheading excellent projects in the diocese to include home based care, mother-to-child ARVs provisions, health education, behavioural change programmes, basic medical care, voluntary counselling, testing, self-help projects and general counselling services. However, sometimes an allusion to an apparent lack of love and care in these ventures was made by the sufferers. Some sufferers referred to the poor quality of love or lack of it and compassion in the implementation of the strategic initiatives, programmes, and interventions aimed at reducing stigmatisation, (Chitando 2007:41).There is a need to evaluate the quality of pastoral care offered to the sufferers, for example, lack of listening skill and welcoming of sufferers (Table 5.7). As discussed in chapter 4, being listened to and being welcomed are sources of healing and help eliminate stigmatisation. In biblical accounts, for example, in the Gospels, there are many examples of Jesus listening and speaking to the sick before healing them. He welcomed and healed everyone in need whether rich or poor, sick or dying and also showed concern especially for the disadvantaged.

Within a Christian community of carers, such narrative traditions and loving ways of relating to others, needs to be correlated specifically with comparable situations of the Church's work in today's world, not least in the context of HIV-AIDS and the need for healing, love and justice for those suffering from its devastating effects. There is need to promote the African concept of "*Ubuntu*" that is "struggle against discrimination based on race, sexuality, age, physical ability and other factors" (Chitando 2007: 56-7). "*Ubuntu* challenges individualism and indifference. It provides a framework for solidarity and active compassion."[315] This is going to be discussed in detail in "Justice Model" in the next Chapter.

5.5.7 The Need for Inclusive Commitment and Involvement

The Catholic Church's teachings on medical and moral matters have been made applicable to the ever-changing circumstances of health care and its delivery. In

[315]Ezra Chitando,(2007), p. 56.

1981 the Catholic Church published the *"Ethical and Religious Care Directives"* calling for all Catholics to share (social responsibility) in the healing mission or ministry of the Church. The Church expressed the need for full commitment and involvement of everyone in the health care ministry; reaffirming the ethical standards of behaviour in health care that flow from the Church's teaching about the dignity of the human person; and providing authoritative guidance on certain moral issues that face Catholic health care today. (Jackson et al., 1999:47).

Despite these commitments there is still a dissonance between these ideals and the Catholic Church's' teaching on issues of sexual morality and sin, which have been shown to play a part in processes of stigmatisation of AIDS patients. This is a complex area and much work has still to be done to reconcile the teachings of the Church with the present facts surrounding HIV/AIDS sufferers. But at the very least, discussion must begin with listening to the first-hand experience and needs of those who are suffering from judgmental approaches to sexuality and to perceived social deviance.

The Church leaders, members and caregivers by their own mission statements aim to embody Jesus Christ's concern and acts for the sick in their care ministries. Jesus Christ's healing ministry went further than caring and treating only for physical affliction. It touched on the deepest level of existence, (physical, mental and spiritual healing, as will be detailed in chapter five). The Gospels portray Jesus as concerned to give abundant life to all who suffer and long for healing and salvation. (George, 2009:244). In the Christian dispensation, acts of healing are inspired by, Christian love, compassion and suffering as a participation in the redemptive power of Christ's passion, death, and resurrection. (Chitando 2007:58-59). "The compassion that ensures from *Ubuntu* should equip African Churches for prophetic role in the era of HIV. If 'I am because you are' it follows that your pain is my pain." (Chitando 2007:58; I Corinthians 12: 26a). This Gospel based contrast-consciousness may have been in the minds of the sufferers when they lamented, the lack of professional, pastoral care, or not being listened to or welcomed (Table 4.5 and 4.7). The Gospel had led them to expect more.

5.6 Summary

This chapter documented the realities of stigmatisation in the Roman Catholic Diocese of Mutare, Manicaland Province, Zimbabwe based on a case study carried out in Manicaland Province during the spring of 2010 by the author. The case study highlighted failings on both the side of those offering care and advice and the sufferers. Nevertheless, there is a cause for hope as all sides become more expert in dealing with the situation and as more information becomes available regarding how to deal both with HIV/AIDS and its accompanying stigmatisation. So too, the Church needs to refrain from linking discourse about sin and blame with discourse about HIV/AIDS. Not to do so will maintain the vicious cycle of stigmatisation in counter-witness to the Gospel and to the core values of Catholic Social Teaching.

Church leaders, members and caregivers, and sufferers had attitudes that discredited or stereotyped each other to justify each other's actions, for example, the failure to see the realities in the inadequacy and unavailability of assistance. There was also a failure to realize that stigmatisation is a process (vicious cycle) that is embedded in community, social and also Church structures in the Roman Catholic Church Diocese of Mutare, for example, isolation as a result of negative labelling of those who reside in high density areas as spreaders of HIV/AIDS. Social distancing from sufferers due to fear of "catching" the disease is practiced by withdrawing normal contact and visit's, this then becomes one more weapon in the armoury of stigmatisation. These processes lead to isolation and disempowerment of sufferers, widening the prevailing imbalances in gender power relations, intensifying patterns of stereotyping, scapegoating and ostracizing of sufferers and all who are close to them. (Share and Lalor, 2009: 110-114).

The practical realities of stigmatisation, as deduced from the case study, were reflected in the behaviours of Church leaders, members and caregivers as well as sufferers, for example:

- they were not at ease in shaking hands with sufferers;
- They rarely used toilets used by sufferers;

- Using judgemental language such as sin and blame and lack of morality
- Using English as a preaching language when poorer people spoke Shona.
- Not involving sufferers in various activities
- Not consulting sufferers about programmes to help them

Of course the sufferers may neglect taking full responsibility for their state of health and not being proactive enough in seeking assistance in the early stages of the disease. I believe that here we can also mention that sufferers may listen more often to local "shamans" traditional healers than to medical experts. Due to their cultural and traditional practices it was not easy to introduce some programmes. Some of the existing HIV/AIDS intervention programmes were based on assumptions rather than on reality factors and so I did not include the active involvement of sufferers in deciding on the needs and strategies of care required by them. All in all, the vision and mission statements and programmes lacked some elements of ways and means of arresting the steps of stigmatisation as a process. They also failed to tap into biblical resources such as parallel biblical texts, teachings and examples from the life and the ministry of Jesus as recorded in the Gospels. This will be addressed more explicitly in chapter five.

Aspects of stigmatisation such as isolation, labelling, stereotyping, scapegoating, unbalanced gender relations and patriarchal leadership, and underlying, structural poverty and injustice and specious attribution to sufferers as spreaders of disease, cannot be reduced by individuals' behaviour change or single sector change alone. These aspects of stigma are interrelated and interlinked to the extent that, they concern human life in its totality, that is, physical, mental and spiritual and cultural in their personal, social and systemic dimensions. It would be difficult to isolate such aspects of stigmatisation without also paying attention to the religious – and in this case, specifically Christian dimensions, including the fundamental belief that each person is created by a loving God in his own image, unique in dignity and capacity. Reduced to victimhood, on the contrary a person finds themselves religiously isolated and isolated and socially alienated. (George, 2009:131-142).

This leads to the need to discuss human dignity and human interrelationship which can be summarised in terms of Recognition, Acknowledgement and Welcome ("RAW") process, which will be dealt with in chapter six.

Chapter 6 A Holistic Pastoral Approach to HIV/AIDS Sufferers

6.1 Introduction

The last chapter surveyed the empirical evidence from field work concerning the case study and identified certain weaknesses in the current pastoral care approach in the diocese of Mutare. In this chapter an argument for a holistic approach to pastoral care will be developed. Pastoral work is the caring activity that takes place when the people of the Church demonstrate compassion, empathy and solidarity with the hungry, the sick, the homeless and the poor, drawing theologically and practically on biblical traditions and particularly the view of Jesus' ministry towards the sick, as well as contemporary pastoral theology and praxis. Thus, a case will be made for a holistic pastoral care model for stigmatised sufferers of HIV which cares for the person in the context of family and community and which addresses the wider socio-political context within which stigmatisation is caused, reproduced and enacted. I shall develop my own model for this care at the end of the chapter.

6.2 Hebrew Approaches to Sickness

As with all the neighbouring cultures the Hebrews practised healing in close connection with religious expression. The Book of Leviticus shows priests playing a physician's role and assuming responsibility for enforcing sanitary laws, a first in medical history (Lev. 13). Leviticus holds to this position even after Elihu comes and repeats the arguments of Job's three friends that he must have sinned'.[316] Job's point of view is summed up in chapter 16:12-13. Morton Kelsey maintains that the nature or brand of teaching in the book of Job was not fully accepted by Hebrew orthodoxy but that its influence was felt, nonetheless, 'in the less orthodox region of Galilee, where a rich demonology had grown up and sickness was understood, in part at least, as the result of evil spirits rather than as coming solely from Yahweh'.[317] This is the context out of which Jesus emerges. Equally important, it

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[316] John A. Sanford, *Healing Body and Soul – The Meaning of Illness in the New Testament and in Psychotherapy,* (Leominster: Gracewing, 1992), p.15

[317] Morton Kelsey, (1976), p. 45

reminds us of the importance of taking the socio-political context of sick and suffering people into account in any holistic pastoral approach, to people's actual needs. Texts in Isaiah and Hosea provide further examples, portraying the realities of forgiveness and healing as a saving from death and sin. Sin is presented as "a barrier that separates humans from God" (González, 2005:160). Such texts also show that healing is of the whole person-body, soul and spirit – in all aspects of their lives- personally, socially, morally, spiritually and cosmically.

It also shows the priests practising folk medicine in the role of sorcerers, disease-demons, dealing in magic and the gradual if grudging emergence of empirical medicine. Sorcerers, most of who, in Hebrew culture, seem to have been female, were believed capable of bewitching people and attacking them with demons. [318] Consequently, recourse was had not just to priests but to other sorcerers for healing.[319] George Dawson notes the use, even by priests, of talismans, amulets, incantations, charms and phylacteries, as well as religious rituals.[320] In many cases, in the texts of the Old Testament, we note that official attitudes to sorcery were severe, including the death penalty (Exodus 22: 18, Deut. 18: 10-12). Yet, there are many Old Testament passages pointing to belief in demonical powers. Regardless of whether these refer to ghosts, fallen angels or the rejected deities of other nations, it was believed that they could cause disease, disaster and death.[321] In fact, belief in magic, demons, sorcerers, as well as in priestly methods of healing continued up to the time of Christ.[322]

In summary, John Wilkinson's claim that the concept of health in the Old Testament may be presented in four propositions, centred on the notion of *shalom* is useful for our purposes.

Thus, health refers to:

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[318] Saul's encounter with the witch of Endor is an important example of the ambivalence towards sorcery in Hebrew life. I Sam. 28:7-25, Is. 2:6, Jer. 27:9.
[319] George G. Dawson, *Healing: Pagan and Christian,* (London: SPCK, 1935), pp. 89-111.
[320]John P. Baker, *Salvation and wholeness: The Biblical Perspectives of Healing,* (London: Foundation Trust, 1973), pp. 23-24.
[321] George Dawson, (1935), p. 101-111.
[322] George Dawson, (1935) p. 101-111.

- a state of wholeness and fulfilment characterizing the person's whole being
- an ethical aspect centred on obedience to Divine Law
- a spiritual aspect centred on the qualities of relatedness
- a physical aspect centred on the twin qualities of strength and longevity.[323]

This all-inclusive point of view takes the total interconnection between being and relationship into account. The word *shalom* occurs about 250 times in the Hebrew Bible. It refers positively to a wide range of meanings encompassing a dynamic condition of relatedness characterised by completeness and fulfilment that expresses the divine nature itself. The quality of life mattered at every level, physical, moral, and spiritual. The conceptuality of *shalom* is also connected to obedience and righteousness. Obedience opens the possibility of a creative relationship with *Yahweh-Shalom*, (Judges 6:24). According to Ps. 119: 165, 'Great peace has those who love thy law; nothing can make them stumble.' In the Hebrew Scriptures, *shalom* lies at the heart of the notion of health and wellbeing in its fullness - embracing prosperity, bodily health, contentedness, good relations between nations and salvation. In fact, *shalom* has to do with fulfilment, completion, wholeness and perfection of the most comprehensive part of a process in which the person, the community, the land and indeed the whole of creation is healed. [324]

Nevertheless, there is also considerable evidence pointing to an alternative view of experience and belief about healing in the Old Testament. This maintains the God-ward vision and presents a countervailing view to that of the Deuteronomic, legal and penal understanding view.[325] This tradition is found in various healing stories, especially those concerning childless women, the healing of children, Naaman the leper, and the somewhat magical abilities of Elisha.[326] The most significant

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[323] John Wilkinson, Health *and healing - Studies in New testament Principles and Practice,* (Edinburgh: The Handsel Press, 1990), pp. 4-7.

[324] Marion Maddox, *The Christian Healing Ministry: A New Edition of the Classic Study of Christian Healing*, (London: SPCK, 1991), pp. 10-11.

[325] Morton Kelsey, *Healing and Christianity: The First comprehensive History of Healing in the Christian Church from Biblical Times to Present*, (London: Harper and Row, 1976),pp. 33-34. 41-45

[326] Gen. 18:10-14; Judges, 13: 2-24; 1Sam1:1-20; Kings 4:8-17; 1Kings 17:17-23; 2Kings 4:18-37; 2 Kings 13:21.

argument against the Deuteronomic theory of sickness and healing is found in the book of Job.[327]

John A. Sanford, writing from the perspective of inner healing and psychological insight, in today's world, proposes that, 'the genius of the book of Job lies in Job's refusal to accept the blame for his illness; he maintains steadfastly his innocence and does not agree that he deserves his suffering. In some instances, God is shown as using balm to soothe or astringent lotions to heal, by drawing out the source of infection. God is portrayed as seeking the abandoned and lost, healing and binding up the broken and restoring them to the heart of the community. The God of the Covenant, who showed a relationship by doing likewise for those among them "the Poor" and in most in need, (Ezekiel 34).

6.3 The Compassionate Face of God

The New Testament, in continuity with many of the Psalms and Prophetic tradition, shows that Jesus in his life and ministry manifests the God of the Covenant the God of compassion, liberation and healing. In the New Testament portrayal of Jesus, the Gospel writers show Jesus to be in continuity with this prophetic tradition – associating himself with such prophetic actions among the downtrodden and excluded ones, for example, in Lk. 4, harking back to Isaiah 61 with direct quotation, thus recalling for those around him earlier remembrance of biblical healings through the power of God's Spirit, and specifically before he performed an act of healing, thus showing that his ministry was a furthering and a radicalising of God's covenant and kingdom in a new time.

Paul would later pick up on this through his favoured symbolic structure of "the Body of Christ" (George, 2009: xi). While Paul's purpose is primarily to denote the relationship between Christ and his Church as a relationship of participative oneness, and the relationship of members of the Church to one another as bearing that same quality of interrelationship of communion, it is significant that he uses

[327]Morton Kelsey, (1976), pp .44-45.

the image of the body, health and dynamic wholeness to evoke this[328]. If one part is sick the whole suffers and vice versa (1Cor. 12). Paul's insight clearly derives from his profound sense of the actual person of Christ, and of Christ's ministry of healing as an embodied manifestation of his saving love (*salus* in its Latin root means salvation and it also signifies health and wellbeing). More than one fifth of the gospel stories are devoted to Jesus' healing ministry and forty-one instances of mental and physical healings are listed."[329] The tradition of healing presents one key way in which the gospel writers understood the saving power embodied in Jesus, that has been handed down to his followers as a pattern for them in living as his body on earth and in continuing his healing ministry.[330]

Pastoral care is one important sphere of the Christian life that is grounded in and can be enhanced by learning from Jesus' teaching and the way he lived and carried out his ministry of healing. Thus, he touched, fed, and forgave sins, setting free all those who lived in bondage. Bernard Häring, the profoundly influential Catholic theologian of the mid twentieth century, who revived the personalist, gospel-centred (rather than legalist and abstract) emphasis that had prevailed previously, identifies the Good Shepherd as the key icon of Jesus as pastor and healer. As noted already, these images find their origins in earlier biblical texts such as Ps. 22, 23 or the Prophet Ezekiel (Ezk.34:11-16.)[331] One notes the connection in this image of the Good Shepherd laying down his life, with that of the Body of Christ in its emphasis on relationship, wholeness, oneness and solidarity of suffering and joy as well as resurrection to new life '*en Christo*/in Christ' a fundamental term in Paul. (George, 2009:127).

Jesus' readiness to die for his sheep is at the heart of his close relationship with the Father, which allows him to embrace the Father's will in an act of sovereign

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328 Francis Cardinal George, O.M.I. *The Difference God Makes: A Catholic Vision of Faith, Communion, and Culture,* (New York: The Crossroad Publishing Company, 2009), p. xi.

329 William J. Bausch, *the Parish of the Next Millennium Mystic,* (CT: Twenty-Third Publications, 1998), pp. 176-177.

330 Roger E. Davis, (art), 'Medical Science before Christ' in John Crowley Smith, (Ed), *Religion and Medicine,* (London: The Epworth Press, 1962), p. 5.

331 Bernard Häring *Healing and Revealing: Wounded Healers: Sharing Christ's Mission,* (Slough: St. Paul Publications, 1984), p. 10.

freedom.[332] It sees him take on the appalling suffering of the outcast, the unclean, the poor, the sinner, thereby revealing the true image of God.[333] Clearly then, healing reveals Jesus in total solidarity with broken creation and shows the world the pain God endured in healing humanity. It reveals love and compassion for each created being and for the whole creation as the motive for divine action and demonstrates that nothing is excluded from redemption except stubborn resistance to Jesus' redeeming love poured out in the grace of the Spirit.[334] The core imagery of Jesus as the wounded healer is found in the Prophet Isaiah – 'and through his wounds we are healed' (Is. 53:5). The wounds of Jesus are intimately linked with his mission as Saviour and Healer. [335]'In Jesus Christ, God reveals himself to us as a God of compassion. This divine compassion is God's being with us as a suffering servant'.[336] God also revealed himself as a liberator in Jesus Christ, (Is. 53), Jesus came to set free the prisoners and the broken hearted (George, 2009:135). God, who is compassionate, feeds, heals, and restores justice to his people.

6.4 The Compassionate Jesus

Jesus was a living sign of God's self-disclosure on earth.[337] In John's portrayal he is "the Word made flesh" (Jn. 1: 14). He had power to give life to humanity. In his mission on earth, Jesus was moved with compassion seeing people who were outcasts, suffering from different diseases, people whom society considered inferior and who were treated differently. Filled with compassion, Jesus in Mark's Gospel (1:40-45), was able to heal the leper. He showed great compassion by coming closer to the leper, touched him and commanded the leprosy to leave him. Similarly in Mathew's gospel, (14:13-14) Jesus was moved with compassion and he healed all those who were sick in the multitude surrounding himself and his followers. Jesus also had compassion on the man whose child was possessed by a

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[332] Pham Perkins (art.), 'Gospel according to John NJBC (61:134-144,) New York: Geoffrey Chapman, ***1990,*** pp. 968-969.
[333] Bernard Häring, (1984) p. 11.
[334] Ibid. (1984), pp. 10, 17, 25.
[335] Albert Nolan *Jesus Today: A Spirituality of Radical Freedom,* (Maryknoll, NY: Orbis Books, 2006), pp. 77-88.
[336]Henry, J., Nouwen, D.P. McNeili and Douglas A. Morrison, *Compassion,* (London: Darton, Longman and Todd, 1980), pp. 34-36.
[337] Ibid. (2010), pp. 40-46.

demon (Lk. 9: 37-43). He cast out the demon, praised the father's faith, healed the child, and, significantly, *restored the boy to his father* . In curing the boy, he also restored the capacity for relationship. Such examples are typical within the Synoptic and Johannine accounts where Jesus showed compassion and people were made whole again, the blind, the lame, the dumb and many others were healed. Frequently, the healing is followed by an instruction or a gesture which symbolises the readmission of the healed person to full life in the community (the healed lepers, for example, are told to go and show themselves to the priest. This brings the healing to symbolic and actual completion, personally and publicly, physically, emotionally and spiritually. The significance of not overlooking stigmatisation in the pastoral approach to those who are sick, excluded or scapegoated could not be clearer.

6.5 Jesus and Jewish Law

The religious authorities of Jesus's day thought God "was a God -whose-passion-is the-observance-of-the-Law." Whereas, the God of Jesus, in line with the God of the Prophets, was a God "whose-passion-is-compassion."[338] In much Jewish theology of the time, God's passion was the observance of the Law rather than the full covenantal life of *Torah*. As revealed in the Hebrew Scriptures this was the opposite of God's relationship with His people. God wanted his People to be able to help one another, and relate justly with Him and all others. The Law was more profound than the laws in the strict legal sense and required great study and understanding. The law was the source of the values and richness in the relationship between God and his people. The underlying authentic relationships between God's people was aimed at the involvement of "everyone to be compassionate and caring to all, and demanded structures that would serve to prevent injustice and oppression amongst the People of God."[339] Jesus, as God's Son, revealed the pastoral compassion of the Father towards all the poor and rejected ones. He embodied earlier biblical calls to justice and compassion (Amos 8:4-6, Isaiah, 10: 1-2, Micah 6:8, Lev. 25: 10-17, " [t]his and only this ... to act justly, to love tenderly..." . He was being inclusive of the sick, the poor and the sinner. He

[338] Peter McVerry (2008), p. 57.
[339] Ibid. (2008), p. 57.

did not exclude, but, rather, included all[340]. The law was to be lived relationally, not observed at the expense of that in need.

Jesus was conscious of the problems of the people and welcomed everyone in need. We read in Matthew's Gospel that Jesus went about all of Galilee, teaching in the synagogues, preaching the gospel of the kingdom, and healing all kinds of sickness and disease among the people. Then His fame went throughout all Syria; and they brought to Him all sick people who were afflicted with various diseases and torments, and those who were demon-possessed, epileptics, and paralytics; and He healed them (Mt. 4:23-24).[341] It is vital that radical theological and ethical insights from biblical revelations of God's compassion, justice, healing and care for all creatures, and from the witness of the life, ministry, death and resurrection of Jesus Christ are recognised. Therefore, it is timely now to explore the implications for practical theology and pastoral practice in the Church (Mac Greal, 1994:25).

6.6 The Church Embodying the Life of Christ

The Church understands itself as guided by the light of Christ who gathers people together. People are always drawn together in their social life, cultural links and work relationships.[342] This seems to explain why so many of the images and models of the Church in the New Testament are essentially interrelational, centred on Christ and enlivened by the Spirit. Thus, "[t]he Spirit dwells in the Church and in the hearts of the faithful, as in a temple.(1 Cor. 3:16; 6:19) " All are called to union with Christ who is the light of the world, from whom we come, through whom we live, and towards whom we direct our lives."[343] The Church is relational and it is always living in the present and in the world of history. "Configuration to Christ creates a communion in which differences as well as similarities are shared" (George, 2009: 309). Thus, the Church is to be "the place where the abiding presence of God in Jesus Christ can be discerned and experienced"[344]. The Church is not just or even primarily an ornate building or an institution or a hierarchy. The

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[340]Donald Dorr, Spirituality *of Leadership – Inspiration, Empowerment, Intuition, Discernment,* (Dublin: Columba Press, 2006), p. 24.
[341] Ibid. (1990), pp. 43-44.
[342] William J. Bausch, (1998), p. 178.
[343] 1 Cor. 3:16; 6:19
[344] William J. Bausch, (1998) p. 179.

significance for Paul of the Body of Christ as the key ecclesial image has been noted above.[345] It is seen by several practical theologians as a key concept and symbolic expression of a practical theological ecclesiology.[346] A prevailing reading of Ephesians and Colossians emphasises the headship of Christ and the subordination of the total Church to him. But it is the earlier vision of 1 Cor. 12 that is the truer representation – with no reference to hierarchy or to headship, but rather a model of dynamic and interpretational Christ-centeredness and *koinonia* or communion in diversity.[347] So too, if we examine the language in John's gospel, Jesus speaks of bodies, which are made new of water and spirit in baptism, testifying to the centrality of embodiment in the earliest discourse about the Church's own self understanding and ecclesiology. It must also be acknowledged that the "Body of Christ" metaphor and symbolic structure has in certain eras and contexts been read in more static and hierarchical terms which, for example, in some ways gave legitimacy to inequality and injustice.

And yet, once care is exercised in avoiding such erroneous interpretations, it remains a deep and appealing way of speaking of the Church,[348] McFague (1993:205) sees embodiment as a model of other religious traditions. She too proposes that it should be used in conjunction with other models for the Church – pilgrim people, liberating community, or as a fellowship of friends.[349] Hence the New Testament concept of the "Church" aligned to the Old Testament concept of "People of God" are intimately related, and help safeguard that inter-relationship, and ensures that hierarchical interpretations of the Body of Christ understanding of the Church remain inclusive and dynamic, rather than hierarchical and static in its fundamental realities.

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[345] Walter Kasper, *Theology and Church*, (New York: Crossroads, 1989), p. 152.
[346] Christo Greyling, 'Poverty, HIV and AIDS – Challenge to the church in the new millennium', in Couture, P D & Miller-McLemore, B J. *Poverty, suffering and HIV/AIDS: International Theological Perspectives*, (Cardiff: Cardiff Academic Press. 2003), pp. 117-136.
[347] Richard R. Gaillardetz, *Teaching with Authority: A Theology of the Magisterium in the Church,* Collegeville, Minnesota: The Liturgical Press, 1997, pp. 8-9, 17.
[348] S. McFague, *The Body of God: An Ecological Theology.* (Minneapolis: Fortress, 1993), p. 205
[349] Ibid, (1993), p. 205

6.7 The Church Participating in Trinitarian Love

The essentially relational dimension in the many New Testament models of Church or *ecclesia* has been underlined - people of God, living temple, household of God, covenant and community come to mind[350]. Some scholars such as Paul Minear, for example, point out how these resonate, with the later emergence in the early centuries of the Church, with the intrinsically relational understanding of the Trinitarian God, as sustaining the consequence for the Church, to embody this Trinitarian reality in her life and work "the Body of Christ" the "Temple of the Spirit", "vine, flock, bride, and wedding party."[351] The three images "indicate the Trinitarian roots of the Church are being." Thus "the most persuasive Trinitarian analogy is the image of Church as "Body of Christ"[352]. In this perspective, God's purpose is to reconcile humanity in one body through the cross. (Eph. 2:11-22). Christ is the one who, by the presence of the Spirit, gives life to the Church that is his body. In this way, Christ who is head of his body, empowering, leading and judging (Ep. 5:23; Col 1:18), is also one with his body (1 Cor. 12:12; Rom. 12:5). The image of the Body of Christ in the New Testament includes these two dimensions, one expressed in Corinthians and Romans, the other developed in Ephesians.[353] The third and linked understanding is that of the Eucharistic body, through which Christ feeds and saves and heals the members of his body.

The Church is therefore called to continue witnessing the presence of Christ for all believers. All those baptised into Christ's body members engage in the building up of that body as a community. "As the members of the human body, though they are many, form one body, so also do the faithful in Christ" (1Cor 12:12). The Spirit by its own power enables the members to have concern for each other. "If one member suffers in any way, all members suffer and if one member is honoured all members together rejoice."[354] Thus, "the whole body, supplied and built up by joints and ligaments, attains a growth that is of God" (Col 2:19). In summary, the

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[350] Romans 9:23-26; Hebrews 8:10; Jam 1:1; 1Peter 2:9 in the Pauline letters.

[351] Paul Minear, *Images of the Church in the New Testament* with a Foreword by Leander Keck, New Testament Library, Leander Keck, ed. (Philadelphia: Westminster/John Knox, (1960/2004), pp. 23-25. See also Gabriel J. Fackre, (2002), p. 16.

[352] Faith and Order Paper *The Nature and Purpose of the Church* (Geneva: WCC/Faith and Order, 1998), p. 13, 181.

[353] Faith and Order (1998), p.13.

[354] See 1 Corinthians 12;26

Church, as the Body of Christ, is called to witness to the mission of Christ and now more than ever in the past, she is now called to reach out to the sick, the hungry and those whom society has rejected. But so too, the Church needs and is enriched by their presence whether in vulnerability, suffering or capability. In short, the Church as the body of Christ is called and empowered to put into practice the *shalom* and justice of God which is for all, greatest and least, fulfilling its mission to care for and with its people to share the message of the gospel.

6.8 Jesus - Person in Community

Pastoral work can be described as one of the sub-divisions of practical theology extended into the church and world. Current thinking would define Practical Theology as "the way in which the faith of the Church works out in practice in the world and raises questions about what it sees, addressing them back to theology"[355] The Church is shaped in the life of Jesus in community. The Trinitarian community is one God in Three Persons. The Father, Son and Holy Spirit all work together for the common good and are one. The Son (Jesus) as person in the community of the Trinity reveals the Father to the world and the Holy Spirit unites the world to the Father. The person of Jesus was to obey the Father and bring the whole creation to the Father, building a relationship between heaven and earth. "Catholic theologians have given a new attention to Cross and Trinity as well". Hans Urs von Balthasar and more recently, John O'Donnell, commenting on his work, assert that the Trinity expresses and communicates its full identity in the event of the Cross and resurrection.[356] O'Donnell spells it out this understanding, that

> ...the mission of Jesus who is fulfilled in the Cross has its origins in the eternal Trinity. If we conceive of the event of the Cross as a divine drama involving the Father and the Son, then as Balthasar argues, this drama must be grounded in the eternal background of the divine life. ...This is the merit of Balthasar's Trinitarian theology...stress[ing] that the cross is a separation of Father and Son, but the dramatic caesura that rends the heart of God on Calvary has already been embraced from all eternity by the divine Trinity. ...But this separation is also bridged over in eternity by the Holy Spirit, the communion of love of the Father and the Son.[357]

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[355] David J Atkinson and David H. Field (Editors) *New Dictionary of Christian Ethics and Pastoral Theology,* (England IVP Academic 1995), p. 42.
[356] Brian O. McDermott, S.J. *Word become Flesh: Dimensions of Christology,* Vol. 9 (Collegeville, The Liturgical Press, 1993), pp. 103, 175.
[357] J. O'Donnell, *the Mystery of the Triune God,* (New York: Paulist Press, 1989), p. 65.

In this theological and moral perspective, lie strong implications for the Church, specifically in the call to conversion - the *metanoia* of the Kingdom of God. This implies a profound change of the whole person and Christian community - a call to see, judge, and act in communion and conformity with the holiness and love of God, made manifest in Christ, and drawing the person to live in a transformed way towards God and others, in deepening enlightenment and "an ever-closer likeness to Christ."[358] This is the human and Christian part of "pastoral theology" and pastoral ministry, framed by and grounded in God's care for all, made known in Christ and to be expressed through those who make up his Body.[359] The Second Vatican Council spoke of the Church as identified with the risen Jesus, as in a mysterious union with the body of the risen Christ,[360] but also as living and witnessing within the world and in changing historical circumstances, it too changing in interaction with these. As Jesus did, the Church grows in age and grace and wisdom. And like any living thing the Church suffers. [361]

Christ still speaks, acts, and heals through his Body, the Church; and through the sacraments of the Church, "we exist, in the Church, through Christ and through each other" (George 2009: 309). Today, the Church is called to examine itself in relation to the sick and particularly to examine the activities of its healing ministry, and in so doing, to take account of the literature of other relevant disciplines anthropology, medicine, sociology, for example, while taking its point of departure from faith and from the life of the Church. Clearly there will be challenges of method and correlations between the different approaches, but they must inform one another. The whole idea of pastoral work is centered on community and the society. The whole notion of acceptance and relationship in the lives of people is the greatest sign of God's sacramental presence of forgiveness. "From this perspective we cannot speak only of the redemption of the material universe, but must include the question of redemption of individuals or of society, but we must

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[358] Jim McManus C.SS.R, *The Healing Power of the Sacraments,* (Notre Dame, Ave Maria Press, 1984), p. 46.
[359]Enda McDonagh, "The Reign of God: Signposts for Catholic Moral theology, in James F. Keenan, S.J., Jon D. Fuller, S.J., M.D., Lisa Sowle Cahill and Kevin Kelly, *Catholic ethics on HIV/AIDS Prevention,* (New York: Continuum, 2000), pp. 317-323.
[360] Austin Flannery, O. P., ed. "Ad Gentes Divinitus, 7 December, 1965", *Vatican Council II The Conciliar and Post Conciliar Documents*, (Northport: Costello Publishing Company, 1988), p. 813-856.
[361] Gabriel J. Fackre 'Ministry as Presence' in *Dictionary of Pastoral Care,* ed. R. Hunter, (Nashville: Abingdon Press, 1990), pp. 950-51.

include the question of the material universe, the matrix and enduring home of the human."[362] This involves a bodily history, not limited to the body of the person during his or her earthly life.[363] A pastorally oriented exercise of the sacraments implies an Christological sense, that the Church becomes Christ's hands, reaching out to touch us and to heal the sick and afflicted.[364] Many theologians understand that pastoral work is committed to the integration of the individual and community and wider society. But, there is also great influence for individual respect and dignity. This therefore, challenges all justification for isolating an individual as just desert for sins committed. Rather, it is the Church's mission to restore the dignity of the person, draw them with compassion into the community and help them build or rebuild their relationship with God. Thus, too, the Church "forgives guilt through God's word of forgiveness entrusted to her ... even as she communicates the Holy Spirit of the Church in baptism ...incorporating Him within herself as the Body of Christ."

The emphatic shift from an individualist perspective to that of the person in community, in society and in the global world is visible. This is based on a vision whereby issues are addressed globally, for example, political, social, and economic and gender issues. So too, practical theology must respond to the crisis in the context of health care, whereby life can be viewed and valued in an interdependent and ecological way. The implications and challenges directed to practical theology and pastoral care come into view, in the need for the Church to think anew, especially in the face of HIV/AIDS, world health and the responsible caring actions of the Christian community (Campbell 1986:23). This calls for networking of different agents in pastoral care, including the governments, politicians, the international community, and the global world. The global challenges combine the need to understand ethical responses and to listen to those who are often kept invisible and their plight disregarded – women and the poor, for example. The eminent Catholic moral theologian, James Keenan confirms this, and indicates the scale of the challenge: "Cooperation among multinational organizations,

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[362] Brian O. McDermott, S.J., *Word Becomes Flesh: Dimensions of Christology,* (Collegeville, The liturgical Press, 1993), pp. 15- 29, 102- 108, 175.
[363] Ibid. (1965), p. 903.
[364] Jim McManus C.SS.R. *The Healing Power of the Sacraments,* (Notre Dame, Ave Maria Press, 1984), p. 46. See also, Karl, Rahner, *Meditations of the Sacraments,* (London: Burns &Oates, London, 1977), pp. 54-55.

partnerships, and the complex levels of authority in governance all indicate efforts that embrace the entire human community, including those without power or voice."[365] Hunter extrapolates a similar view in five practical, pastoral directions: The most basic and most widely accepted' principles of pastoral care today are five in number.

- The minister is to listen and to be responsive primarily to what the parishioner himself or herself wishes to say, and is to be sparing in sharing the interests, enthusiasms and moralism of the pastoral office.
- The minister is to attend to the underlying affect as intently as to the verbal content: what the parishioner "*means,*" frequently unaware, is as important as what the parishioner says and is aware of saying.
- The minister is encouraged to be accepting of negative feelings, especially those of conflict and ambivalence: the experience of *acceptance,* particularly of one's otherwise unacceptable feelings, is especially conducive to personal growth.
- The ministry of pastoral care is to be carried on in an atmosphere of *exploration,* with emphasis on discovery and growth: an open-ended, conversational, collaborative style is the watchword.
- A relatively high degree of emphasis is placed on personal *involvement* and self-disclosure on the part of the minister, rather than on the neutrality emphasized by a number of traditional psychotherapeutic schools.[366]

The new approach to pastoral ministry is called not only to reach out, but also to be able to engage that in need in a multi-pronged, holistic manner that is essentially marked by inclusiveness, collaboration and personal involvement. In relation to the person living with HIV and AIDS who needs pastoral attention in different aspects of life, a holistic approach is needed that includes spiritual, social and ethical care. Keenan, speaking as a Christian ethicist, is to the point: "Among people of faith, personal ethics are paramount. The value of human beings as a whole and integrated entities created by God ensures that each is recognized as both a corporeal, sexual, and spiritual being."[367] In the vicious spiral of stigmatisation, as outlined in earlier chapters, and in such ethical and pastoral perspectives is to be found a sound basis for an alternative constructive pastoral response bent on de-stigmatisation of those suffering: that leads to a kindly and hospitable circle of holistic care and systemic transformation. One important

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[365] James F. Keenan, (ed), *Catholic Theological Ethics Past, Present, and Future: The Trento Conference,* (Maryknoll, New York: Orbis Books 2011), p. 24.
[366] www.religion-online.org/showartilce.asp?title=1704, accessed 06/07/ 2012.
[367] James F. Keenan, (2011), p. 24.

intrinsic area to be addressed – as voiced by those in the Mutare case study and in some of the official pastoral documentation of Church leaders in Zimbabwe, and in the writings of Christian ethicists – is that of prayer and healing

6.9 The Complexity of Human Existence

Everyday life is comprised of a series of overlapping situations: home, leisure, family, political, social, and spiritual and numerous other realities good and bad. Considering the complexity of human existence – and its mystery – pastoral care, which has in some settings become very technically focussed, sometimes is not responsive to the real issues which people struggle with in their daily lives. Although technical skills are very important, pastoral workers can lack skills for relating to people particularly on questions of sorrow and loss, life and death. All spheres of human being and existence: physical, emotional, moral, spiritual, intellectual, social need are not always given due consideration when treating a person. All this means one is left with one meaningful / relevant choice, which is, to look beyond "self" to what "others" need. The question, then, is: What can I offer? What can I contribute? How can I make a difference? Obviously, there is another vital factor which comes into play, here.

It is each individual person's UNIQUENESS that is - what makes each and every person distinct from one another? When Jesus visited the Temple, at twelve years of age, he knew that he was supposed to do His Father's business. Jesus was (a) looking away from "self" and (b) bringing into "play" his unique (God given) talent. The best pay-off is where one's TALENT (that is -one's unique personal gift) is put into service to benefit others (that is to give value). There is a little difficulty in all this in that one may be, a little, 'blind' to one's own UNIQUE TALENT. However, if you pay attention, you will 'see' how others VALUE who you are *uniquely* and what you do *uniquely*.

The care approach is not just about emphasising the individual way of life, since the individual lives in a community of shared beliefs, and values. Also, since It is the practices of a community that maintain the process of stigmatisation, through avoiding, distancing, blaming, excluding, for example as engrained in the

community's values, cultural norms, beliefs and social practices. In this light, the intra-community relationships in different overlapping contexts such as the family, parish, Church and society take on a dynamic and creative potential. The community is made up of many parts which become the building blocks of the whole.[368] It is the objective of this study to identify the "building blocks" in pastoral care to ensure that it is eco-systemic holistic. Human beings have the capacity to develop a highly complex repertoire of behaviours, but while the self has this capacity, the self is not only expressed in its behaviour, which can be attributed in part to other factors such as culture, religion, social influence and environmental challenges). Grave threats exist where there is confusion in the self. Behaviour is then affected, leading varied creative attempts on the part of the self to protect its own wholeness. In this perspective, even such apparently undesirable patterns such as compulsions, obsessions, avoidance, rebellious, addiction to success and manipulation can be understood at least in part as attempts at self-preservation. Illness is also one of the myriad substitute responses created by the self in the face of threats to behavioural self-expression.[369] Pastoral work, therefore, cannot be performed by the Church purely by spiritualising such issues or by concentrating solely on religious issues. It must also address the root causes of stigmatisation in order to develop a comprehensive approach to its reduction. The pastoral approach aims at mitigating factors that affect the stigmatised, reducing stigmatisation and promoting health through attention to the "Justice Model" with nine steps which the researcher has developed for a comprehensive pastoral approach to be successful. The steps are going to be discussed in detail in the Chapter.

6.10 Theology of Suffering - Life to Death and Resurrection

Suffering is unavoidable in the life of a human being. It manifests itself in different forms whether physical, existential, spiritual, emotional, social or economic. There are different questions that arise in the attempt to understand suffering. For

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[368] George, (2009), pp. 277-278.
[369] T. Humpreys and, H. Ruddle, *The Compassionate Intentions of Illness:* (Dublin, Attic Press, 2010), p. 35-40.

example, "What are the causes of suffering, and how can these conditions be eliminated?", and, "What is the meaning of suffering and under what conditions can it make us more human?"[370] These two questions and others like them challenge our understanding of suffering.

Dorothee Soelle has probed such questions ethically and theologically. On the one hand, from a social viewpoint, it is not enough to investigate the various kinds of suffering, without looking at its concrete social causes: "crop failure and war, drought and plague, environmental damage and systematic defoliations."[371] On the other hand, in a theological sense, it is necessary to understand suffering from a Christian perspective. "Christ invites each of us to be active participants in his ministry. In this way the healing supportive presence of Jesus is brought to suffering people of our day."[372] There is a call to relationship and solidarity. For example, the AIDS Policy for the United States Diocese of New Jersey focused on "four primary relationships of the Church to individuals: as pastoral minister, as employer, as educator and as social service provider."[373] These are relationships which anyone ministering to the person suffering needs to be aware of. One can be in the presence of the person dying in the capacity of a pastoral minister or in the service of an educator. For people suffering from illness or are at the point of death at a fundamental level they seek to find someone who is able to:

- Be there- enabling hope
- Touch - continuing to care
- Visit – communicating
- Praying
- Bringing a positive attitude of acceptance
- Being able to listen

The time spent, the quality of listening, assurance, affirming the gift of God's love, positive attitudes, a gentle touch, prayer, confidentiality and support are some of the simple points that need to be promoted in order to understand the sufferer – at the same time avoiding "preaching" to the suffering person.[374]

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[370] Dorothee Soelle, Suffering *trans.* Everett R. Kalin, (London, Darton, Longman & Todd, 1975), p. 5.
[371] Ibid. (1975), p. 6
[372] Origins No Documentary Service, 'AIDS Policy for New Jersey Dioceses, July 2, (1987) Vol. 17, No. 7 p. 1.
[373] Ibid. p. 1.
[374] Catholic AIDS Link London, July 1991, pp 1-4.

Suffering is universal and both Christians and non –believers struggle to understand its meaning in their lives. In Soelle's view, the language derived from "the Sermon on the Mount is relevant and it must be applicable to everyone"[375]. The message that those who are suffering are "blessed" and will be comforted makes sense to all. In the letter of St. Paul to the Romans which says, "weep with those who weep" (Rom12:15). In the biblical Book of Lamentations one witnesses the ministry of Jeremiah prompting his listeners to have the compassion of God for people in their lost and broken state. People are to ask the Holy Spirit for a heart, so that, like Jeremiah, they can comfort and 'bear the burden" of those whose pain is too great to bear. The Book of Lamentations touches on the themes: of Sin and Suffering; Sorrow and Repentance; Prayer and Hope; Faith and Renewal. It presents the story of humanity's 'fall-from-grace' and the need for repentance and submission to release the capacity to enter into God's restoration and deliverance.

There are two modes of living namely the "ward off" language such as struggle, antagonistic, relational or defence are common players in this situation. On the contrary the language which can lead to another way of living is "drawing out" which means dying to self. WARD (off) is all about "ME" that is protecting / safe-guarding 'the self'. DRAW (out) is all about the "OTHER" i.e. reaching-out to an 'other'. In this understanding, when we became detached and isolated we began to experience our individual personal vulnerabilities. This means that "survival" becomes the basic everyday issue and we begin to adopt a two self-protective-mode-of-living." This turns "personal-inter- actions" into a kind of "human-relations-battlefield" where we play "war" games with each other: translated as: "Struggle, Antagonistic Relationships."[376] There are times when a suffering person fails to comprehend the reality of life. Then, denial, lament and anger may follow. This is the moment when words have no meaning to the suffering person. He or she is fighting a spiritual battle in which only God can heal the powerlessness by His presence in the Holy Spirit, confirmed by the Biblical words which say, "Where two or three are gathered in my name I am there". One recognises this in the

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[375] Dorothee Soelle, p. 6.
[376] Ibid. (1975), p. 6.

context of a pastoral care context – an inner knowing that it is time to call on God in silence and simple solidarity. In such a context, it is time also for the pastoral person to learn from the one dying something of the meaning of crying out to God in disbelief, or lamenting, or surrendering and trusting to the love of God.

6.10.1 Trusting in God

God loves and is compassionate, not vengeful. Made in God's image, every human being is of inestimable worth. The life of all persons, whatever their sexual orientation or life station, is sacred, and their dignity must be respected. Jesus offered forgiveness and healing to all who sought it. And when one objected to the compassion, he explained, "Let the one among you who is guiltless be the first to throw the stone" (Jn. 8:7). The word compassion is more than sympathy. It involves an experience of intimacy by which one participates in another's life. The Latin word *Misericordia* expresses the basic idea: The compassionate person has a heart for those in misery. This is not simply the desire to be kind. The truly compassionate individual works at his or her own cost for the others' real good, helping to rescue them from danger as well as alleviate their suffering.[377]

6.10.2 Trinitarian Love – the Context of Pastoral Relationship

Words such as recognise, acknowledge and welcome are helpful in this situation.[378] Thus, in the process of suffering, the pastoral minister has to understand the meaning of the language used in a situation where one is trying to translate the situation into practice. The patient and the pastoral person through the presence and grace of the Holy Spirit form one bond of love. The patient and the pastoral person are all "human" and are not of themselves capable of transforming the soul or the situation except through the Holy Spirit. The relationship is the focus of the suffering person, and through faith a person suffering can be empowered to open up to a deeper life which is spiritual. The physical is limited when it faces death but the spiritual being is active and looking

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[377] U.S. Bishops' Meeting 'Called to Compassion and responsibility: A Response to HI/AIDS Crisis', *Origins,* November 30, (1989), Vol. 19: No. 26 p. 426.

[378] Thomas Moore, *Care of the Soul Medicine: Healing Guidance for Patients, Families and the People Who Care for Them,* (London: Hay House, 2010), pp. 113-136.

for resurrection. Thus the main thrust is to live in the resurrected life united to Christ.

When we recall how someone like Blessed Mother Teresa of Calcutta was putting into pastoral practice the process of dying to self, in order to recognise, acknowledge, and welcome the person who was suffering and dying and who is a child of God. It is therefore of paramount importance that the theological language is promoted as a language that transcends all that exists or is derivable only from what exists.[379] A language of silence or of a smile can reveal what it is to be human. This is the language that can help the suffering person feel loved, listened to in silence, with a sense of belonging, and is approached in their own uniqueness as an important part of the Body of Christ.[380] Through such human relating, a connection may be created through which the person suffering finds hope in God.[381] Thomas Moore speaks of community in such a setting as forming a spirit of common concern and need. Therefore, it is the communal spirit that accounts for a patient's respect and gratitude to all who nursed him/her. Because community arises from such a deep necessity in a person, it is major source of soul in the medical realm as well as the pastoral care.[382] It becomes a source of divine revelation:

> Now at last God has his dwelling among men! He will dwell among them and they shall be his people, and God himself will be with them. He will wipe every tear from their eyes; there shall be an end to death and to mourning and crying and pain; for the older has passed away[383]

It should be remembered, however, that the idea that everything comes from God and everything that is the will of God can also make the individual who is suffering feel powerless. Close attention to this reality is important. Paradoxically, "consciousness that one is powerless is a fundamental element in suffering. Every attempt to humanize suffering must begin with this phenomenon of experienced powerlessness and must activate forces that enable a person to overcome the

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[379] Ibid. (2010), p. 7.
[380]Charles G. Vella *Ethics in the Service of the Sick: Reflections and Experiences of Life at the San Raffaele Hospital, Milan*, (Dublin: Veritas 2009), pp. 81-100, 166-177.
[381]Chris Schlauch, 'Sketching the Contours of a Pastoral Theological Perspective: Suffering, Healing, and Reconstructing Experiencing' in James Woodward and Stephen Pattison (ed.), *The Blackwell Reader in Pastoral and Practical Theology* (Oxford: Blackwell Publishers, 2000), pp. 205-222.
[382] Thomas Moore, p. 217.
[383]N.E.B. Rev. 21: 3-4.

feeling that he is without power".[384] If there is to be any "communication" from the pastoral person it is to focus on the 'Gift' that this is the child of God, God's creation is His gift to the world. In this the sufferer may also come to recognise the presence of the pastoral person as a gift to them – he/she is there for them. Thus, trust can grow as the sufferer and the pastoral carer become able to open up, to receive the other and to give them, and "in this exchange there can emerge the experience of being loved by God unconditionally."[385]This is similar to what Lusseyran referred to as the symbol for totality of love and affirmation that comes from God. This encourages a person not only to go beyond enduring conditions but also to trust.[386] Christianity demands, says Tillich, "that one accept suffering with courage as an element of finitude and affirm finitude in spite of the suffering that accompanies it.[387]

6.10.3Acceptance and Powerlessness

One cannot approach suffering in such pastoral contexts in a planned or schematic way, and yet there are stages and patterns that have been recognised as typical. These have in turn been reflected upon, and have yielded helpful learning and insights which can be helpful in guiding a sensitive pastoral response. Below is an attempt to organise such phases and such a response, though with the accompanying awareness that each persons' situation of suffering will transcend any simple typology. It draws on the work of Dorothee Soelle. For all that she writes as a German woman and not an African, she is not without experience of the global South and has lived and ministered there, and her writing is deeply informed by this solidarity and her writing in the mode of liberation and feminist theology has a global relevance and lends itself to adaptation to the realities of suffering associated with HIV-AIDS suffering in Zimbabwe. She notes three broad phases: The first phase is "the first step towards overcoming suffering ... to find a language that leads out of the incomprehensible suffering that makes one mute, a language of lament, of crying, of pain, a language that at least depicts the situation.

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[384] Ibid. (1975), p. 11.
[385] Ibid. (1975), p. 12
[386] Jacques Lusseyran, *and There Was Light,* Trans. Elizabeth R. Cameron (London: Heinemann, 1963), p. 8.
[387] Paul Tillich, *Systematic Theology,* Vol 2, (Chicago: University of Chicago Press, 1957) p. 70.

Phase two is searching meaning in life. What is depicted is really suffering, but it is no longer at the stage of submissiveness. Phase three calls for a change in attitude and behaviour. It is a moment of transformation, surrendering and acceptance. It is a moment of silent language and being able to trust that God cares. The three phases (top to down) below portray how suffering manifests itself in the moments of serious illness and suffering. It is a lonely story.

Table 6.1 Three Phases of Suffering

PHASE ONE	PHASE TWO	PHASE THREE
MUTE	**LAMENTING**	**CHANGING**
Numb explosive		
Speechless	Aware, able to speak	Organising
Moaning	Psalmic language	Rational language
Animal-like wailing	Rationality and emotion Communicated together	
ISOLATION	***EXPRESSION, COMMUNICATION***	***SOLIDARITY***
The pressure of suffering turns one in on himself	The pressure of suffering Sensitises	The pressure of suffering produces solidarity
Autonomy of thinking, And acting lost	Autonomy of experience (can be integrated)	Autonomy of action that produces change
Objectives cannot be organised	Objectives Utopian (in prayer)	Objectives can be organised
REACTIVE BEHAVIOUR		**ACTIVE BEHAVIOUR**
Dominated by the situation	Suffering from the situation and analysing it	Helping to shape the situation
Submissiveness	Suffering	
Powerlessness	***Acceptance* and *conquest* in Existing structures**	***Acceptance* and *conquest of Powerlessness* in changed structures**

Source: Dorothee Soelle, (1975), p. 73.

Thus the sufferer finds strength and hope in liturgical material such as the psalms, prayer in petition, and lament for God's help to give hope. For example, "Hear me,

O God hears my supplication"[388] The third stage is portrayed as a painful process where suffering is intensified and strips away whatever camouflaged it.[389]

> It can no longer be toned down, either through display of humility or through pessimism about humanity that depicts the suffering as what prevails everywhere, as what is universal. Suffering is now looked at carefully, it is taken seriously. ...Active behaviour replaces purely reactive behaviour.[390]

It is in these moments of suffering that a "common practice springs from a feeling that silence is a fitting stance for the sufferer, before an *almighty* God. That does not remove the lamentations and the physical pain, but it is the image of the story of Jesus' suffering – in which, in some of the gospel accounts, despite his being the Son of God, he is portrayed as isolated and abandoned, crying aloud for God's help. (Mk. 15:34). When in the depth of suffering, people do "see themselves as abandoned and forsaken by everyone"[391] even though unintentional; those closest to them may be physically absent or emotionally unavailable when most desperately needed."[392]

This pattern finds a connection too many types of suffering and particularly illness. Soelle, from within the interpretative framework of Christ's suffering explores and discloses how life and suffering can be understood in knowing that God is present in every situation and that gives hope to all. Somehow, in faith, "in every prayer an angel waits for us, since every prayer changes the one who prays, strengthens him/her in that it pulls him/her to gather and brings him/her to utmost attention, which in suffering is forced from us and which is loving we ourselves give.[393]

It is in the process of the reality of life that suffering is assumed in Christian tradition as an attitude that focuses on acceptance and the capacity of readiness it is a process of faith hope and love.

> The strength of this position is the relationship to reality, even to wretched conditions. Every acceptance of suffering is an acceptance of that which exists. The denial of every form of suffering can result in a flight from reality, in which contact with reality becomes ever thinner, ever more

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[388] Dorothee Soelle, (1975), pp 70-74.
[389] Ibid. (1975), p. 72.
[390] Ibid. (1975), pp. 72-3.
[391] Ibid. (1975), p. 85.
[392] Peter M. Kalellis, *Why Have You Abandoned Me? Discovering God's Presence When a Father Is Absent,* (New York: The Crossroad Publishing Company 2011), pp. 11, 129.
[393] Dorothee Soelle, (1975), p. 86.

> fragmentary. It is impossible to remove oneself totally from suffering, unless one removes oneself from life itself, and no longer enter into relationships, and makes one invulnerable.[394]

Christian express with the word "I believe". To be able to believe means to say yes to this life, to this finitude, to work on it and hold it open for the promised future. It is to wait in hope to be consumed in the next life come. Everyone is waiting for the kingdom of heaven where life the mystery of life is fulfilled.

6.11 The Justice Analysis

Justice is a basic human right and each individual is entitled to and should experience it in all areas of their life. "Justice implies the notions of equality, solidarity, preferential option for the poor and the service of the common good."[395] However, "these views are interrelated and they form the antithesis of social inequality, intolerance, misappropriation of common resources and socio-economic and political exclusion, which lie at the root of the most violent conflicts in Africa"[396] and other parts of the world. Hence, "there is no true peace without fairness, truth, justice and solidarity.[397]"

The thinking behind the understanding of justice can be derived from the words of Blessed Pope John Paul II when he said that:

> One of the greatest injustices in the contemporary world consists precisely in this: that the ones who possess much are relatively *few* and those who possess almost nothing are *many.* It is the injustices of the poor distribution of the goods and services originally intended for all (John Paul II, *On Social Concern,* and no. 28).[398]

It is therefore from this reflection that the Church continues to awaken the hearts of its members by encouraging the faithful to participate in the work for justice and peace. Justice is the umbrella of any development. It influences policies, laws and decisions. This understanding faithfully corresponds to the teaching of Jesus Christ and the church, "In Him we see the direction in which salvation, true wholeness and healing leads us" (Tim. 2:4-5). In the Pastoral Letter of Paul to Timothy, everything meets in Christ as the one who is the pivotal healing point of

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[394] Ibid. (1975), p. 88.
[395] Elias Omondi Opongo, S. J. (ed), *Peace Weavers: Methodologies of Peace Building in Africa*, Nairobi: Paulines Publications Africa (2008), p. 36.
[396] Ibid. (2008), p. 36.
[397] Ibid. (2008), p. 36.
[398] Ibid. (2008), p. 36.

the Church, cosmos and the Holy Spirit. The Church's faith in the Incarnation identifies Jesus as the revelation and the meeting point of a healing salvation for a wounded universe. The love of God is understood in the life of the Son of man. All this is summed up in the title Son of Man which expresses his saving, healing identification with all of humankind. Jesus, as the Gospels portray, clearly adopted a pastoral holistic approach to healing. He not only healed the outward signs of illness but he also healed the whole person. He healed not only the good but also the sinners and in his words and actions, he drew others into the healing of the stricken person making it significant and potentially a healing for the whole community. The challenge of a holistic pastoral approach is such, a multi-faceted, multi-levelled physical, mental, spiritual and social approach to healing.[399] Thus an all-embracing caring approach will be significant for consideration of future Church practices.

The Church can appropriately use a wider range of methods. Roe and Beech indicate the need for a strong emphasis on the place of voluntary work and informal support, and, increasing, care by the community at large and in the Small Christian communities,[400] where all learn "to integrate health and social care."[401]

6.12 The Justice Model/RAW

One approach based on a "Justice Model" which the writer has noted already can be applied in three bold letters: **R**ecognition, **A**cknowledgement and **W**elcome, shortened as RAW. This approach inherent in this model and framework can make a vital contribution to reduce stigma and to restoring the health and dignity of the person and the community. This method is rooted in the embracing of the person in their wholeness. Following the pastoral practice of Jesus, pastoral care is given in a manner that affects a person creatively and interpersonally and helps to restore the broken dignity of the person and their meaning and place in the community. When Jesus healed, he encountered the person fully and healed them of their ills and their sins (recognition), affirmed and restored their dignity (acknowledgement); integrated the person into the community (welcome). He

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[399] Jim McManus, *Healing in the Spirit,* (Spain, Redemptories Publications, 2002) p. 24.
[400] Brenda, Roe and Roger, Beech (eds.) *Intermediate and Continuing Care Policy and Practice,* (Oxford: Blackwell Publishing, 2005), p. 40.
[401] Ibid. (2005), p. 40.

commanded the healed leper to "go show yourself to the priest,"[402] his intention being to challenge and remove the suffered stigma in a deliberately public way.

In such a way, the RAW framework provides for a holistic approach to HIV/AIDS sufferers in the reduction of stigmatisation and their restoration of wholeness. All interventions need to be towards freeing and empowering the person right down to the most practical of ways, for example, through teaching craft competence and skills whereby the person can find a route to greater self-worth and sustainable livelihood. A key question is: How does one change from the ingrained tendency to self- focus? The process involves a movement from personal self to Social Self to spiritual self. Jesus came on earth to show the way – which involves the paradoxical call to *die* to our own *self*. Our life journey, on earth, is one of dying a little more, each day, to our selfishness and rising above (i.e. transcending) revenge in the face of the other's selfishness.[403]

6.12.1 The Justice Model – RAW

The Justice Model is comprised of three main stages in its process: 1. Approach – (i.e. reaching out, recognising): 2. Accomplishment- (i.e. to engage, connect, empathy): and 3. Announcement-(i.e. empowering, self- esteem). The Justice approach is a direct way of *Touching People's Lives*. It is an approach which I have developed based on my own research. This approach will be set out in terms of paramount when implementing a practical project based on the knowledge gained through writing this thesis. The project will be called "AGAPE Leona in Zimbabwe", in the Diocese of Mutare. The meaning of the name is as follows: A. is for acceptance, G. - generosity, A. - action, P. - prayer, E. - education, and Leona stands for all those suffering and who are subject to stigmatisation of one form or another. The name *LEONA* could even derive its meaning from the Shona people's names like "**ONAI"** and "**TARISAI"**, literally meaning a call to looking at something with wonder and being called upon to do something about it. It also has a resonance with the Latin word for lion and in this sense it would mean a call to carefully look at something frightening and likely to do you harm. This would seem

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[402] Mark 1:44.

[403] Peter M. Kalellis, *Why Have You Abandoned Me?: Discovering God's Presence When a Father Is Absent,* (New York: The Crossroad Publishing Company, 2011), pp. 68-69.

apt in the attempt to address the issue of stigma associated with people living with HIV/AIDS. This is neither an easy nor a straightforward project. Telling someone outright, "It will be all right," "Time heals all wounds," "Don't despair," ... does more harm than good."[404] Thus one has to know how to engage with a suffering person sensitively, opening to the hope that lies within them and reflecting it towards a different experience than the pervading negativity and hopelessness.

Woodward [or whoever you are quoting] points to the need to know how to "introduce the person more fully and deeply to her or himself while (re)-introducing her or him to the faith tradition."[405] "On the other hand the person seeking care because of the isolation associated to stigma typically will not recognise that her or his experience is selective and creative – that is, constructive."[406] According to Kohut (1978, 1984), "pastoral theologizing equips the person seeking care to address ignorance and be able to maintain a sustained attentiveness to that person's unique ways of experiencing."[407] This in turn may empower the person seeking care to focus widely on the value of life and past experience enables the growth to maturity of the person's conscience that longs for a different future in terms of faith tradition. It is here that the meaning of AGAPE Leona comes into play. Its vision and objectives lie in the welfare and fullness of life. It seeks to participate in the mystery of transformation in the hearts of those in the pastoral relationship to find meaning in life and especially during painful or dark times.

It will be a pastoral ministry to deal with men and women, children and the young who need care, education and skills development. Reference above to the Justice Model with its three broad stages comes back into view in the process of building justice. These can be identified as (1) Approach, (2) Accomplishment and (3) Announcement. Each of these stages is a connection of a process which relates the

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[404] James Woodward and Stephen Pattison, (eds). *The Blackwell Reader in Pastoral and Practical Theology,* (Oxford: Blackwell Publishers, 2000), p. 218.
[405] Ibid. (2000), p. 218.
[406] Ibid. (2000), p. 218.
[407]Hainz Kohut, "Introspection, empathy, and psychoanalysis: an examination of the relationship between mode of observation and theory." In P. H. Ornestein (ed.), *The Search for the elf: Selected Writings of Hainz Kohut: 1950-1978* (vol. 1, pp. 205-32), (Madison, Conn.: International Universities Press, 1973), (original work published 1959).

needs of the persons or groups to the justice that God intends for them and that should characterise the Christian community. Bearing in mind that human needs are different so also are the ways in which the Justice Model is applied in different situations. It may take different forms in the process of needs assessment, capacity building, empowerment, education, caring, decision-making, policy development and conflict management. Below is the process showing how the 'RAW' dynamic operates in the context of the Justice Model.

6.12.2 Approach – Stage 1

Firstly the person who is isolated and stigmatised needs to be recognised as a human being and given all due respect. One recognises sufferers by using one's powers of awareness. Secondly the stigmatised person needs to be acknowledged with empathy as someone in need. This is done through expressions of empathy, care and physical help. Thirdly there is need for welcoming and practical hospitality. This is done with an open mind and heart and with open arms such that the stigmatised person really feels welcomed back into the heart of the community. A person needs to be taken into consideration in the totality of their life and being.

The diagram following summarises the ideas in stage 1.

Table 6.2 Justice Model/RAW - Approach

RECOGNITION	ACKNOWLEDGEMENT	WELCOME
•HEAD	•HEART	•HANDS

Source: Own

6.12.3 Accomplishment - Stage 2

The key to a holistic pastoral approach is the reciprocal capacity to give and receive by both the sufferer and the carer. The pastoral provider needs to be able to listen attentively. Both parties have to work together in interrelationship. The stigmatised person needs to feel that their position is affirmed and accepted in order to build a firm foundation for successful mitigating of the stigmatisation. Stigmatisation will be visibly reduced by visiting the sufferers in their homes and involving them in practical self-help activities, such as, self-medication. The final

step in this stage is in the ability to evaluate and affirm that reduction of stigmatisation has been accomplished. This becomes visibly embodied in the way the sufferers gradually participate in community events. The diagram 6.2 below summarises the factors in this second stage.

Initially, a mutual relationship is established between the sufferer and the caregiver. As a firm foundation of trust and hope is established the possibility of a win-win for all concerned is recognised. The stigmatised person through a gradual transformation within themselves becomes motivated to engage more actively. In this the stigmatised person takes back their own sense of agency and self-worth, which in turn renews hope, understanding and acceptance that a better future is possible. Thus, in the process the pastoral person encourages dialogue with all interested parties in order to extend participation and effective capacity. All are treated as equals. For this to be successful there is need for cooperation from the individual, groups or community, so that no-one is diminished and everyone wins.

Table 6.3 Justice Model/RAW - Accomplishment

RECIPROCITY	AFFIRMATION	WIN - WIN
•GIVE & TAKE •TAKE & GIVE	•A FIRM FOUNDATION	•EVERYONE WINS

Source: Own

6.12.4 Announcement – Stage 3

The final stage is the announcement of the successful reduction in stigmatisation. This is achieved by building a solid partnership with the stigmatised person. A solid partnership means that the sufferer and the carer work well together to resist and reduce all occasions of stigmatisation. In addition, the pastoral approach can embrace a working partnership towards the provision of basic needs of the sufferers, such as medicine, transport and education. "Social analysis is an effort to obtain a more complete picture of a social situation by exploring its

historical and structural relationships."[408] The ultimate goal of this process is the restoration of health and dignity to the person and integration back into the community. The diagram below summarises what is important in stage 3. A preceding phrase for each phase might be fruitfully added – "Affirmation of the individual or group."

Table 6.4 Justice Model/RAW - Announcement

RELATIONSHIP	ADDED VALUE	WELL BEING
•PARTNERSHIP	•WORTH	•GOODNESS

Source: Own.

As a final word, the above approach is supported by Amartya Sen a prominent social theorist, philosopher and Nobel Prize winner in Economics in 1998 for his contribution to welfare economics. His ideas have been fruitfully integrated into the sphere of pastoral care of HIV-AIDS sufferers by moral theologian, Suzanne Mulligan[409] Such a "capabilities" approach, offers a more holistic way of thinking about human development which refers to what people can actually be, do and become. The capability of a person is a derived notion that reflects a combination of functions (doings and beings) which he or she can achieve.[410] "Capability reflects a person's freedom to choose between different ways of living."[411] One can see the links here with the idea of empowerment which is also centrally valued in the area of Development Studies. Development according to Sen requires, "the removal of major sources of freedom: poverty as well as tyranny, poor economic opportunities as well as systematic social deprivation."[412] Focally, for our purposes, he insists on the need to understand the negatively reinforcing systemic reality: "Social problems and issues, although they may appear to be isolated pieces, are actually linked together in a larger system."[413] "Poverty denies people a

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[408] Joe Holland and Peter Henriot, S.J., *op. cit.*, (1983), p. 14.
[409] Suzanne Mulligan, *Confronting the Challenge: Poverty, Gender and HIV in South Africa,* Africa in Development Volume 4, (Oxford, Peter Lang 2010), p. 102
[410]Suzanne Mulligan, (2010), p. 102.
[411] Suzanne Mulligan, (2010), p. 102.
[412] Ibid. (2010), p. 109.
[413] Joe Holland and Peter Henriot, (1983), p. 10.

share in the goods or freedoms that others enjoy; it drives individuals to adopt "survival strategies" that may assist short-term subsistence but inevitably increases the chances of infection with diseases such as HIV."[414] In addition, poverty excludes the majority of our world's citizens from access to adequate health care and education."[415] Thus this exclusion has a negative impact on the lives of the people as it also "reinforces a sense of powerlessness and hopelessness."[416] "Unless the underlying struggles of millions to survive in the midst of poverty, powerlessness, and hopelessness are addressed, the meanings of AIDS understood in the context of gender relations, HIV will continue to spread."[417] Thus, capability approach according to Sen "allows for greater scope when evaluating development." This means "capabilities refer to what people can actually do and become and therefore the parameters for evaluation will inevitably be much broader than measurements such as economic growth and income."[418] Hence, if the capability approach is going to "consider what people can do and become then it is likely to incorporate factors of gender equality in a way that other indicators may not."[419] Both men and women need on-going formation and development in order to promote justice, build strong relationships, and to respect the dignity of every human person. Such values as fairness, forgiveness, reconciliation, compassion, love and charity are of paramount importance in life. These are some of the values which help to build families, communities and societies of care and hospitality. Nussbaum (2005) asserts that, "Growth is a bad indicator of life quality because it fails to tell us how deprived people are doing: women figure in the argument as people who are often unable to enjoy the fruits of a nation's general prosperity." She argues that the capabilities approach should "examine the level of freedom people have in choosing the sort of lives they wish to

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[414] Suzanne Mulligan, (2010), p. xi.
[415] Ibid. (2010), xi.
[416] Ibid. (2010), xi.
[417] Brooke G. Schoepf, "Gender Development, and AIDS." In The *Women and International Development Annual,* vol. 3 ed. R. Gallin, A. Ferguson, and J. Harper, (Boulder, Colo: Westview Press. 1993), p. 210.
[418] Amartya Sen, "Development as Capacity Expansion," Sakiko Fukuda-Parr and A.K. Shiva Kumar (eds), *Readings in Human Development* 2nd Edition, oxford: Oxford University Press, 2005), p. 102.
[419] Ibid. (2005), p. 102.

lead. It is therefore a more effective way of evaluating development."[420] Thus, it is important to note that the consideration given to any particular country on the level of development in statistical terms, such as Gross National Product (GNP), "reveals little about human development and indicators that promote inequalities that inhibit a person's authentic development."

As a result countries might appear to be doing well "on paper" yet discriminating certain groups and even denying them the basic human rights.[421] So also, "effective pastoral planning necessarily involves [a] movement *from the anecdotal to the analytical."*[422] See, Judge and Act is a process that can apply the trilogy of Canon Joseph Cardijn.[423] The process of empowering individuals according the demands of Sen relate to the ability to interpret a stated vision and goal to be attained. This requires knowledge of the levels of individual interest and skills. Thus social engagement is not only limited to the provision of resources but it goes further to discover the abilities within the individual person's environment, as well as that of the community to which the person belongs. In addition, Sen, found that communities and individuals contributed more where they were allowed to explore their own talents and skills. In summary, the capability model is motivated internally. Similarly, in the justice model the innate dignity of the person is of paramount importance. It shapes the future and can equip the person with self-knowledge that allows the individual to participate in decision making and also participate in society at large. Both the Justice Model and the Capability Approach of Sen are concerned with reducing stigmatisation. The further recognition of the significance of the role of gender will lead to recognition of the rightful role of women in society. This particularly refers to equality and access regarding rights and resources such as salary, land inheritance and participation in power and decision-making. By also focusing on sustainability, it is hoped that poverty can be eliminated or at least very much reduced. One can identify how these approaches

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[420] Martha C. Nussbaum, "Capabilities as Fundamental Entitlements: Sen and Social Justice," Bina Agarwal, Jane Humphries and Ingrid Robeyns (eds), *Amartya Sen's Work and Ideas: A Gender Perspective,* (London: Routledge, 2005), p. 103.
[421] Ibid. (2005), p. 103.
[422] Ibid. (1983), p. 10.
[423] The Belgian priest who, prior to World War II, inspired Catholic social action groups such as the Young Christian Workers, Young Christian students, and indirectly the Christian Family Movement. Cf., Joe Holland and Peter Henriot, (1983), p. 10.

correspond also to the social analysis approach: To be able to "'*see*' one must "look at the facts and figures of a particular situation"[424]. But furthermore – "Beyond these facts and figures lies a framework that provides meaning, a perspective that makes sense of disparate elements."[425] Such guiding principles can be mobilised towards the proper use of, and access to natural resources for the continued benefit of the environment and of citizens.

6.13 Further Guiding Principles for the Reduction of Stigmatisation

The principles outlined in this section are a response to certain specific aspects of the vicious cycle of stigmatisation as outlined in chapters one and 2, and as seen in operation in the reported field study in in the Roman Catholic Diocese of Mutare (Chapter 4). Each principle is related to a specific stigmatisation issue which is explained in detail following the table. The guiding principles set out below will assist the future introduction of a robust holistic pastoral care approach to counter the effects of stigmatisation. Each guiding principle is a response to a particular type of stigmatisation as per the vicious cycle identified in Chapters 2 and 3. Involvement of sufferers and their families will lead to a reduction in isolation, shunning and distancing. By using a rights-based strategic approach, injustices such as the denial of the right to education and health care will be tackled and reduced.

Recognising the role of gender will lead to recognition of the role of women in society. This particularly refers to equal salary, the rights to land inheritance and equal sharing of power in decision making in family, community and society settings. By focusing on sustainability, it is hoped that poverty can be eliminated or at least very much reduced. Also this principle is related to the proper use of natural resources for the continued use of the citizens. Assistance in getting the poor back into the workforce will be vital for continued success. In the area of multi-sectorial collaboration it is envisaged that the problem of exclusion will be addressed. This collaboration requires the Church as a source and resource of

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[424] Ibid. (1983), p. 10.

[425] Canon Joseph Cardijn, "The search for a framework is the task of social analysis. It is the framework to find answers to different questions for example, *why* things are the way they are?" Joe Holland and Peter Henriot, (1983), pp. 10-11.

pastoral care, the sufferer as the recipient of care, and all other parties to co-operate in funding, resourcing and organising care programmes.

All of the above will promote active networking among sufferers, communities and providers. The Church is well positioned to play a major role in this process by providing leadership, vision and fellowship to all involved in the care process. "The church has increasingly recognised that social analysis is important for effective pastoral planning.[426] As already noted, this requires to Church to become more involved at parish, deanery, diocesan and national, level. This can only be successfully accomplished by a comprehensive all-embracing holistic pastoral approach. This will require a major rethinking by all in leadership roles. The core elements in such a holistic approach are summarised in the following table.

Table 6.5 Guiding Principles as a Response

GUIDING PRINCIPLES	AS A RESPONSE TO
1) involvement of sufferers and their families;	Isolation/Distancing
2) using a rights-based strategy;	Injustices/Scapegoating
3) recognizing the role of gender;	Gender-based Inequality/ Disempowerment
4) focusing on sustainability;	Poverty/ecosystemic degradation
5) multi sectoral collaboration	Exclusion/Piecemeal efforts

Source: Own

The next section will discuss those factors which are considered important to ensure the success of the guiding principles discussed above. There is some overlap in terminology but this will serve to add emphasis to the points discussed earlier rather than detracting from them.

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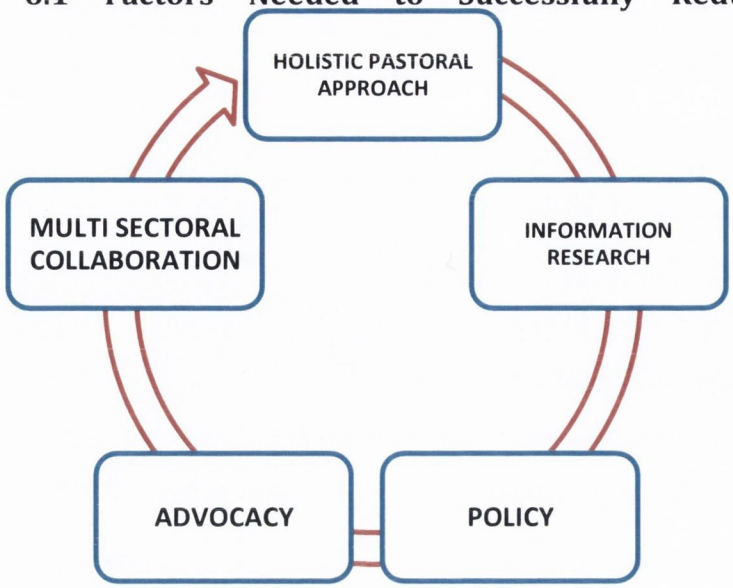
[426] Pope Paul VI, "A Call to Action," (*Octogesima Adveniens),* 1971, in Joe Holland and Peter Henriot, *Social Analysis: Tool of Pastoral Action,* (Maryknoll, NY: Orbis Books, 1983), pp. 13-15.

6.14 Factors needed to Reduce Stigmatisation Successfully

The chapter sets out five guiding principles for the reduction of stigmatisation in the Catholic Dioceses of Mutare. However, no matter how well intentioned the persons involved in the process are, they will not succeed unless they have experienced advocates who are ready to speak on their behalf, have defined policies, have ensured full cross sectoral collaboration and are acting on real and true information. Ultimate successful reduction or elimination of stigmatisation will be a function of how prepared that all parties are for the process. For a Pastoral Approach to produce an effective response there is need for an interlinking of Advocacy, Policy, Multi Sectoral Collaboration and Effective Research (Siyamakela Project, 2003; Nyablade and Mac Quarrie, 2006; Qubuda, 2009). In addition, research can also be added to the four areas identified by Siyamakela *et al.* The addition of research automatically falls under the information heading. Figure 5.4 below is included to show the continuous flow of information and of actions related to each of the factors. No one factor is necessarily more important than the other. It is the interlinking of analysis and of action across the board which will ensure success or failure in establishing a successful strategic plan for reducing stigmatisation.

If we consider the central circle as a door and the four outer circles as hinges, the door will only function properly when the four hinges work interactively. The terms Advocacy, Policy, Multi-Sectoral Collaboration and Information/Research will be explained in greater detail in the next section on the roll out of plan.

Figure 6.1 Factors Needed to Successfully Reduce Stigmatisation



Source: Own

6.15 A Strategic Approach to a Reduction in Stigmatisation

Based on the key elements of the stigmatisation mitigation response, as elicited in the case study and utilising the factors outlined in the above section, the following is a suggested strategy for a holistic pastoral approach to the reduction of stigmatisation. Different stakeholders may have the different skills necessary to fulfil the different elements of the approach.

6.15.1 Priority Area 1 – Information

Information, in the context of figure 6.5 means knowledge and understanding of HIV/AIDS and how it leads to stigmatisation. Full and accurate information is vital to address the fears and challenge the myths surrounding stigmatisation. This information can be used in the roll out strategy to develop a set of action plans, for implementation n over the short, medium and long term. The reality is that stigmatisation can only be reduced and eliminated through education, pastoral communication, use of media and information technology including social media developments.

Figure 6.2 Priority Area 1 - Information

Source: Own

Specific strategies include mainstreaming (grouping) key people or obtaining information from existing published materials and also able to interpret what the majority of sufferers are saying. Innovation involves finding new ways of dealing with long standing problems. Gathering living testimonials means hearing first-hand of the suffering and problems connected to stigmatisation. The specific sources of information identified are not exhaustive. Smith and McDonagh are to the point in highlighting the role of the Church in both word and action: People look to the Church to put into practice what it is saying. The prophetic voice of the Church needs also to be continually heard in its actions with priests, religious and lay people. It needs to be heard in models of good practice that address gender and economic injustice.[427] It is believed that the progress of groups launching HIV prevention initiatives often believe that the provision of information alone will result in the behaviour changes required to prevent infection.[428] Furthermore, "Information, Education, and Communication (IEC) initiatives serve to raise awareness," and lead to more effective campaigns by focusing on "specific

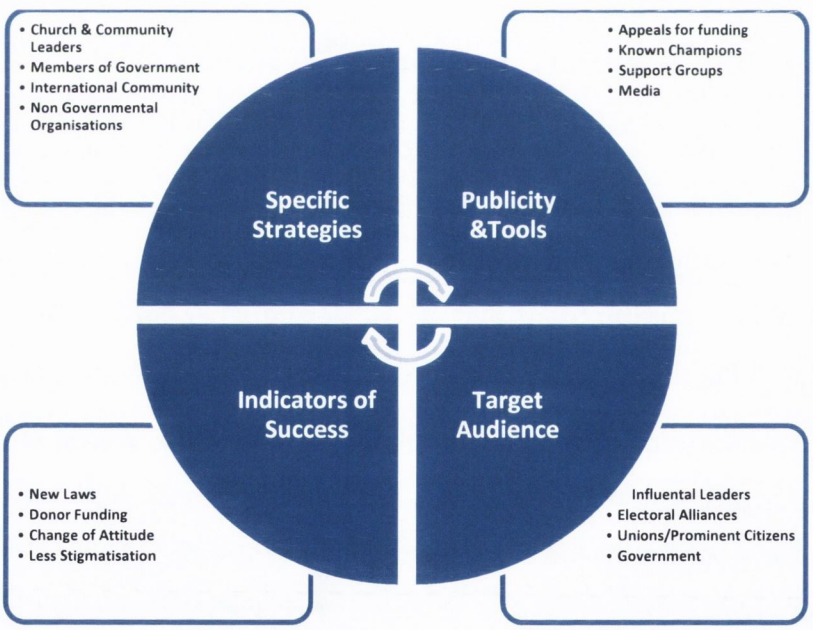
[427] Ann Smith and Enda McDonagh, *The Reality of HIV/AIDS,* (Dublin: Veritas, 2003), p. 145.
[428] Ibid, (2003), p. 66.

groups."[429] For example, groups "according to age, gender, sexuality, ethnicity or social category are more likely to be effective." Also, "tailored IEC programmes are essential to health workers." This improves their "response to the needs" of suffering people.[430]

6.15.2 Priority Area 2 – Advocacy

Advocacy is the concept of speaking on behalf of others, to press their case and have policies amended where necessary, for the common good. Advocacy strengthens commitments to action and builds a network that enables the advocates to tackle and reduce stigmatisation. Through advocacy, interested parties and resources can be mobilized in pursuit of the cause of a reduction in stigmatisation. Church and community leaders, family heads, members of the government, the international community and major organizations need link persons to reach out to where people need to be mobilized.[431]

Figure 6.3 Priority Area 2 - Advocacy



Source: Own

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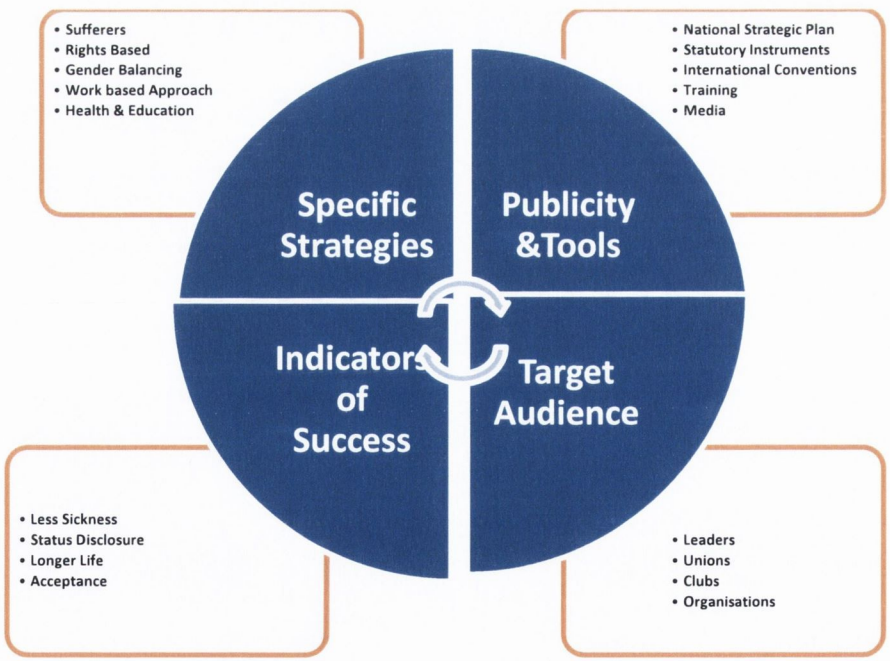
[429] Ibid. (2003), p. 66.
[430] Ibid, (2003), p. 66.
[431] Lorna Gold ed., "Governance and Poverty Reduction" *TROCAIRE Development Review,* (Maynooth, Co. Kildare: TROCAIRE the Catholic Agency for World Development, 2006), p. 17-144.

The list or categories of advocates identified is not exhaustive; as the strategy is developed additional advocates will come to the fore.

6.15.3Priority Area 3 – Policy

The policy framework needs to be discussed at different levels of implementation especially the grassroots need background knowledge and skills and agreed in order to foster a supportive environment. It is within the rights-based parade pending on the intended outcomes the policies can be subjective, that is for a specific target group, or objective, that is for the common good. Policies can be in different forms such as distributive which aims at distributing goods and services to those most in need. It is also necessary to develop policies in the areas of regulation (laws) and specific needs such as education, health, housing and the death of a spouse or spouses, and resultant orphans. No doubt, additional policies will emerge as the process develops. These different types of policies help in the reduction of stigmatisation if used for appropriate purpose.

Figure 6.4 Priority Area 3 – Policy



Source: Own

The policies can be formulated based on ethical, societal, cultural and religious aspects of stigmatisation. A holistic pastoral approach to the reduction of stigmatisation will not succeed if it is applied out of context. At a minimum, how people live their lives, where they live and under what conditions must be taken into account when drafting policy documents and in evaluating the effectiveness of policies.

6.15.4 Priority Area 4 – Multi-Sectoral Collaboration

All role players need to work together, recognizing common goals and each other's unique role specialisations and strategic inputs. They need to work in a coherent, integrated and coordinated way to address the underlying conditions that foster and fuel stigmatisation. Through collaboration and cooperation, (synergy), organizations can take responsibility for a broader strategy, thereby reducing the amount of time and resources required.[432] Local, national and international organisations need to be engaged in this process for the reduction of stigmatisation by mitigating the interlocking conditions which cause it to become endemic.[433]

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[432] Lorna Gold "The Role of NGOs in Conflict Transformation," *TROCAIRE Development Review, 2003/2004*, (Maynooth: TROCAIRE The Catholic Agency for World Development, 2004), pp. 17-127.
[433] Lorna Gold "Challenges in Meeting the Millennium Goals," *TROCAIRE Development Review, 2003/2004*, (Maynooth: TROCAIRE The Catholic Agency for World Development, 2005), pp. 17-151.

Figure 6.5 Priority Area 4 - Multi-Sectorial Collaboration

6.15.5Priority Area 5 Research

Research will increase access to evidence-based information on the causes and dynamics of stigmatisation and this will illuminate the scope of decision-making. Continuous research is necessary in order to have clear and concise knowledge and facts on the ground. Research will also help to establish methods of reducing stigmatisation by updating outworn practices and methods. As part of a holistic pastoral approach, the Church can provide a central point and hub for the collection and circulation of information. This can be achieved by, using all church structures ranging from the Diocesan Social Communication Department, to the parish or family unit, and to Basic Christian Communities.

Figure 6.6 Priority Area 5 - Research

Source: Own

The church can set up small centres that allow people to bring and share information, analyse current documents, translate documents into local languages and provide access to literature on the best findings and developments. As part of the process these centres can also be used as social centres where people learn new knowledge for instance about the teachings of the church, reading and sharing passages from the bible and meeting new friends interested in researching, up skilling on their current skill set and writing on particular topics that help transform the community. The process will enable people to empower themselves by having access to research sources that promote human rights as well as respect for the environment.

6.16 Human dignity and Rights Protection System

The involvement of sufferers in the development, implementation and evaluation of a rational protection system will ensure the approach's credibility and applicability in collaborative combating of stigmatisation. The Catholic Bishops of Zimbabwe, in their pastoral letter of 2011, *Let Us Work for the Common Good, Let Us Save Our Nation*, challenged political leaders on what was required in terms of political decisions and priorities:

i) Prioritize poverty eradication by using proceeds from natural resources like diamonds, land, etc., for the development of the whole nation and all its citizens. In its final message, the Second Special Assembly for Africa of the Synod of Bishops noted that Africa is rich in human and natural resources but 'many of our people are still left to wallow in poverty and misery, wars and conflicts, crisis and chaos. These are very rarely caused by natural disasters. They are largely due to human decisions and activities by people who have no regard for the common good.

ii) Stop the active and tacit collusion of those undermining the fight against corruption. Corruption is a cancer destroying our nation.

iii) Prosecute wrong doers and widely publicize any disciplinary action so that no one is seen to commit crime with impunity.

iv) Desists from intimidating and mistreating members of the public, the media, civic communities, etc. Uphold human rights.

v) Uniformed forces should maintain peace and security for all citizens at all times and especially before, during and after elections, and do so impartially.

vi) We implore our political leadership in the coalition government to reflect deeply on the timing of elections bearing in mind the unhealed state of the nation and the fragile state of the economy. They shoulder a heavy responsibility to serve and save Zimbabwe. They must think and act in pursuit of the Common Good. In the event of elections, implement the SADC guidelines in full.

vii) We expect our members of Parliament to make an effort to spearhead the mitigation of the pressing needs of the people they represent and desist from being preoccupied with enriching themselves.[434]

Figure 6.10 attempts to delineate how an appropriate system of protection could be enabled. The starting point could be the allocation of funds to implement a non-stigmatisation or rights protection programme. The source of these funds could be local, diocesan, government, African, the international community or other charitable overseas bodies. Without funds any plan is doomed to failure. Also any financial support has to be based on a thoroughly researched implementation strategy. Relevant policies on how, when and where the plan will be rolled out need to be established at the highest levels.

A social analysis that is genuinely pastoral can be illustrated in what we can call the 'pastoral circle'. This circle represents the close relationships

[434]ZCBC "Let Us Work For the Common Good Let Us Save Our Nation," A Pastoral Letter of the Zimbabwe Catholic Bishops' Conference 14 January (2011), p. 3.

between four mediations of experience: (1) *insertion,* (2) *social analysis,* (3) *theological reflection,* and (4) *pastoral planning.*[435]

Who will be included in the plan is also a vital ingredient. The diagram below illustrates the pastoral circle on the concept of *praxis* as a continuous process of reflection that is at the same time engaged in action. Thus according to Paulo Freire this praxis circle is also related to hermeneutic circle which is associated with "the method of interpretation that sees new questions continually raised to challenge older theories by the force of new situations."[436] Such a cycle of reflection, praxis, reflection would be an important means of interrupting and weakening the vicious circle of stigmatisation.

The basis of any pastoral action is insertion that helps to locate the geography of our pastoral responses in a lived experience of the individuals and communities. This stage brings out the peoples' feelings and how they respond to situations. People are able to share experiences that give the "primary data" in planning.[437] Secondly, "social analysis examines causes, probes consequences, delineates linkages, and identifies actors."[438] It helps to make sense if all information gathered is properly analysed to give a "broader picture" that can help map up related data.[439]

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[435] Joe Holland, and Peter Henriot, S.J., *Social Analysis: Tool of Pastoral Action,* (Maryknoll, NY: Orbis Books, 1983), pp. 7-10.

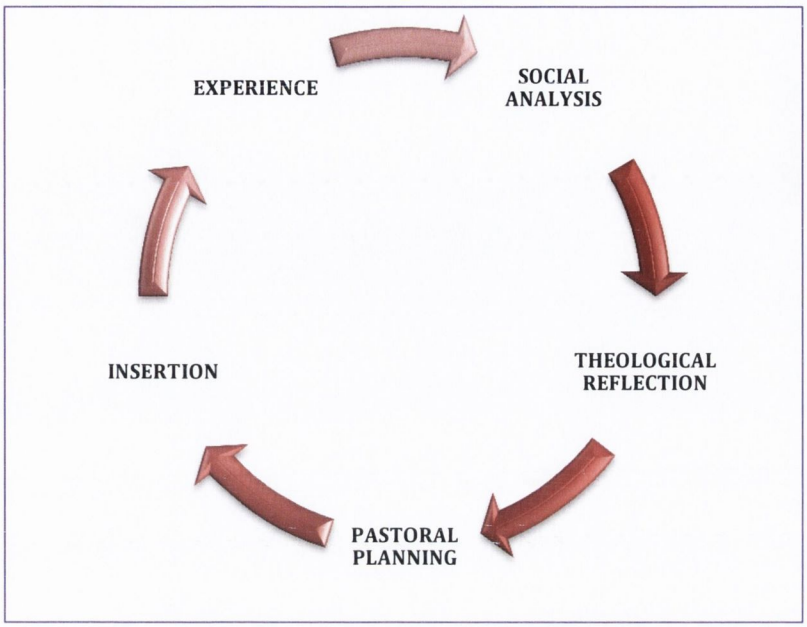
[436] Paulo Freire, *The Pedagogy of the Oppressed,* New York: Herder and Herder, 1970, in Joe Holland, and Peter Henriot, S.J., *Social Analysis: Tool of Pastoral Action,* (Maryknoll, NY: Orbis Books, 1983), p. 9.

[437] Ibid. (1983), p. 8.

[438] Ibid. (1983), p. 8

[439] Ibid. (1983), p. 8

Figure 6.7 Social Analysis Pastoral Circle[440]



Source: Joe Holland and Peter Henriot, S. J.[441] (Diagram modified by the Author).

The third moment is to deal with theological reflection. The whole effort is to analyse data collected in a reflective and indeed prayerful way.[442] This includes "the experience in the light of living faith, scripture, church social teaching, and the resources of tradition."[443] The reflection on the Word of God enables deeper understanding and stimulates new and shared insights on new challenges.

The pastoral planning moment is very crucial because it involves, decision-making and action, is to engage individuals and communities into concrete action.[444] The information gathered from the first moment of insertion to the third moment theological reflection is translated into action for development, improvement and empowering individuals and communities.[445] The pastoral circle is a process whereby response of action in a particular situation brings about a situation of new experiences that are reflected upon. It is an on-going process that translates

[440] Joe Holland, and Peter Henriot, (1983), p. 9.
[441] Ibid. (1983, p. 9
[442] Ibid. (1983), p. 9
[443] Ibid. (1983), p. 9.
[444] Ibid. (1983), p. 9
[445] Ibid. (1983), p. 9.

experiences into new situations and opens to the possibility of transformation and calls for further mediation through insertion, analysis, reflection, and planning. There is no final conclusion, for the pastoral circle probes new challenges as it becomes more of a spiral than a circle.[446] Repeating this process every time allows for the development of fresh ideas and approaches, and collaboration becomes part and parcel of the process. This process helps to bring wholeness in dealing with the difficulties facing people especially the most vulnerable.[447] "Within the context of social analysis, facts and issues are no longer regarded as isolated problems. Rather, they are perceived as interrelated parts of a whole."[448] Thus, social analysis gives "a larger picture in a more systematic fashion."[449] "By dealing with a whole, rather than with detached parts, it becomes possible to move beyond "issue orientation" or a primarily pragmatic *ad hoc* approach, toward a truly holistic or systemic approach."[450]

Pastoral policies have to be fair, inclusive and realistic. Protection services need to be implemented and co-ordinated by suitably trained personnel. Again serious work is required to develop the appropriate type of services to be offered. A primary source of information here is the sufferers: they need to be consulted attentively and respectfully. Information gained in the case studies will form a vital part in designing the most suitable protection services.[451] Co-ordination of the services is required to see that those most in need are first in line. Co-ordination is also required to see that any monies available are spent in the most economical way possible.[452] Finally, there must be administrative representation at government, international community and Church level to continue to forward the needs of stigmatised people and the necessity of tacking stigmatisation systemically and to lobby for more resources.

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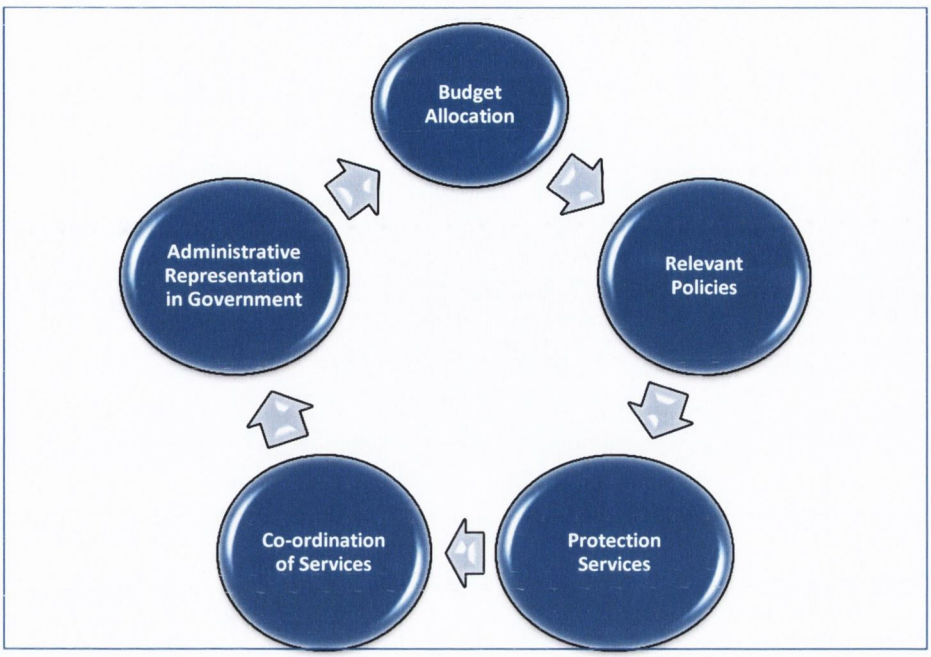
[446] Ibid. (1983), p. 9.
[447] Joe Holland and Peter Henriot, (1983), p. 10.
[448] Ibid. (1983), p. 11.
[449] Ibid. 1983, p. 11.
[450] Ibid. 1983, p. 11.
[451] Ibid. 1983, p. 9.
[452] Mary McNeil and Michael Woolcock, "Capacity Building and Social Development: Engaging with Local Contexts and Processes, in Tara Bedi ed., *Development Review,* (Maynooth, Co. Kildare: TROCAIRE The Catholic Agency for World Development, 2008), p. 69-78.

Figure 6.8 Resources Cycle



Source: Own.

6.17 Conclusion

This chapter was framed around the concept of the provision of pastoral care by the Church. The question was discussed early on, as to whether this pastoral care should be provided on an individual or community sharing basis. A co-ordinated approach is required if any progress is to be made in dealing with the current serious health issues. Reference was made to the early Church and its perception of the causes of health issues. Significant emphasis was placed on the idea and image of Jesus the Healer. The healing ministry of Jesus was all encompassing. He healed the good and the outcasts. He also healed their troubled minds. He was in effect performing pastoral care on an all-inclusive or holistic basis. It would be of benefit to bring this idea and image to the fore in developing a pastoral approach to healing and in all programmes of formation of pastoral carers.

Having addressed the underlying the theological ground, this chapter developed a plan for a current holistic pastoral care process. The requirements for advocacy, health care policies, a multi sectoral approach and research were outlined. The requirement for a budget allocation from national government and others is vital if

a pastoral care approach is to be successful. The adducing of Scripture, as for example in a Christology of Shepherding and Service; in understanding the Church as the Body of Christ; and in the recurrence of such motifs in Church liturgy and teaching, reminds us that Scripture is a fertile source of understanding who Christ is for those who suffer and those who care for them, and points to a theological paradigm of Church and to the specific relation of the second person of the Trinity to the Church's being and witness. The Church continues with the mission of Christ in this world and builds the Kingdom of God through its members. They are united in prayer and worship and extend their charity to the needy. The members live by the Gospel values, of caring, loving, showing forgiveness and compassion. Therefore the Church, "as Body of Christ, it is drawn into the very triune life of God through the Person of the Son."[453] Furthermore the Church is seen as a "divine-human institution."[454] The Triune God is thus portrayed through the encounter with the other. It is therefore important to note that the Church is also vulnerable. Its members have disabilities that need special care and sensitivity of approach. As an institution too, the Church is able to reach out to the poor and marginalised in society.[455]

The expression of the Body of Christ is important in another way when we talk about the Church. It is the sacrifice of the Eucharist which Christians participate in and partake of through faith as a meal, "to be in the Body of Christ is to be in Christ," and make its members participate in his person. The symbol of the bread and wine is an integral act of the Church to keep the Body of Christ alive.[456] His Person is inseparable from his work, his doing from his being. The celebration of the Eucharist is a reminder to Christians of self-giving, obedience to the Father and unity of the Holy Spirit of Jesus Christ. The Eucharist is a sacrament which unites the world to God. The suffering, death and resurrection of Christ, bridges the relationship of God to his people. It is important to understand the body metaphor not in a limiting sense as a static entity i.e. the Church, but in a much more dynamic

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[453]Gabriel Fackre, *the Church Signs, of the Spirit and Signs of the Times: The Christian Story- Pastoral Systematics,* (Cambridge: Wm. B. Eerdmans Publishing Company 2007), pp. 16-17.
[454] Ibid. (2007), p. 15.
[455] Gabriel Fackre, *the Church Signs, of the Spirit and Signs of the Times: The Christian Story- Pastoral Systematics.* (Cambridge: Wm. B. Eerdmans Publishing Company 2007), pp. 16-17.
[456]J L Vander Zee, *Christ, Baptism and the Lord's Supper,* (Downers Grove III: InterVarsity Press, 2004), pp. 135-254.

sense as people who are Church. Thus the body of Christ refers to the *ecclesia* (community of people together) who are alive in Christ and nourished by the Eucharist.

> The Body of Christ was born on earth, formed by and filled with the Holy Spirit, and living under the known sovereignty of its exalted Lord. The Spirit keeps the Body alive and alert, empowering a people to tell and celebrate, to do and the Story - *kerygma, leitourgia, diakonia, koinonia,* "Come Holy Spirit![457]

Jesus was establishing a community of brothers and sisters, free from domination. That was a community which resembled the Kingdom of God –on earth as in heaven. Jesus' kingdom was not from this world or for this world and it was very different from other kingdoms here on earth. It was a kingdom to bring light to shine on human life in the world.[458] The fullness of the Body of Christ as ecclesia is experienced in the multitude of societal relations and structures. The image of the Church as the Body of Christ follows closely on the meaning and intention of Jesus when he spoke about the communion between him and his followers: he promised, he would be with his disciples until the end of time even when his normal human presence finished.

The faithful are one with Jesus in the Spirit. It is through this mystical communion that his followers are constituted as his body. The image of the Church as Body of Christ portrays dramatically the intimacy of the bond between Christ and his Church. The Church gathers around Christ and is united in him, in his Body. The image of the Church as the Body brings out at least three aspects: the unity of all the members with each other as a result of that union with Christ; Christ as head of the Body; the Church as bride of Christ. The Church in pastoral work does well to dwell and reflect on such images of closeness, intimacy and empowerment.

The Church is also challenged to examine itself in the way it relates to those who are stigmatised. The Church is not a single entity. It also has to attend to the needs of its members, remembering that some of them are vulnerable through

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[457]Gabriel Fackre, *The Church Signs, of the Spirit and Signs of the Times: The Christian Story - Pastoral Systematics.* Cambridge Fackre, G. *The Church Signs, of the Spirit and Signs of the Times: The Christian Story-Pastoral Systematics,* (Cambridge, Wm. B. Eerdmans Publishing Co. 2007), p. 8.
[458]Peter McVerry, *Jesus Social Revolutionary?* (Dublin: VERITAS, 2008) pp. 34-36.

stigmatisation and through living precariously on the edge – as so often do the sick, women and children, the elderly and the orphaned. These people deserve recognition, inclusion and welcoming care within the Church especially when they themselves lack the resources to live a full and dignified life. In keeping with the social teachings of the Church there is need to respond to the needs of the stigmatised. Most of these people are marginalised from the normal community. If they are suffering from HIV/AIDS they are considered a threat to the community. But through faith in practice and the living as the Body of Christ, the community of the Church widens the space of its tent, and the gracious liberating Kingdom of truth and justice, love and peace comes once more into their midst here and now, and with a hope-filled promise for the future.

Chapter 7 Conclusions, Recommendations and Future Research

> Stigma remains the single most important barrier to public action. It is a main reason why too many people are afraid to see a doctor to determine whether they have the disease, or to seek treatment if so. It helps make AIDS the silent killer, because people fear the social disgrace of speaking about it, or taking easily available precautions. Stigma is a chief reason why the AIDS epidemic continues to devastate societies around the world.[459]

7.1 Introduction

The aim of this thesis was to examine the background to the HIV-AIDS-related stigmatisation crisis in the Roman Catholic Diocese of Mutare, Zimbabwe, and to argue for the introduction of a holistic pastoral care response to the crisis. The thesis focused on the assumption that one cannot fully understand HIV-AIDS sufferers without a full grasp of stigmatisation related to the disease, which has its basis in social, cultural, religious beliefs and practices. Recommendations resulting from this thesis are from the findings of the case study discussed in chapter 4 in light of sociological, cultural and religious theories of stigmatisation, and research and debate that contributed to the development of the thesis. The case study carried out in the Roman Catholic Diocese of Mutare in Zimbabwe was aimed at giving the researcher first-hand information concerning HIV-AIDS - related stigmatisation from the perspective of sufferers and carers at different levels.

The Roman Catholic Church in Zimbabwe does not operate in isolation to the real world of the political, social, emotional, intellectual, spiritual and physical environment of the Zimbabwean people. Based on the findings of this thesis and particularly the findings of the case study, the Church arguably has a major role to play in all aspects of the HIV-AIDS stigmatisation response. This thesis has come firmly down on the side of a holistic pastoral care response by the Church. Therefore, to develop a strategy that is holistic and effective, the Church has to co-ordinate, collaborate and show leadership in providing a wider vision in the

[459] Ban Ki-moon op-ed 'The Stigma Factor', *The Washington Times,* 6th August, (2008,).

pastoral approach.[460] While it is possible to disagree with aspects of the thesis, there is no doubt that all of the recommendations and suggestions for future research, tackled together according to their interlocking dynamics, can make a significant difference. This concluding chapter summarises and pulls together the main points covered in each chapter and ends with a reflection on what has been learned and what has still to be achieved, recommendations on the implementation of the 'RAW model' and suggestions for future research.

7.2 Introduction to the Thesis

Chapter 1 introduced the thesis and gave a brief background to HIV/AIDS in sub-Saharan Africa. This chapter also looked at the causes of stigmatisation and noted the relationship of HIV/AIDS to stigmatisation. Key terminology was introduced and would be defined and further elaborated on in chapter 2. This introductory chapter also looked at the role the Church played and can play, in the future, when a holistic pastoral approach is established and put into practice.

7.3 The Root Causes of Stigmatisation – Chapter 2

Chapter 2 opened with a with a discussion and description of the sociological, cultural and religious sources and dynamics of stigmatisation in order to describe how it is basically a social process embedded and operating through the core values and beliefs of society. Terms such as, attitude, stigma, myth, prejudice, stereotyping, scapegoating, fear, and deviance were defined and explained. These beliefs and core values include myths and prejudices that make "out-groups" different from "in-groups."[461] "Out-groups" are labelled as deviants because they are seen as having attributes that disturb the existing social order. Those who consider themselves "normal" were presented as going to enormous lengths to maintain the status quo, which was in turn premised on keeping the out-groups conforming and under control.[462] The lessons learned from chapter 2 are 3 fold; firstly, stigmatisation is so embedded in the human psyche and in the structures of

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[460]Austin Flannery, ed., 'Ad Gentes', *Vatican II: The Conciliar and Post-Conciliar Documents,* Volume 1, Chapter 5, "Cooperation", no. 38, (Dublin: Dominican Publications, 1992), p. 851.
[461] Erving Goffman, (1963), p. 16.
[462] Michael Kelly, HIV/AIDS: A Social Justice Perspective, (Nairobi: Paulines Publications Africa, 2010), 129-130.

society that it is a self-perpetuating vicious cycle with violent consequences; secondly, society relies upon core values, including myths and prejudices, which rightly or wrongly are defended at all costs – whether by taboo, cultural norms or coercion; and thirdly, fear is a driving force that makes a society act and react in unthinking and unfeeling ways.[463] Thus, "stigma is a process that goes on inside us."[464]

7.4 HIV-AIDS as a Driver of Stigmatisation – Chapter 3

In Chapter 3 stigmatisation was seen as a complex social reality found in human living and social interaction in multi-faceted ways. Stigmatisation is engrained in societal, cultural, and religious beliefs which have shaped the lives of the people as individuals, family, community, and society at large. While the latter contexts and settings of culture and customs may normally be considered in a positive light, they may also have negative attributes which makes people live in fear of each other,[465] three major points are to be learned from Chapter 3. A "them" and "us" mentality has developed between people with HIV-AIDS and those who are healthy. [466] Secondly, stigmatisation attached to a disease can be even worse than the disease itself. As Nelson Mandela[467] said, "The stigma is something that kills human beings, sometimes far more than the disease."[468]

The challenge is towards accepting those failing to fit a particular category, or failing to fulfil the expected norms, and also critically to re-appraise these categories and norms. Those who fail to fit into a particular category can lose their sense of belonging and in most cases they are discriminated against, whether on grounds of age, race, gender, socio-economic status, colour or disease. Thirdly, the social effects of stigmatisation make it even more difficult for people living with

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[463]Cynthia Renée, Pope, and Robert Malow, 'HIV, Public Health, and Social justice: Reflections on the Ethics and Politics of Health Care', in Pope Cynthia, Renée T., White, and Robert Malow, HIV/AIDS: Global frontiers in Prevention/Intervention, (New York: Routledge, 2009), p. 279.

[464] Michael J. Kelly, HIV/AIDS: A Social Justice Perspective, (Nairobi: Paulines Publications Africa, 2010), p. 129.

[465] Michael J. Kelly, (2010), p. 129.

[466] Michael J. Kelly,(2010), p. 130.

Nelson Mandela; "Meeting Mandela: A Staying Alive Special in Honour of Mandela's 85th Birthday", *MTV Premiered an hour long Documentary,* 18 July (2003).

[468] Ibid, (2003), p. 1..

HIV-AIDS to be fully accepted in the family, community, or society. Society has its own complex network of values and beliefs for normative or acceptable behaviour. The vicious cycle of stigmatisation demonstrated how stigmatisation actually breaks down family life and protective cultural relationships.[469] Sufferers become exposed and vulnerable, often with no one to care for them. They are shunned, misrepresented and scapegoated at every turn. The prevalence of all of these typical patterns as delineated in theoretical discourse were subsequently corroborated by the results of the Mutare case study.

7.5 The Realities of HIV-AIDS in Africa - Chapter 4

Chapter 4 reviewed the historical and current perspectives of the Roman Catholic Church in Zimbabwe and discussed stigmatisation within an African and Zimbabwean context. Chapters 2 and 3 discussed the cultural, sociological and religious background of stigmatisation, in a general and HIV-AIDS related context. A number of important issues came to the fore during research on this chapter. Firstly, the Catholic Church (my main focus group) and other Churches and organisations were shown to be facing challenges in promoting and providing services that can liberate the social mind set, and mitigate damaging cultural and religious practices, freeing sufferers from stigmatisation, and promoting their human dignity and social flourishing.

> Exclusionary othering *stems from* fear, but it can also *lead to fear*; and fear breeds silence, separation, and the othering of discourses that do not coincide with our own. In our globalized society, where instant communication theoretically reduces the strangeness of the other, such fragmentation may be concealed behind the illusion that human family is becoming more inclusive.[470]

At this stage, I began formulating my ideas for an all-embracing Church-based holistic caring system for HIV-AIDS-related sufferers of stigmatisation. The core message was to help people who are "endangered and grieved by HIV-AIDS", by "the call for cultural empowerment through education and other programmes," and by eliciting their own capability and resilience.[471] "In reality, as [Blessed] John

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[469] Diana L. Hayes, "Come Ye Disconsolate: American Black Catholics, Their Church, and HIV/AIDS," in James F. Keenan S. J., et al., Catholic Ethics on HIV/AIDS Prevention, (New York: Continuum, 2000), pp. 96-107.
[470] Joe Holland and Peter Henriot, (1983), pp. 9-12.
[471] Sonja Weinreich and Christoph Benn, *AIDS-Meeting the Challenge: Data, Facts, Background,* (Geneva: WCC Publications, 2004), 8.

Paul II, put it, the world itself is facing a crisis of belonging, and 'the more globalised the market becomes, the more we must counterbalance it with a culture of solidarity that gives priority to the needs of the most vulnerable.'"[472]

Some people were seen to find strength in adversity, and when they were helped by others, to have discovered "faith against meaninglessness, hope against helplessness, and love against judgmentalism."[473] These are the people who need to be affirmed as participants in a holistic pastoral care approach in addressing their attitudes to life, fears, and prejudices.[474] Clearly, also those people, who are stigmatising others due to their status, whether through attitudes towards a taboo illness, poverty, or the misguided narrow focus of their own moral compass, need to be included in the seeking for a holistic remedy.

The second point to be taken from this chapter was that, through the provision of a holistic pastoral care approach, the Church can strategically position itself to put structures in place for an adequate and dynamic response to the systemic HIV-AIDS stigmatisation issue. Thereon highlights the Church as God's body as represented by Jesus Christ, the Head.[475] "In this body the life of Christ is communicated to those who believe and who through the sacraments are united in a hidden and real way to Christ in his passion and glorification."[476] The sacrament of Baptism is the gateway to all the other sacraments. It is "through baptism that we are formed again in the likeness of Christ."[477] "From one spirit we are all baptized into one body." (1. Cor. 12:13). "For we were buried with him by Baptism into death"; and if 'we have been united with him in the likeness of his death, we shall be so in the likeness of his resurrection also." (Rom 6:4-5). The Eucharistic dimension of the Body of Christ comes into view here as the

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[472]Gillian Paterson, "Who Sinned? ADS-Related Stigma and the Church," in Hogan, Linda, ed. *Applied Ethics in the world Church: The Padua Conference, (*Maryknoll, New York: Orbis Books, 2008), pp. 163- 169.

[473] Emmanuel Katongole, "Christian Ethics and AIDS in Africa Today: Exploring the Limits of a Culture of Suspicion and Despair," *Missionalia 29/2* (2001*)*, p. 158.

[474] Austin Flannery, O. P., *Vatican II Documents,* (1992), p. 905.

[475]Jacques P. J. Theron, *Practical Theology: Only Study Guide for PTA 100-T.* (Pretoria: University of South Africa, (1991),pp. 13-17.

[476]Kreeft Peter, ed., *A Summa of the Summa: The Essential Philosophical Passages of St. Thomas Aquinas' Summa* Theologica, (San Francisco: Ignatius Press 1990), pp. 111, 154-156.

[477]Austin Flannery, ed., *The Basic Documents Vatican Council II Constitutions Decrees declarations: A Completely Revised Translation in Inclusive Language, New York, Costello Publishing Company, Inc. Lumen Gentium, 21 November 1964 Dogmatic Constitution on the Church.* (1996), p.6.

sacramental expression of the Church community continuing to share the body of the Lord (1 Cor. 10: 14, 11: 17). The members of this body are all united with the symbol of the one bread, broken and partaken by many (1Cor 10:17; 12:27). The Body of Christ is inclusive of all – including the poor and those excluded and stigmatised – while the behaviour of those wealthy and well-positioned, must be inclusive and hospitable towards them, in Christ, and equal in worth and dignity.

One possible new form for the discipline would represent pastoral care and counseling as *oriented by* ecclesiology, *concerned for* elucidating the structure and dynamic of human being-in-the-world by means of plurality of methods of inquiry, and especially *informed* by the rapidly proliferating literature, experimental and theoretical, on the human life circle. Within such an approach, several themes would play especially important roles: pastoral care as the ministry of the whole congregation in the world; the identity of the ordained minister in his or her pastoral office as both enabler and representative of the calling of all Christians to minister in the world; and a threefold focus of pastoral care, including the person or persons in need, the gospel of Jesus Christ, and the faith of the Christian Church as represented in Scripture and tradition."[478]

The Church is possessed of particular and indeed unique opportunities to be proactive and imaginative, in taking a leadership role in providing education, health, and community development programmes to the stigmatised and those close to them. Therefore, a holistic pastoral approach should address all aspects of life, namely, spiritual, physical, social, economic, intellectual, emotional and religious. So too the Church has the ability to reach out to the whole country through its countrywide dioceses. These dioceses are rich with human resources professional and otherwise, which need to be and can be harnessed and involved in policy-making, policy implementation, communications, health, and education.[479] The services provided by the Catholic Church are still very crucial to the development of social and spiritual structures in Zimbabwe.

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[478] Leroy T. Howe, 'Where Are We Going in Pastoral Care?' in, *the Christian Foundation*, November 11, (1981) pp 1160-1163.
[479] *Zimbabwe Human Development Report*, August, (2003) p. 220.

Thirdly, other aid organisations in Zimbabwe are facing challenges in promoting and providing services that can change the social mind set of the local population to a more just, inclusive, and caring way.[480] These too need to be collaboratively engaged. It has been demonstrated that stigmatisation is greatly enforced by a socially conducive environment. Years of colonial rule no doubt have taken their toll on the actions and interactions of the local Zimbabwean population. Segregated living, schooling, and employment opportunities can reduce a people to subservience and the survival of the strongest. The Church and other organisations by working in tandem can be more effective champions of social, cultural, religious values, cooperation and mutual solidarity in society[481]. What better way for the Church and other organisations to show inclusiveness, health justice and critical effectiveness than by pooling resources and working together.

Lastly, chapter 4 discusses the Bishops' Pastoral Letters of 1980 to 1991. These letters shone some light on how the Church can use its teaching authority and its pastoral service approach to the problem of HIV/AIDS. However, this review also concluded that the Bishops in the region were more focused on challenging the economic and political situation of the day than on those suffering from HIV-AIDS. The recommendation was that these pastoral letters should also become a focal point and an effective channel of communication in the Church's fight for the innate human dignity and rights of every person, and a fairer, just society in Zimbabwe free from stigmatisation in its manifold guises.[482]

7.6 Case Study in Mutare

Chapter 5 documented the realities of stigmatisation in the Roman Catholic Diocese of Mutare, Manicaland Province, Zimbabwe based on the findings of a case study carried out by the author in Manicaland Province during the spring of 2011. The case study highlighted failings on the side of those offering care and advice

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[480] *Zimbabwe Human Development Report,* (2003) pp. 7 – 13.
[481] *Vatican Council II: The Conciliar and Post Conciliar Documents*, "Decree on the Church's Missionary Activity", Vatican II *Ad Gentes Divinitus,* 7 December 1965, General Editor, Austin Flannery O.P., New Revised Edition, Northport, New York: Costello Publishing Company, Northport, New York, no. 2, (1988), p. 815.
[481] *Vatican II Documents,* 'Gaudium et Spes' (1988) p. 903.

and the sense of disempowerment on the part of the sufferers. Clearly, more and more effectively disseminated information must be made available together with the initiation of more health care programmes on how to deal both with HIV/AIDS and its accompanying stigmatisation before there can be cause for hope that both the disease and its attendant stigmatisation can be curtailed.

The case study also highlighted that the Church needs to refrain from linking comments in its preaching and teaching about sin and blame to comments about the living realities and needs of those suffering from HIV/AIDS. The Church's responsibility is to engage its own membership and society more widely in confronting the issues of living with HIV/AIDS and its attendant stigmatisation both strategically and holistically. Not to do so will maintain and indeed reinforce the vicious cycle of stigmatisation.

The practical realities of stigmatisation were demonstrated in the case study, as reflected in the behaviours of Church leaders, members and caregivers alike, as well as sufferers themselves. For example, some Church Leaders, Church Members, and Care Givers by their own self-reporting –

- we're not at ease in shaking hands with sufferers
- rarely used toilets used by sufferers
- Told sufferers, "Be careful, and do not go nearer the visitor."
- used judgemental language, associating the condition with sin and blame and lack of morality
- used English as a preaching language, although most poorer people speak the local language as mother tongue
- did not involve sufferers in various community activities
- Did not consult sufferers themselves about their needs and programmes to help them.[483]

In the researched case study, the writer discovered that sufferers sometimes listen more often to traditional healers, as they believe that these have more power to heal than the medical experts. This is of course part of their traditional background and family beliefs, but such cultural beliefs needs to be explored and understood, and in some circumstances even integrated into a holistic framework of care.

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[483] Sonja Weinreich and Christoph Benn, *AIDS-Meeting the Challenge: Data, Facts, Background,* (Geneva: WCC Publications, 2004).

Another finding was that some care programmes were based on assumptions made about the sufferers, and lacked the active involvement of sufferers or community clientele in deciding on the needs, possibilities and strategies of care that were required by them. All in all, the vision and mission statements and programmes of the various care organisations lacked some elements of ways and means of recognising and making steps of intervention to arrest the process of stigmatisation. The emphasis in the programmes was on the passing acknowledgement of the presence of stigmatisation and on exhortations on behaviour changes.

7.7 Provision of Pastoral Care by the Church

Chapter 6 focused on the provision of pastoral care by the Church. The conclusion was that the Church needs to work together through its own and inter-Church organisations and with other agencies to supply this pastoral care or to enable processes that will contribute to its multi-levelled, multi-sectoral development. The emphasis here was theological, ethical and religious, based on the Church's own belief and realisation that Christ was the model of Christian life. A Christologically-centered approach is key focus in the pastoral ministry. In the time of Jesus, the outcasts were treated with disrespect and were excluded in the community. In the context of HIV/AIDS-related stigmatisation, sufferers also experience isolation and exclusion. But, Jesus visited, touched, healed, prayed, and ate with the sick, unwanted and outcast in his own time. Sufferers must be helped to understand that HIV/AIDS is not a punishment for their sins, and moreover that their suffering is the suffering of Christ.[484] The suffering of one is the suffering of all. Thus too, the Church's self-understanding is that it must "go and do likewise." The same attitudes are expected of the Church today in its diaconal structures of service and care and in its patterns of outreach, as well as of individual Christians who profess to follow the example of Jesus in the manner of his love and care for all, in how he dealt with the outcast, the poor, and those in need of healing.

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[484] Pope Pius XI, "*Miserentissimuss Redemptor*," 1928.

In line with biblical and theological foundations, the pastoral ministry of the Church can contribute to transformation of the lives of the suffering, by becoming a more attractive and effective ministering presence and a source of empowerment. The Church needs to help those without a voice to be heard, and to become their voice in the places of power. So too the Church can more successfully mobilise its own social teaching in forms of education and practice that will challenge and curb the social injustices. The Church can be a sign of love to the sufferers through its actions of empathy to those suffering from HIV/AIDS who are stereotyped, marginalised, demonised and scapegoated. This can be done through actions that practically embody the caring face of Christ and of Christ's Body on earth – by visiting and listening to the sick, bathing them, touching them, feeding and being there for them as an accompanying "presence."[485]

The findings of Chapter 5 also pointed to the need for a holistic pastoral approach to include education on human sexuality. As in many cultures, sexuality and death are often subjects of taboos and secrecy in Zimbabwe. The sensitive ways the Church can engage itself in celebrating the Eucharist among the sick, anointing and praying for them can create an ethos of compassion. So too, in comforting the bereaved, and not abandoning them in isolation, in burying the dead in a faith atmosphere of resurrection and eternal rest for those who have departed, can create an ethos and means of communion, solidarity with the ancestors (communion of saints) and community healing.[486] In considering Zimbabwean culture, the traditions beliefs in ancestral spirits can be re-directed in a better understanding of the 'communion of saints,' diakonia and furthermore mission within community and healing It has been emphasised throughout that the care must follow a holistic integrated approach which deals with the whole person and their life in the community, and be centred on involving the person and the community in different aspects of the pastoral ministry, each ministering to the other whether out of the strength or vulnerability of personal and pastoral resources, as concerned ministers of hope or as wounded healers.

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[485] http://www.vatican.va/holy_father/pius_xi/encyclicals/documents/hf_p xi_enc_08051928_miserentissimus-redemptor_en.html

[486] Vincent Leclercq, AA. *Blessed are the Vulnerable: Reaching out to those with AIDS*, New London, Twenty Third –Publications 2010, 143.

7.8 New Knowledge contributed to Understanding Stigmatisation

The new knowledge contributed by this thesis falls into six distinct areas, which are summarised below: This new knowledge resulted not only from my research into what has already been written and said about stigmatisation and from making fresh connections, for example between cultural and religious aspects, but also and most specifically from the case study completed in the Diocese of Mutare, Zimbabwe during early Spring 2011.

7.8.1 Self-Stigmatisation

Self-stigmatisation refers to persons actually stigmatising themselves through an internalising of external attitudes of low esteem, blame and distancing. People suffering from HIV/AIDS, easily persuade them that people do not value or like them, fear them and are avoiding them. They can begin to believe, even when obviously untrue, that they are felt to be a burden to family and friends. They can even convince themselves that their disease is contagious (a reality that is true only under specific and avoidable circumstances); and that they are going to die shortly and should therefore avoid all human contact. This is a downward spiral from which it is hard to recover.[487] People in this state are tempted to lose all self-worth and continually blame themselves for their condition. While it is true that some may have contributed behaviourally to their own misfortune, structural factors were also at work over which people have little control or choice. So too, many, such as unsuspecting spouses and unborn children of carriers of the disease, are innocent victims. Evidence shows that once a person self-stigmatises, they effectively close themselves off from family, friends, medical help and the benefit's pastoral care. Education about how this downward spiralling dynamic can be interrupted, and about the actualities of cause and treatment, levels of health care provided by Church and state (via media, community-based programmes on health, development and on cultural and religious reflection) are the key step

[487] Paul Chummar, 'HIV/AIDS in Africa: An Urgent Task for an Inculturated Theological Ethics', in Hogan Linda, ed. *Applied Ethics in the world Church: The Padua Conference, (*Maryknoll, New York: Orbis Books, 2008), pp. 155-161.

towards solving the problem of ignorance, fear and disempowerment[488]. Moreover, psychological support is key focus to breaking the vicious downward spiral of thinking and behaviour and must be considered within the context of a holistic pastoral approach to healing.

7.8.2 Dissipation of Family Resources

It became clear to the author during the course of the on-site case study that people who self-stigmatise also tend more needlessly to dissipate scarce family resources. The attitude appears to be, "I might as well spend what I have before I die." Some sufferers even sell family property, in rural areas the source of life, and spend the proceeds recklessly. It is a "live for the day" mentality. Remaining family members including children, can in this state of self-distancing and absorption, be forgotten, with no care for their wellbeing. Again education and media campaigns can highlight that the disease is controllable, with proper intervention and not inevitably terminal. With the right treatment, due care, and access to the proper medicines, it has been found that sufferers can live longer and more fruitful lives. Clear, precise media campaigns, and community and Church-based health education programmes, are one of the best ways to reach a wide audience, using the Shona, English and Ndebele languages.

7.8.3 Loss of Support from Family and Friends

Much has been written in this thesis about the vicious cycle of stigmatisation. I now want to concentrate on what became clear in the research regarding the loss of the support of family, community and friends. The case study interviews highlighted how HIV/AIDS sufferers had fallen victim to the vicious cycle of stigmatisation. In such traditional cultures it is always assumed that one could at least rely on one's family in time of need. Also, it is to be remembered that in an African traditional context the family and clan are always considered most important and the last to abandon their sick ones. However, the onset and sheer epidemic pressures of HIV/AIDS have imposed unprecedented stress on family relationships, old kinship ties and structures, often to the point of breaking down.

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[488] Aquiline Tarimo, 'Globalisation and African Economic Reforms', in Hogan, Linda, ed. *Applied Ethics in the world Church: The Padua Conference, (*Maryknoll, New York: Orbis Books, 2008), pp. 32-38.

Typically, families are fiercely proud and protective of the family name. However, the shame and disrespect of having a relative sick with HIV/AIDS has often altered this solid relational family dynamic. *In extremis*, and in fear of punishment and isolation of the whole family circle, friends, and the community are known to have abandoned the sick, or ignored them and kept them out of community gatherings. Some families have gone one step further: they hide sick persons, making excuses about absence or apparent symptoms, or asserting signs of recovery. Under this strain, it is easy to understand that the sick person comes to be blamed by the family for their sickness and for the added pressures of such social deception being shouldered by family members. Some report having been accused for using scarce family resources for drugs and health care.[489] As a result, the individual is now viewed as a liability to the family and a danger to society. And so the stigmatisation becomes both intimately and socially embedded.

The Church is well placed to come forward and help alleviate family tensions and open up spaces of support – informal and structured pastoral visit's, for example, or through reliable practical assistance, facilitation of information sessions, support-groups and networking-campaigns, as well as counselling and advocacy for sufferers and carers, individually and in groups. Even when resources are scarce, such programmes can find access to government or overseas Church and NGO assistance, but most importantly act as a catalyst to encourage the parish or village community – including the sufferer – to rediscover and draw on their own spiritual and cultural resources of capability, resilience and solidarity, so that, step by step, building block by building block, they can construct together a sustainable multi-focused, holistic pastoral care programme, not only to the unwell but also to the family and the wider community. For a Church community, the example of a healing Christ, who is at the same time, the one who suffers, can be a powerful image and motivation for families. (Chitando 2007: 59, 65-9). Education about the disease can be given, in a family or school context, to reduce the fear and anxiety of families concerning how a HIV/AIDS sufferer is perceived by non-family members. Families can be educated – but also supported – morally, spiritually and practically

[489] Development Review, (2005), pp. 17-149.

in ways to accept the sickness of a loved one and to offer their support and care as best they can. Other agencies also need to mount educational programmes and media campaigns to reduce the impact of fear and despair among families. Nor should the Church's symbolic and ritual practices of healing, meal-sharing, liturgical prayer, and bible sharing be underestimated for their power in gathering people together in hope, and in the shared faith that the healing, compassionate Christ is there in the midst of them. There is no doubt that the Church can take a creative, empowering role in this regard, drawing on the riches of its spiritual, sacramental and pastoral tradition and open to the creative resources of the community as the People of God caring for one another, seeking for health justice and being pastoral to one another. There are many elements and dimensions to a holistic pastoral care strategy, but the key resources may be closer to hand than is often imagined.

7.8.4 Knowledge about the Stigmatiser

Much has been written about stigmatisation and the subtle ways that stigmatisation is perpetuated against those suffering from HIV/AIDS. Not so much has been written about the stigmatiser. This is strange, since stigmatisation can so clearly be traced to cultural, social, and religious beliefs and no doubt to such other factors as economic misdistribution and global injustice. But the question lingers as to why these factors conspire to influence those who stigmatise, whether consciously or unconsciously, and whether these factors are so ingrained in their psyche that they will evoke the same reflex to stigmatise vulnerable others despite knowing that stigmatising is a debilitating and often destructive action. Those looking for ways to interrupt and halt stigmatisation need to understand the gaps and unexamined assumptions in the emotional, psychological, economic, political and social life of a stigmatiser.

Until more is known about the psyche of the stigmatiser, stigmatisation will continue to be a problem. And yet, those who stigmatise are not a breed apart. One need look no further than to one's own life and social practice to recognise at least in retrospect times when one has stigmatised another to a lesser or greater degree. What can be said about racism, sexism, ageism can also be said about "stigmatism".

Is there not a stigmatiser within every person, potentially or actively, given the cultural and religious taboos and the structural exclusions in which we all share? Social psychology, anthropology, sociology, and theology have much light to shed on human behaviour, but so have personal and communal processes of critical reflection and self-examination.[490]

The Church, the government of Zimbabwe, and other social and aid agencies need to invest time and money in a concerted effort to further analyse why, how, when, and where social, cultural, and religious factors have a negative impact on stigmatisation or on efforts at de-stigmatisation and inclusion. As has been stressed, education and more accurate information about HIV-AIDS and about stigmatisation will form a basic part of the solution to the problem. What is sure is that more information about the social, cultural, family and religious background of stigmatisers and about how stigmatisation has become institutionalised is required. It has already been noted that herd instinct, survival-fear, or the drive to survival of the fittest, is no doubt part of the issue. This being the case, those who most readily stigmatise others need to be helped to understand that HIV/AIDS sufferers will not bring about the end of the world. They may be sick. AIDS may have assumed epidemic proportions in some contexts; it – and those who suffer from it – cannot be associated with the contagious plagues of old. It is a controllable disease and great strides have already been made. Structural inequity and health injustice, access to treatment, poverty, gender subjugation and the many other already highlighted structural factors that intensify the prevalence can and must be tackled, structurally and systematically. In this thesis, the Church – specifically the Roman Catholic Church in Mutare – has been a key focus in challenging stigmatising attitudes and behaviour, fearlessly rooting out the seeds of stigmatisation in its own culture, catechesis and practice, and transforming the ethos and structures of pastoral care on behalf of those so unjustly stigmatised through loving action, care and enablement. The Church's efforts will be as effective as its leadership by example.

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[490] Bate (2010), pp. 65-79.

7.8.5 Church Standing in Judgement

The Church probably without realising it was itself stigmatising and demeaning some of its members. The Church leaders, health care workers, educators and pastoral workers according to the testimony of the people interviewed, were as likely as others at times to use the language of condemnation, disapproval, and blame, rather than the language of concern, solidarity, support or forgiveness. HIV-AIDS sufferers were, in the past, condemned as immoral. While it *may* have been an immoral act, according to Christian understanding, which led to a person becoming infected, the God revealed by the person, teaching and ministry of Jesus is not a God of condemnation and punishment. A new understanding of atonement theology is needed. For those afflicted by the disease, they did not need to be denounced or upbraided. Their sin does not equate with punishment. Atonement rather should be seen as 'At-one-ment,' that they are called towards healing and reconciliation to be one with God. What was required was sound information, medical attention and pastoral care, comfort, and help rather than moral condemnation, social disapproval or religious shunning. Too often, I heard from AIDS sufferers that the Church was standing in judgement and regarded HIV/AIDS as the result of a sinful act, and – astonishingly – a punishment for transgressing. Also, the Church did not bring it's teaching or pastoral focus on the broader moral and social issue of stigmatisation, nor investigate and raise awareness of the devastating consequences of stigmatisation, in its pastoral letters or locally-held seminars, even though some of its members were being visibly stigmatised, shunned, and demonised. Such pastoral letters as were sent to Zimbabwean Churches concentrated on political issues or emphasised pastoral actions of providing food and health care. It is possible that the Church did not want to bring the taint of the disease and stigmatisation too close to home?

Going forward, the Church needs to use every pastoral outlet of communication, education and discussion as a pathway of information dissemination on healthy living and stigmatisation, alongside the spiritual aspects of life and social engagement. But it needs also to bring a spotlight to bear on the Church's own failure and to lead the way in actions of repentance, apology and atonement. The

Bishops in pastoral letters and preachers in seminars and pastoral organisations alike need also to take a stand, and give bold example in calling its members to be more tolerant, compassionate, hospitable and just to the sick – as an imperative of the Gospel.

7.9 Recommendations for Dealing with HIV/AIDS Stigmatisation

The significance of this thesis lies in the recommendation to the Church to introduce a holistic ministry of Pastoral Care. The substance and implications of this is have been explored particularly in chapter 6. The aim is to re-awaken the Church to the needs of its most afflicted and abandoned members. To bring to the fore the fact that stigmatisation, which is embedded in the actions of everyday life and the structures of society, is seriously damaging to the mental and physical health of its members. In this regard, a policy shift is needed so that the emphasis of care and other programmes needs to be moved to rotate around the requirements of the sufferer as opposed to the wishes of the organisation offering the programmes. Programmes have to emphasise health justice, human dignity, human rights and equal access to education – and specifically there is a need for programmes which lay bare the dehumanising dynamics of stigmatisation and the daily patterns whereby upstanding and ordinary members of the community, actively or unconsciously collude in everyday modes of mental, emotional and religious exclusion and inflicting of pain on the most vulnerable among them, damaging their capacity to act and contribute as agents in their own healing and the wellbeing of the community.

7.9.1 Integrated Community Care

It has been argued that this pastoral care needs to be structured along participative lines and on a community basis, rather than on an individual basis solely so that a parish unit forms a community or communities of care. I have also recommended an eco-systemic approach with laity and clergy standing side by side with other bodies in partnership and collaboration in raising awareness, empowerment, development, and delivering care services. The Church also has to realise that it cannot do all the work on its own out of its own resources. Churches

can also learn to practise the art of networking – for example with the World Council of Churches, national councils of Churches; with the National Government, and other African bodies for example, Pan African Congress, and with International Institutions such as UN and WHO[491] and well as national and local community health providers. Such organisational bodies, along with the Church development agencies, are already active in Zimbabwe and they, presumably, can help with access to much needed funds.

The Church, similar to other organisations is involved in discrete projects funded by international donors. Michael J Kelly has observed that sometimes the Church has engaged some sufferers by forming groups and focusing on isolated aspects, for example, focusing on some particular areas/needs.[492] However laudable this may be, what is more fundamentally required is a plan of action by the Church and other agencies. This will pull all the efforts together into a concentrated, comprehensive and co-ordinated strategy, including crisis intervention, middle range and long term planning. For example, in Zimbabwe there are many Church organisations of different denominations that unite to address a particular problem, ranging from health, education, transport and unemployment. There is a need for networking and sharing of ideas, resources, skills and expertise. An exchange programme should also be established to facilitate the learning and sharing of best practices amongst various groups. Also, as for capacity building, there can be provision for the transfer of programmes between groups for the benefit of society. Workshops can be arranged that will cater and build strategies that are inclusive.

7.9.2 Church and Education

Kelly is right in arguing that the Church has to work in areas of "education for prevention, care, treatment and support."[493] Such a plan of action needs to be holistic both personally and socially with the Church aiming specifically at a pastoral and strategic approach, where the physical, emotional and spiritual needs

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[491]See for example, UNAIDS (2009), *Religion and AIDS: UNAIDS' Work with Faith-Based Organizations,* http://www.unaids.org/enPartnerships/Civil+society/religion and AIDS.asp accessed 12/8/2012.

[492] Michael Kelly, *HIV and AIDS: A Social Justice Perspective,* (Nairobi, Paulines Publications Africa 2010), pp. 226-36.

[493] Michael Kelly, (2010), pp. 244-49.

of the individual will be met, taking account of the significance of family and community context. Kelly aptly calls for programmes at all levels, national, local and community that "seek to develop an enhanced sense of sexual responsibility."[494] It must be noted, nonetheless, that too often this sexual concern has over-ridden the other dimensions thus preventing a truly wholesome holistic perspective and programme. A well thought-out media campaign is required to advise people of new inclusive pastoral strategies. Creative approaches can be envisaged to make this a desired and rewarding way of contributing to de-stigmatisation and social transformation and of building up the Christian community as the Body of Christ concerned for the wellbeing of all.

7.9.3 Identifying Structures of Negativity

To understand stigmatisation, particular attention needs to be given to identifying and dealing with 'structures of negativity', or, 'reinforcers of stigmatisation', which worsen poverty, creates demeaning conditions, deprivation and underdevelopment. These 'structures of negativity' can be demonstrated as humanly constructed, maintained and reinforced by human intervention. Unjust laws, inequitable economic policies, and trade agreements that arise from disordered thinking and oppressive hegemonic power disposition and practices can, however, be challenged and transformed through analysis, human interaction, and social critique in the light of constructive theory, best practice, and ethical practices grounded on the Gospel message. Pastorally, these realities need to be correlated to Christian teaching and wholeness of truth, justice and liberation, as exemplified in the life if Christ and according to a model of Church as the living Body of Christ. This needs to be tackled, not inspirationally, not in general terms but specifically and conscientiously, and in a way that engenders hope.

7.9.4 The Church and the Laity

There is a need for a shift in today's model of Church to engage more with the laity, in keeping with the recommendations of the Second Vatican Council, in consideration of the entire people of God who are called to fullness of life and participation in Jesus's

[494] Michael Kelly, (2010), p. 237.

preaching of liberation, justice and healing.[495]The Laity are the pillars of the Church, who are able to portray the beauty, truth and goodness of Christ, in the heart of humanity today. The Laity are able to deliver the Church's role in society at multiple levels across different strata of society, including the family, workplace, community and society at large. The laity brings and encounters Christ in the market place.

Lay people can help reduce stigmatisation through their own expertise in different disciplines of life. For example, the Church needs to work with nurses and doctors on issues pertaining to medical health and counselling. Those trained in community education can present workshops and make follow up visits to check on the understanding of the agreed systems of care and quality of attention that the sick are receiving in the community. *Lumen Gentium*, (1964:369) says,

> In order to shepherd the People of God and to increase its numbers without cease, Christ the Lord set up in his Church a variety of offices which aim at the good of the whole body. The holders of office, who are invested with a sacred power, are, in fact, dedicated to promoting the interest of their brethren, so that all who belong to the People of God, and are consequently endowed with true Christian dignity, may, through their free and well-ordered efforts towards a common goal, attain to salvation.[496]

Psychologists, sociologists, theologians and others, all have their role to play in an enhanced, coordinated pastoral care approach. So too, different offices, parish teams, youth groups, liturgical prayer groups, healers, teachers, catechists and pastoral visitors, mentors and simple helpers, all have a role in making a holistic community response a success. The Church has to become more holistic, all-embracing, in its eco-systemic strategy of pastoral care. According to Bosch (1980:222) "the Church as an alternative society lives in this world with others, with whom it is bound in solidarity and yet simultaneously from whom it differentiates itself."[497] According to such a vision, the Church is called to develop a holistic pastoral care approach that is at once collaborative *and* distinctive, complementing what others do, but recognising that the Church cannot do everything out of its own spiritual and moral resources of healing, and hope.

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[495] Austin Flannery O.P. et al. ed., *Vatican Council II: The Conciliar and Post Conciliar Documents*, New Revised Edition, (Dublin: Dominican Publications, 1992), E.J. Dwyer, PTY, Ltd., Newtown, Australia, ninth printing, 1992, *Lumen Gentium*, 21 November, (1964), p. 358.
See also Lk. 4:18;
[496] Austin Flannery O.P. et al. ed., 1992), p. 369.
[497] David J. Bosch Witness to the World: The Christian Mission in Theological Perspective. (Atlanta: John Knox. 1980), p. 222.

Holistic in this sense is in the words of Jeffrey D. Hamilton Gestalt (1997:41) "... all nature is unified in a coherent whole."[498] The whole community has to be comprehensively cared for, with spiritual, intellectual, emotional, medical, and material care. It is a system that "is bounded by a set of interrelated components and activities that constitute a single entity. This set of components work together for the overall objectives of the whole."[499] Thus, the objective of holistic pastoral care is connecting all components together to achieve a common goal.

Emmanuel Katongole, a Ugandan Catholic theologian, reminds us of the importance of the Church's symbolic and spiritual mission and urges the Church to continue carrying out its mission and performing it's liturgical rites for the dead with special care. It is an opportunity where the Church can make a much needed impact by symbolic reverence for the body even in death, by celebrating funeral rites, consoling the bereaved and promoting praxis of support and compassionate empowerment in time of grief and mourning.[500] According to Katongole, the Church is challenged to revise the way in which it understands herself and her mission.[501] It has to be transformed – from being "a moral and spiritual umpire, to a practice of cultural empowerment." Such cultural and spiritual expressions are at the heart of Church community and living. Katongole insists further – "Among other things this means that the Church begins to see herself in terms of providing not so much spiritual guidance and consolation but a new culture through which Christians see themselves and relate to the world."[502] Through such a transformation, hope becomes real.

7.10 The Church a Community of Discipleship

Enda McDonagh is one of the most prominent and prolific writers on the subject of the spiritual and theological renewal of Catholic moral theology. He is also a first-

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[498] Jeffrey D. Hamilton, *Gestalt in Pastoral Care and Counseling: A Holistic Approach*, (Binghamton: The Haworth Pastoral Press, 1997),pp. 41-42.
[499] Ibid. (1997),p. 85.
[500] Robert E., Beckeley and Jerome R. Koch, *the Continuing Challenge of Aids: Clergy Responses to Patients, Friends, and Families (*Westport: Auburn House, 2002), pp. 4-5.
[501] Emmanuel Katongole, "Christian Ethics and AIDS in Africa Today: Exploring the limits of a culture of Suspicion and Despair," *Missionalia 29/2* (2001),p. 158. See also Michael Kelly, (2010), p. 249.
[502] Ibid. (2001), p. 158.

hand witness to the changing and developing needs of the church in Ireland. His subject emphasis is predominately on community as on a community of discipleship. Discipleship has many aspects, it is Christian doing, it is a genuine partnership with God; it is experiencing and expressing the teachings of Jesus. In the spirit of 'diakonia', different members of the church are parts of the Body of Christ.

Human otherness within community, within some actual and possible communication, provides the basis of the moral situation. Without the communal dimension, human otherness could provide no insight into experience of morality. And the 'communal-' dimension seems necessarily reciprocal. To be in community, to communicate, to achieve communion – all involve mutual recognition, respect and response.[503] The Church is called upon to connect on a continuous and tireless basis the people to the mystery of God and to establish communication and reciprocity between men and women.[504] Gender should no longer be considered a barrier to good man-woman relations. Rather, it can be viewed as a gift and opening to good and creative inter-relationship that accepts difference and equality for the betterment of society. This is a basis for a transforming moral and ecclesial vision for the Church in a society where stigmatisation is dismembering communities.[505] But gender-based discrimination needs to be engaged as a priority. "The Church needs to read the signs of the times and see where God is to be found, what He is saying and how one responds to God in all this."[506]

7.11 A Successful Holistic Pastoral Caring Ministry

Primarily, if the Church is to implement a successful holistic pastoral caring ministry, ordained clergy and all the laity – women, men, children and the young will be called to bring their own unique gifts to bear on the task ahead. The Church

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[503] Vincent Leclercq, AA, *Blessed are the Vulnerable: Reaching out to those with AIDS*, (New London: Twenty-Third Publications 2010), p. 159.
[504] Ibid. (2010), p. 159.
[505]Megan McKenna, *Not Counting Women and Children: Neglected Stories from the Bible,* (Maryknoll, New York: Orbis Books, 1994), pp. 124-125.
[506] Michael J. Kelly (2010), p. 249.

needs to be at the forefront not only in comforting the stigmatised but also in confronting their own patterns of exclusion and stigma and challenging patterns of shunning and stigmatisation wherever it is found in society and in the Church.

> The Church cannot neglect its work of care, treatment and support and likewise it should continue its ministry of teaching and work for the maintenance of high moral standards. But at the same time, it must go more deeply into the issues, deepening and transforming it's thinking, asking what it means to be a Church with AIDS in a world with AIDS.[507]

The Church can make a change in society by actively participating and applying the Justice Model approach to the HIV/AIDS problem. The sufferers need to be Recognised, Affirmed, and are Welcomed in the bigger Church. The attitudes of the people can be transformed through the teachings of the Church seeking always for truth and restoration of the dignity of the person. The Justice Model aims to help "the Church be able to destroy the roots of the pandemic, so that it may become a Church without AIDS in a world without AIDS."[508] It is for this reason that, the Church is building the "Kingdom of God" in this world if they are able to accept, forgive, care, and empower those in need.[509] There is great need to empower women in Africa, and promote a spirit of solidarity among those who are excluded.

7.12 Final Remarks on the Contribution of this Thesis

This thesis recommended the introduction of a Holistic Pastoral Caring approach by the Church. It also introduced, explained and highlighted an introduction of a Justice focused model on changing people's lives which was discussed in detail in section 6.11. This is a new model that will help all organisations the Church included, to help those afflicted with HIV/AIDS. It will demonstrate to the afflicted that they are loved and that they belong. The aim of this approach is to promote and instil "self-esteem" to the wider community. It is a flexible and universal model that can be applied to any sector, ranging from social, health, educational, political or religious. Organisations such as NGO's, the United Nations or other international organisations can incorporate the justice model into their existing programmes.

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[507] Michael J. Kelly, (2010), p. 249.
[508] Ibid. (2010), p. 249.
[509] Ibid. (2010), p. 249; see also Chitando, (2003), pp. 28-29.

Universities, Colleges, Schools and Hospitals can use the Justice Model in drafting the annual school curriculum, particularly when drafting programmes on human sexuality. The Justice model can bring our humanity and inclusive nature to the fore-front. Respect for human life, empowerment and capacity building are the core essences of the justice model. Likewise, when adhering to the justice model, media communication should be focused on promoting the dignity of the community rather than sensationalism or for profit making. Gender equality in life and employment is also emphasised.

Justice for all can be the rallying cry. The thesis pointed out that international laws are not always enacted into local laws. Sometimes they may be enacted and implemented differently than originally envisaged. Also international laws along with local laws may have results that were not envisaged at the drafting stage or may be unfair to sections of the community. The latter is true in the case of the disclosure of health status, even in situations where health status is not an issue. International and local laws should be structured to preserve at all times the dignity and well-being of those affected by the law. Laws in particular need to consider the marginalised and the poor who generally speaking, are least able to defend themselves against unfair laws.

Last, but certainly not least, the Church needs to show Leadership, Authority, Truth, Love and Inclusivity. The message of the gospels can be transformed into practical action. Once more the Church has to bring the sacraments to the fore. In particular, the sacraments of the Sick, Marriage and the Eucharist – Caring, Love and Sharing – have to become part of daily life. The Church needs to engage with its followers on a daily basis. How better to do this than through the Sacraments and a holistic pastoral approach to those in need. The Church was always to the fore in education to the less well off. She needs to find this vocation again and once more be the leading educator of the needy.

7.13 Conclusion

This thesis examined the background and context of the current problem of stigmatisation attached to the sufferers of HIV-AIDS in Zimbabwe. Particular

reference was made to the area surrounding Mutare in the Manicaland Province. The ultimate aim of the thesis was to explore how the Roman Catholic Church in Zimbabwe might respond and make a difference in bringing down stigmatisation in its many and interlocking forms. I have concluded that a holistic pastoral care approach is the best response that the Church can make in the current circumstances.

Stigmatisation has been shown to be a multifaceted problem. It is not difficult but necessary, nevertheless, to prove how many social, cultural, and religious factors feed into the malaise. Isolating particular factors is more of an issue. However, I have concluded that attitudes, fear, and social control are the top three driving forces. Attitude, though hard to observe, is a mental state or outlook conditioned by an individual's social status, family and cultural context. Social control is associated with the way people are regulated in society be it political or societal. Social control is also a negative frame of mind. Attitude, fear, and social control, form part of the dilemma of difference and the difficulty of relating to those who are seen as different, and these conspire together to keep the vicious cycle of stigmatisation turning.

Stigmatisation has been highlighted as a vicious downward cycle, fuelled by other factors such as powerlessness, socio-economic inequalities, cultural constraint, and structural violence. I am firmly of the opinion that poverty is a socio-economic factor which significantly reinforces stigmatisation. Poverty in this case, refers not alone to lack of financial resources, it also relates to poverty in education and health care. Poverty is particularly problematic for females. Although, females are in many respects the breadwinners, their share of the family income is small and they rank in the bottom when it comes to work opportunities. Therefore, they suffer most from lack of money for education and health care. Females are furthermore, easy targets for stigmatisation in a male-dominated society. Poverty makes this degradation even easier. Stigmatisation has produced another, possibly less obvious, result. African families were traditionally tight knit and operated in groupings. The onset of HIV-AIDS has changed, probably forever, the idea of such close knit families. What was probably considered impossible to

dismantle in the past is now a reality, where family members will not risk the shame and stigmatisation which will follow the family where a member is perceived to have crossed the boundaries of "clean living". In such instances, the family honour must be maintained at all costs, even at the cost of death.

In the gospel stories of the life of Jesus, he reached out in a preferential way to all who were downtrodden and outcast, the sick, and the poor and public sinners. What these had in common was that they suffered from the hostile and rejecting attitude and behaviour of society. They were all despised, looked down upon, treated as sinners, and kept at arm's length. Typically, in ancient near Eastern cultures, society during the times of Jesus Christ could not accommodate these people for fear of breaking taboos against impurities and contamination. Research already cited indicates the continuing prevalence of such a stance in many places today and the case study of Mutare illustrates this in the Zimbabwean context.

Different reasoning's were called into play to justify this. The infirm were looked down upon because it was believed that they (or their parents) had sinned and they were therefore being punished by God who was angry with them. Because they were no friends of God, the righteous around them believed that they should be no friends of theirs either. They were therefore consigned to the margins of their society.[510] Similarly, the poor were despised because they did not know the Law. These were despised because of their way of life. Thus in the minds of God's people, they would be rejected by God. Such sinners were marginalised by fellow countrymen and women and deemed to be marginalised by God. Therefore society adopted negative attitudes towards them and kept them apart.[511]
This holds its own pastoral challenge to the Church in Zimbabwe.

The process of stigmatisation is challenging the Church in Zimbabwe. While forms of exclusion and stigmatisation have existed in Zimbabwe, as in many places, what is new is specifically HIV/AIDS-related stigmatisation. In the early years of the HIV/AIDS epidemic, the Church used the language of "the wages of sin,"

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[510]Peter McVerry, S.J. *Jesus Social Revolutionary?* (Dublin: VERITAS Publications, 2008) p. 17. See also (John 9:1-2).
[511]Peter McVerry, (2008), pp. 17-19.

condemnation and blame instead of grace, encouragement, and hope for healing. While the Church may have started on the wrong road, it is nevertheless, strategically placed to facilitate and help conscientise and put structures in place for an adequate and dynamic response to the emergent stigmatisation crisis. The Church needs to turn once again to its prophetic Christ-centred missionary calling, expressing the presence of Christ in her whole life. The call is to respond to Christ poor, Christ's serving, Christ's healing, Christ's suffering, and Christ's dying. This is why I believe that the Church needs to revitalise its pastoral caring mission. This pastoral caring approach should reach out to all aspects of human life, namely, spiritual, physical, social, economic, intellectual, and emotional. This pastoral caring mission based on a community wide approach will be vital to any successful reduction the vicious cycle of stigmatisation of HIV/AIDS.

This study has demonstrated that this will not be an easy process to implement. The case study even revealed examples of stigmatisation within the current caring systems – for example, that certain Church members, carers and Church leaders were not at ease shaking hands with sufferers or using the same toilet facilities. However, to me the most important outcome from the case study was the lack of real consultation between the service providers and those whom they were intended to serve – the sufferers themselves. Some programmes were mainly based on unchecked assumptions, and failed to attend to specific needs of sufferers who felt excluded from active involvement. The service providers decided on the needs of those in their care and strategies of care required by them. The vision and mission statements and programmes did not encompass a holistic concern for inclusion and involvement of those being cared for, and thereby lacked focus on key elements, ways and means of arresting the steps of the stigmatisation cycle. This counter-productive reality allied with a lack of appropriate training for care givers suggests that the current system is neither effective nor sustainable. Nor does it engender a sense of fulfilment, satisfaction and hope. This helped me to formulate my thoughts and further convince me that a pastoral care approach by the Church, properly envisioned, collaboratively formulated, staffed and financed

is the best way forward in breaking the chains of stigmatisation.[512] The call to pastoral care by the Church was highlighted in *Gaudium et Spes*, the decree of the Second Vatican Council which addressed relations between the Roman Catholic Church and the modern world.[513] Christians and the Church were urged to become more involved in world events and responsibilities. If ever a world event required the Church to get involved, it was the emergence of HIV/AIDS in the 1980s.

The Church has always been involved in pastoral care, health care and education. I believe that the time is now urgent for the Church once again to exercise a leadership role in these three areas wherever people are neglected, excluded and deprived of access. Their leadership in addressing the multiple challenges of HIV-AIDS is particularly suited to the development of a holistic pastoral caring mission. This is not the first time that I have used the word holistic in this summary, and deliberately so. I arrived to the conclusion that a holistic approach was required based on my research and the evidence obtained from the case study. The care has to be for the whole person in their milieu and to be useful and appropriate to the person's specific need. The person receiving the care has to be seen as the priority rather than the institution providing the care. The care has to be what is actually required and not what the Church or any other agency may consider offering. The care has to be all-embracing, including, physical, social, psychological, spiritual and practically supporting.

In addition, I recommend that this care be given on a community basis, as it is through community spirit that people live and flourish and whereby the Church can be most fruitful in its pastoral life and service. Community based care is more likely through time to regenerate feelings of goodwill and social freedom among families and members of the community. In chapter five, I also recommended that the Church should work with other organisations to harness the contribution of the most suitable people together with the necessary financial and physical resources. This recommendation is reiterated here and I urge the Church and

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[512] *TROCAIRE, Addressing the HIV and AIDS Crisis: TROCAIRE Policy and strategy 2007-2012,* (Kildare, *TROCAIRE,* 2007), p. 14.
[513] *Vatican Council II "Gaudium et spes"*, 7 December (1965, 1988), p. 906.

other agencies to embrace the concept of cooperation and partnership rather than going it alone in isolation and ineffective service.

The road ahead will not be easy, but hard work, dedication, prayer and a concerted effort by all, but particularly by the Church, can lead to a reduction in HIV/AIDS related stigmatisation in Zimbabwe. The introduction of a Holistic Pastoral Care Approach by the Church is one vital step on the way to achieving that aim. Finally, I end the thesis with the encouraging words of Pope John Paul II on his visit to HIV/AIDS sufferers in a Californian hospital in the United States in September 1987. He said,

> God loves you all, without distinction, without limit ... He loves those of you who are sick, those suffering from AIDS. He loves the friends and relatives of the sick and those who care for them. He loves all with an unconditional and everlasting love.[514]

This was a message of hope which the Church can continue to embrace in its mission to the sick and marginalised.

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[514] Joseph Berger. The Papal Visit. *NY Times* 18/9/87.

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APPENDICES

Appendix 1 Research Permission Diocese of Mutare

DIOCESE OF MUTARE

Bishop's House, P.O. Box 47, Mutare, Zimbabwe

Telephone: (020) 62347
Fax: (020) 62347
E-mail: redomu@commone.co.zw

23 June 2008

Sister Annah Nyadombo
Carmelite Sisters' Mother House
P.O Box 1903
Mutare

Dear Sister Annah Nyadombo

I am happy to hear that you have been offered a place to study at Trinity College, Dublin in Ireland. Your thesis topic is Liberation from Stigmatization: *"A Holistic and Effective Pastoral Approach to HIV and AIDS in the Diocese of Mutare, Zimbabwe."* You are most welcome to carry-out your research in the Diocese as per your request.

As you know, the problem of HIV and AIDS is affecting individuals, families, communities and our society at large. Hence, your research and study will suggest effective pastoral approaches, interventions and strategies to reduce stigmatization and discrimination among the infected and affected people. Indeed, your study will certainly enrich the local Church and our society in many ways.

Wishing you a fruitful study overseas,

Fraternally Yours in Christ

+ Muchabaiwa

Rt. Rev. Bishop A. C. Muchabaiwa
Bishop of Mutare

Roman Catholic Diocese of Mutare
The Bishop's House
Christo Fidelis
P.O. Box 47, Mutare
Zimbabwe
Tel : 62347
Fax: +2632062347

Appendix 2 Letter from Irish School of Ecumenics- Trinity College.

Irish School of Ecumenics
Trinity College Dublin

To Whom It May Concern:

17 Feb 2011

RE: **SR ANNAH NYADOMBO**

Student no: **08131953**

Dear Sir/Madam

Sr Annah is registered as a full time student on the PhD programme at the Irish School of Ecumenics, Trinity College Dublin. Sr Annah will travel to Zimbabwe for research purposes in support of her PhD dissertation and will return to Dublin to complete this.

Sr Annah resides at Mount St Mary's Hostel, Dundrum Rd., Dublin 14

I would be very grateful if you could afford our student with any assistance required.

If you require any further information in relation to this please do not hesitate to contact me.

Sincerely

Christine Houlahan
Executive Officer to the PhD Programme
Direct phone: 2060353
Email: ressec@tcd.ie

Correspondence to:
Irish School of Ecumenics
Bea House, Milltown Park
Dublin 6, Rep. of Ireland
Tel: +353 (0) 1 260 1144
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Irish School of Ecumenics
683 Antrim Road
Belfast BT15 4EG, Northern Ireland
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Web: www.tcd.ie/ise

Appendix 3 - Survey Consent Form

Trinity College Dublin
College Green
Dublin 2

December 12, 2010

Dear Participant,
My name is Annah Nyadombo; I am a PhD candidate in the Irish School of Ecumenics, Trinity College Dublin, Ireland. The topic for my PhD thesis is "A holistic pastoral approach: Reduction of stigmatisation of HIV/AIDS sufferers in the diocese of Mutare, Zimbabwe." As part of my thesis, I am conducting a survey among Church Leaders, Church members, Caregivers and Sufferers in the Diocese of Mutare. If you are at least 15 years of age you are eligible to participate in the survey.

You are being asked to participate in the survey as you have been identified as an individual with an interest in furthering an understanding of the impact of HIV/AIDS on the lives of people. Your participation in the survey is entirely voluntary. You may decline to be involved or if you agree to be involved you may decline to answer specific questions which you do not wish to answer. You may also add additional information relevant to the survey if you so wish.

If you do agree to take part in the survey, please do not write your name on the questionnaire. This ensures that your responses will be totally confidential. Data from the survey will be summarised and included in my thesis in a combined manner. No one other than me will have access to the individual completed questionnaires. No information collected from these questionnaires will be made available to any other individual or body.

Once you have completed the Questionnaire, please put it in the envelope proved, and then seal the envelope. The sealed envelope will be collected by one of my team members or by me. The team member collecting the envelope will provide proof of identity and authority to collect the envelope.

If you complete and return the Questionnaire it will be assumed that you have fully consented to taking part in the survey. Please keep this letter for your records.

Thank you for agreeing to take part in the survey. Your responses will provide valuable information in formulating an effective holistic pastoral approach to the reduction of stigmatisation of HIV/AIDS sufferers in the diocese of Mutare.

Yours sincerely,

Annah Nyadombo
PhD Candidate: Trinity College, Dublin, Ireland

Appendix 4 – Case Study Questionnaires

1 QUESTIONNAIRE FOR CHURCH LEADERS

TOPIC: A HOLISTIC PASTORAL APPROACH TO HIV/AIDS SUFFERERS: REDUCTION OF STIGMATISATION IN THE DIOCESE OF MUTARE, ZIMBABWE

You are kindly asked to respond to all questions. Please do not write your name.

Thanks for your assistance.

Please mark and write in the relevant block with a cross.

WHAT IS YOUR GENDER?

MALE		FEMALE	

WHAT LANGUAGE DO YOU REGARD AS YOUR DOMINANT HOME LANGUAGE?

English		Shona		Ndebele	

MARK LOCATION OF CHURCH

High Density Urban	
Low Density Urban	
Peri-Urban	
Rural	

PERIOD OF EXPERIENCE AS PASTORAL CARE GIVER

Less than 1 year	
1 – under 2 years	
2 – under 4 years	
4 – under 6 years	
6 – under 8 years	
8 – under 10 years	
10 years and above	

DO YOU CARRY OUT PASTORAL VISIT'S – INDICATE LOCATION?

	Hospitals	**Homes**	**Centres**
Yes			
No			

IF YES, TO QUESTION 1.5, HOW MANY TIMES PER MONTH?

In Hospital_____

In Homes_____

In Centres_____

WHAT IS YOUR OPINION OF THE QUALIFICATIONS OF PASTORAL CARE GIVERS?

Happy	
Unhappy	

HOW DID YOU COME TO HAVE THOSE FEELINGS ABOUT THE QUALIFICATIONS OF PASTORAL CARE GIVERS?

_____

CAN YOU GIVE EXAMPLES OF EFFECTIVE AND/OR INEFFECTIVE PASTORAL CARE?

_____

WHAT DO PEOPLE DO TO CURE THEMSELVES FROM HIV/AIDS?

_____

_____

HOW DO YOU HELP PEOPLE SUFFERING FROM HIV/AIDS?

_____

_____

WHAT PROBLEMS DO YOU FACE IN HELPING SUFFERERS OF HIV/AIDS? (LIST 4)

1._____

2._____

3._____

4._____

HOW MANY PEOPLE BENEFIT FROM YOUR PROGRAMME?

_____

HOW WOULD YOU DESCRIBE THE UNDERSTANDING OF PEOPLE, WHO DO NOT HAVE HIV/AIDS, OF THOSE WHO HAVE HIV/AIDS?

_____

IS STIGMA CONCERNING HIV/AIDS SUFFERERS WIDESPREAD?

_____

CAN A PASTORAL APPROACH BE USED IN THE FIGHT AGAINST HIV/AIDS STIGMA?

YES	
NO	

CAN YOU DESCRIBE WHAT A PASTORAL APPROACH TO THE FIGHT AGAINST HIV/AIDS STIGMA WOULD LOOK LIKE?

_____

DO YOU ENCOUNTER PROBLEMS HELPING PEOPLE LIVING WITH AIDS AND HOW DO YOU RESPOND TO THEM?

_____

2 QUESTIONNAIRES FOR CHURCH MEMBERS

TOPIC: A HOLISTIC PASTORAL APPROACH TO HIV/AIDS SUFFERERS: REDUCTION OF STIGMATISATION IN THE DIOCESE OF MUTARE, ZIMBABWE

You are kindly asked to respond to all questions. Please do not write your name.

Thanks for your assistance.

Please mark and write in the relevant block with a cross.

WHAT IS YOUR GENDER?

MALE		FEMALE	

WHAT LANGUAGE DO YOU REGARD AS YOUR DOMINANT HOME LANGUAGE?

English		Shona		Ndebele	

MARK LOCATION OF CHURCH

High Density Urban	
Low Density Urban	
Peri-Urban	
Rural	

DO PEOPLE READILY MIX WITH HIV/AIDS SUFFERERS?

YES	
NO	

If not, why not?

_____

HOW DO PEOPLE IN YOUR COMMUNITY PERCEIVE HIV/AIDS SUFFERERS?

As a threat	
Dangerous	
Friendly	
Victims	
Scapegoats	

Please comment on your response:

_____

_____

_____

WHAT IS THE BEHAVIOUR OF PEOPLE TOWARDS HIV/AIDS SUFFERERS?

_____

_____

HOW MANY PEOPLE HAVE COME TO SEEK HELP WHO HAVE BEEN STIGMATISED IN YOUR COMMUNITY? HOW OFTEN DO THEY COME?

_____

WHAT HELP DO YOU GIVE?

_____

_____

WHAT DO YOU THINK CAN BE DONE TO TREAT HIV/AIDS IN YOUR COMMUNITY?

_____

_____

3 QUESTIONNAIRES FOR HIV SUFFERERS

TOPIC: A HOLISTIC PASTORAL APPROACH TO HIV/AIDS SUFFERERS: REDUCTION OF STIGMATISATION IN THE DIOCESE OF MUTARE, ZIMBABWE

You are kindly asked to respond to all questions. Please do not write your name.

Thanks for your assistance.

Please mark and write in the relevant block with a cross

WHAT IS YOUR GENDER?

MALE		FEMALE	

WHAT LANGUAGE DO YOU REGARD AS YOUR DOMINANT HOME LANGUAGE?

English		Shona		Ndebele	

MARK LOCATION OF CHURCH

High Density Urban	
Low Density Urban	
Peri-Urban	
Rural	

WHAT IS YOUR EXPERIENCE OF STIGMATISATION TO THIS ILLNESS? MARK MOST RELEVANT DESCRIPTION.

Isolation	**Hurt**	**Dehumanised**	**Stereotyped**	**Distanced**

Unworthy	**Labelled**	**Blamed**	**Marginalised**	**Unloved**

WHAT IS YOUR OPINION OF YOUR ILLNESS?

_____

ARE YOU RECEIVING ENOUGH ASSISTANCE FROM YOUR CAREGIVERS?

Yes	
NO	

WHAT ARE YOU DOING TO HELP OTHER PEOPLE WITH A SIMILAR ILLNESS?

_____

_____

_____

_____

HOW OFTEN DO YOUR RELATIVES AND FRIENDS VISIT YOU?

Frequently	Monthly	3 Monthly	Every Year

ARE PEOPLE JEALOUS ABOUT THE HELP YOU ARE GETTING? IF THEY ARE JEALOUS, PLEASE PROVIDE EXAMPLES OF THEIR JEALOUSLY.

_____

_____

4 QUESTIONNAIRES FOR CAREGIVERS

TOPIC: A HOLISTIC PASTORAL APPROACH TO HIV/AIDS SUFFERERS: REDUCTION OF STIGMATISATION IN THE DIOCESE OF MUTARE, ZIMBABWE

You are kindly asked to respond to all questions. Please do not write your name.

Thanks for your assistance.

Please mark and the relevant block with a cross

WHAT IS YOUR GENDER?

MALE		FEMALE	

WHAT LANGUAGE DO YOU REGARD AS YOUR DOMINANT HOME LANGUAGE?

English		Shona		Ndebele	

MARK LOCATION OF CHURCH

High Density Urban	
Low Density Urban	
Peri-Urban	
Rural	

HOW MANY PEOPLE WITH HIV/AIDS DO YOU CARE FOR?

_____

_____

WHAT TYPE OF ASSISTANCE DO YOU GIVE?

_____

_____

PLEASE PROVIDE EXAMPLES OF HOW PEOPLE WITH HIV/AIDS BENEFIT FROM YOUR ASSISTANCE.

_____

_____

WHAT OTHER ORGANISATIONS ARE INVOLVED IN YOUR EFFORT?

_____

_____

WHAT CAN BE DONE TO PROMOTE A HOLISTIC PASTORAL APPROACH CARE FOR PEOPLE WITH HIV/AIDS?

_____

_____

Appendix 5 – Interview Summary

Interviews, Discussions and Observations

Interviews on a one to one basis were held with 10 out of the 90 respondents. This included 2 Church members, 2 Church leaders, 2 caregivers and 4 HIV-AIDS infected persons. The interviews helped to clarify some questions and obtain further qualitative data. The interviews followed a series of pre-set questions on areas such as, isolation, disempowerment, gender, ostracism, poverty and stereotyping. The interview questions were independent to the questions in the questionnaire.

The researcher clarified points as the interviews progressed. The semi-structured nature of the interviews allowed the author to probe for more information. The researcher remained objective and sought to avoid interview bias, which could have been caused by verbal cues or personal views. The respondents were encouraged to express themselves freely.

Appointments were arranged with leaders where the respondents were located, so that they could consult and organize meetings with the respondents. The interviews gave the author the opportunity to explain the purpose and importance of the study to the respondents. Interviews were conducted during the same weeks as the questionnaires were completed. The interviewees consented to the interviews and encouraged the researcher to make notes of the interviews. Personal observations were made as the researcher toured the places where the respondents resided.

Group Discussions

As well as the ten individual interviews, the author also used group discussions as a method of collecting data. Both formal and informal discussions were held with forty respondents, comprised of 10 caregivers and thirty HIV-AIDS infected persons. The participants in the group

discussions were divided into four groups, each group was made up of 5 females and 5 males. The members of the group discussions volunteered to take part, once the purpose of the exercise was explained.

It was through interviews and the group discussions that the nature and extent of issues of isolation, empowerment, gender relations, seclusion, verbal abuse and harassment were fully established. For example, it emerged from the group discussions that, sufferers felt that they were considered to be burdens to their families

Interview/Discussion Questions and Responses

Q: Why do you think that there are more male Church leaders that female?

A: 1 Church leader commented that, in African Society, men are considered superior to women. (CL1. Para 5.4)

However, 2 female Church members and 1 Church leader challenged Church rules that reinforced the exclusion of women from leadership. The point was made that there is no proof that men were superior to women in leadership roles.(CL 2 Para. 5.4)

Q: Is the treatment of women and men equal and fair?

A: 5 female sufferers pointed out that, although women outnumbered men the custom in African society was to favour men in terms of "possessions, education and welfare in the home". (Para. 5.4)

Q: Who is mainly responsible for the care of the sick?

A: Caregivers emphasized that caring for the sick was mostly the role of women "as women were more caring and loving than men" (CG 1 Para 5.4)

Q: What are the main languages used in daily life?

A: From the group discussions, interviews and questionnaires, the response was that English and Shona were the main languages used. (Table 5.2)

Q: What language is mostly used in writing books, newspapers and preaching in the Church?

A: 100% of the respondents agreed that English was the language mainly used for communication. Recently the Church introduced separate preaching hours for those understanding English and those understanding Shona or Ndebele. The extent of the use of the various languages is a function of the location of the Church. (Para 5.4)

Q: Why are HIV/AIDS sufferers stigmatised?

A: 24 of the respondents said that the sufferers were stigmatised because they had in some way angered their ancestral spirit's, leading them to be bewitched and hence isolated. (Table 5.4)

Q: Were you aware that you could become HIV infected through risky sexual practices?

A: 15 of the sufferers admitted that, they were not fully aware of some of the risky situations that could have led them into the situation in which they now found themselves. 9 of the sufferers interviewed admitted engaging or being forced to engage in sexual activities. (Para 5.4.3)

Q: Are you afraid of mixing with sufferers?

A: 15 of the Church members were afraid to mix with sufferers as they feared that they might contract the disease or be associated with sufferers. Some Church members labelled sufferers as prostitutes or people of immoral behaviour. This made the sufferers feel isolated from Church members. (Para. 5.4.7)

The interview process also disclosed that of the Church leaders acknowledged that, there was less mixing between Church leaders and sufferers. (Para. 5.4.6)

Q: Is there a high level of mixing between Church leaders and sufferers?
A: Church leaders acknowledged that, there was less mixing between Church leaders and sufferers. Moreover, the Church leaders were not always with the sufferers. 3 of the Church leaders perceived sufferers as threatening, dangerous, fearful, and unfriendly and spreaders of the disease. (Para 5.4.6)

Note, the questionnaires disclosed a difference of opinion in terms of how Church Leaders, Church Members and Caregivers are perceived by Sufferers. The interview process disclosed that of the had there been a better level of agreement then this could have been a good starting point to build on the current level of pastoral care and reduce stigmatisation.

Q: Church leaders were asked if all caregivers were adequately trained.
A: The Church leaders said that there were a few caretakers and pastors that were trained and most of these were doing a splendid job in giving care to the sufferers. However, the Church leaders did comment that some caregivers needed more counselling and training. The Church leaders were not pleased with the work of some caregivers, especially with those who were not trained. They neglected the sick and distanced themselves from the sufferers. (Table 5.7).

Appendix 6 – ZCBC Pastoral Letter Example

ZIMBABWE CATHOLIC BISHOPS' CONFERENCE

Let Us Work For the Common Good
Let Us Save Our Nation

A Pastoral Letter of the
Zimbabwe Catholic Bishops' Conference
14 January 2011

"Glory to God in the highest Heaven, and on earth peace Among those whom he Favours!"

The Zimbabwe Catholic Bishops' Conference:
+Angel Floro, Bishop of Gokwe (ZCBC President)
+Robert C. Ndlovu, Archbishop of Harare
+Alex Thomas, Archbishop of Bulawayo
+Alexio Muchabaiwa, Bishop of Mutare (ZCBC Vice President)
+Michael D. Bhasera, Bishop of Masvingo
+Martin Munyanyi, Bishop of Gweru (ZCBC Secretary/Treasurer)
+Dieter B. Scholz SJ, Bishop of Chinhoyi
+Albert Serrano, Bishop of Hwange
+Patrick M. Mutume, Auxiliary Bishop of Mutare

Published by:
The Social Communications Department
Zimbabwe Catholics Bishops' Conference
Africa Synod House, 29-31 Selous Avenue
P.O. Box CY 2220
Causeway, Harare, Zimbabwe
14 January 2011

1. Introduction

As we begin the New Year 2011 we, the Zimbabwe Catholic Bishops' Conference, address this pastoral letter to Catholics and to all people of good will. We invite you in this new year to work for the Common Good and to save our nation. The theme of this pastoral letter arises from recent and current experiences within our country. We continue to hope for a time when we can genuinely make the song of the heavenly host our own, "Glory to God in the highest heaven, and on earth peace among those whom he favours!" (Lk. 2:14). However, the evolving trends in our country are worrying and, if not corrected, can lead to our loss of nationhood, the disintegration of our society and to the forming of degenerate militias with opposing loyalties. The Social Teaching of the Catholic Church urges us to 'Work for the Common Good'. Indeed, "How very good and pleasant it is when kindred live together in unity!" (Psalm 133:1)

2. The Social Teaching of the Church

"The joys and the hopes, the grief's and the anxieties of the men of this age, especially those who are poor or in any way afflicted, these are the joys and hopes, the grief's and anxieties of the followers of Christ" (Vatican II, The Church in the Modern World, Gaudium et Spes, no. 1). To this end the Catholic Church has over the years developed ten principles that form the pillars of its social teaching. The ten principles provide criteria for judgment and directives for action in matters of justice, integrity, truth and social well-being. They are the Dignity of the Human Person; the Common Good; Option for the Poor; Human Rights and Responsibilities; Participation; Subsidiarity; Solidarity; Economic Justice; Stewardship of God's Creation; and Promotion of Peace.

It is clear that all the ten principles are relevant to our situation but for the present we have chosen to dwell on the second principle as we invite you to work for the Common Good and save our Nation.

3. The Common Good

Everyone has a responsibility to contribute to the Common Good of all members of society. A better society is not for the benefit of elite but for all. The way in which we organize our society directly affects human dignity and the capacity of individuals to grow together in community and contribute to the Common Good.

The Common Good is the sum total of social conditions which allow people, either as groups or as individuals, to reach their fulfilment more fully and more easily. The Common Good concerns the life of all and consists of 3 essential elements: respect for the person; the Social Well Being and Development of the Group; and Peace, which gives stability and is the source of security for a just order.

4. Signs of Hope in our Nation

Dear Brothers and Sisters in Christ, we, your Shepherds, congratulate you for your patience over the many years of suffering and hardship. You have proved to be very innovative in overcoming or at least alleviating economic hardships and working for the survival of your families, dependents, the Church and our country. To fight misery and to struggle against injustice is to promote the human and spiritual progress of all people and, therefore, the

Common Good of Humanity. Peace is something that is built up day by day, in the pursuit of an order intended by God, which implies a more perfect form of justice among men (Paul VI,
Populorum Progressio, On the Development of Peoples, no. 76).

The signing of the Global Political Agreement in September 2008 and the forming of the
Government of National Unity in February 2009 bore signs of hope for the restoration of our nation, notwithstanding the worrying and tragic circumstances which gave rise to those developments. These were positive steps whose value has been eroded by lack of collective commitment and political will.

5. Our Concerns
We are concerned that not all the tenets of the Global Political Agreement have been implemented, leading to the continued isolation of the country by most of the international community and the postponement of national healing, recovery, restoration and the enjoyment of fundamental human rights by all.

Given our situation it is important that we express openly and strongly our concern that every political party should engage in serious discussion about the Common Good. Without this sincere engagement we will continue to be dogged by violence, political intolerance, hate language in the public media, injustice, rigging of elections, fear, deception, etc. It is disheartening that State media never really went out of its way to promote COPAC and its quest for a people-driven constitution. So too, national healing, reconciliation and integration, which are so vital for national well-being, never seem to be given much serious media coverage.

We are concerned about incidences of politically motivated violence in some provinces. The liberation of Zimbabwe was achieved through the efforts of those who were inside the country (both armed and unarmed), outside the country and by the international community. The claim to have monopoly in the liberation struggle by any single sector or party is, therefore, false and may be the misconception solely responsible for the abuse of human rights and the erosion of the sovereignty of the citizens in Zimbabwe.

6. A Spiritual And Moral Crisis
In our Pastoral Letter for Easter 2007, we insisted that "the crisis (in our Country) is not merely political and economic but first and foremost a spiritual and moral crisis. As the young independent nation struggles to find its common national spirit, the people of Zimbabwe are reacting against the 'structures of sin' in our society. Pope John Paul II said that the 'structures of sin ' are rooted in personal sin, and thus always linked to the concrete acts of individuals who introduce these structures, consolidate them and make them difficult to remove. And thus they grow stronger, spread and become the source of other sins, and so influence people's behaviour. The Holy Father stressed that in order to understand the reality that confronts us, we must 'give a name to the evils which afflict us.' (God Hears the Cry of the Oppressed, Pastoral Letter, Zimbabwe Catholic Bishops' Conference, Holy Thursday 2007, No 16.)

7. Save Our Nation: Our Recommendations:
In its final message, the Second Special Assembly for Africa of the Synod of Bishops held in

Rome in October 2009, had a word for African Catholics in public life saying, 'We commend the many of you who, not minding all the dangers and uncertainties of politics in Africa, have generously offered yourselves for the public service of your people, as an apostolate to promote the common good and God's kingdom of justice, love and peace, in line with the teachings of the Church (cf. Gaudium et Spes, 75). You can always count on the encouragement and support of the Church. EIA (the Church document Ecclesia in Africa) expressed the hope that saintly politicians and heads of state would emerge in Africa. This is by no means a futile wish. It is heartening that the cause of the Beatification of Julius Nyerere of Tanzania is already on course. Africa needs saints in high political office: saintly politicians who will clean the continent of corruption, work for the good of the people, and know how to galvanize other men and women of good will from outside the Church to join hands against the common evils that beset our nations.' (no.23).

7.1 We urge our political leaders to:
i) Prioritize poverty eradication by using proceeds from natural resources like diamonds, land, etc., for the development of the whole nation and all its citizens. In its final message, the Second Special Assembly for Africa of the Synod of Bishops noted that Africa is rich in human and natural resources but 'many of our people are still left to wallow in poverty and misery, wars and conflicts, crisis and chaos. These are very rarely caused by natural disasters. They are largely due to human decisions and activities by people who have no regard for the common good ....' (No.5).

ii) Stop the active and tacit collusion of those undermining the fight against corruption. Corruption is a cancer destroying our nation.

iii) Prosecute wrong doers and widely publicize any disciplinary action so that no one is seen to commit crime with impunity.

iv) Desist from intimidating and mistreating members of the public, the media, civic communities, etc. Uphold human rights.

v) Uniformed forces should maintain peace and security for all citizens at all times and especially before, during and after elections, and do so impartially.

vi) We implore our political leadership in the coalition government to reflect deeply on the timing of elections bearing in mind the unhealed state of the nation and the fragile state of the economy. They shoulder a heavy responsibility to serve and save Zimbabwe. They must think and act in pursuit of the Common Good. In the event of elections, implement the SADC guidelines in full.

vii) We expect our members of Parliament to make an effort to spearhead the mitigation of the pressing needs of the people they represent and desist from being preoccupied with enriching themselves.

7.2 All Catholics and People of Good Will:
i) We can be confident that God is with us, loves us and will save us. We, your Shepherds, therefore, urge you to be more faithful in your prayers. We need to pray as a nation without ceasing, for the restoration of our country.

ii) As citizens we must put into action the tenets of our faith and beliefs. In its final message, the Second Special Assembly for Africa of the Synod of Bishops reminds all lay faithful that you 'share in the mandate of the Church to be ambassadors of Christ, working for reconciliation of people to God and among themselves. This requires of you to allow your Christian faith to permeate every aspect and facet of your lives; in the family, at work, in the professions, in politics and public life. This is no easy task. That is why you must assiduously access the means of grace, through prayer and the sacraments. The scripture text of the theme of our Synod, addressed to all followers of Christ, refers in a special way to you: "You are the salt of the earth ... You are the light of the world" (Mt. 5:13-14).' (no.22). Never as citizens must we lose respect for the dignity of another by being involved in violence, corruption, etc. God commands us to love Him and our neighbour always (Lk. 10:27), that is, even during heated elections. One cannot be a true Christian and a perpetrator of violence at the same time. Having different political views is normal and healthy in building our nation. We do not have to fight over our different views.

iii) It is not enough to recall principles, state intentions, point to crying injustice and utter prophetic denunciations; these words will lack real weight unless they are accompanied for each individual by a livelier awareness of personal responsibility and by effective action. It is too easy to throw back on others responsibility for injustice, if at the same time one does not realize how each one shares in it personally and how personal conversion is needed first. The
Christian's hope comes primarily from the fact that he knows that the Lord Jesus Christ is working with us in the world (Paul VI, *Octogesima Adveniens*, A Call to Action, no. 48).

8. Conclusion

Many of you, who have endured much, are beginning to show signs of losing hope as the political, economic and social hardships, which should have disappeared by now, still persist. This is especially true of most people in rural areas who can hardly access foreign currency. Our situation is volatile. We can still move forward but can also just as easily return to our difficult past. Let us be exemplary so that we set the pattern for moving forward in faith. "Blessed are those who hunger and thirst for righteousness, for they shall be satisfied" (Mt. 5:6). When we work together for the Common Good we succeed in building a Kingdom of justice, respect for the dignity of persons and their rights, truth, unity, forgiveness, political tolerance, service, free and fair elections, good national ethics, good media, solidarity, peace and good stewardship of God's creation.

A bare reading of this pastoral letter may have limited impact on the reader. Discussing with others will be beneficial. Bringing the fruit of one's discussion before God in personal prayer will lead one to seek the Holy Spirit's gifts of wisdom and courage. Strengthened by these gifts, we can strive to apply the Social Teaching of the Church to our daily lives for the promotion of a more just Zimbabwe, which upholds the Common Good. Let us all say the prayer at the end of this Pastoral Letter for our country, Zimbabwe.