A critical evaluation of the gendered nature of HIV and AIDS programs in medical missions of the Church of Christ, Mashoko Mission in Zimbabwe

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Declaration

By submitting this thesis, I declare that the entirety of the work contained therein is my own, original work, that I am the authorship owner thereof (unless to the extent explicitly otherwise stated) and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

April 2019

Abstract

Despite collective efforts by government, Non-Governmental Organizations (NGOs), and other key stake holders to eradicate gender inequalities in health issues, gender remains a determining factor that intensifies the scourge of HIV and AIDS in Zimbabwe. This study observes that gender disparities should be considered in inceptions of administrative structures of Churches, NGOs, state health systems and other stakeholders that combat the adverse socio-economic impact of the scourge. This investigation is motivated by the conviction that the church, in its missional endeavours, has a crucial role to play in alleviating the impact of both gender injustice and the HIV pandemic in church and the society.

The research explores, from a missional and a feminist perspective, the gendered nature of the HIV and AIDS programs offered in medical missions of the Church of Christ at Mashoko Mission in Zimbabwe. The aim being to assess how the programs are framed for a gender sensitive healing ministry, which is a dimension of the all-inclusive *missio Dei*. The study takes gender justice as a missional issue that implores high priority attention from the church. The study attempts to point out some gender mainstreaming achievements and gaps in the HIV and AIDS programs at Mashoko Christian Hospital (MCH). It further discusses some implications of the gendered nature of the HIV and AIDS programs for the all-inclusive *missio Dei*.

The findings of the research indicate that the gender disparities in the HIV and AIDS programs mirror the societal perceptions as well as teachings and praxis of the church. While the gender imbalances exacerbate the impact of HIV and AIDS, the epidemic intensifies the deeply ingrained gender disparities in the society. However, some institutionalised socio-cultural, economic and religious factors fuelling gender disparities, such as patriarchy and gendered labour practices, are both preventable and manageable. In light of the mandate of the church in the all- inclusive *missio Dei,* these factors require the church to play a leading role in fighting both gender injustice and the HIV pandemic.

Further, the study attempts to forward some recommendations to the church based on the findings of the research. The recommendations are meant to sustain and enhance gender justice achievements as well as proposing potential strategies to bridge the gender sensitivity gaps in the HIV and AIDS programs offered in the medical missions of the Church of Christ at MCH and probably to the rest of Zimbabwe. The respect for equal human dignity and the all-inclusive *missio Dei* can be the basis for seeking to achieve the long overdue gender justice in the

ongoing battle against the epidemic. In the end, the study also raises some points for further research in the area of Christian mission in relation to gender and HIV and AIDS.

Opsomming

Ondanks kollektiewe pogings deur die regering, nie-regerings-organisasies (NGOs), en ander sleutel belanghebbendes om gender-ongelykheid in kwessies oor gesondheid uit te wis, bly gender ‘n bepalende faktor wat die plaag van MIV en Vigs in Zimbabwe vererger. Hierdie studie bemerk dat gender-verskille in ag geneem moet word by die ontstaan van administratiewe strukture van kerke, NGOs, staats-gesondheidstrukture en ander belanghebbendes wat die ongunstige sosio-ekonomiese impak van hierdie plaag bestry. Hierdie ondersoek is gemotiveer deur die oortuiging dat die kerk, in haar missionale strewes, ‘n noodsaaklike rol kan speel in die verligting van die impak van beide gender-onreg en die MIV-pandemie in die kerk en samelewing.

Die navorsing ondersoek die gender-aard van die MIV-en-Vigs-programme in die mediese uitreike van die Church of Christ by Mashoko Mission in Zimbabwe. Die doel is om te assesseer hoe die programme ontwerp is vir ‘n gender-sensitiewe genesende bediening, wat ‘n dimensie is van die alles-insluitende *missio Dei*. Die studie werk met gender-geregtigheid as ‘n missionale kwessie wat smeek vir voorkeur-aandag van die kerk. Die studie streef ook om sommige prestasies en tekorte in terme van die toonaangewende posisie van gender in die MIV-en-Vigs-program van die Mashoko Christian Hospital (MCH), uit te wys. Dit bespreek ook sommige van die implikasies van die gender-spesifieke aard van die HIV-en-Vigs-programme vir die alles-insluitende *missio Dei*.

Die bevindings van die navorsing dui aan dat die gender-ongelykhede in die MIV-en-Vigs-programme, maatskaplike persepsies sowel as lering en praxis van die kerk weerspieël. Terwyl gender-wanbalanse die impak van MIV en Vigs vererger, verskerp die epidemie diep-gewortelde gender-dispariteite in die samelewing. Sommige gevestigde sosio-kulturele, ekonomiese en godsdienstige faktore wat gender-ongelykhede aanvuur, onder meer patriargie en gender-arbeidspraktyke, is egter voorkombaar en bestuurbaar. In die lig van die kerk se mandaat in die alles-insluitende *missio Dei*, vra hierdie faktore dat die kerk ‘n leidende rol speel in die bevegting van beide gender-onreg en die MIV-pandemie.

Die studie poog ook om, op grond van die bevindings van die navorsings, sommige aanbevelings aan die kerk te maak. Die doel van die aanbevelings is om gender-geregtigheid-prestasies vol te hou en te verbeter, en ook om potensiële strategieë aan te bied vir die tekorte in terme van gender-sensitiwiteit in die MIV-en-Vigs-programme wat aangebied word by die

mediese uitreike van die Church of Christ by MCH en waarskynlik in die res van Zimbabwe. Respek vir gelyke menswaardigheid en alles-insluitende *missio Dei* kan die grondslag wees om lank-uitstaande gender-geregtigheid in die deurlopende stryd teen die epidemie, te behaal. Uiteindelik noem die studie ook enkele punte vir verdere navorsing op die gebied van Christelike sending in verhouding tot gender en MIV en Vigs.

Dedication

This research project is a special dedication to all the victims of a joint blight of gender injustice and the HIV pandemic, including my late mother, Anna Chauke Mudzanire. Momma worked assiduously for us to have a future. Alas, life was too short for her to eat what she planted. I could not say thanks *Mamulilo*.

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- Last but by no means least, I am deeply indebted to my lovely wife, Dolce and my amazing daughter Oshea. I denied them their quality time with daddy during the course of this study. I appreciate all their support and love.

Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
AHBC	AIDS Home Based Care
ART	Antiretroviral Therapy
CoC	Church of Christ
CoCZ	Church of Christ in Zimbabwe
HTC	HIV Testing and Counselling
HIV	Human Immunodeficiency Virus
LGBTQI	Lesbian Gay Bisexual Transsexual Queer Intersexual
MCH	Mashoko Christian Hospital
MoHCC	Ministry of Health and Child Care
MoHCW	Ministry of Health and Child Welfare
MDG	Millennium Development Goals
PICT	Provider-Initiated Counselling and Testing
PLWH	People Living with HIV
PMCTP	Prevention of Mother to Child Transmission Program
PPSG	Peer to Peer Support Groups
SRHR	Sexual and Reproductive Health Rights
UNICEF	United Nations Children's Emergency Fund
VCT	Voluntary Counselling and Testing
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization

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Map of Zimbabwe

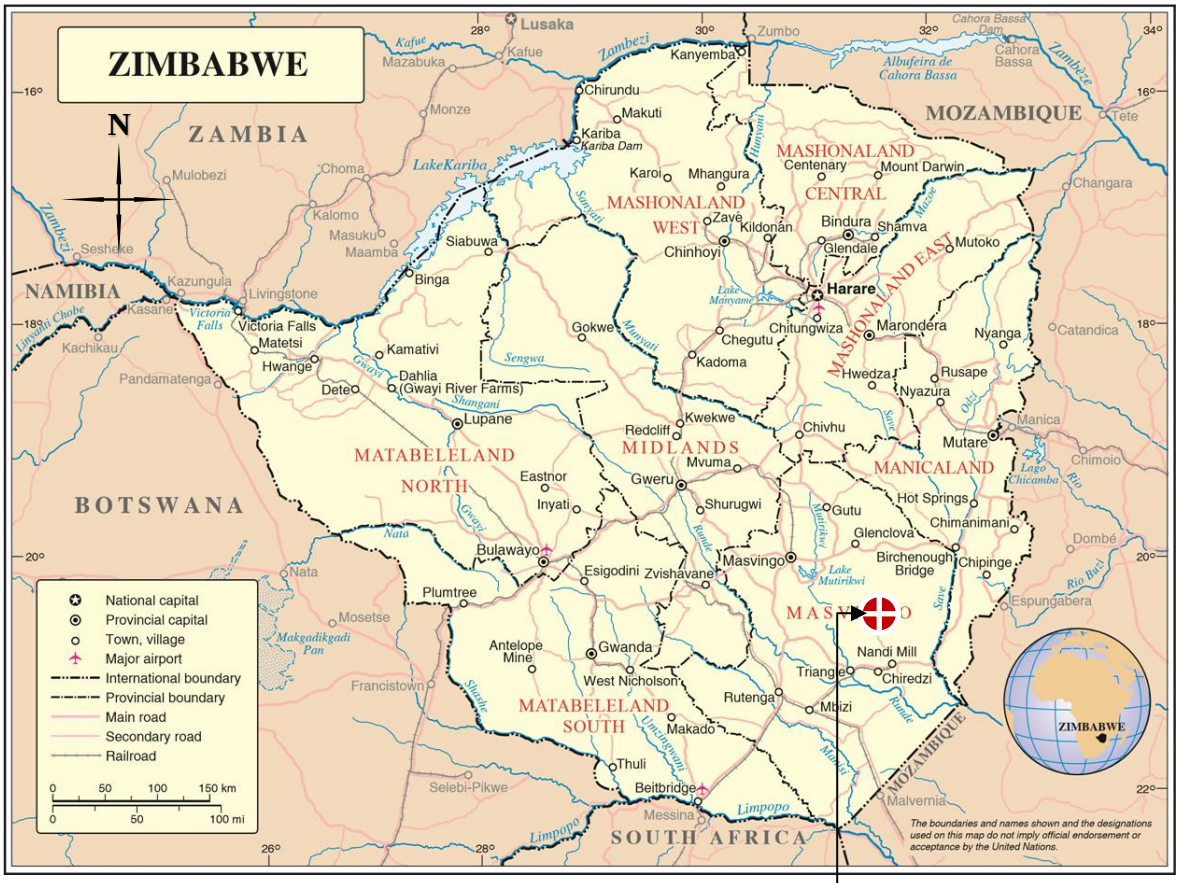

Figure 1. Map of Zimbabwe showing the location of Mashoko Christian Hospital[1]

[1] Source: http://www.un.org/depts/cartographic/map/profile/zimbabwe. [Accessed 2018, 1 November].

CHAPTER ONE

INTRODUCTION AND BACKGROUND

1.1. Introduction

This chapter focuses on providing the introduction to the study. It consists of the background to the study, research motivation, research problem, research questions, research aim and objectives, research methodology and limitations of the study. It also gives definition of key terms and a brief overview of the chapters. This introduction provides the setting and context of the study.

1.2. Background to the study

This study seeks to critically evaluate, from a *missio Dei*[2] and a feminist perspective, the gendered nature of Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) programs offered in medical missions of the Church of Christ at Mashoko Christian Hospital (MCH) in Zimbabwe. According to Kuhlmann and Annandale (2012:1), gender remains a significant determining factor in health that impacts on the spread of HIV and AIDS in Zimbabwe and globally regardless of efforts to eradicate gender disparities in the issues of health over the years. While gender disparities exacerbate the scourge of HIV and AIDS, the epidemic is also intensifying the deeply rooted gender inequalities in societies (*ZWRCN*[3], 2003:4) Currently, HIV and AIDS remains a major public health problem, threatening the socioeconomic fibre of Zimbabwe (*MoHCC*[4], 2016:15). Yet, the rigid gender role differences in the society continue to have an effect on how men and women access healthcare services and how their different health needs are dealt with (*WHO*[5], 2010:1). Consequently, this calls for the church, government organizations, faith-based communities and other key stakeholders to significantly improve efforts to reduce the effects of gender inequality with regard to the HIV epidemic across the globe (*AVERT*[6], 2018:1). The church through its missions is, thus, implored to actively participate in fighting both gender injustice

[2] See section 1.13.16. for a definition of the term *missio Dei*

[3] Zimbabwe Women's Resource Centre and Network

[4] Ministry of Health and Child Care

[5] World Health Organization

[6] AIDS Virus Education and Research Trust

and the epidemic. This reality points to a serious need for a missiological study such as this one.

Gender inequality also continues to create disparities in how the HIV pandemic affect women and men globally, but most seriously in Sub-Saharan African countries (*AVERT*, 2017:1). In Zimbabwe, there is a wide gender differentiation in HIV prevalence. Reports in 2014 reveal that in young people within the age group of 15 to 25 years, the prevalence of HIV is 1.5 times higher in women than in men (Loewson and Shamu, 2014:31). In that same year, the number of women living with HIV was 54% of the total number of people living with HIV (*MoHCC*, 2016 :15). This is due to a number of reasons. For instance, gender disparities socially, culturally, educationally and economically often hinder women's autonomy to sexual health services, condom use, HIV testing and treatment (Haddad, 2003:151-152; *AVERT*, 2017:1). In the same vein, gender based violence, including between intimate partners, fuels women's vulnerability to HIV and hinders their access to services. The burden is also heavier to marginalized women such as sex workers, disabled women, migrant women and women who are highly poverty stricken. Child bearing further advances HIV and AIDS in women since pregnancy weakens the immune system (*AVERT* et al., 2017:13). This suggests that social norms, and perhaps healthcare policies and programs, continue to favour a particular gender as well as particular facets of society.

The gender disparities also amplify HIV vulnerability to lesbians, gay, bisexual, transsexual, intersexual and queer (LGBTQI) people. In Zimbabwe, as the case is similar in South Africa, the society generally has negative attitudes towards LGBTQI people due to homophobia and ignorance. Homosexuality is perceived as social deviation against African culture and Church teachings. The issue is very sensitive and there are so many fears, misconceptions, and prejudices around people who are deemed homosexuals in Zimbabwe. The former president of Zimbabwe, Robert Gabriel Mugabe publicly pronounced that lesbians and gays do not have rights at all in the country. He described them as 'worse than dogs and pigs and should hounded out by society'(Shoko, 2010:644). In fact, some acts associated with LGBTQI people are criminalized (*SIDA*[7], 2014:1). Consequently, the challenge of disclosing sexual orientation becomes a barrier for LGBTQI to getting information and proper treatment of HIV and AIDS

[7] Swedish International Development Authority

(*IAGCI*[8], 2016:4). Hence, LGBTQI people face more discrimination and isolation in accessing health care services than their cisgender and heterosexual counterparts.

Although HIV and AIDS programs that promote gender justice have been put in place, there is still a significant need to improve commitment as gender injustice continues to persist globally. As Kuhlmann and Annandale (2012:3) observe, gender mainstreaming[9] policies and programs are still overshadowed by unsolved gender problems. In that respect, this study seeks to explore whether the gendered nature of these programs promotes exclusion or inclusion of the affected men and women in Zimbabwean society.

The Church of Christ in Zimbabwe, as many other faith-based organizations (FBOs) do today, makes use of its evangelistic arm of medical missions to proactively participate in providing HIV support and care programs for those affected by HIV and AIDS. Medical missions is an important paradigm of the church's understanding of healing ministry. Although healing has been intrinsic in the biblical tradition (Grundman 2006:372), medical missions is largely as a result of the influence of enlightenment. Since medical missions is based on science of medicine and rationalism (van Reken, 1987:8), it stands in sharp contrast to miraculous healing. In that regard, medical missions is both a component of science as well as a religious enterprise. Bongmba (2016:503) traces the history medical missions in Africa and asserts that, at times, it is contrary to some aspects of African tradition. As such, medical missions has received mixed and critical reviews. In the current study, this healing ministry stands as an essential approach of the Church of Christ's missionary engagement with issues of HIV and gender particularly through the HIV and AIDS programs.

However, evaluation of the effectiveness of the HIV programs in relation to gender justice has been a relatively low policy priority for the church. As Kuhlmann and Annandale (2012:1) observe, efforts to consider issues of gender in relation to healthcare often turn out to be simply a compilation of reports on sex differences without serious deliberation of real life challenges of the affected men and women. Therefore, this study further explores the influence of the church's medical missions on gender justice in the HIV and AIDS programs. Finally, the study will culminate in developing recommendations that can possibly address the existing gaps in

[8] Independent Advisory Group on Country Information

[9] See section 1.12.11 for a definition of the term gender mainstreaming.

the gendered scope and healthcare delivery of the organization. The subsequent subsection presents the motivation of this research.

1.3. Research Motivation

The motivation to study gender, and HIV and AIDS from a *missio Dei* perspective stems from the fact that the researcher is a minister of the Church of Christ in Zimbabwe. Currently, I serve as the Senior Hospital Chaplain at MCH. I also lead and direct the Medical Evangelism Department. My duties involve providing pastoral presence, counselling and confidential support to patients, hospital staff, students and their immediate families when they struggle with issues such as crisis, loss, stress, or any other social or work related problems. Further, I am part of the debriefing process after traumatic events. In this regard, I am placed in an important position where I offer care and support, while also providing hope and comfort to HIV and AIDS victims.

I am also directly and indirectly involved in the HIV and AIDS programs offered and facilitated at MCH such as: AIDS Home Based Care (AHBC) outreaches, Peer to Peer Support Groups (PPSG), Voluntary Medical Male Circumcision (VMMC), Voluntary Counselling and Testing (VCT), Prevention of Mother to Child Transmission Program (PMCTP) and Provider-Initiated Counselling and Testing (PICT). My position and various responsibilities within medical missions brought to my attention a number of gender related realities such as discordant couples, violation of sexual rights, gender based violence and health risk behaviours along with numerous other problems caused by gender inequality in accessing HIV care. In light of this, it is undeniable that gender inequality continues to play a detrimental role against collective efforts to improve health.

I minister in a patriarchal society, where androcentric practices are the norm. Expressing how patriarchal norms fuel the pandemic, Teresa Okure is cited in Ackerman as saying:

> The first virus is the one that assigns women an inferior status to men status in society....this virus fuels sex industry in which young women, themselves are the victims of abuse, become infected and then pass it on to others, then even to the babies. This is the virus that causes men to abuse the women (Ackermann, 2004:35-36).

As a result of the patriarchal practices in the society, widowed HIV positive women are still stigmatized and blamed for their husbands' death. Women and girls are more exposed to violence and abuse that, in turn, increases the spread of HIV. Consequently, they are the most vulnerable and worst affected by HIV and AIDS due to the uneven gender terrain. This study

sheds light in this regard and also propose what medical missions, being an evangelistic arm of the church, may proactively do to promote gender justice in HIV and AIDS programmes.

In the same vein, going through the Masters Theology, Gender and Health Core Module classes at Stellenbosch University was illuminative, enabling me to perceive the way in which my context is structured in a way that promote patriarchal norms. A number of issues stood out from the course including gender inequality, health risks, discrimination against certain sexualities, and violation of human rights and the intersecting nature of these issues. I realized that the traits of gender inequity permeate all sectors of society, and in turn undermine the joint struggles to alleviate the effects of HIV and AIDS. Thus, the Gender and Health Core Module has sensitized me to the need to challenge these structures.

To a degree, this study is deeply personal, as I have seen numerous families crumbling in Zimbabwe, not only because of the detrimental effects of HIV and AIDS, but largely due to the uneven gender terrain that precedes the disease. As I carry out this study, both of my parents are deceased due to the same reason. I am, therefore, in a compelling position to carry out the study. This stance influences my commitment to interpret the implications of the gendered nature of HIV and AIDS programs, and to negotiate a societal change.

Looking at previously conducted studies, there is no doubt that issues of gender, in relation to HIV and AIDS, have been vastly researched. However, there is a considerable gap with regards to missiology and feminism being conversational partners in the issues of gender justice and HIV and AIDS. Therefore, this necessitates continuity of studies on the particular role of gender in relation to HIV and AIDS from a missiological and feminist perspectives.

Undeniably, the Church also has a meaningful role to play in alleviating effects of HIV and AIDS perpetuated by gender inequity in the society. The Church can use its influence to uphold the acutely needed gender justice in the effort to alleviate the impact of HIV and AIDS. Thus, the conviction that the church has the potential to contribute towards the needed gender justice also serves as a motivation for this study.

1.4. Research Problem

Observable realities and documented statics demonstrate that gender disparities remain a significant determining factor of health that impacts on the spread of HIV and AIDS in the Zimbabwean society. In an effort to promote gender justice, the Church of Christ in Zimbabwe has partnered with the government in adopting gender mainstreaming HIV and AIDS programs

in their medical missions. However, despite the establishment of these programs, women and men continue to be disproportionately infected and affected by HIV. Yet, the evaluation of the effectiveness of these programs, particularly in relation to gender justice and theology of healing ministry, as already mentioned, has been a low policy priority for the Church of Christ in Zimbabwe. Apparently, the lack of understanding of the healing ministry as a dimension of the all-inclusive *missio Dei* is seriously causing gender insensitivity in the HIV and AIDS programs offered in the medical missions. In light of that, this study seeks to identify the gaps that possibly exist regarding gender justice in the HIV and AIDS programs and develop recommendations that can potentially serve to address the gaps.

1.5. Research Aim and Question

This study aims to critically evaluate the gendered nature of HIV and AIDS programs in the medical missions of the Church of Christ, Mashoko Mission in Zimbabwe using the *missio Dei* and feminist perspectives. In doing so, the study will be trying to answer the following primary question:

How are the HIV and AIDS programs offered in the medical missions at Mashoko Mission framed for a gender sensitive healing ministry as a dimension of the all-inclusive Missio Dei?

1.6. Sub-questions

In that regard the sub-questions for the research are:

1. What is the nature of HIV and AIDS programs in the medical missions of the Church of Christ at Mashoko Mission?

2. How does the gendered nature of the HIV and AIDS programs possibly disregard the affected men and women in the society?

3. What are the implications of the gendered programs in view of gender justice and the Christian healing ministry part of the all-inclusive *missio Dei*?

4. What are the existing gaps regarding gender justice and missional challenges that probably exist in the HIV and AIDS programs?

5. How could the existing gaps in the gendered nature of the HIV and AIDS programs be possibly addressed?

1.7. Research Objectives

In an attempt to answer the stated research questions, the following objectives of the study have been formulated:

1. To investigate the nature or characteristics of HIV and AIDS programs in the medical missions of the Church of Christ at Mashoko Mission.

2. To determine how the gendered nature of HIV and AIDS programs possibly disregards the affected men and women in the society.

3. To find out the implications of the gendered nature of the HIV and AIDS programs in light of gender justice and the healing ministry as a dimension of the all-inclusive *Missio Dei.*

4. To identify gaps regarding gender justice and missional challenges that possibly exist in the HIV and AIDs programs.

5. To develop recommendations, arising from the research findings, on how to address the existing gaps in the gendered nature of the HIV and AIDS programs.

1.8. Synopsis of the theoretical framework

This study is missiological, and based on a theoretical framework that merges missiology and feminist theology as complementary analytical focal points. This section will give a glimpse of the theoretical framework, but the framework will be discussed in detail in the second chapter of the study.

1.8.1. Missiology – All-inclusive *missio Dei*

The missiological aspect of this study is built on the all-inclusivity of *missio Dei*, as expressed in Bosch's assertion that Jesus' 'mission is one of dissolving alienation and breaking down all walls of hostility, of crossing boundaries between individuals and groups'(Bosch, 2011:28). According to van Reken (1987 :2) the medical missions or the healing ministry is regarded not only as a tool for missions but as a demonstration of God's love and concern for suffering people, and thus it is a legitimate part of the overall missions. In light of this, the healing ministry is undeniably part of the all-inclusive *missio Dei.*

David Bosch, in the final part of *Transforming Mission: Paradigm shifts in Theology of Mission*, describes a new framework for understanding Christian mission in the world. He calls this new framework the 'emerging ecumenical paradigm of mission' (Bosch, 2011:377). He contends that the new paradigm comprises of profound elements that are intimately related.

Four of these are of particular importance to this study, namely mission as *missio Dei*, mission as the transformation, mission as mediating salvation, mission as the quest for justice and mission as liberation.

In this new view of Christian mission, Bosch (2011:377) maintains that the church can neither be viewed as the ground nor the goal of mission. Instead, the final goal of the church should be the glorification of the Father and the Son. Secondly, the church is not the Kingdom of God, but rather the beginning of that Kingdom. Further, the church's missionary involvement does not only call individuals into the church, but also liberates people from being subjected to social, economic and political conditions in this world (Bosch, 2011:377).

In addition, the church should be viewed as the dwelling of the Spirit of God and a movement of the Sprit toward the world in the journey to the future (Bosch, 2011:377-378). Finally, because of its integral relatedness to the world, the church should function as a conveyer of glad tidings rather than a barrier. These elements of the emerging paradigm of mission contribute immensely to this study. They give reasons as to why the Church of Christ in Zimbabwe should be involved in fostering gender justices in the HIV and AIDS programs within her medical missions.

As Ute Hedrich also observes, in her essay titled 'Missiology and HIV and AIDS: Defining the contours', the pandemic has created new challenges to the field of missiology that require a development of a new contextual perspectives (Hedrich, 2011:217). In that respect, Hedrich (2011:2017) acknowledges that the Christian mission has embraced the challenges of the epidemic through missiologist conferences, a few publications, study processes and mission organization policies on HIV and AIDS. However, Hedrich (2011:217) also argues that there are still gaps with regards to the published literature. She observes that there is lack of analysis within various missiological influences and traditions that promoted the existing perceptions of sexuality and moral discussion as a response to HIV (Hedrich, 2011:228). This gap guarantees the importance of this study, which seeks to evaluation of HIV and AIDS programs in medical missions.

Stephen Bevans and Rodger Schroeder, in *Constants in Context : A theology of Mission for Today* , uphold that 'mission as participation in the mission of the triune God' cannot afford to ' proceed in ways that neglect the freedom and dignity of human beings'(Bevans and Schroeder, 2004:348). It is in this light, that this study seeks to evaluate the HIV programs provided in the medical missions of the Church of Christ in relation to gender justice and human

dignity. The element of human dignity and gender justice that is demonstrated to be part of the *missio Dei* is also intrinsic in feminist theology. It is that common ground that ties the missiological framework and feminist theology as complementary analytical tools in this study.

1.8.2. Feminist Theology- human dignity for all

According to Rakoczy (2004:4) feminism is a ' revolution in theory and practice which asserts that women are truly and fully human beings,' and based on this reasoning, 'their human dignity must be intrinsic to every way human beings structure their lives.' The revolution, according to Rakoczy, cuts across political, social, economic, and religious dimensions. In this regard, feminist theology is part of the revolution that 'engages in a radical critique' of the 'past and present theology and praxis, challenging the presuppositions, beliefs, dogmas and the whole of Christian life from the perspective of women's dignity' (Rakoczy, 2004:4).

Although there are various other reasons to support human dignity, Reginald (2017:222) notes that the Christian faith upholds that 'all humans are bearers of *imago Dei'* (image of God) as such they are regarded as having 'equal and inherent dignity'. Despite the fact that the Universal Declaration of Human Rights (UDHR) charter of 1948 by the United Nations (UN) does not point to the imago Dei as the basis of human dignity, it also places in the first article the notion that 'all humans are born free and equal in dignity and rights'(*UN*, 2015:4). The overarching notion in all this is that all persons are equal in dignity irrespective of their sex, class, religion, social, political, or economical or health condition (Claassens et al., 2003:13; Andorno, 2014:45). From all this, as Koopman (2015:20) writes, 'emanates the theological imperative to acknowledge and respect dignity' of all people. In that respect, this study engages the critical lenses of feminist theology to assess, from the perspective of equal human dignity, the relevance HIV and AIDS programs provides in Christian healing ministry of the Church of Christ at Mashoko Hospital.

The key principle of feminist theology that is instrumental in this study is, therefore, 'the promotion of the full humanity of women'(Reuther, 1993:18). The method for pinpointing areas of sensitivity or insensitivity of that human dignity is best articulated by Elizabeth Johnson. She says, 'whatever enables this [women's humanity] to flourish is redemptive and of God; whatever damages this is…contrary to God's intent'(Johnson and Rakoczy, 1997:53-54). In this regard, feminist theology plays a liberating role to women from acts of injustice. As Rakoczy (2004:17) also notes, it has two main tasks, that of deconstructing gender injustice traditions in theological thought and that of formulating new perspective. That element of

feminist theology concurs with the all-inclusive *missio Dei* which is also 'crosses boundaries of hostility' (Bosch, 2011:28) and manifest as liberation and quest for justice. Hence, the two, missiology and feminist theology find a common platform as complementary analytical focal points of this study.

1.9. Research Methodology

This study is a qualitative, non-empirical research. It engages the above mentioned analytical lenses to interrogate documents and other secondary literature on four key HIV and AIDS programs that are provided at Mashoko Christian Hospital, namely: 'AIDS Home Based Care (AHBC), Antiretroviral Therapy (ART), HIV Counselling and Testing (HCT), and Prevention of Mother to Child Transmission (PMTCT).' In order to achieve this objective, the study will employ document analysis method.

A critical analysis of the existing documents (declarations, policies, reports and other relevant material) related to the HIV and AIDS programs being provided in the medical missions of the Church of Christ at Mashoko Mission will be applied. Documentary analysis involves 'the study of existing documents, either to understand their substantive content or to illuminate deeper meanings which may be revealed by their style and coverage' (Strydom and Delport, 2011:377). The research will also require an analysis of documented sources (books, articles, archival material and church reports) on the history of the medical missions of the Church of Christ in Zimbabwe, particularly with regard to beliefs, teachings and advocacies on gender, health, HIV and AIDS and healing ministry. This method of data collection is very instrumental, as Strydom and Delport (2011:377) note, in circumstances where observation interviews are not applicable.

As can be found in most data collection techniques, there are some limitations and disadvantages that are particularly for document study. According to Strydom and Delport (2011:388) document study bears some weaknesses that include incompleteness, lack of availability, and lack of standard format. However, this study will take advantage of the strength of this technique, chiefly that most documents will be available at relatively low cost.

On program evaluation, the researcher will adopt the Southern Africa Development Community (SADC) Checklist for Measuring Implementation of the Gender Mainstreaming Guidelines in HIV and AIDS Programs. The checklist is a quick instrument to promote

effective implementation of gender mainstreaming in HIV and AIDS and other communicable diseases[10] programs. It contains nonspecific guidelines for use by SADC member states to measure levels of conformity to mainstreaming of gender in the policies and programs. They also allow program managers to measure gender sensitivity in their programs (SADC, 2011:4). Application of the checklists in this study will be instrumental in creating a systematic and quick way to pinpoint program areas in which there is gender (in) sensitivity.

The framework and checklists will be tailored to the context of MCH. The outcomes from the checklist will then be assessed using the missional and feminist lenses. This will be done through juxtaposing the guidelines of the SADC checklist with the guidelines provided in the manuals and polices used to run HIV and AIDS programs at MCH. The checklist provides relevant questions to assess gender mainstreaming compliance in the way in which the programs are formulated. For instance, it poses a question such as: Does the program promote the involvement of both men and women? The responses to the questions are then given in form of ticks placed in relevant columns marked 'yes', 'no' or 'in progress'.

The SADC checklist, therefore, will be helpful in identifying and measuring the gender mainstreaming efforts in HIV and AIDS programs provided at MCH. It will also help to pinpoint areas of success as well as areas that require improvement in the programs. In the end, this will enable objective assessment of the effectiveness of HIV and AIDS programs in achieving gender justice and meeting the expected outcomes of the all-inclusive *missio Dei.*

The study will culminate in developing recommendations, arising from the findings of the research conducted, on how to possibly address the existing gaps in the gendered nature of the HIV and AIDS programs.

1.10. Ethical Considerations

The researcher is aware of the ethical values applicable in conducting a research study. This study will make use of secondary data in the public domain. This includes information in form of books, articles, journals, declarations, policies, resolutions and other literature related to MCH, medical missions of the Church of Christ and HIV and AIDS programs. The SADC

[10] The checklists are designed to cater for three communicable diseases, HIV and AIDS, Tuberculosis and Malaria. However, this study will only make use of pointers that are particularly applicable to HIV and AIDS programs an leave out some questions that are particularly relevant for Malaria and Tuberculosis.

Checklist of the Gender Mainstreaming Guidelines in HIV and AIDS Programs is going to be used in relation to information provided in the policies and manuals that are used in running the HIV and AIDS programs at MCH. No confidential or sensitive information, such as from patient's cards, will be used in the process. Permission to carry out a study at MCH and to access suitable documents has been granted by relevant authorities. Due caution and proper referencing will be exercised in consulting the mention forms of information.

1.11. Potential impact of the study

The overriding objective is that this research project will be instrumental in assisting the Church of Christ in Zimbabwe and elsewhere on the African continent where similar contexts require missiological stimuli to stir communities to actively participate in promoting gender justice in issues pertaining to HIV and AIDS. As was noted by Chitando (2011:237), that religion is ' part of the problem and part of the solution' in the challenges paused by HIV and AIDS pandemic, the church has to take responsibility in bringing solutions. This has a potential to improve gender justice in the collective efforts to fight the HIV pandemic.

Again, as Hedrich (2011:227) observes, one of the most important gaps that has to be filled in the existing literature is lack of critical evaluation of missiological influences and traditions that has caused the current understanding of gender in relation to the HIV pandemic. Thus, it is expected that this study will also compliment the limited body of literature available on missionary engagement to gender justice and HIV and AIDS.

HIV has been described as a 'gendered epidemic'. Such description shows the seriousness of the gender dimensions of the pandemic and appeals for a study like this. As Gouws (2012:279-280) also observes, gender blindness supports the gendered nature of social problems, including HIV and AIDS. Thus, the gendered social challenges ultimately call for gendered solutions

Apart from these, other FBOs dealing with PLWH can significantly benefit from this study. Findings and recommendations from this study can be useful in different contexts where similar HIV and AIDS programs are being offered. The same effect can be realised in other hospitals and clinics other than Mashoko Christian Hospital.

In the long run, the impact of the study will be the flourishing of gender justice in issues of the HIV pandemic. The Church will be a better place to carry out its mandate in the all-inclusive *missio Dei.*

1.12. Limitations of the study

The latitude of this research is limited. Its focus is on HIV and AIDS programs offered in the Church of Christ's medical missions (healing ministry) at Mashoko Christian hospital in Zimbabwe. In addition to that, the researcher is carrying out the study from the perspective of an insider's perspective or as minister and member of the church, as well as a chaplain at Mashoko Christian Hospital. Fouche and de Vos (1998:125) point out that carrying a study as an insider compromises objectivity, but it also qualifies the researcher more, because the researcher has more knowledge and experience than an outsider. In that regard, this researcher has more knowledge and experience on issues pertaining to HIV and AIDS programs being offered at Mashoko Christian Hospital. The researcher is also aware of gender related issues and particularly from a Church of Christ perspective.

In addition to that, this study is limited in terms of the engaged methodology. This study uses document analysis. As Silva (2012:14) attests, each document is compiled within a specific context and that may lead to biased or selected understanding of the information presented. Again, at times authors in inevitably record or omit some information as per their assumption (Silva, 2012). Nevertheless, this researcher intends to overcome the limitations by using both church and government documents that are related to HIV and AIDS programs at Mashoko Christian Hospital.

1.13. Definition of key concepts

It is of importance to define some key terms that are employed in this study. The subsequent terms shall be used with meanings ascribed to them as follows:

1.13.1. Church (es) of Christ

In this study, Church (es) of Christ refer to autonomous and self-governing congregation(s) that are also known as Christian Church (es). *(CNCCZ*[11], 2014:1) The group falls within the mainline Protestants of the Reformed tradition under the 'Restoration Movement'. The 'Restoration Movement' , sometimes called the 'Stone-Campbell Movement', started from efforts of the three American men, Barton W. Stone, Thomas and Alexander Campbell in the nineteenth century (Foster et al., 2004:11) . They are associated with each other through common but distinctive beliefs and practices. They claim precedence of the Bible in their teachings and trace their origins to the New testament Church. They believe that

[11] Constitution of the National Conference of the Church of Christ in Zimbabwe

denominationalism is an error and drifts the church from the New Testament church (Arnold, 2013:4).

The group is commonly found in the New Zeeland and the United States of America. They, however developed into diverse traditions and are generally dispersed in other parts of the world including Zimbabwe. The main strands of the movement encompass churches named 'Churches of Christ, Christian Church (Disciples of Christ) and the Christian Churches of Christ' (Williams et al., 2013:11).

1.13.2. Discrimination

The term is used in this study to refer to a prejudicial attitude, thought or action leading to a distinction against a person or people and unfair treatment, based on being perceived or on their belonging to a certain group or class (*MoHCC*[12], 2004:xi).

1.13.3. Evaluation

A systematic analysis of qualitative and quantitative data , program characteristics, activities and outcomes so as to assess improvement towards the goals of a program(*MoHCC*, 2004:xi).

1.13.4. Feminism

The term feminism is derived from the French *feminsime* describing 'women with masculine traits' (Pilcher and Wheleham, 2004:48). Generally the term describes a radical conviction that women are subjugated due to their sex and that they deserve equality like all people. In this study, the term is used in tandem with Susan Rakoczy who defines it as a 'revolution in theory and practice which asserts that women are truly and fully human beings,' and based on this reasoning, 'their human dignity must be intrinsic to every way human beings structure their lives'(Rakoczy, 2004:4).

1.13.5. Feminist Theology

The term feminist theology is used in this study in harmony with the definition given by Susan Rakoczy. She describes feminist theology as 'a critique of the past and present theology and praxis, challenging presuppositions, beliefs, dogmas and the whole of chaotic life from a perspective of women's dignity' (Rakoczy, 2004:4).

[12] Ministry of Health and Child Care

1.13.6. Gender

In this study, the term gender denotes socially constructed roles and responsibilities for men and women. The term is also used as an analytical category to differentiate sexual differences and the general perceptions that are held about the characteristics, behaviours and traits which are assigned as either feminine or masculine(Pilcher and Wheleham, 2004:56).

1.13.7. Gendered

According to Pilcher and Wheleham (2004:59) the term gendered describes something that is either masculine or feminine with a nature or characteristics that displays forms of gender differences. In another sense, as Pilcher and Wheleham (2004:59) something is described as gendered when it is dynamically involved in a social process that yields differences between men and women.

1.13.8. Gender equality

In this study, the term gender equality is used to describe a state that is achieved when men and women, boys and girls have equal opportunities, rights, power, responsibilities and life prospects. As Douglas (2007:3-4) notes, this does not imply sameness of men and women, rather it entails that their opportunities and responsibilities are not determined on 'whether they are born male or female'.

1.13.9. Gender equity

Gender equity, in this study, refers to a process of ensuring fairness to men and women, boys and girls. Gender equity put into consideration social and historical drawbacks that hinders men and women, girls and boys to operate on an equal standing (Douglas, 2007:4). In that respect, gender equity can be regarded as the means whilst gender equality can be looked at as the result (*UNESCO*[13], 2003:2).

1.13.10. Gender justice

In this study, the term gender justice describes the promotion and protection of social, economic, political and civil rights in relation to gender equality. It involves assessment of access as well as obstacles to the rights for men and women, boys and girls and it necessitates adoption of gender sensitive strategies in promoting and protecting them (Douglas, 2007:4).

[13] United Nation Education Scientific Organisation

1.13.11. Gender mainstreaming

In this study, gender mainstreaming is used to describe a strategy meant to make men and women, boys' and girls' concerns and experiences a primary dimension in planning, implementing, monitoring and evaluating policies and programmes in all social , political and economic platforms. It aims to make men and women, boys and girls benefit equally and to guard against inequality (Douglas, 2007:3).

1.13.12. Gender sensitivity

Gender sensitivity, in this study, refers to an attitude of having 'a sympathetic awareness of the social and cultural construction of male and female identity and roles while recognising the reality of gender differences and complementarity'(*GOZ*[14] 1999:60)

1.13.13. Holistic approach/ holism

The term holistic approach is used in this study to refer to a strategy or a perspective that looks at the total person, spiritually, physically, socially and psychologically (*MoHCC*, 2004:xii). It is used in accord with Yamamori (1996:1) to describe a ministry that takes 'evangelism and social action as functionally separate, rationally inseparable and essential to the total ministry of the church'.

1.13.14. Human dignity

In this study, the term human dignity is used to express an inherent quality of worthiness in individuals. It is that attribute of worthiness that makes both men and women fit and deserving of respect and honour. According to Koopman (2015:20-21), the dignity is divinely founded and is conferred equally upon women and men on the basis of the Creator, love for humanity.

1.13.15. Medical missions

In this study, the term medical missions is used in accord with the definition given by Sydney R. Hodge to describe 'the missionary enterprise of the Christian Church that seeks to spread the gospel of Christ Jesus through healing the sick.'[15] The medical missions are fundamentally an agency that seeks to promote and propagate the kingdom of Christ in the world and thus its purpose is essentially evangelistic.[16]It should not be mistakenly perceived as a mere

[14] Government of Zimbabwe
[15] Source: http://www.oldandsold.com/articles20/medical-missions-1.shtml
[16] Source: http://www.oldandsold.com/articles20/medical-missions-1.shtml

accompaniment or a side channel of the broader *missio Dei*, but should be regarded as one of the keystones of the whole scheme of God's mission.

1.13.16. *Missio Dei*

The term *missio Dei*, Latin for mission of God, in this study is used in line with David Bosh's description. It articulates the notion that 'mission is, primarily and ultimately, the work of the triune God, Creator, Redeemer, and Sanctifier, for the sake of the world, a ministry in which the church is privileged to participated' (Bosch, 2011:402). It conveys the conviction that the inmost source of mission and cannot be a human invention. Mission exists because God loves his people and it is out of that sending love that God instituted mission (Bosch, 2011:402).

1.14. Chapter overview

This research is structured in six thematic components of the study. The lay out the chapters is as follows:

The first chapter constitutes the introductory components of the entire study. The chapter provides background to the study, research motivation, research problem, research questions, research aim and objectives, research methodology, and limitations of the study. It also gives definitions of key terms and a brief overview of the chapters. This introduction provides the setting and context of the study by highlighting the importance of promoting gender justice in issues related to HIV and AIDS.

The second chapter aims to review literature related to this study. It further clarifies the theoretical framework of the study. This literature review generally shows that gender is strongly associated with the spread and impact of the HIV and AIDS pandemic. It shows the importance of gender justice in relation to the alleviation of the impact of the pandemic, including the usefulness of religious resources and theological perspectives. It also delineates the strong link between missiological and feminist theoretical perspectives in relation to human dignity and gender justice. The gendered nature of HIV and AIDS, the importance for evaluating the HIV and AIDS programs, and the role of the Christian healing ministry (medical missions) as part of an all-inclusive *missio Dei*, are major themes that will be explored in the literature review. The chapter will close with a summary of its elements.

The third chapter briefly traces the historical background of the Church of Christ medical missions. It particularly gives a detailed overview of the medical missions at Mashoko Mission in relation to church's engagement in the HIV and AIDS programs provided at Mashoko

Christian Hospital. It highlights the Church of Christ's theology and practice of healing ministry. The chapter also crystallises on some of the held perceptions, teachings and practices of the Church of Christ in relation to gender issues and HIV. This chapter provides a detailed context and setting of the study as well as giving a basis for the next chapter.

The fourth chapter gives a detailed description of key HIV and AIDS programs at Mashoko Christian Hospital namely: AHBC, ART, HCT, and PMTCT. The chapter further assesses the programs using the SADC Checklist for Measuring Implementation of the Gender Mainstreaming Guidelines in HIV and AIDS Programs. The evaluation aims at checking whether the institution is doing enough to promote gender justice in the HIV and AIDS programs as stipulated in the SADC Checklist for Measuring Implementation of the Gender Mainstreaming Guidelines in HIV and AIDS Programs.

The fifth chapter is the penultimate part of the study. It serves to give an analysis of the implications of the HIV programs to the all-inclusive *missio Dei*. It engages the missiological and feminist lenses, as described in chapter two, to point out the probable existing gaps in each of the selected HIV and AIDS programs provided at Mashoko Christian Hospital. The chapter further draws some missiological implications on the findings of the study with regard to theory and praxis of the healing ministry as a dimension of the all-inclusive *missio Dei.*

The last chapter constitutes the final elements of the study and recapitulates the chapters of the study. It discusses some recommendations to the church of Christ in Zimbabwe. The recommendations possibly enhance gender justice in the HIV and AIDS programs that are being provided by the Church of Christ at Mashoko Mission and the rest of Zimbabwe. The chapter also proposes further research in the area of Christian mission in relation to gender and HIV and AIDS.

1.15. Conclusion

This chapter sets out to provide the general background to this research mainly focusing on evaluating, from a missional and feminist perspective, the gendered nature of the HIV and AIDS programs at Mashoko Christian Hospital. The chapter introduces the reader to the significance of the study by providing a background to the study, research motivation, research problem, research aim, research questions, research objectives, research methodology, and limitations of the study. It also gives definitions of key terms and a synopsis of the chapters.

In particular, this thesis points to the importance of promoting gender justice in issues related to HIV and AIDS. This includes the contribution of the church in the same scheme. The research attempts to sensitise the Church of Christ at Mashoko Mission to the need to assess their input with regards to gender justice and HIV and AIDS programs that they offer.

In tandem with the preceding outline of the thesis, the following chapter reviews literature related to theology, gender and HIV and AIDS. Further, it will provide a detailed theoretical framework that will set the parameters for analysis in this study.

CHAPTER TWO

LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

2.1. Introduction

The preceding chapter introduces the study by presenting the background to the study, research motivation, research problem, research questions, research aim and objectives, research methodology, and limitations of the study. It also provides definitions of key terms and a brief overview of the chapters. The aim of this current chapter is to do an in-depth review of literature related to this study. The chapter interrogates varied view points in the literature as well pointing as to gaps which this study attempts to fill in. The concepts that are mainly dealt with include all-inclusive *missio Dei*, feminism, patriarchy, and gender justice as an expression of respect to human dignity for all. The chapter elaborates more on the conceptual framework of the study. It also explores some themes that are key to this study such as, the gendered nature of HIV and AIDS, and the relevance of theological resources, including medical missions as a dimension of all-inclusive *missio Dei*, in response to issues of gender and HIV pandemic. The chapter closes with a summary of its elements.

2.2. All-inclusive *missio Dei*

As previously highlighted in the first chapter, the study's missiological perspective hinges on the concept of all-inclusive *missio Dei* as expressed by David Bosch in his book, *Transforming Mission: Paradigm Shifts in Theology of Mission.* He writes,

> What amazes one again and again is the *inclusiveness* of Jesus' mission. It embraces both the poor and the rich, the oppressed and the oppressor, both the sinner and the devout, [*both the male and the female*]. His mission is one dissolving alienation and breaking down walls of hostility, of crossing boundaries between individuals and groups (Bosch, 2011:28) [emphasis is mine].

Prior to these sentiments, Bosch (2011:27) indicates that Jesus' s ministry turned to all marginalised people spanning the sick, prostitutes and sinners who were discriminated on social, religious and political grounds. According to Bosch (2011:27), these people were marginalised in the Jewish society and, as it happens in today's society, their affliction was occasioned by exploitation, repression and violence. Thus, he argues that the society today should not look down upon the marginalised people. Bosch (2011:28) also indicates that the inclusiveness of Jesus's ministry aimed at preaching love in order that, if at all possible, the

ostracised be won over. Slater (2015:120) also writes that the concept of inclusivity has been 'an identity and characteristic of nascent Christianity and lends itself to a natural specification of being a follower of Christ'. The inclusiveness of Christianity in the church is concretised at the formation of the early church in Acts 2:16-18 where the spirit was poured on all, gentiles and Jews, males and female as well as slaves and masters alike (Slater, 2015:117). Therefore, the love sentiments conveyed in Jesus's ministry are eminently missionary. In that regard, Bosch (2011:31-32) maintains that this salient feature of Jesus's ministry helps us to have a better appreciation of the missionary thrust of his work and its implications to missionary endeavours of our own time. This study shares the same perspective. It aims at sensitizing the *Church of Christ* in Zimbabwe to the need of becoming inclusive, as much as possible, in their missionary engagement especially with critical issues such as gender disparities in relation to the HIV pandemic.

The inclusiveness of Jesus' ministry, as portrayed by Bosch (2011:31) 'was such that he consistently challenged the attitudes, practises, and structures which tended arbitrarily to exclude certain categories of people from the Jewish community'. It becomes abundantly clear, therefore, that the thrust of Jesus' ministry entails that Christian mission should be holistically comprehensive. This comprehensive nature of mission is evident in the model of mission which David Bosch proposes as a relevant missionary approach in his book, *Transforming Mission: Paradigm shifts in theology of Mission*. In that regard, Bosch (2011:377-448) raises a number of elements that he believes should constitute what he calls an 'Ecumenical Missionary Paradigm'. However, this study takes an inclination towards four particular themes drawn from that missionary approach namely: mission as transformation; mission as mediating comprehensive salvation, mission as a quest for justice and mission as mediating integral liberation. The thrust of the study is that these themes can form a basis as to why the Church of Christ in Zimbabwe should be involved in fostering inclusivity in form of gender justices in the HIV and AIDS programs within its medical missions.

2.2.1. All-inclusive *missio Dei* as instituting transformation

In explaining the title of his book, *Transforming Mission*, Bosch (2011:xxi) notes that the term 'Transforming' can be taken as an adjective that describes mission 'as an enterprise that transforms reality'. However, Bosch (2011: xxi) decides to use the term as 'a present participle' expressing an 'activity of transforming' meaning that the book dwells much on mission as 'something that is itself being transformed'. In that regard, Bosch decides to take the other dimension of the term 'transforming', but at least he acknowledges the power and the

mandate of mission to change reality. The dimension to say mission transforms reality, which David Bosch decides to overleap, is quite stressed in *Mission as Transformation*, a book co-edited by Vinay Samuel and Chris Sugden. The volume covers the material that has been developed by the international network of evangelicals on the understanding of mission as transformation. In that respect, transformation is defined as:

> The change from a condition of human existence contrary to God's purposes to one which people are able to enjoy fullness of life in harmony with God (Jn 10:10; Col 3:8-15; Eph. 4:13). This transformation can only take place through the obedience of individuals and communities to the Gospel of Jesus Christ whose power the lives of men and women by releasing them from guilt, power and consequences of sin, enabling them to respond with love toward God and toward others (Rom5:5) and making them 'new in Christ' (2 Cor 5:17) (Samuel and Sugden, 1999:x)

This perspective of mission fits squarely with the view of mission as expressed by Price and Richards (2013:19) as the 'work to transform the world into a picture of God's desire for humans'. From this viewpoint the notion of transformation implies, 'a means of introducing people to Christian faith by changing the environment around them, offering empowerment, voice and autonomy'(Price and Richards, 2013:19).

Mission as Transformation is organised in three thematic parts. The first part discusses the 'biblical and theological foundation for a wholistic mission theology known as transformation' (Samuel and Sugden, 1999:5). In that regard, Samuel and Sugden (1999:13) show that God, as the creator of the whole universe 'placed the world under the stewardship of women and men made in God's image', but humanity tragically rebelled against the creator. The rebellion brought devastation, evil and disorder to the whole creation. However, for Samuel and Sugden (1999:13), God did not never gave up his desire to establish His reign over the lives of people. Thus, God began to reveal His plan to save and restore creation to a realm of 'justice and peace-wholeness in all areas of life- for men, women and children' Samuel and Sugden (1999:13). Therefore, that story of God's desire to restore wholeness to humanity forms the basis of mission as transformation.

The second part constitutes the missiological expressions of Transformation as linked to development, to evangelism and to modernity. The third part comprises of a number of publications that altogether examines diverse practical issues from the perspective of

transformational theology. On the whole, Samuel and Sugden (1999:xvi) offer a model of transformation which in their words is described as,

> …rooted in the theology of mission of the Kingdom of God and seeks to express the Lordship of Jesus over every aspect of life, economic religious, and personal, political. It does not give priority to any area of life as an area of mission, but it insists that religious change is at the heart of all real change. But this change will be effected whenever people address issues of life directly, rooted in a gospel perspective.

In other terms, the missiology of transformation forms the basis of why the Christian mission should holistically engage with the world so as to extend the reconciliation work of God. Therefore, the transformation theology can prove to be an important resource for the Church of Christ in Zimbabwe to mediate the lordship of Christ in all areas of people's lives including issues of gender injustice in relation to HIV and AIDS.

2.2.2. All-inclusive *missio Dei* as mediating comprehensive salvation

According to Bosch (2011:402) salvation is an essential concern of all religions. In Christianity, salvation is at the centre of faith as evident in the conviction that God decisively brought salvation through Jesus Christ. Actually, the name of the founder, Jesus means 'Saviour'. Consequently, as Bosch (2011:402) observes, the Christian missionary movements throughout history have been driven to arbitrate salvation to all. As Slater (2015:124) also asserts, 'equality in being and worth is a clear biblical teaching affirming that all human beings – male and female – have equal standing before God, in need of salvation through Christ and called to the same destiny'. However, in the same way the understanding of the relationship between the church and mission has gone through several paradigms, there has been also shifts in the understanding of the nature of salvation which the church has to mediate.

In that respect, Bosch (2011:403) illustrates some shifts in the understanding of the nature of salvation. He describes Luke's notion of salvation as 'present salvation'. For Bosch (2011:403), Luke uses salvation language in respect of a diverse range of human circumstances that include poverty, illness, demonic possessions and sin or in respect of social, political, economic, physical and psychological suffering. Paul puts greater emphasis, as Bosch puts it, 'in inchoative nature of salvation'(Bosch, 2011:403). Thus, Paul's view is apocalyptic and he sees total salvation as reserved for the future triumph of God.

According to Bosch (2011:403-404), in the West (Protestant and Catholic) churches salvation was perceived as the 'redemption of individual souls in the hereafter', happening at the point

the individual ‘s death. For Bosch (2011:404), this definition of salvation also leads to narrowly defined church activities. As a result, it severely complicates the believers’ involvement in society since such involvement has nothing to do with salvation but simply to bring people to church so as to have access to salvation. Bosch (2011:404) writes that the coming of Enlightenment challenged the idea of salvation coming from God with and totally out of reach to human power and capability. Religion as an expression of total dependency upon God in the hereafter was ridiculed as an anachronism of human kind’s period of childhood. An alternative understanding of salvation emerged in which people were to be active in using technology and science in order to improve their socio-political conditions in the present. The church responded to that in two ways. First, both catholic and protestant circles continued to define salvation in traditional terms, ignoring the challenge of Enlightenment. Secondly, the church attempted to take challenges of modernism seriously(Bosch, 2011:404).

Following that paradigm, Bosch (2011:404), contends that in the 1970s both the secularist and liberationist definitions of salvation were challenged. Thus, there was a crisis in the modern understanding of salvation. He maintains that salvation and wellbeing, even though the two are closely knit, do not converge completely. However, Bosch (2011:404)
perceives that it is problematic to return to the classical, into classical interpretation of salvation though there are some indispensable elements. Thus, against this paradigm Bosch affirms that salvation should take effect in people’s present contexts on their way to a perfect world in the future.

However, Bosch (2011:404) argues that the challenges of the modern world to the mission with regards to the interpretation of salvation cannot merely be ignored. He sees the need for new responses. Consequently, Bosch (2011:404) asserts that circumstances propel a rereading of the biblical notions of salvation with a realisation that traditional and modern interpretations of salvation are inadequate. Thus, in the emerging Ecumenical missionary paradigm, Bosch (2011:408-409) advocates for a comprehensive interpretation of salvation which makes what he calls ‘*the totus Christus*’ (Christ in full). This interpretation takes in all the Christological elements, ‘incarnation; earthly life; death; resurrection and parousia’ (Bosch 2011:409) as essential for today’s church.

For Bosch (2011:409), it is then tenable to say that the mediating of ‘comprehensive’, ‘total’ or ‘universal’ salvation is increasingly recognised as the purpose of mission. This interpretation of salvation overcomes the traditional and more recent dualism. That comprehensive nature of

salvation demands a broader scope of the church's mission than it has been connoted traditionally. Bosch (2011:409) states that salvation is 'broad and deep as the needs of human existence'. Hence, mission means engaging in the ongoing dialogue between the saving God and evil world. It means being sent to proclaim in deed and word the Christ who lived, died, rose and lives to transform human lives and to overcome death. From the same salvific perspective, Slater (2015:126) asserts that all people, despite their difference, have the 'same privilege of covenantal union with God in Christ'. Hence, the Church of Christ should reinforce its efforts in addressing the gender disparities in the access of the services and, in turn, promote total salvation.

According Mikhael (2013:113, it should be remembered that the entire Bible bears a story of God's involvement in a salvific mission to 'all humanity'. Mikhael (2013:113) also writes,

> Even though humanity had lost its original state, God, through his grace, intended to continue in relation with the whole humanity to establish his redeeming purpose, and when the time was fulfilled God chose to act directly through Jesus Christ, God's complete and perfect mission to redeem the world. In Jesus' death and resurrection God made salvation a reality for all who believe the good news of the Gospel, and God chose to do it within the Abrahamic community.

This study is in accord with this element of a holistic *missio Dei*. It asserts that a comprehensive salvation that involves redemption of all facets of human lives should be a central concern in medical missions as part of such a holistic and inclusive *missio Dei.* As such, the Church of Christ in Zimbabwe should earnestly ensure that they are mediating a comprehensive salvation, even in issues of gender and HIV and AIDS.

2.2.3. All-inclusive *missio Dei* as quest for justice

Bosch (2011:410) argues that efforts for justice and evangelism are strongly married to each other though the two cannot be equated. However, the relationship between these two constitutes one of the problematic areas in practice of mission and theology.

According to Bosch (2011:411), social justice is undoubtedly at the centre of prophetic custom of the Old Testament. This is discernible in the ministry of prophets, such as Amos and Jeremiah, challenging the injustice of their contemporary kingdoms (Bosch, 2011:410). On the contrary, the socio-political context of the early church was fundamentally different. In the Roman Empire, Christianity was regarded as a '*relegio illicita'* (unlawful religion) and it was persecuted (Bosch, 2011:411). As a result, Christians could not address authorities on the basis

of their faith. As such, Bosch believes that the New Testament is erroneously regarded as more spiritual than the Old Testament.

The inability of Christianity to challenge social injustice, Bosch (2011:411) asserts, prevailed in the reign of Constantine till the beginning of the modern era. The compromise was due to the fact that Christian leaders collided in injustice with leaders of the empire since the Christian religion was the only legitimatised religion. However, by the time of Augustine there was a tendency to divide the holiness of the church and the darkness of the world as clearly discernible in *The City of God*. That legacy, according to Bosch (2011:411), was passed on from Catholicism to Protestantism. In this regard, the world was perceived as evil and unredeemable, and it was not within the church's responsibility to change its structures.

According to Bosch (2011:411), the coming in of the Enlightenment period, with its differentiation of ideas between the public world and the private world, the state was assigned to the former and church to the latter. The relationship between the Church and the state was severed and the church could not appeal to the state on the basis of shared faith. If the church could do ministry outside its bounds, it was limited to development and charity. Nevertheless, the neat division between the church and the state was dissolved as bishops started to interfere in politics (Bosch, 2011:411).

Bosch (2011:412) argues that the issues involved in the relationship between evangelism and social responsibility can be well understood following an observation by Reinhold Niebuhr. Bosch (2011:412) interprets Niebuhr as saying that a rational ethic aims at justice whilst a religious ethic makes love ideal. The religious ethic breeds mystic hopes for a society in which the ideal love and equity will be fully realised. Nevertheless, this is complicated because the mystic emphasis that exists side by side with a prophetic emphasis. While the mystical dimension tends to withdraw from the word claim that the true home is in heaven, the prophetic dimension prompts the society to be involved in the society for the sake of the neighbour. For Bosch (2011:412), Niebuhr sees a problem with the 'religious idea that tends to be more interested in the perfect motive of the believer than in fleshing the consequences of love'. Bosch (2011:412) declares that such a preoccupation is dangerous to the society.

In respect to that, Bosch (2011:413) argues that an effort to solve the complex relationship between evangelism and social responsibility could be to distinguish two different mandates of the Christian mission, one being spiritual and the other social. While the spiritual mandate refers to the commission to announce the good news of Jesus Christ's salvation, the social

mandate calls for Christians to participate in societal obligations that include working for justice. The two cannot be divorced from each other. Bosch (2011:413) writes that this was discernible in the Evangelical Awakening though it was gradually diluted by pre-millennialism's protest against this-worldliness of social gospel.

By and large, Bosch (2011:418) sees many ambiguities that are yet to be addressed in an effort to sort out the nature of the church's involvement in society. The ambiguities are, however, due to theologians' failure to adequately address the problem. However, as Bosch (2011:418) expresses, it quite clear that the 'spiritual gospel' and the 'material gospel' were in Jesus a one gospel. This study complies with the notion of marrying efforts of justice with evangelism as two inseparables. In this regard, the *Church of Christ* in Zimbabwe, as participants in the commission to announce the gospel, should also execute their social duty including working for justice in matters of gender and the HIV pandemic.

2.2.4. All-inclusive *missio Dei* as mediating integral liberation

Bosch (2011:442-443) posits that the theology of liberation is a multifaceted phenomenon manifesting itself as Latin American theology, Black theology, feminist theology, South African black theology and various other related theological movements. However, in all intends and purposes, Bosch (2011:442-443) maintains, that liberation theologies are Third-World Theologies or theologies of the Third-World within the First World. Their primary focus is in the Ecumenical Association of Third World theologians, which was formed in 1976 in Dar es Salaam. However, while Bosch (2011:442) notes that the theologies significantly evolved in protest against the inability of Western church and Missionary circles to come to grips with the problems of social justice, Canaan Sodindo Banana speaks of liberation theology from an earlier stage. Banana (1996:278) maintains that the Church is actually implored to 'an active prophetic ministry based upon teachings from the Old Testament'. It is, however, crucial to follow David Bosch's narrative on the evolution of the liberation theology.

According to Bosch (2011:442-443), the concept that gives birth to the expression of liberation is development. Based on flowed assumptions, governments of the First and Second Worlds attempted to solve Third-World poverty through technological resources and expertise. The project failed disastrously as the few elite benefited and the majority found themselves in more poverty. It was not recognised that poverty was not only as result of ignorance and lack of skills, or moral and cultural factors but rather it had to do with global structural relationships. However, Bosch contends, it was virtually impossible to convince the Western church and their

governments that their development model was full of inconsistencies because of the obsession of technology and secularization.

In the 1950s, Bosch (2011:445) posits that the mood in Third-World began to change as the countries, especially in Latin America, started to dispute the Western development model. Poverty would not be solved by pouring technological skills in poor countries but by removing the root causes of injustice and, since the West was reluctant to endorse such projects, the Third-World decided to take their destiny into their own hands and liberate themselves through a revolution. In this regard, Bosch (2011:445) writes that socio-political development was replaced by revolution and, ecclesiastically and theologically, it was replaced by liberation theology. Eventually, liberation was reproducing everywhere in the ecclesiastical landscape.

According to Bosch (2011:445), World Conferences such as the Geneva (1966); Uppsala (1968) and Bangkok (1973) played a significant role in changing the climate. Bosch (2011:445) writes that there were no longer attempts to evade the faces of the poor. Terms like ‘‘salvation’ was now translated as ‘liberation’, ‘fellowship’ as ‘solidarity’ ‘Bosch (2011:445). In a sense, according to Bosch (2011:445), the poor were no longer mere objects of mission; they had become agents and bearers.

Bosch (2011:448) also notes that it is often contended that liberation theology is merely a variant of liberal theology. In that respect, he clearly delineates the fundamental similarities and differences between the two. He points out that both theologies have a strong social concern and reject the tendency to interpret Christian faith in other worldly categories. They also appear to be anthropocentric rather than ethnocentric. However, Bosch (2011:449) explains that Liberation theology sometimes tends to be naively religious and Biblicist at times. Unlike liberal theology that tends to be evolutionary in its philosophy, liberation theology believes that the law of history is not development but revolution.

Liberation and contextual theologies, according to Bosch (2011:450), are often accused of having committed the Christian Gospel into Marxist ideology. Bosch maintains that this is expected of since both liberation theology and Marxist ideology reject the capitalist model. Again, liberation theories tend to use Marxist analysis as an instrument of critique rather than a prescriptive. Bosch (2011:451) sees nothing wrong in using Marxist theory as a tool in social analysis. For Bosch (2011:451), it is actually of tremendous value. However, he points out that Liberation theologians strongly reject the atheistic dimension of Marxism.

By and large, Bosch (2011:453) posits that liberation theology has assisted the church to rediscover its earliest faith in God whose involvement with human history as a God of righteousness and justice champions the cause of the weak and oppressed. Since life and faith are two inseparables, Bosch (2011:453-454) contends that this liberation is to be effected at three different levels: social situations of oppression; personal servitude; and from sin. These three levels are interconnected but different. Therefore, Bosch rebuts the tendency to elevate the political to a position of an indisputable level.

Ackermann (1993:28) believes the 'liberating praxis is grounded in the actions that characterises the reign of God as exemplified in the praxis of Jesus'. In Bosch's (2011:457) view, the theology of liberation is often misinterpreted, criticised and vilified, yet in spite of its failings, it represents a new phase of theological reflection that finds its basis from the apostolic tradition. It is not a whim but a serious endeavour to let faith make sense to the postmodern era. Bosch(2011:458) affirms Gutierrez's perception that at every juncture of theologizing there is need to refine or improve and possibly correct prior formulations in order to employ a language that is both understandable and authentic to the important Christian message and to the experienced realities. In view of Bosch's perception of mission as mediating liberation, this study posits that the *Church of Christ* at *Mashoko Mission* should involve itself in mediating an integral liberation agenda to champion the cause of the oppressed and weak in relation to issues of gender and the HIV pandemic.

The rest of the book, *Transforming mission: Paradigm Shifts in Theology of Mission* presents a number of strengths in Bosch's perspective of mission. One such strength is that the book provides both a retrospective and projective view of mission theology and practice. The retrospective overview grandly serves as a pointer to historical pitfalls that have to be avoided in the future of missions. The projective view offers a way forward towards a meaningful theology and practice of mission. All these bear a significance to how the Church of Christ in Zimbabwe should view their medical missions' theology and practice, with regards to gender and HIV pandemic issues.

In their book, *Constants in Context: A Theology of Mission for Today*, Bevans and Schroeder (2004:34) also bring in some elements of the all-inclusive *missio Dei* pivotal to this study. They assert that one of the greatest tasks to Christian mission is to deal with culture. For them it has to be investigated,

> … as to whether human culture can be a vehicle or an obstacle for communicating the gospel, whether it can be a resource for new insights into the reality of God and God's self- giving in Jesus Christ, whether it needs to be destroyed or transformed or explored by the church in mission – these questions regarding the goodness, the wickedness, the value or the menace of culture can never be separated from what defines Christianity or from what the church is about in its missionary task.

In that regard, it has to be questioned as to whether the Zimbabwean sociocultural perceptions on gender are a vehicle or an obstacle to the church's missionary efforts to promote justice in issues of the HIV pandemic. Getting an answer to such a question will enable the church to determine whether the Zimbabwean cultural perceptions on gender have to be totally discarded or changed or reconnoitred to suit the appropriate aims and praxis of an all-inclusive *missio Dei.*

In order to answer such kind of questions, Bevans and Schroeder (2004:34) propose six questions that should be continuously answered by the church in mission. They call these questions 'the six constants of mission'(Bevans and Schroeder, 2004:35). The six questions, according to Bevans and Schroeder (2004:35), are namely:

a) Who is Jesus Christ and what is his meaning?
b) What is the nature of the Christian church?
c) How does the church regard its eschatological future?
d) What is the nature of the salvation it preaches?
e) How does the church value the human?
f) What is the value of human culture as the context in which the gospel is preached?

Bevans and Schroeder (2004:34) believe that the church should constantly seek to answer the above mentioned questions in order to be able to ascertain the way in which it should participate in missions.

Based on Justo L. Gonzalez and Dorothy Solle's three distinctive paradigms of theology, Bevans and Schroeder (2004:34) give the various ways in which the constants of mission might be perceived as the church participate in the *missio Dei.* The three paradigms are namely: (a) Type A. theology that focuses on 'mission as saving souls and church extension'; (b) Type B theology, which focuses on 'mission as discovery of truth' and (c) Type C theology in which the mission of God is regarded as commitment to liberation and transformation. Bevans and Schroeder, (2004:72) believe that the three paradigms have been helpful in providing the way

in which the church lived out its mission in the ever-changing contexts. However, they propose a model for mission they term, 'mission as prophetic dialogue' which they believe is relevant to the turbulent twenty first century (Bevans and Schroeder, 2004:281). This model of mission synthesises all the three approaches to understanding mission.

Following Bevans and Schroeder's arguments, this study synthesises the three different approaches to understanding of mission but is greatly inclined to Type C theology in which mission is regarded as embracing commitment to liberation and transformation. Type C theology provides a basis for appreciation of human dignity. Bevans and Schroeder note that Type C anthropology presents humanity 'as created in the image of God and called to grow into the divine likeness' (Bevans and Schroeder, 2004:69). Humanity is also perceived in the context of 'cosmic wholeness'(Bevans and Schroeder, 2004:70). Culture, from the Type C approach, is seen in a very positive view but it has to be purified from human sin and enslavement. In that regard, there is need for the church in mission to interact with culture. Thus the implication of Type C to this study is that the dignity of both men and women who are affected and infected with HIV is of paramount importance. The *Church of Christ* in Zimbabwe should be both holistic and inclusive in its missionary endeavour, aiming at reconciliation with Christ but at the same time promoting gender justice in their medical missions. The expectation is that the *Church of Christ* in Zimbabwe must ensure gender justice leading to liberation of men and women living in the era of the pandemic.

The approaches to mission presented by Bevans and Schroeder resonate well with Bosch's (2011: 402, 410, 442) notion of 'mission as mediating salvation', as 'quest for justice' and as 'liberation'. For Bosch (2011:402), mission as mediating salvation depicts *missio Dei* as holistic. In the same way, mission as quest for justice emphasises social justice as an integral part of the *missio Dei*. That concept of mission concurs with the notion of liberation as expressed by Bevans and Schroeder. Both notions stress commitment to fighting all forms of oppression, marginalisation, violence and injustices that undermine human dignity. Thus, the *Church of Christ*'s missionary involvement in the Zimbabwean context should not only call individuals into the church, but should also liberate people from being subjected to social, economic and political conditions that dehumanise them. The dehumanising conditions include gender injustice and negligence and stigmatisation of victims of the HIV pandemic in the communities.

As Ute Hedrich also observes, in her essay titled 'Missiology and HIV and AIDS: Defining the contours', the pandemic has created new challenges to the field of missiology that require a development of a new contextual perspectives (Hedrich, 2011:217). Although Hedrich acknowledges that the Christian mission has embraced the challenges of the epidemic through missiologist conferences, a few publications, study processes and mission organization policies on HIV and AIDS, she also argues that there are still gaps in the published literature. She observes that there is lack of analysis within various missiological influences and traditions that promote the existing perceptions of sexuality and moral discussion as a response to HIV (Hedrich, 2011:228). This gap echoes the objective of this study, which points to the importance of evaluation of HIV and AIDS programs within medical missions.

Once again, Stephen Bevans and Rodger Schroeder, in *Constants in Context : A theology of Mission for Today* , uphold that 'mission as participation in the mission of the triune God' cannot afford to ' proceed in ways that neglect the freedom and dignity of human beings'(Bevans and Schroeder, 2004:348) .It is in this light, that this study seeks to evaluate the HIV programs provided in the medical missions of the *Church of Christ* in relation to gender justice and human dignity. The element of human dignity, which is demonstrated to be part of the *missio Dei* is also intrinsic in feminist theology. It is that common ground that ties the missiological framework and feminist theology as complementary analytical tools in this study. In view of that, the next section considers the feminist theology perspective of this study.

2.3. Human dignity for all

The feminist theology perspective of this study, as highlighted in the first chapter, is built on the affirmation of gender justice as an essential expression of respect to human dignity. This notion is conveyed by Susan Rakoczy in her book, *In Her Name: Women doing Theology*. While feminist theology is a contested phrase, Rakoczy describes feminism as 'a revolution in theory and practice which asserts that women are truly and fully human beings and thus their human dignity must be intrinsic to every way beings structure their lives' (Rakoczy, 2004:4). She then defines feminist theology as 'a critique of the past and present theology and praxis, challenging presuppositions, beliefs, dogmas and the whole of chaotic life from a perspective of women's dignity' (Rakoczy, 2004:4).

According to Rakoczy (2004:17), feminist theology has two key tasks in its methodology, that is to deconstruct the male cultural paradigms in theological thought and to construct new perspectives. She also shows that feminist theology uses all the sources (scripture, tradition,

reason and experience) available to traditional theology, but in a new way that affirms the full humanity of women (Rakoczy, 2004:18). The views presented by Rakoczy are in tandem with most of the works by the Circle of Concerned African Women Theologians. She thus give some special attention to works of African Women Theologians and commend them for doing so much in supporting the emergence of women's theological voices since 1989.The notion of regarding gender justice as an expression of human dignity is important because it provides a basis for the Zimbabwean Church of Christ to uphold gender justice in her medical mission.

Rakoczy (2004:28-56) presents a chapter entitled *Truly God's image: Woman as Person* that focuses on the central issue of the dignity of women as full humans and the images of God. The chapter presents the ambivalent perspectives of women in the Christian tradition. On one hand it outlays and criticises the patriarchal Christian tradition that minimises women's humanity. According to Rakoczy (2004:32) the tradition of minimising women's humanity is greatly influenced by the Jewish tradition and the body-mind dualism from Greek philosophy which has been the matrix for early Christian theology. The pejorative patriarchal Christian tradition is further perpetuated by African tradition in the African context (Rakoczy, 2004:36). On the other hand the chapter affirms the resources in the Christian tradition that assert women's full dignity namely: the example of Jesus' interaction with women, new theological interpretations of women as truly created in the image of God and some aspects of catholic social teachings on women's dignity (Rakoczy, 2004: 40-46). Rakoczy (2004: 56) concludes that Jesus is a true icon of God demonstrated in his life and ministry that women and men are fully human. Men and women were presented as partners and equal disciples. Thus, Rakoczy(2004: 56) advocates for the life-giving spirit that Jesus had, the spirit of compassion and full love that helps 'women to their full human dignity'. That spirit calls the Church of Christ in Zimbabwe to love and care for both men and women in face of gender injustice and the HIV pandemic. It challenges the church, if she has to follow the pattern of Jesus's ministry, to put measures in her medical missions to promote full human dignity.

Living with Dignity: African Perspectives on Gender Inequality, a book edited by Elna Mouton, Gertrude Kapuma, Len Hansen and Thomas Togom is a collection of essays that address gender equality as a fundamental expression of human dignity. The essays are a product of extended gender workshops that were run by Net ACT (Network for Africa Congregational theology) in 2011 (Limuru, Kenya) and 2012 (Worcester, South Africa). The volume presents practical alternatives to elements of gender inequality in the society.

The first section titled 'Gender Equity: An Issue of Faith and Dignity' is made up of two important essays. In the first essay entitled 'Men and Women in Church and Society: Equal in dignity? United in diversity?' Koopman (2015:19), employs the Trinitarian rationale to demonstrate how men and women are equal members of both the church and the society. He also portrays the unity of men and women from the notion of unity and diversity. In the end, Koopman, (2015:30) concludes that the confession of equality in dignity of men and women offers some imperatives to the church, namely to seek gender freedom and gender justice.

Matsveru and Gillham (2015:33) in their study titled 'In God's Image: A Biblical Theological Survey of the Dignity of Women and Men', examine the issue of dignity of men and women in the biblical story of salvation. Matsveru and Gillham (2015:38-42) determine that both men and women were 'created in the image of God' and that should motivate an attitude of respect towards both of them. However, that image has been distorted by sin due to the fall of mankind. Sin has, thus, found varied expression (including gender violence and oppression) throughout history. Therefore, there is need of redemption from such aberrations (Matsveru and Gillham, 2015:42). The needed redemption comes through Jesus Christ who cannot just redeem women but can also restore their dignity (Matsveru and Gillham, 2015:47). In that regard, Matsveru and Gillham (2015:48) conclude that Christian men and women should be on the forefront in sharing this redemptive and restorative image of God. Thus, the Christocentric view of human dignity demonstrated in the biblical story of salvation should also motivate the Zimbabwean Church of Christ, in all their missionary engagements, to view both men and women in the image of God and yearn to restore their dignity.

In her essay, 'Cultural Perspectives on Gender Equality: Preliminary Indicators for the Christian church in Sub-Saharan Africa', Theron (2015:53) maintains that women could play a pivotal role in the societal development but culture can be a great obstacle for people, especially women, in realising their full potential and dignity. She also notes that gender inequality does not only hinder human rights and social justice but also hampers sustainable development, including the Millennium Development Goals such as the target to combat HIV and AIDS (Theron, 2015:53). In view of that, Theron (2015:65) reminds the church in Sub-Saharan Africa that she has a profound role to play in the transformation of the socio-cultural milieu. She proposes the concept of *Imago Dei* (where both male and female were created in the image of God) and the *Missio Dei* (where both male and female were given the same mandate to dominate the earth), as examples of God's indicators for gender justice and equality (Theron, 2015:65). She believes the Church should critically examine the culture and embrace

positive elements but discard all the detrimental practices of the culture. The challenge that is being brought forward is that the Church of Christ in Zimbabwe should, in its missionary engagement with issues of gender and HIV, actively participate in the transformation of socio-cultural practices that promote gender injustice and inequality.

In tandem with Theron, Zulu (2015:81) in his paper titled 'Masks And The Men Behind Them: Unmasking Culturally-Sanctioned Gender Inequality', argues further that even though there are beneficial cultural practices, there are so many other practices that discriminate against women and deny their dignity. He challenges African Christian men to use their power to actively play a role in reforming the demeaning practices and restoring gender justice.

Morkel (2015:125) in her article titled 'Aware and Empowered Responses to Gender Injustice: A Challenge to the Church', uses her personal narrative to challenge the church to see the need for awareness and empowerment against gender injustice. She also uses Kaethe Weingarten's four positions grid, developed from the intersection between awareness and empowerment, to explain people's responses to everyday witnessing of violence (Morkel, 2015:126). Finally, she assets 'gender inequality is constructed as a social hierarchy with devastating effects on the safety of women' (Morkel, 2015:143). She also concludes that language plays a pivotal role in sustaining the detrimental social hierarchal structures that exclude women from leadership. She concludes that the church in Africa should act as a change agent against its patriarchal structures and language that does not only affect the church but also the larger society (Morkel, 2015:144). By the same token, the Church of Christ in Zimbabwe is challenged and urged to be a change agent against the patriarchal structures and language that dehumanises both men and women

In an essay entitled, '"Do Not Tell the Person Carrying You That You Are Stink": Reflections in *Ubuntu* and masculinities in the context of sexual and gender based violence and HIV', Ezra Chitando reflects on the concept of *Ubuntu* in the context of sexual and gender based violence and HIV in Africa. Ubuntu is an African concept that expresses 'personhood or humanness'(Masango, 2006:931; Meiring, 2015:1). According to Chitando (2015:275), '*Ubuntu* is an African approach to reality that places emphasis on the community and taking responsibility for each other's burdens'. At the heart of the concept lies the notion that 'one's humanity (humanness), one's personhood, is dependent upon one's relationship with others'(Meiring, 2015:1). Therefore, it can be said *Ubuntu* is a concept that calls for humanness, togetherness, unity and interconnectedness of people in society.

Chitando (2015:69) states that *Ubuntu* is regarded as a valuable ethical resources that can be used in addressing most of the contemporary challenges of the larger society. He, thus, contends

> *Ubuntu* could be utilised towards contributing to the emergence of more harmonious, life-giving and transformative/liberating masculinities. Such masculinities would empower men to become actively involved in the overall response to sexual and gender-based violence and HIV. They would nurture gender-equitable men who are opposed to violence against women in their intimate relationships.(Chitando, 2015:270)

However, Chitando (2015:280) argues, that Africans have sustained the demeaning patriarchal practices that hurt women, 'the people who toil and break themselves for us'. He then concludes that Africans can 'de- partriarchalise *Ubuntu*, [and] it can be deployed to contribute towards detoxifying aggressive masculinities' (Chitando, 2015:280). In that regard, *Ubuntu* can be instrumental in assisting men to challenge sexual and gender based violence.

This study shares the same thrust with Chitando's view on the usefulness of *Ubuntu* in dealing with gender and HIV and AIDS challenges. However, Chitando is discussing *Ubuntu* in the context of gender violence and HIV, but this study particularly looks at the link of gender injustice and the HIV pandemic as it is handled in the medical missions of the Church of Christ in Zimbabwe. Interestingly, the concept of *Ubuntu* find a common link with both the missiological concept of all-inclusive *missio Dei* and the feminist concept of human dignity. Ubuntu connects with the all-inclusive *missio Dei* in that both concepts affirms the value and interdependence of men and women. In addition to that, as Masango (2006:937) points out, in the spirit of *Ubuntu*, 'the image and likeness of God' as reflected in humans is highly respected in African societies. On that point, *Ubuntu* connects with feminist theology in that they both affirm humanity and dignity of all people (Tutu, 1999:35). Therefore, *Ubuntu* is in harmony with the inclusivity of *missio Dei*. Hence, this study echoes the conviction that the appropriation of *Ubuntu* can be instrumental to the African church in its endeavour to address repressive patriarchal practices and their link to gender injustice and the HIV epidemic.

2.4. Patriarchy

The term patriarchy literary means 'rule by male head of a social unit,' but in feminist conceptualisation it refers to 'social system of masculine domination over women'(Pilcher and Wheleham, 2004:93). As Chitando (2007a:26) also observes, most African societies and

churches are constructed by the patriarchal social system. Hooks (2014:1) maintains that patriarchy is a pervasive socio-political system that continue to put men in place of domination and persistently making women weak and inferior through various forms psychological violence and terrorism. Therefore patriarchy gives power and dominance to men in the hierarchy of power relations between women and men. It also enforces gender stereotypes that promote inequality between men and women in society. In this regard, as Banana (1991:58) writes, the complaint by feminists is that the male dominated culture oppresses women yet,

> It should be noted that women do form a legitimate part of human community and are beings who are to be benevolently listened to; because they can contribute to central issues. It is deemed to attempt to build a community in which a person can function as a human being, helped rather than hampered by his or her sex. Men and women should know their place and play their role ungrudgingly and none should feel suffocated by societies, definition of femininity or masculinity (Banana, 1991:58).

Studies have shown that patriarchy and other forms of gender injustice in most parts of Southern Africa have been among major factors driving the HIV pandemic (Ackermann, 2004:36-37 ; Chitando, 2007a:26). In accord with that, Ackermann (2004:37) describes South Africa as one of the prime examples in which 'cultural traditions of male dominance, bolstered by a particular understanding of the place of men in the Christian tradition, has resulted in continued inequity for women' in this pandemic era. The patriarchal patterns in South Africa bears striking similarities with those in the Zimbabwean context. Sophie Chirongoma writes that the spread of HIV and AIDS among Zimbabwean women is propelled by a 'social system of patriarchy that continues to deny women their rights (Chirongoma cited in Chitando, 2009:73). Therefore, patriarchy in both the church and society intensifies the impact of the epidemic.

Chitando (2007a:26) asserts that the African church's insensitivity to patriarchy and other form of gender injustice has blunted its response to the pandemic. Chitando (2007a:26) believes that the church has struggled to deal with the pandemic and gender injustice because the church has not fully comprehended the cause and 'it remains the bastion of patriarchy and male privilege'. In accord with that notion, Haddad (2003:155) writes,

> For centuries the patriarch of the church has provided the almost solely male leadership with a measure of power that enables abuse, or at least collusion in abuse of women, to continue unabated. Theological justifications are all too often used to encourage women to

> be "faithful" to their marriage vows and thus remain in relationships that are potentially. Patriarchy continues to dominate and women's voices are silenced as they cry not their pain. The onslaught of HIV makes their cries more desperate.

In light of the persistent patriarchal patterns in the African church and society, (Chitando, 2007a:28) maintains that women the church need to be empowered in order to resist patriarchy. In agreement with Chitando, Haddad (2003:155) need to take up the challenge and break ' silence of their oppression, abuse, and disenfranchisement within the church.' Chitando (2007b: 31), however, believes that even the men are in need of being liberated from patriarchy. He writes,

> Men, too, need liberation from patriarchy. The context of HIV and AIDS calls for a deconstruction of aggressive masculinities that lead men to have multiple sexual partners, perpetrate violence against women and engage in risky pursuits. (Chitando, 2007a:31)

Thus, it can be said that both men and women and women need to be liberated from patriarchy.

Undoubtedly, the church cannot comprehensively deal with the issue of HIV and AIDS without addressing with repressive patriarchal practices in both the church and the society. Writing from a South African context, Haddad (2003:155) states,

> The church can no longer assert to be the moral watchdog of society without challenging men to take responsibility for their sexual behaviour. Issues of gender violence, HIV/AIDS, and the links between the two cannot be dealt with without addressing the abuse of power in relating to women, and dare I suggest without addressing the abuse of power within structures of the church. One cannot theologise nor moralise while patriarchy continues unabated.

The thrust of this study is in accord with Haddad's suggestion that the church need to address patriarchy in order to deal with gender issues, HIV and the links between the two. Ackermann (2004:37) shares the same views and she maintains that this kind of understanding 'should be at the heart of all HIV and AIDS programmes whether located in the churches or in state structures.' In the same light, Dube (2004:12) also reinforces that mainstreaming of gender should not only be 'factored in all sectors', but 'each sector must also mainstream gender planning, analysis and monitoring in their prevention, care, mitigation of impact and the eradication of stigma programs.' This study, therefore, echoes the same perspective.

In harmony with Beverly Haddad, Ackermann (2008:106-109) shows the impact of the links between patriarchy and HIV and AID in South Africa and contends that HIV and AIDS is indeed a 'gendered pandemic. However, while there are some striking similarities in the manifestations of patriarchal patterns between the South African and Zimbabwean contexts, there is need to consider that they cannot be treated as homogeneous cases where specific conclusions drawn about one context could be true of the other. Instead, these similarities of patterns have peculiarities varying with the specific social contexts that makes it imperative to make comparisons of the contexts as heterogeneous, in order to allow for a better insight of each (of which the Mashoko case study in Zimbabwe has peculiarities) as those contexts reflect on each other in a way that helps to make informed conclusions. Literature drawn from the South African canon enriches this research but the limitations of that literature is that the specific problems of HIV and AIDS being investigated in the Zimbabwean case in which it seeks to unravel may be different from the concerns for which the literature in the South African canon sought to mitigate.

2.5. Gender justice and HIV in Zimbabwe

In 2003, the World Health Organization (WHO) Department of Gender and Women's Health gave a report showing that both women and men were dying of AIDS, but that there were significant 'differences between men and women in the underlying mechanisms of HIV/AIDS infection and in social and economic consequences of HIV/AIDS'(*WHO*, 2003). Factors associated with these differences span across the spheres of 'biology, sexual behaviour and socially constructed gender differences between women and men in roles and responsibilities, access to resources and decision making power' (WHO, 2003). As a result, WHO advocated for increased investment in further research on gender differences and HIV and AIDS. Again, the need for gender mainstreaming in HIV and AIDS programs and policies was emphasized.

The National Health Strategy of Zimbabwe (2016-2020) states that Zimbabwe is still working on unfinished Millennial Development Goals (MDGs). It highlights the importance placed on Goal 3, namely to 'Ensure healthy lives and promote wellbeing for all at all ages,' and Goal 5, namely to 'Achieve gender equality and empower all women and girls' (*MoHCC*, 2016:2). Despite these efforts, HIV continues to be a serious challenge with statistics as of 2010, showing that more females (18%) are being infected than males (12%). A survey that was carried out in 2014 also showed that more females than males (aged 15-49) were being tested (*ZIMSTAT*, 2016:22). This clearly shows the gender disparities within the Zimbabwean population in relation to the impact of HIV as well as in accessing healthcare services.

2.6. Relevance of theological resources in gender and HIV/ AIDS issues

From a theological perspective, there is a growing body of literature on gender justice in relation to the HIV epidemic. Particularly relevant to this study are the publications by *Circle of Concerned African Women Theologians*.[17] One such publication is a book edited by Phiri et al. (2003) entitled *African Women, HIV/AIDS and Faith Communities*. This book is a wealthy collection of research papers presented by different members of the Circle of the Concerned African Women Theologians at a conference held in Addis Ababa, Ethiopia, from the 4th to the 8th of august 2002. The conference ran under the theme: *Sex: Stigma and HIVI/AIDS: African Women challenging Religion, Culture and Social Practices*. The central focus of the articles in this book is to show that gender and HIV/AIDS go hand in hand. In this light, if the world would make a difference in combating HIV and AIDS, it is imperative to deal with gender. The writers maintain that power relations, physiological, social, cultural and economic differences between men and women are significant determining factors of health.

In 2004 the *Circle of Concerned African Women Theologians* produced a second publication of their series titled, *Grant Me Justice! : HIV/AIDS & Gender Readings of the Bible*. The book is co-edited by Musa W. Dube and Musimbi Kanyoro. The authors propose a gender sensitive hermeneutical approach to the Bible in face of the HIV pandemic. They highlight some approach factors that fuel the epidemic including gender, class and sexual identity. In view of those factors, the authors propose a re-reading of the bible that, on one hand affirms healing, care and life and, on the other hand, counteracts gender injustice, poverty, sexism, stigma and other social structures that promote the spread of the pandemic.

Another significant resource from the Circle is a book titled *Women, Religion and HIV/AIDS in Africa* and edited by Hinga et al.(2008). The contributors to the book reflect on ways in which religion and gender intersect in shaping an African response to the pandemic. The essays bring forth the factors that fuel the vulnerability of African women to HIV and AIDS. These factors include gender disparities, poverty, rape and lack of education. The authors also analyse theological and ethical issues raised by HIV and AIDS. In the end, they challenge the church leadership to action, imploring it to regard HIV and AIDS in Africa as a theological and ethical matter that needs urgent practical response. The publications from the Circle stimulate a deeper reflection on the place and role of faith communities in response to issues of religion, gender

[17] The Circle of Concerned African Women Theologians, also known as the Circle, is a Pan-African organization of women theologians coming together to theologize on religious and cultural experiences of African women. Founded in 1989, the stirring behind the formation of that community is attributed to a Ghanaian Methodist theologian, Mercy Amba Oduyoye (Phiri 2003:5).

and HIV and AIDS. In addition, it offers some substantive resources for use in faith communities. Their suggestions have a firm basis in reality and therefore are worthy of consideration.

Another noteworthy publication is the one edited by Beverly Haddad. The book is titled *Religion and HIV and AIDS: Charting the Terrain.* It provides an overview of both the past and a proposed future concerning the role of religion on the impact of HIV and AIDS. The authors chiefly convey that religion (Christianity, Islam, and African Traditional Religions) plays a pivotal role in perpetuating stigma and discrimination people living with face HIV(Haddad, 2011:5). However, the book also acknowledges the profound efforts of faith-based organizations in offering HIV care, support and providing hope and comfort to victims. The essays portray the value of the role that religious institutions have in alerting the government and health care professions to their responsibility to HIV and AIDS victims in their areas. In this regard, the essays demonstrate the need for more serious engagement on the part of the public, religious and theological sectors of society as a way forward in the battle against HIV.

The book, *Religion and HIV and AIDS: Charting the Terrain* is organised in four main sections. In the first section, there are four essays that advocate for public engagement in the HIV struggle. They portray the value of the role that religious institutions have in coercing the government and health care professions in their responsibility in the pandemic era. In this regard, religious organizations and the government must complement each other. The religious organisations are also encouraged to seriously consider advice on their practices from health professionals. Again, religious organizations must provide HIV care and support to the victims in underprivileged communities despite their religious inclinations and perceptions. They should respect the religious identities of the communities and continue to assist even if they do not change their religious identities.

The second section of the book chiefly focuses on the importance of engaging the religious and theological communities in raising awareness of and fighting against the adverse effects the pandemic. The section brings out that the Christian community has embraced the challenges related to HIV and AIDS through conferences and published works. However, there is still need for constant dialogue. Hedrich (2011:228), for example, points out that although the mission activity in world religions began a long time ago, there is still a considerable gap in terms of interreligious dialogue on questions of health and healing.West (2011:160) also holds

the view that there is still a lot of misunderstandings pertaining different traditions and how they influence sexuality and morality in relation to HIV. In that respect, a rethinking of how sacred texts are being interpreted by religious communities is greatly encouraged.

The third section comprises of four chapters on engaging the socio-cultural realm in the ongoing struggle with the pandemic.Chitando (2011:237-250) opens this section by demonstrating that there subsists a vast body of publications and documentation alluding to the negative impact of practices and beliefs in the African indigenous religions. Yet there is so much still to be taped form these indigenous religions that is useful in the response of HIV and AIDS. van Kilinken (2011:275-297) holds that amidst many questions that have been raised concerning how religion reinforces the role of man and the influence of masculinities in the context of HIV and AIDS, there is still need for further exploration in order to transform negative manifestations of masculinity into positive expressions of masculinity and realise gender justice. James (2011:300-310) asserts that children remain one of the most marginalised and vulnerable groups in religious discourses. Consequently, the church cannot afford to keep silent on the plight of children and has to engage in a revolutionary agenda of empowering the children.

In the fourth section, the content covers issues of prevention, stigma as well as community care and support in the context of HIV. The book ends by presenting the stories of hope as indicators to the possibility of navigating new pathways of life in the era of the pandemic. Regarding prevention, Manning (2011:321-345) surveys and analyses research conducted on the relationship between HIV prevention and religion so as to coerce theological efforts in addressing individual, national and international concerns. He affirms that the religious and theological discourse related to HIV prevention is finding immediate application in a wide variety of situations. From a practitioner's view, Mokgethi-Heath (2011:346-348) argues that a holistic prevention approach must involve responding to the needs of people involved in transmission in a given community. Thus, for him, religious communities should intensify a holistic approach rather than just teaching on prevention.

Paterson (2011:350-365) alludes to the critical need for an educated, interdisciplinary conceptualization of stigma that can provide a base for theological reflection in effort to fill the gaps in HIV and AIDS stigma. In response, Byamugisha (2011: 366-367) affirms Peterson's view and gives more insight on the complexity of dealing with stigma despite the growing knowledge about HIV progression, treatment and mitigation. Thus, Byamugisha (2011:367)

also advocates for further research in an effort to understand how best the different types of stigma, especially which stems from the church, can be confronted and neutralised. The book then closes with touching stories of people living with HIV (PLWH). The stories demonstrate on the value of engaging PLWH in the ongoing struggle with the pandemic.

African Women, HIV/AIDS and Faith Communities edited by Isabel Apawo Phiri, Beverly Haddad and Madipoane Masenya is another book with a wealthy collection of research papers presented by different members of the Circle of the Concerned African Women Theologians at a conference held in Addis Ababa, Ethiopia from the 4th to the 8th of august 2002. The conference ran under the theme: 'Sex: Stigma and HIVIAIDS: African Women challenging Religion, Culture and Social Practices'. The central focus of the articles in this book is to show that gender and HIV/AIDS go hand in hand. In that light, if the world would make a difference in combating HIV and AIDS then it is imperative to deal with gender. The writers maintain that power relations, physiological, social, cultural and economic differences between men and women are significant determinants of health.

In chapter one, Phiri (2003:5-7) precisely introduces the *Circle of the Concerned African Women Theologians* and the goals of the organization. She explains that African women theologians are concerned with the problem of sex; HIV/AIDS and stigma because women are at the centre of the storm of HIV/AIDS. She gives some recommendations on what the Circle could do to curb the HIV and AIDS scourge. Her main argument is that the Circle should respond to HIV and AIDs because they have tools, the ability to research, disseminate information and influence that community as well as the theological curricula.

The first part of the book contains articles that advocate for a re-reading of the Bible in this era of the HIV and AIDS pandemic. In that regard, Anderson (2003:23-43) interprets the story of the healing of Naaman (2Kings 5:1-27) in three hermeneutical perspectives in order to fully explore the meanings of the text for the African-American today. Anderson fruitfully draws some parallels between the case of leprosy in the ancient setting and HIV/AIDS in today's setting. The healing miracle of Naaman that had to happen after crossing numerous boundaries is likened to the unusual stance one is expected to take in today's crisis for an intervention to take place. The condemnation of Ghazi's greediness is analogous to the disapproval of those who exploit people seeking HIV and AIDS treatment.

Bruce (2003:44-70) examines some Old Testament texts that deal with virginity in light of the cultural practice of virginity testing that is widespread in the province of KwaZulu-Natal. She reveals that both the texts and the practices share common negative assumptions and attitudes toward women. They are designed to control women and are as a result of unjust gender power relations. She believes that in this era of HIV and AIDS there is need for a new ethic of sexuality in Church and virginity is an important aspect of it. However, if the church has to advocate for virginity, it will have to do so on grounds that are not harmful to women.

Dube (2003a: 71-93) presents a re-reading of the story of Jairus' daughter (Mark 5:21-43) in the context of globalization, HIV/AIDS in the lives of women and the girl child. She remarkably draws some striking similarities between the story and the current context of globalization and HIV/AIDS. In regard to HIV and AIDS the story has patients that have been sick for a long time; physicians who attend to patients, take money but cannot heal them and desperate parents trying to seek help for their children. The story highlights gendered identities and apparent unequal power distribution. Women are largely nameless, without professions and their voices are silent and the ones who need to be helped. In that regard, Musa exposes three models of gender empowerment offered by the story. The story presents a model of abuse of power as embodied by the physicians and a model of using power to empower others as Jesus does in the story about Jesus and Jairus. The story also offers the model of the oppressed becoming the agents of their own empowerment. Dube concludes by challenging readers to take their place in the story and rethink their role in ensuring that the girl and the woman are called back to life in the age of globalization and HIV and AIDS.

Akintude (2003:94:109) looks at the attitude of Jesus in the event of 'anointing prostitute' in view of the contemporary Church's perspectives towards those in prostitution with the result and effect of being an HIV/AIDs carrier. According to Akintude (2003:108), the story speaks to the Church today that has no outreach to prostitutes in need of salvation spiritually, physically and economically. She also believes that prostitutes should also take some lessons from this woman. In her circumstances, she was an outcast but even the religious castigation could not bar her to approach Christ. People living with HIV and AIDs are also reminded that they are not outcasts.

The second part of the book is composed of presentations that challenge faith communities about their way of responding to issues of sex; stigma and HIV and AIDS. Under that section Masenya (2003:13-127) challenges the South African churches to rise and speak God's mind

and proclaim life to the situation of women. According to her, HIV and AIDS have added an additional burden to the situation of women who are already trapped between the negative interpretations of both the African Culture and the Christian Bible. In the same manner, Chauke (2003:128-1-148) presents the unbearable circumstances of women in the South Eastern part of Zimbabwe. She believes that women, being the culturally despised of the human race, feel the infliction of HIV and AIDS more than their male counterparts. She, therefore, urges the church listen to the voices of the victims of the epidemic. She also urges the women to resist all forms of oppression and pursue their liberation with courage determination and hope.

Haddad (2003:149-167) calls the church to accountability for its actions in the face of gender violence and HIV/AIDS in South Africa. She notes that the Church is mostly silent on issues of gender justice, including the violence perpetrated to women. She shows that gender violence is pervasive in South Africa and increases women's vulnerability to AIDS. In that light she calls for the change of behaviour and attitudinal patterns of men in the church. For her,men should stand on the side of justice.

Reisenberger (2003:168-185)introduces some principles of the Jewish tradition and Jewish laws regarding sexual relationships as they pertain to women's issues so as to understand the impact of the pandemic to the Jewish community and particularly to the Jewish women. She shows that Judaism takes the Bible as the standard teaching of how they should live. The religion is prescriptive; values education and takes life as the holiest. However, the religion undermines the status of women. Women are excluded from partaking in rituals, voting, and even to attend meetings. It also controls women's sexuality.Reisenberger (2003:181) acknowledges all these negatives that work against women in this era of HIV and AIDS, but she urges the Jewish women must take advantage of education and economic means that are obtainable to the Jewish community in South Africa.

In part three, the book proposes some practical resources which the faith communities may make use of in fighting the pandemic. In that respect, Landman (2003:189) maintains that spiritual care giving to women affected by HIV/AIDS is very important practical resources for the faith communities. She proposes that there is need for spiritual care that will break through isolation, make denial unnecessary and feeds our belief in a caring God that will acknowledge human dignity and not find false safety in money, race and status. The spiritual care giving can help the affected women to move towards wholeness.

Chapter 11 presents an overview of the HIVand AIDs Curriculum for theological institutions in Africa. The curriculum is designed to reduce and finally eradicate the spread and impact of HIV/AIDS in Africa, strengthen the church's role to respond to HIV and to equip Christian workers with necessary knowledge and skills in the struggle against HIV/AIDs. In the same light, Kithome (2003:240) also argues that the use of distance learning is also an ideal alternative to residential theological education in the dissemination of knowledge to rural women in Africa. This is fundamental in an effort to bring HIV and AIDS education to rural women because formal theological education tends to be exclusive to those who do not meet requirements for entrance.

Govinden, (2003:259) closes the book by presenting some prayers and poems related to HIV and AIDS. She maintains that prayers and poems are creative aspects that could help us to explore the meaning of the pandemic in our contemporary society and understand its challenges to our Christian faith. She believes creative liturgy with poetry and prayers play a necessary restorative role for HIV/AIDS survivors and sufferers.Govinden (2003:287-288) advocates for development of other forms of artistic expression to invoke the various images that the disease raises and creates healing responses to it.

This book is a very rich repository of varied perspectives that altogether challenge Christian and cultural traditions that condone and perpetuate the spread and impact of HIV and AIDS. Unlike in single author books, the varied perspectives in this book bring us closer to the reality of multidimensional experiences of women in the context of the pandemic. Collectively, the authors are successful in showing how women are the most affected and infected by the pandemic. The book stimulates a deeper reflection on the place and role of faith communities in response to HIV and AIDS and, above that, offers some substantive resources material for use to the faith communities. The suggestions have a firm basis in reality and, therefore, are imperatively considerable.

Another important view is shared in *Abundant Life: The Churches and Sexuality,* a book, edited by Ezra Chitando and Nyambura Njoroge, which deals with critical issue concerning sexual and reproductive health rights (SRHR) and the responses of African churches in the context of the HIV pandemic. The book points out that the church leadership in Africa has been , to some extent, condoning SRHR, especially on issues related to provision of HIV services and information to the LGBTQI people , but there is need to acknowledge that the church leaders are strategically placed ' to contribute toward ' life in abundance' (John :10:10)'

(Chitando and Njoroge, 2016:2). It, therefore, follows that SRHR can be effectively dealt with if the resource of religious organizations is mobilised and the support of religious authority is availed.

Chitando and Njoroge (2016:2) point out that amongst numerous lessons that the pandemic has brought toward promoting SRHR in Africa, there is need to take cognisant that the churches are now more open to change and transformation of their theology. Again, as the church's response to HIV has indicated , the church is capable of 'transforming harmful cultural practices, death-dealing theologies, and oppressive systems into helpful practices, life-giving theologies and liberating systems'(Chitando and Njoroge, 2016:3).In the same manner that the church would strategically and effectively deal with SRHR it would also deal with issues of gender injustice in the era of the pandemic. Chitando and Njoroge's views provide a basis for appreciating the capability of the Church of Christ in Zimbabwe, as a church in the African context, to deal with issues relating to gender justice and HIV.

In another book by Ezra Chitando entitled *Acting in Hope: African Churches and HIV/AIDS 2,* churches are urged to demonstrate their competence in responding to the HIV epidemic. Chitando (2007:1) sees an urgent need to transform theological training in Africa, to carry out a critical evaluation of African cultures and to throw away the negative practices against gender justice and sexuality so as to effectively address the complexities of the epidemic. Chitando, (2007:42) also makes a crucial point in noting that the church, in an effort to participate in the full-embracing vision, should reconsider its mission to men. For Chitando, it is not helpful to assume that men are already in position of power as such, they need no particular attention. He writes that even though the men are the majority of leadership in church, women significantly outnumber them. In that regard, the African churches should not hope to transform men's perspectives in relation to HIV when the bulk of men are only nominal members of the church(Chitando, 2007:42). Hence, the church is urged to do away with a counterproductive attitude of marginalizing men in issues of HIV, but to reach out, call them to account and convince them that transformation of gender relations is beneficial to them (Chitando, 2007:43). Following Chitando's argument, African churches, including the church of Christ in Zimbabwe are called to deal with dominant masculinity as well as to create a constructive partnership with men.

Chitando (2007:89) also challenges the African church to devise and implement measures as well as to identify some beliefs and practices that could possibly enhance the response to HIV.

Again, the church is urged to address a number of challenging factors that promote vulnerability to the pandemic. Such challenges include gender inequality, poverty, and orphan crisis and AIDS illiteracy(Chitando, 2007:89). All these challenges that the African church is called to address are within the context of the Church of Christ in Zimbabwe. Thus, the Church of Christ is not an exception in the call to demonstrate competence in response to the challenges.

Sue Parry (2008) in her book, *Beacons of Hope: HIV Competent Churches a Framework for Action*, provides a framework for action to Church leadership in their response to HIV. The book explains the critical need of HIV competent churches[18] .Parry (2008: 1) and acknowledges that indeed the FBOs have been beacons of hope in providing care and support initiatives from the onset of the pandemic. Nevertheless, there have been some faults in developing the appropriate and effective responses as the epidemic continued to unfold and progress. According to Parry (2008:1) the suffering , stigma and discrimination of those living with HIV compels the church to relook at the judgements, assumptions and language that may have ignored the realities and experiences of many people who are affected by the pandemic. For Parry (2008:1) that oversight has seen unbalanced response to HIV failing. Thus, the situation calls for an acknowledgement of organizational shortfalls and ineffective service delivery. In turn, that necessitates a paradigm shift to a response that is socially relevant and culturally appropriate as well as theologically and technically sound (Parry, 2008:8-9).

Parry (2008:45) demonstrates how Christian churches face a critical challenge that requires them to continuously examine the theology and spirituality that drives their ministry. She shows that HIV, in as much as it is an obstacle, stands as an opportunity for the church to refocus on the divine commission that calls man and women to rediscover their dignity (Parry, 2008:45). Thus, HIV challenges the Church of Christ in Zimbabwe to continuously question its theology of ministry, its vision of what it means to be human and its methods in seeking to fulfil the commission.

18 An HIV Competent Church is described as a,

> Church that has first developed an inner competence through internalization of the risks, impacts and consequences and has accepted the responsibility and imperative to respond appropriately and compassionately. In order to progress to outer competence, there is need for leadership, knowledge and resources. Outer competence involves building theological and institutional capacity in a socially relevant, inclusive, sustainable and collaborative way that reduces the spread of HIV, improves the lives of the infected and affected, mitigates the impact of HIV and ultimately restores hope and dignity (Parry, 2008:15).

Parry (2008:47) also notes that there are so many religious and cultural beliefs that jeopardise a sense of self respect from people. For her, the practices and beliefs promote inequalities and social injustices between male and female icons of God such that the gospel of life cannot afford to ignore it. Thus it appears to be a gender warfare that requires a radical address from a Christian perspective (Parry, 2008:47). Following that argument, the Church of Christ in Zimbabwe, through its missionary arms including their healing medical missions, should also engage in the warfare to fight gender injustices that are promoted by cultural and religious beliefs of people within it setting.

According to Parry (2008:47-48) theological competence compels the church to ask and seek to address some fundamental questions. For the purpose of this study, selected questions from the provided list include:

a) What/who is God?
b) Why did God create human beings, what is the purpose?
c) Why did he create us male and female?
d) Where is this God to be found in the lives and experiences of people living with and affected by HIV?
e) What kind of healing can we hope for in that context of HIV?
f) When someone has been faithful to one partner and that partner has infected him or her, how can we learn to forgive/
g) Does the encounter with Jesus Christ empower one to remain free of infection if so how?

Parry (2008:48-49) stresses that the most important thing being theologically competent church is not in finding solutions or to answer the difficult questions. Rather it is fundamentally in learning to ask questions and reflecting upon them. Although the answers may not be found, a competent church must not tire in its quest. This view provides a basis for the Zimbabwean Church of Christ to continuously reflect on its theology in relation to the healing ministry, issues of gender justice and HIV and AIDS.

The Palgrave Handbook of Gender and Healthcare edited by Kuhlmann and Annandale does not particularly relate religion to HIV and AIDS. However, through a collection of essays, it portrays gender as a major determining factor to the general state of health, health seeking behaviour and healthcare delivery. The handbook is an integrated approach to changing healthcare and gender relations. It pays attention to institutional approaches to healthcare, men and women's health, and also the needs of professional and service users. In short, the

collection conveys that 'gender mainstreaming policies and the new discourses of 'gender medicine' or 'sex-specific medicine' are overshadowed by unsolved gender troubles' (Kuhlmann and Annandale, 2012: 3). The essays advocate for a greater caution and propose some methods to deal with the sex-gender dimensions more systematically in its social, cultural, and structural context, as well as in how they intersect. However, the book puts an emphasis on Anglo-American and European contextual examples as opposed to African ones.

By and large, there is a growing body of literature that explores gender and HIV and AIDS. Again, there is a remarkable increase in studies that point to the usefulness of FBOs in fostering gender justice in relation to HIV and AIDS. This study is an attempt to complement that body of knowledge by adding a perspective based on the evaluation of the gendered nature of HIV programs in the medical missions of the Church of Christ in Zimbabwe.

2.7. Conclusion

This chapter covers a literature review on the concepts related to this study. The concepts that are dealt with include all-inclusive *missio Dei* and gender justice as an expression of human dignity. The chapter further gives an illumination on the conceptual framework of the study. The gendered nature of HIV and AIDS, and the relevance of theological resources, including the usefulness of medical missions in response to issues of gender and HIV pandemic, are major themes explored in this literature review. The chapter also highlights some gaps that need to be filled in the enterprise of missiological engagement with issues of gender and HIV and AIDS. The next chapter will briefly trace the historical background of the Church of Christ medical missions. It will particularly give a detailed overview of the medical missions at Mashoko Mission in relation to the church's engagement in the HIV and AIDS programs provided at MCH. It will highlight the Church of Christ's theology and practice of healing ministry. The chapter will also shed some light on the held beliefs, teachings and practices of the Church of Christ in relation to gender issues and HIV. This chapter will provide a summary of the context and setting of the study as well as giving a basis for the next chapter.

CHAPTER THREE

CHURCH OF CHRIST MEDICAL MISSIONS AND HIV AND AIDS PROGRAMS

3.1. Introduction

The previous chapter presents a literature review on the concepts related to this study. The concepts that are mainly dealt with included an all-inclusive *missio Dei*, patriarchy, feminism and gender justice as an expression of respect to human dignity. The chapter further presents the conceptual framework of the study. The gendered nature of HIV and AIDS, and the relevance of theological resource in response to issues of gender and HIV pandemic, including the Christian healing ministry (medical missions) as part of an all-inclusive *missio Dei*, are major themes explored in this literature review.

The current chapter briefly traces the historical background of the Church *o*f Christ missions. It will particularly give a detailed overview of the medical missions, in relation to church's engagement in the HIV and AIDS programs provided at MCH. It will highlight the Church of Christ's theology and practice of healing ministry in relation the HIV pandemic. The chapter will also shed light on some perceptions on gender issues that are held in the Churches of Christ. Finally, it will explore some elements of a holistic and inclusive ministry in the medical missions at Mashoko and also provide a detailed setting and context of the study as well as a basis for the next chapter.

3.2. Churches of Christ missions in historical context

The mission work of the Churches of Christ has a long history. It can be traced as far back as almost to the roots of the church itself. It is, therefore, obligatory to briefly highlight the origins of the church before exploring its medical missions. The Churches of Christ were born out of an eighteenth century American Christian movement known as the Stone-Campbell[19] movement or the Restoration movement (Williams, Foster and Blowers, 2013:1). The leaders of the movement had abandoned their former denominations with the expectation to restore and establish a church solely founded on the teachings of the New Testament. They identified the goal of their efforts as 'the *restoration* of apostolic Christianity, rather than a mere reform of existing Christianity'(Williams et al., 2013:1). Failing to decide on a single name, the followers of the movement were variously called Christians and Disciples of Christ. Their

[19] The 'Stone-Campbell movement' was named so after the reform efforts of its American leading figures namely, Barton Warren Stone, Alexander and Thomas Campbell.

churches came to be known as the Christian Churches , Churches of Christ and Disciples of Christ (Williams et al., 2013:1). Thus, the Stone-Campbell movement gave birth to three distinct brands of the same church.

According to (Kershner, 1965:7) the leaders of the Restoration movement had no intentions of forming a distinct denomination. Their endeavour was to come up with Bible believing Christians within the existing denominations. Their focus was on teaching people the truth as taught in the Bible (Kershner, 1965:7). Nevertheless, as Bhebhe (2009:107) also observes , the movement efforts resulted in the founding of the Churches of Christ, Christian Churches and the Disciples of Christ. Eventually these churches evolved into 'makers of the spread of congregations from the most conservative to the liberal ones, respectively' (Bhebhe, 2009:107). Hence, in this manner, the Restoration movement gave birth to varied versions of the same denomination.

Later, the conservative and liberal members movement divided themselves into two more significant groups, the Instrumental and the non-instrumental Churches of Christ (Bhebhe, 2009: 108). On one hand, the Non-instrumental constituted the conservatives who want to strictly follow the New Testament as it is written word for word. On the other hand, the instrumental church is composed of liberals who loosely follow the New Testament (Bhebhe, 2009:108). For instance, while the Non-instrumental group would say the New Testament does not state the use of musical instruments in worship so the church should not use musical instruments whereas the Instrumental group would say there is nothing wrong for the church to use the musical instruments because the bible does not state that it is wrong(Bhebhe, 2009:108).

In the Zimbabwean context, the division between the Instrumental and the Non-instrumental churches of Christ became more pronounced in the 1950s ((Bhebhe, 2009:108). Apparently the Instrumental /liberal group continued to incorporate what is regarded as non-biblical in their structures. For example, they adopted the use of uniforms for their ladies fellowship known as *Ruwadzano* (Bhebhe, 2009:108). Thus, the gap between the two groups became more and more outstanding. The Church of Christ at Mashoko is the brain child of the Instrumental or the liberal group. Hence, this study will, from this point, focus on the liberal Church of Christ.

According to Bhebhe (2009:117) the responsibility to do mission work came squarely on the leaders of the Restoration movement before they even become a church. Williams et al. (2013:2) state that the movement was on its way to fulfil their mandate to unite the church and

to evangelise in the world. The leaders were, however confident in the 'righteousness of the movement's dedication to the Lordship of Christ, the banishment of Creeds as tests of fellowship, the honouring of liberty of theological opinion and the reign of scripture in matters of faith and practice in the church'(Williams et al., 2013:2). As (Bhebhe, 2009: 117) notes, the movement's mission had shown a great impact, particularly on the American soil, thus the leaders would not doubt their ability to reach out to the entire world with the gospel.

However, the method of operation had been a bone of contention among those who were interested in reaching out to the rest of the world (Bhebhe, 2009:117). The key question was whether the church should be the generator of the missionary enterprise or the movement was to mastermind what the church could not possibly do (Phillips, 1960:15). Eventually, the discussions on the topic ended in the formation of the American Christian Missionary Society (ACMS), the first ever organization in the life of both the church and the movement. The organization was founded in October 1849 at the convention that was held in the United States of America at Cincinnati, Ohio (Phillips, 1960:16). The missionary organization was first led by Alexander Campbell, one of the prominent leaders of Restoration movement (Bhebhe, 2009:117).The ACMS was, therefore, the first formal organization to facilitate missionary efforts towards the spread of the Restoration movement internationally.

By the year 1853, the Stone-Campbell missions had made their first attempts on the African soil, although they were not successful (Foster, Blowers, Dunnavant and Williams, 2004:3). The missionary attempts are said to have been initiated on the realization that the restoration movement had no portion in the African continent although they had made a great impact in the USA and Canada.[20] Despite the failure of the first attempts, the Stone-Campbell missions in Africa grew and eventually were fruitful. The expansion saw the establishment of Bolenge Mission Station in Congo. The establishment of Bolenge Mission is credited to the efforts of a man named Royal John Dyer and Ever Nicholas Dyer as well as Ellsworth Farris (Foster et al., 2004:3). In that regard, the Bolenge Mission became the earliest emblem of the Restoration movement on the African soil.

Soon the Stone-Campbell movement appointed scores of missionaries to various parts of the African continent. The missionary contribution of the movement is registered in several countries in the Southern region of Africa including Zimbabwe, South Africa, Zambia,

[20] Source: Global Ministries, 2017. The Restoration (Stone-Campbell) Movement in Africa: Its Beginning and Development. [Online]. Available: www. Globalministries.org [2017 August, 29].

Botswana and Swaziland.[21] The efforts of these missionary groups gave birth to congregations, educational health and charitable institutions, (Bhebhe, 2009:121) including the ones in Zimbabwe.

3.3. Brief overview of Church of Christ missions in Zimbabwe

In Zimbabwe, the story of the Churches of Christ starts with an English stonemason known as John Sheriff (Lusby , 1990:7 ; Holloway, 2005:1).Although Sheriff was not directly involved in medical missions, he is credited for opening the path to the rest of the scores of Church of Christ missionaries that followed after him. Sheriff was born in 1864 in Christchurch, New Zealand (Holloway, 2005:1). Before he arrived in Zimbabwe, Sheriff's first destination in Africa was Cape Town, South Africa in February 1986 (Holloway 2005:1). In 1887, he moved to Johannesburg for a while and proceeded to Pretoria. Eventually he crossed Limpopo and ended up in Bulawayo, Zimbabwe then Rhodesia (Holloway 2005:1). It is recorded that during 1889, Sheriff conducted the first Lord's supper with some European friends in Bulawayo, that marked the beginning of the Churches of Christ in Zimbabwe (Zvobgo, 1996:78). Soon several other missionaries from New Zealand decided to join Sheriff. Lusby (1990:8) records a list of missionaries who followed after Sheriff that include Mr Mrs F.L Hadfield, Thomas Anderson, Mr and Mrs William Waldon Mansill, W.S Coulter and A. Bowen.

According to Holloway (2005:1), by the year 1912, several mission stations were opened almost on yearly basis, including Ingome, Belingwe and Dadaya mission. Dadaya soon became one of the prominent mission stations in the country. The mission station was led by different missionaries. Some prominent names in the list of the station leaders include, Wall, Mansill, Fredrick Philips and his wife Mary Fitzsimons (Lusby, 1990:9). Mr Phillips is mentioned amongst the first people to assist the natives medically (Holloway, 2005: 2). Besides various other duties, He is hailed for having treated over five hundred cases.

Another significant phase in the history of Church of Christ missions in Zimbabwe is marked by the efforts of Mr R.S Garfield Todd and his wife Willison Todd. The two arrived in 1934 from New Zealand (Holloway 2005;West,1992:301). They came to Zimbabwe , then Southern Rhodesia, as missionaries of an organisation known as the Association Churches of Christ in New Zealand (West, 1992:301) According to Holloway (2005:2) Todd became the station superintendent of the Dadaya Mission whilst Grace Todd worked in education. Todd

[21] Source: Global Ministries, 2017. The Restoration (Stone-Campbell) Movement in Africa: Its Beginning and Development. [Online]. Available: www. Globalministries.org [2017 August, 29].

demonstrated his leadership skills and raised Dadaya from just a small mission into a reputable educational institution (West, 1992:301). Grace complimented these efforts by shaping the education structures of the institution and eventually of the whole country (Holloway 2005:2).

Later Todd developed interest and joined politics. Due to his reputation, he was elected a member of the legislative assembly of Rhodesia in 1964 (West, 1992:301). Soon Todd was a force to reckon with in the stimulation of the then emerging African nationalism that rejected the dominance of White power (Sundkler and Steed, 2004:800). He quickly rose through the ranks and after only a period of seven years in parliament, Todd became a Prime Minister of Southern Rhodesia taking from Godfrey Huggins (West, 1992:301). Todd was the Prime Minister of the Southern Rhodesia from 1953 until 1958 (West, 1992: 298). During this period, Todd used his influence to invite the American missionaries to the then Rhodesia. As shall be discussed in the next section, the influence and efforts of Garfield and Grace Todd are of importance in the history of Mashoko medical missions. The subsequent section deals with the Church of Christ mission work at Mashoko station.

3.4. Church of Christ missions at Mashoko station

The mission station at Mashoko was opened in 1928 (Holloway 2005:2). The station is situated in a tribal area, 'then a wild and primitive place' (Grubbs, 2009:45), known as Matsai that in the Southern-eastern corner of Zimbabwe (Holloway 2005:2).The land of Matsai had large portions of untamed and undeveloped area (Pruett, 2007:41). In the 1920s, Matsai area had a population of about 6300 people, 'untouched by the missionary influence' and 'had never seen a white person' (Holloway 2005:2). Eventually, building schools began in the area of Mashoko with the guidance of Mr and Mrs John Hay (Bhebhe, 2009:139). According to Holloway (2005:3), the establishment of the nine schools in the area is also credited to Mr. Alf Bowen.

According to Bhebhe (2009:140) the mission work at *Mashoko* was launched officially in 1932. In that year the New Zealand churches delegated Mr and Mrs Todd to manage Mashoko station (Lusby 1990:10). It is this engagement with Mashoko Mission that prompted Todd to invite the American Missionaries to Zimbabwe when he became the Prime Minister of the then Rhodesia (Bhebhe 2009:140). In 1934, with the advent of the Great Depression, the New Zealand missionaries were forced to focus their efforts and resources on Dadaya Mission (Bhebhe 2009:140). As a result, the Mashoko Mission station was left in the custodianship of native Christian leaders(Grubbs, 2009:46). Due to continued economic hardships the Mashoko station was temporarily closed (Lusby 1990:10; Grubbs 2009:45). At the end of World War

Two, missionaries from Dadaya could temporarily return to Mashoko area and camp there for four weeks(Grubbs 2009:46). That was the beginning of another phase of the life of Mashoko mission station. However, the government threatened to take over the station if the church could not find missionaries who could permanently stay at Mashoko (Grubbs2009:46). The threats of the government to take over the mission station at Mashoko led to another important shift in the history of the Churches of Christ mission work in Zimbabwe. That is when the medical mission work at Mashoko was handed over from the New Zealanders into the administration of American missionaries.

3.5. Medical missions at Mashoko mission

Todd, who was then the Prime Minister of Rhodesia had plans to attend a convention of the Churches of Christ that was held in Canada in the city of Toronto (Grubbs 2009:46). He had heard news that two American men, John Pemberton and Denis Pruett were planning to start mission work in Rhodesia. Todd went to the convention and met the two. He offered them the station at Mashoko so they would carry over with the work there. Pemberton and Pruett agreed (Grubbs 2009:46). Thus the custodianship of Mashoko Mission was now handed over to the custodianship of American Churches of Christ.

In 1956, Holloway (2005:3) notes that John Pemberton moved with his family from the United States to take responsibility for the work at Mashoko Mission. Pemberton's focus was mainly on the work of evangelism and literacy (Lusby, 1990:10). Pruett followed at a later stage and added the medical dimension in 1958 (Holloway2005:3). The medical work of that time at Mashoko started in makeshift tents (Pruett 2007: 40). The clinic tents were later on developed into a cluster of huts covered under grass roofs (Grubbs 2009:48). Dr Pruett and his staff helped patients from as far as Portuguese Eastern African, the Chimanimani Mountains, the Sabi River and other places bordering South Africa (Pruett 2009:40). Thus, the beginning of medical mission of the Churches of Christ at Mashoko Mission is greatly credited to Denis Pruett. The growth and expansion of medical work at Mashoko saw the hospital being officially opened on the 27th of August 1961 (Grubbs, 1988:12). After the leadership of Pruett, MCH was led under the administration of David Grubbs from the 1970s to the 1980s (Holloway, 2005:3). Following Grubbs, the hospital came under the administration of the first Zimbabwean doctor at MCH, Zindoga Bungu (Holloway, 2005.3). Bungu continues to run the hospital to the time of writing of this study.

3.6. The commencement of HIV and AIDS programmes at Mashoko

Grubs, former medical superintendent and missionary at MCH relates that he first saw cases of HIV and AIDS patients at Mashoko some ten years before the disease was known through the rest of the world. He was also not aware of the kind of disease he was dealing with (Grubbs, 2009:189). During that particular time, the medical personnel at the station could not even take safety precautions when they were working with such patients. The situation remained like that until the government laboratory developed a test to screen for HI. MCH tests were then run in Masvingo, a town in the province in which the hospital is located (Grubbs, 2009:189). The tests were particularly done when blood was needed for transfusion. Thus it was just a procedure to guard against potential HIV positive blood donors.

Grubbs (2009:190) narrates how HIV was first detected in some hospital staff members at Mashoko during a random study of twenty five health blood donors. One of the four staff members who tested HIV positive was a vibrant young female nursing student(Grubbs, 2009:191). According to Grubs (2009:191), the young woman was a devoted young Christian who had divorced from an abusive and alcoholic husband. No one suspected that she could be positive until she tested positive. Most people who tested positive, like this vibrant lady, appeared healthy. The young lady later finished her training and was employed at the mission as part of the mission team. As time progressed, she struggled with illness and died (Grubbs, 2009:200). The story of the young woman serves as a good example of how the gendered nature of HIV affects the society.

According to Grubbs (2009:192) the tragedy of HIV and AIDS was fuelled by the government's initial response. Grubbs (2009:192) says that the government was in the first place concerned with economic and political fallout rather than the suffering of the people. McCarty (1991:2) attests to this negative response by the government. She notes that at Chidamoyo Christian Hospital (a sister hospital to MCH), they started to notice HIV positive patients in 1986. When they noticed the first cases, they then warned the government that, however, chose to ignore the case with a declaration that there were no confirmed tests in the country (McCarty, 1991:2) Although the screening tests were commercially available and were in supply to every province in the country, the government could not report the results to United Nations (UN) (Grubbs, 2009:192). Thus, it would appear as if HIV was not existent in Zimbabwe. According to Grubbs (2009:192), doctors were not allowed to write HIV or AIDs on patients' records nor could they record it on a death certificates. At MCH they developed a code word for HIV/AIDS. They wrote 'NS' representing 'new serology'(Grubbs, 2009:192).

All this was because the government wanted to keep a good record in case they could discourage tourists from visiting (Grubbs, 2009:192). Therefore, the initial government attitude and response to HIV and AIDS was part of the problem at the onset of the tragedy.

The negative attitude of the government did not only promote a rapid spread of HIV, but it also delayed teaching and awareness programs to Zimbabweans, Mashoko mission community included. According to Grubbs (2009:194), most Zimbabweans could hear about HIV and AIDS from other sources other than their own government. People in Mashoko were told that AIDS was an abbreviation for 'American Information to Discourage Sex'[22]. Some were told that AIDS was developed in American germ warfare laboratories and was spread by Central Intelligence Agency to kill the Africans (Grubbs, 2009:194). Meanwhile thousands of people died.

Some of the first cases at MCH were young adults who had weight loss and tuberculosis and these patients could not respond to standard treatment offered at MCH (Grubbs, 2009:193). Although their tuberculosis could improve due to multiple drug therapy, their weight loss progressed and eventually they would die (Grubbs, 2009:193). It was later discovered that the tuberculosis and Sexually transmitted paramount indicators that the patient had AIDS (Grubbs, 2009). A great incidence of HIV positive infants and weight losing children was also found (Grubbs, 2009:193). In that light, it continuously became easier to suspect HIV in patients.

The first random test that was done on the 25 healthy blood donors at MCH was an eye opener on how the HIV and AIDS problem was greater than could be imagined. One hundred more women who came to MCH prenatal Clinic were also tested as a further step to determine the scope of the problem in Mashoko community (Grubbs, 2009:194). The feeling was that the population represented a cross section the young men and women in the Mashoko community. The average age of the selected women was thirty years. In the study, twenty five percent of the population tested positive (Grubbs, 2009:194). This was a very significant finding that saw continuous efforts to deal with the problem.

[22] Such kind of interpretations of AIDS were as a result of the rumour that was spreading on claims that the American Government wanted to restrict the population of Black people in Africa thus they told AIDS so as to keep black people from having sex and avoid masking babies.(Grubbs, 2009:194)

The findings from the study of one hundred women who came for prenatal clinic meant that one in every four women was HIV positive(Grubbs, 2009:194). Similarly, one of four babies delivered at MCH was covered in fluids carrying HIV virus. Thus the MCH maternity nurses and doctors were at high risk of infection. During that time, a delivery was regarded as a casual event at MCH and no serious precautionary measures were taken during a surgical procedure or when performing a delivery.

A study of another group of one hundred pregnant women was repeated again two years later. Unfortunately when results came out, it was found that the infection had rose to forty percent (Grubbs, 2009:195). During that time, Grubbs (2009:195) indicates that more than half of the patients that were admitted at MCH had AIDS related illness. Also, the disease affected, at most the paediatric population (Grubbs 2009:195) and this MCH historical journey, in an effort to deal with HIV and AIDS, reveals two significant facts useful in this study. The first being the fact that women, infants and children were the most affected by the disease from the onset. The second point is that it was easier to test and attempt to assist women than it was for men.

The tragic effect of HIV forced a change in many of MCH practices. Grubbs (2009:195) says that the financial costs rose and it affected a lot of things. For instance, before the pandemic, gloves that were used for delivering babies could be sterilised for use again. Now they had to be used once in each surgery. At times they could even double the gloves to guard against exposure after tearing of the gloves. Now they could not reuse sterile syringes as they would do before AIDS (Grubbs, 2009:1950). As Louw (2008:416) observed, the tragedy was rapidly unfolding and challenging daily life stability. Thus, the diseases did not only pose challenges pertaining to the health of the infected but it made a lot of things very difficult even in medical practice.

As the number of people suffering from AIDS increased, Grubbs (2009:196) testifies that it also became tempting to deal with the patients in groups, but they had to value privacy and personal dignity. If the MCH medical staff got to conclude that a patient might be HIV positive, the discussion with the patient was done privately before facilitating for the testing of blood. The blood sample was then sent to a government laboratory with a number of the patient on it. No names were used to identify the blood samples(Grubbs, 2009:196). The list of names and associated numbers were kept safely in the medical Superintend office where only the registered nurses and physicians would access the list. Results from the government lab were matched with the name and the number when they were back. The person would then be

counselled privately(Grubbs, 2009:196). The privacy of the patient was, therefore, highly safeguarded despite the person's education, class or gender.

In those days, children often contracted HIV from their mothers either through the birth canal or through breast feeding(Grubbs, 2009: 197). It was not a common concern in Zimbabwe for children to get HIV through the placenta or through sexual abuse (Grubbs, 2009: 197). As a result the MCH staff would not do C-section on every HIV positive mother so as to protect her unborn baby. However, there was a serious challenge concerning what could be done as an alternative to breastfeeding.(Grubbs, 2009:197). According to Grubbs (2009:197) the rural homes had neither refrigerators nor ways to do sterilization. Hence, HIV positive mothers were urged to breastfeed with the fear that babies were more likely to die from diarrhoea than they would likely to contract HIV through breastfeeding(Grubbs, 2009:197).Thus, HIV brought with it a multitude of other problems, one of which was intergenerational sex.

In Zimbabwe, intergenerational sex was a common problem and sexual transmission was a common way in which older children and teens would acquire HIV (Grubbs, 2009:197). The culture fuelled the pandemic. Culturally, a young girl or a teen was not expected to resist the sexual demands of an older man. Thus young girls , as young as thirteen would come to MCH delivering after having been impregnated by a relative, neighbour or any other older men (Grubbs, 2009197-198).Such cultural traits, would and still give a girl child or young ladies a great disadvantage as compared to their male counterparts. Therefore, patriarchy in Mashoko community provided a fertile ground for the spread of HIV at the onset of the diseases.

Initially, the government under the leadership of President Robert Gabriel Mugabe, did not do much to alleviate the HIV pandemic (McCarty, 1991:2). According to Grubbs (2009:198) President Mugabe would rarely mention the issue of HIV in his speeches. He actually denied the existence of HIV only to start speaking about it as late as 1985. As a result, the country's first HIV/ AIDS policy was not approved until 1999 (Grubbs, 2009:198). The following year a National AIDS Council (NAC) was founded to oversee HIV programs. The founding of NAC was through taxing workers because the government had little funds to support the program(Grubbs, 2009:198) Therefore, the intervention of the government in another way came with an additional burden upon workers and other citizens.

At a time when anti-retroviral drugs were not yet available, the MCH medical personnel would do their best to assist in all other ways possible. In April 1991, Kathy McCarty, a senior nurse at Chidamoyo Christian Hospital started an AIDS Home Based Care Program(AHBCP)

(McCarty, 1996:55) and it was also adopted at Mashoko(Grubbs, 2009:199).The program had a team made up of a chaplain, a nurse and a driver that would visit homes of HIV/AIDS patients that were discharged from the hospital. The team took with them multivitamins, medicines and instruments to the family. The nurse could also deal with any immediate problem that she could manage at home. The chaplain gave spiritual support to the caregivers and the patient(Grubbs, 2009:198).In some sense the AHBCP team was designed so as to be holistic in approaching the patients. Each member of the team had to touch a certain dimension (physical, spiritual and psychological) of the total person.

When a patient in the home-based program had a challenge like an opportunistic infection, the person would come to the hospital for that infection to be treated then immediately go back(Grubbs, 2009:199).A track record of how many patients stayed in the hospital was kept at the hospital. Whether the patient was kept in the hospital or sent home for most of their care, there was no much difference in the quality of health improvement. In essence, it was more benefial for the patient to be at home surrounded by family members than to be at the hospital(Grubbs, 2009:200).

The home AHBCP was also beneficial to the church because it necessitated the planting of Churches(Grubbs, 2009:200).Some of the patients were coming from places where there was no Church of Christ. During the visits the chaplain would preach to the family of the patient as well as to the neighbours(Grubbs, 2009:200). In this regard, the HIV tragedy presented as a very strategic opportunity of ministry.

By and large, the commencement of AHBCP at Mashoko marked the beginning of HIV programs at MCH. Since then numerous more programs have been adopted and successfully implemented. Most of the programs were developments that came as a result of continuous efforts to do the best possible means to alleviate the effects of the pandemic. In 1999 the government of Zimbabwe under the leadership of President Robert Gabriel Mugabe, established a national policy on HIV and AIDS in Zimbabwe that would serve as the primary guideline for prevention and intervention strategies against HIV and AIDS. The strategies includes HIV programmes such as, Antiretroviral Therapy (ART), HIV Counselling and Testing (HCT), Prevention of Mother to Child Transmission (PMTCT) and several other interventions. A detailed description of selected HIV programs shall be given in chapter four of this study. The next segment deals at the Churches of Christ's theology of healing in the face of the pandemic.

3.7. Churches of Christ's theology of healing and the HIV pandemic

As Togarasei (2010:428) also notes, most religions provide their adherents with 'a framework of understanding' the issues of life in relation to a supreme being. The framework serves to explain puzzling and difficult issues including life threats and it has an influence on actions of the adherents in response to the existential matters (Togarasei, 2010:428). In that light, as Schenk (1993:68) would say, every church is challenged to define their position about persons infected with HIV as well as about those that are indirectly and directly affected. Churches of Christ, like most religious groups or FBOs, is compelled to have a theological framework that serves to explain their position in response to life threats. The church should, as well, influence the followers' attitude and response in the context of sufferings, such as those caused by the pandemic. This section shall attempt to discuss and ascertain the Church of Christ's theological position in matters of healing in the context of HIV.

There are two significant salient features of the Churches of Christ that are paramount to the indication of the church's position in relation to healing and HIV/AIDS. First, the church asserts that the scriptures are the sole authority of faith and practice of believers (Bhebhe, 2009:109). Key to this position is the notion that the standards of true Christianity are measured by the inspired word of God as it is written in the canonical scriptures. As Kershner (1965:8) observes, the leaders of the Restoration movement that gave birth to the Churches of Christ were strong advocates of the inspiration and integrity of scriptures.

In view of the Churches of Christ's position on the authority of the Bible, it is incumbent that the church takes what the scriptures offer, though from their understanding and interpretation. Grundmann (2014:5) shows that healing is a prevalent feature in Biblical times and among the people of God as early as in the times of Exodus. As can be noted in Exodus 15 verse 26, Numbers 12: verses 10 to 16 and Isaiah 38 verses 1 to 6, health was linked to faith in the God of Israel and was as a result of obedience to God's commandments (Grundmann, 2014:5). Hence, it is inevitable that the Churches of Christ uphold the concept of healing as linked to God and his providence to his obedient children. This position is affirmed by some claims in connection to their medical mission as shall be discussed indicate the chapter and section where that shall be discussed.

The second outstanding feature, constituting the Churches of Christ and paramount to their position in matters of healing, is their emphasis on the restoration of the New Testament or apostolic church. According to Bhebhe (2009:110), the Restoration movement stressed that all

human practices and innovations in church that could not have a scriptural basis should be thrown away. Rather, everything that has to be done in church should follow the pattern and the ordinances prescribed by the New Testament church. With regards to this principle, Grundmann, (2014:6) also demonstrates that healing was a prominent feature in the Apostolic church. As narrated in the book of Acts, there are many examples where the apostles healed crippled people (Acts 3 verses 1 to8); the paralytic (Acts (verse 32to 35) and even the raising of the dead (Acts 9 verses 36 to 41). Thus, the Churches of Christ, with their position of following the pattern of New Testament Church, are greatly influenced by the biblical church in their theology of healing.

However, despite the prevalent Biblical expressions of miraculous healing, the churches of Christ do not uphold miracle healings as with most Pentecostal churches. McCarty (1991:2) states that since the Church today cannot heal people through laying of hands, the church should highly appreciate medical innovations as God's provision of healing. McCarty's sentiments show a view that is highly upheld in the churches of Christ with regards to the affirmation of healing in the form of medical missions and, on the other hand, inadvertently tenders a criticism of miraculous healing. As put forward by Lewis (1990:10), some Christians take miraculous healing as 'extremism' and, in some cases, as 'deception. Hence, the Churches of Christ, in accord with Grundmann (2014:5), highly prize the medical missions as an expression of and witness to God's unconditional love to all the people. Commenting on the importance of MCH medical evangelism in Christian ministry Garfield Todd once said,

> This hospital springs from the depths of the Christian message. Jesus did and said many things when he was on earth, but some of the loveliest stories that are told of him deal with his compassion for people who were sick. Many people were brought to follow Him because of the love they saw expressed in His leading. We are so glad today that at Mashoko Mission there is added to the ministry of evangelism the ministry of healing *(CAS*[23], 1996: 21)

It is evident in Garfield Todd's sentiments that he equates Jesus' healing ministry with the hospital ministry. Medical missions and the biblical healing are, in this view, regarded as of equal standing.

[23] Central Africa Story

More to that, the Churches of Christ hold that healing in Jesus ministry was a corporeal element of salvation and, therefore, churches should follow Jesus's pattern in conveying the gospel (Mudzanire, 2017:26). The Church of Christ missionaries that founded MCH supported this view of the healing ministry with Matthew 9 verse 3 that says 'Jesus went about all cities and villages, teaching in their synagogues and preaching the gospel of the kingdom, and healing every sickness and every disease among the people.' In that regard, the Church of Christ mission work is a threefold ministry spanning preaching, teaching and healing (Lusby, 1990:22). At MCH, this notion is actually tailored into a motto that says, 'We preach, teach and heal' (Bungu, 2013:13). The essence of the motto expresses the organisational goal to 'offer a holistic ministry [that] touches the body, the mind and the soul'. The Church of Christ, in this regard, is in accord with Yamamori (1996:1) whose description of a true holistic ministry 'defines evangelism and social action as functionally separate, relationally inseparable and essential to the total ministry of the church'. Therefore, from the Church of Christ missionaries' perspective, to do the work of healing ministry is to convey Christ's ministry to His people.

Through their medical missions, the Churches of Christ in Zimbabwe have been involved in fighting HIV and AIDS as early as the time of discovery of the disease in the country. McCarty (1991:2) states that they are amongst the first to see cases of HIV positive patients at Chidamoyo Christian Hospital in 1986. However, the attitude or and theological perspective towards HIV in the entire church was ambiguous. As Kelly (2009:17) puts it, the discovery of HIV and AIDs met ambivalent responses from various Christians and it is difficult to come up with a generalised view of the Christian response to the disease.

Nevertheless, there are two wide-ranging trends of responses that can be ascertained in the history of the Churches of Christ in Zimbabwe in relation to HIV and AIDS.

3.7.1. The first response of Churches of Christ in Zimbabwe to HIV.

The first theological position that was taken by most Church of Christ member at the onset of HIV is that the disease is a punishment to sinners. Grubbs, (1991:3) says, 'the first pulpit pronouncements were about the 'curse that God had sent on the homosexuals''. Lovemore Togarasei, in his study titled 'Christian Theology of Life, Death and Healing in an Era of Antiretroviral Therapy: Reflections on the Responses of Some Botswana Churches', makes an important observation. He pointed out that the notion of taking HIV as a punishment was chiefly influenced by what he calls the 'Deutronomistic theology'(Togarasei, 2010:430). The Deutronomistic theology, according to Togarasei (2010:430), holds the belief that obedience

to God results in the blessing and disobedience results in cursing (Deuteronomy 7 verses 12 to 15). When HIV was first discovered in Zimbabwe, as Kelly (2009:16) notes, the disease was imbued with varied definitions, meanings and attributions. Among the numerous things it has been linked to 'sex, specifically who has sex with whom, what they do, how often they do it, where they do it' Kelly (2009:16) and so forth. It has been viewed as a biomedical, cultural, and even political problem.

The pandemic has been defined as 'gay-related immune-deficiency (GRID) and linked to heroin addicts' (Kelly 2009:16). With all these attributions, it became easy for Christians under the influence of the Deutronomistic theology to regard the pandemic as an outcome of disobedience to God's will. Christians subscribing to this school of thought would find a lot of scriptural support to their view because the concept of God inflicting sickness on sinners as form of punishment is a prevalent theme in the Old Testament(Togarasei, 2010:431).Therefore, this theological perspective, as in many other Christian churches, has been the earliest and prominent response to HIV by most Church of Christ members.

However, even in those early days of HIV, not all Church of Christ people held the view that the pandemic is a punishment to sinners. Grubbs (1991:3) writes that this interpretation of AIDS by people as punishment from God results from their failure to realise that most people who are affected by HIV are not homosexuals. Rather, HIV has had a great impact on infants and children. Again, Grubbs (1991:3) indicates that the view of regarding HIV as a punishment to sinners became an obstacle to seeing the pandemic as a ministry opportunity. Grubbs' sentiments lead to the second general theological response of the Churches of Christ to HIV.

3.7.2. The second response of the Churches of Christ in Zimbabwe to HIV.

The second theological position of the Churches of Christ in Zimbabwe in response to HIV is hinged on the opinion that the disease created an opportunity for ministry and evangelism. Togarasei (2010:432) believes that this kind of perception is influenced by the understanding that God is the source of things, all knowing and also the healer. The viewing of HIV and AIDS as doors to ministry is even expressed in the church's teachings. For instance, a handbook on Christian doctrine that is designed for church leaders and potential church leaders plainly states,

> In these days of the AIDS epidemic in Zimbabwe, the church must be at the front in showing love to the victims and the families of AIDS. Some people fear ministry to AIDS sufferers because they feel that it is a judgement from God and we should not interfere with God's punishment of sinners. Others are afraid that if they touch people

> with AIDS, they will get the diseases themselves. When Jesus fed the four thousand (Matthew 15; 29-39), he healed people for three days. The account does not mention that he preached to them. It says, 'Great crowds came to him, bringing the lame, the crippled, the dumb, and many others and laid them at his feet, and healed them." Our duty is not to judge but to use whatever ministry God has given us(*CAMELS*[24], 1992:56)

It is this view that has been a driving force to those that are in the medical missions of the churches of Christ to continually make efforts to offer the best possible care and support to the infected and affected people. In 1991, as part of the evangelistic efforts of the Churches of Christ in Zimbabwe, Chidamoyo Christian Hospital staff decide to implement the first program in response to the tragedy of HIV. In the words of Kathy A. McCarty, the program was set to:

> …deal with the crisis as a family problem and use the community as the primary care givers-supported by the medical community-instead of having institutionalized care for terminally ill patients...Incorporated from the beginning of the project was the desire to minister holistically through medical, psychological, social and spiritual support of a person infected with AIDS and that person's family. AIDS is a disease of the family as well as of the community.(McCarty, 1996:54)

Subsequently, the program was also adopted at MCH(Grubbs, 2009:199). The program in both communities yielded enormous results spanning behavioural change in sexual matters, cultural changes and above that people embraced life affirming attitudes (McCarty, 1996:58).In this regard, *Churches of Christ* in their medical missions embraced what Odendaal (2013::90) described as an 'integral mission' that upholds both the great commandment of Matthew 22 and the great commission of Matthew 28. Instead of doing the spiritual and the physical work separately, it seems it has been prompting to regard the two as seamlessly integrated. This presents another shift paramount to the description of the Churches of Christ approach to healing ministry in regards to gender issues and HIV pandemic. Before looking at some elements of a holistic ministry in the churches of Christ, the subsequent section explores the gender perceptions in the history and life of the Churches of Christ that influence how the medical missions of Mashoko Mission in Zimbabwe handles gender issues.

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3.8. Gender perceptions in the Churches of Christ.

The task to describe gender notions in the Churches of Christ is daunting, due to the lack of confined denominational teachings in the church. There has never been a homogeneous view on gender issues in the Churches of Christ since the beginning of the Restoration movement (Grasham, 1948:1) Perhaps, as Grasham, 1948:1) also notes, the lack of uniformity in views is due to a freedom of belief and practices that is fostered by the movement's rejection of authoritative clergy, power structures and rigid creeds. What is noticeable is that the view of the status of men in the Churches of Christ is held in ambivalence.

The ambivalence of perceptions on the place of men and women in the church, home and community is even substantial in the first leaders of the restoration movement. A notable example of such ambivalence is in Alexander Campbell, who is debatably one of the most influential leaders of the movement (Massey, 2016:1). Besides being an influential leader, Campbell enormously gave the movement some energy that defined most of its doctrines (Massey, 2016:1).

Alexander Campbell's perceptions on the place men and women are basically revealed in his articles that were published in a periodical known as the Millennial Harbinger (Massey, 2016:2). The writings portray a dramatic conflict of views. To some extent, Campbell advocates the equality of women and men, mainly because they are both redeemed by Christ. Again in some of his speeches and writings he expresses a clear recognition that the spirit of the gospel is opposed to the injustice and degradation suffered by women throughout history (Massey, 2016:2). Nevertheless, as Massey (2016:2) notes, Campbell's doctrinal position on the status of women at home, in the church and in society is against the spirit of that egalitarian gospel. Grasham (1948:3) writes that Campbell's interpretation of the Bible concurs with Luther and Calvin in Campbell's assertion that 'God designed woman as the helper of man and that her divinely appointed role secondary, supportive and subordinate' (Massey: 2016:2).

Undoubtedly the conflicting views in Campbell's position on the place of men and women in church, home and community were as a result of literal biblical interpretation. Massey (2016:2) proclaims that Campbell's view was that the Bible is the blue print in all issues pertaining faith and Christian life. Conversely, that perception detracts Campbell's ability to promote equality and gender justice as he would want in some instances. As Massey (2016:2) observes, that literalism was inherited by the majority of his followers in the generations that came after him, as exemplified in the insistence by the Non-Instrument Church of Christ that the New

Testament does not command the use of musical instruments in worship. For another relevant example, Bhebhe (2009:108) writes that the Non-instrument Church of Christ particularly teaches that, 'as the Bible teaches in Timothy 2 verses 11 to 12 that a woman should learn in quietness and full submission she must be silent during worship services and also 1 Corinthians 13 verse 34 states that, women should remain silent in the churches'. Unfortunately that has caused some divisions in the churches of the Restoration movement.

Without doubt, the stone-Campbell movement supported women education. Hull (2008:1) demonstrates that church-related opportunities led women into new areas and enabled them to positively shape the community and the church. Hull(2008: 1-2) reveals that the promotion of future education in the Restoration movement became a precursor of women's active involvement in establishing church missionary organisations, colleges and their services as pastors, educators, evangelists and Missionaries. According to Grasham (1948:3) the high number of congregations with women leaders, teachers and preachers in the Stone movement seems to suggest that they were highly regarded and affirmed as using legitimate spiritual gifts. However, there has been a continued controversy over the role of women in public worships even after the division between the Disciples of Christ and the Churches of Christ Grasham (1948:12). Thus, the Churches of Christ have a long and somewhat conniving journey that is over two centuries, of diverse and conflicting views on the role of and place of women in the church, home and society.

By and large, the Churches of Christ today still hold diverse views on gender issues. In some cases they promote equality, respect and dignity of both men and women (Massey 2016: 11). In other instances they still impose subjugation of women, rejecting female leadership and restricting women in work Grasham (1948:38). For instance, at Mashoko women are not allowed to preach. Also, very few women are in the leadership positions. However, that is not the case with all other Churches of Christ within the same region. Apparently, these diverse and in some cases conflicting perceptions, are chiefly due to congregational autonomy and liberty to individual opinion that is inherent in the churches. In light of that, the succeeding section traces some perceptible elements of holistic and inclusive approach to medical missions at Mashoko.

3.9. Elements of a holistic and inclusive approach to medical missions at Mashoko

In tandem with the notion of medical missions as a dimension of all-inclusive *missio Dei* , Louw (2008:116) points out that illness is a problem to the total person because it is linked

with the bodily existential needs of the whole person. Therefore, when a one is ill , the person 'should be approached as a systematic unity and totality'(Louw, 2008:116). Further, Louw (2008:116) stresses that bodily disorders 'affect the entire person, as well as one's sense of identity'. In agreement with Louw, Yamamori, (1996:2-4) demonstrates that it is actually a biblical mandate for the church to minister to the whole person and the theme is prevalent both in the Old and the New Testament. It is , therefore, very important for a church or a church ministry that is involved in health care to realise the significance of ministering to the whole person especially in face of matters related to gender and HIV, which are issues closely knit to human dignity.

In the medical missions of the Churches of Christ at Mashoko, there are some noticeable rudiments of a holistic and inclusive ministry. In essence, they articulate that their goal is to 'offer a holistic ministry that touches the body, the mind, and the soul'[25].As Mudzanire (2017:34) observes, the arrival of Pruett at Mashoko in 1958 saw the medical work expanding and greatly contributing to the threefold (healing, teaching and preaching) mission work of the Churches of Christ in Zimbabwe. In that regard, the missionaries have been putting effort to serve in a manner that is both holistic and inclusive (Bhebhe, 2009:142). This effort to be holistic and inclusive is clearly expressed in both the vision and mission statement of MCH. The mission statement of MCH goes:

> Mashoko Christian Hospital exists to preach the gospel to all who seek for treatment of their physical ailments at Mashoko Christian Hospital and other institutions of the association of health institutions and services of the churches of Christ in Zimbabwe as well as to support Christian growth and new church development in Zimbabwe. (Bungu 2013:17).

The vision of MCH states, "We seek to provide the best health care possible to all those who enter our doors so that in the end they see Jesus' compassion in us and praise God for it (Bungu, 2013:17).The expression in the MCH mission statement vision communicates that their goal culminates in achieving the glorification of Jesus. The notion that their mission focuses on " preaching to all", conveys nothing other than the mandate of the all- inclusive mission in that it seeks not fulfil any other achievements but to serve all people for Christ's sake. It can be regarded as inclusive in that it upholds and seeks to serve, "all who come for treatment". There

[25] Source: Hippo Valley Christian Mission, 2013. [Online]. Available: http// hipovalley.org//about-our-mission.html [2017 September, 28].

is no doubt that the, “all" encapsulates people of different race, status and gender differences. In concurrence to this, Dennis Pruett once stated that medical evangelism as practiced at MCH instils an understanding that “the love that god had for all people is manifested in his servant", Pruett cited in Bungu (2013:4). The sentiments of Dennis Pruett allude to both the concept of all-inclusive mission as well as to the notion of gender justice as an expression of human dignity.

With regards to the HIV pandemic, the Churches of Christ have made some visible imprints of a holistic ministry to the infected and affected people. Commenting on the AHBCP that was adopted at MCH, McCarty (1996:55) acknowledges that AIDS might enter a family through a single member of the family but it ‘affects the physical, social, psychological, economic and spiritual well-being of all members of the family’. Eventually, people involved in medical missions came up with a spiritual therapy that is designed to meet the needs of the affected family by providing spiritual, psychological and social support. Some notable elements of inclusivity in the medical missions of the Churches of Christ are evident in their response to HIV when it was first realised in Zimbabwe. David Grubbs denounces gender insensitive declarations by some preachers. He notes that some preachers pronounce that AIDS is a curse that God sent to punish people against homosexuality. Grubbs (1991:3) condemns that attitude as a failure to recognise that most of the affected people in the world are not homosexuals. He points out that most of the sufferers of AIDS are infants and children (Grubbs 1991:3). David Grubbs' attitude may not necessarily represent the general perception of those that worked in the medical missions but it is a prime example of positive elements of inclusivity in the mission work at Mashoko that were in the leaders.

Another noteworthy element of inclusivity in the missions of the Church of Christ at Mashoko is portrayed in the lives and work of the missionaries themselves. It has been a very significant feature in the history of Churches of Christ that the work of soul winning has been for both male and female missionaries. Just to start at the historical point of Mashoko mission since 1956. The line-up of missionaries who served at the station has been so often a blend of both man and women. Amongst the numerous, the list includes John Pemberton and his wife Marjorie, Pruett and his wife Denny (Pemberton, 1996:2), and so it is with Zindoga and Diana Bungu. Although the ministry has been inclusive in that manner, it is selective in that some roles played by males and females were exclusive to certain gender.

Invariably, all of the noted features of a holistic and inclusive ministry are paramount to the realisation the church's goal in medical missions. Similarly, it is imperative for *the Churches of Christ t*o have a deeper scrutiny of the gendered nature HIV and AIDS programs to safe guard against stigma and discrimination. Walsh (2005:5) points out that gender insensitivity in HIV and AIDS programs is a pervasive and direct abuse of human dignity, 'it makes the solution part of the problem'. Therefore, there is need for the church to take special care when dealing with HIV and gender issues so as to combat the perpetuation of discrimination and stigma hurled at the people affected, especially women, sex workers, children and the LGBTQI people. The need for that sensitivity in the church is the drive behind the current study.

3.10. Conclusion

This chapter briefly traces the historical background of the Church of Christ missions. It particularly gives a detailed overview of the medical missions at Mashoko Mission and the commencement of the HIV and AIDS programs provided at Mashoko Christian Hospital. The chapter also highlights the Church of Christ's theology and practice of healing ministry in relation to the HIV pandemic. Further, the chapter explores some gender perceptions held in the Churches of Christ as well as some elements of an inclusive and holistic ministry at Mashoko.

The next chapter will give a detailed description of key HIV and AIDS programs at Mashoko Christian Hospital, namely AIDS Home Based Care (AHBC), Antiretroviral Therapy(ART), Voluntary Counselling and Testing (VCT), and Prevention of Mother to Child Transmission. The chapter will further evaluate the programs using the SADC Checklist for Measuring Implementation of the Gender Mainstreaming Guidelines in HIV and AIDS Programs. The evaluation aims at checking whether the institution is doing enough to promote gender justice in the HIV and AIDS programs as stipulated in the SADC Checklist for Measuring Implementation of the Gender Mainstreaming Guidelines in HIV and AIDS Programs.

CHAPTER FOUR

THE NATURE OF HIV PROGRAMS AT MCH

4.1. Introduction

This chapter presents a detailed description of key HIV and AIDS programs at MCH namely AHBC, ART, HCT, and PMTCT. The chapter also provides an assessment of the programs using the SADC Checklist for Measuring Implementation of the Gender Mainstreaming Guidelines in HIV and AIDS Programs. The evaluation aims at checking whether the institution is doing enough to promote gender justice in the HIV and AIDS programs as expected of a healing ministry that upholds human dignity and the inclusivity of *missio Dei*. In that regard, a further description of the SADC Checklist for Gender Mainstreaming Guidelines will be presented before an exploration of the HIV programs.

4.2. The SADC Checklist for Gender Mainstreaming in HIV Programs

As stated in chapter one in the methodology section, the assessment framework used in this study is borrowed from the SADC Checklist for Measuring Implementation of the Gender Mainstreaming Guidelines in HIV and AIDS Programs. The framework is deemed to be instrumental in assessing how the HIV and AIDS programs offered in the medical missions at MCH are framed for a gender sensitive health care ministry. The checklist is designed by the SADC secretariat in order to support implementation of SADC gender mainstreaming guidelines for communicable diseases, namely tuberculosis, Malaria and HIV and AIDS(*SADC*[26], 2011:1). However, this study will particularly focus on HIV and AIDS programs only. Hence, the checklist is not used its entirety, only some specific assessment questions relevant to this study are selected.

The checklist is a tool intended to enable policy makers and program managers to assess how programs, aligned policies and strategy frameworks are framed for gender sensitivity(*SADC*, 2011:4).On the whole, the SADC checklist is: a planning and management tool that will give an overview of the gender mainstreaming status in program specific areas; an important method in pointing out areas of priority that call for interventions and to identify current efforts and gains; and an instrument to facilitate intend consideration of effective ways to implement

[26] Southern Africa Development Community

gender mainstreaming(*SADC*, 2011:). This is, therefore, a very relevant tool in assisting this researcher to assess the extent to which HIV programs at MCH have been made gender sensitive.

The assessment framework looks at all key elements of the programs in which gender sensitivity is required. The checklist present some questions that are paramount to checking as to whether issues of gender are clearly pronounced in the program policy and its development strategies through major components such as the vision, objective or goals, targeted audience, guiding principles and standards, activities and the budget for the program(*SADC*, 2011:5). This is helpful to this study in determining the level of gender sensitivity in these key components of the program.

The SADC checklist is also helpful in that it is highly flexible and can be tailored to suit various contexts. It is designed in such a way that it can be further adopted to, and or be integrated with some other checklists (*SADC*, 2011:5). Thus, it is easier to custom the checklist to specifically suit the MCH context.

The checklist is designed in a form of a table presenting a column of assessment questions. Adjacent to the column of questions there are three other columns in which the answers to the question could be ticked as “Yes”, “No” or “In progress”. There is also another provision for an explanation for cases where the answer is ticked as “No”. According to the guide, all areas that will be ticked “No” are the highest priority areas that call for gender mainstreaming interventions. The areas ticked “In progress” can be given second priority for gender mainstreaming. For areas that are ticked “Yes”, it means gender mainstreaming is implemented in the program. However, those areas require continued attention and management to sustain the existing gender sensitivity. The questions asked may differ from program to program. The following figure is an example of how the checklist is tabulated.

Table 1. Example of the checklist table

Example Checklist	HIV Testing and Counselling	Yes	In Progress	No	If "No" provide reasons for not implementing
Has the programme component taken cognisance of the specific needs and concerns of women and men in order to facilitate easy access to those services?			✓		
Has the programme developed and implemented gender sensitive protocols of disclosure?		✓			
Has the programme increased access to treatment for women and men?				✓	The program is not expanding due to lack of resources.

Thus, after completing the checklist table, the table indicates the level of gender mainstreaming that would have been achieved in the assessed program. The table also shows the areas that need attention and mainstreaming priority. The explanation provided in the cases ticked "No" are indicators of the actual challenges that have to be dealt with so that, eventually, those areas will be solved.

The gender mainstreaming questions that are posed in the checklist are meant to asses a number of key program areas. The program areas that have to be assessed in line with the checklists include: policy and strategic framework review and development, monitoring and evaluation, service delivery, institutional coordination, communication and social mobilisation, capacity development, decentralisation of services and financing for gender mainstreaming. In addition to that, there are some questions that are specifically designed for each program. Hence, each program has to be assessed independently although there are some areas in which there are common characteristics.

4.3. The HIV programs at MCH

Since the commencement of AHBC as the first HIV program at MCH, a number of other programs were soon adopted and implemented to address the multifaceted effects of the pandemic. In addition to AHBC, the government of Zimbabwe also launched a number of HIV programs aiming to prevent HIV infection as well as to provide treatment and care to PLWHA. With time, the programs evolved to suit local contexts as well as the changes in expectations and attitudes of the Zimbabwean population(Chevo and Bhatasara, 2012:1). These programmes have been directed by different stakeholders spanning private and public sectors, FBOs, nongovernmental organizations, informal and formal institutions as well as intergovernmental organizations such as WHO[27], UNICEF[28], UNAIDS[29] and PEPFAR[30] (Chevo and Bhatasara, 2012:1). Following those developments, MCH also embraced these interventions that do not only form an integral element of health care services but also sustain lives in the country.

4.4. AIDS Home Based Care (AHBC) Program

The AHBC program is described as 'the provision of holistic quality care for the sick in the home. The programme involve the family or other primary care givers, with the support of the community, secondary care givers and a multidisciplinary, multi-sector term' (*MoHCW*, 2005:13). In Zimbabwe, most HIV and AIDS programs are national programs and most hospitals in the country carry out the programmes as a national mandate. However, as highlighted in chapter three, the AHBC program at Mashoko started in 1996 as an initiative of Chidamoyo Hospital, a sister hospital of MCH (McCarty, 1996:55). It was then adopted at MCH the following year (Grubbs, 2009:199). Nevertheless, the program's success is as a result of a commitment to follow set objectives, the principles as well as the standards that govern the program in the country.

4.4.1. Objectives of AHBC program

The objectives of the AHBC program for people living with HIV and AIDS (PLWHA) include ensuring quality care to a person living with HIV and Aids after being released from a health facility. The program seeks to promote acceptance of the patient into the family and the society setup and reduces the discrimination that is usually associated with AIDS (*MoHCW*, 2005:13).

[27] World Health Organization
[28] United Nations Children's Emergency Fund
[29] United Nations Programme on HIV/AIDS
[30] President's Emergency Plan for AIDS Relief

More to that, the AHBC fosters community and family awareness of HIV prevention and care. It also provides the community and family with appropriate skills and knowledge required to guarantee care and support in the long run (*MoHCW*, 2005:14). Hence, the programme facilitates family and community care for PLWHA.

At Mashoko, the AHBC program is facilitated by a home care visit team consisting of a nurse, an HIV primary counsellor, a chaplain and a driver (Grubbs, 2009:199). The nurse serves to provide the patients with medicines, instructions on satiation and nutrition. She also addresses any immediate illnesses that can be easily dealt with at home. The primary counsellor offers psychological support. The chaplain gives spiritual support to the patient, the family and any other care givers (Grubbs, 2009:199). Nevertheless, this entire team from the hospital is regarded as secondary care givers, the primary care givers are the people who stay with the patient at home. In the context of MCH, AHBC program, therefore, serves as an expression of holistic evangelism ministry.

Unlike in most HIV Programmes, the greater part of care is given at home or community level and the care is provided by women and children(*MoHCC*, 2010:8) . Male involvement in the program of AHBC has been gradually increasing with time. Thus, AHBC has been, and still is, largely carried out by women.

4.4.2. Principles guiding AHBC program

As part of a continuous endeavour to improve support and care for HIV and AIDS patients and their families, MCH follows some AHBC principles that were set by the Ministry of Health and Child Care in 2004. The first principle, as provided in the national guidelines, focuses on care and support for patients and family. The s principle is holistic in approach. It compels care providers to identify needs of patients. The principle promotes sharing of information and skills, medical support and counselling *(MoHCC*, 2004:4). The primary objective behind this principle is promotion of care especially to youth and children that are affected and infected with HIV and AIDS (*MoHCC*, 2004:4). Thus, the first standard of AHBC promotes care, especially to the vulnerable.

The second principle compels care providers to take AHBC as a community program involving a variety of sectors of the society such as traditional leaders, religious leaders and social workers. It aims at enhancing the competencies of caregivers as they execute their duties in

AHBC (*MoHCC*, 2004:4). The principle promotes networking, collaborations and linkages as well as coordination of resources to enhance provision of care and support (*MoHCC*, 2004:4). Hence, the second principle of AHBC upholds networking among all the people involved in the program.

The third principle deals with governance and management of quality care. Under this principle care providers are expected to ensure continual supervision such that care teams cannot operate in isolation. It also coerces record keeping, documentation and meetings. Again, it compels care providers to ensure financial support to AHBC activities and good management of resources (*MoHCC*, 2004:4). Thus, third principle of AHBC enables maintenance of high standards of care.

The fourth principle focuses on educating, informing and training of care teams as well as their families. This enables patients and families to make informed decisions and it empowers the patients to complement the efforts of care providers (*MoHCC*, 2004:4). This principle also promotes the continuity of the program in the community since information and knowledge will be passed on.

The fifth principle of AHBC focusses on monitoring and evaluation of the program. Under this standard, care providers should continually review and asses the programs through activities like supervisory visits, reviews and evaluation meetings (MoHCC, 2004:4). Thus, this particular principle ensures that guidelines are being followed. It also necessitates determination in the care teams paramount to the fulfilment of the program's objectives. Again monitoring and evaluation enables program managers to quickly identify problems and develop solutions or take necessary action.

4.4.3. Current uptake of the AHBC programme at MCH

The catchment area of MCH has a projected total population of about 10975 people (*MCH*[31], 2018:1). Out of that total population, 1576 are currently registered as HIV positive patients at MCH Opportunistic Infections (OI) Clinic (*MoHCC*, 2018:1). AHBC takes care of the critically ill HIV and AIDS patients, and only 44 patients are currently registered as eligible for home care visits(*MCH*, 2018b:2). Among the 44 AHBC patients that are eligible for visitations, 23 are females, 17 are males and 4 are adolescents(*MCH*, 2018c:1). However, there

[31] Mashoko Christian Hospital Projected Population Report

is no record of people living with unknown gender or LGBTQI people in the AHBC reports and records at MCH.

4.4.4. Assessment of gender mainstreaming in AHBC program at MCH

The following table shows the current level of gender mainstreaming in the AHBC program at MCH .The table indicate areas of achievement in gender sensitivity as well the areas that need attention and mainstreaming priority.

Table 2. AHBC Program Gender Mainstreaming Checklist

AHBCP Checklist	HIV Testing and Counselling	Yes	In Progress	No	If "No" provide reasons for not implementing
Are gender issues clearly articulated in the institution's program policy through vision, objectives and guiding principles?				✓	MCH does not have its own policy on gender and HIV issues. Instead they use a Government policy
Does the strategic framework clearly stipulate deliberate measures for targeting special groups, and disadvantaged and vulnerable women and men		✓			
Does the programme carry out periodic knowledge, attitude and perceptions surveys to determine whether women and men's ethical needs are met after health research trials?			✓		

Does the programme conduct periodic gender-sensitive research on: knowledge and awareness, Treatment-seeking behaviours, and sociocultural factors/barriers and the effects of treatment on women and men?			✓	Apparently MCH does not place priority in researching or addressing sociocultural factors behind gender disparities
Has the program established gender focal points and coordinating committees from the existing staff with clear terms of reference to oversee the mainstreaming of gender issues?				There is neither staff nor office at MCH that administers gender mainstreaming.
Do the monitoring and evaluation systems have gender-specific indicators to reflect the disparate impact and management of HIV on women and men?	✓			
Does the programme provide adequate financial resources to support gender-sensitive surveillance, monitoring and evaluation systems?			✓	Lack of funds
Does the programme integrate sensitising activities on gender, sex and sexuality, male involvement in the provision of care for the sick, and gender-based violence for both women and men through existing outreach programmes?		✓		

Has the programme formed strategic partnerships with relevant stakeholders who can influence policy change with regards to gender mainstreaming in communicable diseases?		✓		
Has the program component taken cognisance of the specific needs and concerns of women and men in order to facilitate easy access to those services?		✓		
Does the programme encourage open discussions in communities on gender-based violence, stigma and discrimination with regards to HIV and AIDS?		✓		
Has the programme increased access to treatment for women and men?			✓	The program is not expanding due to lack of resources.
Has the programme intensified partner testing and counselling to effectively deal with gender-based violence, stigma and discrimination—issues that are commonly experienced HIV-positive women?	✓			
Does the programme promote the use of gender- and culturally-sensitive materials and community based interventions to deconstruct negative stereotypes about femininity and masculinity, while taking into account high illiteracy levels among women?			✓	MCH is not taking initiatives to address gender issues through community interventions

Has the programme developed and implemented gender mainstreaming capacity building activities for all staff in the health sector, with a view to promoting an understanding and appreciation of the gender dimensions?		✓		
In order to ensure access to such services by both women and men (especially those that cannot afford indirect costs, such as transport), has the programme decentralised diagnosis health services for HIV?	✓			
Does the programme provide adequate financial resources to support gender-sensitive surveillance, monitoring and evaluation systems?			✓	MCH does not have a budget to particularly finance gender mainstreaming issues.

4.5. Antiretroviral Therapy (ART) Program

In Zimbabwe, ART is a national program and it forms 'an integral part of the provision of comprehensive service for HIV and AIDs prevention, treatment, care and support (*MoHCC*, 2010:4).The commencement of the ART program in Zimbabwe has radically transformed the pandemic from being a 'life threatening infection into a chronic and manageable condition' (*MoHCC*, 2013:4). Although ART does not cure the disease, it has dramatically brought down the morbidity and mortality where it has been used appropriately (*MoHCC*, 2013:4). MCH has, thus, embraced this national program and has facilitated access of the services to thousands of people in Mashoko community. The success of the programme at MCH is partly due to following the national guidelines that provide a standard approach to the services.

4.5.1. Objectives of ART Program

The ultimate aim of the ART program is to enable, 'universal accesses to the Antiretroviral drugs (ARVs) to all who need them (*MoHCC*, 2016:4). According to WHO, the phrase 'universal accesses' refers to 'establishing an environment in which HIV prevention, treatment, care and support interventions are available and accessible and affordable to all who need them. It covers a wide range of interventions that are aimed at individuals, households, communities and countries'(*MoHCC*, 2016:4) . The objectives of the program include: (a) durable and maximum suppression of HIV, (b) restoring and or preserving of a functional immune, (c), reducing mortality and morbidity related to HIV and AIDS, (d) life quality improvement (d) preventing mother-to-child transmission of the virus from infected to uninfected person by using ARVs also known as 'treatment as prevention' (*MoHCC*, 2016:20).

The fulfilment of the objectives of ART program is facilitated by the service providers' commitment to follow the standardised treatment guidelines. The guidelines employ both the public health as well as the family centred approach'(*MoHCC*, 2016:5). It has been proved that even countries with restricted resources but employing public healthy approach to the disease they achieve similar effectiveness as with the more affluent contexts (*MoHCC*, 2016:5). MCH, therefore, is committed to the standardized guidelines in implementing the ART program.

4.5.2. Principles guiding ART program

The principles that govern ART programs in Zimbabwe orders the healthcare personnel to continually receive medical education and training so as to be updated on changes of ART recommendations (*MoHCC*, 2016:17). ART is a complicated program and requires an in-depth knowledge about: ARVs, the side effects of the drugs, issues related to the immune system, the management of opportunistic infections (OIs), time to initiate ART and to change medicines or to switch second and or third line therapy and counselling (*MoHCC*, 2016:17). As such, these skills can only be acquired through relevant training and practical learning. Thus, healthcare personnel is expected to improve their skills through tools such as clinical mentoring.

Another important standard that has to be followed to ensure success of the program has to do with adherence to treatment schedules and systematic plan of therapy (*MoHCC*, 2016:17).There is , therefore, a need for strict monitoring of patience during ART in order to closely manage adherence, side effects, as well as treatment failure. Any indication of treatment

failure should alert the health personnel on the need to switch the therapy to next line(*MoHCC*, 2016:17).

The guiding principles and standards of ART include initiating of ART, as a priority, to all individuals in the subsequent groups, despite their CD4 cell count: (a) pregnant women and or breastfeeding with HIV, (b) patients with active TB, (C) people with HBV co-infection as well as severe chronic liver disease (*MoHCC*, 2016:21).The patients are expected to be started on the treatment as fast as possible. The patients should be examined for TB symptoms. They should then receive prophylaxis and cotramoxizole. As the case is with all patients, they are closely monitored for three months because they will be a period of highest risk to be infected by bacteria. They should also report to the health facility as soon as they feel unwell (MoHCC, 2016:21).

4.5.3. Current uptake of the ART program at MCH

MCH is one of the hospitals with the greatest access to ART with a total number of 1535 people who are currently on treatment (*MoHCC*, 2018:1). Out of those 1535 patients , 963 are females and 527 are males (*MoHCC*, 2018:1). The program currently serves of 84 females who are aged between 0 and 19 and 83 male counterparts. Females from the age of 20 and above accounts for 881 of the people and the male counter parts amount up to a total number of 444 (*MoHCC*, 2018:1). As in the AHBC program, there are no records of patients with unknown gender or LGBTQI people.

4.5.4. Assessment of gender mainstreaming in ART program at MCH

The following table shows the current level of gender mainstreaming in the ART program at MCH .The table shows areas of achievement in gender sensitivity as well as exposing the areas that need attention and mainstreaming priority

Table 3. The ART Program Gender Mainstreaming Checklist

AHBCP Checklist	HIV Testing and Counselling	Yes	In Progress	No	If "No" provide reasons for not implementing
Are gender issues clearly articulated in the institution's program policy through vision, objectives and guiding principles?				✓	MCH does not have its own policy on gender and HIV issues. Instead they use a Government policy
Does the strategic framework clearly stipulate deliberate measures for targeting special groups, and disadvantaged and vulnerable women and men		✓			
Does the programme carry out periodic knowledge, attitude and perceptions surveys to determine whether women and men's ethical needs are met after health research trials?			✓		
Does the programme conduct periodic gender-sensitive research on: knowledge and awareness, Treatment-seeking behaviours, and sociocultural factors/barriers and the effects of treatment on women and men?				✓	Apparently MCH does not place priority in researching or addressing sociocultural factors behind gender disparities

Has the program established gender focal points and coordinating committees from the existing staff with clear terms of reference to oversee the mainstreaming of gender issues?				There is neither staff nor office at MCH that administers gender mainstreaming.
Do the monitoring and evaluation systems have gender-specific indicators to reflect the disparate impact and management of HIV on women and men?	✓			
Does the programme provide adequate financial resources to support gender-sensitive surveillance, monitoring and evaluation systems?			✓	Lack of funds
Does the programme integrate sensitising activities on gender, sex and sexuality, male involvement in the provision of care for the sick, and gender-based violence for both women and men through existing outreach programmes?		✓		
Has the programme formed strategic partnerships with relevant stakeholders who can influence policy change with regards to gender mainstreaming in communicable diseases?		✓		
Has the program component taken cognisance of the specific needs and		✓		

concerns of women and men in order to facilitate easy access to those services?				
Does the programme encourage open discussions in communities on gender-based violence, stigma and discrimination with regards to HIV and AIDS?		✓		
Has the programme increased access to treatment for women and men?			✓	The program is not expanding due to lack of resources to expand
Has the programme intensified partner testing and counselling to effectively deal with gender-based violence, stigma and discrimination—issues that are commonly experienced HIV-positive women?	✓			
Does the programme promote the use of gender- and culturally-sensitive materials and community based interventions to deconstruct negative stereotypes about femininity and masculinity, while taking into account high illiteracy levels among women?			✓	MCH is not taking initiatives to address gender issues through community interventions
Has the programme developed and implemented gender mainstreaming capacity building activities for all staff in the health sector, with a view to promoting an understanding and appreciation of the gender dimensions?		✓		

In order to ensure access to such services by both women and men (especially those that cannot afford indirect costs, such as transport), has the programme decentralised diagnosis health services for HIV?	✓			
Does the programme provide adequate financial resources to support gender-sensitive surveillance, monitoring and evaluation systems?			✓	MCH does not have a budget to particularly finance gender mainstreaming issues.
Does the programme create awareness about the availability of free ARV prophylaxis treatment, such as cotrimoxizole, as well as existing services to encourage both women and men to seek care and comply with treatment?	✓			
Does the programme have mobile clinics to ensure that treatment reaches household and community levels?			✓	Lack of material and human resources.
			✓	

4.6. HIV Counselling and Testing (HCT) Program

HCT is another important program in fostering care and prevention of HIV as well as reducing high risk behaviour and promoting life supporting actions(*MoHCC*, 2005:4). With several other health care institutions in the country, MCH adopted the program as soon as the government launched it in Zimbabwe. Since it is a national program, MCH stresses adherence to the national standards in provision of the program services. The national standards are also in line with World Health Organization (WHO) HIV testing models.

The programme is divided into two key approaches. The first approach is known as Voluntary Counselling and Testing (VCT) or Client Initiated Testing and Counselling (CITC). The second approach is known as the Provider Initiated Testing and Counselling (PITC) (*MoHCC* 2005:9). The chief difference between the two approaches is that, in VCT the client, at his or her own will, decides to seek the services at a station that provides the program(*MoHCC*, 2014:9), whilst in the CITC the care provider makes a routine to initiate and offer the services to all clients that come to the institution. In both approaches, the care provider adheres to the guiding principles and standards as provided in the national guidelines.

4.6.1. Objectives of the HCT Program

The main objective of HCT is to 'contribute to the prevention of new HIV infections and reduction of HIV related morbidity and mortality for improved quality of life' (*MoHCC*, 2017:15). The program runs in line with the vision of the Zimbabwean government to promote knowledge of HIV status in each and every citizen as well appropriation of high standards of HIV prevention, treatment, care and support services(*MoHCC*, 2017:15) The concern for providing high quality service, in this regard, precedes quantity so as to ensure correct results, appropriate counselling and care (*MoHCC*, 2017:15). The service providers are also obliged to strive for inclusiveness and to consider the best interests of children. In addition to that, the provided services should uphold the rights, dignity and values of diverse population groups (*MoHCC*, 2017:15). In that light, MCH is also committed to providing appropriate, high quality, accessible as well as affordable HIV testing and counselling services.

4.6.2. Principles guiding the HCT Program

In Zimbabwe all healthcare provider institutions are bound by ethical values and principles paramount to provision of quality care as much as possible. HCT program at MCH and in Zimbabwe at large is guide by three core values. The first core value states that the services provided should be of value to the client. The second value focuses on the respect of human life. As such, care providers are expected to recognize 'the fundamental rights, dignity and worth of all people and ensure that clients suffer no physical or psychological harm during counselling' (*MoHCC*, 2014:4). The third core value focuses on promoting human rights. This obliges health care provider institutions to serve everyone despite their race, nationality, ethnicity, political affiliation, culture, sex marital status, gender disability, social and economic status or any other classification (*MoHCC*, 2014:4).

In addition to the three core values, the HCT program is also guided by five key principles that health service providers should adhere to when delivering the HCT services. The first guiding principle centres on the competence of the health care provider. The principle obliges the service provider to give high quality HCT services and ensures that correct test kits and quality assurance measures are put in place (*MoHCC*, 2014:14). Again, the personnel that facilitate HTC must be trained so as to give quality services, improve their professional practice and receive supportive supervision. They should also be able to know the parameters of their competence so that they can also do proper referrals (*MoHCC*, 2014:14).

The second principle coerces the service provider of HCT to protect confidentiality. The service provider should ensure that confidentiality is protected in the best way possible at all times (*MoHCC*, 2014:4). Irrespective of whether the client tested positive or negative, the person's right to privacy must be respected. This principle promotes the trust that is critically needed in counselling. Thus, anything that reduces confidentiality has a negative impact against effective counselling. In that light, the service provider should respect all of the information pertaining the client's health, HIV tests and results. It is clearly stated in this principle that the service provider should agree with the client as to the level of confidentiality. The agreement on confidentiality is respected even after the death of the client (*MoHCC*, 2014:4-5). In addition to that, the client has to be informed when the confidentiality has to be shared with other health workers that may be involved in the client's care. Also, the service provider should make a secure provision for the purposes of maintaining and keeping of the client's records or information (*MoHCC*, 2014:5). Therefore, this principle ensures that only the people who are directly involved in the management of the client's health may have access to their client's records or information.

The third principle stipulates that testing must be voluntary and of consent (*MoHCC*, 2014:5). Under this principle the service provider is expected to explain the process and also confirm that the client is not forced to request the HIV test. The most important matter to be respected is the client's choice.

The fourth guiding principle centres on the lawful age of informed consent to HCT. This principle stipulates that full informed consent can only be given by a person aged sixteen or above. That person might be a child, parent, married or pregnant (*MoHCC*, 2014:5). The full consent for HCT is a requirement prior to performing an HIV test. In light of that, any test to

be done to a child who is below sixteen years of age, consent should be given by a parent or a care giver. A child below the age of informed consent may be regarded as a 'mature minor' (*MoHCC*, 2014:5) in certain circumstances and be allowed to give full consent to HCT. This is so, if he or she is able to demonstrate maturity in making decisions individually. In that case the counsellor has to consider subsequent factors, namely, the client's ability to appreciate the importance of HCT and the seriousness of the test result, the child's development, physically, emotionally and mentally as well as the level of responsibility that the minor assumes for personal life. In the event that the parent, or a caregiver is not able to give consent for a minor, the health worker can act for the benefit of the child and get approval to perform an HIV test from the senior person in charge of the institution offering the health services (*MoHCC*, 2014:5).

The fifth guiding principle focuses on acting in the best interest of a child in providing HCT. As highlighted in the fourth principle, the service provider is expected to seek approval from the senior person in charge of the clinic or the hospital so as to provide HCT to a minor who or whose caregiver cannot give consent. This spares situations where a minor is critically ill and there is need to offer appropriate treatment and care (*MoHCC*, 2014:6). This also includes situation when a child survives sexual abuse, a minor is sexually active, a minor expresses concern about mother-to-child transmission, a minor is exposed to HIV and when a minor is concerned about an HIV positive result (*MoHCC*, 2014:6). In all these cases, the service provider is supposed to constitute HTC in the best interest of the child.

4.6.3. HCT for pregnant and lactating women

At MCH the HCT program serves as another entry point into PMTCT for pregnant and lactating women. Thus the program ushers women into PMTCT(*MoHCC*, 2014:26). Through this approach, HCT is routinely offered to antenatal clinic clients. However, even in that approach the given principles should be adhered to. Hence, testing of the pregnant woman has to be voluntary (*MoHCC*, 2014:26) as in all other clients. However, a woman should be counselled and encouraged to consider HIV test. She should be told about the benefits of the test. The services provided to women also require the counsellor to observe an additional principle when counselling a woman during labour. The counsellor should ensure that the woman is comfortable (*MoHCC*, 2014:26).

In the event that a lactating or pregnant woman tests HIV negative, the woman should be taken through post-testing counselling as a way to reduce the risk of infection in the future. The post-test counselling chiefly focuses on maintenance of the HIV negative status as the woman continues to get a routine antenatal care (*MoHCC*, 2014:27). The woman has to get a retest for HIV at a time that is between thirty two and thirty four weeks as a way to 'detect late seroconversion and allow time for service providers to implement PMTCT interventions' (*MoHCC*, 2014:27). If the pregnant or lactating woman tests HIV positive, she should be examined according to WHO staging and determine the clinical stage that she will be in. The pregnant or lactating woman should also be screened for TB as well as go to through rapid adherence counselling. Finally, the woman should be initiated on 'option B+' also known as 'life-long ART' on that same day of detecting the virus (*MoHCC*, 2014:27). Follow-ups will be done, and the woman should be encouraged to bring her partner for couple counselling and testing (*MoHCC*, 2014:27). This enables relevant and practical interventions to be implemented.

4.6.4. HCT for couples

The national guidelines that are used at MCH to run HTC program encourage counselling of couples. A couple is defined as 'two persons in an ongoing sexual relationship, and each of the persons referred to as a partner' (*MoHCC*, 2014:27). However, it is recognised that individuals perceive their relationships differently depending on social and cultural contexts (*MoHCC*, 2014:27). What is more important is that people in a sexual relationships desire to get tested together and have a mutual reception of their results, they should be encouraged to have the HTC. The personnel at the hospital should ensure that services are 'inclusive and non-judgemental and support partners to test together irrespective of the length or stability their relationship (*MoHCC*, 2014:27). Health workers should also note that in premarital counselling, the persons receiving counselling may not be in a sexual relationship but it should be assumed that they will be sexually active after they are married. Thus, at MCH, two or more individuals in a sexual relationship are entitled to accessing HTC. This includes people that could be in a marriage, regular sexual partners, cohabitating or intending to have sex. The program is designed to promote mutual knowledge and disclosure of HIV status to each other.

4.6.5. Involvement of males in HCT

Since Zimbabwe is 'a patriarchal society where the roles of males in the decision making process is important' (*MoHCC*, 2014:60) there is need to increase access of the programs to men. The national HIV policy stipulates that health institutions should foster health education on men in order to have better knowledge on HIV programs, such as HCT for the benefit of the family (*MoHCC*, 2014:60). MCH, as the case is with other health institutions in the country, follows this principle. In this regard, HCT services at MCH are male friendly and designed in such a way that HCT is offered at times that are also conducive for men. Counselling focuses on issues concerning men and the health workers should be gender sensitive (*MoHCC*, 2014:60) as much as possible.

4.6.6. Current uptake of the HCT program at Mashoko

In 2017 a total number of 2287 visited MCH to get HCT services (*MCH*, 2018d:336). On average ten people are served in the HCT program at MCH on daily basis. However, only one male is tested in every ten females(MCH, 2018e:22). Out of the entire population that receives HCT at Mashoko, it turns out that more women are tested than males. Again, of the total number of both males and females tested, the number of HIV positive females is higher as compared to their male counterparts(*MCH*, 2018d:337). There is neither any record of people of unknown gender nor LGBTQI.

4.6.7. Assessment of gender mainstreaming in HCT program at MCH

The following table shows the current level of gender mainstreaming in the HCT program at MCH .The table shows areas of achievement in gender sensitivity as well as exposing the areas that need attention and mainstreaming priority

Table 4. The HCT Gender Mainstreaming Checklist

AHBCP Checklist	HIV Testing and Counselling	Yes	In Progress	No	If "No" provide reasons for not implementing

Are gender issues clearly articulated in the institution's program policy through vision, objectives and guiding principles?			✓	MCH does not have its own policy on gender and HIV issues. Instead they use a Government policy
Does the strategic framework clearly stipulate deliberate measures for targeting special groups, and disadvantaged and vulnerable women and men	✓			
Does the programme carry out periodic knowledge, attitude and perceptions surveys to determine whether women and men's ethical needs are met after health research trials?		✓		
Does the programme conduct periodic gender-sensitive research on: knowledge and awareness, Treatment-seeking behaviours, and sociocultural factors/barriers and the effects of treatment on women and men?			✓	Apparently MCH does not place priority in researching or addressing sociocultural factors behind gender disparities
Has the program established gender focal points and coordinating committees from the existing staff with clear terms of reference to oversee the mainstreaming of gender issues?				There is neither staff nor office at MCH that administers gender mainstreaming.

Do the monitoring and evaluation systems have gender-specific indicators to reflect the disparate impact and management of HIV on women and men?	✓			
Does the programme provide adequate financial resources to support gender-sensitive surveillance, monitoring and evaluation systems?			✓	Lack of funds
Does the programme integrate sensitising activities on gender, sex and sexuality, male involvement in the provision of care for the sick, and gender-based violence for both women and men through existing outreach programmes?		✓		
Has the programme formed strategic partnerships with relevant stakeholders who can influence policy change with regards to gender mainstreaming in communicable diseases?		✓		
Has the program component taken cognisance of the specific needs and concerns of women and men in order to facilitate easy access to those services?		✓		
Does the programme encourage open discussions in communities on gender-based violence, stigma and discrimination with regards to HIV and AIDS?		✓		

Has the programme increased access to treatment for women and men?			✓	The program is not expanding due to lack of resources to expand
Has the programme intensified partner testing and counselling to effectively deal with gender-based violence, stigma and discrimination—issues that are commonly experienced HIV-positive women?	✓			
Does the programme promote the use of gender- and culturally-sensitive materials and community based interventions to deconstruct negative stereotypes about femininity and masculinity, while taking into account high illiteracy levels among women?			✓	MCH is not taking initiatives to address gender issues through community interventions
Has the programme developed and implemented gender mainstreaming capacity building activities for all staff in the health sector, with a view to promoting an understanding and appreciation of the gender dimensions?		✓		
In order to ensure access to such services by both women and men (especially those that cannot afford indirect costs, such as transport), has the programme decentralised diagnosis health services for HIV?	✓			

Does the programme provide adequate financial resources to support gender-sensitive surveillance, monitoring and evaluation systems?			✓	MCH does not have a budget to particularly finance gender mainstreaming issues.
Has the HIV testing and counselling programme component taken cognisance of the specific needs and concerns of women and men in order to facilitate easy access to those services?		✓		
Has HIV testing and counselling been integrated into the mainstream health service delivery systems to enhance access to services?	✓			

4.7. Prevention of Mother to Child Transmission (PMCT) Program

PMTCT refers to the interventions to prevent 'transmission of HIV from an HIV positive mother to her infant during pregnancy, labour, childbirth and breastfeeding'(Kak et al., 2011:116). In an effort to make the program more gender sensitive, in Zimbabwe, it is also known as 'Prevention of Parent-to-Child Transmission (PPTCT)' and also stresses that each parent takes efforts to protect the infant(*MoHCC*, 2010a:56).The greater part of PMTCT interventions centre on detecting HIV in mothers and working to prevent infections to the unborn and new-born. The rest of the program ensures the 'survival of children from traditional causes of death, especially the high risk neonatal period'(Kak et al., 2011:112).Hence, PMTCT plays a pivotal role in the alleviation of the impact of the pandemic on women, unborn, new-born, children, families and the entire health system in the country .

The Zimbabwean government, through the Ministry of Health and Child Care rolled out the PMTCT program in 2011in line with the WHO guidelines (Buzdugan et al., 2015:18). As in most national HIV programs, PMTCT is spearheaded by various organizations that provide

health care services. In that regard, MCH embraced the programme and they are committed to the goals and objectives of the programme as provided in the national guidelines.

4.7.1. Objectives of PMTCT program

MCH runs a comprehensive program of PMTCT that functions to fulfil some key objectives. Some of these are : (a) primary prevention of HIV infection among women of reproductive age (b), prevention of HIV transmission from HIV infected women to their infants during pregnancy, labour, child birth and breastfeeding through HIV testing and counselling, ARV prophylaxis , ART for life for all pregnant and breastfeeding women and safer infant feeding practices,(d) provision of comprehensive care to mothers living with HIV, their children and families (*MoHCC*, 2016:35). In light of that, MCH is obliged to fulfil the four objectives in their PMTCT program.

4.7.2. Principles guiding the PMTCT program

The guiding principles and standards for PMTCT at MCH are in line with the national guidelines that are also compatible with WHO standards. The program is guided by quite a number of standards that should be followed during antenatal, labour, delivery, postnatal, and after discharge from the health facility.

First, the principles for PMTCT obliges the health facilities to take PITC as a must and regular element of the 'package of care in all antenatal, child birth, postpartum and paediatric care settings' (*MoHCC*, 2016:36). In the Zimbabwean context and particularly in Mashoko community where mothers normally breastfeed, HIV negative lactating mothers should have periodical tests throughout the breastfeeding period (*MoHCC*, 2016:36). The HIV negative pregnant women should be tested in their first trimester of pregnancy, their third trimester or at delivery at six weeks post-natal as well as twice per year during the period of breastfeeding.

Secondly, couples and partners coming for antenatal services should be offered HCT services that support 'mutual disclosure' (*MoHCC*, 2016:36). At MCH pregnant women that come for antenatal services are encouraged to bring their partners for HTC. To promote the culture of bringing a partner, when a couple together, they are served first. In addition to getting first attention, the couple is offered other medical check-ups services free of charge.

Third, when a pregnant woman tests HIV positive, she should receive a service package. The package is intended to effect preventing the infant from contracting HIV during pregnancy. This package includes, planned breast feeding, dual protection through use of condoms, counselling and planning of Childbirth that fosters delivery in a healthy facility and access to PMTCT services, use of ARVs, complete testing services, maternal nutrition counselling, infant feeding advice, infant HIV testing and counselling on sexual as well as reproductive health concerning family planning and reliable contraception (*MoHCC*, 2016:36-37). At MCH, HIV positive pregnant women are at times given food hampers as part of this package to enhance maternal nutrition.

Finally, all HIV positive women, on pregnancy or breastfeeding should start lifelong ART immediately after they are confirmed to be HIV positive. The initiation of ART is regardless of their CD4 count (*MoHCC*, 2016:37). Once started on ART, the mothers should continue throughout the period of breastfeeding and beyond. Healthcare providers should asses the women's redness to start ART. In the cases where the person is not ready for initiation, the woman should be started on 'triple ARVs (ART)' that is to be taken for at least the breastfeeding period (*MoHCC*, 2016:37).

At MCH, because of the prevalence of HIV in the antenatal clinic, all pregnant and breast feeding women should be initiated on ART even if HIV is detected late in pregnancy or at a later stage of breast feeding. This is because the most effective method to guard against mother-to-child HIV is to minimise maternity viral load(*MoHCC*, 2016:37). The ART is initiated and the maintained with ongoing HIV care.

4.7.3. Current uptake of the PMTCT program at MCH

PMTCT services are offered to almost every pregnant woman who comes to MCH for antenatal or any other medical services. In 2017, a total number of 241 pregnant women were served in the PMTCT program at the hospital(*MCH*, 2018d:336). Although the PMTCT services are designed to involve men, of the 22421 women that were served in the program, it is only 81 who managed to bring their male partners for counselling and testing (*MCH*, 2018d: 336). As in the above three programs, there is also no record of LBTQI people who came for the PMTCT services.

4.7.4. Assessment of gender mainstreaming in PMTCT program at MCH

The following table shows the current level of gender mainstreaming in the PMTCT program at MCH. The table shows areas of achievement in gender sensitivity as well as exposing the areas that need attention and mainstreaming priority

Table 5. The PMTCT Program Gender Mainstreaming Checklist

AHBCP Checklist	HIV Testing and Counselling	Yes	In Progress	No	If "No" provide reasons for not implementing
Are gender issues clearly articulated in the institution's program policy through vision, objectives and guiding principles?				✓	MCH does not have its own policy on gender and HIV issues. Instead they use a Government policy
Does the strategic framework clearly stipulate deliberate measures for targeting special groups, and disadvantaged and vulnerable women and men		✓		✓	
Does the programme carry out periodic knowledge, attitude and perceptions surveys to determine whether women and men's ethical needs are met after health research trials?			✓		

Does the programme conduct periodic gender-sensitive research on: knowledge and awareness, Treatment-seeking behaviours, and sociocultural factors/barriers and the effects of treatment on women and men?			✓	Apparently MCH does not place priority in researching or addressing sociocultural factors behind gender disparities
Has the program established gender focal points and coordinating committees from the existing staff with clear terms of reference to oversee the mainstreaming of gender issues?				There is neither staff nor office at MCH that administers gender mainstreaming.
Do the monitoring and evaluation systems have gender-specific indicators to reflect the disparate impact and management of HIV on women and men?	✓			
Does the programme provide adequate financial resources to support gender-sensitive surveillance, monitoring and evaluation systems?			✓	Lack of funds
Does the programme integrate sensitising activities on gender, sex and sexuality, male involvement in the provision of care for the sick, and gender-based violence for both women and men through existing outreach programmes?		✓		

Has the programme formed strategic partnerships with relevant stakeholders who can influence policy change with regards to gender mainstreaming in communicable diseases?		✓		
Has the program component taken cognisance of the specific needs and concerns of women and men in order to facilitate easy access to those services?		✓		
Does the programme encourage open discussions in communities on gender-based violence, stigma and discrimination with regards to HIV and AIDS?		✓		
Has the programme increased access to treatment for women and men?			✓	The program is not expanding due to lack of resources to expand
Has the programme intensified partner testing and counselling to effectively deal with gender-based violence, stigma and discrimination—issues that are commonly experienced HIV-positive women?	✓			
Does the programme promote the use of gender- and culturally-sensitive materials and community based interventions to deconstruct negative stereotypes about femininity and masculinity, while taking			✓	MCH is not taking initiatives to address gender issues through community interventions

into account high illiteracy levels among women?				
Has the programme developed and implemented gender mainstreaming capacity building activities for all staff in the health sector, with a view to promoting an understanding and appreciation of the gender dimensions?		✓		
In order to ensure access to such services by both women and men (especially those that cannot afford indirect costs, such as transport), has the programme decentralised diagnosis health services for HIV?	✓			
Does the programme provide adequate financial resources to support gender-sensitive surveillance, monitoring and evaluation systems?			✓	MCH does not have a budget to particularly finance gender mainstreaming issues.
Does the programme provide food supplements to all HIV positive mothers who have been advised not to breastfeed, with a major focus on those who are from food-insecure households?			✓	Insufficient funds
Does the programme provide psychosocial support to all HIV-positive mothers and attend to their specific concerns regarding side effects of ART, as well as stigma and discrimination?	✓			

Does the programme promote male involvement in PMTCT to reduce gender-based violence, stigma and discrimination?	✓			
Does the programme strengthen post-testing counselling and peer support by training HIV-positive people in lay counselling to provide PMTCT services in their communities?	✓			
Has the programme trained its health personnel to be responsive to the needs of HIV-positive pregnant women and their partners, as well as to the needs of adolescent pregnant girls, and does it do so using a rights-based approach?	✓			
Has the programme devised functional follow-up mechanisms through community-based programmes to reach out to HIV positive adolescent pregnant girls who may not attend clinics, as well as to all HIV-positive mothers who have gone through the PMTCT programmes after delivering their babies, in order to avoid rapid progression towards AIDS?			✓	Apparently it is not a priority issue to MCH

4.8.Overall guidelines for HIV programs in relation to gender in Zimbabwe

In addition to principles and standards that guide particular HIV programs in specific settings, the government of Zimbabwe provides some overall guidelines governing all healthcare providers in the country. The guidelines are provided through key policy and strategy

documents that serve as 'operational blue prints for management of HIV/AIDS(*ZWRCN*[32], 2003:4) . These documents include the National HIV and AIDS Policy for Zimbabwe 1999, the Zimbabwe National HIV and AIDS Strategic Plan (ZNASP) 2015-2020 and the Extended Zimbabwe National HIV and AIDS Strategic Plan (ZNASP) 2015-2020 as well as the Zimbabwe Public Services HIV and AIDS Implementation Strategy. These documents provide an overall standpoint of the Zimbabwean government in management of HIV including dealing with HIV in connection to gender issues.

The National HIV and AIDS Policy for Zimbabwe 1999 presents some principles that guide the formulation of the policy in relation to gender. The policy is guided by a principle stating that 'human rights and dignity of all people, irrespective of their HIV status, should be respected and avoidance of discrimination against people living with HIV/AIDS (PLWHA) should be promoted' (*GOZ*[33], 1999:2). In addition to that, the policy pronounces that gender sensitivity and gender equality must be integrated into various policies(*GOZ*, 1999:2).

The National HIV and AIDS Policy for Zimbabwe 1999 also recognises the need to promote gender sensitivity through awareness campaigns among men and women so as to support 'communication and more responsible sexual relationships and to reduce gender violence'(*GOZ*, 1999:34). In that regard, the policy offers some strategies to enforce equal constitutional rights of both men and women in every area of life. The strategies include mobilizing men and women to question social norms that cause power imbalances, improving the status of women through education, recognizing the disadvantages of females and promoting family responsibility (*GOZ*, 1999:39).

The Zimbabwe National HIV and AIDS Strategy Plan 2015-2020 also reinforces mainstreaming of human rights and gender responsive approaches in AIDS planning and service delivery mechanisms. This includes responses to gender based violence and adolescent sexual and reproductive health rights'(*MoHCC*, 2015:26). It also fosters 'gender transformative approaches' noting that the success of the country in managing HIV is largely dependent on promoting the sexually excluded, and vulnerable people(*MoHCC*, 2015:51). In

[32] Zimbabwe Women's Resource Centre and Network
[33] Government of Zimbabwe.

light of this, all healthcare institutions in Zimbabwe including MCH are expected to adopt these principles in their own HIV policies and programs.

The Extended Zimbabwe National HIV and AIDS Strategy Plan 2015-2020 outlines nine core strategies designed to fight gender inequality and support reduction of gender related HIV effects. The core strategies include: empowerment of women and girls economically, gender mainstreaming in all areas of HIV response, enhancing information sharing, reinforcing holistic interventions, gender activities coordination and implementation, increasing male participation in HIV gender sensitive programs and sourcing some resources for mainstreaming of gender into the HIV programs(*MoHCC*, 2015:62).

The government of Zimbabwe also recognises the need for a more targeted response to highly vulnerable populations. The populations regarded as vulnerable span transgender people, sex workers, men who have sex with men and gay men (*MoHCC*, 2015:30). In addition to this, healthcare providers are compelled to recognise varied needs of women and men in relation to HIV and AIDS and to design programmes that address those gender disparities(*NAC*[34] and *ILO*[35], 2011:5). These principles are all encompassing in all HIV and AIDS programs and services at each and every healthcare facility in Zimbabwe including MCH.

4.9. Conclusion

This chapter presented a detailed description of key HIV and AIDS programs at Mashoko Christian Hospital, namely AHBC, ART, VCT, and PMTCT. The chapter also provided an assessment of the programs using the SADC Checklist for Measuring Implementation of the Gender Mainstreaming Guidelines in HIV and AIDS Programs. The next chapter will analyse the implications of the HIV programs to the healing ministry as part of the all-inclusive *missio Dei*. It will engage the missiological and feminist lenses, as described in chapter two, with a view to identify the probable existing gaps in each of the selected HIV and AIDS programs provided at Mashoko Christian Hospital.

[34] National AIDS Council
[35] International Labor Organization

CHAPTER FIVE

ANALYSIS OF THE FINDINGS

THE ALL-INCLUSIVE *MISSIO DEI*

5.1. Introduction

The preceding chapter presents a detailed description of key HIV and AIDS programs at MCH namely AHBC, ART, HTC, and PMTCT. The chapter also provides an assessment of the programs using the SADC Checklist for Measuring Implementation of the Gender Mainstreaming Guidelines in HIV and AIDS Programs. The evaluation aims at checking whether the institution is doing enough to promote gender justice in the HIV and AIDS programs as stipulated in the SADC Checklist for Measuring Implementation of the Gender Mainstreaming Guidelines in HIV and AIDS Programs.

This chapter analyses the research findings and the implications of the HIV programs within the framework of an all-inclusive *missio Dei*. As previously indicated this chapter engages the missiological concept of all-inclusive *missio Dei* and the feminist concept of human dignity for all, as lenses to affirm some achievements and to point out some gaps in the HIV and AIDS programs provided at MCH. The chapter further analyses the praxis of the Church of Christ in their medical missions in view of the some elements of the all-inclusive *missio Dei*.

5.2. An Overview of the findings

The assessment of AIDS programs at MCH in chapter four highlights three main outcomes. First, is that there are several areas where gender mainstreaming has been implemented. In these areas, according to *SADC* (2011:4), it is considered that gender justice is attained. In this respect, the Church of Christ has shown some elements of inclusivity and respect to human dignity of both men and women. However, there is need to continually monitor the program areas to sustain the existing achievement. Therefore, it can be said that the Church of Christ is working in tandem with the spirit of all-inclusive *missio Dei* in some areas of its HIV and AIDS programs at MCH.

Secondly, there are also numerous areas in which the assessment has shown that gender mainstreaming is not being implemented and, consequently, they 'require high priority attention'(*SADC*, 2011:4) from MCH policy makers, since gender justice is not yet attained. In such areas, the church is not demonstrating their commitment to inclusivity as well as respect

to human dignity for all. In that respect, the programmes as are presently designed at MCH tend to be working against the all-inclusive *missio Dei.*

Thirdly, the study also shows that there are some areas in the HIV and AIDS programs at MCH where gender mainstreaming is still in progress. Those areas, according to *SADC* (2011:4) call for secondary priority for gender mainstreaming since gender justice is still being instituted. Therefore, it can be said that MCH, in this regard, is still working towards a missional approach that is both inclusive and respectful of human dignity of both men and women. Hence, the church is still working on the all-inclusive *missio Dei*.

5.3. Achievements and gaps in the programs

In light of above stated outcomes, there are several implications for the Churches of Christ's medical missions considering that the church is committed to this dimension of the all-inclusive *missio Dei*. The implications guarantee an analysis of the gender justice achievements and gaps in the following program key areas: guiding policy and strategic framework, monitoring and evaluation, service delivery, institutional coordination, service decentralisation, financing and uptake of the program.

5.3.1. Guiding policy and plan for HIV and AIDS programs at MCH

It has been established that MCH does not have its own written policy tailored to the national policy to address gender disparities in carrying out the HIV and AIDS programs at their institutions. Instead, the personnel at MCH are guided by the national policies and guidelines on HIV and AIDS programs. However, in as much as the national policy and guiding standards promote gender justice, they also bear some gaps in that regard. Indeed, the National HIV and AIDS Policy of Zimbabwe of 1999 and other government documents pay attention to gender issues and promote gender sensitivity in the prevention, management and treatment of HIV and AIDS in the country. For instance, as indicated in chapter four, the national policy respects the 'human rights and dignity of all people' and promotes gender sensitivity through awareness initiatives and campaigns and targets highly vulnerable populations such as men that have sex with men (*GOZ,* 1999:2. The policy also recognises the right of each individual to consent or object to HIV testing. To some extent, all these positive aspects in the policy are in accord with the theory and praxis of the all-inclusive *missio Dei*.

However, it is evident that 'gender equality continues to be treated as a side-line issue not worthy of national priority' (*ZWRCN*, 2003:5). As noted by *ZWRCN* (2003:5), the national HIV and AIDS policy does not acknowledge the fact that most care givers are women and

there is ‘ no legal provision for women in relationships to protect themselves’(*ZWRCN*, 2003:8). In addition to that, the policy document does not elaborate on the gender disparities in the effect of HIV and AIDS in order to facilitate ‘definition of relevant stakeholders groups, their gender characteristics and [varied] practical and strategic needs’(*ZWRCN*, 2003:9). Use of such a policy that has so many loops of gender justice, is at variance with the spirit of the all-inclusive *missio Dei* because the loop holes of the policy will undermine efforts towards equity.

By, and large, the fact that neither the Church nor the hospital has a written policy tailored to the national policy in relation to gender and HIV issues bears some negative implications. It probably suggest that gender issues at MCH are of secondary importance. It may also imply that the Church of Christ in Zimbabwe does not perceive gender issues as missional issues that are worthy to give high priority. In light of that, the government, in this case, which owns the policy, may be credited for all the gender-mainstreaming efforts in the HIV and AIDS programs at MCH. Hence, the absence of a written policy on gender and HIV issues at MCH seem to undermine elements of inclusivity in their healing ministry.

5.3.2. Monitoring and evaluation

There is some ambivalence in the outcomes regarding monitoring and evaluation of the HIV and AIDS programs at MCH. The evaluation system of the programs involves keeping of records with gender specific indicators showing disparities in the impact of HIV and AIDs on both men and women. Again, the management of information systems involve gender variables showing the disparity in the management of HIV and AIDs at MCH. However, some of these statics are just kept for the sake of record keeping and it seems very little is being done to correct the disparities that could have been brought out by the records. This is also at variance with all-inclusive *missio Dei*, since there is very little effort to enhance inclusivity and respect of equal dignity.

It is only in the ART/ OI program where an electronic system has been developed in order to collect data for use in analysing sex and age, disaggregated information for diagnosis, health seeking, access to health services and treatment adherence. The rest of the programs are monitored on manually managed records such as monthly progress reports, client registers and tally sheets. In that regard, there is still a need to build the relevant monitoring and evaluation system of the HIV and AIDS programs in relation to gender and strategic needs. It is also essential for the institution to build the capacity of the relevant staff capable of enhancing

gender sensitivity in monitoring and evaluation of all the HIV and AIDS programs. Thus, the church of Christ is apparently lagging behind in enhancing inclusivity and respect to equal human dignity in this area of its HIV and AIDS programs.

5.3.3. Service delivery in the programs

With regard to service delivery, it has been shown that there is promotion of gender balance on issues pertaining to prevention, control, care and support. It is an overarching principle especially for couples that they should be encouraged to mutually participates in fighting the effects of the pandemic. Again, in all of the for programs there is promotion of ' female based control methods' (*SADC*, 2011:9) such as female condoms. These constitute some positive elements that concur with an all-inclusive healing ministry in the service delivery of the HIV and AIDS programs.

However, there is no deliberate engagement of the church or the hospital with the community and traditional leaders specifically to fight the prevailing social and cultural factors that reinforce gender disparities and vulnerability of women and men. MCH is still building on integrating sensitivity and awareness activities, such as campaigns and outreaches. Although the hospital facilitates some other outreach programs, such as evangelism, oral health and VMCC outreaches, there are no deliberate intentions to deal with gender issues. There are no initiatives to stimulate awareness of crucial issues such as sex and sexuality, gender-based violence and their impact to the scourge of the pandemic. In this regard, these missing elements tends to undermine inclusivity and the realisation of a holistic approach to fighting HIV and AIDs in the medical missions of the Church of Christ.

5.3.4. Institutional coordination

In all the HIV and AIDS programs at MCH, there is evident coordination of the institution with other relevant stakeholders, such as the MoHCC and other organisations that support women health such as ZACH[36], PSI[37], and SAFAIDS[38]. However, there is need to engage more with organization especially those that particularly advocate for women's rights such as WASN[39] Zimbabwe and ZWRCN[40]. The institution has built a remarkable strategic partnership with other stakeholders that can influence gender-mainstreaming policies, especially in the PMTC,

[36] Zimbabwe Association of Church-Related Hospitals.
[37] Population Services International
[38] Southern African HIV and AIDS Information Dissemination Services
[39] Women and AIDS Support Network
[40] Zimbabwe Women's Resource Centre and Network

ART and HTC. As a result, in these particular programs there is continual assessment and resource mobilisation to address gender dimensions of HIV and AIDS. The door is open for any other relevant organisations that intend to partner in supporting men and women's health care initiatives and their fight against HIV and AIDS. There is no doubt that this multi-sectorial approach heightens effective control and management of the gender dimensions of HIV and AIDS challenges. In turn, this enhances inclusivity and holism in the Church of Christ's approach to medical missions.

Conversely, MCH has not established gender focal points that specifically deal with gender issues. The institutions have not created coordination committees to oversee gender issues in the implementation of HIV and AIDS programs. There are several focal points for other issues, such as diseases that include Malaria and TB, but not in relation to gender issues. The absence of the coordinating committee or focal persons that particularly look into gender issues at MCH entails that gender sensitivity is still regarded as a marginal issues. The absence of committees on gender issues confirms that MCH lacks functional structures that can draft policies to co-opt elements that realise gender sensitivity and inclusivity in the implementation of medical missions at the institution.

5.3.5. Community mobilizations

MCH has developed a base to spread information and education on HIV and AIDS programs but has not taken similar steps to address negative gender stereotypes. There is, of course, progress in the promotion of information dissemination in the programs evident in the health education sessions MCH offered to every client or patient coming to them, even for services outside HIV programs.

However, very little is being done at MCH in terms of community-based interventions to raise awareness and to transform prevalent androcentric norms in the society. There is still a great need to encourage men and women to take responsibility for the wellbeing of their families on issues pertaining to gender and HIV and AIDS. In that regard, MCH is not facilitating open discussions in the surrounding community on gender based violence and discrimination that is usually associated with HIV and AIDS. In turn, it derails equal involvement of men and women in community mobilizations and knowledge increase on gender dimensions of HIV and AIDS. Thus, it also sabotages an inclusive and holistic approach in Church of Christ medical missions.

In spite of the fact that MCH has information materials that educate people on HIV and AIDS program, however, it has not yet developed specific information targeting fathers, mothers,

adolescent boys and girls. In this respect, there is still need for MCH to build its capacity on gender information dissemination if the church has to be truly engaged in the all-inclusive *missio Dei*.

5.3.6. Capacity building for gender mainstreaming

Gender mainstreaming capacity activities at MCH are still in progress. MCH has a nursing training school and, in a bid to promote further understanding and a better appreciation of gender dimensions, the school recently introduced gender studies in its training curriculum. In this regard, gender sensitisation on HIV and AIDS programs begins in the training of Health personnel at MCH. However, there is still need to improve these efforts since all other personnel outside the nursing profession are not yet involved. In this respect, the Church of Christ in Zimbabwe is still lagging behind in its efforts to realise inclusivity in the HIV and AIDS programs that are offered in the medical missions at MCH.

5.3.7. Decentralisation of program services

In a bid to promote the accessibility of the HIV and AIDS programs at the hospital, MCH has decentralised some of the programs such as ART and HTC services to other surrounding clinics namely, Odzi, Mukanga, Gava and Nyangambe. These clinics assist in the areas further than MCH's catchment area. A number of services within those programs including, diagnosis, counselling, and treatment programmes that are now easily available in those areas and it turn a larger population can access the services. In addition to that, the decentralisation of these services greatly assist in easing financial constraints to those that cannot afford to afford some costs like transport fares. Again, that lessens the burden for MCH and in turn improves the efficiency of the institution in its operations. These efforts are in tandem with the spirit of all-inclusive *missio Dei* since they promote inclusivity in the HIV and AIDS programs.

5.3.8. Financing gender mainstreaming

In so far as the information that has been availed to this study, there are no records at MCH that show a budget set to directly finance mainstreaming of gender in the HIV and AIDS programs. However, the administration provides a higher portion of financial support to the antenatal services. In addition to that, the institution has implemented sourcing of resources for the maternal services at the institution. Those efforts turn advance an indirect financial support of gender mainstreaming activities in the PMTCT program since the program is part of maternal services. However, there seem to be no budget that is particularly set for gender mainstreaming in the rest of the programs. This seem to suggest that gender mainstreaming is

still being viewed as a secondary issue in the medical missions at MCH. This is against the spirit of all-inclusive *missio Dei*.

5.3.9. Uptake of the programs

In all the selected programs, ART, AHBC, HTC and PMTCT, there is disproportional uptake of the program. Generally, the programs at Mashoko are serving more women and children than men. There are several factors behind that but it is chiefly because in programs such as PMTCT and PITC, women are compelled to go through the program when they come for antenatal clinic services. In all other programs where one has a choice to or not to access the services, men are also relatively fewer. There is general increase of both men and women in the uptake of the program over the years since the inception of the first HIV and AIDS program at MCH. However, there are no records of LGTBQI people coming to access the services in all of the programs despite the fact that they are regarded as target populations in the HIV and AIDS National Policy. The absence of LGBTQI people on record does not necessarily indicate that the society does not have such people, instead it suggest that there are some factors impeding them to disclose. Again, that may mean that the institution is overlooking the necessity to address that misnomer. This undermines efforts towards inclusivity in the medical missions of Church of Christ at MCH.

Some socio-cultural factors continue to affect gender balance in the uptake of the HIV and AIDS programs offered at MCH. For instance, negative cultural perception towards LGBTQI people make it difficult for them to come out in the open in order to get appropriate assistance. The impact of such cultural perceptions is evident in the absence of records of LGBTQI people coming to access the program services. This could be just a tip of the iceberg; numerous more challenges of the same kind are quite possible. In that regard, the Church of Christ still has a long way to go in promoting openness and supporting such people as well as in fighting against discrimination and stigma that is usually associated with the LGBTQI people.

Education plays a pivotal role in matters pertaining to gender and HIV and AIDS in the Mashoko community. The program records and reports show that both men and women who have better education are making informed decisions concerning their personal health as well as in issues of gender and HIV. On the other hand, people with lower levels of education have difficulties in making choices even in their personal health matters.

5.4.The church's praxis in light of the elements of all-inclusive *missio Dei*

As highlighted in chapter two, there some elements that buttress the all-inclusive *missio Dei* namely: inclusivity, transformation, comprehensive salvation, integral liberation, evangelism and justice, and equal human dignity. In light of these elements, this section discusses the praxis of the Church of Christ in their medical missions at MCH.

5.4.1. Inclusivity

As discussed in chapter two of this study, medical missions are a dimension of the all-inclusive *missio Dei*. It is also pointed out that, as Bosch (2011:28) notes, the all-inclusive *missio Dei* dissolves boundaries of alienation and hostility between people. Therefore, church in all its endeavours should affirm inclusivity in a manner that resist distinctions between men and women and other walls of alienation and oppression. This offers an imperative for the Church of Christ in Zimbabwe to uphold inclusivity in its praxis, including its operations in the HIV and AIDS programs that are offered as part of medical missions.

In addition to that, the inclusive missio Dei compels the church to take care of the vulnerable, such as the women, children, widows, LGBTQI people and orphans. That is a well and clearly stated mandate of the church (Matthew 25:40-45). Nevertheless, there are several detrimental and retrogressive cultural aspects in society that seem to undermine this purpose of the church. Those negative aspects promote the blows of HIV on the vulnerable people. In agreement, le Roux (2012: 54) argues that some cultural practices are continuing unopposed because the Christian faith embraces the prevailing cultural views on gender and sex. Some of these cultural beliefs place women in positions of subjugation to men. Consequently, the Church of Christ should uphold a mission theology that promote inclusivity. It should affirm the notion that in Christ all walls of hostility and alienation between individuals are of no relevance as expressed in Galatians 3:28,

> There is neither Jew nor Greek, slave nor free, *male nor female*, for you are all one in Christ Jesus. If you belong to Christ, then you are Abraham's seed, and heirs according to the promise.

The church becomes a beacon of inclusivity in which discrimination based on gender or any other forms of social differences is out of place.

However, this may not be the picture portrayed in most churches. The way in which scriptures are understood and interpreted in most churches does not place men and women on an equal footing. Phiri (1997:12) points out that women in most African churches cannot be in

leadership positions because they are not allowed to command authority over their male counterparts. Thus, patriarchy in African churches is promoted by a misinterpretation of the Bible (Phiri, 2002:20). Although it is evident that the Church of Christ at MCH is, to some extent, promoting gender justice in the HIV and AIDS programs, it is also apparent that the issue is still being taken lightly.

The absence of an institutional policy that reinforces gender justice, and very few women in the decision-making positions at MCH, are prime indicators that the church is not actively involved in fighting patriarchal practices and forms of gender injustice. In addition to that, the fact that very few men are coming for the HIV services at MCH and that very little is being done to correct that, shows that men and women are not treated as equals. This is being taken lightly at the institution as well as in the community from which the men and women come. In other terms, it entails that the Church of Christ is not viewing the issue of gender injustice in the community as a missional matter that should be given priority.

While it may not be an easy task to establish a fair uptake of the HIV and AIDs programs at MCH, it takes an inclusive missional approach to promote justice among the marginalised and the vulnerable. The fact that women in Mashoko community do not have full autonomy regarding issues of their health calls for deliberate actions by the church to try and correct that injustice. If the church implements relevant measures to facilitate justice, it will go a long way in fostering a conducive environment for the vulnerable. It is also important for the Church of Christ to take cognizance that women are the most active group of people in the church and the community and, as such, their involvement is pivotal in the alleviation of the pandemic.

Undoubtedly, there are some elements of inclusivity in the Church of Christ's medical missions at MCH as expressed in efforts towards gender justice in the HIV and AIDS programs offered at the institution. The elements of inclusivity are in line with the all-inclusive *missio Dei.* They enhance disbanding of some forms of gender related alienation and discrimination that perpetuate the impact of the pandemic among individuals and the society. In that regard, the church is moving towards the all- inclusive *missio Dei.* However, these inclusive elements are still minimal considering some important areas of gender imbalances that are being overlooked in HIV and programs at MCH. In light of that, the Church of Christ should regard gender issues as missional challenges that require the Church's attention and effort.

5.4.2. Comprehensive salvation

In chapter two, it is noted that the all-inclusive *missio Dei* involves mediation of comprehensive salvation that aims at redemption of *all* people and in *all* the facets of their lives. As such, the church should ensure that they are facilitating a 'comprehensive' or 'total' salvation in their missions (Bosch, 2011:409). As Slater (2015:124) also asserts that all people, male and female are equally in need of salvation. However, the key question might be how the church can mediate that comprehensive salvation in a community where people are not placed in a position of equal standing. The church should be able find an approach to handle a society that excludes some of its members on the grounds of gender and sexuality issues in order to reach its goal of mediating a comprehensive salvation.

In addition to that, a comprehensive salvation takes into account what Bosch (2011: 409) calls 'the *totus Christus*' which encapsulates the essence of all the Christological elements, namely, life, death, resurrection and second coming. These are indispensable for today's church. In light of this, the church in it missional endeavours is driven to arbitrate salvation both this life, 'present salvation' and the future salvation (Bosch, 2011:403). The present salvation involves liberation from a diverse range of human circumstances that include illnesses, oppression, injustices and any others earthly infirmities. On the other hand, the future salvation implies the coming triumph of God's reign. Hence, redemption in all dimensions should be central to the church's missional efforts including the medical missions.

In analysing the praxis of the Church of Christ medical missions at MCH in line with comprehensive salvation as a missional lens, the church is relatively mediating salvation in all facets of human life. In as much as there are some aspects of holism in the MCH's approach to the HIV and AIDS programs, there are also significant gaps which show lack of it. For instance, the fact that there is completely no record of LGBTQI people coming to access all of the HIV and AIDS programs at the institution does not necessarily imply that there are any such people in the community.

Rather, this is informed by the community's as well as the Church's perspective about that group of people. It may entail that the LGBTQI people are negatively perceived in the community to the extent that they cannot openly come out and the church is doing very little about it. Indeed, there could be some factors behind that, such as the punitive laws of the country and cultural perceptions against some sexualities, but the church would purposefully create conducive environments for them to come out in the open and get relevant services. In

that respect, the church would be able to facilitate redemption of such people from societal ostracism and discrimination that is usually associated with the LGBTQI.

Despite the fact that the Church of Christ, through medical missions at MCH, is trying to involve both men and women in AHBC, ART, HCT and PMTCT programs, the general uptake of the programs by men is still very low. However, the church is doing very little as part of corrective measures to those gender disparities, yet God's perfect missio is centred on redeeming the entirety of humanity. In light of that, the Churches of Christ should reinforce efforts to mediate a complete salvation in line with that perfect mission of God. This also entails that those efforts should be evident in the praxis of the church's medical missions and their approach to social ills, such as the gender injustice and the HIV pandemic.

5.4.3. Integral liberation

As discussed in chapter two, the theology of liberation finds its basis on the apostolic tradition and is a serious endeavour that makes faith relevant in the postmodern era (Bosch, 2011:458). In agreement with these perspectives, it has been noted that Christian mission should mediate an integral liberation in order to champion the cause of the oppressed and vulnerable. Therefore, it sets an imperative for the church, through missions, to promote liberation of the people including those that endure gender injustice as well as those that are affected and infected by HIV and AIDS.

This study has shown that while HIV and AIDS programs offered at MCH promote gender sensitivity to a certain extent, gender disparities in relation to prevention, care, management, treatment as well as the effects of the pandemic are still very significant in the community. Challenges such as low program uptake by men, low support for affected and infected women, inadequate capacity to cover gender issues, absence of gender focal points and several other related problems at MCH are an indication that the Church of Christ still have a long way to go to promote gender justice. In other terms, MCH is offering services to people who still need a great deal of libation in issues pertaining to gender and HIV and AIDS in as much as they would need spiritual redemption.

As Oduyoye (2001:37) also observes that in general gender injustice continues to prevail in the community as well as in the churches, and Mashoko community is not an exception. Oduyoye (2001:38) also notes that the gender injustice is not only perpetuated by patriarchal social systems but also by other cultural beliefs and practices such as taboos, folktales and proverbs. In addition to that, it is also fuelled by lack of education and misinterpretation of scripture in

churches (Rutoro, 2015:318). All these factors would be aggravated if there is lack of understanding of the element of liberation in the all-inclusive *missio Dei*. All this underscores the need for the Church of Christ at Mashoko mission to facilitate an integral liberation of people from every type of subjugation spanning, patriarchal social system, detrimental cultural beliefs, lack of education and oppressive and contrived interpretation of scripture.

According to Ackermann (1993:28), the liberating praxis is a continuous fight against 'oppressive structures that exploit people and rob them of their full humanity'. In that respect, the church should endeavour to establish alternative relations and structures which will promote 'the reign of God as expressed in justice, love, freedom, equality, wholeness and shalom' (Ackermann, 1993:28). In keeping with this notion, the Church of Christ in Zimbabwe should be prophetic in its missional efforts and seek to liberate the oppressed in the community. However, based on the findings in relation to gender and HIV programs offered at MCH, the church is involved in providing relief and charity services but is doing very little to champion the cause of the oppressed and vulnerable of it society.

A critical analysis of the medical missions of the Church of Christ's medical missions at MCH using the liberating praxis as a lens brings out that while the church is promoting gender justice in the HIV programs, there is still a long way to go for the church to establish alternative relations and structures to foster its efforts. For instance, in all the programs, there is collection of sex aggregated data but very little is being done to set up systems and practical interventions that will resolve the disparities shown in records.

Even though the hospital personnel provides some teachings on HIV and AIDS in health education sessions, not much is taught against traditional and cultural practices that undermine women and such groups of people like the LGTBQI. Hence, the culture of putting women under positions of subjugation and discrimination of the LGBTQI people is still prevalent in the community. For instance, when a husband dies of AIDS, the community still blames the wife for having infected the man. Again, if one discloses their gender as one of the LGBTQI people, the person faces intense discrimination. There is need for the Church of Christ to scrutinise the contexts of these challenges and ascertain why these unjust practices persist. The church should then in line with the liberating praxis of the all-inclusive *missio Dei,* intensify its efforts in seeking alternative systems to address those oppressive practises.

Chilongozi (2017:12) proposes that 'a clear understanding of cultural hermeneutics' is instrumental in liberating African women. Cultural hermeneutics is defined as 'the analysis and

interpretation of how culture conditions [influence] people in understanding of reality at a particular time and location'(Kanyoro, 2002:7) . In light of this, the Church of Christ should make effort to understand and address the negative cultural practises in order to liberate the women and the LGBTQI people who are suffering the double blow of the oppressive culture as well as the scourge of the pandemic.

Several other traditional and cultural practices, such as early and polygamous marriages, are still common in the Mashoko community. Such harmful practices also deny women autonomy and rights and in turn promote the risk HIV infection to both men and women. Thus, despite the running of HIV and AIDS programs at MCH, positive efforts towards alleviating HIV are weakened by such anomalies. Therefore, the Church of Christ should uphold a liberating praxis and redeem the people from cultural and traditional practices and the fear that keeps them under bondage.

Furthermore, as noted in chapter two, the theology of liberation negates the attempts to address the negative health and social consequences accruing from the people's lack of liberation while ignoring the causes of their state of oppression. The most informative example to explain this phenomenon requires to consider what happened in in the rise of liberation theology. During that era, the Third World resisted the attempt by the First World to prescribe poverty eradication initiatives in the Third World by pouring technological resources while ignoring the economic injustice of colonialism, capitalism and imperialism that was then the evident cause-root of poverty ((Bosch, 2011:445). Similarly, the problems of Mashoko community requires the church to look into the causes of the challenges. This, therefore, underscores the imperative for the Church of Christ to intensify efforts towards uprooting the causes of gender injustice in the community rather than dealing with its effects alone. As, Banana (1990:95) would say, the 'church should start to change the content and character of its mode of witness' and begin to 'formulate new theological concepts and ways of understanding faith in concordance with liberating praxis of underprivileged'.

5.4.4. Evangelism and social justice

Chapter two also discusses, explains and illustrates that the efforts for evangelism and social justice are strongly married to each other. Bosch (2011:411) demonstrates that justice is key in the prophetic tradition of the Old Testament. In addition to that, the 'spiritual gospel' and the ' material gospel' were but a single entity in Jesus's ministry (Bosch, 2011:418). According to Heldt (2004:151) the relationship between social action and evangelism, also known as

'holistic mission' is what the 1974 Lausanne Covenant, expressed as ' biblical integration of evangelism and social action, word and deed, proclamation and demonstration'. Thus, as Michael Frost states, the two, evangelism and social justices are 'interdependent activities of the church' and they can be rightfully described as 'two interlocking cogs of mission'[41]. Therefore, the praxis of justice and evangelism belong together.

Ideally, the church has an obligation to proclaim what John Mott describes as the 'whole gospel' (Mott cited in Heldt 2004:151). In that respect, all church related institutions, such as hospitals, schools, orphanages and old people's homes are, in the words of (Heldt, 2004:151), not only agencies of evangelization' but they are in themselves 'evangelisation'. Hence, the Church of Christ in Zimbabwe should view its medical evangelism at MCH and other related institutions as evangelisation aiming to address both the physical and the spiritual needs of the people.

In analysing the praxis of the Church of Christ in line with evangelism and social justice as integral elements of the all-inclusive *missio Dei,* it is evident even in the hospital's motto, 'We preach, teach and heal!' (Mudzanire, 2017:25), that the church is aware that they should offer a holistic ministry. The motto is actually a claim that they offer a ministry modelled in line with Jesus' threefold ministry that encompasses preaching, teaching and healing (Matthew 9:35).However, there is still a long way to go in the Church's efforts to promote social justice in issues of gender and HIV and AIDS. As demonstrated in the findings of this study, MCH does not yet recognise gender issues as missional. Yet the church's redemptive mission involves rectifying unjust relationships as well as 'creation and restoration of right relationships' that are based on biblical principles (*JC*[42], 2018:2).

As modelled by Christ and the New Testament church, the 'living word must not only be proclaimed but actively lived out with our good deeds following a compelling demonstration of confessed faith' (*JC*: 2018:1). In other terms, the gospel is best received when it is not just in form of word but it is also put into practice.(Chitando and Chirongoma, 2013:10) assert that the churches' effort in fighting gender justice must 'go beyond mere verbal articulation'. It must also be reflected in the manner in which theological institutions approach issues of gender. In that regard, the Church of Christ is still lagging behind on issues of demonstrating their approach on gender issues.

[41] Source https://mikefrost.net/the-interlocking-cogs-of-social-justice-and-evangelism/
[42] Jubilee Centre – http://www.jubilee-centre-org/

The praxis of justice is closely related to the praxis of liberation and they both set an imperative for the church to have a commitment in fighting the social ills of the community, such as oppression and abuse. It upholds the understanding that 'to know God is to do justice' (Gutierrez cited in Ackermann 1993:26). In light of that, Church of Christ in their medical missions at MCH is compelled to fight the demeaning patriarchal practices that intensify women oppression and abuse in the community as well as perpetuating the scourge of the pandemic. Hence, justice becomes 'a theological hermeneutic for the proper understanding of spirituality' (Ackermann, 1993:26-27).

According to Heldt (2004;153) the earthly ministry of Jesus, on which all other Christian missions should be modelled, is replete with examples of a holistic mission. A good case of such is expressed in Luke 4:18-19,

> The Spirit of the Lord is on me, because he has anointed me to preach good news to the poor. He has sent me to proclaim freedom for the prisoners and recovery of sight for the blind, to release the oppressed, to proclaim the year of the Lord's favour.

In the above passage, Jesus expresses a holistic understanding of the multidimensional human life (Heldt, 2004:155).According to that passage there are four key dimensions of human life being addressed in the ministry of Jesus namely, the physical (as entailed by 'eyesight to the blind'), the economic (as entailed by 'good news to the poor'), the social (as entailed by 'release of the captives') and the spiritual (entailed by 'liberty to the oppressed'). In light of Jesus' understanding of ministry, the church's praxis should deal with the entirety of human life. Heldt (2004:156) demonstrated interconnection of the four elements of human life through interlocking circles as shown below:

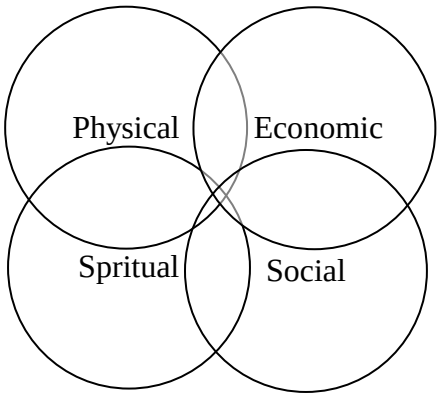

Figure 2.The four interlocking elements of human life human life (Heldt, 2004:156)

According to (Heldt, 2004:156) the key elements of this model elaborate that the four dimensions of human life are interrelated. In essence, it is impossible to deal with one without affecting the three others. One can safely say, therefore, that if the dimensions of one is addressed, the impact is also distributed to the rest.

In relation to evangelism and social justice, Luke's gospel looks at 'human life in its totality'(Heldt, 2004:158) and shows the necessity of a holistic ministry. Hence, the mission of the church should include these dimensions. This underscores the need for the Church of Christ in Zimbabwe to be holistic in their missionary approach including in the HIV and AIDS programs that are offered in their medical missions. One way of dealing with the social needs of the people in issues of gender and HIV would be to challenge the patriarchal social systems. Economically, the church may serve the community by deliberately budgeting for resources and programs that are designed to promote gender justice. However, the church can be credited for covering the spiritual and the physical as evidenced in the provision of ART and preaching of the gospel to their clients

5.4.5. Transformation

It has been discussed in chapter two, that the all-inclusive *missio Dei* can be viewed from the perspective of transformation. As Samuel and Sugden (1999:28) observe, one of the important responses to Christian mission is to see 'missions as transformation'(Samuel and Sugden, 1999:28). In that respect, transformation is defined as 'the change from a condition of human existence contrary to God's purposes to one which people are able to enjoy fullness of life in harmony with God' (Samuel and Sugden, 1999:28).

This perspective of mission fits squarely with the view of mission as expressed by Price and Richards (2013:19) as the 'work to transform world into a picture of God's desire for humans'. From this viewpoint the notion of transformation implies, 'a means of introducing people to Christian faith by changing the environment around them, offering empowerment, voice and autonomy'(Price and Richards, 2013:19). It is has been shown, therefore, that it is the church's missional mandate to see that the environment of the society is conducive for sharing of the faith as part and parcel of the transformational process. As a result, 'transformation is required at various levels, including an address to unjust structures' (Price and Richards, 2013:20). The ultimate goal of transformation being, thus, to bring people into a standard of life that is desired by God.

In light of the perspective of Christian mission as transformation, there is no doubt that the Church of Christ at Mashoko mission is trying to create an environment that may be described as 'God's desire for humans' through provision of the HIV and AIDS programs and other medical services. These medical services that are being provided by the church's ministry contribute to the physical wellbeing of people, a condition that promotes reception of the gospel and ultimately leading to a transformed life.

However, as indicated in chapter four, the church overlooks some conditions that significantly undermine efforts of transformation. There are some condoned aspects of gender injustice in the HIV programs at MCH that disempower men and women instead of giving them 'empowerment, voice an autonomy' (Price and Richards, 2013:19). For instance, it has been discussed that the national policy for HIV and AIDS does not have a provision for women in relationships to protecting themselves when they suspect that they are at risk of contracting HIV. It has been also noted that the LBTQI people in and around the Mashoko community cannot freely disclose their sexualities because of the cultural negative perceptions and challenging legal environments in the community. These are serious issues that, when left unattended, may undermine the efforts of gender justice in the HIV programs at MCH. All these underscore the need for the church of Christ in Zimbabwe to scale up their efforts in trying to transform the environment of the society in order to make it more conducive for the sharing of the faith.

It can be argued, as Price and Richards (2013:19) note, that 'social transformation requires a concomitant desire for the spiritual welfare of human beings in order to ensure that they are enabled to grow and flourish'. It is, thus, arguably necessary for the Church of Christ through its medical missions at MCH to account gender justice as a missional issue that, if attended to, would greatly improve the preaching environment and promote spiritual growth as well as better quality of the lives of men and women in the community.

According to Dzubinsiki (2012:332) the message of the gospel in itself is a message of transformation and it aims at full transformation of individuals, families, relationships, organizations and communities. However, social injustice continues to plague the society despite the permeation of the gospel in the societies. Dzubinsiki (2012:332) believes that persistence of injustice, despite the message of the gospel, is because the society lacks the transformation that comes with the gospel. Hence, Dzubinsiki (2012:332)urges that mission organisations to seek ways to bring about 'transformation that does good for women, for men,

for society and for the spread of the gospel'. As a mission organisation, one of the ways in which MCH would promote such benevolent transformation to men and women of Mashoko community is to seek gender justice in their HIV and AIDS programs.

5.4.6. Human dignity

As discussed in chapter two, gender justice is an expression of respect to human dignity. Claassens et al. (2003:7) point out that the respect of human dignity is palpable in all the 'three religions of the book, Judaism, Christianity and Islam'. Rakoczy (1996:4) shows that the impetus behind the feminist theology and praxis is all for affirming women as fully human beings and that their human dignity must be respected as in all other humans. In the same accord, Koopman (2015:23) asserts that 'dignity is bestowed upon all human beings both male and female and for that matter also upon people with various sexual orientations'. Furthermore, the human dignity, as Reinders (2013:40) notes, 'is conferred upon each and every one of us because of our equal relationship with God'.

In agreement with the notion of divine conferment of human dignity, Webster (2006:24) notes that 'God crowns creatures with glory and honour, marking them out as the recipient of his approval, and setting them apart for fellowship with himself. Creation is exaltation; creatures have dignity as they are dignified by God'. As Koopman (2005: 20) also points out, this divine foundation of human dignity offers an imperative for the church to affirm and respect dignity. Therefore, the church of Christ is mandate to respect human dignity in its missionary endeavours.

According to Koopman (2015:21) the calling with regards to 'acknowledging and affirming, actualising and fulfilling dignity is to witness in word and indeed to the dignifying decisions and actions of God the creator'. In that light, the Church of Christ can be viewed as relatively fulfilling the mandate to acknowledge and affirm human dignity in its medical missions. In the program areas where gender mainstreaming is in place like in most areas of PMTC and HTC, it can be argued that MCH is acknowledging and affirming the dignity of both men and women by placing the on an equal standing in terms of accessing the services of the programs.

However, in all the areas that still need high priority in gender mainstreaming, the church can be viewed as neglecting the responsibility to promote human dignity. If the church, through its medical missions at MCH could regard gender issues an issue of human dignity and possibly play an active role in affirming the dignity of both men and women in their HIV and AIDS programs that could bring a big difference in the community.

Claassens and Spronk (2013:1-2)point out that even though the human dignity is 'inherent in all human beings regardless of race, class, sexual orientation, intellectual abilities, or other traits, this dignity is, however, a fragile dignity'. The fragility of dignity is seen in the 'conditional violation of human worth that affect individuals and communities'. In that regard, the church in its missionary endeavours should seek to protect the fragility of human dignity. One way in which the Church of Christ in Zimbabwe could protect the fragility the dignity of man and women in Mashoko community is through fighting the oppressive systems and structures that violate their rights. The church should scale up efforts to eliminate elements of alienation that betray men and women due to their gender or sexual orientation. These systems and structures fuel the impact of the pandemic and in turn they diminish the divinely conferred dignity of humanity. Thus, the church of Christ can play an active role in protecting the fragility of dignity by taking the issue of gender justice in relation to HIV and AIDS as an issue of dignity in which the church is mandated to protect and affirm.

The fragility of human dignity also entails that the church should seek 'freedom and justice for men and women' (Koopman 2015:27). Jones (2009:79-93) outlines five forms of subjugation that men and women should be liberated from namely: marginalization, powerlessness, exploitation, cultural imperialism and violence. All of the forms of oppression are evident in the Mashoko community. The church of Christ would assert the dignity of men and women in the community by finding ways to fight those forms of oppression through the HIV and AIDS programs as a missional tool. One way of doing so is to facilitate women empowerment programs in the church and the community. Women need to be empowered through various forms of empowerment spanning spiritual, intellectual and economic support. Furthermore, it would bring much difference if the church would work towards the freedom of marginalised sexualities such as those of the LGBTQI people and openly minister to their particular needs.

Koopman (2015:27-28) also notes that the 'equality in dignity' of men and women offers an imperative for the church to promote a joint participation of men and women in the quest for justice. This entails that the church should actively seek to create an environment that supports and necessitates involvement of both men and women in activities of empowerment such as in the access of education, health care services. This also accentuates the need for the Church of Christ to respect human dignity and foster joint participation of both men and women in decision making, policy implementation and service delivery in the various areas of medical missions including the HIV and AIDS programs.

Still on the issue of respecting human dignity. It has been indicated in chapter two of this study that *Ubuntu* affirms human dignity (Tutu, 1999:35) and is in tandem with the all-inclusive *missio Dei.* It has been also highlighted that is a very important ethical resource that can be used to address societal challenges such as the demeaning patriarchal practices that hurt women in the society (Chitando, 2015:280). In light of that, the Church of Christ in Zimbabwe may also make use of *Ubuntu* as an intervention to fight against gender discrimination, stigmatization and exclusion in relation to HIV and AIDS in their society. For instance, since people of Zimbabwe and particularly in Mashoko community uphold *Ubuntu* values, then it is a non-discriminatory cultural value that extend its warm hand to women and LGBTQI people who are being undermined in the society. In turn, the church will enhance inclusivity and respect of human dignity in its medical missions

By and large, gender justice in the HIV and AIDS programs that are being offered at MCH might be greatly enhanced if the Church of Christ would regard the issue as one of dignity that has a great bearing on an inclusive and holistic *missio Dei.* In all of the program areas where gender justices is still regarded as a secondary issue, the dignity of men and women is also being undermined. On the other hand, in all the program areas where gender justice is being esteemed, it follows that human dignity is being acknowledged and affirmed.

5.4.7. Conclusion

This chapter analyses findings of the study and the implications of the HIV programs to the all-inclusive *missio Dei*. The analysis outlines an overview of the findings, gender justice achievements and gaps in the Mashoko Christian Hospital HIV and AIDS program key areas namely: guiding policy, monitoring and evaluation, service delivery, institutional coordination, community mobilisation, decentralisation of health services, financing, and programme uptake. It engages the missiological and feminist lenses, as described in chapter two, to point out the probable existing achievements and gaps in each of the selected HIV and AIDS programs provided at MCH in relation to the all-inclusive *missio Dei*. The chapter further draws some missiological implications on the findings of the study with regard to theory and praxis of the healing ministry as a dimension of the all-inclusive *missio Dei*.

The next chapter constitutes the concluding elements of the thesis and it summarises the chapters of the entire study. It discusses some recommendations to the Church of Christ in Zimbabwe. The recommendations are meant to sustain and enhance gender justice achievements as well as proposing potential strategies to bridge the gender sensitivity gaps in

the HIV and AIDS programs at MCH and probably the rest of Zimbabwe. In so doing, the chapter also proposes areas for further research in the investigation of Christian mission in relation to gender and HIV and AIDS.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1. Introduction

This study explored how the HIV and AIDS programs offered in the medical missions of the Churches of Christ at Mashoko Mission are framed for a gender sensitive healing ministry as a dimension of the all-inclusive *missio Dei.* In that respect, the study investigates the nature or characteristics of the programs in order to determine how they possibly disregard the affected men and women in the society. Further, the study identifies some achievements as well as some gaps in relation to gender justice in the HIV and AIDs programs.

In light of those findings, the foregoing chapter gives an analysis and the implications of the HIV programs to the all-inclusive *missio Dei*. The chapter outlines an overview of the findings, gender justice achievements and gaps in the Mashoko Christian Hospital HIV and AIDS program key areas namely: guiding policy, monitoring and evaluation, service delivery, institutional coordination, community mobilisation, decentralisation of health services, financing and programme uptake. It engages the missiological and feminist lenses, as described in chapter two, to point out the probable existing achievements and gaps in each of the selected HIV and AIDS programs provided at MCH in relation to the all-inclusive missio Dei. The chapter further draws some missiological implications on the findings of the study with regard to theory and praxis of the healing ministry as a dimension of the all-inclusive missio Dei.

This chapter constitutes the concluding elements of the thesis and it summarises the chapters of the study. It presents conclusions on the adopted research approach. It also discusses some recommendations to the Church of Christ in Zimbabwe. The recommendations are meant to sustain and enhance gender justice achievements as well as proposing potential strategies to bridge the gender sensitivity gaps in the HIV and AIDS programs at MCH and probably to the rest of Zimbabwe. In so doing, the chapter also proposes further research in the area of Christian mission in relation to gender and HIV and AIDS. The chapter attempts to answer the following research question: *How could the existing gaps in the gendered nature of the HIV and AIDS programs be possibly addressed?* It is hoped that the answer to this question may lay the foundation for effective praxis in the all-inclusive *missio Dei* within the Church of Christ and perhaps in the Zimbabwean churches at large.

6.2. Summary of Chapters

The first chapter constitutes the introductory components of the entire study. The chapter provides background to the study, research motivation, research problem, research questions, research aim and objectives, research methodology, and limitations of the study. It also gives definitions of key terms and a brief overview of the chapters. This introduction provides the setting and context of the study by highlighting the importance of promoting gender justice in issues related to HIV and AIDS.

The second chapter reviews literature related to this study. It further clarifies the theoretical framework of the study. This literature review generally shows that gender is strongly associated with the spread and impact of the HIV and AIDS pandemic. It shows the importance of gender justice in relation to the alleviation of the impact of the pandemic, including the usefulness of religious resources and theological perspectives. It also delineates the strong link between missiological and feminist theoretical perspectives in relation to human dignity and gender justice. The gendered nature of HIV and AIDS, the need for evaluation of HIV and AIDS programs, and the role of the Christian healing ministry (medical missions) as part of an all-inclusive *missio Dei*, are major themes that are explored in the literature review. The chapter closes with a summary of its elements.

The third chapter briefly traces the historical background of the Church of Christ medical missions. It particularly gives a detailed overview of the medical missions at Mashoko Mission in relation to church's engagement in the HIV and AIDS programs provided at Mashoko Christian Hospital. It also highlights the Church of Christ's theology and practice of healing ministry. The chapter sheds light on the held beliefs, teachings and practices of the Church of Christ in relation to gender issues and HIV. This chapter also provides details of the context and setting in which the study is carried out, as well as giving a basis for the subsequent chapter.

The fourth chapter gives a detailed description of key HIV and AIDS programs at Mashoko Christian Hospital namely AIDS Home Based Care (AHBC), Antiretroviral Therapy (ART), HIV Counselling and Testing (HCT), and Prevention of Mother to Child Transmission (PMTCT). The chapter further gives an evaluation of the programs using the SADC Checklist for Measuring Implementation of the Gender Mainstreaming Guidelines in HIV and AIDS Programs. The evaluation aims at checking whether the institution is doing enough to promote gender justice in the HIV and AIDS programs as stipulated in the SADC Checklist for

Measuring Implementation of the Gender Mainstreaming Guidelines in HIV and AIDS Programs.

The fifth chapter is the penultimate part of the study. It gives an analysis of the implications of the HIV programs to the all-inclusive missio Dei. It engages the missiological and feminist lenses, as described in chapter two, to point out the probable existing gaps in each of the selected HIV and AIDS programs provided at Mashoko Christian Hospital. The chapter further draws some missiological implications on the findings of the study with regard to theory and praxis of the healing ministry as a dimension of the all-inclusive missio Dei.

As indicated in the introduction section of the current chapter, the sixth and final chapter constitutes the concluding elements of the thesis and it summarises the chapters of the study. It presents conclusions on the adopted research approach. It also converses on some recommendations to the Church of Christ in Zimbabwe. The recommendations are meant to sustain and enhance gender justice achievements as well as proposing potential strategies to bridge the gender sensitivity gaps in the HIV and AIDS programs at MCH and probably to the rest of Zimbabwe. In the end, the chapter also proposes further research in the area of Christian mission in relation to gender and HIV and AIDS.

6.3. Conclusions on the adopted research approach

As previously stated, this study adopted a qualitative non-empirical approach to interrogate documents and other related literature on HIV and AIDS programs at MCH[43]. The study engaged the missiological concept of the all-inclusive *missio Dei* and the feminist concept of equal dignity as complementary analytical lenses to explore the gendered nature of the HIV and AIDS programs offered in the medical missions of the Church of Christ at MCH. The research is interdisciplinary in nature. It is situated within the Stellenbosch University Theology, Gender and Health program with a major in Missiology. Thus, the study employed an interdisciplinary and intersectional approach to gender, health and theology.

The methodology and research design employed in this study were very instrumental in achieving the objectives of the research. Nonetheless, the process of engaging that multidimensional approach was not a simple task. At times it was challenging to decide on the appropriate approach to particular areas of study. In the end, however it yielded the subsequent key findings with regards to the research questions and objectives of the study.

[43] See section 1.8 for a detailed description of the research methodology.

6.4. Key findings of the research

This study aims at meeting the following objectives: to investigate the gendered nature of HIV and AIDS programs in the medical missions of the Church of Christ at Mashoko Christian Hospital, to determine how the nature the programs possibly ignores the affected men and women in the society, to identify gaps regarding gender justice and missional challenges that possibly exist in the HIV and AIDs programs, to find out the implications of the gendered nature of the programs for the healing ministry as a dimension of the all-inclusive *Missio Dei*, and to develop recommendations, based on the findings , that may possibly address the existing gender justice gaps in the HIV and AIDS programs.

Following the stated research objectives, some key findings that were identified are as follows:

6.4.1. Relative gender mainstreaming in the programs.

The assessment of AIDS programs at MCH in chapter four exposes three main outcomes. First, that there are program areas where gender mainstreaming has been implemented. In these areas, it is considered that gender justice is attained. However, there is need for continual monitoring of the program areas so as to sustain the existing achievement. Secondly, there are also numerous areas in which the assessment has shown that gender mainstreaming is not being implemented and, thus, they require high priority attention from MCH policy makers, since gender justice is not yet attained. Thirdly, the study also shows that there are some areas in which gender mainstreaming is still in progress and such portions require secondary priority for gender mainstreaming since gender justice is still in advancement,

6.4.2. Higher program uptake by women as compared to men

Generally, the HIV and AIDS programs at Mashoko are serving more women and children than men. There are several factors behind that but it is chiefly because women are compelled to go through programs such as PMTCT and PITC when they come for antenatal clinic services. In all other programs where one has a choice to or not to access the services, men are also relatively fewer. There is general increase of both men and women in the uptake of the program over the years since the inception of the first HIV and AIDS program at MCH. However, there is no record of LGTBQI people coming to access the services in all of the programs despite the fact that they are stated as target populations in the HIV and AIDS National Policy.

6.4.3. Inadequacies in the policy that guides the running of the programs

It has been learnt in the process of study that neither the Church nor the hospital has a written policy that is tailored to the national policy in relation to gender and HIV issues. It probably

entails that gender issues at MCH are still regarded as secondary issues. It may also imply that the Church of Christ in Zimbabwe does not perceive gender issues as missional issues that are worthy to be given high priority. In light of that, the government, in this case, which owns the policy may be credited for all the gender mainstreaming efforts in the HIV and AIDS programs at MCH. Hence, the absence of a written policy on gender and HIV issues at MCH undermines elements of inclusivity in their healing ministry.

6.4.4. Socio-cultural constructions of gender and sexualities.

There are some socio-cultural factors that continue to affect gender balance in the uptake of the HIV and AIDS programs offered at MCH. For instance, negative cultural perception towards LGTQI people make it difficult for them come out in the open in order to get appropriate assistance. The impact of such cultural perceptions is evident in the absence of records of LGBTQI people coming to access the program services. As Dube (2004b:135) observes, any group of people, community or individuals who are denied of their rights have a greater vulnerability to infection and lack of quality care service. This could be true with LGBTQI people in Mashoko community and this could be just a tip of the iceberg, numerous more challenges of the same kind are possible. In that regard, the Church of Christ still have a long way to go in promoting openness and supporting such people as well as in fighting against discrimination and stigma that is usually associated with the LGBTQI people.

The negative socio-cultural perceptions on gender and sexualities in the Mashoko community is, however, palpable in the church or the Christian contexts. It is, thus, evident that there is an element of inculturation that is taking place in the church in Zimbabwe although conversations on gender sex and sexualities are rarely deliberated in church. According to Bosch (2011:454), inculturation involves the interaction of the gospel and culture. However, the church should not take in any cultural practices. As Bevans and Schroeder (2004:34) observed, culture may end up being an obstacle to the task of communicating the gospel and in turn it makes the missionary work challenging. The social cultural perceptions on gender and sexuality in the Zimbabwean culture helps make sense of the prevalence of gender injustice despite collective efforts to put it to end.

In essence, the study reveals that there is some influence of the interaction between Zimbabweans' cultural perceptions and Christianity on initiatives taken to address gender issues. Thus, Küster (2003:7) made a correct observation that religions in the same contexts influence each other. The influence of African Traditional Religion and cultural systems in the

communication of the gospel (Bevans and Schroeder, 2004:45) are evident in the societal attitude of gender discrimination, exclusion and stigmatisation as well as in the missions. Thus, it can be argued that gender discrimination in Zimbabwe is greatly a social construct

6.4.5. Church of Christ in Zimbabwe and gender issues

As discussed in the previous sections, the study explores some gender perceptions in the Church of Christ[44]. It has been indicated that there are some diverse views on gender issues in the church. However, the church, particularly the one in Zimbabwe, still portrays some elements of women subordination. Women are not allowed to preach in church services. In addition to that, very few women occupy leadership positions. The same elements of women subordination are reflected in the medical missions at MCH. Very few women are involved in the design, implementation and decision making with regards to HIV and AIDS programs. Thus, it can be concluded that women exclusion and lack of participation in the HIV and AIDS programs at MCH is partly promoted by the gender perceptions that are held in the Church of Christ.

6.4.6. Organisational networking and coordination

In all the HIV and AIDS programs at MCH, there is evident coordination of the institution with other relevant stakeholders, such as the MoHCC and other organisations that support women health such as ZACH[45], PSI[46], and SAFAIDS[47]. The institution has built a remarkable strategic partnership with other stakeholders who can influence gender mainstreaming policies especially in the PMTC, ART and HTC. As a result, in these particular programs there is continual assessment and resource mobilisation to address gender dimensions of HIV and AIDS. The door is open for any other relevant organisations that would want to partner in supporting men and women's health and their fight against HIV and AIDS. There is no doubt that this multi-sectorial approach heightens effective control and management of the gender dimensions of HIV and AIDS challenges. In turn, this enhances inclusivity and holism in the Church of Christ's approach to medical missions.

6.4.7. Lack of gender focal points in the medical missions

It has been indicated in chapter four of this study that there are no gender focal points in the Church of Christ or in their medical missions. The institution have not created coordination

[44] See section 3.8 for a discussion of gender perceptions in Church of Christ.
[45] Zimbabwe Association of Church-Related Hospitals.
[46] Population Services International
[47] Southern African HIV and AIDS Information Dissemination Services

committees to oversee gender issues in the gender issues in the in the implementation of HIV and AIDS programs. There several focal points for other issues such as for diseases like Malaria and TB but not in relation to gender issues. The absence of the coordinating committee or a focal persons that particularly look into gender issues at MCH entails that gender sensitivity is still regarded as a side-line issue. It also turns to countermine elements of gender sensitivity and inclusivity in the medical missions at MCH.

6.4.8. Education plays a pivotal role in gender and HIV issues

It has been established that education plays a pivotal role in matters pertaining to gender and HIV and AIDS in the Mashoko community. The program records and reports show that both men and women who have better education are making informed decisions with regards to their personal health as well as in issues of gender and HIV. On the other hand, people with lower levels of education have difficulties in making choices even in their personal health matters.

6.4.9. Community engagement in dealing with patriarchal systems

Very little is being done at MCH with regards to community outreaches and awareness campaigns in relation to gender and HIV issues. There are some outreach programs at the hospital but they are not particularly designed to deal with issues of gender and HIV and AIDS. Nevertheless, the hospital endeavour's to give health education to each and every client or patient coming for services of the hospital.

6.5. Recommendations

If the Church of Christ in Zimbabwe does not employ concrete strategies in addressing the challenges of gender imbalances in the HIV and AIDS programs at MCH, the challenges will go on unabated. In light of the above stated findings, this study presents the subsequent recommendations with the hope that the proposals will help to sustain and enhance gender mainstreaming achievements as well as bridging the gender sensitivity gaps in the HIV and AIDS programs at MCH and probably to the rest of Zimbabwe. In turn, that may lay the foundation for effective praxis in the all-inclusive *missio Dei* within the Church of Christ' medical missions.

6.5.1. Reconstruction of gender perceptions

The study established that issues of gender exclusion and discrimination in the medical mission of the Churches of Christ at MCH mirrors the general perceptions of the community and the church. In essence, gender constitutes socio-culturally constructed and learned attributes (Douglas, 2007:3). Thus, the socio-cultural perceptions mediate gender disparities in the

church as well as in the church's missions. In that respect, persons of particular gender or sexuality are looked down upon in the Mashoko community and this also reflects in the church as well as in the exclusive attitude expressed in the medical missions at MCH. Bevans and Schroeder (2004:34) believe that culture can pose a great challenge to missions. For that reason, some elements of culture must be transformed and in some cases discarded depending on the dynamics of the context. In accord to that perspective, Küster (2003:73) assert that people should continually 'construct their religious identity on the basis of contexts that always change. In addition to that, Douglas (2007:3) points out that gender is 'context-and time-specific and changeable'. In light of that, there is a need for the Church of Christ to endeavour in the reconstruction of gender perception in the community that they serve.

This recommendation fits squarely with the missiological concept of mission as transformation, where the church's missional mandate is to see that the environment of the society is conducive to sharing of the faith as part and parcel of the transformational process (Price and Richards, 2013:19). Hence, it can be argued that the cultural environment of Mashoko Mission is not conducive for an all-inclusive gospel and it needs to be transformed. This implies a shift from some cultural perceptions and practices. The church can work towards that through several tools including dissemination of educational information, communication materials that help in addressing negative sociocultural perceptions and gender stereotypes.

6.5.2. Rethinking missional priorities.

The church of Christ should reconsider their missional priorities. As indicated in earlier sections, Bevans and Schroeder (2004;34) present six questions that should be continuously asked to assess the church's mission namely: (a)Who is Jesus Christ and what is His meaning? (b) What is the nature of the Christian church? (c) How does the church regard its eschatological future? (d) What is the nature of the salvation it preaches? (e)How does the church value the human? (f) What is the value of human culture as the context in which the gospel is preached? These questions may provoke a reflection on the relevance of the Church's mission. The church of Christ should continuously endeavour to answer these questions and asses their standing in missions.

In the process of reflection, the churches of Christ will begin to formulate their theology and praxis with inclusivity and respect to equal human dignity in perspective. It will be possible for the marginalised persons to end up being respected for who they are. This would enhance equal access of services in the medical mission which will possibly impact equity in the HIV

and AIDs programs that they offer in their medical missions. As Bosch (2011:340) notes, the *missio Dei* is an attribute of God and God's tool to reconcile the world to himself because of his unconditional love. By condoning gender discrimination in their HIV and AIDS programs, the church is disregarding it mandate to share the unconditional love of God. In accord with Bosch, Bevans and Schroeder (2004:348-395) emphasize that Christian mission should combat social injustice, marginalisation and oppression so as to be regarded as holistic. Hence, the church of Christ has a missionary task to reflect and reform their theologies, polices and praxis so as to ensure gender justice in their missions.

6.5.3. Biblical teachings as an intervention

According to Rakoczy (1996:19); le Roux (2012:58) scriptures are used to support gendered notions. Phiri (2003:23) gives examples of such kind of teachings as when women are taught not deny their husband' sexual advances. This study indicates that such is the situation with the Church of Christ in Zimbabwe. It has been indicated that there are elements of women subordination in the church. For instance women are not allowed to preach or to occupy some leadership positions on the basis of some scriptural interpretations. However, as McNair and Sanchez (2008:36) notes, biblical interpretations can bear both negative and positive impact on people perceptions. In that light, Banana (1993:17) challenges Christians to seriously consider the undertaking of 'rewriting the Bible' implying the task to 'liberate the Bible from culture-specific world views'. Rakoczy (1996:17) also affirms the need, but in particular, of a scriptural interpretation that deconstruct the male cultural paradigms in theological thought and construct new perspectives that are liberating and welcoming to women.Russell (2004:202) calls for what she describes as 're-imagining the Bible in a pandemic of HIV/AIDS'. That kind of scriptural interpretation affirms women's dignity. Hence the pastors and preachers in Church of Christ can adapt a redemptive scriptural interpretation of scriptures , as this will aide in yielding teachings that are liberating and inclusive. On the basis of that, this study proposes disseminating Bible teachings founded on liberating hermeneutics as an intervention for the gender discrimination and exclusion in the HIV and AIDS programs at MCH.

6.5.4. Medical missions: reflection beyond duty

As previously indicated, the gender mainstreaming achievements at MCH have been chiefly as a result of an imperative to meet the standards of the National Policy on HIV and AIDS for Zimbabwe. However, neither the church nor the hospital has a written policy that is tailored to the national policy with regards to gender and HIV issues. In that respect, gender issues that are being addressed at MCH in order to fulfil set obligations by the government, but the church

on its own is not taking deliberate initiatives towards gender justice in the HIV and AIDS programs offered in theirs medical missions.

The recommendation is for the Church of Christ to look beyond the requirements of the government and consider gender justice as a missional issue. The Church of Christ in Zimbabwe should also have a their own clear policy designed from a missional perspective to guide in the issues gender in relation to the HIV and AIDS programs that are being offered at MCH This will enable the church to intentionally seek inclusivity and respect of human dignity in their medical missions.

6.5.5. Establishment of gender focal points in medical missions

It has been also indicated that that neither the Church nor the hospital has put in place gender focal points in terms of office, staff or a committee that oversees issues gender in the HIV and AIDS programs or in other medical services. The recommendation is for the church to put in place an office, personnel or a coordinating committee that deals with issues of gender as it is with all other critical issues at the institution. The church may utilise the existing staff and integrate specific gender responsibilities in their job descriptions as well as in their key result areas. Those responsibilities may be integrated into people like hospital chaplains, nurses or people in department of counselling services at MCH. That initiative will be helpful in enhancing accountability, implementation, monitoring as well as the assessment of gender mainstreaming.

6.5.6. Integrating gender in theological training

The Church of Christ may make use of their Bible college an integrate gender studies in the training curricula of their pastors. As le Roux (2012:59) also points out, theological training institutions are the most strategic platforms to connect with the future church leaders as well as the future church. Phiri (2003:16) also asserts that theological institutions can be useful platforms to equip ministers with skills to address gender and the pandemic. Dube (2003:209) presents ‘an HIV and AIDS curriculum for theological institutions in Africa’. Phiri (2003:16-17) asserts that it is helpful for theological institutions to familiarise with the curriculum and to make use of it. Thus, if the Church of Christ would consider to be truly inclusive in their future involvement in the *missio Dei,* there is need for the church to integrate gender studies in the training of future pastors and church leaders. Hence, the Church of Christ in Zimbabwe can make use of its theological training institutions to perpetuate inclusivity and respect to equal

human dignity in their Church, and that will be expressed into their missions including in the work of HIV and AIDS programs.

6.5.7. Advocacy, community engagement and social mobilisation

As previously indicated, the Church of Christ is doing very little in terms of engaging the surrounding community specifically in issues pertaining to gender and HIV programs. In that respect, the recommendation is for the Church of Christ, through MCH, to develop community based interventions in order to raise awareness and enhance deconstruction of negative stereotypes about masculinity and femininity. The church may promote open discussions in the church and community on issues relating to stigma, gender violence and exclusion with regards to HIV and AIDS programs. The church should also encourage equal involvement of both women and men as well as traditional leaders such as the chiefs, kraal heads and headmen in their mobilisation campaigns. The church may utilise usual community gatherings such as *dare ramambo* (chief's court), commemorations and political meetings to educate people about gender dimensions of the HIV pandemic. MCH may as well design educational sessions targeting varied groups of people, such as pregnant women, fathers, mothers, school children, boy and girls.

This intervention will not only help in raising awareness but will also facilitate the increase of knowledge and behavioural change. It will also promote community participation in advocating for gender justice. It will enhance efforts to address cultural barriers, values, beliefs, negative stereotypes and sociocultural norms about femininity and masculinity that perpetuate the spread and impact of HIV and AIDS (*SADC*, 2011:10). In addition to that, community members will be encouraged to take responsibility of the family members in their efforts to seek medical services as well as in taking care of the sick. While this intervention aides in alleviating the effects of the deeply ingrained gender injustice and scourge of the epidemic, it is also a buttress for the church's involvement in a medical missions that is part of a genuine all-inclusive *missio Dei*.

6.6. Suggested areas for further study

This study has attempted to indicate that gender in issues in relation to HIV and AIDS are missional issues that the church in its missions should take a leading role in addressing if it has to participate in a genuine all-inclusive *missio Dei*. However the scope of this study is limited and could not cover many issues paramount to Christian mission engagement with issues gender and HIV and AIDS programs. Hence, there are so many other aspects guarantees further

study with regards to Christian mission, gender and HIV and AIDS. Future study may also cover the following:

- This study is a non-n empirical study but there is need of an in-depth empirical research on the intersection of theology gender and health that may explore issues of the pandemic and gender so as to fill in the gaps that are left by this study.
- It may also be of immense value to develop a doctoral thesis from this study, and incorporate interviews through the model of quantitative research methodology. That would be very useful in tracing how responsible African authorities, in whose hands these Church of Christ institutions are left, towards the original missional objectives. That may also be of importance to do a comparison of MCH with other institutions sprouting in this age, the Pentecostal churches such as those run by Emanuel Makandiwa, Walter Magaya in Zimbabwe and TB Joshua's and Shepherded Bushiri's, in Nigeria and Zambia respectively. That study may be important in exploring and assessing the notion that church is now perceived as a space for personal aggrandisement versus missiological endeavours. The value of such a study lies in exposing the truth in order to liberate the weak by changing the oppressive upper class' consciousness.
- This investigation has focused on the medical missions of the Church of Christ in Zimbabwe but, in future, studies may deal with other churches in Zimbabwe and how they are dealing with issues of gender and HIV. A study in that direction can be useful in involving other churches so as to extensively explore the church's engagement with issues gender and HIV.
- The diverse dimensions of gender also implores further studies pertaining to missionary engagement with the LGTBQI people in Zimbabwe. This can be helpful inn exploring specific challenges relating the LGBTQI people and possibly influence equity for the in the church and community.

6.7. Conclusion

Finally, this chapter summarises the five chapters of the thesis, offers key research findings and discuses some conclusions that are drawn from the study. It also offers some recommendations to the Church of Christ in Zimbabwe. The recommendations are meant to sustain and enhance gender justice achievements as well as proposing potential strategies to bridge the gender sensitivity gaps in the HIV and AIDS programs at MCH and probably to the rest of Zimbabwe. In so doing, the chapter also proposes further research in the area of Christian mission in relation to gender and HIV and AIDS.

By and large, the effect of gender inequalities in perpetuating the scourge pandemic implores the church to take gender justice as a missional issue that calls for high priority attention. The proposal of this study is that the Church of Christ in Zimbabwe should have a clear policy designed to guide in tackling gender issues in relation to the HIV and AIDS programs that are being offered at MCH. The church should establish a gender focal point in their medical missions that would oversee gender mainstreaming issues in their programs. In addition, the church should continue to teach against retrogressive cultural practices and androcentric systems in church and the community. The church should also exert more effort in raising awareness on gender issues and ways that can aide in alleviating the effects of the deeply ingrained gender injustice and scourge of the epidemic. Even though gender disparities in HIV and AIDS issues are still high, the collaborative efforts of the church, FBOs, government, NGOs and other key stakeholders can greatly assist in reducing the nemesis in society.

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