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## Religion, Health, and Healing

### An Interdisciplinary Inquiry

Edited by Alexander Rödlach and Barbara Dilly

## 9. Religious Institutions and Volunteering to Provide Care to People Living with HIV and AIDS in Zimbabwe

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### Introduction

[1] Zimbabwe's healthcare system encourages communities and organizations to support the public healthcare sector by initiating home-based care activities and training volunteers to assist households in caring for people living with HIV and AIDS (PLWHA). Responding to this appeal, groups of volunteers were formed, particularly in churches, to provide various types of support to members of AIDS-affected households, and the public healthcare system now relies on significant contributions by religious institutions and volunteers to provide care for PLWHA. This paper explores the role of religious organizations in encouraging and sustaining the commitment to volunteer to provide care for PLWHA and members of their households in Zimbabwe. I argue that the inclusion of religious organizations into a

comprehensive healthcare plan has the potential to improve this commitment, and subsequently, the care provided by volunteers.

[2] This paper is based on research conducted in the summer of 2001 and all of 2003 in Nkulumane, a low-income residential area – a so-called township – in Bulawayo, the second largest city in Zimbabwe. Follow-up research was done during June and July 2009 at two municipal Bulawayo clinics and in the surrounding townships Emakhandeni, Magwegwe, and New Lobengula. Data were collected using local research assistants. During the various research stages, voluntary home-based caregivers spent many days with me walking through the townships to visit the homes of PLWHA. They organized in-depth individual and group interviews between me and these individuals, including patients on antiretroviral therapy (ART), as well as other township residents. The majority of the latter are either directly affected by the disease through having a member of the household living with HIV and AIDS, or indirectly by having an infected or sick individual in the extended family.

[3] Within the overarching approach of participant-observation, data were systematically collected through open-ended and semi-structured interviewing, conducting a survey with a randomly selected sample of a section of Nkulumane, and using freelists and pilesorts (Bernard and Ryan: 163-189) with convenience samples of residents in Nkulumane, Emakhandeni, Magwegwe, and New Lobengula, and faculty and staff at the National University of Science and Technology (Rödlach 2005, 2009). The survey data have been analyzed through bivariate analysis using SPSS. The freelist and pilesort data were analyzed using multidimensional scaling and hierarchical clustering with two software programs, Anthropac and UCINET. Interview data were interpreted using Open Code 3.4, a text analysis program, following the “grounded theory” approach (Glaser and Strauss).

### **Home-Based Caregiving in Zimbabwe**

[4] In Zimbabwe, where about 15% of adults are estimated to be HIV-positive (UNAIDS), home-based care programs, also called community-based care programs, play a vital role as an overwhelmed public health system fails to cope with the demands of the AIDS epidemic (HDN; PHR; Rödlach 2009). Across southern Africa, such programs provide a continuum of care to patients and their families, addressing their material, physical, psychosocial, palliative, and spiritual needs (CADRE; WHO). In their ideal form, they consist of formal and informal components (Kipp et al.). The formal part comprises healthcare professionals who admit patients into the home-based care programs and, when the need arises, carry out home visits. The informal component is represented by family members who are the principal caregivers for AIDS patients at home. Groups of trained voluntary caregivers link the formal and informal parts of home-based care, mediating between the clinic and the home, while providing basic in-home care for PLWHA (Marston; Jacques and Stegling).

[5] In the early 1990s, groups of volunteers were formed in Zimbabwe in response to the government’s desperate call for home-based care programs (Jackson and Mhambi; Woelk et al.; Mupedziswa), informed by government policies, standards, and training manuals (Government of Zimbabwe 1999, 2001, 2004, 2005). The severely underfunded public healthcare system was overwhelmed by the number of people living with AIDS. The growth of such groups has resulted in the discharge from hospitals of increasing numbers of AIDS patients to be cared for in their homes (Gwatirisa and Manderson). Despite substantial

efforts, the former Minister of Health and Child Welfare, David Parirenyatwa, admitted that the overall impact of home-based care programs has not been satisfactory, mainly due to a lack of resources (Parirenyatwa). Subsequently, some observers argue that for patients in Zimbabwe, 'home care' often means 'home neglect' (Jackson and Mhambi). Even the involvement of volunteers did not have a significant positive impact. Since the early 1990s, the programs have become increasingly dependent on churches, non-governmental organizations (NGOs), and community resources, with only minimal material and financial support from the government or the international community (HDN). More recently, increasing numbers of volunteers have dropped out of these programs, worsening an already dire situation.

### Home-Based Caregiver Groups in Bulawayo

[6] Various home-based care programs in Bulawayo townships, by and large started by various churches that actively responded to the earlier mentioned call by the government, sought to address the needs of households that include people living with AIDS (Rödlach 2009). The broader emphasis on households instead of only focusing on the individual suffering from HIV and AIDS is influenced by observations that sick individuals directly benefit from household interventions. A short video clip illustrates the common pattern of the care provided by these groups of volunteers. The clip shows a caregiver from the Brethren in Christ Church in Nkulumane during a fairly typical visit (see Clip 1 at <http://www.youtube.com/watch?v=xZsqYkaroK8>). The voluntary caregiver enters the home of a woman suffering from AIDS. The sick individual, her husband, and two of their children are present. After the culturally appropriate greeting of all household members present, encouraging words are uttered and spiritual support is provided through singing a church song and praying for the sick individual. Leaflets with Bible quotes and religious texts are given to the head of the household, as is disinfectant and soap. If it had been a considerable time since the sick individual had been seen by a doctor, the caregiver would have provided a voucher entitling the individual to a free consultation at the local clinic. If the household of the sick person had not been able to afford to send the children to school, the volunteer would have contacted a municipal program that assists children from low-income households to go to school. If one of the parents had passed away, the children would have been enrolled in a supplementary feeding program. These three services were not needed in this case, as the woman visited by the caregiver was recently seen by a doctor, her older daughter was attending school, and her husband was healthy and employed.

[7] Most of the home visits by caregivers that I observed followed the same pattern of providing some minimal material support, as well as meaningful spiritual and psychological support to patients and their families. As material support (e.g., in terms of food assistance and financial subsidies to pay for rent or school fees) was limited, the nature of the visits was generally to provide support through prayer and being available to listen to the sick individual and other household members and to offer advice. Since the roll-out of free treatment programs in urban areas, which have shown their impact in Bulawayo since the beginning of 2009, the number of AIDS patients who are bedridden and the resulting wide range of suffering for the whole household have been significantly reduced (nursing staff at Emakhandenic and Magwegwe clinics, personal communication), and the voluntary

caregivers are more involved than during previous years in monitoring the treatment process in home settings and reporting back to the local clinic.

[8] The voluntary caregivers were trained either by a municipal community nurse, the Red Cross, or other instructors provided by faith-based organizations. Until recently, they were organized in various groups at a variety of Christian churches, which operated independently in the same neighborhood, parallel to each other. During these initial years, the Ward AIDS Action Committee (WAAC) was supposed to coordinate and supervise the groups and organize the disbursement of government funds to them. However, the WAAC was generally ineffective, inefficient, and lacked significant member involvement (Rödlach 2005). Suspicions were



Figure 1: Widespread suspicions of the misappropriation of public funds raised through a national "AIDS Levy," an income tax, are expressed in a national newspaper (in Rödlach 2005: 103).

frequently raised by volunteers and others, based on reports in the national media and rumors in the local township, that AIDS funds have been diverted into the pockets of public sector employees, politicians, as well as WAAC members. Such suspicions were expressed in a cartoon published in a local newspaper (Figure 1). Furthermore, politically motivated individuals dominated the WAAC and used the committee as a venue to strengthen their influence in the township. Subsequently, the voluntary care groups operated independently and did not pay much attention to the WAAC, which failed to coordinate the efforts of the various voluntary caregiver groups and their collaborations with healthcare professionals at the local clinics. In 2009, none of my interviewees made a single reference to the WAACs.

[9] The WAACs finally lost the little influence they had when the local clinics recently started to coordinate voluntary home-based caregiving. Even though different organizations train the volunteers and keep separate organizational structures for their volunteers, the actual caregiving is now supervised and coordinated by municipal clinics. Volunteers now meet regularly at the clinics, receive additional training from professional health workers, are given information about patients who are sick, are asked to follow-up on these patients, and then provide the clinic personnel with feedback on the patients' health, adherence to treatment regimens, and other issues affecting their physical and mental health. Volunteers are increasingly utilized as clinic extension workers. The fact that clinic personnel tend to be of a similar socio-economic background and often live in the same neighborhoods eases the communication between them and the volunteers, which has a positive impact on this collaboration between health workers and volunteers.

### Churches and Home-Based Caregiving

[10] During my interviews with township residents, it emerged that churches and church members who are voluntary caregivers are greatly appreciated in the community, as shown

by the following representative quote from an interview in 2003 with a resident living in Nkulumane:

Churches provide psychological healing and give encouragement to the sick not to lose hope and not to die before their time. Within churches, there are dedicated home-based caregivers who attend to the sick.

This perception that churches support people living with AIDS and motivate their members to volunteer to care for those struck by this disease is strongly evident in most interviews. My interview data also include various references to a wide range of volunteers' motivations to provide care. These range from an expectation that the volunteers will benefit from the access to resources – such as food and funds – entrusted to volunteers, to the hope that they will gain some sort of employment in the civil or NGO sector, to the aspiration to expend their time and energy in order to gain social capital and status (Bourdieu), to a desire to get close to others who are actively involved in the township, hoping that such social connections can be translated into political power.

[11] My research data, however, suggest that motivations rooted in religious beliefs and practices, reinforced by longstanding patterns of care within the local worldview, are the strongest motivations encouraging volunteerism (Rödlach 2009). These religious motivations are formed, cultivated, and nurtured in churches and associations within churches. Most volunteers tend to be committed members of their churches and are actively involved in associations within their churches. This was also recognized by some of the NGOs involved in home-based caregiving. The director of one small, local organization that provides counseling services to PLWHA explicitly mentioned to me that most people involved in voluntary caregiving are members of various churches and groups within these churches that encourage their members to care for the sick. In order to understand volunteering, it is therefore necessary to know the religious backgrounds of volunteers and to understand their churches' approach to sickness and healing.

[12] The overwhelming majority of township residents belong to one of many Christian denominations. On Saturdays and Sundays, the faithful congregate either in church buildings, homes, or open spaces, and the singing of religious hymns creates a soundscape permeating township life on weekends. Irrespective of the Christian denomination, references to health, illness, and healing are frequently expressed during services, church gatherings, prayer meetings, and informal conversations among church members. The Biblical quotes pertaining to Christ the healer and the curing power of the Holy Spirit, the significance of health, illness, and healing in the Biblical texts, and healing miracles in the Sacred Scriptures are well known to them (e.g., Acts 10:38, James 5:14-15, Mark 5:21-43, Matthew 8:2-4, and Romans 8:11). During prayers, references such as the following are frequently made:<sup>1</sup> *God, heal us; Almighty, soothe the pain of our sick brothers and sisters; Jesus, our healer, lay your lands on us; and Holy Spirit, come down and heal our sick.* Though the content and

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<sup>1</sup> In the language of the Ndebele: *Nkulunkulu, usisilise* – God, heal us; *Somandla, pholisa ubublungu bazalwane bethu abagulayo* – Almighty, soothe the pain of our sick brothers and sisters; *Jesu, msilisi wethu, beka izandla zakho phezu kwethu* – Jesus, our healer, lay your lands on us; *Yehla, Moya ongewele, yelaphe izigulane zethu* – Holy Spirit, come down and heal our sick.

the specific meaning of such religious messages and the health-related praxis of religious groups need to be further studied, as Adogame convincingly argues, the centrality of such references in collective and individual prayers suggests that health and healing are central to Zimbabwean Christian religiosity.

[13] Church members not only regularly pray for health and healing, they also spend a substantial amount of time visiting the sick in their neighborhoods, as part of church groups. Various times, I went with church members to visit the sick in the township; for example, with a group of women belonging to the Association of Saint Anne, a Catholic organization for married women. They went from house to house, visiting and praying over the association's sick members, as in the one depicted on the photo (Figure 2). These practices, their underlying beliefs, and the expectation to show concern for the sick encouraged churches to respond to the call for establishing formal groups of volunteers looking after individuals living with AIDS and the affected households.



Figure 2. Women of the Catholic Association of Saint Anne's, visiting one of their members who is infected with HIV and suffering from AIDS (photo by Alexander Rödlach).

[14] Visiting sick relatives and neighbors is not a mark particular to Christians, but rather is an important aspect in the general community worldview and way of life. Church members not only care for the sick as an expression of their faith and to give witness to the system of belief and practice of their religious group, they also do so because it is expected from them as relatives, neighbors, and colleagues. There is also substantial social pressure to show concern for sick individuals, supported through beliefs that someone who does not show concern for a sick person belonging to his or her social network may somehow be implicated in the genesis of the disease. In general, the local community's worldview finds a strong expression in local Christian groups.

[15] Most of my interviewees do not even separate their worldview, their "tradition," from Christianity, but instead regard Christianity as part of their worldview, emphasizing commonalities between aspects of their worldview of different provenience: between elements of their worldview that can be traced back to pre-colonial times and elements that arrived relatively recent, such as Christianity. However, the vitality of churches depends to a large extent on their ability to emphasize curing and caring into their belief systems and practices. The point here is that Christian messages are not the sole source of encouragement to care for the sick and respond to the government's call to volunteer as home-based caregivers. Other norms and values too, which are part of the local worldview, support the development of these groups of volunteers. The fact that religious and other cultural messages of caring and curing mutually strengthen each other explains why it was primarily members of religious groups who responded to the government's call to start voluntary home-based caregiving groups.

[16] The structure of praying and caring for the sick is comparable across different religious groups, despite obvious denominational differences: the church member often enters the home of a diseased person while singing a religious hymn, which symbolically expresses that they are not only coming as individuals concerned about the health of the sick individual. The singing of hymns unites them and emphasizes the collectivity of believers over individual concerns for the sick. The texts of the hymns usually speak about the power of God and the hope this implies for all who suffer. Thus, it is not only the church group that comes to the house of the sick individual; rather, the church is entering with God. When all have entered, people greet each other in a culturally appropriate manner, ask the sick person about his or her health, and then offer words of comfort. This is followed by singing a hymn emphasizing human suffering and God's healing intervention. Then one of the leaders starts to pray, which may involve physically touching the sick person, at times even shaking the patient, symbolically representing – as some interviewees argued – the divine force that can move and heal the sick person. Others may follow with praying for and touching the sick person. Another hymn is sung and the prayer ends. The group then informally chats with the sick individual and all others present.

[17] At times the group offers some material help, such as cash and food items, which are by and large not sufficient to alleviate the economic woes of the household. Even when some material help is offered, the main emphasis is on prayer, on what we could call spiritual healthcare: framing the illness experience through religious beliefs and assuring the sick person that God can heal him or her. I observed how such prayer can improve psychological well-being and physical health, such as in the case of a dying woman suffering from AIDS who received the Catholic sacraments of anointing the sick and confession, followed by the cleansing of the house through prayer, sprinkling of Holy Water and protecting the house from evil forces through marking all openings of the house with the protective sign of the cross. In the days after the prayer, she seemed to recover without additional medication, and was able to resume a somewhat normal life for a couple of months, until opportunistic infections due to the progressing HIV infection returned. Another example of the positive impact of prayer was witnessed by a physician who went with others to pray for various sick church members (personal communication). She measured patients' blood pressure before and after the prayer and reported impressive reductions. The fact that Christian groups represent the majority of voluntary home-based caregiver groups explains why prayer is also an important element in the home-based care groups, as exemplified in the earlier mentioned video clip (see Clip 1).

[18] While there is no harm in praying for PLWHA, the prominence of religious groups in home-based caregiving groups also can be problematic because of (1) specific explanations of the epidemic that are common in some churches, such as interpreting HIV/AIDS as divine retribution and the infection of individuals as the result of sinful sexual behavior, and (2) certain views on preventing HIV infection that are widely mentioned during prayers and homilies in various churches and that also influence voluntary caregivers' understanding of the epidemic, such as the widely held negative perception about the use of condoms. I will elaborate on these explanations and views in the following section.

### Problematic Theologies and Home-Based Caregiving

[19] First, it is common to hear among committed members of Christian groups that, in the local community, the AIDS epidemic is the result of the imminent apocalypse that was triggered by our immoral behavior (Rödlach 2007). For example, Sheunesu Shumba, an artist living in the township, carved a figure of a preacher announcing that the end of times has arrived (Figure 3). The preacher raises his hands, supporting his passionate call that we all need to convert (1) as individuals and live according to the moral guidelines of the faith if we want to avoid an HIV infection, and (2) as a collective if we want to prevent the annihilation of life as we know it (Rödlach 2010). The survey data from a randomly selected sample of a section of Nkulumane township, which is representative of townships in Bulawayo, indicates that this message has been readily accepted by many (Rödlach 2005): 43.7% of the 486 respondents (n=213) agreed with the explanation that “The End-of-Days has arrived and AIDS is the proof,” and 32.2% (n=157) agreed with the statement that “God punishes us for our immorality and other sinful behavior.” The interpretation of HIV/AIDS as divine retribution is also evident in the pilesort data analysis: 482 respondents were asked to group together items that were mentioned during freelistings and associated with HIV and AIDS. When analyzing the responses through multidimensional scaling and hierarchical clustering, it became apparent that respondents closely associated the following three items: “punishment for sin,” “God,” and “lack of faith” (Rödlach 2005: 529-531). This strong association of HIV/AIDS with sin and divine retribution implies that those infected with HIV and dying from AIDS are individually responsible for being ill and deserve it. This association may interfere with other religious messages calling for compassion and care, and negatively impact the care provided by volunteers.



Figure 3. Carving by Sheunesu Shumba showing a Christian preacher interpreting that HIV/AIDS is an indicator that the Apocalypse has begun (photo by Heinz Helf).

[20] The association of HIV/AIDS with transgression of morals and values is frequently expressed by church leaders and preachers during services, and also in texts published in the mass media and other print media. For example, the Catholic priest Fr. Jerome Nyathi published a couple of poems on HIV/AIDS, such as *Ngiyakuthanda Aids* (2001), which literally means “I love you, AIDS.” I quote some verses from the English translation of this poem:<sup>2</sup>

<sup>2</sup> The original in the Ndebele language was translated by Jabulani Mthombeni: *Ngiyakuthanda ngob' utbi sigcin' amasiko, pbela wen' utbi sithandane sibloniphane, yebo, sibloniph' umtombombo wempilo. Ngiyakuthanda AIDS, wen' utbob' abazigqajayo, wen' uqondisi' iziqhwaga, hlala lami singehlukani AIDS. Lab' obathathayo AIDS ubas' ekhaya lesithembiso,*



I love you, for you say we should keep tradition.  
For you say we should love and respect each other.  
Yes, respecting the well of life.  
I love you AIDS for you humble the proud.  
You straighten the thugs.  
Oh, live with me AIDS!  
Those you take, AIDS, you take them to the Promised Land.  
The land that was built and promised to us.  
You only do what you were sent for.  
I love you AIDS for you don't discriminate.  
Surely you don't choose whether young or old.  
Your only commandment is one, "control yourselves."

This poem echoes what is being said from many pulpits, during prayer meetings, and in informal conversations: the epidemic was sent, implying sent by God, to remind us of the value of inherited norms, the value of "self control," referring to the need to restrict sexual expression to that which occurs within marriage. Those who are too "proud," referring to those who do not accept divinely ordained rules and norms, will be humbled through an HIV infection. Those who are "thugs," referring to those who deliberately transgress these rules and norms for their own selfish goals, will be "straightened out," becoming HIV-positive. The poem also indicates the tension that exists in many Christian organizations between rules and norms for sexual behavior and showing compassion for the sick. Nyathi writes that those who die of AIDS will be taken to the Promised Land, will be saved even though their earthly life is taken. Overall, such messages are highly problematic because they reduce the various modes of HIV infection to a single one – sex, and more specifically sex that transgresses values and norms. In other words, an HIV infection is the fault of the infected and the result of sinful behavior. The resulting stigma of the epidemic is further reinforced through the association of HIV/AIDS with immoral individuals, promiscuity, and prostitution. Not surprisingly, AIDS is sometimes also called *umkhublane wokuwula*, "whoring disease." The exposure of the voluntary caregivers to these messages may negatively influence their caregiving activities because this stigma of the disease devalues the suffering individuals and their right to be cared for by others. This issue will be discussed later in this paper.

[21] Another problematic issue arises when religious organizations are involved in disseminating messages aimed at preventing new HIV infections. In southern Africa, the most widely known prevention approach is the so-called ABC model: (A) abstain if you are unmarried, (B) be faithful if you are married, and (C) use a condom if you cannot abstain or be faithful. While religious groups generally readily accept A and B, they tend to reject C. This, however, destroys the model, which integrates value-based interventions with other interventions and gives people the choice to select a prevention method that makes the most sense to them at a given time and in a specific situation (Rödlach 2008). Some people within churches even alter the meaning of this ABC model to match their views on AIDS

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*lon' esalidalelwayo salitbenjiswa futbi, wena wenz' okuthunyiveyo. Ngiyakuthanda AIDS ngob' awulamblobo, impel' anulay' omncan' ingab' omdala, wena owakho umlayo munye: Ziphatheni!*

prevention. I observed a workshop attended by a church youth group. The instructors taught the participants a radically altered ABC: (A) abstain, (B) be faithful to this commitment, and (C) change if you have difficulties adhering to this commitment. Condoms were eliminated in this model. Such an approach does not consider the context within which decisions on sexual relationships are made and disempowers individuals to choose what makes most sense to them at a given moment – to choose either A, B, or C, or something else, for that matter. Thus, this approach is highly problematic and potentially exposes individuals to a higher risk of being infected with HIV.

[22] The question, however, is whether such church teachings are really significantly influencing the caregiving behavior of church members. During my years of researching and living in Zimbabwe, I have often recorded contradictory statements uttered by a single individual about the same topic. The anthropological lesson learned is that knowledge is never an absolute: what makes sense in one context is irrelevant in another. This explains why someone may express support for the official churches' rejection of the use of condoms when asked in a church-related context, but has no problem positively viewing the use of condoms in another setting (e.g., at clinics). Most township residents are somewhat affiliated with one of the many churches operating in the area. Many of these churches condemn the use of condoms. However, people's views and arguments differ when asked the same question in a different context (Rödlach 2005). This finding can be illustrated through data collected during my most recent research in 2009. The analysis of freelist data collected at a local clinic from a convenience sample of patients indicates that the association of premarital abstinence and marital fidelity with HIV prevention is weak compared to safe sex, specifically the use of condoms. Particularly hierarchical clustering of the data clearly suggests that HIV prevention is strongly associated with safe sex, but only weakly associated with abstinence and even less with marital fidelity. In other words, individuals do not immediately think of abstinence before marriage and fidelity within marriage when asked about HIV, but are more likely to think of condoms.

[23] In contrast, interviews conducted concurrently in other settings, such as homes and places of worship, suggest the opposite, namely that premarital abstinence and marital fidelity are the preferred means of preventing new HIV infections. In other words, the venue and context of conversations influences responses. This also suggests that people do not blindly accept a particular view, such as the one preached from the pulpit, but that they express a view that makes most sense in the immediate context. When probing individuals' views on such "contradictions," interviewees showed a strong tendency to express complex and varied views. For many of them, an abstract doctrine did not exist but was applied to particular situations and gained new meanings from being contextualized and applied to individuals known to the interviewee. For example, I asked one woman about causes of and contributing factors driving the epidemic. She mentioned that AIDS is sent by God as punishment for our sins. Later in the conversation, when we discussed illness in her family and neighborhood, she "contradicted" this general explanation of HIV/AIDS. She said that she cannot understand how our loving creator could punish us so severely by sending a terminal disease. Her rhetorical question at the end of the interview was: is not God merciful and forgiving?

[24] While interpretations on the nature and meaning of HIV and AIDS were context-dependent, religious and cultural messages that encouraged caring for the sick were not. The call to support those who are suffering tends to be more consistent because this is a basic tenet of religious belief, which is reinforced by longstanding local worldviews, and is applied without distinction and preference to any suffering individual. One likely reason why explanations of illnesses tend to be dynamic is because the Biblical texts can be interpreted differently. Further, the organic and dynamic nature of illnesses, as well as the social context, calls for varied interpretations.

[25] To sum up: religious organizations encourage their members to care for the sick. They provide the bulk of voluntary home-based caregivers. However, religious groups also contribute to the stigmatization of HIV and AIDS and compromise prevention efforts through their interpretation of HIV/AIDS and views on preventing new HIV infections. However, there is evidence that people creatively alter such interpretations and views. While these interpretations and views are context-dependent, the local worldview and Christian compassion for the sick are strongly emphasized in all contexts. My research suggests that the negative impact of problematic messages about the AIDS epidemic is minimal and does not compromise the caregiving provided by members of home-based care groups. My conversations with voluntary caregivers and observation of their caregiving activities indicate that they, on one hand, express their commitment to belonging to a particular church by reiterating church teaching, while on the other hand, they emphasize God's curing power and compassion during actual visits in the homes of people suffering from AIDS. In short, problematic doctrine preached from the pulpit seems not to compromise church members' participation in voluntary caregiving groups and their practices of care, both the material and the spiritual healthcare.

### Women in the Churches and Home-Based Caregiving

[26] Not all members of religious groups participate equally in voluntary caregiving. Within churches it is mainly women's associations that provide the majority of volunteers (see Amare). Associations of women tend to have a strong presence and powerful influence in many Christian denominations across southern Africa. This is particularly evident in the townships on Thursdays, the day when church women usually meet. This day was traditionally the day off for domestic workers and therefore was selected by women's association as the preferred day for their meetings. On this day, women dressed in uniforms identifying them as committed members of their churches and could be seen in townships on their way to churches: Methodist women in their red and black dresses, Anglicans in their dark blue and white dresses, Presbyterians in their black and white dresses, and Catholics in their beige



Figure 4. Women in the official dress of the Catholic Association of Saint Anne.

and brown or light blue and white dresses, depending on the association to which they belong. The pattern of the dresses is often identical, at least among the more traditional missionary-based churches, consisting of a hat, blouse, and skirt. The image in Figure 4 shows the typical uniform worn by the Catholic Association of Saint Anne. Thursday is also often the day when women visit the homes of sick neighbors or the hospital. It is not uncommon on this and other days during the week for pastors to visit hospital wards with groups of such women, surrounding the beds of their church members and singing and praying for them. The church groups normally visit members of their own community but tend to be open to requests by other patients for prayer, which are frequently made. Health workers tend to accept these prayers and only intervene if they disrupt the hospital routine and disturb other patients in the hospital ward.

[27] When the members of these women's associations meet on Thursdays, prayer and preaching are an essential part of their meetings and usually touch on issues of importance to them, including the illnesses of some of their members and how association members responded to it. Generally, the different groups representing the associations report back to the associations about their activities. When women are involved in voluntary home-based caregiver groups, the associations' members who are also volunteers report about their activities. Usually, they summarize what they did during the past week, such as how many sick individuals they visited, what they did during caregiving activities, and how much material support they were able to provide. Reporting holds the caregivers accountable and provides encouragement. The other women present generally cheer on the volunteers for what they are doing and motivate them to continue their ministry.

[28] The volunteers gain respect among their peers for what they are doing (see Amare). As the association reports the activities of its members to the church leaders, the association too gains respect in the eyes of the local church community because of its involvement. The association gains status within the church through its commitment to voluntary caregiving and the involvement of its members in home-based care groups. The higher status gives the members a stronger voice within the church community to push their agendas within the local church. At the same time, the church community as a whole also gains status and influence within the township and among the community leaders. Such public accountability is common among the various church groups across denominations. The volunteers, the association, and the church gain "social capital," which can be used like any form of capital (Bourdieu). Obviously, such an interpretation only captures a few notions of the caregiving dynamics within churches. To gain social capital through caregiving is not the primary goal of church women who engage in caregiving, though this motivation seems more common among volunteers who are not actively involved in a church community (see paragraph 7). The church women mainly volunteer because their faith encourages them to do so and because of expectations to show concern for the sick within the local community's worldview (Rödlach 2009). Their caregiving is simply reinforced by the other dynamics.

### **Suggestions for Policymakers**

[29] The bulk of the voluntary caregivers are women who belong to various churches and associations for women within these churches. The women's motivations for caregiving have not yet been sufficiently studied (see Mahilall). Some recent studies have addressed this issue

(Amare; Rödlach 2009), but more research is needed. My research suggests that in southern Zimbabwe and possibly elsewhere, religious motivations are the main factor explaining why someone engages in voluntary caregiving. Understanding the religious motivations behind volunteering is of particular urgency because throughout southern Africa, volunteers' commitment to caregiving has diminished during the past years – particularly among individuals who are not actively involved in churches but also, to a lesser degree, among those who are committed members of their church communities – mainly due to the stigma of HIV/AIDS, lack of funding and other support, the need to prioritize one's own family over devoting time to individuals suffering from AIDS, and volunteer 'burnout' (Rödlach 2009). When these volunteers' religious motivations are better understood, attempts can be made to strengthen them and to counteract the decrease in commitment to volunteering. Based on my research findings, I would suggest the following:

[30] First, governmental and non-governmental organizations involved in the care of those living with AIDS need to directly engage church communities and their leaders, despite their ambiguous role in responding to HIV/AIDS. In particular, health workers at local clinics could communicate with pastors and visit church communities, especially the women's associations. Clinic health workers are more likely to engage these groups because they are from comparable social backgrounds, and many health workers are also actively involved in their respective denominations. In addition, they tend not to be as prejudiced against churches and their teachings as international NGOs, particularly those that are headquartered in Europe; many of these organizations find it difficult to work with churches, partly because the organizations want to provide a value-free approach to AIDS awareness, prevention, and treatment. The churches' focus on value-based interventions, such as premarital abstinence and marital fidelity, is often discredited by many NGOs as counterproductive to preventing new HIV infections (Green; Green and Herling Ruark: 72-77). The organizations' representatives are often heavily secularized and, because of this background, have difficulty accepting religious organizations as equal partners in addressing the AIDS epidemic. They tend to overlook the fact that religious organizations are often the only functioning and credible organizations within a large network of grassroots communities that would provide a suitable point of entry for awareness about healthcare interventions.

[31] While there are obvious differences and disagreements between religious communities and governmental and non-governmental organizations involved in the field of AIDS awareness, prevention, and care, these differences are often context-dependent, as I argue in this paper. Further, there is much common ground, particularly concerning care for PLWHA (Rödlach 2006, 2008). Governmental and non-governmental organizations providing care for people living with AIDS can only benefit from engaging churches and church members in their efforts. A starting point should be showing appreciation for what church members are already doing regarding caregiving. Further, it is important to discuss the religious messages that nurture caregiving, which will result in a better understanding of these messages among caregivers, and will strengthen the positive messages about caregiving. Through such communication and interaction, problematic aspects of church teachings may over time become less prominent in church preaching and practice. At the same time, such interaction could strengthen the commitment of volunteers in churches to provide care to

people living with AIDS and their households. They will see that their efforts in caregiving are recognized, acknowledged, and appreciated and, therefore, will be more likely to continue their caregiving activities.

[32] Second, public events that show appreciation for volunteers who care for those living with AIDS should be organized to raise the status of volunteering and the volunteers within the township community (see Amare). While volunteers feel appreciated by their associations and churches, expressions of gratitude by community and healthcare leaders for the service they are providing could strengthen their commitment. Though such events are occasionally organized, they are more the exception than the rule. Generally, the groups of volunteers are invited to public events, such as the launching of a new program or the opening of a new clinic, but the purpose of the invitation is often only to embellish the event, generally not to explicitly recognize their service. I attended the official launch of an HIV/AIDS awareness program in the municipal wards at a clinic. The local counselor and other dignitaries were present at this event open for all residents of the township. One group of home-based caregivers enthusiastically presented itself, its purpose, and efforts through a singing and dancing performance. Even though this group is not affiliated with a particular church – it is organized by the city's Department of Health and Human Services – being invited to public events is a common occurrence for all groups. I later videotaped the performance at a different venue (see Clip 2 at <http://www.youtube.com/watch?v=7Yucr-EMXU>). The English translation of the original text in the Ndebele<sup>3</sup> language clearly explains how the members of the group view themselves:

We went to the Maqhawe Clinic.  
Oh, send us to the sick, even though it is difficult.  
We do not discriminate them.  
I ask for the phone, I call the Home-Based Care Group.  
It is not easy, it is tough,  
When you are looking after someone who is sick, Mothers, Fathers

They present themselves to the health and political leadership as well as the township community as willing to provide care for anyone in need and to support anyone burdened by caring for a household member suffering from AIDS. Yet the leadership did not explicitly show gratitude for their service, which may be related to the fact that the contribution of voluntary caregiving for PLWHA is often not recognized (Rödlach 2009). From the perspective of the organizers, the purpose of the performance was to provide some entertainment for those present, including the local leadership, and not to include the volunteers in this healthcare-related event in order to appreciate their contribution to healthcare delivery.

[33] At the same time, when voluntary caregivers organize events for themselves, public participation is minimal, even though these events are attended by some community leaders and local politicians. I observed, for example, that caregivers in New Lobengula were organizing a memorial service for those in their groups who had passed away during the

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<sup>3</sup> The Ndebele texts sung are the following: *Thina sangena eMaqhawe. Haye, thuma thina noma kunzima ezigulaneni. Kasizikbethi. Ngicela iTelephone ngitshayele iHome Based Care Akulula kunzima nxa ugulehwa, Bomama, Bobaba.*

previous year. No health worker or politician was present. No one provided these groups with a culturally appropriate meal suitable for such events, such as cornmeal porridge with choumollier and beef. The presence of leaders in healthcare, politics, and community life, as well as a simple token of appreciation, could boost the morale among the voluntary home-based caregivers, raise their image among their neighbors and in other social networks, make their churches proud, and motivate others to join them. These and other factors would have strengthened the volunteers' commitment to provide care for those living with AIDS and their households.

### **Summary**

[34] During the past years, many voluntary caregivers, religiously affiliated and others, have dropped out of home-based caregiving groups that are active in many townships in Bulawayo and elsewhere in Zimbabwe and southern Africa. In this paper, I have highlighted the fact that most volunteers are motivated by the wider community's worldview and religious beliefs to provide caregiving to those in their neighborhoods who are suffering from AIDS. They are committed members of their churches and religious associations, particularly women's groups, and conceptualize their service in terms of religious beliefs and practices. I argue that a better understanding of these beliefs and practices, which nurture commitment to caregiving, will help to strengthen the commitment of voluntary caregivers. Further, it is necessary to engage religious communities and their leadership in efforts to provide support for PLWHA. Governmental and non-governmental organizations need to overcome their mistrust in and suspicion of religious groups because these groups are often the only credible and functioning network in townships. In addition, public recognition of the services provided by volunteers will strengthen their motivation and subsequently their commitment to caregiving. So far, both governmental and nongovernmental organizations involved in the care of PLWHA have bemoaned the drop in volunteers within home-based caregiving groups, but have only insufficiently addressed this issue.

### **Future Directions**

[35] This paper does not explore an obvious and important question; namely, how gender affects voluntary caregiving in Zimbabwe and within religious groups. Future research should also explore how expectations of and assumptions about women, particularly concerning caregiving within the family, the kingroup, and beyond, positively and negatively affect voluntary home-based caregiving. After all, the overwhelming majority of volunteers are women. The literature documents that in southern Africa and elsewhere, women are socialized as caregivers (Tlou). They are expected to provide care, but that care deserves no special recognition. This raises the question of how women build social capital when much of the care they provide is expected and assumed to be simply intrinsic, natural to their role as women in society. Such perceptions may be either solidified or challenged within religious institutions and groups, raising the question of the role of women within churches.

[36] Finally, my paper does not explicitly address the important question of how public health workers view the volunteers. Are they seen as an integral part of a comprehensive approach to provide adequate care for PLWHA, as implied by official government statements? My fieldwork data suggest that many health workers do not regard the

volunteers as valuable collaborators (Rödlach 2009). This may explain their absence from and support of functions organized by the volunteers. In contrast, volunteers clearly expressed during interviews that their services are an essential part of the public health care sector. Additional research is needed to better understand this matter, which has the potential to compromise efforts of providing care for PLWHA.

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### Video Clips

Clip 1: Mrs. Moyo of the home-based care group organized by the Brethren in Christ Church visiting a household where the mother is suffering from AIDS.

Clip 2: A home-based care group performing a song, which they had performed during the official opening ceremony of the local municipal neighborhood clinic.

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