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CHAPTER ONE
ORIENTATION OF RESEARCH

1.1 Introduction

The size and duration of the HIV/AIDS epidemic poses a critical challenge to the world. Concerted efforts are required to check the rapid spread of the epidemic and mitigate the impact of HIV and AIDS, especially in Sub-Saharan Africa, where infection rates constitute about two thirds (67%) of people living with HIV/AIDS globally (UNAIDS and WHO 2009). A plethora of ways is being sought to check the incidence of HIV and ameliorate the affliction of people living with HIV/AIDS (PLWHA). It is hence of crucial importance that resources and efforts are mobilized to empower people living with HIV/AIDS and their caregivers with essential (and useful) information on HIV/AIDS and how to manage it optimally (PWG 2008; Ndhlovu 2007; Mulenga 2009; van Dyk 2005 etc). Moreover, concerted efforts are needed to decelerate the growth of the epidemic (considering the current stark absence of a cure or a vaccine for HIV and AIDS) and hopefully arrive at a point where HIV transmission will be minimal.

Historically, faith based organizations (FBOs[1]) have responded to human crises based on the moral tenets of their faith (cf. Denis 2009). The Church inherently being a caring community is obligated to be involved in intervention strategies aimed at meeting human need (Hendriks 2002, Ndhlovu 2007,

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[1] This work defines FBOs as organizations that have one or more of the following characteristics: affiliation with a religious community, a mission statement with explicit religious references, receiving financial support from religious sources, selection of board members or national leaders or staff based on religious beliefs, and use of religious beliefs in decision making. FBOs may operate out of individual Churches or other faith structures. They may also be independent organizations. Religious bodies or denominations are faith structures that are organized in one way or another at national and international level (Ebaugh et al 2003:411*)*. Green (2003) essentially agrees with this definition of FBOs. Emphasis in this work will however, be laid on Evangelical Churches in Zambia.

Mulenga 2009). At this point in history, the HIV epidemic poses a critical challenge to the missional, that is to say the practical theological, being of the church (Hendriks 2002, van Wyngaard 2006). The church cannot be indifferent to the HIV/AIDS epidemic without being untrue to numerous biblical injunctions commanding us to care for the afflicted and the less privileged, who happen to be the most affected (UNAIDS and WHO 2009; Magezi 2005; Mulenga 2009). Therefore, the church is called to practical care and proactive involvement in the alleviation and prevention of the spread of the HIV/AIDS epidemic (cf. Matt 25). Ndhlovu (2007:1) notes well, "The Church is to be a representative of Jesus Christ by encouraging care of, love and compassion for the sick and oppressed, an understanding of those affected and infected in the communities, taking responsibility, speaking the truth and living as the light of the world (Mathew 5: 13-16 NIV)". This means that the church cannot avoid responding to the HIV/AIDS crisis.

The contention of this study is that not only must the Church be involved in the care of people living with HIV/AIDS, but it should also work toward influencing behaviour change by transforming worldviews[2] that underpin risky behaviour in most Sub-Saharan Africa, of which Zambia is a part in order to stem the spread of the epidemic. The study presupposes that the church has the ability to initiate a process of worldview transformation which will change risky behaviour and therefore help check the hitherto unabating spread of HIV/AIDS in Zambia. The church in Zambia has no choice but to provide

[2] In this work the term "worldview" means the way in which a people make sense out of life. Hence worldview is about a people's life "outlook" (Ntozi &Kirungu 1997). The work essentially understands worldview as that part of culture where "heart values, norms, beliefs, understandings, and behavioral rationale are embedded in any people group" (Hiebert 2004).The researcher will give an in-depth discussion of the concept of worldview in chapter three.

"transformational leadership" (cf. Osmer 2008) in the context of an unrelenting HIV/AIDS epidemic. The study will argue that an integral part of the church's mission is to transform cultural norms and practices that predispose many Zambians to HIV/AIDS infection (cf. Orobator 2005). The researcher in his Master of Arts mini-thesis titled *'Empowering Church-Based Communities for Home-Based Care: A Pastoral Response to HIV/AIDS in Zambia'* noted that "in order to reduce effectively HIV/AIDS prevalence in Zambia, socio-cultural changes must be made, especially in the area of sexual behaviour" (Mulenga 2009:57). This researcher will argue that enduring and authentic socio-cultural transformation in Zambia can only occur when change agents aim at catalysing change at the deep-culture level, the worldview, which rationalizes behaviour (Kapolyo 2007; Kraft 2005). Arguably, HIV risk behaviour in sub-Saharan Africa seems to persist integrally due to strong culturally-conditioned perceptions (and motives) in the realm of sexual expression (Dinkelman et al. 2006; Chondoka 1988).

Furthermore, the global HIV Prevention Working Group (PWG 2008) is unequivocal in its conviction that wherever the HIV/AIDS tide has been turned downwards behaviour change has been the main thrust of preventative efforts. Balog, writing in a context of wartime relief work in the Balkans, emphasizes evangelical Christians' critical role as agents of societal socio-cultural transformation, when he asserts:

> The aim for preaching and communicating the message is related to the Church's unique aspiration: to influence change in the social behaviour of target groups to which this message is conveyed. Evangelistically speaking, with responsible behaviour and a holistic approach to preaching the gospel and caring for the poor, the Church becomes the transforming yeast

> for the societies in which it operates, refining, enriching, and sanctifying them (Balog 2007:29).

Arguably, the church in any society has the task of engaging its people groups to effect behaviour change, including HIV risky behaviour at the traditional practices and lifestyle level in order to stem the spread of HIV/AIDS infection. This study will suggest means of transforming worldviews in order to change HIV/AIDS risky behaviour in Zambia. The researcher is a native of Zambia (of the Bemba[3] speaking tribe) and will, therefore, approach the issue at hand with an insider's perspective which is influenced by evangelical Christianity[4].

1.1.1 The Epidemiology of HIV/AIDS in Zambia

That HIV/AIDS has been reported from every inhabited continent and every country is an indisputable fact. Hardest hit, however, is Africa south of the Sahara Desert where the epidemic is gaining speed (UNAIDS and WHO 2009; UNAIDS and WHO 2007; CSO et al. 2009). This section sketches both the global and Zambian contexts in as far as the HIV/AIDS epidemic is concerned as at the close of the year 2007. The UNAIDS/WHO 2007 AIDS Epidemic Update reveals that "Every day, over 6800 persons become infected with HIV and over 5700 persons die from AIDS, mostly because of inadequate access to HIV prevention and treatment services" (UNAIDS and

[3] Bemba is a Bantu language spoken by natives originating from the Northern and Luapula provinces of Zambia—also called Chibemba.

[4] In the present work Evangelicalism alludes to the movement in contemporary Christianity "transcending denominational and confessional boundaries, which emphasize conformity to the basic tenets of the faith and a missionary outreach of compassion and urgency. A person who identifies himself with it is an 'evangelical', one who believes and proclaims the gospel of Jesus Christ" (Elwell 2001:405). In Zambia, most evangelicals are also members of the Evangelical Fellowship of Zambia (EFZ).

WHO 2007: 4). The Update (2007) further admits that the HIV epidemic remains the most serious of infectious diseases to challenge public health. At the end of 2007, there were 32.2 million adults and children living with HIV. The figure was scaled down from 39.5 million (UNAIDS and WHO 2006) due to the improvement of estimation methods used to arrive at HIV statistics (UNAIDS and WHO 2007:3) whereby India significantly revised her figures. The world map (Figure 1:1) shows the global distribution of people living with HIV. Notably, Sub-Saharan Africa leads in HIV prevalence with 22.5million which is approximately 63% of all people infected with HIV globally.

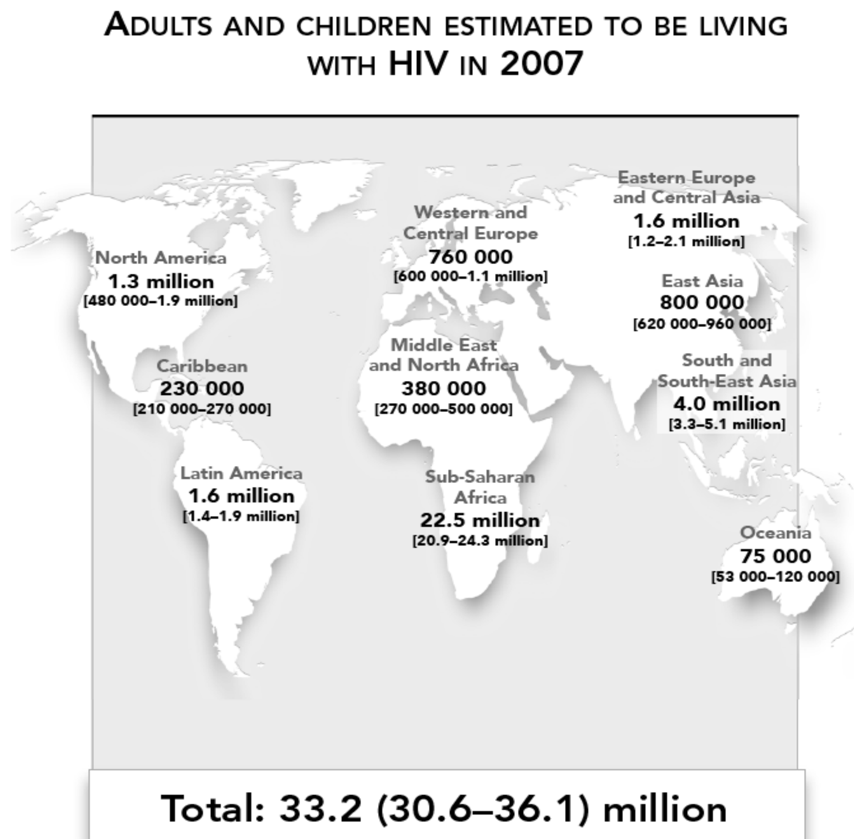

Figure 1.1 Source: UNAIDS and WHO 2007:38

The Sub-Saharan Region also leads in new HIV infections. Figure 1.2 gives us the estimated number of Adults and Children who were newly infected with

HIV during 2007. Globally 2.5 million people were newly infected with HIV of which 1.7 million occurred in Sub-Saharan Africa, that is, over two thirds (68%) of new HIV infections in the world occurred in this region (UNAIDS and WHO 2007:40). Additionally, there were a total of 2.1 million HIV related deaths in 2007 of which Sub-Saharan Africa contributed 1.7 million deaths, meaning that over three quarters (76%) of all HIV/AIDS deaths worldwide occurred here. Zambia happens to be in the south-central area of southern Africa. The situation of the HIV/AIDS epidemic is clearly a serious one and requires concerted efforts to check its growth. But what precisely is the HIV/AIDS situation in Zambia?

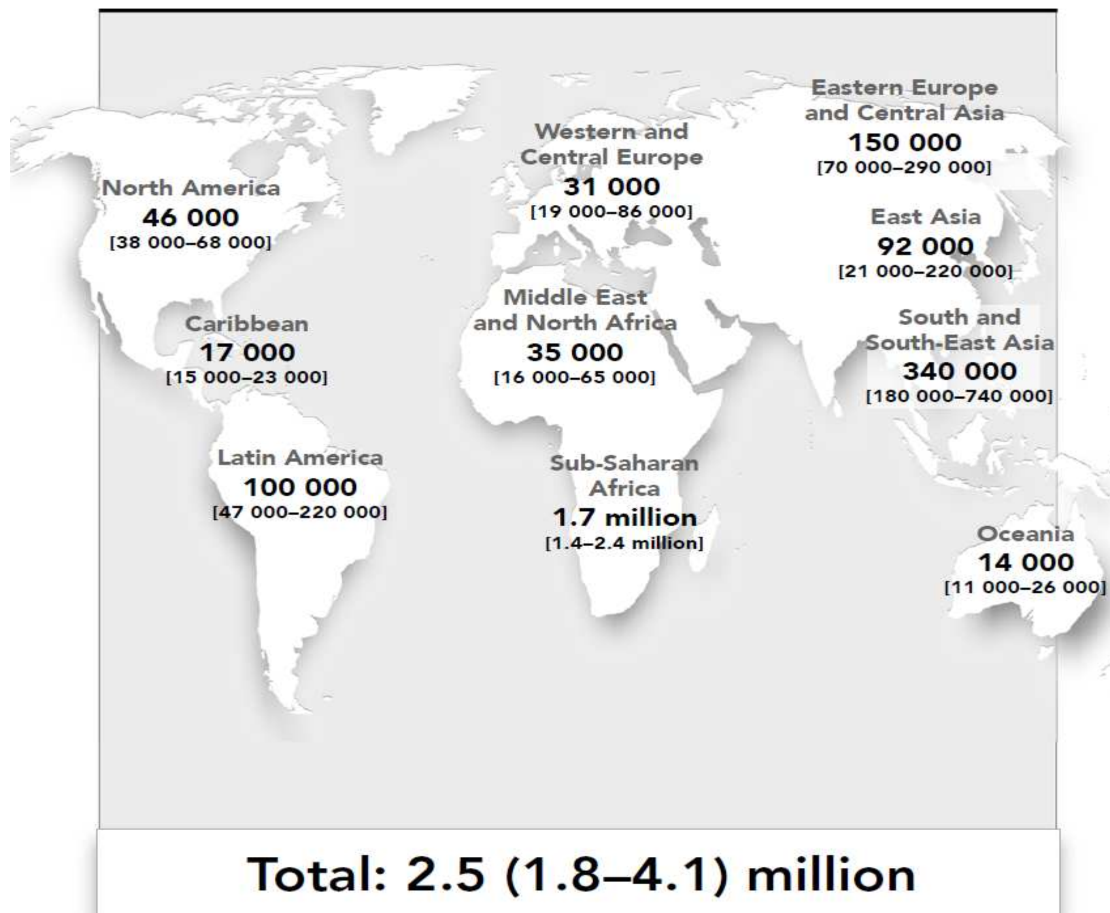

Figure 1.2 Source: UNAIDS and WHO 2007:40

According to the Sub-Saharan Africa 2006 AIDS Epidemic Update (2006:10) "Southern Africa [Zambia included] remains the epicentre of the global HIV epidemic: 32% of people with HIV globally live in this subregion and 34% of AIDS deaths globally occurred there." The Zambia 2007 Demographic and Health Survey (ZDHS) reveals that 14% of Zambians aged 15 to 49 years are HIV positive (CSO [Zambia] et al. 2009: 16).

Currently in Zambia HIV prevalence is higher among women than men in both urban and rural areas. On the whole, 16% of women and 12% of men are HIV-positive. HIV prevalence is twice as high in urban areas as in rural areas (20% versus 10%). The HIV prevalence of 14.3%, according to the 2007 ZDHS, represents a slight decrease from the 15.6% prevalence observed in the 2001-02 ZDHS. In the 2007 survey, 16.1% of women and 12.3% of men are HIV- positive. By comparison, in 2001-02, 17.8% of women and 12.6% of men were HIV-positive. However, none of these decreases are statistically significant, admits the 2007 ZDHS. According to the ZDHS 2007, HIV prevalence in Zambia ranges from a low of 7% in Northern Province and North-Western Province to a high of 21% in Lusaka Province. Figure 1.3 below describes HIV prevalence rates of Zambia on a province by province basis.

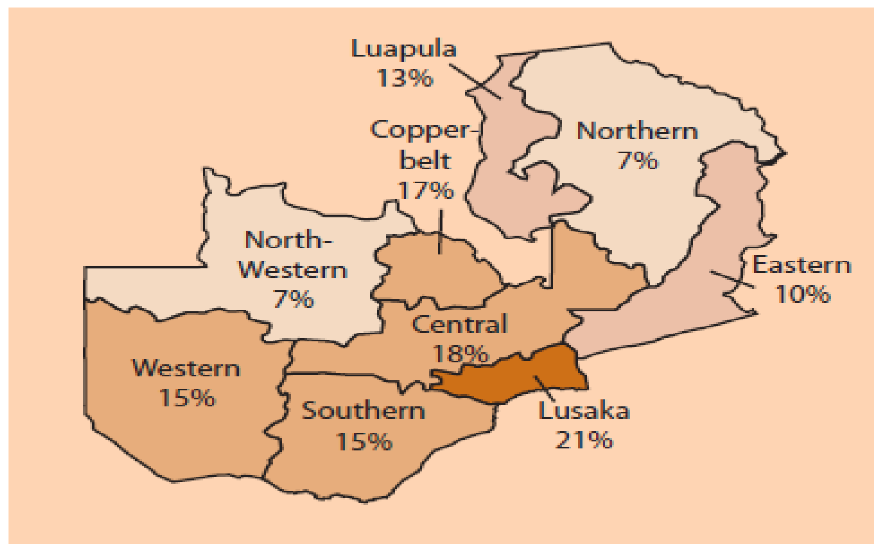

Figure 1.3—HIV Prevalence by Province
(Source: CSO et al. 2009:16)

Furthermore, according to the 2007 ZDHS (2009) HIV prevalence increases with education for both women and men. Ironically, HIV prevalence among women with more than secondary education is almost twice as high as among women with no education (CSO et al. 2009). HIV/AIDS in Zambia, as in most parts of Sub-Saharan Africa, has a “feminine face” (Mtonga 2007), meaning that the majority of people living with HIV/AIDS are females. It is the researcher’s view that this trend is partially attributable to cultural norms and practices in Zambia, which tends to work against women (cf. HRW 2002).

The “feminization of HIV/AIDS in Zambia” (Mtonga 2007) is not a simplistic issue, but seems to point to cultural traits (underpinned in worldviews) among most Zambian people groups, as in the majority of sub-Saharan African people groups, which looks down on women in sexual matters and consequently leads to risky behaviour (cf. Hinga et al. 2008; Loosli 2004; Chondoka 1988). The researcher will demonstrate that a way of changing

risky behaviour in Zambia will essentially involve transforming traditional norms and practices at worldview level. However, to be able to achieve this transformation of worldviews, identifying factors responsible for the rapid escalation of the HIV/AIDS epidemic will be crucially important. What precisely, then, are the factors perpetuating the spread of HIV/AIDS in Zambia? How much of these factors are anchored in Zambian people groups' worldviews?

1.1.2 Factors Perpetuating HIV/AIDS Growth in Zambia

DJ Louw (1995:29-44) in his insightful article, *'Pastoral Care for the Person with AIDS in an African Context'*, highlights the following crucial factors responsible for the rapid spread of HIV/AIDS in Africa:

- African males are traditionally polygamous, or have several wives or sexual partners. "Also, despite the effect of modern life on tribal customs, polygamy and concubinage are still tacitly accepted as normal cultural practices among Africans. Even if linked to the threat of AIDS, therefore, sexual promiscuity is unlikely to carry a stigma of approval" (Mokhobo 1988:43);
- Migratory labour and continuous moving between rural areas and cities heightens the risk of AIDS spreading;
- Women's lack of status gives them very little bargaining power in sexual relationships. They have very little chance of insisting that their husbands use condoms. "Many blacks perceive the contraceptive advice as a political manoeuvre supporting white engineered intentions" (Mokhobo 1988:34);
- Women's lack of economic power contributes to increased prostitution. So for example, the second virus, known as HIV2, was discovered in 1985 among prostitutes in Senegal. The virus is transmitted mainly through heterosexual activities. Therefore, the research of Hoffman and Grenz (1990:93-94) reaches the conclusion: "HIV in Africa is predominantly a heterosexually transmitted disease, the main factor being the degree of sexual promiscuity rather than sexual orientation (as in the United States)";
- Fertility in some groups leads to continuous procreation by AIDS infected parents;
- The high incidence of sexual diseases enhances the spreading of AIDS;
- AIDS is rapidly increasing among children in South Africa;

- AIDS programmes, providing information, also on prevention, often do not reach those groups in the highest risk factor. Many people are illiterate, while ignorance and carelessness play an important role (Louw 1995:32).

Louw's observations for South Africa are true for Zambia as well, except for the last point where he seems to suggest that information is not reaching "those groups in the highest risk factor." In the case of Zambia, knowledge of HIV and AIDS is nearly universal (CSO et al 2009:189), but sadly sexual behaviour has not significantly changed in tandem with this awareness. According to the 2007 ZDHS, nearly all Zambian adults have heard of HIV and AIDS, but knowledge of HIV prevention measures is lower. For example, only 69% of women and men age 15-49 know that the risk of getting HIV can be minimized by using condoms and limiting sex to one faithful partner. However, 85% of women and men know that abstaining from sexual intercourse can reduce the risk (CSO et al. 2009:14). Principally, however, Louw's observation about South Africans generally resonates with the Zambian HIV/AIDS situation where risky behaviour appears to be the norm rather than the exception (cf. Phiri 2008). The Republic of Zambia National HIV/AIDS/STI/TB Policy identified similar factors for the proliferation of HIV infection to those highlighted by Louw as the major drivers of the unending growth of the HIV/AIDS epidemic in Zambia (cf. NAC/Ministry of Health 2002:9-10).

Essentially, the NAC/MoF (2002) points to social-cultural beliefs and practices, which look down on women in society, as a potent cause of the rapid growth of the HIV/AIDS epidemic in Zambia. For instance, in traditional

premarital and post-marital counselling women are taught never to refuse a husband sexual intercourse even when it is plainly known that he is having extra marital sexual liaisons, or is suspected to have HIV or indeed any other STI (NAC/Ministry of Health 2002; HRW 2002; Haworth et al 2001; Mulenga 2009). Furthermore, multiple concurrent partnerships (perceived to be normal in most African societies including Zambia) are subtly fuelling HIV infection in Zambia (CSO et al. 2009; Phiri 2008). Other socio-cultural drivers of the epidemic are 'Widow/widower cleansing"[5], Dry sex[6], to name a few.

The HRW (2002) reported that a close interaction between poverty and HIV/AIDS in Zambia exists. According to this researcher, it is now a well-worn observation that HIV can bring poverty and poverty can escalate HIV/AIDS (cf. Stone 2001, van Niekerk et al. 2001; Usdin 2003; Fernandez 2003; Magezi 2005; Ndhlovu 2007; Mulenga 2009; etc). A little over 80% of Zambians fall below the poverty level and the majority of these are women (HRW 2002; World Bank Report 2005b). A rising proportion of female-headed households are emerging in Zambia mainly due to the HIV and AIDS epidemic. Child-headed homes in most Sub-Saharan Africa are no longer a rarity. Thus poverty is a significant element in the rapid growth of HIV/AIDS in Zambia and Africa as a whole (Barnett & Whiteside 2002; NAC/MoF 2002; Magezi 2005; Ndhlovu 2007, Hinga et al 2008).

[5] This is a custom where a surviving spouse is required to have sexual intercourse with a close relative of the deceased. It is believed that this cleanses the surviving spouse from being haunted by the 'ghost' of their dead spouse. Some people have been infected with the HI virus via this custom of sexual cleansing (NAC/MoF 2002; Loosli 2004). This practice was identified quite early as a driver of the HIV infection and has been fundamentally transformed among many tribal groupings to prevent the spread of the HIV/AIDS epidemic (Mulenga 2007).

[6]Dry sex in Zambia is the traditional practice of engaging in heterosexual activity where the vagina has been dried by the use of drying agents such as herbs and chemicals in the belief that it will heighten the man's sexual pleasure. The practice is so pervasive that when a women is known to be unsuccessful at reducing vaginal lubrication during sexual activity she is termed '*Chambeshi River'*. Needless to say that women are physically hurt by this unfortunate practice which also facilitates STIs including HIV infection.

Growing poverty has in some instances forced households to give their girl children into "sex for survival" (HRW 2002:35). Magezi (2005: 57) succinctly explains the close link between poverty and HIV/AIDS:

> The connection between these two issues (i.e. poverty and HIV/AIDS) works in two directions. Poverty increases vulnerability to HIV infection and plunges the family into deeper poverty, and HIV/AIDS exacerbates poverty as the potentially productive person becomes powerless and draws from savings. Consequently, poverty trickles down to the whole family….

Undoubtedly then poverty is a potent factor in fuelling risky behaviour and may be a critical player in the high HIV/AIDS prevalence in Zambia, but poverty has always been present for much longer[7]. The researcher therefore posits that while poverty is a key determinant of risky behaviour in Zambia, and most sub-Saharan Africa countries for that matter, effective preventive work should also be directed toward transforming socio-cultural perceptions, beliefs and norms entrenched in worldviews (cf. Brewer, DD et al 2003; PWG 2008).

1.1.3 Modes of HIV Infection

Barnett & Whiteside (2002) observe that HIV is not an aggressive virus and it is difficult to transmit. HIV can only be transmitted through HIV-contaminated

[7]Arguably, the poverty and HIV/AIDS interaction is definitely logical, but this does not imply the interplay between poverty and HIV/AIDS is simplistic. It is more intricate than it appears and the situation calls for a cautious stance toward its perception (cf. Magezi 2005:64-65, 70; Loosli 2004; Fernandez 2003, etc.) Barnett & Whiteside (2002) also point out that poverty intrinsically makes people susceptible to HIV/AIDS infection and HIV/AIDS exacerbates poverty levels. This researcher assents to the observation that poverty is definitely a driver of the HIV/AIDS epidemic in Zambia, but also contends that a worldview underpinning HIV risky behaviour is a significant fact in the growth of the epidemic. For example, in a study of sexual behaviour among young men in Zambia it was found that a stereotypical perception (rooted in most Zambian tribal worldviews) exists asserting that it is normal, and therefore laudable, for men to have concurrent sexual partners as a way of proving their "manhood" (Ndubani & Hojer 2001).

body fluids. HIV Infection will occur when sufficient quantities of the virus enter the body of a person (van Dyk 2005; Barnett & Whiteside 2002). Essentially, the virus has to pass through an entry point in the skin and/or mucous membrane into a person's blood stream. Therefore, the principal modes of HIV infection identified so far are unprotected sexual intercourse with an infected partner, use of infected blood and blood products, and mother to child transmission (MTCT). The researcher will survey these key media of HIV transmission in Zambia.

1.1.3.1 Sexual Transmission

In this mode of transmission HIV infection mainly occurs through unprotected (sex without a condom), penetrative vaginal or anal[8] sexual intercourse. Van Dyk (2005) notes that the HI virus can also be transmitted through oral sex under certain conditions, such as when there are wounds in the mouth. She also points out that for the HI virus to enter into the body it must attach itself to CD4 cell receptors. Many of the cells in the lining of the genital and anal tract have just such receptors, which makes it easier for HIV to enter into the body when having unprotected vaginal or anal sexual intercourse (van Dyk 2005). Furthermore, the mucous membrane of the genitalia has an abundant presence of antigen-presenting cells such as *Langerhans*[9] cells that are ready

[8] Some new studies posit that unprotected anal sex between men is perhaps a more significant dynamic in the epidemics in sub-Saharan Africa than is usually thought (UNAIDS 2008:43). In Zambia, 33% men surveyed who have sex with men tested HIV-positive (Zulu, Bulawo & Zulu 2006).

[9] "Langerhans cells are found in the skin and in the mucous membranes of the body, and there are large numbers of them in the mucous membranes of the female and male genitalia. The Langerhans cells are antigen-presenting cells, which mean that they present foreign antigens to the immune system. The Langerhans cells circulate continuously between the peripheral mucous membranes and the CD4 lymphocytes found in the lymph nodes and other lymphoid tissue…. the Langerhans cells may well be the key to understanding how HIV is transmitted across an intact genital mucous membrane—in other words, when there are no breaks in the mucous membranes—during sexual intercourse. …It is believed that once the Langerhans cell is infected by HIV in the mucous membrane, its natural migration route transports it to the CD4 cells in the lymphoid tissue where it functions as an antigen-presenting cell, presenting the HIV antigen directly into the waiting hands (or CD4 receptors) of the CD4 cell. Langerhans cells can therefore be called the 'taxi cells' of the immune system" (van Dyk 2005:24).

to carry the HIV antigens[10] to CD4 cells. Heterosexual sexual intercourse accounts for the majority of HIV infections in sub-Saharan Africa (Haworth et al 2001; NAC/Ministry of Health 2002; Central Statistical Office/Central Board of Health [Zambia] 2003; WHO 2005a; Mbewe 2005; UNAIDS and WHO 2007, 2009).

1.1.3.2 Mother-To-Child Transmission of HIV

Mother-to-Child transmission (MTCT) or vertical transmission of HIV is a main cause of HIV infection in children. Van Dyk (2005:31) writes, "Unless preventive measures are taken, 20-40% of children born to HIV-positive women are infected." An HIV positive mother can transmit HIV to her child through the placenta while pregnant, through blood contamination during labour, or through breastfeeding. According to Evans (van Dyk 2005:31) a mother is especially likely to transmit "the HI virus to her baby during pregnancy, childbirth or breastfeeding if:

- She becomes infected with HIV just before the pregnancy, during the pregnancy or during the breastfeeding period (because she will have a high viral load in her blood or breast milk during seroconversion[11]); and if
- she has advanced, symptomatic HIV disease with
  - a high viral load (>50 000 viral particles/ml);

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[10] According to Van Dyk (2005:10) "An antigen is any foreign (or invading) substance which, when introduced into the body, elicits an immune response like the production of antibodies that react specifically with these antigens. Antigens are almost always composed of proteins, and they are usually present on the surface of viruses or bacteria. When antibodies react to antigens, they can either destroy or de-activate the antigens."

[11] "Seroconversion is the point at which a person's HIV status changes from being negative to positive. After seroconversion an HIV test will be positive. Seroconversion usually occurs 4-8 weeks after infection with the HI virus" and usually coincides with the end of the window period (van Dyk 2005: 27).

- a low CD4 cell count (>200 cells/mm3);
- symptoms of AIDS."

Van Dyk (2005:31) further explains that if "the mother has a low viral load during pregnancy, childbirth or breastfeeding (<1000 viral particles/ml), the likelihood of transmitting the virus to her baby is low." MTCT accounts for the majority of HIV infections in children in Zambia (CSO et al. 2009; NAC/Ministry of Health 2002) followed by the sexual abuse of girls[12] (Human Rights Watch 2002).

1.1.3.3 Use of Infected Blood and Blood Products[13]

HIV infection also occurs when a person receives HIV contaminated blood in a blood transfusion; or when he or she uses contaminated skin piercing instruments such as needles, syringes and razor blades. Tissue transplant and organ transplants, including blood products used for treating blood disorders such as haemophilia can also cause HIV infection (Haworth et al 2001:15; van Dyk 2005: 27-31; etc). Alan Haworth and colleagues (2001:15) note that in Zambia "blood transfusions with infected blood accounts for 5-10% of HIV transmission." Magezi (2005:19) notes that in South Africa HIV infection through blood transfusion of contaminated blood accounts for only 1% of all cases. But remote as that probability of HIV transmission from blood

[12] Abuse of girls in Zambia (as in the rest of sub-Saharan Africa) is principally rooted in a faulty belief that an HIV positive man will be cured of the disease if he has sexual intercourse with a virgin. Hence some men resort to sexually abusing young girls. This belief is partially strengthened by a worldview, which has high regard for witchcraft and the traditional medicine man.

[13]To avoid such incidences, the World Health Organization (WHO) stipulates that all donated blood be screened for HIV, hepatitis B and syphilis (and hepatitis C where facilities are available)[van Dyk 2005:28]. The issue of the 'window period' (the period after infection but before antibodies are formed to an ample level for detection) gives problems to blood transfusion services, however.

transfusion is, it must be noted that there is no such thing as 'risk-free blood' (WHO 2005a; van Dyk 2005).

The sharing of syringes, needles and other sharp objects also has a high risk of transmitting the HI virus. Intravenous drug users are an example of situations where HIV infection has happened when contaminated needles are shared. Accidental exposure to blood-contaminated needles or other sharp instruments can transmit HIV infection. This is especially a risk with which health professionals live (van Dyk 2005). The HI virus is also transmissible through ear piercing, tattooing, and contact with infected blood at an accident scene, and the ritual of circumcision or scarification in some African tribes (cf. Loosli 2004; van Dyk 2005; Magezi 2005; Mulenga 2009).

Having briefly surveyed the major routes of HIV/AIDS transmission in Zambia, it is fitting that we take a cursory look at the country's response to the epidemic since its first incidence nearly three decades ago. In the main, the country had a slow response to the epidemic and there was immense stigma attached to HIV/AIDS infection by almost all stakeholders. The section below takes a short look at Zambia's response rate to the HIV and AIDS epidemic.

1.2 A Slow Response to HIV/AIDS in Zambia

This section of the study seeks to tackle two vital aspects to Zambia's response to the HIV and AIDS epidemic. Firstly, the researcher will describe the rate of response to HIV/AIDS since its first reported case in 1984. And secondly, the researcher will highlight the approaches to risky behaviour

change with the aim of indicating the vitality of addressing worldview transformation as a valid solution to the HIV and AIDS epidemic in Zambia. In the main, Zambia had a sluggish response to HIV and AIDS characterized by denial and stigma rooted in a moralization of HIV infection.

1.2.1 A Sluggish Start

The fact that Zambia has had a sluggish response to the HIV/AIDS epidemic in its' initial stages is an incontrovertible observation (cf. Noble 2006; Mulenga 2009; Ndhlovu 2007). Today, HIV/AIDS is widespread in Zambia (Haworth, A et al. 2001:11, NAC/Zambian MoH 2002). There is practically no part of Zambian society that is not affected by the epidemic (see figure 1.3 above for HIV prevalence by province). The most vulnerable groups to the HIV/AIDS epidemic are young women and girls, partly due to their meagre economic empowerment levels and HIV infection predisposing cultural-traditional practices (NAC/Zambian MoH 2002, WHO 2005b, CSO et al. 2009). It is also significant to note that the disease has worst struck men and women in their most productive years (15-49 years). Close to every household in Zambia has felt the adverse economic impact of AIDS[14].

While responses to the HIV/AIDS epidemic in Zambia had a sluggish start, it has fundamentally changed with the government now playing a leading role in the fight against it. Since the first AIDS diagnosis in Zambia in 1984, a rising trend in HIV incidence has been more of the norm than the exception. By

[14] UNDP estimates that the incomes of AIDS-affected households can be reduced by up to 80 percent; and a 1999 study of AIDS orphans reported that, for 2/3 of Zambian households that have suffered paternal death, disposable income fell by 80 percent in the first year alone (PVA Report 2005:199-200).

1993, infection rates among pregnant women had risen to 27% in urban areas and 13-14% in rural areas. These levels have remained more or less stable ever since (UNAIDS and WHO Epidemiological Fact Sheet - 2004 Update, Zambia). Haworth and colleagues (2001:11) underscore this tragedy by pointing out that “AIDS is a serious problem in Zambia [which] has spread though out the country.” Haworth and colleagues (2001) further hint that the HIV epidemic in Zambia could be worse than is officially reported when they assert,

> [T]here is much more to the pandemic than the number of reported cases since there is evident under-reporting of the cases, non-reporting of cases especially in rural areas and by privately owned health facilities. The true picture of the AIDS situation suggests that Zambia has one of the highest HIV/AIDS prevalence rates in Sub-Saharan Africa (Haworth et al. 2001:11).

This researcher agrees with Haworth and colleagues’ (2001) position that Zambia may have one of the highest HIV prevalence rates in the sub-region. The researcher thinks that the HIV/AIDS situation in Zambia could be worse than is officially known because HIV/AIDS associated stigma (see Ndhlovu 2007; Ogden & Nyblade; ICRW 2003) has made openness about the disease a difficult matter for conversation[15].

The ZDHS 2001-2002 (2003) findings showed that HIV/AIDS in Zambia is not evenly distributed across geographic and demographic groupings. Indications are that while males were disproportionately infected during the early stage of the disease, the majority of infections currently occur among women, especially in younger age groups. This trend may also be attributable to trans-

[15] The Zambia 2007 Demographic and Health Survey (ZDHS 2007) found that 47% of women and 55% of men in the survey indicated that they would not want to keep a secret that a family member was infected with HIV (CSO et al. 2009:198). This finding implies that HIV-related stigma is still strong in Zambia. The researcher will show in chapter 2 that HIV-related stigma has been a major hindrance to HIV/AIDS mitigation and prevention work in Zambia.

generational sex[16], which is nearly a traditional norm in Zambia (Chondoka 1988).

Within the first two years of the first AIDS reported case in Zambia, the National AIDS Surveillance Committee (NASC) and National AIDS Prevention and Control Programme (NAPCP) were established to coordinate HIV/AIDS-related intervention activities (NAC/Zambian MoH 2002, Noble 2006b). Sadly, however, much of what was known about HIV prevalence was not divulged for public knowledge due to the high levels of HIV/AIDS-Associated stigma. As a result, by the end of the 1980s many Zambians were still in denial and stigmatization was not uncommon (Noble 2006b; Ndhlovu 2007; Mulenga 2009). Thus the HIV and AIDS epidemic spread silently but rapidly. At the end of the 1990s there was still little goodwill by authorities towards the HIV/AIDS crisis in Zambia. It was only in the new millennium that a noticeable change in the political leadership's attitude towards the problem occurred. The National HIV/AIDS/STD/TB Council (NAC) was created in March 2000, but only became functional in December 2002 when parliament finally approved its formation (NAC/Ministry of Health 2002). Hence, it is clear that the fight against HIV/AIDS in Zambia had a sluggish start. Presently the government has admitted that the need for a multidisciplinary approach[17] to HIV/AIDS

[16]Trans-generational is a term describing a situation where older persons have sex (for whatever reasons) with people significantly younger than them (Loosli 2004). It is this researcher's opinion that the social trend where older men prefer sexual liaisons with younger women than with their peers exists in Zambia. This preference appears to partially explain the higher infection rates among younger women and girls compared to their male counterparts, beside sexual abuse of girls and transactional sex or gift-sex (situations in which women give in to sex in order to meet material needs from their partners) [cf. ZDHS 2003; Loosli 2004; Ndhlovu 2007; CSO et al 2009).

[17]This is an all-embracing approach to the fight against the HIV/AIDS epidemic through actively involving a varied array of sectors, such as, agriculture, health, and includes private enterprise, NGOs and other sectors to combat the spread of the HIV/AIDS epidemic. This approach also recognizes that churches have a crucial role to play in the fight against the spread of HIV and AIDS (cf. NAC/ Zambian MoH 2002; Magezi 2005, Ndhlovu 2007, Mulenga 2007 etc)

management is essential to the fight against the HIV/AIDS epidemic (NAC/Ministry of Health 2002; Mulenga 2009; Ndhlovu 2007).

The researcher will demonstrate that it is indisputable that Zambia is facing a significantly high HIV incidence in spite of the almost universal knowledge on HIV/AIDS and its modes of transmission (ZSBS 2000; NAC/Zambia MoH 2002). The situation is a vexing one, especially that a principal assumption of the organized response to the epidemic is seemingly failing—the assumption that with more knowledge on HIV/AIDS infection people will begin to change HIV risky behaviour[18]. But risky behaviour change is far from happening as evidenced by the escalating HIV/AIDS morbidity and mortality rates in sub-Saharan Africa (PWG 2008, 2006b; UNAIDS and WHO 2007).

1.2.2 Current Approaches to Risky Behaviour Change in Zambia[19]

Though Zambia had a slow start in response to the HIV/AIDS epidemic, there is ample evidence that rigorous attempts are now being made to check the impact and growth of the scourge (cf. NAC/Zambian MoF 2002; CSO et al 2003; WHO 2005a; Ndhlovu 2007; Chituwo 2008; CSO et al. 2009). However, one crucially important question should be posed: What have been the approaches toward risky behaviour change in Zambia so far and to what extent have they been successful?

1.3 Problem Statement

[18]The United Nations (2002:4) pointed out, “Public awareness of AIDS is an important prerequisite of behavioural change. Levels of awareness provide a measure both of the impact of past information campaigns carried out by Governments, non-governmental organizations and the mass media, and of the magnitude of the challenges lying ahead.”

[19]Chapter two of the study will deal with this issue in more detail to show the gap which this researcher’s thesis seeks to close.

Manasseh Phiri (2008), a long standing medical doctor in Zambia, admits that in spite of the almost universal knowledge that Zambians have on HIV and AIDS, risky behaviour[20] is not uncommon in Zambia. Phiri (2008: v) further points out that in Zambia "more than 90 per cent of HIV infections is transmitted and contracted through the sexual route." The situation in Zambia, where the HIV/AIDS epidemic is not relenting despite considerable preventive efforts spanning over nearly the past three decades, is a clear attestation to the fact that HIV/AIDS awareness (or education) does not entail risky behaviour change (PWG 2008). The assumption therefore that HIV/AIDS awareness will produce risky behaviour change does not appear to be entirely valid. King (1999) says that education alone is not enough to induce behaviour change among most individuals. King admits that sexual behaviour is a complex matter. She adeptly writes, "…social researchers have come to realize that because complex health behaviours such as sex take place in context, socio-cultural factors surrounding the individual must be considered in designing prevention interventions" (1999:5).

Since HIV infection in Zambia is mainly spreading through the heterosexual route, it is clear risky behaviour change is not happening despite the many preventive measures being taken by stakeholders[21]. In view of this predicament, the question being posed is "What can be done to help people change HIV-risk behaviour so pervasive in sub-Saharan Africa and Zambia in

[20] Risky behaviour constitutes those actions which expose or promote the transmission of the HI virus, such as, having unprotected sexual intercourse (vaginal or anal), concurrent and multiple sexual partnerships, sharing needles, etc. The researcher will tackle especially the route of heterosexual intercourse to which is attributed more than 90% of HIV incidence in Zambia (Phiri 2008; UNAIDS and WHO 2009).
[21] This situation where the HIV/AIDS epidemic is not slowing down despite high knowledge levels is not unique to Zambia, but is generally true to most sub-Saharan Africa countries (UNAIDS 2007; Dinkelman et al 2006, etc).

particular?" What precisely can the church in Zambia do toward changing sexual behaviour in the context of the HIV and AIDS epidemic?

Presently, interventions which are meant to check the spread of HIV throughout the world are as diverse as the contexts in which they are found. King (1999:5) writes,

> Not only is the HIV epidemic dynamic in terms of treatment options, prevention strategies and disease progression, but sexual behaviour, which remains the primary target of AIDS prevention efforts worldwide, is widely diverse and deeply embedded in individual desires, social and cultural relationships, and environmental and economic processes. This makes prevention of HIV, which could be essentially a simple task, enormously complex involving a multiplicity of dimensions.

King's (1999) observation is informative. She however, fails to propose a feasible and holistic solution to the dilemma posed by HIV risky behaviour. What praxis must evangelical Christians in Zambia adhere to in order to initiate a feasible approach to successful and enduring HIV-risk behaviour change?

Peterson (2000:780) defines praxis as "the outgrowth of commitment to a dynamic hermeneutical methodology that interacts with the concrete historical reality on one hand and the biblical text on the other. This dialectical process is foundational to respond adequately in an integral manner to the spiritual and physical needs of hurting people." Thus the very nature of Evangelical Christianity calls for a relevant response to the suffering of people by effecting behaviour change processes in order to check the growth of the HIV and AIDS epidemic (Hendriks 2002). Evangelical Christians in Zambia are

therefore obligated to respond to the dilemma of unsafe sexual behaviour amidst the HIV/AIDS epidemic. In other words, What praxis must the church pursue to help people groups in Zambia change sexual behaviour? Is behaviour change achievable in Zambia at this juncture?

1.4 Purpose of the Study

This research aims at investigating how the Church can facilitate effectively HIV risky behaviour change by transforming worldviews of Zambian people groups as a pastoral intervention to the current growth of the HIV and AIDS epidemic. The study will be done with an awareness of the impact of the epidemic both within a global, sub-regional, and Zambian setting. This will entail that a Zambian perspective and mindset will have a critical bearing on the relevant intricacies involved in both being and doing Practical Theology in a context of an unrelenting epidemic.

The study aims to design a praxis model which will engage cultural worldviews from a biblical standpoint in order to change inherent cultural dynamics which predispose many Zambians to HIV/AIDS infection. The researcher posits that authentic behaviour change is feasible in Zambia when transformation occurs at the culture's core—the worldview level. Therefore, a Zambian spirituality, situated in sub-Saharan Africa's Spirituality, will interface with the HIV/AIDS epidemic with a goal of evaluating existent behaviour change theories and models to design a feasible evangelical model that will address worldview transformation toward the change of unsafe sexual behaviour. The researcher aims at designing an approach to risky behaviour

change that will be efficacious through the transformation of people's worldviews as a means of decelerating the growth of the HIV and AIDS epidemic in Zambia.

1.5 Relevance of the Study

The Joint United Nations Programme on HIV/AIDS (UNAIDS) reports that "Southern Africa remains the epicentre of the global HIV epidemic with 32% of people with HIV globally living in this subregion and 34% of AIDS deaths globally occur there" (Sub-Saharan African 2006 Epidemic Update 2006: 10). Zambia is located right in the heart of Southern Africa. The HIV/AIDS epidemic in Zambia continues to grow through the heterosexual intercourse route (ZSBS 2002; ZDHS 2003; Ndhlovu 2007; UNAIDS 2007; Phiri 2008; CSO et al. 2009; UNAIDS and WHO 2009) in spite of the almost universal HIV/AIDS awareness by the country's inhabitants. Arguably, there is hardly a person in Zambia who has not felt the impact of the disease either through the loss of a loved one to an HIV/AIDS-related illness (Dube 2003b; Magezi 2005; Mulenga 2009; Ndhlovu 2007) or is caring for a person living with HIV/AIDS. This study seeks to develop a Practical Theology, which will help evangelical Christians in Zambia to participate effectively and precipitate behaviour change through transforming the necessary worldviews.

1.6 Hypothesis

It cannot be overemphasized that some traditional practices and customs have significantly contributed to the rapid growth of the HIV and AIDS epidemic in Zambia (NAC/Zambian MoH 2002; HRW 2002; Loosli 2004;

Ndhlovu 2007; CSO et al. 2009). It is not the practices and customs in and of themselves that are faulty, but the presuppositions and beliefs at worldview level that underlie the behaviour (Ntseana & Preece [Undated]). This researcher posits that in order to win the fight against the continued growth of the epidemic in Zambia, evangelical Christians doing theology, should aim at facilitating the change of risky sexual behaviour (to which is attributed more than 90% of new HIV/AIDS infections annually) by engaging Zambian worldviews that underpin the socio-cultural practices of risky behaviour toward transformation. Furthermore, it is the researcher's proposition that authentic HIV behaviour change will only happen if it occurs at the worldview level, that is, from inside out and not the reverse (cf. Hiebert 2008; Kapolyo 2007; Kraft 1996). The researcher also posits that this approach to HIV/AIDS intervention in Zambia falls with the evangelical church's task of "doing" Practical Theology[22] in the context of a growing epidemic (cf. Hendriks 2002; Magezi 2005; Ndhlovu 2007). In short, this researcher hypothesizes that a significant solution to the HIV/AIDS risky behaviour change dilemma lies in the Church that embraces a praxis which aims at the transformation of worldviews of Zambians.

1.7 Method of Study

The Practical Theology methodology suggested by Hendriks (2004: 34) will constitute the basis of this study. This methodology recognizes the fact that

[22]Ndhlovu (2007:56) adeptly says that Practical Theology is concerned with "[doing] theology by first focusing on local and particular issues with the intention of doing something about the reality and problems confronting the faith community, as well as society. It does this because God in his coming to us in and through Jesus Christ initiated something that changed people and formed them into a community of a people called to love God and their neighbour." The researcher holds that Practical Theology is much more than word proclamation, but rather calls for a praxis which in the context of HIV and AIDS will not only give care to people living with HIV/AIDS (cf. Mulenga 2007), but will also proactively act to stem the growth of the pandemic.

'doing theology' is about demonstrating insight and producing a hermeneutic which seeks to respond biblically to contemporary issues in a germane manner. This insight, then, leads to the involvement of the Church in society for the honour of God. This involvement is a response (praxis) to the presence of the triune God who interacts with the faithful through Scripture and tradition in a specific situation and beckon them to the future (cf. Hendriks 2004). This beckoning to the future entails change in praxis on the part of the Church to become agents of transformation in that particular context.

This methodology further has a particular bearing on the issue of HIV risky behaviour change as it encourages the church to interface with worldviews, the bedrock of behaviour (Stone 2001). Other studies (Ntozi and Kirungu 1997; King 1999; Loosli 2004; Ntseana and Preece [undated]) have shown that psychology's theories and models of behaviour change alone appear not to be adequate for the African context. King (1999) notes that psychological theories and models have been extensively and effectively used in the United States of America, especially among the gay community, but she is in doubt whether they can be transplanted into the African setting without major adaptations. This research will not ignore the psychological theories and models of risky behaviour change, but will interface with them from an evangelical perspective[23].

[23] The present researcher would like to refer to a very precise and pertinent practice of concern, namely transforming culturally driven mores to change risky sexual behaviour in a context of the HIV/AIDS pandemic in Zambia. The research, focusing on changing risky behaviour in Zambia, will be the "moment of praxis" (Muller 2005:3) out of which Practical Theology will emerge. August (2009) demonstrates that Postfoundationalism permits the researcher to engage in an interdisciplinary dialogue between science and theology to gain a theological reflection to inform practice. This means that authentic interdisciplinary conversation between Theology and Science can be done when "safe spaces where both

The study will be based on literature review of HIV risky behaviour change taking cognisance of similar studies undertaken in the sub-Saharan Africa region (cf. Dinkelman et al 2006). Sufficient sources on the problem of HIV/AIDS risk behaviour change and its connection to the transformation of worldviews are available for such an approach. An evangelical viewpoint will form the bedrock of this study, however. The research methodology will use primary data sources from the Zambian MOH, National HIV/AIDS/STD/TB Council (NAC), Zambia Demographic and Health Surveys, the Zambia Sexual Behaviour Surveys, WHO Reports, UNAIDS, Global HIV Prevention Working Group (PWG), FBOs involved in HIV/AIDS work, and other NGOs combating the HIV and AIDS epidemic in Zambia. Admittedly, the nature of this research calls for an interdisciplinary study and consulting secondary data sources from areas of Christian Ethics, Missiology, Psychology and Sociology of religion, Cultural Anthropology, to mention a few. Hence, the researcher will interact with such secondary sources, such as, journals, reports, case studies, and theses which touch on the subject of theories and models of behaviour change and relate them to the HIV and AIDS epidemic in Zambia. Ultimately, the researcher will make use of secondary sources such as books, journals, magazines and relevant websites in order to make a critical evaluation of their standpoints from a biblical perspective and to posit a feasible approach toward risky behaviour change through worldview

strong Christian conviction and the public voice of theology are fused in public conversations with the sciences" (August 2009:50) are identified.

transformation as a pastoral intervention to a still growing HIV and AIDS epidemic in Zambia.

1.8 Description of Chapters

1.8.1 Orientation of Research

Chapter one is an introduction to the research. It will make a synoptic description of the problem of a growing HIV/AIDS epidemic in spite of an attested fight against its continued growth undergirded by the presupposition that HIV/AIDS awareness, and education on modes of infection, inevitably induces risky behaviour change. Having sketched the background of the research, the chapter will state the purpose of the research, its relevance, hypothesis, and methodology. The chapter closes with a description of chapters.

1.8.2 Doing Practical Theology in a Context of HIV/AIDS

Chapter two will review pertinent literature on the dilemma of risky behaviour change and its connection to worldview transformation. The chapter will discuss the concept of HIV-risk behaviour, describe and critique contemporary theories and Models of HIV risk behaviour change, and give a biblical rationale for doing theology amid a growing HIV and AIDS epidemic in Zambia. The chapter will close with preliminary conclusions.

1.8.3 Worldviews and Changing HIV Risky Behaviour

Chapter three will define the concept of worldview. The chapter will investigate the role a worldview fulfils in the culture (the total outward

behaviour or life way[24]) of any people group. Chapter three will further explain the link between a worldview and HIV-risk behaviour change. This chapter is based on the premise that contemporary HIV/AIDS preventive interventions are largely failing in sub-Saharan Africa because they are not addressing the worldview of contemporary Africans. The Chapter will close with pertinent preliminary inferences.

1.8.4 Transforming Worldviews to Change HIV-Risk Behaviour

Chapter four will discuss the dynamics of worldview transformation, posit how contemporary behaviour change approaches are not affecting the majority of Zambian worldviews, and design an evangelical model for worldview transformation toward HIV-risk behaviour change. Essentially chapter four will discuss the theological task of initiating and sustaining worldview transformation in order to effect HIV-risk behaviour change in Zambia. Chapter four will close with relevant conclusions.

1.8.5 Thesis Summary, Prospective Issues and Conclusion

Chapter five will constitute the conclusion of the study. The chapter will summarize the preceding chapters' findings, make recommendations toward a worldview transformative evangelical praxis, describe and discuss

[24] Shorter, when explaining the nature and function of culture, writes:

> Culture is the whole way of life, material and non-material, of a human society....'that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by human beings as members of society' (Shorter 1998:22).

Arguably Shorter (1998) sees a connection between worldview and the way people behave in society. Chapter 3 will hence sketch the dynamic interplay between worldview and culture and show that change can be initiated at either, but intense resistance to change, and cultural disequilibrium, occurs when the novelty is not accepted by the recipient culture at worldview level (cf. Luzbetak 2000; Kraft 2005).

prospective issues emerging from the research for further study. The overall conclusion of the thesis will be stated.