CHAPTER TWO

DOING PRACTICAL THEOLOGY AMID A GROWING HIV/AIDS EPIDEMIC

2.1 Introduction

Ndhlovu (2007:146) says that HIV and AIDS in Africa is for African theology what Auschwitz and Hiroshima were for the North Atlantic theology. The HIV/AIDS epidemic in Zambia poses a critical theological challenge to Christians. God the Creator is concerned about the current situation because it has touched his image (human beings) in the realm of creation. By its very nature and mission, the Church, the apostolic faith community, cannot ignore the call to fight the spread of the HIV/AIDS epidemic (Hendriks 2002, Magezi 2005, Ndhlovu 2007). This chapter will define and describe the task of doing theology amid a growing HIV/AIDS epidemic. It will also review pertinent literature on the dilemma of risky behaviour change and its' connection to worldview transformation. The chapter will survey and critique contemporary approaches to HIV-risk behaviour change and end by giving a biblical rationale for doing theology amid a growing HIV/AIDS epidemic in Zambia.

2.2 Defining Practical Theology

Hendriks (2002:9) defines theology as "an ecclesial, missional methodology ….a scientific or rational as well as a spiritual dimension". Hendriks then makes a comprehensive statement on the meaning of theology. He astutely posits that Practical Theology is about the following eight (8) critical tenets of the Christian faith:

a. The missional praxis of the triune God, God Creator, Redeemer, Sanctifier
b. and about his, body, an apostolic faith community,
c. at a specific time and place within a globalized world (a contextual situation)
d. where members of this community are involved in a vocationally based critical and constructive interpretation of the present reality,
e. drawing upon an interpretation of the normative sources of Scripture and tradition,
f. struggling to discern God's will for their present situation (a critical correlational hermeneutic),
g. to be a sign of God's kingdom on earth while moving forward with an eschatologically, faith-based reality in view, … and
h. while obediently participating in transformative action at different levels: personal, ecclesial, societal, ecological and scientific (a doing, liberating, transformative theology….) [Hendriks 2002:9].

In a word, Hendriks seeks to define the practice of theology as a discipline which wants to be germane to its context as an intervention to a community's challenges and perplexities. The HIV/AIDS epidemic is one such challenge and perplexity that requires an urgent and relevant theological response with a view of decelerating the speed with which it is growing in sub-Saharan Africa. The current researcher considers the church in society as an important player in the fight against the HIV/AIDS epidemic as she is almost a ubiquitous institution in this sub-region and is by nature a caring community arising from both the cultural (Genesis 1:28) and evangelistic (Matthew 28:19,20) mandates. The Church, therefore, must carry out its mandate by endeavouring to find means of doing theology to avoid the traps which characterized the previous century, where evangelical Christians, for the most part, concentrated on the proclamation of the Gospel at the expense of doing the “good works” (Ephesians 2:10) by applying biblical solutions to societal crises. The researcher will seek to engage the complex situation of an escalating HIV/AIDS epidemic in Zambia in order to propose a feasible

intervention through transformative action (cf. Hendriks 2002). Ndhlovu (2007: 146), an eminent Zambian theologian, asserts that "Zambian Churches do not have an effective strategy in place that addresses the issue of HIV in a holistic way at a congregational level where it can effectively reach and influence members." The present researcher shall endeavour to fill this gap, to which Ndhlovu alludes, by proposing an approach to HIV-risk behaviour change through intentional engagement of socio-cultural norms, values, and beliefs which are fuelling the HIV/AIDS epidemic in Zambia at the cultural core, that is, the worldview level.

The central idea of Hendrik's foregoing delineation of Practical Theology is that it relates to the church's participation in God's praxis. Consequently, doing theology in the context of HIV/AIDS in Zambia will entail an interpretation of what God would have the church do both to mitigate the impact of the epidemic and to check its continued growth by being involved in a quest for efficacious behaviour change. Furthermore, it is the researcher's standpoint that doing theology is about exercising compassion and care for people living with HIV/AIDS (PLWHA) and about providing structures which empower faith communities toward becoming a transformative force toward forestalling the spread of HIV and AIDS without 'moralizing'[25] it (Magezi 2005, Ndhlovu 2007). The researcher posits that doing theology in Zambia essentially entails involvement in changing any behaviour which predisposes people to HIV infection. Hence, it is this researcher's position that facilitating and advocating for the change of risky sexual behaviour is not a preserve of

[25] Hlongwana and Mkhize (2007) adeptly deplore the perception which imply that being HIV positive is a punishment from God for an individual's sexual depravities (misdemeanors). Moralizing HIV/AIDS infection, then, is the error of equating an HIV positive status to sexual promiscuity. Moralizing, then, is a subtle manifestation of HIV-associated stigma.

health and social scientists[26]. The Church should play a role in the quest for HIV-risk behaviour change seeing that she has considerable influence in society, which she is found in almost every part of the country, and that its mandate has ethical implications. Thus the discipline of Practical Theology requires that the church in Zambia makes concerted efforts to develop a relevant theology of HIV/AIDS and engage itself in a process of facilitating the change of HIV-risk behaviour.

Webster (2001: 686) suggests a method of doing theology which "requires the theologian to be immersed in his or her own intellectual and socio-political history." He writes,

> Theology is not a system of timeless truths, engaging the theologian in the repetitious process of systematization and apologetic argumentation. Theology is a dynamic, ongoing exercise involving contemporary insights into knowledge (epistemology), humankind (anthropology) and history (social analysis). Praxis means more than the application of theological truth to a given situation. It means the discovery and formation of theological truth out of a given historical situation.... (Webster 2001:686).

Although the researcher disagrees with Webster's innuendo that theology is 'fluid discipline' he concurs that every incidence in contemporary history must receive theological reflection toward establishing a response from faith communities. The question "What would the Lord have us do as His people in this context?" must be posed and answered in every emergent crisis or

[26] Julian Muller (2004) astutely points out that an interdisciplinary approach is an indispensable reality to doing practical theology in HIV/AIDS. He writes,

> …a one-size-fits-all methodology cannot be applied. But this interdisciplinary movement is part and parcel of practical theology. It includes the conversation with other theological disciplines and with all the other sciences. The researcher has to listen carefully to the various stories of understanding and make an honest effort to integrate all of them into one (2004:303).

The current researcher therefore approaches the issue of risk behaviour change with a practical theological awareness that other disciplines have made gains toward precipitating success in the endeavours and will not simplistically dismiss theories and models whose epistemology varies with evangelical theological praxis. The approach will be integrative, but not syncretic, and will thus hold a healthy "tension" (Louw 1997; Magezi 2005) between the two.

situation. Thus, in a situation where risky HIV behaviour is not changing amid an unrelenting and incurable epidemic, such as HIV and AIDS, the church becomes a critical player toward both mitigating the impact of HIV/AIDS and decelerating its' spread through facilitating behaviour change. In this sense therefore the church is not meant to be "theoreticians but practitioners engaged in the struggle to bring about society's transformation" (Webster 2001:686). This position implies that Christians are not to remain passive and indifferent to the issue of initiating HIV/AIDS preventative behaviour change. The researcher, therefore, posits that advocating HIV-risk behaviour change is a plea for costly discipleship and a reminder that following Jesus Christ has spiritual, ethical, practical, and social implications. Fundamentally, reducing HIV-risk behaviour is amenable to social, practical, ethical and spiritual transformation (cf. Roman 12:1-2).

2.3 HIV-Risk Behaviour Defined

But what is meant by HIV-risk behaviour? The high incidence and prevalence of HIV/AIDS in sub-Saharan Africa (of which Zambia is a part) as compared to the rest of the world seem to suggest that unique dynamics contributing to infections are extant here. Although it is presupposed that some traditional and cultural practices in sub-Saharan Africa favour the transmission of HIV, precise studies have not been done to establish the connection. However, such practices seem so ingrained in culture that it appears impossible to stop them. Loosli (2004) asserts that it is feasible to alter behaviour, but admits that this route of combating HIV/AIDS is fraught with difficulties which are deeply rooted in cultural diversities. For instance, safer sex practices have not

been accepted by everyone throughout the world, but evidence does exist to the effect that by intensive and consistent awareness and empowerment efforts, attitude and behaviour change is possible (Kelly 1995, King 1999, Loosli 2004, Gary et al. 2006; PWG 2008). Kelly, Parker and Lewis (Stone 2001:251) observe that, “behaviour change” is usually perceived as the main focus of HIV/AIDS preventive work, and efforts to model responses to the HIV/AIDS epidemic provide conducive grounds for investigating the idea of behaviour change.

Kelly, Parker and Lewis (Stone 2001) further explain that behaviour change approaches to HIV/AIDS were first attempted during the early years of the epidemic when medical researchers applied them to well-defined at-risk groups (where risk could be attached to particular relationships and behaviours). These included HIV/AIDS positive gay men in the United States, or groups like truck drivers, sex workers, and intravenous drug users. In the case of such target groups, the main modes of transmission were relatively easy to determine, and success relied on the adoption of specific behaviours. The measurement of effectiveness could also be observed by using pointers of precise behaviour change, such as starting to use condoms (cf. Kelly 1995). However, Kelly and colleagues (Stone 2001) are quick to caution that advanced HIV/AIDS epidemics (as in most sub-Saharan Africa) are different and hence, it is difficult to measure the effectiveness of behaviour change approaches. In this respect, the present researcher posits that the fact that behaviour change is difficult to gauge does not mean it is infeasible to pursue as an intervention to the HIV and AIDS epidemic (cf. PWG 2008).

2.4.1 The Dilemma of HIV-Risk Behaviour Change in Zambia

Kelly and colleagues argue that context has a vital effect on successful behaviour change in HIV/AIDS preventive work. They assert that 'behaviour change' is often thought as the primary focus of HIV/AIDS preventive work, and attempts to model responses to the HIV/AIDS epidemic provide fertile grounds for exploring the concept of behaviour change" (Stone 2001: 251). Kelly and colleagues' view imply that behaviour change approaches are applicable to the HIV and AIDS epidemic in sub-Saharan Africa.

Kelly and colleagues (Stone 2001) cite three critical issues which are complicating efforts to change risky sexual behaviour change in sub-Saharan Africa. The current researcher posits that these complexities are relevant to combating effectively the HIV/AIDS epidemic in Zambia, where no less than 90 per cent of HIV infections are attributable to heterogeneous sexual activity (CSO et al. 2009; Phiri 2008).

Firstly, target groups are larger and more diverse today. Those who are at risk, and the relationships and behaviours, through which the virus might be transmitted, cannot readily be isolated as before. In the initial phases of the epidemic it was much easier to define the at-risk groups and to target the exact behaviours for change as a preventive measure to the proliferation of HIV and AIDS. Among the critical factors that have contributed to widespread HIV incidence in sub-Saharan Africa include a high level of sexually

transmitted infections (STIs), low levels of male circumcision[27], very low levels of condom use, concentration of the population along the railroad lines, a sufficient level of sexual networking to spread the virus, and HIV-related stigma[28] (Inungu and Karl 2006). These factors continue to be challenges to the fight against the HIV/AIDS epidemic in Zambia. Early stages of HIV prevention in Zambia were characterized by the state-led approach of information, education, and communication (IEC) with mass media campaigns as the primary modality to warn people of the dangers of HIV/AIDS and promote abstinence before marriage (NAC 2005; AVERT 2006). This approach carried the assumption that individuals needed information about health risks and that providing knowledge would result in changing risky behaviour. Non-governmental organizations (NGOs) and churches provided services such as counselling and home-based care programs, but coverage has often been low and small in scale (cf. Byron et al. 2006). These HIV preventive efforts had well-defined target groups who were engaging in risky sexual behaviour. The same cannot be said of HIV-risk sex in Zambia, where both the target behaviour and intervention are so diverse and seem to be relatively ill-defined[29].

Barnett and Whiteside (2002) elucidate that the concept of the core group is premised on the idea that some sections of a population are more probable to

[27] Section 2.4.3.5 will briefly discuss the subject of medical circumcision as an HIV preventive measure in Zambia.

[28] According to the 2007 ZDHS there is still a lot of stigma associated with HIV in Zambia. While most men and women said they were willing to take care of a family member with HIV, about half said that they would want to keep secret that a family member was HIV-positive. About two thirds of women and three-quarters of men said that they would buy fresh vegetables from an HIV-positive shopkeeper" (CSO et al. 2009 b: 14).

[29] The ZDHS 2007 has, however, defined higher-risk sex as "sex with a partner who is neither a spouse nor lived with the respondent in the 12 months preceding the survey. Overall, 17% of women engaged in higher-risk sex in the year before the survey, as did 38% of men. Half of these men and 37% of these women used a condom at their most recent higher-risk sex" (CSO et al. 2009:14). The researcher thinks that ZDHS 2007 definition of higher-risk behaviour is a helpful one for a targeted behaviour change response in the Zambian context.

transmit sexual infections than others. In the late 1970s Herbert Hethcote and James Yorke (1984) demonstrated this notion. They contended that a comparatively small group of people—definable by its characteristics, geographic, socio-demographic, behavioural—was responsible for keeping gonorrhoea at epidemic levels in the US society. They pointed out that within such a definable group one infected person generated at least one new infection and concluded that in the absence of such core groups the infection would not be sustained or propagated in a general population. Hethcote and Yorke (1984) concluded that it is possible to isolate such core groups irrespective of their size. The implications for control were hence clear: deal with the infection in the core groups and prevent the disease from spreading to wider society. A major problem with gonorrhoea (as with HIV) is that asymptomatic carriers will always be there. This problem is even greater with the window period in HIV (Barnett and Whiteside 2002:77). Barnett and Whiteside's point is lucid: the HIV/AIDS epidemic is complex in a sense that such identifiable 'core groups' aren't the only ones fuelling the spread of the generalized epidemic in sub-Saharan Africa. The problem of the HI virus is much greater as the target groups for behaviour change are more diverse.

Secondly, enthusiasm for promoting behaviour change as a direct route to HIV prevention is dampened by findings from a plethora of research which indicate that socio-economic and cultural factors immensely influence the risk of HIV infection (cf. Kelly et al. 2001 Barnett & Whiteside 2002, Magezi 2005, Byron 2006, Kelly 2006). Buve and colleagues (2002: 2013) write,

> Cultural and socioeconomic features common to most societies in sub-Saharan Africa have played, and still play, a part in the

> spread of HIV-1 infection. These factors include the subordinate position of women in society, impoverishment and the decline of social services, and rapid urbanisation and modernisation. To this gloomy picture must be added the many wars and conflicts in Africa.

Barnett and Whiteside (2002:78) admit that interventions at the biomedical and behavioural levels are critical, "[b]ut there is little in the armoury. There is no vaccine. Multi-drug therapy prolongs life but is very expensive, requires sophisticated medical backup, and will not be available to the huge numbers of people who are infected worldwide. Prices may be falling but in many countries' infrastructure will be the constraint" (2002:78). They essentially agree that behaviour change interventions are feasible and effective as long as they are maintained (2002:79). For instance behaviour change has seen the decline of HIV infections among the homosexual male communities in the US, Thai brothels (where condom use is over 90 per cent), and among intravenous drug users and needle exchange programmes in the UK and Netherlands. However, these interventions target "core transmitters."

However, Barnett and Whiteside are quick to admit that in the epidemics in sub-Saharan Africa and elsewhere such strategies will not be sufficient as the epidemics are already generalised rather than in isolable "core transmitter groups " (2002:79). Thus they recommend that "Societies confronting generalised epidemics, or where the epidemic is already generalised, *should contemplate interventions that do not usually receive sufficient consideration*. These are at the social, cultural and economic levels...." (Barnett and Whiteside 2002:80 emphases added). The present researcher holds that Barnett and Whiteside are correct in saying that contemplation should be

given to *"interventions that do not receive sufficient consideration."* This phrase obviously does not only open the door to social, cultural and economic interventions, but also admits theological interventions to HIV-risk behaviour change amid a growing epidemic.

And thirdly, Kelly and colleagues (Stone 2001) contend that new thinking must be applied to concepts of HIV preventive behaviour and behaviour change. They write, "It cannot be assumed that we choose to be sexually active in the way that we are sexually active or that sexual activity is the outcome of individual decision-making processes only" (Stone 2001: 252). Although Kelly and colleagues (2001) seem to suggest a disputable view that all HIV risky sexual behaviour is somewhat excusable (or even inevitable and, therefore, impossible to do otherwise) since such behaviour is almost 'natural'[30], they 'create' ample provision for an HIV preventive approach which aims at transforming perceptual underpinnings of HIV predisposing sexual behaviour. The current researcher will contend that HIV-risk sexual behaviour can be changed by transforming people's worldviews which fuel them. In the case of Zambia this approach will entail engaging people at the worldview level in order to effect change of the socio-cultural norms, beliefs, and practices which facilitate new HIV infections.

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[30]. That is to say that those who engage in HIV risk sexual behaviour are incapable of changing their behaviour. When explicating the relationship between the concepts of "Actions" and "Behaviours" Kelly and colleagues (Stone 2001:253) write,

> "In the philosophy of science, 'action' has been distinguished from 'behaviour' ... with 'behaviour' being the more inclusive term. Use of the term 'action' refers to that which is intentional, or that which is deliberately achieved. Behaviours, in contrast, are not necessarily or specifically performed as *intentional* acts. 'Behaviour' is, broadly speaking, 'what humans do' and refers to all events, whether or not they are consciously willed" (emphasis theirs).

Kelly and colleagues (2001) seem to be discrediting the biblical teaching of human responsibility for behaviour/lifestyles. They seem to posit that human-beings have no choice but to behave in a risky manner as they do, that is to say, humans are bound in their HIV risky behaviour. The Bible is unmistakably clear on its teaching of human accountability for all behaviour/actions (cf. Roman 2, 3; Galatians 5) and the possibility of change no matter how one is inextricably bound to a lifestyle/mindset (2 Corinthians 5:17).

Fylkesnes and colleagues (2001) investigated trends in HIV prevalence and behaviours in Zambia during the 1990s. In their work Fylkesnes and colleagues used a double-pronged methodology with two essential components: firstly, HIV sentinel surveillance at selected antenatal clinics (ANC) in all provinces; and, secondly, population-based HIV surveys in selected sentinel populations (1996 and 1999). The former was refined in 1994 to improve the monitoring of prevalence trends, whereas the latter was designed to validate ANC based data, to study change in prevalence and behaviour concomitantly and to assess demographic impacts (Fylkesnes et al 2001). Fylkesnes and colleagues (2001) discovered that the ANC-based data indicated a dominant trend of significant declines in HIV prevalence in the 15-19 years age-group, and for urban sites also in age-group 20-24 years and overall when rates were adjusted for over-representation of women with low education. In the general population prevalence declined significantly in urban women aged 15-29 years whereas it showed a downward trend among rural women aged 15-24 years. A significant drop in HIV prevalence was seemingly associated with better education, whereas stable or rising prevalence was associated with poor education. There was evidence in urban populations of increased condom use, decline in multiple sexual partners and, among younger women, delayed age at first birth.

Fylkesnes and colleagues (2001:907) concluded that their research outcomes posited a falling trend in HIV prevalence that corresponds to declines in incidence since the early 1990s attributable to behaviour changes. However,

these researchers were quick to admit that their findings were not all good news. They cautioned,

> Efforts to sustain the ongoing process of change in the well-educated segments of the population should not be undervalued, *but the modest change in behaviour identified among the most deprived groups represents the major preventive challenge* (Fylkesnes et al 2001: 907 emphasis added).

Based on Fylkesnes and colleagues' (2001) findings, it would seem that individuals with little or no education in Zambia have poor access to safe-sex information. The ZDHS 2007 has arrived at the same conclusion that although "almost all Zambian adults have heard of HIV and AIDS, but knowledge of HIV prevention measures is lower" with only 69% of men and women aged 15 to 49 years knowing that the risk of getting HIV can be reduced by using condoms and limiting sex to one faithful partner (CSO et al 2009b:14).

Buve and colleagues (2002) also arrived at a similar conclusion where they established that condom use in sub-Saharan Africa is associated with higher levels of education. It is therefore, the present researcher's view that the dilemma of HIV behavior change lies in the fact that whereas some modest gains may be happening among the minority well-educated sections of Zambians, similar gains are still not occurring among the most deprived and less-educated groups. The researcher posits that this status quo is chiefly attributable to adherence to certain deep-rooted traditional and cultural influences, values, beliefs, norms and practices which they find hard to let go of (Kapolyo 2005, Phiri 2008). It is hence imperative that interventions to control the spread of HIV/AIDS should not only target individuals, but also aim

at changing those facets of cultural and socioeconomic[31] contexts which heighten vulnerability to HIV infections (cf. Buve et al. 2002).

The questions we must pose then are: Which precise practices and beliefs in Zambia's cultural and socioeconomic milieu need theological transformative attention? How precisely are these behavioural traits rooted in the cultural and socioeconomic milieu of Zambia's peoples, and how are they perceived to be fuelling the HIV/AIDS epidemic? Why are people embracing them and what can cause them to refrain from these HIV-risk behaviour trends? The following section attempts to tackle these important questions.

2.4.2 Cultural and Traditional Practices

Before making any effort toward effecting HIV-risk behaviour change it is critically important to gather further and accurate information about the exact practices and beliefs that should be targeted for transformation at the worldview level. The researcher posits that HIV-risk behaviour is so entrenched in Zambia's populace, because it is inherently bound in the cultural norms, practices and beliefs highly cherished by them (cf. Kapolyo 2007; Moyo 2009). Therefore, HIV prevention in Zambia entails dealing with the cherished values and life ways of which the locus is in worldviews. Furthermore, the researcher posits that the rationale for these cultural practices and tenets are imbedded in Zambians' worldview assumptions

[31] Buve and colleagues (2002: 2016) assert, "Cultural and socioeconomic features common to most societies in sub-Saharan Africa have played, and still play, a part in the spread of HIV infection. These factors include the subordinate position of women in society, impoverishment and the decline of social services, and rapid urbanization and modernization. To this gloomy picture must be added the many wars and conflicts in Africa" (Buve et al. 2002: 2013). The researcher contends that a critical influence of these socio-cultural drivers of HIV risky behaviour is located in the worldviews on sexuality which must be transformed in order to stem risky behaviour and hence check the current spread of HIV infections. This view is premised on the observation that "Sexual behaviour patterns are determined by cultural and socioeconomic contexts, some of which have contributed to the extensive spread of HIV... infection" (op cit).

which also fundamentally influence risky sexual behaviour. Kraft helpfully explains the intricate link between worldview and behaviour change when he writes:

> Significant culture change is always a matter of changes in the worldview. Just as anything that affects the roots of a tree influences its fruit, so anything that affects a people's worldview will affect the whole culture and, of course, the people who operate in terms of that culture (1999:388).

The researcher will in greater detail deal with the relationship between a people's culture and their worldview in chapter three, but suffice it to say at this juncture that identifying the precise cultural behaviours and tenets which facilitate HIV-risk behaviour in Zambia is an indispensable step toward effecting behaviour change in order to assist reversing the HIV and AIDS epidemic. Consequently the following question may be posed: 'What practices and beliefs are more likely to change and which ones of these may be great obstacles and how must we rise above them?' Broadly speaking, HIV-risk behaviour in Zambia seems to be propelled by cultural practices, beliefs and deep-seated perceptions which are rooted in specific and pervasive worldviews. The researcher proposes the following cultural practices, beliefs and perceptions in Zambia to be core determinants of HIV-risk behaviour.

2.4.2.1 Sexual Rituals

The first culturally-conditioned group of HIV-risk behaviour in Zambia has to do with sexual rituals. Certain sexual rituals in traditional Zambia, rooted in cultural beliefs, predispose people to HIV infection (Moyo 2009). Under this caption, the researcher will briefly discuss three of the common ones, namely,

the sexual abstinence of motherhood, widow/widower sexual cleansing, and wife inheritance.

2.4.2.1.1 Sexual Abstinence of Motherhood

In traditional Zambia a significant number of communities advise husbands not to have sexual relations with their wives during pregnancy and when their wives are breastfeeding their infants. They argue that sexual intercourse would give ailments to the baby hence mothers must abstain from sexual intercourse. The practice of 'motherhood sexual abstinence' is especially common in rural areas. This 'motherhood sexual abstinence' can last from one to two years. This myth works as a natural birth control as women are enabled to space their children. However, the practice of this myth has catastrophic implications on the part of husbands seeing that it calls for avoiding sexual intercourse with their matrimonial partners for considerably long. Hence, they seek substitute sexual partners in order to meet their sexual needs during this time of 'forced' abstinence from sexual intercourse. Admittedly, husbands' sexual contacts with other women introduce a significant HIV risk element. A case study in Guinea–Bissau revealed that husbands who abstained from sexual intercourse with their wives during breast feeding were more susceptible to risk-taking behaviour as compared to husbands who did not abstain from sexual intercourse with their wives (Loosli 2004:11). The situation is no different for Zambia since during this prolonged abstinence due to their spouses' motherhood, husbands take to HIV-risk behaviour by taking other partner(s). In some instances this situation has led to polygamous arrangements in order to satisfy men's sexual needs.

2.4.2.1.2 Widow/Widower Sexual Cleansing

A second sexual ritual practiced in traditional Zambia is sexual cleansing where a wife or husband is deemed sexually unclean on the death of a spouse. According to this cultural belief, a person becomes 'unclean' on the death[32] of a spouse. Hence, according to this belief, the widow/widower must be sexually cleansed in order to 'remove the ghost of the dead husband/wife from her/his body'. In traditional Zambia, the sanctions against defilement are heavy and includes remaining single until death or contracting incurable illnesses which can lead to a premature death of the new spouse. It is believed that would-be suitors to a woman defiled by the death of her husband will suffer from inexplicable illnesses and misfortunes because the ghost of the late spouse would not have been placated by the performance of the cleansing ritual. Consequently, widowed persons are constrained to be 'cleansed' for fear of these sanctions. The cleansing ritual involves having sexual intercourse (often unprotected) with a close relative of the deceased[33] spouse. This ritual clearly has HIV infection risk implications to both the widow/widower and the cleanser (the relative tasked to have sexual intercourse with the surviving spouse). Either the deceased spouse could have died of HIV/AIDS and the widow/widower may be a carrier of the HI virus (in which case the cleanser is exposed to the risk of HIV infection) or the

[32] In the cibemba language, a tribal language to which the current researcher belongs, this is termed ***ukufwilwa*** (literally translatable to be "bereaved") and the surviving spouse is called ***mukamfwilwa*** (literally a person whose spouse has died or simply widow or widower).

[33] Thankfully, a good number of tribes like some Bemba speaking of Zambia, to which the researcher belongs, are moving away from this risky practice with growing HIV/AIDS awareness. Most merely perform a replacement ritual where the family of the late husband/wife smear white maize meal on the head of the widow/widower and declare her/him cleansed and free as signified by the purity of the white maize meal (see Malungo 2001 for similar transformations of this custom, due to its implication for HIV/AIDS transmition, among the Tonga speaking peoples of Southern Zambia).

cleanser may be HIV positive with the consequence that the widow/widower contracts the HI virus in the 'cleansing' process.

2.4.2.1.3 Wife Inheritance

A third cultural ritual, closely related to widow cleansing, is wife inheritance (often by the brother or very close kin of the deceased). This practice is common in a number of sub-Sahara African people groups. When a woman is widowed, the husband's family is customarily obliged to choose a member of their family to become the widow's 'new husband'. This practice is seen as some form of social security for the widow and the orphans. A partial rationale for this practice is the notion that the deceased husband had paid dowry when marrying the woman and therefore she became his 'property'. At his death, then, the widow is inherited by the family just like the rest of the deceased's assets (Richardson 2004; Mbuwayesango 2007). If a woman declines to be inherited, she is considered as an outcast since this worldview presupposes that a calamity will befall the community for not caring for her by the inclusion of inheritance. Obviously the risk of HIV infection[34] is inherently high in this custom since the HI virus can be contracted by either the inheritor, if the deceased was HIV positive, or the widow may be infected with the HI virus from the inherited husband.

2.4.2.2 Sexual Violence and Myths

A second group of worldview-based HIV-risk behaviour in Zambia has to do with the issue of sexual violence and myths. The Zambia 2007 Demographic

[34] The Zambia 2007 Demographic and Health Survey found that "HIV prevalence is particularly high among widows and those who are divorced or separated; 53% of widowed women and 63% of widowed men are HIV-positive" (CSO et al. 2009b:16).

and Health Survey has again highlighted unfortunate attitudes towards wife beating and refusing sex:

> More than six in ten women and half of men agree that a husband is justified in beating his wife for certain reasons. Fifty-seven percent of men agree that women are justified in refusing sexual intercourse with her husband for certain reasons compared with only 39% of women who agree with a wife's right to refuse sex (CSO et al. 2009:17).

The researcher holds that a wide range of forms of sexual violence and myths persist to this day in Zambia supported by a worldview which looks down on women (HRW 2002).

2.4.2.2.1 Sexual Violence

Sexual violence means any sexual action performed against the will of a person. It represents many forms of forced sexual activities. Rape is only one amid many types of sexual violence. Loosli (2004) explains that sexual violence does not necessarily entail a rape case. She asserts,

> Even if someone consents to a sexual activity, the brutality that the partner shows might make this consent pleasure turned into coercion. Sexual violence describes a behaviour which is adopted during a consented or non-consented sexual activity, it can occur even with a regular partner outside of a rape situation (Loosli 2004:12).

Loosli's observation points to the possibility of sexual violence within the marriage context when a spouse coerces his partner into sexual activity which exposes them to the risk of HIV infection. But more precisely, rape is the felony of "*forcing* a person to submit to sexual intercourse against that person's will" (Loosli 2004). Hence, according to this broad definition of rape, *a person (a* woman, a girl, a man or a boy) can be raped by a stranger or non stranger including a regular partner. In Zambia (as in most of Africa) a

perception seems to exist that forced sexual activity with an acquaintance is not rape. Due to this perception, a large proportion of rape cases go unreported.

Research in Tanzania showed that compared to HIV-negative women, young HIV-positive women were 7 to 10 times more likely to have been subjected to unwanted sex through rape, beatings, or other forms of coercion (Loosli 2004:13). Consequently, sexual violence is presently pointed out as a vital component of women's risk to HIV infection within the context of a relationship. Ample evidence exists that rape inflicts pain and injury which is capable of facilitating HIV transmission especially in females whose genital physiology is wider, tenderer, and hence particularly susceptible to the passage of the HI virus (van Dyk 2005). However, more studies on the connection between partner violence, male dominance, and HIV infection still need to be done. Suffice it to say that sexual violence is a potent means of transmitting the HI virus.

Sexual violence is not uncommon in Zambia (cf. CSO et al. 2009). The researcher thinks that HIV preventive efforts in Zambia should increase its emphasis on combating sexual violence. But again curbing the scourge of sexual violence in Zambia will only happen when traditional perceptions which justify wife (spouse) beating are changed. The behaviour of "wife beating" is one of those traditionally entrenched behaviours in Zambia to such an extent that some women look forward to being beaten by their husbands as an expression of their love for them. The researcher is of the view that sexual

violence in Zambia can be checked by changing this perception through transforming the deep-culture worldview which supports it (see chapter 4 below).

2.4.2.2.2 The Virgin Myth

A misperception currently exists in most of sub-Saharan Africa that engaging in sexual intercourse with a young girl can prevent infection with the HI virus or cure AIDS (van Dyk 2005). This myth finds expression in the belief that sexual intercourse with a virgin (a young girl or a baby) cures HIV/AIDS as the purity of the virgin removes impurities from the HIV/AIDS sufferer responsible for their illness. This erroneous myth also says that the younger the virgin, the more potent the cure. Consequently, there has been an upswing in cases of child sexual molestation with a large number of children testing HIV positive after being violated by men who have been misguided by the 'virgin myth'.

2.4.2.2.3 Misperceptions on Condoms

A condom is an old contraceptive. Condoms are believed to have been in use as contraceptives by the Egyptians as far back as 1000BC (History of Condoms 2004). The story of origins of the condom is shrouded in mystery and still remains unknown today. However, from the etymology of the word we can glean some valuable historical lessons. The word 'condom' comes from the Latin word "condos", which means receptacle or container. It is alleged that there is a historical person known as Dr. Condom, because this particular gentleman supplied King Charles II of England with animal-tissue

sheaths so that he could not sire illegitimate children or contract STDs from prostitutes (History of the condom 2004). The material used to make condoms has changed considerably over the ages. In contemporary times, more recent technologies have enhanced condom production both in terms of quality and types. Condoms are manufactured in latex, multiple colours, textures and flavours. Polyurethane condoms are also made for those allergic to latex.

Condoms have, however, not enjoyed widespread popularity in Africa (van Dyk 2005:122). Green (van Dyk 2005) learnt that although AIDS knowledge in Uganda in 1993 was appreciably high and a huge number of condoms were being distributed, a meagre 3% of Ugandan men were consistently using them. Even today, it is arguable that condom use in most sub-Saharan Africa is still insignificant going by the number of new HIV infections in the sub-region (UNAIS/WHO 2007). Van Dyk (2005:122) observes that although young people are using condoms increasingly…condom use remains a serious problem in Africa. Loosli (2004:15-16) points out,

> Originally, the socio-cultural context is badly predisposed to condom use since it is against basic traditional values. Condom [use] had never been really a strong contraceptive method in Africa given contraception is not a concern of most of African people although health department (sic) endeavour to develop familial planning. Few people used it apart from some prostitutes.

The present researcher agrees that it would be erroneous to ascribe the lack of condom use in most of African traditional life to promiscuity, permissiveness, and a lack of moral and religious values as assumed by some western researchers (Caldwell et al. in van Dyk 2005:122). Van Dyk

points out that such a notion is "clearly due to a lack of understanding of the African philosophy behind sexuality and disrespect for African cultural beliefs" (2005:122). Furthermore, what is clear from van Dyk (2005) and Loosli (2004) is that there are deep-rooted cultural beliefs against condom use in most parts of Africa. Although some measure of progression toward safer sex is perceptively emerging, an intrinsic cultural logic[35] constitutes a formidable resistance to condom use. The challenge, therefore, lies in discovering this logic of resistance and engaging it toward transformation.

Hence, comprehending this 'intrinsic cultural logic' which discourages condom use in most of sub-Saharan Africa is of critical importance since it seems that condom rejection is attributable to traditional notions, negative constructions against AIDS, and strong misinformation on condoms. Some of the socio-cultural reasons for rejecting condoms and their implications for HIV-risk behaviour change are now briefly discussed.

2.4.2.2.3.1 The Need for Children and the Value of Semen

It has been proved scientifically that condoms do prevent pregnancies and sexually transmitted infections (STIs), including HIV infection, when correctly and consistently used. The precise function of the condom to limit the birth of children (especially in a matrimonial context) becomes a critical barrier to safer sex in most Africa where having children is an indispensable expression of personhood. Granted, cultures in Africa may vary from place to place, but the high value placed on procreation is undeniably pervasive to the extent

[35] The present researcher will demonstrate in chapter three of his work that that 'intrinsic cultural logic" is anchored in a people group's worldview. The task of changing risk behaviour is fundamentally an issue of initiating change at the worldview level. Such an approach will both be meaningful to Africans and will accord better chances for success toward authentic HIV risk behavioral alteration.

that sexual activity has become synonymous to an act of fecundation. In Zambia, as in most sub-Saharan cultures, barrenness is in fact viewed as an extremely unfortunate situation for a married couple. This means that couples will do all they can to have children and they seem not to care about the risk of HIV infection in their quest for progeny.

Sadly, the priority of procreation often seems to far overweigh the need for protection against HIV infection in the mindsets of most men and women in Africa. For example, a woman who has no children can have the audacity of having unprotected sex in order to see if she can become pregnant. The desire for children has led many married men and women to engage in risky sexual behaviour. In Zambia a significant number of childless couples would seek extramarital sexual liaisons to test if it's not their partner's fault that they are not bearing children. Clearly, this is a reason why it seems that the highest rate of HIV infection is among married individuals since the absence of a child in marriage is calamitous and incomprehensible. This observation gives weight to the contention that a large number of people living with HIV/AIDS in Zambia became infected while married and could be a reason married people appear to be more at-risk to HIV infection than single people (Barnett & Whiteside 2002, Loosli 2004, Hinga et al. 2008).

At the same time a study in Rwanda discovered that opposition to condom use was not attributable to ignorance, but a precise social and cultural facet to Rwandan sexuality (van Dyk 2005:122). Many Rwandans believe that the flow of fluids which occurs in sexual intercourse and procreation stands for

the exchange of the *'gift of life'* and place an incalculable value on this event in the relationship. Using a condom is therefore understood to "block this vital flow between two parties, and such a blockage is seen as causing infertility and also causing all sorts of illness" (van Dyk 2005:122). Traditionally, semen has an additional value. According to Rwandese belief, the value of semen is in the fact that it is seen as an element of mutual acceptance between the two partners. The associated value of semen to procreation and mutual acceptance, consequently, causes condom use to be seen as "a *waste of semen"* (Loosli 2004: 16 emphasis hers). Furthermore, if a woman denies unprotected sex (i.e. does not receive the semen of the man in her body) that could be understood as an absence of love for her partner. On the other hand, a man must show his love for his woman by depositing his semen in her body as his 'signature' inside her to mean that he has conquered her body. According to this mindset, then, using a condom does some violence to the psychological makeup of traditional sub-Sahara African men and undermines their pride and masculinity (Loosli 2004; van Dyk 2005).

2.4.2.2.3.2 Condoms prevent the 'ripening of the Foetus'

A general belief exists in many parts of Africa (e.g. East Africa, the DRC, the Zulus in South Africa, and Zambia) that repeated addition of semen is vital to 'create' or 'ripen'[36] the growing foetus in the womb of woman (van Dyk 2005:123). Therefore, a further reason against condom use in this context is that not only do condoms reduce pleasure, but they also interfere with the

[36] In the researcher's tribe (the Bembas of Zambia) couples are encouraged to continue engaging in sexual activity as far as it is safe after conception on the understanding that semen helps to 'form' the growing foetus. The Bemba term used in this connection is "***ukukoshyo umwana***" (literally translatable as 'to make the foetus mature or stronger').

process of natural foetal development. This misperception can be a significant deterrent to condom use as a risk-reduction strategy in Zambia.

2.4.2.2.3.3 A Mixed Message on Condoms

A mixed message on the safety of condom is still being heard in Zambia. The controversy is centered on the varied positions held by religious communities and some organizations involved in HIV/AIDS preventive work[37]. Churches are essentially against prevention messages which encourage and support condom use as a foolproof method of HIV/AIDS prevention. Zambian churches argue that the manner condoms are (being) promoted do more harm than good in the fight against the HIV epidemic as they seem to entice people into more sexual activity into which they otherwise would have had no notion of indulging[38]. This has fundamentally been the church's position in Zambia from the early 1980s when AIDS was first reported. However, in recent times a change of position is happening with leading Zambian theologians (Catholics and Protestants alike) conceding that condom use, as an HIV preventive method, must be embraced on the principle of 'the lesser evil' (cf. Kelly 2006, Ndhlovu 2007). Kelly (2006:10) writes,

> But while abstinence and fidelity remain the ideal (and the practice of very many) a place has to be found for the other two options (non-penetrative sex and condom use). Hence it is

[37] Condoms are also seen as a sign of infidelity in married circles in Zambia, whereby if a married person is caught with a condom it's construed as an indication that that the person is having extra marital sex. Interestingly, condoms were regarded as irrefutable evidence for infidelity in a divorce case in rural Malawi and a presiding justice granted the divorce application by a wife (Smith & Watkins 2004). In South Africa, the use of condoms in long-term relationships may be construed as signalling a lack of trust or an admission of infidelity, and is therefore often avoided (Hallman 2004). Such an 'incriminating' mindset on condoms seems to be pervasive in Zambia as well.

[38] Pope Benedict XVI's standpoint on this issue fundamentally and outrightly discourages condom use as a panacea for the HIV/AIDS pandemic. During his visit to Africa in March 2009 the Pope told reporters that AIDS was a tragedy "that cannot be overcome through the distribution of condoms, which even aggravates the problem" (Benedict XVI 2009:3). The present researcher's opinion is that the Pope's statement has a pithy nuance which must not be taken lightly by proponents of condom use. However, correct condom use has a significant HIV preventive trait.

> necessary to ask whether they can be upheld on moral grounds. The answer is that they can, with the ethical justification for these practices, and for advocating them, lying in the *principle of the lesser evil* (and for married couples, in the *principle of double effect*). The principle of the lesser evil states that if an individual contemplates placing an action that involves the violation of more than one ethical principle, it is lawful (and in certain circumstances even obligatory) to modify the action in a way that will reduce the violations. For example, if an individual is determined to carry out a robbery with violence, it is legitimate to counsel that, whatever else may happen, violence should be avoided. In the case of high-risk sexual activity, there may be two evils—the wrong use of sex and the danger of transmitting (or acquiring) a potentially life-threatening infection. The first evil violates chastity. The second violates justice by posing a threat to the health or life of an individual. The principle of the lesser evil states that if sexual activity is to take place in these circumstances it should be performed in such a way that the danger of transmitting HIV is eliminated or at any rate reduced. Since the condom reduces this risk, its use can be advocated. The ethically wrong use of sex remains, but without a condom the action would add the further ethically wrong dimension of putting oneself or another person at risk of HIV infection (Kelly 2006:10 emphasis his).

This researcher agrees with Kelly's position of advocating condom use as a preventive method of HIV infection arguing from the ethical principle of the 'lesser evil'[39]. Kelly further counsels "…condom use is not only morally lawful but, where HIV is present, is morally required" (2006:10). Gathogo supports this standpoint asserting, "…while abstinence is the ideal methodology in the war against the epidemic, the use of condoms, in certain cases should be accepted as a lesser evil" (2007:21). Furthermore, the World Health Organization (WHO) maintains that regular and accurate condom use minimizes the risk of HIV transmission by 90 percent. While there may be breakage or slippage of the condom that can lead to failure, condoms are not manufactured with netting or holes that allow viral passage. Fundamentally,

[39] Geisler argues that the principle of the "lesser evil" is unbiblical. Christ was tempted in every way like us, yet he did not sin. Consequently, Christ did not commit the "lesser evil", else he would be guilty of sin (Geisler 1979:70).

then, condom use is a *safer* means which can be used to avoid HIV infection at this point in the epidemic's history. This researcher assents that churches in Zambia should not discourage responsible marketing/promotion of condoms as a risk-reduction measure in the fight against a growing HIV/AIDS epidemic.

2.4.3 A Taboo on Sex Education

Another cultural proclivity to HIV risk-reduction resistance is the taboo on discussing sexual matters. This is a pervasive cultural trait in the majority of African cultures. Predominantly among men in Zambia, there is a pervasive shame culture to talk openly about sexual matters with their children. A spin-off of this 'silence' is that young people get wrong sex education from wrong sources often leading to risky sexual behaviour which ultimately exposes them to HIV infection. It is imperative that a change in this trend of 'silence' on the issue of sexuality be facilitated (Cilliers 2007; Ndhlovu 2007).

Often in Zambia, people who have the courage to talk openly about sexuality are perceived to have a wrong education or are seen to be sexually promiscuous. It is undeniable that, in Africa, sex is the most taboo theme to be approached. The experience of Uganda stands out as a good example of the importance of open discussion on sexuality as an effective way of turning around the HIV/AIDS epidemic. Ugandans made efforts to stem the HIV spread through teaching that safer sex is not a concern of one person, but involves partners who should openly communicate on the issue to decide on the rule of safer sex before they act (cf. Gary et al. 2006; Loosli 2004:17).

2.4.4 Lack of Male circumcision

According to Loosli (2004), the word circumcision has roots in the Latin words *circum which* means "around" and *coedere* (literally "to cut"). The word circumcision hence means to "cut around". Surgically, then, circumcision is a procedure that removes some or all the prepuce or foreskin of the penis early in childhood or later. This has been a cultural practice in most African cultures. In Zambia circumcision is practiced among the north-western province tribes and Muslim communities in eastern province and elsewhere for both STI preventive and hygienic purposes, or just to 'fit in'[40]. North-Western and Northern provinces have the lowest HIV prevalence rates in Zambia, but syphilis rates are closer to national averages (Circumcision in Zambia [2008]).

The question is whether male circumcision really minimizes the risk of transmission or reception of HIV infection? At the turn of this century medical professionals where hesitant to include male circumcision as one of the HIV infection preventive measures, but current thinking is more supportive of circumcision as an HIV risk reduction intervention (Szabo & Short 2000; USAID/AIDSMark 2003; Wilson 2006). Wilson (2006) reports that from randomized trials in South Africa it was established that male circumcision reduced HIV transmission by 60 to 70 percent. In Zambia male circumcision is being practiced as an HIV transmission prevention method and

[40] Groups traditionally practicing male circumcision (MC) in Zambia believe that not having MC entails uncleanness, predisposition to premature ejaculation in coitus, and unfitness for marriage. The rationale is that MC marks the attainment of manhood, gives protection against sexually transmitted diseases, and increases the man's capacity to please women sexually. Protection against STIs in MC is attributed to a harder, drier glans (cf. Circumcision in Zambia [2008]).

circumcision clinics, have been established, especially in urban centers, safe circumcision can be performed. More health professionals, such as nurses, are being trained to handle circumcision cases, infection control, and manage the pain which ensues after the procedure has been done (cf. USAID/AIDSMark 2003).

In hospitals and clinics, circumcision of children is done under local anaesthesia, but adults have to be put under general anaesthesia. However, when the procedure is done outside of clinics and hospitals, it is more often than not conducted without anaesthesia. Consequently, the experience is excruciatingly painful and can lead to trauma with enduring psychological impact, even though the ritual environment is a justifying aspect. Furthermore, in a traditional setting, the hygiene condition of the surgery is suspicious, especially with regard to the safety of the cutting tools used (Loosli 2004:23). Customarily, in most of African countries, traditional healers are asked to do the circumcision of men at ritual ceremonies for initiation into adulthood, or circumcision for cultural habits and faith purposes[41].

[41]Loosli (2004) recommends that in order for circumcisions to be safe two basic guidelines must be adhered to. First, it must be done at a hospital or clinic with an experienced medical physician who must perform the procedure and institute infection control both during and after the circumcision. And secondly, in the event that the person has no access to a medical expert, or the ritual background is of essence, a well-trained and experienced healer who practices infection control is desirable. In that case it is recommended that the procedure be performed with sterilized or single use apparatus (one sterilized knife to be use for one person) to stop transmission of HIV and other blood-borne illnesses. Even in these customary quintessential circumcisions medical backup should be prepared in case of grave bleeding and other unforeseen complications (see Szabo & Short 2000; USAID/AIDSMark 2003; Loosli 2004).

2.4.5 Multiple and Concurrent[42] Sexual Partnerships

Current thought on behaviour change and prevention of sexual transmission of HIV has established that acute infection and concurrent sexual partnerships constitute a significant element in the rapid growth and diversity of the HIV/AIDS epidemic in sub-Saharan Africa (cf. Wilson 2006). Phiri (2008) has already sounded the warning to Zambians on the lethal nature of multiple and concurrent sexual partnerships[43] and the window period of HIV infection. Wilson (2006) and Phiri (2008) point out that half of HIV incidences occur during the acute infection stage when the individual carrying the HI virus does not know about his/her positive status and a test during this period would have most probably been negative [see figure 2.1 for Seroconversion (acute infection) stage].

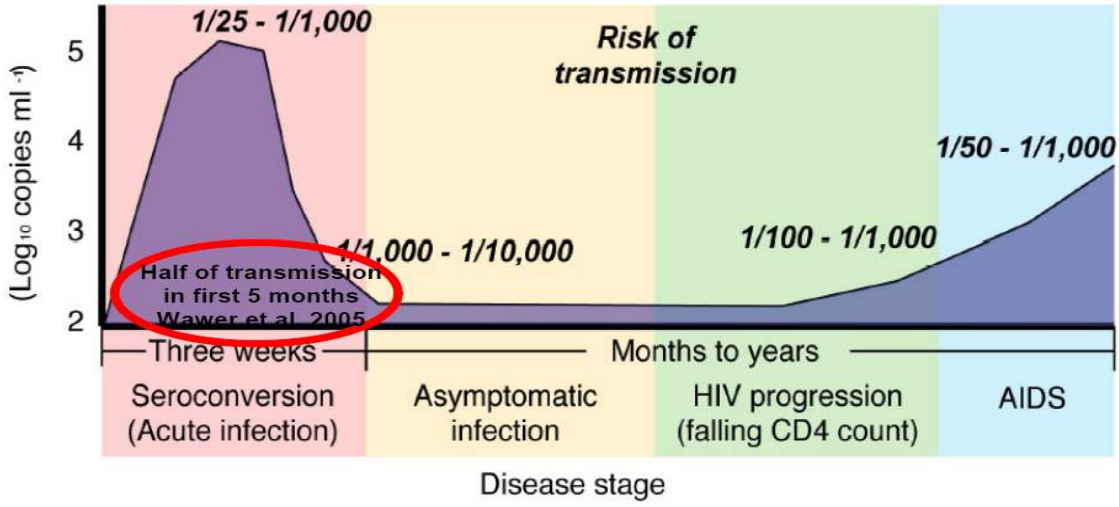

Figure 2.1 HIV Transmission Risk [Source: Wilson 2006:9)

[42] Concurrent sexual partnerships are broadly defined as "sexual relationships that overlap in time" (UNAIDS 2008:44). Although the link between the concept of concurrency and HIV prevalence levels needs further study (UNAIDS 2008), it is undeniable that having multiple sexual partners is a significant risk factor in the transmission of HIV (Malamba et al. 1994; van Dyk 2005; Mishra et al. 2007; Mtonga 2007; Phiri 2008).

[43] In Zambia, multiple concurrent sexual partnerships are traditionally approved and are hence highly common (cf. Phiri 2008). Zambian men have the erroneous view that they do not commit adultery when they have extramarital liaisons, but merely behave 'manly' when they engage in extramarital sexual liaisons (and often) through multiple concurrent partnerships. It is not uncommon for Zambians to look down on a woman who exposes a sexually erring husband. Men will say "he is stupid how did he get caught?" and women will scorn their fellow woman that she ought not to have embarrassed herself in that fashion.

Wilson (2006:12) is of the opinion that “Concurrent sexual partnerships and limited male circumcision fuel and [is] the match that lit southern Africa’s unique hyper-epidemics—together, these factors may increase HIV transmission 30-fold—explaining much heterogeneity in HIV epidemic potential.”

The researcher has discussed the idea of circumcision as a preventive method to HIV transmission in section 2.4.4 above. In the current sub-section he tackles the impact of multiple and concurrent sexual partnerships on the growth of the HIV/AIDS epidemic in Zambia. What forms of multiple and concurrent sexual partnerships exist in Zambia? Three key types of multiple and concurrent sexual partnerships are identifiable in Zambia (and most of Africa for that matter)—namely, polygamy, Intergenerational and transactional sex, and the multi-partnerships of people who are ‘mobile’ (Kapolyo 2006, Mbuwayesango 2007; Mulenga 2009, Hinga et al. 2008).

2.4.5.1 Polygyny and Polyandry

Polygyny and polyandry are the two types of polygamy, that is, the marriage of one person to at least two spouses. Polygyny is when a man has at least two wives, and polyandry, is when a woman has at least two husbands. Polygyny and polyandry both increase the number of sexual partners and by so doing expose partners involved in the relationship to the risk of HIV transmission, unless condom use is regular and correct. However, of the two, polygyny is more common in African societies than polyandry. Hence, the researcher will give closer attention to it.

Polygyny fulfils a significant socio-cultural function in most of sub-Saharan Africa[44]. Seeing that many traditional African men value a large family, they often resort to marrying more than one woman in order to sire many children. Tangwa writes that "There is no part of Africa where children are not greatly valued and where, as a consequence, large families do not exist or polygamy is not practiced. Conversely, childlessness remains the main cause of divorce, as a childless marriage is considered to be equivalent to no marriage at all" (2002:55).

Since a large family, often including the extended family, is the *de facto* social security safety net[45], most Africans consider childlessness as virtually a curse. Consequently it makes a lot of sense to an African man to raise a large family chiefly through having own children from whom it is anticipated that when he is old and unable to work his children will take care of him[46]. Additionally, a large family provides the much needed 'workforce' to provide food security and to meet other exigencies of life (Eitel 1986, Kapolyo 2005, Mulenga 2009). Due to such a mindset, it is not, therefore, uncommon that even men who are currently in monogamous relationships might later enter into polygamous arrangements if their present spouses are unable to bear children (Eitel 1986; Tangwa 2002). Similarly, traditional African husbands

[44] In Zimbabwe an inevitable form of polygyny exists, where at the death of a husband, the wife's sexuality still belongs to her husband's kin-group. The wife is viewed as part of the deceased's estate to be inherited by her late husband's brother or close kin together with the rest of the estate otherwise his widow will be left destitute (Mbuwayesango 2007).

[45] Inungu & Karl (2006) assert that in Africa, polygamy is a social practice used to ensure the continued status and survival of widows and orphans within an established family structure.

[46] The Bembas in Zambia have a saying that ***"[Ing'ombe] iyakula yonka kubana***" (literally transliterated, "an aging cow or bull suckles from its offspring").

whose wives do not give birth to sons, but to daughters only, may enter polygamous situations in order to raise sons. In Zambia polygamy is most common among tribal groupings in the Southern Province of the country, especially among the Tonga speaking people. The Tonga speaking people are more overt about polygamous arrangements than any other tribal grouping in Zambia (Malungo 2001). This researcher is of the view that many other Zambian tribes clandestinely practice polygyny[47]. Polygamous arrangements have created a potent route of HIV transmission in Zambia[48].

2.4.5.2 Intergenerational and Transactional Sex

Both intergenerational and transactional sex is popularly practiced in Zambia and seems to be motivated by poverty, particularly women's poverty. Transactional sex happens when one partner in a sexual activity indulges in sex for cash, material gifts or any other favour (Chatterji et al 2006). The transaction may be instigated by either the man or the woman. According to Loosli (2004) individuals drawn into transactional sex are not necessarily defined as sex-workers in spite of the fact that the two share several commonalities. The essential difference is that woman may often engage in transactional sex to meet specific problems or needs once-off (Loosli 2004; Chatterji et al. 2006).

[47] For example, the researcher's own brother had no children with his first wife and against family advice took a 'second wife' under customary law with whom he bore three children. He has maintained the first wife and is very secretive about his second wife. Polygyny is practiced by virtually all tribal groupings in Zambia albeit covertly.

[48] Among the Bemba's of Northern and Luapula provinces of Zambia men sometimes enter a type of polygamous marriage, socially tolerated, called ***ing'anda inono*** (literally a 'Small house'). Or a post-menopause wife would 'nominate' a younger sibling as a helper to meet her husband's sexual needs. This sibling in the Bemba language is termed as ***impokeleshi*** (literally 'a reliever of the elder sister's sexual obligations to her husband') [Mbozi 2000:75; cf. Kelly & Maveneke 2005 for a similar practice in Zimbabwe].

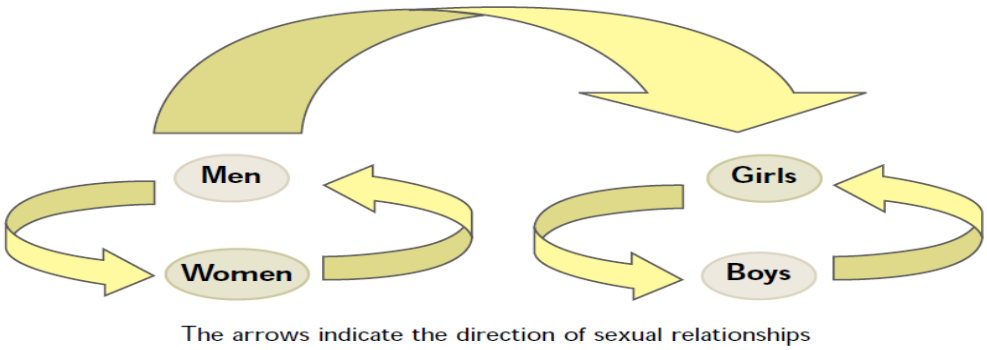

Figure 2.2: Intergenerational Transmission of HIV
[Source: Whiteside et al. 2003:24]

In Zambia it is not uncommon for much older men to have sexual liaisons with younger females in exchange for money or favours either in the general community or at the work-place[49]. In Zambia (as in some other sub-Saharan countries) these much-older sexual partners are known as 'Sugar Daddies'. A similar trend is common in neighbouring Zimbabwe where a study found that nearly 25% of women in their 20s are in sexual relationships with men at least 10 years their seniors (United Nations, 2003). It is also clear that these types of relationships are a key factor in the feminization of HIV/AIDS in Africa (UNAIDS 2004:95). Figure 2.2 illustrates the dynamics responsible for the proliferation of the HIV/AIDS epidemic in Swaziland, but applicable in most parts of sub-Saharan Africa. The arrows show the direction of sexual partnerships. The researcher perceives that the current high rates of HIV prevalence among young African women may be attributable to the intricate

[49] Young females who like this risky sexual behaviour of transactional sex call it 'bottom power'. They say if they cannot have what they need through the normal process of doing or obtaining things (favours) they will resort to 'bottom power' (transactional sex) which almost always guarantees success at anything. Anecdotal evidence from studies in developing countries shows that women are having multiple sex partners for economic reasons (Hallman 2004). Irrespective of the reasons for this trend in Zambia, the UN Secretary-General's Task force on Women, Girls, and HIV/AIDS in Southern Africa has established that both intergenerational sex and transactional sex have become the norm in many countries (cf. Loosli 2004).

dynamism of both intergenerational and transactional sex so pervasive in sub-Saharan Africa.

2.4.5.3 'Mobile People's' Multi-partnerships

The term "Mobile people's Multi-partnerships" represents groups of the Zambian population who are particularly susceptible to HIV infection due to the displacement connected to their occupation. These include migrant workers, traders, teachers, truck drivers, civil administrators, police, and army personnel. These people groups are often away from home and are constantly moving from place to place because of their occupations. The connection between mobility[50] and HIV/AIDS infection is highly proportionate to the socio-economic circumstances of the migrant. NAC/MOF Zambia (2002) points out that migration and mobility increase vulnerability to HIV/AIDS—both for those who are mobile and their partners back home**.** Arguably, people who are frequently transferred from one place to another momentarily or seasonally could hardly move with their family at all times. Hence, due to their frequent separation from their regular sexual partners they often assume risky sexual behaviour by adding on new partners in the places they go. Their HIV-risk behaviour is attributed to the fact that they often have to deal with isolation and loneliness associated with various causes (difference of race, culture, language, etc), lack of friendship and health service support (cf. Loosli 2004). For instance, many truck drivers have 'call wives' in a number of towns and villages where they either stop over for

[50] According to the UNAIDS (2008:44) "Multiple and concurrent partnerships are usually linked to mobility (including labour-related mobility), in that people may have different partners at their different residences; also, those staying behind may themselves have other partners…."

rest or spend considerable lengths of time. In Zambia, border towns or port towns such as Mpulungu, Chirundu border post, Chipata, Kanzungula, just to name a few, are known for high HIV incidence and prevalence because of this phenomenon. Among uniformed personnel serving in armed forces, multi-sexual partnerships are common to such an extent that it's not uncommon to laud those who have had sexual relations with the highest number of women. Given that more often than not these men are unwilling to use a condom during sexual intercourse, HIV prevalence among army personnel is high. UNAIDS (2006) asserts that many of African military personnel have infection rates to the level of five times more than that of the civilian population (cf. Mwansa[51] 2004; Inungu & Karl 2006).

2.4.6 HIV-Associated Stigma

HIV/AIDS stigma is defined as a deeply discrediting attribute that reduces the bearer of HIV/AIDS from a whole and valued individual to a tainted and discounted person. Stigma is present when a person is classified by a label that ostracizes him or her and associates him or her with undesirable stereotypes which produces unfair treatment and discrimination (cf. Goffman 1963:11-56).

The all too common silence surrounding the HIV and AIDS epidemic in sub-Saharan Africa has stymied open discussion and produced unending stigmatization of people living with the HIV and AIDS (Cilliers 2007). In

[51] Mwansa is Associate Professor of Adult Education and Founder of Zambian Open University in Lusaka, Zambia. This thought is in a paper he prepared for presentation at the Workshop on "*Learning and Empowerment: Key Issues for HIVAIDS Prevention"*, organized by UNESCO Bangkok Office, the Regional Bureau for Education and the University of Chiangmai from 1-5th March, 2004.

Zambia, as elsewhere in the rest of sub-Saharan Africa, lack of public response to HIV/AIDS is partly due to a number of factors. Cultural and religious taboos, as discussed in the preceding section, have obstructed open discussion of an epidemic which spreads largely through sexual contact. Some faith groups still seem to believe that AIDS is God's chastisement for those who are sexually promiscuous (cf. Denis 2009). In a sense, these factors account for the hesitance of not many people to admit openly of carrying the HI virus.

Stigma needs urgent attention seeing that it is clearly responsible for both the cause and effects of secrecy and denial, which both catalyses the transmission of the HI virus (Nyblade et al. 2003; Louw 2006). Individuals carrying AIDS-like symptoms would usually claim to be afflicted by a less stigma-laden ailment, like cancer or tuberculosis. Anecdotally, stigma stalls HIV testing; a fundamental initial step to treatment and other preventative measures (van Dyk 2005). Stigma may also discourage pregnant women from seeking HIV testing, with a domino effect that infected mothers (unwittingly) expose their babies to HIV transmission through delivery or breast-feeding. The present researcher posits that unless the stigma linked to HIV/AIDS is acknowledged and addressed with the seriousness it deserves, the quest for HIV-risk behaviour change will always be fraught with insurmountable setbacks.

2.5 Current Approaches to Risky Behaviour Change

Having surveyed the economic and socio-cultural determinants of HIV risky behaviour, the researcher will now discuss Zambia's approaches to changing risky behaviour. What approaches to behaviour change are currently being pursued in order to check the spread of the HIV/AIDS epidemic in Zambia? It is the researcher's view that in the process of investigating contemporary approaches to HIV risk reduction interventions, it is imperative to have an appreciation of the fundamental principles which undergird the quest for risk behaviour change. Such an approach to the crisis will certainly help to assess the impact of current HIV-risk reduction approaches and will provide a good chance of discovering what has to be done to stem successfully the continued growth of the HIV and AIDS epidemic in the sub-region.

According to Kelly (1995), successful implementation of HIV-risk behaviour change requires the development and use of a number of cognitive, attitudinal and behavioural skill competences. He identifies seven elements which are crucial to HIV-risk behaviour change, namely—Risk Education, Threat Personalization, Perceived Efficacy of Change, Intention to Act, Risk Reduction Behavioral Skills Acquisition, Cognitive Problem Solving Skills for Change Implementation and Maintenance, and Reinforcement of Behavior Change Efforts (Kelly 1995:19). Table 2.1 summarizes and briefly describes Kelly's seven critical elements to risky behaviour change in HIV.

Table 2.1—Elements Critical to Risk Behaviour Change (Kelly1995:19)

Risk Education	Practical understanding of factors responsible for risk and behaviour changes needed to reduce risk
Threat Personalization	Accurate appraisal of personal level of risk based upon one's own behaviour
Perceived Efficacy of Change	Belief that one is capable of implementing risk reduction behaviour changes and that these changes if made, will have protective value.
Intention to Act	Commitment to initiate personal action to reduce risk.
Risk Reduction Behavioral Skills Acquisition	Acquisition and ability to skilfully perform behavioral skills needed to effect risk reduction (including condom use, safer sex guidance, assertiveness skills to refuse risk coercions, self management skills needed to implement cognitive and environmental changes needed to reduce risk vulnerability)
Cognitive problem solving skills for change implementation and maintenance	Planning strategies for implementation of behaviour changes and courses of action if obstacles are encountered or lapses occur.
Reinforcement of behavior change efforts	Self-reinforcements and social supports needed to sustain behaviour changes over time.

Kelly's proposition invariably leads us to a survey of the theories and models of sexual behavioural change in HIV as he presents a well thought out approach to the issue. Hence, the researcher will now survey the theoretical framework for risk behaviour change bearing in mind Kelly's model of risk behaviour change.

2.5.1 Theories and Models of HIV-Risk Behaviour Change

Current interventions to the continuing growth of HIV infection throughout the world are as diverse as the settings where they are found. King insightfully remarks,

> 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 (1999:5).

Almost all approaches to HIV prevention measures directly or indirectly are founded on theory (cf. Kelly 1995). Furthermore, a significant number of HIV preventative approaches are premised on the assumption that giving accurate information about transmission and prevention will induce behaviour change (King 1999, Kelly 1995). However, research has proven many times that information alone is not enough to stimulate behaviour change in most persons (CSO et al. 2003, 2009; Kelly 1995; Simbaya et al. 2004; Nsteana and Preece [2008]).

In recent times, social scientists have realized that due to the fact that intricate health behaviours like sex happen in a milieu, socio-cultural factors surrounding the individual must be taken into account when designing HIV prevention approaches (see Barnett & Whiteside 2002, Kelly 1999). Furthermore, there are bigger issues in the realm of structural and environmental determinants which seem to affect significantly sexual behaviour. The main goal of this section is to make a broad examination of

interventions in order to try and identify what seems to be working in the Zambian situation. The researcher will hence survey the theories and models of behaviour change and the main approaches to behaviour change in HIV/AIDS. This section is divided into four sections that cover the most frequently used theories and models of behaviour change from a variety of perspectives. The section begins with theories which centres on the individual's psychological processes, such as attitudes and beliefs, then describes theories stressing social relationships, and concludes with structural factors that explain human behaviour[52].

2.5.1.1 Theories Focusing on the Individual

Since HIV transmission is driven by behavioural factors, theories on how persons change their behaviour have accorded the basis for most HIV prevention approaches worldwide (cf. Kelly 1995). These theories have broadly been created employing "cognitive-attitudinal and affective-motivational constructs" (King 1999). The researcher will hence discuss the psychological theories and models which have been most influential in making and developing HIV prevention approaches.

2.5.1.1.1 Health Belief Model (HBM)

The Health Belief Model (HBM) says that health behaviour is a function of a person's socio-demographic characteristics, knowledge and attitudes. According to this theory an individual must adhere to the following beliefs to be able to change behaviour:

[52] This division is artificial as there is unavoidable overlap in the classifications. It may well be helpful to see the theories as a continuum of models moving from the strictly individually focused to the macro level of structural and environmentally centred models.

1. Perceived susceptibility to a particular health problem (“Am I at risk of HIV?”)
2. Perceived seriousness of the condition (“How serious is AIDS; how hard would my life be if I got it?”)
3. Belief in the effectiveness of the new behaviour (“Are condoms effective against HIV transmission?”)
4. Cues to action (“witnessing the death or illness of a close friend or relative due to AIDS”)
5. perceived benefits of preventive action (“if I start using condoms, I can avoid HIV infection”)
6. Barriers to taking action (“I don’t like using condoms”) [King 1999:6].

According to the HBM encouraging action to change behaviour entails encouraging an individual to change his or her beliefs. The person weighs the advantages against the perceived costs and hindrances to change. Therefore, in order for change to happen, the advantages must outweigh the costs. King points out that HIV prevention work usually aims at changing the individual’s “perception of risk, beliefs in the severity of AIDS (“there is no cure”), beliefs in the effectiveness of condom use and benefits of condom use or delaying onset of sexual relations” (King 1999:6).

The HBM has two crucial limitations. First, as a psychological model, it ignores other factors, such as environmental or economic factors, that might influence health behaviours. And secondly, the model ignores the influence of social norms and peer influences on people's decisions regarding their health behaviours (a point to consider especially when working with adolescents on HIV/AIDS issues) [Denison 1996]. This model is popularly used by NGOs in Zambia which focus on HIV prevention among young people such as CHEP and Youth Alive.

2.5.1.1.2 Social Cognitive (or learning) Theory (SCT)

This theory holds that new behaviours are learned either by modelling the behaviour of others or through experience. The SCT centres on the key roles "played by vicarious, symbolic, and self-regulatory processes in psychological functioning and looks at human behaviour as a continuous interaction between cognitive, behavioural and environmental determinants" (King 1999:7). According to King (1999), the key tenets of the Social Cognitive Theory are:

- Self-efficacy[53] – the belief in the ability to implement the necessary behaviour ("I know I can insist on condom use with my partner")
- Outcome expectancies - beliefs about outcomes such as the belief that using condoms correctly will prevent HIV infection.

Programmes based on SCT put together information and attitudinal change to augment motivation and strengthening of risk reduction skills and self-efficacy. In particular, SCT activities concentrate on the experience people have in talking to their partners about sex and condom use, the positive and negative beliefs about adopting condom use, and the types of environmental barriers to risk reduction (King 1999:7).

2.5.1.1.3 Theory of Reasoned Action (TRA)

The Reasoned Action theory is founded on the premise that people are frequently rational and have the ability to make systematic use of the information they have. People think about the consequences of their actions

[53] Self-efficacy alludes to an individual's confidence in the ability to take action and persist in that action. Bandura (1989) introduced this concept in 1977. He sees self-efficacy as perhaps the single most important factor in promoting changes in behaviour (Bandura 1986).

in a given setting at a specific moment prior to deciding whether to engage or not engage in a given behaviour, and that the majority actions of social significance are under volitional control. The Theory of Reasoned Action is theoretically analogous to the Health Belief Model, but includes the idea of behavioural intention as a factor of health behaviour. The focal points of the two theories are “perceived susceptibility, perceived benefits and constraints to changing behaviour”. However, the Theory of Reasoned Action distinctively concentrates on the function of personal intention in determining whether certain behaviour will transpire. This theory posits that an individual’s intention is determined by two issues: (1) attitude (toward the behaviour), and (2) ‘subjective norms’, i.e. social influence.

Beliefs play a central role in the Theory of Reasoned Action. They generally aim on what a person believes other people, particularly the significant others, would expect him/her to do. For instance, in order for an individual to begin using condoms, his/her thoughts may be that “having sex with condoms is just as good as having sex without condoms”, but the impact of social influence (subjective norms or beliefs) could be that “most of my peers are using condoms; they would expect me to do so as well”. Interventions using this theory to guide activities concentrate on attitudes about risk-reduction, response to social norms, and intentions to change risky behaviours (King 1999).

A good number of school-based and peer-education interventions are based on insights from this theory.

A limitation of the TRA includes its failure, because of its individualistic approach, to take into account the role of environmental and structural issues and the linearity of the theory components (Kippax & Crawford 1993). For instance, it has been pointed out that individuals can first alter their behaviour and then their beliefs/attitudes about it (Denison 2002).

2.5.1.1.4 Stages of Change Model

Psychologists invented this theory in 1982 to compare smokers in therapy and self-changers along a behaviour change continuum. The intention for classifying people in stages was to tailor an individual's needs at his/her specific point in the process of change (Denison 2002). The Stages of Change Model suggests six stages that persons (or groups of people) undergo when changing behaviour, namely, pre-contemplation, contemplation, preparation, action, maintenance and relapse. When applied to condom use, the stages could be delineated as:

1. **Pre-contemplation**—the person has not considered using condoms
2. **Contemplation**— the person recognizes the need to use condoms
3. **Preparation**—the person is thinking about using condoms in the coming months
4. **Action**—the person is using condoms consistently for less than 6 months
5. **Maintenance**—the person is using condoms consistently for 6 months or more
6. **Relapse**—the person slips-up with respect to condom use

According to this theory, an intervention can only succeed when it targets the appropriate stage of the individual or group. For instance, for a person to progress from stage one to two, the appropriate preventive activity will be information impartation (i.e. raising HIV awareness). It is possible however, that people groups and individuals may experience all the stages, but do not automatically move in a linear manner (Denison 2002; Kings 1999).

A limitation of this theory is that it focuses on the individual without assessing the role that structural and environmental factors might exert on a person's capability to effect behaviour alteration. Additionally, since the stages of change are more of a descriptive than a causative explication of behaviour, the relationship between the stages is not always clear [Denison 2002; Mwansa (2008)].

2.5.1.1.5 AIDS Risk Reduction Model (ARRM)

This model, introduced in 1990, uses ideas from the Health Belief Model, the Social Cognitive Theory and the Diffusion of Innovation Theory (described below), to explain the process people pass through while they experience HIV-risk behaviour change (Catania et al. 1990). ARRM sees three stages toward reducing the risk of HIV infection: (1) behaviour labelling, (2) commitment to change, and (3) taking action.

Stage one (behaviour labelling) is about recognizing and labelling of the person's behaviour as risky. The assumed influences are:

- knowledge of sexual activities associated with HIV transmission

- belief that one is personally susceptible to contracting HIV;
- belief that AIDS is undesirable; and
- social norms and networking (Denison 2002).

Stage two (Commitment to Change) is about making a commitment to reduce high risk sexual contacts and to increase low-risk activities. The assumed influences are:

- cost and benefits;
- enjoyment (e.g. will the changes affect my enjoyment of sex?);
- response efficacy (e.g. will the changes successfully reduce my risk of HIV infection?);
- self-efficacy (does the person have the confidence to effect the desired change?)
- knowledge of the health utility and enjoyability of a sexual practice, as well as social factors (group norms and social support), are believed to influence a person's cost and benefit and self-efficacy.

Stage three (Action) is about taking action. This stage has three sub-phases in it: (1) information seeking, (2) obtaining remedies, and (3) enacting solutions[54]. This stage is based on these premises; social networks and problem solving choices (self-help, formal and informal help);

- Prior experiences with problem and solutions;
- Level of self-esteem;
- Resource requirement of acquiring help;

[54] Depending on the individual, phases may happen concurrently or phases may be skipped (Denison2002).

- Ability to communicate verbally with sexual partner;
- Sexual partner's beliefs and behaviours

In addition to the stages and influences itemized above Catania and colleagues (1990) identified other internal and external factors which may motivate a person's move across the stages. For instance, aversive emotional states, like high levels of distress over HIV/AIDS that blunt emotional states, might facilitate or hinder the labelling of a person's behaviour. External motivators such as public campaigns, an image of a person dying from AIDS, or informal support groups, could also cause individuals to examine and potentially change their sexual activities (Denison 2002). Gary and colleagues (2006) seem to suggest that ARRM was effective in reversing HIV and AIDS in Uganda through concerted educational and mass media efforts.

A limitation of the ARRM is its focus on the individual. For example, many women in an ARRM-based research in Kampala felt at risk of HIV infection, not due to their own behaviour, but due to the behaviour of their sexual partners. Consequently, McGrath and colleagues proposed that this model give greater consideration to socio-cultural factors, which influence and may limit an individual's behaviour choices and capacity to take action (McGrath et al. 1993).

The current researcher concurs that the foregoing theories and models, which focus on the individual, are essentially helpful toward giving vital guidance to approaches in designing and evaluating HIV interventions with various

populations in a wide array of contexts. But they do not on their own explain why some populations have higher HIV prevalence than others or the intricate interactions between contextual and individual behaviour. Therefore, it is needful to investigate community, structural, and environmental influences on behaviour change in HIV.

2.5.1.2 Theories and Models Focusing on the Community

The theories and models of HIV-risk behaviour change which were discussed in the preceding section hugely rest on the individual's role and responses to his or her social context. The limitation of these approaches to HIV-risk behaviour change, as evaluated in each of them, is that they appear to ignore the wider context in which the individual is located. The individual does not live in isolation. According to a systems approach, the individual is a part of the whole and his/her actions (responses) impact and are impacted by the socio-cultural, economic and environmental milieus (cf. Steinke 1996). King helpfully notes:

> Overemphasis on individual behavioural change with a focus on the cognitive level has undermined the overall research capacity to understand the complexity of HIV transmission and control. Focus only on the individual psychological process ignores the interactive relationship of behaviour in its social, cultural, and economic dimension thereby missing the possibility to fully understand crucial determinants of behaviour (1999:8).

She adds,

> …in many cases, motivations for sex are complicated, unclear and may not be thought through in advance. Societal norms, religious criteria, and gender-power relations infuse meaning into behaviour, enabling positive or negative changes. A main difference between individual and social models is that the latter aim at changes at the community level. Sociological theories assert that society is broken up into smaller

> subcultures and it is the members of one's immediate surroundings, the peer group that someone most identifies with, that has the most significant influence on an individual's behaviour. According to this perspective, effective prevention efforts, especially in vulnerable communities that do not have the larger societal support, will depend on the development of strategies that can enlist community mobilization to modify the norms of this peer network to support positive changes in behaviour (King 1999:8).

King's thoughts point to an increasing level of interest in investigating the context surrounding individual behaviour. Arguably, the social environment of an individual can influence the growth of HIV risk-reducing behaviours. The following social theories and models of behavioural change focus on community-level approaches. The researcher will look at the following theories particularly germane to the Zambian context: Diffusion of Innovation Theory; Social Influence or Social Inoculation Model; Social Network Theory; and the Theory of Gender and Power.

2.5.1.2.1 Diffusion of Innovation Theory[55]

The Diffusion of Innovation Theory (Rogers 1983) describes the process of how an idea is dispersed throughout a community. According to this theory, there are four fundamental elements toward changing HIV-risk behaviour, namely: the innovation, its communication, the social system, and time. The theory argues that people's exposure to a new idea, which occurs within a social network or through the media, will determine the rate at which diverse

[55] The Diffusion of Innovation Theory seems to be an application of anthropological insights on how culture change is triggered. Luzbetak (2000:307-308) explains that culture change may be triggered from within or from without the society. If it is triggered from within the society, anthropologists call it "origination"; if from without, they term it "diffusion" which may be described as unconscious, voluntary, or forced diffusion depending on the recipient culture's perception of the change agent. If the change agent is insensitive to the people's worldview and social authority structures, then the novelty may be seen as forced diffusion. However, when the change agents are sensitive to social authority and worldview issues the change might be voluntary and unconsciously diffuse throughout the community especially when the opinion leaders support the new idea.

people implement a new behaviour. The Diffusion Innovation Theory postulates that individuals will most probably assume a new behaviour if favourable evaluations of the idea is communicated to them by other members of their social network whom they respect (Kegeles et al. 1996). King elucidates,

> …when the diffusion theory is applied to HIV risk reduction, normative and risk behavioural changes can be initiated when enough key opinion leaders adopt and endorse behavioural changes, influence others to do the same and eventually diffuse the new norm widely within peer networks. When beneficial prevention beliefs are instilled and widely held within one's immediate social network, individuals' behaviour is more likely to be consistent with the perceived social norms (1999:9).

Interventions employing this theory broadly look into the best process to disseminate messages within a community and identify (opinion) leaders in the community with the capability of being role models to change community norms. These opinion leaders become the epicentre of transformative behaviour. The opinion leaders then provide transformative leadership for behaviour change. The researcher sees the influence of Diffusion of Innovation Theory in the approaches of the Salvation Army's HIV prevention work in the Southern Province of Zambia (cf. Lucas 2004).

2.5.1.2.2 Social Influence or Social Inoculation Model

This model is essentially an educational model founded on the notion that young people take on behaviours including early sexual activity partially due to general societal influences, but more precisely from their peers (Howard and McCabe 1990). This theory proposes exposing young people to social pressures and at the same time teaching them to scrutinize and develop skills

to deal with these pressures. The model is often dependent on role models such as teenagers slightly older than programme participants to present factual information, identify pressures, role-play responses to pressures, teach assertiveness skills and discuss problem situations (Howard & McCabe 1990). The Social Influence Model has been used extensively in Zambia to reduce HIV-risk behaviour among primary and secondary school learners (cf. CHEP; Raising [2006]).

2.5.1.2.3 Social Network Theory

The Social Network Theory sees social behaviour not as an individual phenomenon but through relationships, and understands that HIV-risk behaviour, unlike many other health behaviours, directly involves two people (Morris 1997). Regarding sexual relationships, social networks centre on both the impact of selective mixing (that is, how diverse people choose who they interact with), and the differences in partnership patterns (length of partnership and overlap). Although the complexities of relations and communication within the couple, the smallest unit of the social network, is important to the comprehension of HIV transmission in this model, the extent and nature of a person's broader social network, those to whom people refer, and who sanction behaviour, are vital to understanding individual risk behaviour (Auerbach et al. 1994). This theory entails that "social norms are best understood at the level of social networks" (King 1999:9). Programmes employing the Social Network Theory for guidance would investigate the following issues:

- the composition of important social networks in a community,

- the attitudes of the social networks towards safer sex,
- whether the social network provides the necessary support to change behaviour, and
- whether particular people within the social network are at particularly high risk and may put many others at risk.

Although few network-based approaches to HIV risk reduction efforts have been experimented with, the idea has been compatible with individual-based theories when designing prevention programmes, especially when dealing with partnerships as well as the larger social group. Analysis of network mixing provides the means to see efficiency of transmission and effective points of intervention. Phiri (2008) has made a passionate call to find a solution to the risk of HIV infection engendered by concurrent multiple partnerships which appear to thrive on social networking and are all too common in Zambia.

2.5.1.2.4 Theory of Gender and Power

The Theory of Gender and Power is a unique approach to HIV prevention as it, unlike other psychosocial theories which are fundamentally gender insensitive, is a social structural theory tackling the wider social and environmental problems affecting women, such as the sharing of power and authority, emotional influences, and gender-specific norms within heterosexual relationships (Connell 1987). Guided by this theory HIV intervention development affecting women in heterosexual relationships can assist in examining how a woman's commitment to a relationship and lack of

power can determine her risk reduction choices (DiClemente & Wingood 1995). Programmes applying this theory would evaluate the impact of structurally determined gender disparities on interpersonal sexual relationships (particularly opinions of socially approved gender associations).

Social theories and models understand a person's behaviour as rooted in her or his social and cultural context. Instead of concentrating on psychological processes as the ground for sexual behaviour, it leans on the conviction that social norms, relationships, and gender inequalities are responsible for individuals' behaviour and behaviour change. These theories insist that attempts to cause change at the community level will be more effective on individuals who are considering changes and on those who have already changed but require support to maintain the changes. Social theories have been used more and more with people groups particularly susceptible to actions and behaviours of partners and peers (cf. King 1999).

2.5.1.3 Structural and Environmental Theories and Models

Many studies have demonstrated that Influences on sexual behaviour can be viewed as a function not only of individual and social factors, but also of structural and environmental factors (Caraël et al. 1997; Sweat & Denison 1995; Tawil et al. 1995). These factors may include civil, organizational, policy, and economic elements. In this section the researcher will survey key theories and models based on structural and environmental factors which may impact HIV-risk behaviour change.

2.5.1.3.1 Theory for Individual and Social Change or Empowerment Model

This theory states that social change takes place by dialogue in order to form a critical insight of the social, cultural, political and economic forces that constitute reality and by acting against forces that are oppressive (Parker 1996). The model entails that empowerment must enhance problem solving in a participatory manner and participants' comprehension of the personal, social, economic and political forces in their milieu in order to enable them to act toward improving their situations. King defines empowerment as "the process by which disadvantaged people work together to take control of the factors that determine their health and their lives" (1999:10). There are three types of empowerment: personal, organizational and community empowerment. Personal empowerment deals with the psychological processes and is akin to self-efficacy and self esteem. Organizational empowerment includes both the processes by which individuals grow in their control within the organization and the organization's influence on the policies and decisions in their community. Ultimately, empowered communities employ individuals' skills and resources and organizations to meet relevant needs.

The researcher understands that approaches using empowerment means should consider vital notions like beliefs and practices which are essentially connected to interpersonal, organizational and community change. According to this model, activities can focus on problems at the communal and organizational level such as fundamental needs which the community

identifies, and any collection of communal history by members of the community. Consequently, it is essential to include communal participation in the planning and implementation of activities for this intervention informed by this theory to be effective.

2.5.1.3.2 Social Ecological Model for Health Promotion (SEMHP)

McLeroy and colleagues (1988) state that in the SEMHP patterned behaviour emanates from interest and behaviour and is influenced by a number of factors. They identify the following vital factors:

1. intrapersonal factors – characteristics of the individual such as knowledge, attitudes, behaviour, self-concept, skills
2. interpersonal processes and primary groups—formal and informal social network and social support systems, including the family, work group and friendships
3. institutional factors – social institutions with organizational characteristics and formal and informal rules and regulations for operation
4. community factors – relationships among organizations, institutions and informal networks within defined boundaries
5. public policy – local, state and national laws and policies (McLeroy et al. 1988).

The applications arising from this intervention encompass a wide variety of strategies which range from skills development at the intra-personal level to mass media and regulatory adjustments at other levels. The theory accepts the significance of the interaction between the individual and the environment, and attributes unhealthy behaviour to multi-level influences. The down side of this approach is evident, however. It appears that the centrality of the individual in the process of behaviour change is almost entirely ignored, thus making it impersonal. The positive (though paradoxical) side of this approach

is that it provides support (or enabling) structures for the individual to pursue behaviour change.

2.5.1.3.3 Socioeconomic Factors

Numerous studies have demonstrated that economic factors have a powerful effect on individual sexual behaviour, especially through poverty and underemployment (van Niekerk et al. 2001; Barnett & Whiteside 2002; Fernandez 2003; Hallman 2004; World Bank 2005). Worldwide, countries with higher poverty levels are also the ones with the highest HIV incidence (Sweat and Denison 1995; Fernandez 2003; Magezi 2005, UNAIDS 2006). Both in developed and developing countries, poverty is linked with HIV, and HIV exacerbates poverty (Usdin 2003; Fernandez 2005). The suggested dynamics for this relationship are: young married couples not living together due to critical economic circumstances necessitates urban migration, seasonal work, long-distance truck driving, sex work, and civil strife. Civil strife precipitates displacements creating refugee populations who not only lose their social and familial support systems, but become highly vulnerable to HIV due to social and economic straits in foreign cultures (Caraël et al. 1997). Thus, as far as the displaced individual is concerned, “HIV concerns take a very low priority in a risk hierarchy, and any previous or planned efforts for the control of HIV transmission are disrupted, if not destroyed” (King 1999:11).

The foregoing discussion implies that community-level theories or models deem human behaviour as rooted not only in the individual or his/her immediate social relationships, but as contingent on the community and the

political and economic environment as well. Consequently, approaches to HIV behaviour change which are spurred by social theories, are thus multifaceted and attribute the individual's behaviour to the surrounding larger environmental systems. Therefore, HIV-risk behavior interventions employing Structural and Environmental Theories target organizations, communities and policy. The researcher thinks that the Treatment Action Campaign (TAC) of South Africa appears to be informed by this theory in its work.

2.6.1 Major Approaches to HIV-Risk Behaviour Change in Zambia

At the beginning of the AIDS epidemic, findings of population surveys made public health officials aware of a plethora of sexual behaviours and of the necessity for quick interventions. The initial interventions which applied insights of the behaviour change models were principally reactionary to decelerate the spread of the epidemic more than anything else. Currently, the majority of the interventions toward reducing the spread of HIV have been developed using a combination of behavioural theories based on the socio-cultural, political, or economic context, and on the stage of the epidemic. The application of insights from a variety of models has led to adapting them in order to fit the population and context as essential ingredients toward effective execution of prevention projects. In the ensuing section the researcher will look at approaches targeting individual behavioural change and interventions aimed at communities in Zambia. It will sketch appropriate theories and give examples of how these are being applied in the Zambian HIV and AIDS situation.

2.6.1.1 Interventions Aimed at Individuals

The current section surveys HIV-risk behaviour interventions which target the individual in the Zambian context and will reflect on the individual's interplay with mass preventive approaches. Hence the researcher will discuss the following approaches to HIV risk reduction in Zambia—(i) Information, education and communication (IEC), (ii) Mass and small group education, (iii) Peer education, and (iv) Voluntary Counselling and Testing (VCT).

2.6.1.1.1 Information, Education and Communication (IEC)

Virtually all HIV-risk reduction interventions which target individuals are founded on the premise that when individuals have accurate information on HIV transmissions it will not only dispel myths about HIV/AIDS infections, but will also facilitate risk behaviour change. Hence information, education and communication (IEC) play key roles in most theories of HIV risk behaviour change today. IEC still constitute a critical element of the fight against HIV/AIDS in Zambia (CSO et al. 2000; NAC/MOF Zambia 2005; Chituwo 2008).

2.6.1.1.2 Mass and Small Group Education

Since information was at the outset considered by many to be the critical factor toward behaviour change, HIV prevention interventions started with a concentration on raising awareness about the ways of transmission and prevention. Educating the masses was usually viewed as an essential element to any thorough AIDS prevention strategy (Holtgrave 1997). In Zambia, for instance, mass media target the general public with the explicit

goal of teaching people vital facts, encouraging healthy behaviour, allaying anxiety on the causes of transmission and discouraging prejudice (NAC/MOF Zambia 2005). Additionally, concerted efforts have been targeted at small groups as a means of HIV/AIDS awareness education to reduce HIV-risk behaviour. But importantly, small group AIDS prevention programmes must have three key elements: content, context and strategies.

The content of a programme would constitute goals, objectives, and activities. The key content focus in most small group intervention activities incorporate: basic teaching about AIDS, sensitization to one's personal risks for HIV, instruction in individual actions that can reduce a person's risk, and investigating new means of communicating with sex partners. Whole interventions or study questions are often designed to address any one of these content fields.

Secondly, small group HIV preventive programmes have to do with context. The diverse facets of the intervention must be intended to suit the cultural, gender and developmental issues of participants.

Finally, strategy entails the process itself. Here emphasis is placed on the means by which the interventions are implemented between participants and group leader. Key issues to consider include how to promote trust, build group cohesiveness, and encourage motivation and mutual support among participants and between participants and the facilitator. Although evaluations of small-group prevention programmes tend to focus on content

and facilitation skills, all the three elements are vital to the success of intervention aimed at the individual through the small group (cf. King 1999).

2.6.1.1.3 Peer Education

Peer education is an approach to small group HIV prevention often targeting individual behaviour. The peer health educator approach recruits leaders in communities at risk to be implementers of the education programme to their peers. A good choice of peer educators is essential to the ultimate effectiveness of any peer education programme and usually entails:

- acceptance by other group members
- being an opinion leader, thus well respected in the group
- willingness to be trained, and
- a commitment to the aims of the programme (Sepulvede et al. 1992).

A lot of HIV preventive programmes merge peer education with other approaches such as condom social marketing (Roy 1998), outreach (Seema 1998; King 1999) and the utilization of social networks, since these approaches are complementary.

According to Wingood and DiClemente (1996), working with peers, rather than with ‘experts’ from outside the social network, has many advantages for many at-risk groups. They observed that peer educators were a more credible source of information for women, may communicate in more comprehensible terms, and may serve as positive role models. Other studies have proposed that when the group at risk is very diverse culturally from the majority, peers

seem to know the cultural risks and most appropriate and realistic risk-reduction strategies from experience.

The peer educator approach has been used among low- and middle-class general population in Zambia (Kathuria 1998). Peer educators do varying tasks ranging from development and distribution of IEC materials such as video clips and pamphlets, condom discussion and distribution, and conversations with peers on varied themes like empowerment, health and human rights, to basic AIDS information. The Copperbelt Health Education Project (CHEP) has been successful in its peer educator's programmes in Zambia.

2.6.1.1.4 Voluntary Counselling and Testing

Voluntary Counselling and Testing (VCT) has emerged as a major strategy for the prevention of HIV infections and AIDS in Zambia, as in the rest of Africa today. VCT is a process whereby an individual undergoes counselling to enable him or her make an informed decision about being tested for HIV antibodies (van Dyk 2005). Research has shown that knowing one's status, whether negative or positive, can be instrumental to effecting behaviour change and assuming safer sex practices (De Zoysa et al. 1995; Mkaya-Mwamburi et al. 2000; van Dyk 2005). Additionally, early detection of the HI virus facilitates referral for clinical care and psychosocial support. De Zoysa and colleagues (1995) point out that HIV counselling and testing may have a critical social impact as people who know their serostatus share it with others and hence lay the foundation for changes in social norms about HIV and

AIDS. A positive HIV test result has sometimes encouraged some individuals to give personal testimonies in their communities, an end result that may have an influential effect on individual attitudes, behaviours and social norms.

In most traditional Zambia, as elsewhere in Africa, where cultural settings highly value fertility, VCT provides significant behaviour-change options to consistent condom use. The theoretical underpinnings on which interventions providing VCT are built chiefly involve the stages of change model (De Zoysa et al. 1995; King 1999). VCT may encourage progression across the scale of the stages of change. For instance, in rural south-western Uganda, a situation which had high HIV prevalence, majority respondents in a study said that they had already initiated behaviour changes due to AIDS, but making more changes to protect themselves was dependent on knowing their HIV status (Bunnell 1996). Consequently, it has been posited that VCT promotes HIV risk reduction by growing perception of risk, self-efficacy and personal skills, and through reinforcing social norms or responsibility (King 1999:16). King, however, cautions,

> *...there is no question that HIV VTC [sic] can and does motivate behavioural change in some individuals*, but also that VTC [*sic]* alone does not always lead to changes and does not have the same effect in all populations and in different situations …. As with most other approaches, the stage of the epidemic and surrounding contextual factors will contribute to the outcome of the intervention. In addition, the quality of the counselling provided is a key variable in predicting the impact of the intervention (King 1999:16 emphasis hers).

A literature study (cf. CSO et al. 2009; Chituwo 2008) on VCT as an HIV risk behaviour intervention suggests the inclusion of the following elements as essential to its' effectiveness: increasing participants' ability to communicate

effectively about sex; helping participants increase their condom use skills; personalizing risk, achieving participants perception of risk avoidance as an accepted social norm, providing reinforcement and support for sustaining risk reduction. It is the opinion of this researcher that for individual level interventions to be effective, context specific information and skills are of paramount importance. In Zambia VCT as an HIV prevention intervention has been popularized by Kara Counselling and Training Trust, New Start, VCT services at the University Teaching Hospital, to name a few, and appears to be significantly contributing to the deceleration of the growth rate of the epidemic at individual level (cf. Chituwo 2008). However, the Zambia 2007 Demographic and Health Survey (CSO et al. 2009) has revealed that over half of HIV-positive women and almost three quarters of HIV-positive men do not know that they are infected (see Figure 1.3). This shows that a significant number of Zambians have avoided the HIV test, for whatever reasons, but chiefly because of the stigma associated with an HIV-positive status.

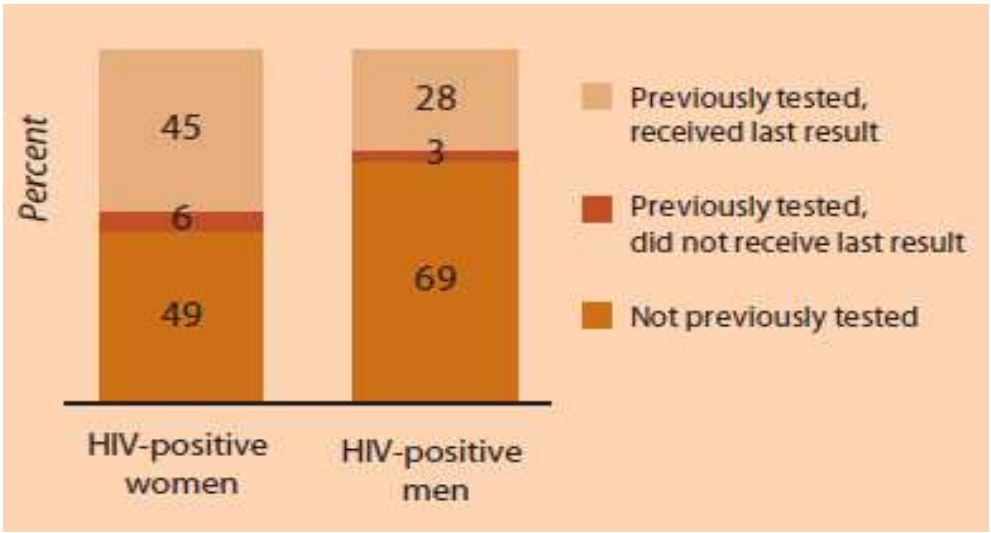

Table 2.2— Prior HIV Testing among HIV-Positive Respondents (Source: CSO et al. 2009)

2.6.1.2 Interventions Aimed at Communities

Community-level interventions toward HIV-risk behaviour reduction emanated from the realization that, regardless of the huge risk reduction efforts through individual-level behaviour change, a plethora of community-level interventions were necessary as well. The researcher will now consider community level programmes covering the most common approaches to HIV-risk behaviour reduction namely: interventions founded on social influence and social networks, outreach programmes, school-based programmes, condom promotion and social marketing, community organizing and empowerment and policy level approaches, each of which either attempts to reduce individual susceptibility to or the transmission of the HI virus, transform community norms, limit the spreading of high prevalence networks or transform community organizational structures making them less risky (Friedman & O'Reilly 1997). Transforming community cultures or norms gives a motivation for individual HIV-risk reduction. Several of the following programmes apply ideas from the Theory of Reasoned Action, the Diffusion of Innovations Model and the Theory of Social Influence to marshal peer pressure or to exclude individuals who persist in HIV-risk behaviour.

2.6.1.2.1 Social Influence and Social Network Interventions

The theories of Social Influence, Diffusion of Innovation, Reasoned Action and Social Cognitive Theory, are frequently used as a basis for interventions which employ peers and social networks to spread information. Social influence interventions identify key persons in communities who are able to influence others. The Social Cognitive Theory is based on the premise that

trusted role models are a vital element in the milieu and the milieu has a mutual connection both with behaviour and the individual (King 1999). According to the theory of Reasoned Action, perceptions of social norms possess a vital influence on behaviour. These social norms which are shaped by opinion leaders have a strong effect on behaviour. The Diffusion of Innovation theory emphasizes that changing behaviour will most probably occur if the new behaviour is companionable with the accepted social norms of a particular social network, if it is simple to do, and if it has observable outcomes (Kalichman 1998; Gary et al. 2006). For example, encouraging outcomes in changing social norms and safer sex behaviour have been observed in a number of community-level social influence interventions in Uganda and Thailand, where a combination of concerted efforts produced behavior changes that impacted seroprevalence (cf. Gary et al 2006).

2.6.1.2.2 Outreach Interventions

Outreach interventions have a similar impact to Social Influence interventions because they also employ individuals to pass on information within social networks. However, the influential person might be an outsider to the community targeted. In outreach interventions the outreach worker enters and engages the social system (often that of a hard-to-reach people group such as sex workers or isolated rural communities) to initiate behaviour change as an individual change agent. Outreach interventions frequently use risk reducing strategies like providing condoms to a sex worker without necessarily addressing the behaviour itself (King 1999; Onyango-Ouma et al. 2006). This intervention has been used in Zambia among migrant workers,

truck drivers, and sex workers in border towns and urban centres like Lusaka, Livingstone, Mpulungu, and Chipata by organizations like World Vision International, CHEP, Tasintha, to name a few.

2.6.1.2.3 School-based interventions

In Zambia, school-based interventions are led by organizations such as the Copperbelt Health Education Project (CHEP) and Youth Alive who target primary and secondary school learners. The Zambian ministry of education also encourages HIV/AIDS education in schools as part of the larger government effort to stem the spread of the epidemic (USAID 2000; NAC 2005; Chituwo 2008). King suggests that above and beyond interventions that merely offer basic AIDS information in the classroom, "multi-dimensional school-based programmes generally include classroom skills-building sessions, school-wide peer-led activities, and social norm changing programmes" (King 1999: 19).

The promotion of condom use among youth has not been a popular element of school-based outreach in Zambia as a perception persists that *this* promotes early sexual activity (Ndhlovu 2007). However, a review of school-based interventions showed that no wide-ranging school-based HIV-prevention interventions studied produced evidence to support this perception (UNAIDS 1997).

2.6.1.3 Policy Level Interventions

Policy level interventions are essentially 'empowering' approaches that try to take away structural obstacles at a larger level. Many researchers hold that AIDS interventions are moving from exclusively investigating individual approaches to multidimensional models of community mobilization, empowerment and structural policy level interventions (cf. Barnett, T and Whiteside 2002). Therefore, it is arguable that HIV prevention at the community level is a fundamental component in order to stop the continued spread of HIV. This means that in working with communities, as opposed to individuals; focus will be placed on changing policy, social structures, social norms and cultural practices which may form individual risk behaviours. King asserts that "Community level changes working at the level of changing subcultures have potential to effect long-term maintenance of changed behaviours, by changing the environment surrounding individuals to support safer behaviours" (King 1999:23). The researcher posits that the church's involvement at community-level is important as it fulfils its' *salt-and light* function both as the preservative from 'decay' and as the pointer to safer lifestyles in the broader environs which will ultimately contribute to HIV-risk behaviour change.

2.7 Toward a Theology of HIV-Risk Behaviour Change

To a practical theologian, the discussion of theories and models of HIV-risk behaviour change, should lead to the formulation of a theology of HIV-risk reduction. The very nature of Practical Theology entails that 'doing theology' calls for germane approaches to the issue of transforming worldviews which

underpin HIV-risk behaviour in the face of an unrelenting HIV and AIDS epidemic in sub-Saharan Africa. The researcher posits that a relevant theology of HIV-risk reduction should include at least the following important ideas.

2.7.1 HIV-Risk Behaviour and Moralizing[56]

What precisely is the relationship between HIV-risk behaviour and sin? The study has established that HIV-risk behaviour constitutes people's attitudes and actions which make them susceptible to HIV infection. The big question here is whether these behaviours are inherently immoral or not. For sub-Saharan Africa, the research of over two- decades into the enigma of HIV/AIDS proliferation has established that the epidemic is integrally sexually transmitted and that most of it is occurring through the heterosexual intercourse route (UNAIDS 2006; Phiri 2008; UNAIDS 2008; UNAIDS and WHO 2009). It will surely be amiss to assert that all sexual activity is unethical or immoral *per se*. Sexual activity is a gift of God to humanity intended for both procreation and pleasure (La Haye & La Haye 1976; Wheat & Wheat 2002; Baloyi 2007). But what has gone amiss that the very thing God designed for humanity's pleasure and perpetuation of the race has become the means of intense suffering and terminating human life?

[56] The idea of moralizing HIV risk behaviour refers to thoughts about, or the expression of, moral judgments or reflections on the HIV status as related to sexual activity. A significant number of PLWHA tend to 'moralize' their status as a coping mechanism especially when looking at the issue from the 'lenses of Christianity (cf. Hlongwana and Mkhize 2007). They seem to believe that they are HIV positive as a punishment from God for past sexual promiscuity in their lives. But an HIV positive status is not necessarily an outcome of promiscuity. The researcher is of the view that such a perception is too simplistic and at best promotes HIV-stigma.

McDonagh (van Wyngaard 2006:268) contends that HIV/AIDS does not raise new questions about God. But it raises old questions on the relation between human suffering and God in a different form. Some sectors of the church have argued that HIV/AIDS is God's punishment for sin (Müller 2004; Magezi 2005; Wyngaard 2006; Ndhlovu 2007 etc).

The question whether sickness and suffering could be the direct result of sin has been contended with from biblical times. For instance, this issue occupies the central theme of the biblical book of Job, which captures the reality that the relationship between human suffering and sin should not be taken simplistically (cf. Job). In the context of HIV/AIDS some people are happy to say that those who are HIV positive have that status due to their own promiscuity such as drug users and homosexuals who are merely getting their just recompense for their sexual deviance. With this point of view HIV/AIDS is not viewed as God's chastisement on humanity in general, but more particularly as God's punishment over persons who indulge in an unethical sex-life. But a growing number of people are becoming aware that such a standpoint is too simplistic (Müller 2004; Hlongwana and Mkhize 2007; Ndhlovu 2007).

Two issues pose a problem to such thinking: what about the many individuals who overtly live immorally, why are they not HIV positive? Why doesn't God punish them? Furthermore, a number of people living with HIV (such as a faithful spouse or children) may have acquired the illness not because of their misdeeds. The researcher's view is that contemporary theological thought

should oppose the school of thought which holds that an HIV positive status is God's chastisement for a specific sinful conduct. The closest one can get to this moralizing school of thought is to say that people living with HIV/AIDS are but victims of the disease (van Wygaard 2006). What is certain, however, is that HIV-risk behaviour is a consequence of the power of humanity's ethical imperfection (cf. Erikson 2002). Hence, the researcher suggests that a theology of HIV-risk reduction should take into account the fact that the world of human beings is tainted by sin and any approach toward risky behaviour change should not forget sin's mastery over humanity. Consequently the legality of the link between sin, evil, dirtiness, and HIV infection appears to be unresolved, and may remain an issue for debates in the future (Hlongwana and Mkhize 2007). However, the researcher recognizes that arguments for or against the issue are polarised with both ends claiming biblical validity.

2.7.2 A Conversation on Sex and Sexuality

The World Council of Churches (2004:33) has observed:

> ...if sound moral decisions are required of people, an environment conducive to making such decisions is necessary, an environment in which openness to honest sharing of experiences and concerns is promoted and the integrity of people and their relationships is affirmed. Apart from such an environment, the vulnerability of marginalized groups to high-risk behaviour is greatly increased.

Consequently, a theology of HIV-risk behavior change should clearly encourage lifting the taboo on sex education so pervasive in sub-Saharan African cultures. When we learn to speak openly about sex and sexuality chances will be good that risk-reducing behaviour may become a reality (cf. Cilliers 2007). This point is germane to the Zambian context where a taboo on

speaking on sex and sexuality still persists (cf. CSO et al. 2007). The researcher proposes that Christian churches in Zambia become more courageous so as to have open and relevant conversations on sex and sexuality. Such is the only feasible way of dispelling misinformation which is so prevalent in Zambia. For instance The Zambia 2007 Demographic and Health Survey reported that many Zambians still have a lot of misconceptions about HIV and AIDS (CSO et al. 2009b) which can be tackled through open and non-stigmatizing dialogue (Moyo 2009).

2.7.3 God and HIV-Risk Behaviour Change

Where is God in HIV-risk behaviour change? Some researchers have resigned to the whole idea of changing people's sexual behaviour (cf. Kelly 1995). The corollary question may be posed in this connection: 'Can human beings make an enduring difference in the quest for HIV-risk behaviour change?' These indeed are profound questions requiring theological reflection and action. The World Council of Churches (WCC) helpfully asserts, "The churches have strengths, they have credibility, and they are grounded in communities. This offers them the opportunity to make a real difference in combating HIV/AIDS. To respond to this challenge, the churches must be transformed in the face of the HIV/AIDS crisis, in order that they may become a force for transformation – bringing healing, hope, and accompaniment to all affected by HIV/AIDS" (WCC 2001:3).

The WCC (2001) statement points to the possibility of HIV-risk behaviour change and identify the body of Christ (human beings) as one of God's

means of precipitating transformative change. For transformative change to occur the church should make a paradigmatic shift from an attitude of non-involvement and stigmatization to empathy and engagement on the prevention to care continuum (Müller 2004; Louw 2006; Magezi 2005; Mulenga 2009; Ndhlovu 2007). A story narrated to the WCC general assembly on HIV/AIDS in Nairobi highlights the importance of sub-Saharan Churches' proactive involvement in HIV-risk reduction efforts:

> When my cousin was dying of AIDS, he found it easy to tell his family and friends about the disease. In his final days we gathered the family together to say goodbye, and discussed with Mathunya the plans for his funeral. We asked him what he wanted to happen at the service, and he said, 'I want you to tell them the truth that I died of AIDS'. So we planned a service that could celebrate his life and educate those who came to the funeral, especially the young people. At his funeral, my grandmother walked to the front of the church and laid her hand on her grandson's coffin, and said, 'My grandson no longer has to suffer with AIDS.' Then, with her hand still on his coffin, she turned to the pulpit and said to the preacher who was about to preach to the people gathered in the church, 'Now… talk to them freely about this disease' (WCC 2001:3).

The task at hand is about compassionately speaking about HIV-risk behaviour change without stigma. Therefore, as evangelicals in Zambia formulate a theology of HIV-risk behaviour change, they need to face the very possibility of HIV-risk behaviour change through spiritual means. Essentially the church's participation in promoting HIV-risk behaviour change is a sign of God's continuing presence in the practice of transformation. Since the church has HIV/AIDS it follows that stigmatization is incongruous to the very nature of the church as an accepting and forgiving community. Thus a theology of HIV-risk reduction is to be done in the very presence of God and for His glory (cf. 1 Cor 10:31) with a non-condemnatory attitude of empathy.

2.7.4 HIV-Risk Behaviour Change versus HIV-Associated Stigma

The late Jonathan Mann, former head of WHO's Global Program on AIDS, astutely called stigma as the "third epidemic" (the first two being the hidden but accelerating spread of HIV and the visible escalation of AIDS cases)" [Nyblade et al. 2005:5]. A theology of HIV-risk behaviour change must hence be wary of stigma nuanced approaches which forgets the legitimate gains in other behaviour change disciplines. Nyblade and colleagues (2003:5) write that "Stigma still remains one of the most significant challenges in developing countries for all HIV and AIDS programs, across the prevention to care continuum". Stigma linked to health conditions is greatest when commingled with 'immoral' behaviour especially if it is perceived that the person is to blame for the condition.

As theologians spell out a Theology of HIV/AIDS and risk-reduction, it is critical that the associated stigma is tackled through openly conversing about the disease. The inherently segregative language of 'them' and 'us' must be dropped for more empathetic and acceptance language. We are rather to allude to PLWHA our brothers and sisters for if one member of the body suffers, all suffer together (1 Corinthians 12:26).

2.8 Conclusion

The foregoing chapter has essentially established that doing theology in a context of HIV/AIDS in Zambia entails that Christians interface with contemporary theories and models of HIV-risk behaviour change. This is based on the premise that Christians will acquaint themselves with the

existing behaviour change theories in a concerted quest for HIV-risk behaviour reduction.

Three critical conclusions emerge from chapter two. First, doing theology amidst a generalized HIV/AIDS epidemic in Zambia implies that Christians refrain from being passive and indifferent toward initiatives for HIV-risk behaviour change. This inference posits that the task of doing theology amid a growing HIV/AIDS epidemic in sub-Saharan Africa entail advocating HIV-risk behaviour change and is a plea for costly discipleship (a reminder that following Jesus has spiritual, ethical, practical, and social consequences). The researcher assumes that changes effected at the surface level are inadequate to produce authentic and enduring HIV-risk behaviour change. The researcher holds that enduring HIV-risk behaviour change will only happen when it comes from "inside out" (Crabb 2006), that is to say, first the transformation of individuals' worldview on sex and sexuality and then behaviour change will happen. The researcher thus posits that authentic and enduring HIV risk behaviour change is characteristically a change of heart—the core culture or the worldview—the root of all human behaviour (cf. Proverbs 4:23).

Secondly, chapter two has demonstrated that cultural, economic, and historical factors converge to accelerate the spread of HIV and AIDS in Zambia, as in most of sub-Saharan Africa. The present researcher holds that while the factors and effects of HIV/AIDS in sub-Saharan Africa are overwhelming, the fight toward risk behaviour change is not a lost cause.

Chapter two has discussed and demonstrated that the social theories of behaviour change have recorded laudable successes, such as in Uganda, Senegal (cf. Green 2003) and Nigeria[57](Ezeokana et al. 2009), and are not in fundamental conflict with the task of doing theology amidst a growing HIV/AIDS epidemic. Hence the researcher posits that HIV-risk behaviour change is not a lost cause. The church has the potential of influencing behaviour change through compassionate, empathic and non-stigmatizing involvement in the fight against the HIV/AIDS epidemic.

And thirdly, chapter two has established that individuals with little or no education in Zambia have poor access to safe-sex information (cf. Fylkesnes et al. 2001; Buve et al. 2002), which poses an HIV-risk reduction conundrum since the poor are in the majority. The present researcher posits that the dilemma of HIV-risk behaviour change lies in the fact that whereas some modest gains may be happening among the minority well-educated sections of Zambians, similar gains are still not occurring among the most deprived and less-educated groups (the majority). This status quo appears to persist due to an obdurate adherence to deep-rooted cultural and traditional influences, values, norms and practices to which majority of the underprivileged in Zambia (and a significant section of the well-educated) find hard to let go of (Kapolyo 2005, Phiri 2008). Thus, it is imperative that interventions to check the unrelenting growth of the HIV/AIDS epidemic should not only target individuals, but also aim at changing those facets of cultural and socioeconomic factors which heighten vulnerability to HIV

[57] Empirical research done by Ezeokana and Colleagues in South-Eastern Nigeria observed a strong link between religiosity and the virtue of religious teachings of the church in mitigating the high-risk sexual behaviour which facilitates the spread of HIV/AIDS (Ezeokana et al. 2009).

infections (cf. Buve et al. 2002, Inungu et al. 2006). The researcher concludes that a truly proactive approach to HIV prevention entails transforming worldviews of the majority of Zambia's people groups for enduring HIV-risk behaviour change to occur. But what is the connection between worldview transformation and behaviour change? In the next chapter the researcher will explore the relationship between a people's worldview and changing HIV-risk behaviour toward formulating an evangelical model for HIV-risk behaviour change.