

**CHANGING RISKY BEHAVIOUR THROUGH
WORLDVIEW TRANSFORMATION: A PASTORAL
INTERVENTION TO THE SPREAD OF
HIV/AIDS IN ZAMBIA**

BY

Kennedy Chola Mulenga

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SUPERVISOR: Professor Julian C. Müller
CO-SUPERVISOR: Dr. Linzay Rinquest

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DECLARATION OF AUTHORSHIP

I, Kennedy Chola Mulenga, declare that the thesis, which I hereby submit for the degree PHILOSOPHIAE DOCTOR at the University of Pretoria, is my own work and has not previously been submitted by me for a degree at another university/institution.

SIGNED: _____

DATE: _____

PLACE: Cape Town Baptist Seminary



DEDICATION

To

Elizabeth M. B. Mulenga

who has been my partner in ministry,

my friend and confidante, the mother of my children

and my patient, courageous, enduring and beloved wife of twenty-one years.

ABSTRACT

The study investigates how the church in Zambia can effectively facilitate change toward reducing HIV-risky behaviour. The researcher posits that an intricate connection exists between HIV-risky behaviour and the socio-cultural context of majority people groups in Zambia. He further argues that much risky behaviour is imbedded in pervasive socio-cultural norms and traditions propelled by a worldview which essentially resists transformation. From an insider's perspective the researcher will design a praxis model for transforming Zambian worldview facets with regard to HIV/AIDS predisposing behaviours in order to achieve enduring HIV risk reduction. The study reviews current literature on HIV behavioural change theories and models to understand where the theories have taken all the stakeholders, including theological praxis. The study will demonstrate the link between Zambian cultural worldviews and trends in sexual behaviour which, arguably, facilitates the proliferation of HIV risky behaviour. The study culminates in designing an evangelical theological praxis/model for transforming relevant cultural worldviews toward changing HIV risky behaviour in Zambia.

KEY CONCEPTS

Changing Risky Behaviour, HIV-Risk Behaviour, Worldview Transformation, Pastoral Intervention, HIV/AIDS, Zambia

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Kennedy Chola Mulenga
Cape Town November 2010

ACRONYMS AND ABBREVIATIONS

| | |
|--------|--|
| AHD | American Heritage Dictionary |
| AIDS | Acquired immune-deficiency Syndrome |
| ANC | Antenatal Clinic |
| ARHAP | African Religious Health Assets Programme |
| ARRM | AIDS Risk Reduction Model |
| ART | Assisted Reproductive Technology |
| AVAC | AIDS Vaccine Advocacy Coalition |
| CD4 | Stands for cluster of differentiation. CD4 is a molecule on the surface of some white blood cells onto which HIV can bind. The immune cell that carries the CD4 on its surface is called a CD4 cell. A CD4 test measures the number of CD4 cells in a person's blood. The more CD4 cells there are per millilitre the stronger is the immune system. The stronger the immune system the better the body can fight illness. |
| CHEP | Copperbelt Health Education Programme |
| CSO | Central Statistical Office |
| CBoH | Central Board of Health |
| EFZ | Evangelical Fellowship of Zambia |
| FBO | Faith-Based Organization |
| HBM | Health Belief Model |
| HEARD | Health Economics and HIV/AIDS Research Division |
| HIV | Human Immunodeficiency Virus |
| HRW | Human Rights Watch |
| ICRW | International Centre for Research on Women |
| JAMA | The Journal of the American Medical Association |
| MoH | Ministry of Health |
| MTCT | Mother To Child Transmission |
| NASC | National AIDS Surveillance Committee |
| NAC | National HIV/AIDS/STD/TB Council |
| NAPCP | National AIDS Prevention and Control Programme |
| NERCHA | National Emergency Response Council on HIV/AIDS |

| | |
|--------|---|
| NGO | Non-Government Organization |
| NIV | New International Version |
| PLWHA | People Living With HIV/AIDS |
| PWG | Global HIV Prevention Working Group |
| PVA | Poverty and Vulnerability Assessment |
| SARPN | Southern African Regional Poverty Network |
| SCT | Social Cognitive (or learning) Theory |
| STD | Sexually Transmitted Disease |
| STI | Sexually Transmitted Infection |
| TB | Tuberculosis |
| TNIV | Today's New International Version |
| TRA | Theory of Reasoned Action |
| UNAIDS | Joint United Nations Programme on AIDS |
| UNODC | United Nations Office on Drugs and Crime |
| USAID | United States Agency of International Development |
| VCT | Voluntary Counselling and Testing |
| WCC | World Council of Churches |
| WHO | World Health Organization |
| ZDHS | Zambia Demographic and Health Survey |
| ZSBS | Zambia Sexual Behaviour Survey |

LIST OF FIGURES AND TABLES USED

| Figure | Page |
|--|-------------|
| 1.1 Adults and Children living with HIV and AIDS in 2007 | 5 |
| 1.2 Estimated number of Adults and Children Newly Infected With HIV during 2007 | 6 |
| 1.3 HIV Prevalence by Province | 8 |
| 2.1 HIV Transmission Risk | 61 |
| 2.2 Intergenerational Transmission of HIV | 65 |
| 3.1 Culture and Worldview Interplay | 114 |
| 3.2 The Dimensions of Culture | 122 |
| 3.3 Levels of Culture | 128 |
| 3.4 The Configurational Nature of Knowledge | 134 |
| 3.5 The Process of Worldview Change and Its' Results | 141 |
| 3.6 Traditional Public Health and Social Marketing | 149 |
| 4.1 Three Levels of Transformation | 171 |
| 4.2 The Nature of Worldview Shifts | 177 |
| 4.3 Further Worldview Shifts | 178 |
| | |
| Table | Page |
| 2.1 Elements Critical To Risk Behaviour Change | 70 |
| 2.2 Prior HIV Testing among HIV-Positive Respondents | 95 |



Table of Contents

| | |
|--|----------|
| Declaration | iii |
| Dedication | iv |
| Abstract | v |
| Acknowledgements | vi |
| Acronyms and Abbreviations | viii |
| List of Figures and Tables Used | x |
| Table of Contents | xi |
| CHAPTER ONE: ORIENTATION OF RESEARCH | 1 |
| 1.1 Introduction | 1 |
| 1.1.1 The Epidemiology of HIV/AIDS in Zambia | 4 |
| 1.1.2 Factors Perpetuating HIV/AIDS Growth in Zambia | 9 |
| 1.1.3 Modes of HIV Infection | 12 |
| 1.1.3.1 Sexual Transmission | 13 |
| 1.1.3.2 Mother-To-Child Transmission of HIV | 14 |
| 1.1.3.3 Use of Infected Blood and Blood Products | 15 |
| 1.2 A Slow Response to HIV/AIDS in Zambia | 16 |
| 1.2.1 A Sluggish Start | 17 |
| 1.2.2 Current Approaches to Risky Behavioural Change in Zambia | 20 |
| 1.3 Problem Statement | 20 |
| 1.4 Purpose of the Study | 23 |
| 1.5 Relevance of the Study | 24 |
| 1.6 Hypothesis | 24 |
| 1.7 Method of Study | 25 |
| 1.8 Description of Chapters | 28 |



| | |
|---|-----------|
| 1.8.1 Orientation of Research | 28 |
| 1.8.2 Doing Practical Theology in a Context of HIV/AIDS | 28 |
| 1.8.3 Worldviews & Changing HIV-Risk Behaviour | 28 |
| 1.8.4 Transforming Worldviews to Change Risky Behaviour | 29 |
| 1.8.5 Thesis Summary, Prospective Issues, and Conclusion | 29 |
| CHAPTER TWO: DOING PRACTICAL THEOLOGY AMID A GROWING HIV/AIDS EPIDEMIC | 31 |
| 2.1 Introduction | 31 |
| 2.2 Defining Practical Theology | 31 |
| 2.3 HIV-Risk Behaviour Defined | 35 |
| 2.4.1 The Dilemma of HIV-Risk Behaviour Change in Zambia | 37 |
| 2.4.2 Cultural and Traditional Practices | 44 |
| 2.4.2.1 Sexual Rituals | 45 |
| 2.4.2.1.1 Sexual Abstinence of Motherhood | 46 |
| 2.4.2.1.2 Widow/Widower Sexual Cleansing | 47 |
| 2.4.2.1.3 Wife Inheritance | 48 |
| 2.4.2.2 Sexual Violence and Myths | 48 |
| 2.4.2.2.1 Sexual violence | 49 |
| 2.4.2.2.2 The Virgin Myth | 51 |
| 2.4.2.2.3 Misperceptions on Condoms | 51 |
| 2.4.2.2.3.1 The Need for Children and the Value of Semen | 53 |
| 2.4.2.2.3.2 Condoms prevent the 'ripening of the foetus' | 55 |
| 2.4.2.2.3.3 A Mixed Message on Condoms | 56 |
| 2.4.3 A Taboo on Sex Education | 58 |
| 2.4.4 Lack of Male circumcision | 59 |
| 2.4.5 Multiple and Concurrent Sexual Partnerships | 61 |



| | |
|--|----|
| 2.4.5.1 Polygyny and Polyandry | 62 |
| 2.4.5.2 Intergenerational and Transactional Sex | 64 |
| 2.4.5.3 'Mobile People's' Multi-partnership | 66 |
| 2.4.6 HIV-Associated Stigma | 67 |
| 2.5. Current Approaches to Risky Behaviour Change | 69 |
| 2.5.1 Theories and Models of HIV-Risk Behavioural Change | 71 |
| 2.5.1.1 Theories Focusing on the Individual | 72 |
| 2.5.1.1.1 Health Belief Model (HBM) | 72 |
| 2.5.1.1.2 Social Cognitive (or learning) Theory (SCT) | 74 |
| 2.5.1.1.3 Theory of Reasoned Action (TRA) | 74 |
| 2.5.1.1.4 4 Stages of Change Model | 76 |
| 2.5.1.1.5 AIDS Risk Reduction Model (ARRM) | 77 |
| 2.5.1.2 Theories and Models Focusing on the Community | 80 |
| 2.5.1.2.1 Diffusion of Innovation Theory | 81 |
| 2.5.1.2.2 Social Influence or Social Inoculation Model | 82 |
| 2.5.1.2.3 Social Network Theory | 83 |
| 2.5.1.2.4 Theory of Gender and Power | 84 |
| 2.5.1.3 Structural and Environmental Theories & Models | 85 |
| 2.5.1.3.1 Theory for Individual and Social Change or Empowerment Model | 86 |
| 2.5.1.3.2 Social Ecological Model for Health Promotion (SEMHP) | 87 |
| 2.5.1.3.3. Socioeconomic Factors | 88 |
| 2.6.1 Major Approaches to HIV-Risk Behaviour Change in Zambia | 89 |
| 2.6.1.1 Interventions Aimed at Individuals | 89 |
| 2.6.1.1.1 Information, Education and Communication (IEC) | 90 |
| 2.6.1.1.2 Mass and small group education | 90 |
| 2.6.1.1.3 Peer Education | 92 |

| | |
|---|-----|
| 2.6.1.1.4 Voluntary Counseling and Testing | 93 |
| 2.6.1.2 Interventions Aimed at Communities | 96 |
| 2.6.1.2.1 Social Influence and Social Network Interventions | 96 |
| 2.6.1.2.2 Outreach Interventions | 97 |
| 2.6.1.2.3 School-based interventions | 98 |
| 2.6.1.3 Policy level interventions | 99 |
| 2.7 Toward a Theology of HIV Behaviour Change | 99 |
| 2.7.1 HIV-Risk Behaviour and Moralizing | 100 |
| 2.7.2 A Conversation on Sex and Sexuality | 102 |
| 2.7.3 God and HIV-Risk Behaviour Change | 103 |
| 2.7.4 HIV Behaviour Change versus HIV-Associated Stigma | 105 |
| 2.8 Conclusion | 105 |

CHAPTER THREE: WORLDVIEWS AND HIV-RISK BEHAVIOUR CHANGE 109

| | |
|---|-----|
| 3.1 Introduction | 109 |
| 3.2 Exploring the Concept of Worldview | 111 |
| 3.2.1 Origins of the Concept of Worldview | 117 |
| 3.2.2 A Model of Worldview | 121 |
| 3.3 Functions of Worldviews | 123 |
| 3.3.1 Plausibility Framework | 123 |
| 3.3.2 Emotional Security | 124 |
| 3.3.3 Basis for Ethical Judgements | 124 |
| 3.3.4 Integrates a People's Culture | 125 |
| 3.3.5 Regulation of Culture | 125 |
| 3.3.6 Society's Psychological Reassurance | 125 |
| 3.4 Characteristics of Worldviews | 126 |
| 3.4.1 Worldview Depth | 127 |

| | |
|--|------------|
| 3.4.2 Worldviews Are Not in the Genes | 129 |
| 3.4.3 Worldviews are Implicit | 130 |
| 3.4.4 Worldviews and Causality | 131 |
| 3.4.5 Worldviews are Integrated Systems | 132 |
| 3.4.6 Generativity of Worldviews | 134 |
| 3.4.7 Worldviews are Constructed and Contested | 135 |
| 3.5 Worldview Transformation Dynamics | 136 |
| 3.5.1 An Elementary Model of Worldview Change | 137 |
| 3.5.2 A Worldview Change Model | 140 |
| 3.5.3 Transformational Culture Change | 144 |
| 3.6 The Role of Worldview in Behaviour Change | 145 |
| 3.7 Conclusion | 147 |
| CHAPTER FOUR: TRANSFORMING WORLDVIEWS FOR HIV-RISK BEHAVIOUR CHANGE | 151 |
| 4.1 Introduction | 151 |
| 4.2 Understanding Worldview Transformation | 155 |
| 4.2.1 Transformation and Cognitive Categories | 156 |
| 4.2.1.1 Intrinsic and Relational Sets | 156 |
| 4.2.1.2 Digital and Ratio Sets | 158 |
| 4.2.1.3 The Bible's View of Transformation | 160 |
| 4.3 Transformation and HIV-Risk Behaviour Change | 163 |
| 4.3.1 Worldview Transformation and Cultural Dimensions | 164 |
| 4.3.1.1 Cognitive Transformation | 165 |
| 4.3.1.2 Affective Transformation | 166 |
| 4.3.1.3 Evaluative Transformation | 167 |
| 4.3.2 Levels of HIV-risk Behaviour Transformation | 169 |



| | |
|---|------------|
| 4.3.3 Varieties of Worldview Transformation | 174 |
| 4.3.3.1 Normal Worldview Transformation | 174 |
| 4.3.3.2 Paradigm Shifts | 175 |
| 4.4 Ways of Transforming Worldviews | 180 |
| 4.4.1 Transformation by Examining Worldviews | 181 |
| 4.4.2 Transformation by Exposure to Other Worldviews | 185 |
| 4.4.3 Transformation by Creating Living Rituals | 188 |
| 4.5 Conclusion | 190 |
| CHAPTER FIVE: THESIS SUMMARY, PROSPECTIVE ISSUES, AND CONCLUSION | 194 |
| 5.1 Introduction | 194 |
| 5.2 Synopses of Chapters | 198 |
| 5.2.1 Synopsis of Chapter one | 198 |
| 5.2.2 Synopsis of Chapter Two | 199 |
| 5.2.3 Synopsis of Chapter Three | 202 |
| 5.2.4 Synopsis of Chapter Four | 204 |
| 5.3 Prospective Issues | 210 |
| 5.4 Conclusion | 212 |
| 6.0 BIBLIOGRAPHY | 215 |

CHAPTER ONE

ORIENTATION OF RESEARCH

1.1 Introduction

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

Historically, faith based organizations (FBOs¹) have responded to human crises based on the moral tenets of their faith (cf. Denis 2009). The Church inherently being a caring community is obligated to be involved in intervention strategies aimed at meeting human need (Hendriks 2002, Ndhlovu 2007,

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

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

The contention of this study is that not only must the Church be involved in the care of people living with HIV/AIDS, but it should also work toward influencing behaviour change by transforming worldviews² that underpin risky behaviour in most Sub-Saharan Africa, of which Zambia is a part in order to stem the spread of the epidemic. The study presupposes that the church has the ability to initiate a process of worldview transformation which will change risky behaviour and therefore help check the hitherto unabating spread of HIV/AIDS in Zambia. The church in Zambia has no choice but to provide

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

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

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

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

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

Arguably, the church in any society has the task of engaging its people groups to effect behaviour change, including HIV risky behaviour at the traditional practices and lifestyle level in order to stem the spread of HIV/AIDS infection. This study will suggest means of transforming worldviews in order to change HIV/AIDS risky behaviour in Zambia. The researcher is a native of Zambia (of the Bemba³ speaking tribe) and will, therefore, approach the issue at hand with an insider's perspective which is influenced by evangelical Christianity⁴.

1.1.1 The Epidemiology of HIV/AIDS in Zambia

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

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

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

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

ADULTS AND CHILDREN ESTIMATED TO BE LIVING WITH HIV IN 2007

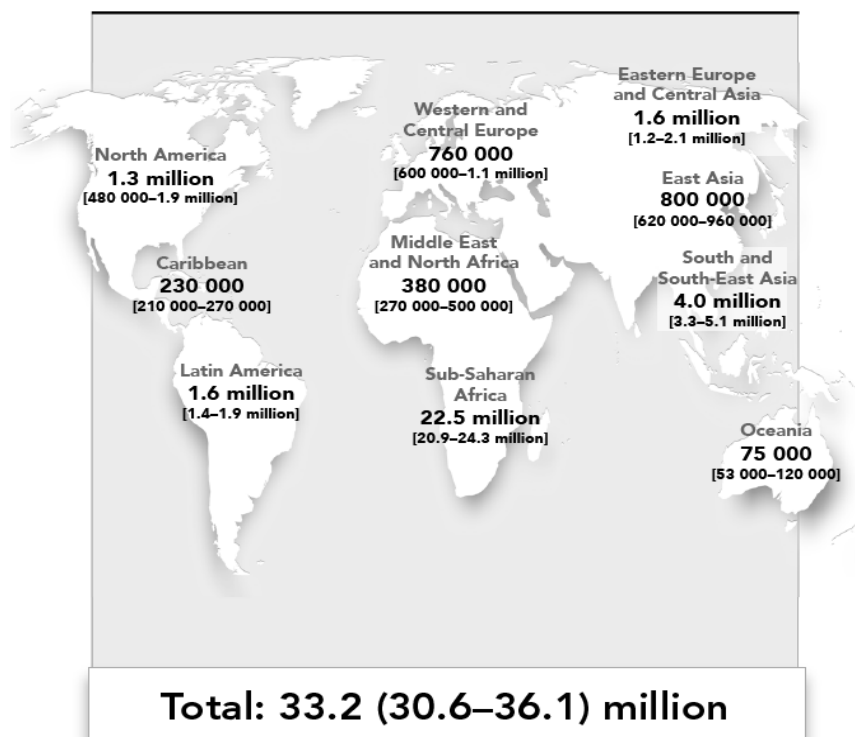


Figure 1.1 Source: UNAIDS and WHO 2007:38

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

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

ESTIMATED NUMBER OF ADULTS AND CHILDREN NEWLY INFECTED WITH HIV DURING 2007

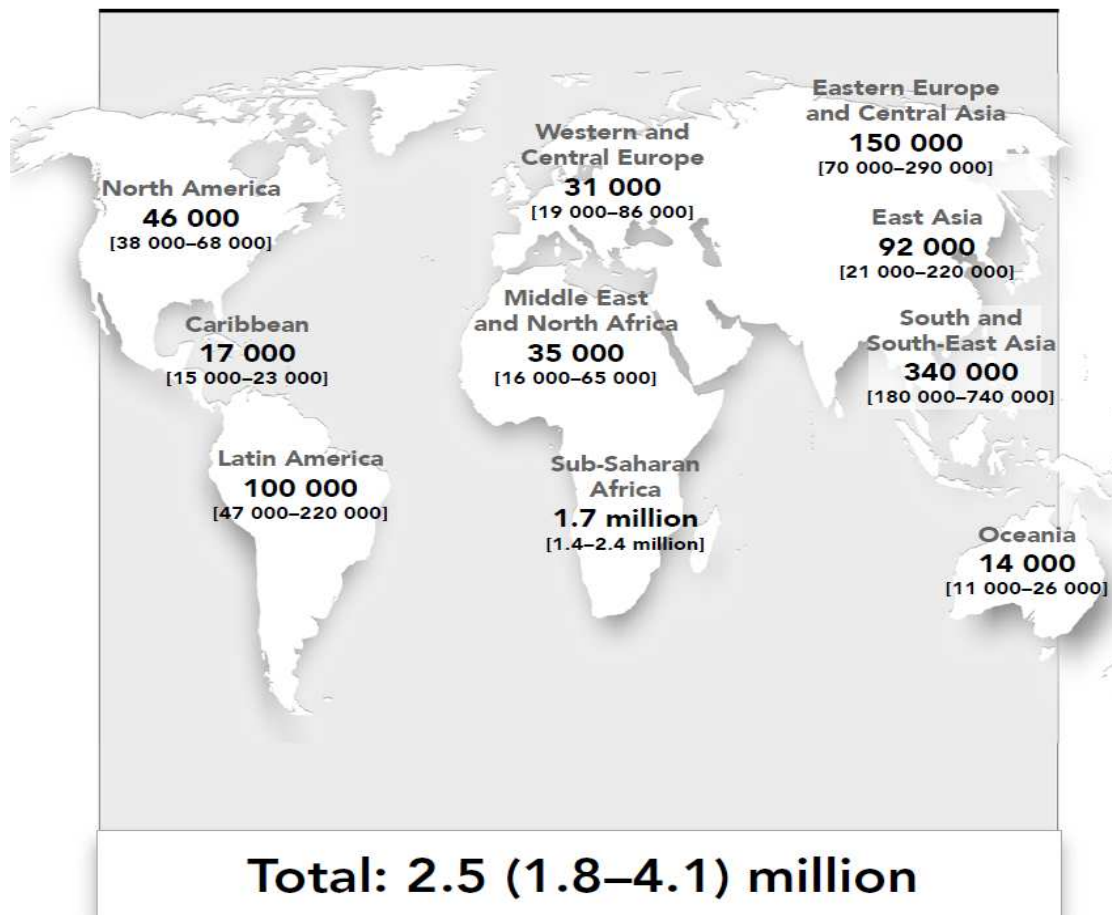


Figure 1.2 Source: UNAIDS and WHO 2007:40

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

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

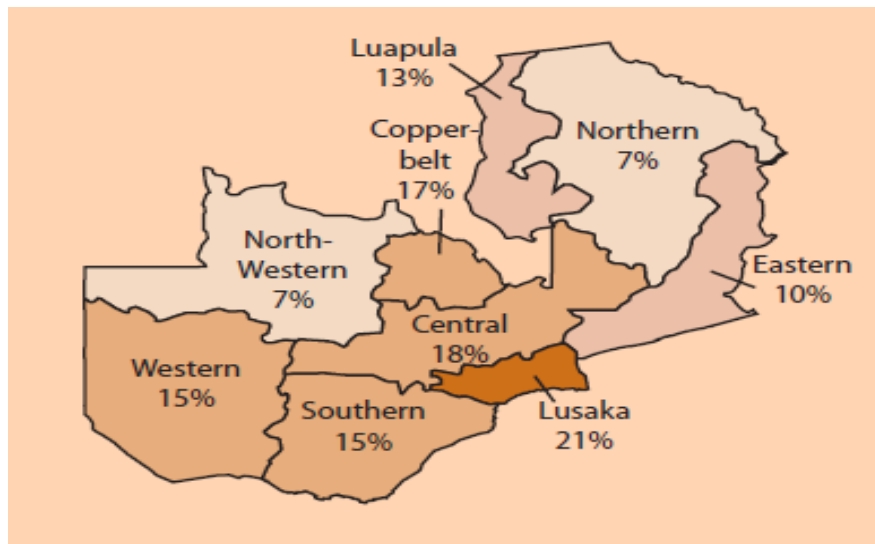


Figure 1.3—HIV Prevalence by Province
(Source: CSO et al. 2009:16)

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

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

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

1.1.2 Factors Perpetuating HIV/AIDS Growth in Zambia

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

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

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

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

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

premarital and post-marital counselling women are taught never to refuse a husband sexual intercourse even when it is plainly known that he is having extra marital sexual liaisons, or is suspected to have HIV or indeed any other STI (NAC/Ministry of Health 2002; HRW 2002; Haworth et al 2001; Mulenga 2009). Furthermore, multiple concurrent partnerships (perceived to be normal in most African societies including Zambia) are subtly fuelling HIV infection in Zambia (CSO et al. 2009; Phiri 2008). Other socio-cultural drivers of the epidemic are ‘Widow/widower cleansing’⁵, Dry sex⁶, to name a few.

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

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

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

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

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

Undoubtedly then poverty is a potent factor in fuelling risky behaviour and may be a critical player in the high HIV/AIDS prevalence in Zambia, but poverty has always been present for much longer⁷. The researcher therefore posits that while poverty is a key determinant of risky behaviour in Zambia, and most sub-Saharan Africa countries for that matter, effective preventive work should also be directed toward transforming socio-cultural perceptions, beliefs and norms entrenched in worldviews (cf. Brewer, DD et al 2003; PWG 2008).

1.1.3 Modes of HIV Infection

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

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

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

1.1.3.1 Sexual Transmission

In this mode of transmission HIV infection mainly occurs through unprotected (sex without a condom), penetrative vaginal or anal⁸ sexual intercourse. Van Dyk (2005) notes that the HI virus can also be transmitted through oral sex under certain conditions, such as when there are wounds in the mouth. She also points out that for the HI virus to enter into the body it must attach itself to CD4 cell receptors. Many of the cells in the lining of the genital and anal tract have just such receptors, which makes it easier for HIV to enter into the body when having unprotected vaginal or anal sexual intercourse (van Dyk 2005). Furthermore, the mucous membrane of the genitalia has an abundant presence of antigen-presenting cells such as *Langerhans*⁹ cells that are ready

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

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

to carry the HIV antigens¹⁰ to CD4 cells. Heterosexual sexual intercourse accounts for the majority of HIV infections in sub-Saharan Africa (Haworth et al 2001; NAC/Ministry of Health 2002; Central Statistical Office/Central Board of Health [Zambia] 2003; WHO 2005a; Mbewe 2005; UNAIDS and WHO 2007, 2009).

1.1.3.2 Mother-To-Child Transmission of HIV

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

- She becomes infected with HIV just before the pregnancy, during the pregnancy or during the breastfeeding period (because she will have a high viral load in her blood or breast milk during seroconversion¹¹); and if
- she has advanced, symptomatic HIV disease with
 - a high viral load (>50 000 viral particles/ml);

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

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

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

Van Dyk (2005:31) further explains that if “the mother has a low viral load during pregnancy, childbirth or breastfeeding (<1000 viral particles/ml), the likelihood of transmitting the virus to her baby is low.” MTCT accounts for the majority of HIV infections in children in Zambia (CSO et al. 2009; NAC/Ministry of Health 2002) followed by the sexual abuse of girls¹² (Human Rights Watch 2002).

1.1.3.3 Use of Infected Blood and Blood Products¹³

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

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

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

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

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

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

1.2 A Slow Response to HIV/AIDS in Zambia

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

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

1.2.1 A Sluggish Start

The fact that Zambia has had a sluggish response to the HIV/AIDS epidemic in its' initial stages is an incontrovertible observation (cf. Noble 2006; Mulenga 2009; Ndhlovu 2007). Today, HIV/AIDS is widespread in Zambia (Haworth, A et al. 2001:11, NAC/Zambian MoH 2002). There is practically no part of Zambian society that is not affected by the epidemic (see figure 1.3 above for HIV prevalence by province). The most vulnerable groups to the HIV/AIDS epidemic are young women and girls, partly due to their meagre economic empowerment levels and HIV infection predisposing cultural-traditional practices (NAC/Zambian MoH 2002, WHO 2005b, CSO et al. 2009). It is also significant to note that the disease has worst struck men and women in their most productive years (15-49 years). Close to every household in Zambia has felt the adverse economic impact of AIDS¹⁴.

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

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

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

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

This researcher agrees with Haworth and colleagues’ (2001) position that Zambia may have one of the highest HIV prevalence rates in the sub-region. The researcher thinks that the HIV/AIDS situation in Zambia could be worse than is officially known because HIV/AIDS associated stigma (see Ndhlovu 2007; Ogden & Nyblade; ICRW 2003) has made openness about the disease a difficult matter for conversation¹⁵.

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

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

generational sex¹⁶, which is nearly a traditional norm in Zambia (Chondoka 1988).

Within the first two years of the first AIDS reported case in Zambia, the National AIDS Surveillance Committee (NASC) and National AIDS Prevention and Control Programme (NAPCP) were established to coordinate HIV/AIDS-related intervention activities (NAC/Zambian MoH 2002, Noble 2006b). Sadly, however, much of what was known about HIV prevalence was not divulged for public knowledge due to the high levels of HIV/AIDS-Associated stigma. As a result, by the end of the 1980s many Zambians were still in denial and stigmatization was not uncommon (Noble 2006b; Ndhlovu 2007; Mulenga 2009). Thus the HIV and AIDS epidemic spread silently but rapidly. At the end of the 1990s there was still little goodwill by authorities towards the HIV/AIDS crisis in Zambia. It was only in the new millennium that a noticeable change in the political leadership's attitude towards the problem occurred. The National HIV/AIDS/STD/TB Council (NAC) was created in March 2000, but only became functional in December 2002 when parliament finally approved its formation (NAC/Ministry of Health 2002). Hence, it is clear that the fight against HIV/AIDS in Zambia had a sluggish start. Presently the government has admitted that the need for a multidisciplinary approach¹⁷ to HIV/AIDS

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

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

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

The researcher will demonstrate that it is indisputable that Zambia is facing a significantly high HIV incidence in spite of the almost universal knowledge on HIV/AIDS and its modes of transmission (ZSBS 2000; NAC/Zambia MoH 2002). The situation is a vexing one, especially that a principal assumption of the organized response to the epidemic is seemingly failing—the assumption that with more knowledge on HIV/AIDS infection people will begin to change HIV risky behaviour¹⁸. But risky behaviour change is far from happening as evidenced by the escalating HIV/AIDS morbidity and mortality rates in sub-Saharan Africa (PWG 2008, 2006b; UNAIDS and WHO 2007).

1.2.2 Current Approaches to Risky Behaviour Change in Zambia¹⁹

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

1.3 Problem Statement

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

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

Manasseh Phiri (2008), a long standing medical doctor in Zambia, admits that in spite of the almost universal knowledge that Zambians have on HIV and AIDS, risky behaviour²⁰ is not uncommon in Zambia. Phiri (2008: v) further points out that in Zambia “more than 90 per cent of HIV infections is transmitted and contracted through the sexual route.” The situation in Zambia, where the HIV/AIDS epidemic is not relenting despite considerable preventive efforts spanning over nearly the past three decades, is a clear attestation to the fact that HIV/AIDS awareness (or education) does not entail risky behaviour change (PWG 2008). The assumption therefore that HIV/AIDS awareness will produce risky behaviour change does not appear to be entirely valid. King (1999) says that education alone is not enough to induce behaviour change among most individuals. King admits that sexual behaviour is a complex matter. She adeptly writes, “...social researchers have come to realize that because complex health behaviours such as sex take place in context, socio-cultural factors surrounding the individual must be considered in designing prevention interventions” (1999:5).

Since HIV infection in Zambia is mainly spreading through the heterosexual route, it is clear risky behaviour change is not happening despite the many preventive measures being taken by stakeholders²¹. In view of this predicament, the question being posed is “What can be done to help people change HIV-risk behaviour so pervasive in sub-Saharan Africa and Zambia in

²⁰ Risky behaviour constitutes those actions which expose or promote the transmission of the HI virus, such as, having unprotected sexual intercourse (vaginal or anal), concurrent and multiple sexual partnerships, sharing needles, etc. The researcher will tackle especially the route of heterosexual intercourse to which is attributed more than 90% of HIV incidence in Zambia (Phiri 2008; UNAIDS and WHO 2009).

²¹ This situation where the HIV/AIDS epidemic is not slowing down despite high knowledge levels is not unique to Zambia, but is generally true to most sub-Saharan Africa countries (UNAIDS 2007; Dinkelman et al 2006, etc).

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

Presently, interventions which are meant to check the spread of HIV throughout the world are as diverse as the contexts in which they are found.

King (1999:5) writes,

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

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

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

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

1.4 Purpose of the Study

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

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

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

1.5 Relevance of the Study

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

1.6 Hypothesis

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

Ndhlovu 2007; CSO et al. 2009). It is not the practices and customs in and of themselves that are faulty, but the presuppositions and beliefs at worldview level that underlie the behaviour (Ntseana & Preece [Undated]). This researcher posits that in order to win the fight against the continued growth of the epidemic in Zambia, evangelical Christians doing theology, should aim at facilitating the change of risky sexual behaviour (to which is attributed more than 90% of new HIV/AIDS infections annually) by engaging Zambian worldviews that underpin the socio-cultural practices of risky behaviour toward transformation. Furthermore, it is the researcher's proposition that authentic HIV behaviour change will only happen if it occurs at the worldview level, that is, from inside out and not the reverse (cf. Hiebert 2008; Kapolyo 2007; Kraft 1996). The researcher also posits that this approach to HIV/AIDS intervention in Zambia falls with the evangelical church's task of "doing" Practical Theology²² in the context of a growing epidemic (cf. Hendriks 2002; Magezi 2005; Ndhlovu 2007). In short, this researcher hypothesizes that a significant solution to the HIV/AIDS risky behaviour change dilemma lies in the Church that embraces a praxis which aims at the transformation of worldviews of Zambians.

1.7 Method of Study

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

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

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

This methodology further has a particular bearing on the issue of HIV risky behaviour change as it encourages the church to interface with worldviews, the bedrock of behaviour (Stone 2001). Other studies (Ntozi and Kirungu 1997; King 1999; Loosli 2004; Ntseana and Preece [undated]) have shown that psychology’s theories and models of behaviour change alone appear not to be adequate for the African context. King (1999) notes that psychological theories and models have been extensively and effectively used in the United States of America, especially among the gay community, but she is in doubt whether they can be transplanted into the African setting without major adaptations. This research will not ignore the psychological theories and models of risky behaviour change, but will interface with them from an evangelical perspective²³.

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

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

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

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

1.8 Description of Chapters

1.8.1 Orientation of Research

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

1.8.2 Doing Practical Theology in a Context of HIV/AIDS

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

1.8.3 Worldviews and Changing HIV Risky Behaviour

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

behaviour or life way²⁴) of any people group. Chapter three will further explain the link between a worldview and HIV-risk behaviour change. This chapter is based on the premise that contemporary HIV/AIDS preventive interventions are largely failing in sub-Saharan Africa because they are not addressing the worldview of contemporary Africans. The Chapter will close with pertinent preliminary inferences.

1.8.4 Transforming Worldviews to Change HIV-Risk Behaviour

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

1.8.5 Thesis Summary, Prospective Issues and Conclusion

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

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

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

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

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

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 methodologya 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 scientists²⁶. 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 circumcision²⁷, 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 stigma²⁸ (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-defined²⁹.

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.

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 socioeconomic³¹ 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 death³² 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 deceased³³ 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 transmission, 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 infection³⁴ 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 (UNAIDS/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 logic³⁵ 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 outweigh 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-Saharan 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 work³⁷. 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 indulging³⁸. 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 were 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 purposes⁴¹.

⁴¹Loosli (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 Concurrent⁴² 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 partnerships⁴³ 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].

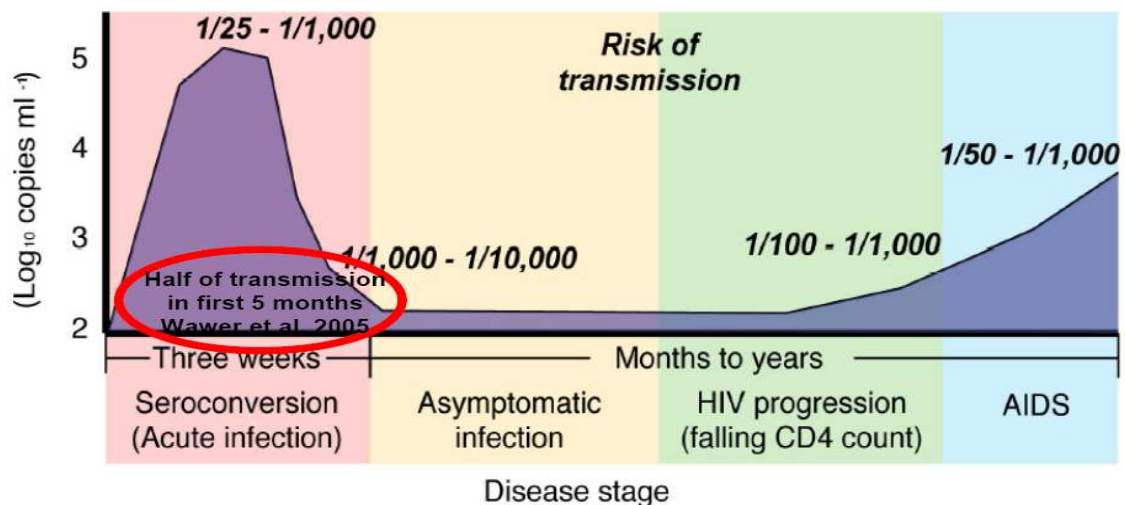


Figure 2.1 HIV Transmission Risk [Source: Wilson 2006:9]

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 Africa⁴⁴. 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 net⁴⁵, 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 him⁴⁶. 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 polygyny⁴⁷. Polygamous arrangements have created a potent route of HIV transmission in Zambia⁴⁸.

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].

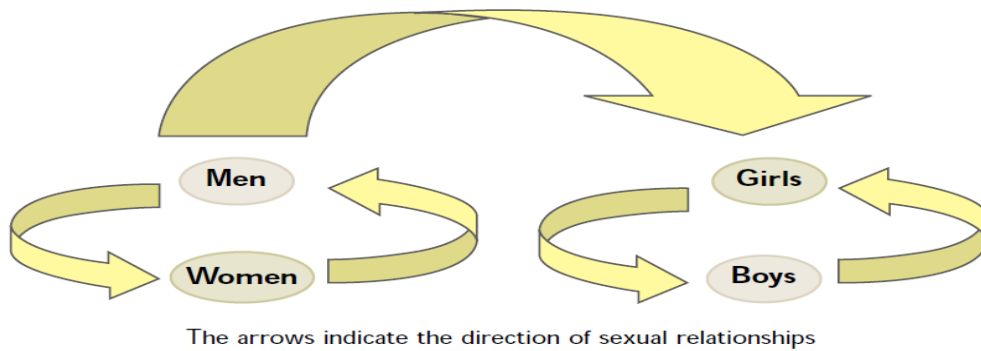


Figure 2.2: Intergenerational Transmission of HIV
[Source: Whiteside et al. 2003:24]

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-place⁴⁹. 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 mobility⁵⁰ 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. Mwansa⁵¹ 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 HIV/AIDS 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; Nsteanu 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 behaviour⁵².

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-efficacy⁵³ – 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 solutions⁵⁴. 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 Theory⁵⁵

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 (Sepulveda 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.

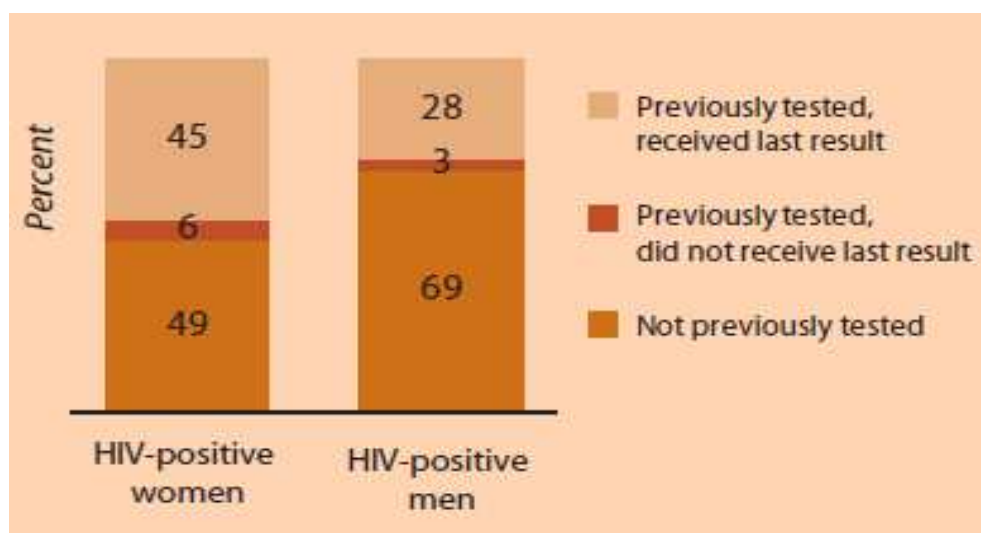


Table 2.2— Prior HIV Testing among HIV-Positive Respondents
(Source: CSO et al. 2009)

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 Moralizing⁵⁶

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 Nigeria⁵⁷ (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.

CHAPTER THREE

WORLDVIEWS AND HIV-RISK BEHAVIOUR CHANGE

3.1 Introduction

Chapter two has established that the task of doing theology in a context of the HIV/AIDS epidemic obligates Christians to interface with contemporary theories and models of behaviour change. As HIV infection is ordinarily a consequence of human behaviour, change in behaviour has long been understood as indispensable to curbing the spread of infection. The Global HIV Prevention Working Group (PWG) states that “In all cases where national epidemics have been reversed, broad-based behaviour changes were central to success” (PWG 2008:8). The researcher understands the PWG’s statement to mean that behaviour change is a priority issue in as far as reversing the HIV/AIDS epidemic in Zambia is concerned. Therefore, practical theology must engage in critical thinking and non-condemnatory action with the goal of facilitating HIV-risk behaviour change to stem the growth of the epidemic.

A Second observation of the preceding chapter was that although cultural, economic, and historical factors have converged to accelerate the spread of HIV and AIDS in Zambia, as in most of sub-Saharan Africa, the fight for behaviour change is not a lost cause. Though behaviour change is hard to achieve, it is not impossible. Due to the misperception that behaviour change is impossible to achieve, a significant number of HIV prevention efforts in Zambia seem to de-emphasize its criticalness to reversing the growth of the epidemic. It is this researcher’s view that although behaviour change is hard

to achieve it is not impossible. The Global HIV Prevention Working Group (PWG 2008) aptly points out:

To be more effective in the 21st century, the HIV prevention effort must confront several challenges of perception: misplaced pessimism about the effectiveness of behavioral HIV prevention strategies; unfortunate confusion between the difficulty in changing human behavior and the inability to do so; and misperception that because it is inherently difficult to measure prevention success—a “nonevent”—prevention efforts have no impact....

The foregoing assertion by the PWG is certainly a heartening one to the cause for HIV-risk behaviour change from a Practical Theology standpoint. Practical Theology is about perspective transformation rooted in humanity’s obedience to biblical truth (cf. Hendriks 2002). The researcher thus accedes that behaviour change is central to reversing the growth of HIV and AIDS from a Practical Theology perspective.

And a third key finding of the preceding chapter was that doing theology amidst the HIV/AIDS epidemic in Zambia will entail a proactive attitude to HIV-risk behaviour change initiatives. This finding presupposes that doing theology amidst a spreading HIV/AIDS epidemic in sub-Saharan Africa during the 21st Century will largely entail advocating behaviour change, which is a plea to costly discipleship and a reminder that following Jesus Christ has spiritual, practical, ethical, and social ramifications. In the present chapter the researcher will show that enduring HIV-risk behaviour change advocacy will only happen when it targets changing the worldviews (deep-level culture) of Zambians related to issues of sex and sexuality. This approach is necessitated by a finding of chapter two that cultural dynamics which predispose most people groups to HIV-risk behaviour are not being effectively

touched on by contemporary HIV/AIDS prevention messaging (cf. Dwelle 2006). Whereas HIV/AIDS education is effectively far-reaching in Zambia, it is a known reality that HIV knowledge has not necessarily induced behaviour change (CSO et al. 2002, 2003, 2009a).

In the current chapter the researcher will contend that enduring HIV-risk behaviour change is not happening chiefly because it is not being appreciated at the worldview level of most Zambian cultures; particularly in the area of sexual expression. But what, precisely, is the relationship between culture (worldview) and HIV-risk behaviour? Or, asked differently, what role does worldview/culture play in HIV-risk behaviour? How does a worldview affect behaviour? How can worldviews be transformed? To answer these questions it will be necessary to define the concept of worldview so as to understand what role it plays in human behaviour. Therefore the researcher will in the ensuing chapter define the concept of worldview (and its relation to risky sexual behaviour among Zambians), sketch the origins of the concept of worldview; discuss a model of culture, delineate the functions and characteristics of worldviews, and describe worldview change dynamics.

3.2 Exploring the Concept of Worldview

What precisely is a worldview? The American Heritage Dictionary of the English Language gives two useful definitions of the noun *worldview*: First, “The overall perspective from which one sees and interprets the world” and Second, “A collection of beliefs about life and the universe held by an individual or a group” (AHD Third edition, 1992). This is a helpful description

of the word worldview, but it is not amply exhaustive for our purpose here. To understand the term better it must be related to the concept of culture.

Culture⁵⁸ is the composite term which describes a people's total life-way and at the same time shows us how that life-way is organized by an underlying worldview. Dyrness (2001:227) explains that "Culture includes all behaviour that is learned and transmitted by symbols (rites, artifacts, language, etc.) of a particular group and that grows out of certain ideas or assumptions that we call a worldview." Dyrness's definition helps us discern the intricate link between the concepts of worldview and expressive culture. This intricacy of relationship between worldview and culture renders it impossible to discuss either idea in isolation from the other. Kraft (1996:52, emphasizes his) clarifies,

...I define worldview as the culturally structured assumptions, values, and commitments/allegiances underlying a people's perception of reality and their responses to those perceptions.... *Worldview is not separate from culture.* It is included in a culture as the structuring of the deepest-level presuppositions on the basis of which people live their lives. Like every aspect of culture, worldview does not *do* anything. Any supposed power of worldview lies in the *habits* of the people. People are the ones who do things. But the worldview provides the cultural bases and part of the structuring for people's actions.

Kraft hence inextricably connects worldview and culture as two inseparable concepts. John RW Stott asserts that culture is "a term which is not easily

⁵⁸ Stott comprehensively and helpfully defines the concept of culture when he writes:

Culture is an integrated system of beliefs (about God or reality or ultimate meaning), of values (about what is true, good, beautiful and normative), of customs (how to behave, to relate to others, talk, pray, dress, work, play, trade, farm, eat, etc.), and of institutions which express these beliefs, values and customs (government, law courts, temples or churches, family, schools, hospitals, factories, shops, unions, clubs, etc.), which binds a society together and gives it a sense of identity, dignity, security, and continuity (Stott 1996:81).

The researcher posits that the close relationship of worldview and culture makes the possibility of risk behaviour change through worldview transformation essential to the fight against the spread of HIV/AIDS in sub-Saharan Africa. Section 3.5 below discusses the dynamics involved in transforming worldviews and how that might impact on behaviour change to stem the spread HIV/AIDS in Zambia.

susceptible of definition” (1996:78). Stott helpfully explains the intricacy of relationship between worldview and culture thus:

At its [culture] centre is a worldview, that is, a general understanding of the nature of the universe and of one’s place in it. This may be ‘religious’ (concerning God, or gods and spirits, and our relation to them), or it may express a ‘secular’ concept of reality, as in a Marxist society. From this basic worldview flow both the standards of judgement or values (of what is good in the sense of desirable, of what is acceptable as in accordance with the general will of the community, and of the contraries) and standards of conduct (concerning relations between individuals, between the sexes and the generations, with the community and with those outside the community) [Stott 1996:79]

Stott also fundamentally and inextricably links the concepts of worldview and culture. Stott does not see a separation between the two although they are distinctly definable. Kraft further explains the close relationship between the concepts of culture and worldview, when he writes,

The term *culture* is the label anthropologists give to the structured customs and underlying worldview assumptions [with] which people govern their lives. Culture (including worldview) is a people’s way of life, their design for living, their way of coping with their biological, physical, and social environment. It consists of learned, patterned assumptions (worldview), concepts and behavior, plus the resulting artifacts (material culture). Worldview, the deep level culture, is the culturally structured set of assumptions (including values and commitments/allegiances) underlying how people perceive and respond to reality. Worldview is not separate from culture. It is included in culture as the deepest level presuppositions upon which people base their lives (Kraft 2004:385).

Kraft proceeds to compare the intricate relationship between culture and worldview to a river which has a surface level and a deep level. The surface of the river is visible, but the largest part of the river, which lies below the surface, is invisible. However, whatever occurs on the surface is affected by deep-level phenomena such as the current, other objects in the river, the cleanness or dirtiness of the river, and so on. Whatever occurs on the surface of a river is effected by both outside forces and forces from the traits of the

river. In a similar manner what we see externally as patterned human behaviour is the lesser part of a society's whole culture. Kraft thus implies that at the deeper level is seated the assumptions on the basis of which people regulate their surface-level behaviour. When a thing occurs at the surface-level of a culture it may change that level. The magnitude and degree of that change will be significantly influenced by the deep-level worldview configuration within the culture. Kraft points out that there are several levels of culture (and worldview) and the "higher" the level the more diversity can be included. Figure 3.1 is Kraft's diagrammatic description of the interplay between (surface-level) culture and (deep-level) worldview⁵⁹.

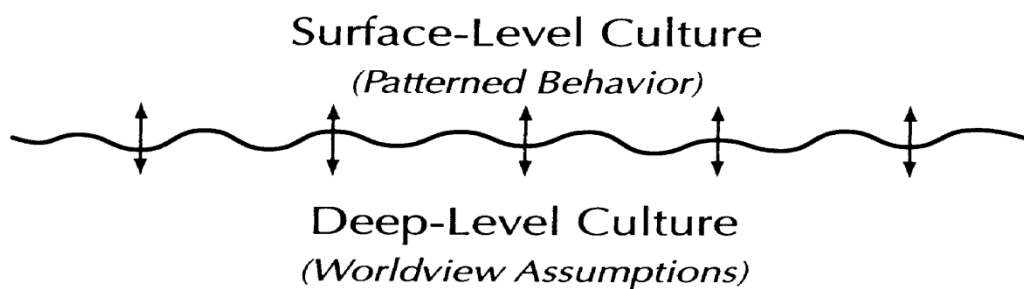


Figure 3.1 Culture and Worldview Interplay (Source: Kraft 2004: 385)

Bush (1991:70) also writes that "A worldview is that basic set of assumptions that gives meaning to one's thoughts. A worldview is the set of assumptions that someone has about the way things are, about *what* things are, about *why* things are." Bush agrees with Kraft's standpoint on the intricacy of culture and worldview. Dwelle (2006), in his presentation "*New Paradigms in Public Health Messaging*" elaborates that a worldview is:

⁵⁹ Kraft elucidates, "Culture consists of two levels: the surface behavior level and the deep worldview level. At the core of culture and, therefore, at the very heart of all human life, lies the structuring of the basic assumptions, values, and allegiances in terms of which people interpret and behave. These assumptions, values, and allegiances we call *worldview*" (1996:11 emphasis his). The researcher will use and apply Kraft's definition of the relationship between culture and worldview in the rest of this work.

- The way people see or perceive the world, the way they “know” it to be
- The colored glasses through which people see themselves and the universe around them
- The way people characteristically look outward upon the universe or especially to the way a man, in a particular society, sees himself in relation to all else
- The way people look at reality (2006).

Bush (1991) and Dwelle (2006) are basically in agreement over the idea that a worldview supports a people’s behaviour, rationalizes that behaviour, and gives meaning to their sociocultural situations.

Noebel (2001), however, explains the concept of worldview in much broader terms when he writes,

The term worldview refers to any ideology, philosophy, theology movement, or religion that provides an overarching approach to understanding God, the world, and man’s relations to God and the world. Specifically, a worldview should contain a perspective regarding each of the following ten disciplines: theology, philosophy, ethics, biology, psychology, sociology, law, politics, economics, and history (2001:2).

Noebel understands worldview as a paradigm which affects perspectives on all of life and consequently affects its adherents’ overt behaviour—the culture.

Similarly, Futrell (2006) explains that much of a person’s worldview is shaped by his or her upbringing. However, he admits that it is more complex than that the notion of “worldview is *not* merely a philosophical by-product of a person’s culture, like a shadow”, rather it is the basis on which a whole cultural system adheres. He explicates thus,

[A worldview is] *the very skeleton of concrete cognitive assumptions on which the flesh of customary behavior is hung...*[It] may be expressed, more or less systematically, in cosmology, philosophy, ethics, religious ritual, scientific belief, and so on, but it is implicit in almost every act. It is a person’s internal mental framework of cognitive understanding about reality and life meaning (Futrell 2006 emphasis his).

Futrell's point is that a worldview and culture are inseparable, but distinguishable. Similarly, Kraft defines worldview by emphasizing the centrality of the concept to a cultural entity. He consequently makes a credible suggestion for enduring cultural (and behaviour) change to occur when he locates such change at worldview level. He writes,

A worldview is seen as lying at the heart of every cultural entity (whether a culture, subculture, academic discipline, social class, religious, political or economic organization, or any similar grouping with a distinct value system). The worldview of a cultural entity is seen as both the repository and the patterning in terms of which people generate the conceptual models through which they perceive of and interact with reality. *I suggest that the basic appeal for ...whatever conceptual transformation... is to be made at the worldview level* (Kraft 2005:43, emphasis added).

The researcher agrees with Kraft's view that enduring perceptual (and hence behaviour) change must be anchored in worldview transformation. This position entails that any change which is not in tandem with worldview reconfiguration will be resisted and ephemeral at best.

Hiebert (2008) points out that the concept of worldview has emerged from the 1980s to the present times as a vital concept in many fields of study including philosophy, philosophy of Science, history, anthropology, and Christian thought. He is also quick to point out that the concept of worldview is not only fascinating, but also a frustrating word to thoroughly comprehend. He explains that the word's "ambiguity generates a great deal of study and insight, but also much confusion and misunderstanding" (Hiebert 2008:13). As the foregoing discussion would show there is no single definition agreed upon

by all scholars. However, a brief survey of the origin of the concept of worldview might help our understanding toward successfully formulating a pastoral application to HIV-risk behaviour change in Zambia⁶⁰.

3.2.1 Origins of the Concept of Worldview

The roots of the concept of worldview are traceable to several sources. First, it can be traced to Western philosophy in which the German word *weltanschauung* was coined by Immanuel Kant and used by several authors such as Kierkegaard, Engels, and Dilthey as they contemplated on Western culture. By the 1840s the word was assimilated into German as a common word. Albert Wolters (Hiebert 2008:13-14) observes:

Basic to the idea of *Weltanschauung* is that it is a point of view on the world, a perspective on things, a way of looking at the cosmos from a particular vantage point. It therefore tends to carry the connotation of being personal, dated, and private, limited in validity by its historical conditions. Even when a worldview is collective (that is, shared by everyone belonging to a given nation, class, or period), it nonetheless shares in the historical individuality of that particular nation or class or period.

During the nineteenth century, history scholars in Germany moved from the study of politics, wars, and eminent persons to studying ordinary people.

⁶⁰ Ryken is unequivocal in his definition of worldview, however. He writes:

A worldview—or “world-and-life view,” as some people call it—is the structure of understanding that we use to make sense of our world. Our worldview is what we presuppose. It is our way of looking at life, our interpretation of the universe, the orientation of our soul. It is the “comprehensive framework of our basic belief about things,” or “the set of hinges on which all our everyday thinking and doing turns.” Ideally, a worldview is a well-reasoned framework of beliefs and convictions that gives a true and unified perspective on the meaning of human existence....A worldview is sometimes compared to a pair of spectacles, but maybe our eyes themselves would be a better analogy. When was the last time you noticed that you were seeing? We don’t even think about seeing; we just see, and we are seeing all the time. Similarly, even if we never think about our worldview, we still view everything with it, and then we apply our view of things to the way we live (2006:7-8).

The researcher will endeavour to show that changing HIV-risk behaviour in Zambia is fundamentally an issue of transforming the culture through “knowing and living out a Bible-based, Christ-centred, Spirit-empowered, God-glorifying worldview” (Ryken 2006:11).

Since they could not study the lives of every individual or incident, they concentrated on examining whole societies to discern broad cultural patterns. They tried to explain cultural phenomena such as festivals, etiquette, folk beliefs, and contemporary science in relation to the overarching theme of individualism. Oswald Spengler showed how cultures selectively borrowed characteristics from other cultures and how they changed the meanings of these characteristics corresponding with their undergirding worldviews. Wilhelm Dilthey explained various eras of history in terms of “spirit of the times” (*Zeitgeist*, German). So from the historical standpoint, this investigation of human activities precipitated vital questions: How do cultural patterns emerge? How do they spread from one area to another? And why do some die and others continue living for a long time? Consequently historians in Germany used the term *weltanschauung* to allude to “the deep, enduring cultural patterns of a people” (Hiebert 2008:14).

A second source of the concept of worldview is traceable in anthropology where anthropologists empirically studied people around the world and discovered that profound and radically varying worldviews underlying their cultures. Anthropologists found that the more they studied these cultures; the more they became conscious that worldviews deeply sculpt the ways people perceive the world and their lives. They discovered that whereas some cultures had similar traits, others were radically different from one another. This finding became the basis for the theory of cultural cores and diffusionism, which stated that cultural patterns usually spread from one group of people to another (cf. Luzbetak 2000). The theory of cultural

diffusionism precipitated into the notion of 'cultural areas'. 'Cultural areas' comprise of societies which share common culture complexes. The idea of 'cultural areas' in turn produced the idea that a culture has a basic configuration, or *Volksgeist* (cf. Hiebert 1983, 2008).

As anthropologists examined various cultures more deeply, they discovered that underneath the surface of speech and behaviour are beliefs and values which produce a people's speech and actions. They discovered deeper levels of culture which profoundly affected how a people's beliefs are shaped—the hypotheses that people formulate regarding the nature of things, the groups in which they think, and the rationale that organizes these groups into a logical comprehension of reality. This led to the inescapable conclusion that "people live not in the same world with different labels attached to it but radically different conceptual worlds" (Hiebert 2008:15). This growing knowledge motivated further studies into the nature of deep culture. Anthropologists thus begun to make use of such terms as "ethos", "zeitgeist," "cosmology," "cosmos within," "outlook on life," "world event", "world metaphor," "world order," "world hypothesis," "plausibility structure," "world picture," "the whole world seen from the inside view," and "worldview" to describe this emergent concept of deep-culture. All these words are imprecise, hence problematic, but they do give us a facet of the meaning of deep-culture.

Hiebert (2008:15) prefers the word "worldview" to all the other words (and phrases) as more descriptive of the idea of 'deep culture', but is quick to point out that it too is fraught with problems. First, due to its roots in philosophy, it

seems to concentrate on the cognitive side of cultures and appears to neglect the affective and moral dimensions, which are equally important to the idea of culture, and does not show how these three dimensions of being human interact with each other.

Second, the word ‘worldview’ is founded on the apparent primacy of sight or view over sound or hearing. All cultures use both sight and sound, but in the majority sound is the main sensory occurrence. Hiebert (2008:15) observes that “Spoken words are more immediate, relational, and intimate than printed ones.” He adds, “Written words are impersonal, detached from specific contexts, and delayed”. Hence that the weakness of the perceived priority of sight in the word worldview seems to relegate sound to the peripheral should be noted.

And thirdly, the word worldview is problematic as it applies both to individuals and communities. Kraft (1996), however, remedies this perceived error of the word worldview by noting that worldviews can be categorized as individual, sub-cultural, cultural, or even national. Notwithstanding these problems, the term “worldview” is the best the researcher will use in the present study as it is both well known and a more descriptive term.

The present researcher has consequently adopted Hiebert’s definition of the concept of worldview: the “fundamental cognitive, affective, and evaluative presuppositions a group of people make about the nature of things, and which they use to order their lives.” (2008:15). Therefore a people’s worldview is

what a community takes as given realities, the maps they have of reality and use as a pattern for living. The worldview not only inform their behaviour (overt culture), but also gives them a sense of societal continuity, security, and equilibrium (cf. Luzbetak 2000). The question may be posed as to whether or not worldviews can be studied to understand their role in behaviour and whether or not they are important to the quest for HIV-risk behaviour change. To answer these vital questions, the researcher will seek to understand elements which constitute a culture whole beginning with a model of worldview.

3.2.2 A Model of Worldview

But how exactly does one study a specific worldview? To answer this question in a more practical manner the researcher will begin by broadly identifying the critical dimensions present in a cultural whole. Hiebert (2008:25-26) helpfully comments that a “worldview” is the “foundational cognitive, affective, and evaluative assumptions and frameworks a group of people makes about the nature of reality which they use to order their lives”. He adds that worldview “encompasses people’s images or maps of the reality of all things that they use for living their lives. It is the cosmos thought to be true, desirable, and moral by a community of people” (2008:26). Hiebert thus suggests that there are three dimensions in a worldview which in reality works simultaneously in human experiences. Hiebert’s depiction of the notion of worldview entails that people think about things, have feelings about things, and make judgements about right and wrong depending on their thoughts and feelings. The moral aspect is concerned with people’s ideas of righteousness

and sin and their chief allegiances (what they worship). Figure 3.2 graphically shows how experiences impact on the beliefs, feelings, and values of individuals (held together by a worldview) which in turn affect decisions to produce behaviour. In a word, according to Hiebert, a people’s beliefs, feelings, and values, structured around their worldview, determine behaviour.

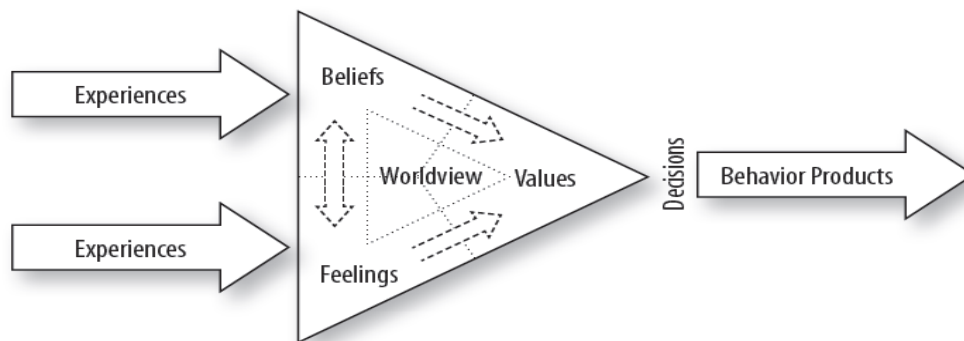


Figure 3.2—The Dimensions of Culture [Source: Hiebert 2008:26]

Arguably, a worldview profoundly influences the behaviour of its adherents. A worldview in this sense is more than a vision of life. Walsh and Middleton adeptly contend that a “world view (sic) that does not actually lead a person or a people into a particular way of life is no world view (sic) at all. Our world view (sic) determines our values....It sorts out what is important and what is not, what is of highest value from what is less....It thus advises how its adherents ought to conduct themselves in the world” (1984:54). Worldviews are not merely foundational ideas, feelings, and values, but “worlds” that are inhabited— “sacred canopies” that provide a cover of protection for life under which making homes, shaping communities, and sustaining life can happen (Hiebert 2008: 28). Kraft (2005:43) agrees with Hiebert’s standpoint by asserting that “The worldview lies at the very heart of culture, touching, interacting with and strongly influencing every other aspect of the culture.”

Kraft's assertion means that all of a people's culture is rooted in a worldview. The worldview then plays a critical role in the external behaviour of any group of people however large or small.

3.3 Functions of Worldviews

What role do worldviews play in a people group's culture? Simply put; what are the functions of worldviews? Broadly speaking, worldviews provide people with a coherent way of looking at life. Clifford Geertz (1973:169) adeptly clarifies that, "worldviews are both models of reality—they describe and explain the nature of things—and models for action—they provide us with the mental blueprints that guide our behaviour." He adds, "Models influence human actions, but the two are not the same. Our behavior is determined not only by our norms and ideals but also by conflicting forces and changing circumstances that pressure our everyday lives." But it must also be noted that mental blueprints alone do not explain distinctive variations in a people group's culture. It is possible, however, to adduce a number of critical cultural and social purposes which worldviews fulfil (cf. Kraft 2004 and Hiebert 2008).

3.3.1 Plausibility Framework

First, worldviews are a people group's plausibility structures which supply answers to their ultimate questions, such as, 'What is the nature of the world?' 'What does it mean to be human?' 'How do we explain the presence of evil and suffering in life?' 'What is the path from brokenness and insecurity to a life that is whole and secure?' Worldviews address these ultimate questions by giving people mental models of deeply embedded assumptions,

generalizations, or pictures and images that form how they comprehend their world and how they behave. Worldviews are the bases on which people build their plausibility systems and provide reasons for belief in these systems. When people accept their worldview presuppositions, their beliefs and explanations will make sense. The presuppositions themselves are usually taken for granted and rarely examined. A people group's worldview supplies them with "models or maps *for living*" (Hiebert 2008: 29 emphasis his). Put differently, worldviews supply their adherents with the theoretical designs which guide their behaviour.

3.3.2 Emotional Security

Second, worldviews provide a people with emotional security. Living in a context of constant danger, unpredictable and uncontrollable forces and upheavals such as drought, illness, and death, and overwhelmed by concerns of a future fraught with uncertainties, people often resort to their deepest cultural beliefs for comfort and security. A people's worldview protects their deep-seated beliefs with emotional reinforcements so that those beliefs are not easily ruined.

3.3.3 Basis for Ethical Judgements

Third, worldviews authenticate a people's deepest cultural norms, which they call upon to evaluate their experiences and decide how they should behave in a given set of circumstances. Consequently, worldviews provide a people with their ideas of righteousness and sin and with ways to handle them. They shape their opinion as to the way things are and ought to be. They function as

maps for guiding a people group's behaviour. Kraft (1996) notes well that worldview assumptions are the basis for ethical judgements. He asserts, "It is assumed that the underlying reason for differing understandings of ethicality lies in differences in the deep-level worldviews of the peoples of the world" (Kraft 1996:419).

3.3.4 Integrates a People's Culture

Fourth, worldviews aid to integrate a people group's culture. They organize their ideas, feelings, and values into a unified vision of reality (see figure 3.2 above). People's worldviews provide them with a feeling that they live in a world that makes sense to them.

3.3.5 Regulates Culture Change

Fifth, worldviews regulate culture change (Kraft 1979: 56). People continuously encounter new ideas, new behaviour, and new products either from within their society or externally. These new situations may usher into a cultural grouping assumptions that undermine their way of thinking. It is their worldviews which help them choose the assumptions which suit their culture and discard those that do not. Worldviews also assist a people group to reinterpret the adopted assumptions so that they are not in complicit with their general cultural pattern (cf. Luzbetak 2000; Kraft 2005).

3.3.6 Society's Psychological Reassurance

Finally, worldviews supply psychological comfort that the world is truly as it is seen and also offers its' adherents a sense of peace and of being at home in

the world in which they operate. People meet a worldview predicament when there is a gap between their worldview and their experience of reality. This situation may happen when sometimes a people group's integrating process fails to keep abreast with the changes occurring in a culture. A process of disintegration begins to happen. Disintegration is a kind of cultural pathology which makes an individual's enculturation meaningless (Luzbetak 2000).

Luzbetak writes,

Disintegration brings uncertainty, confusion, frustration, and low morale, behavior loses its meaning and becomes unpredictable; the values become doubtful and hazy. Such *dyspattern*, *dysfunction*, and *dysconfiguration* (and consequent decay) can come from within as well as from without the society. History is full of tragic disappearances of cultures, notable examples being Ancient Egypt, Greece, and Rome (2000:316 emphasis his).

In a word, then, the worldview of a people group reassures them of continuing societal stability and peace.

3.4 Characteristics of Worldviews

Having surveyed the functions of worldviews, the researcher will now sketch its characteristics to have insight on how a worldview can be transformed to achieve behaviour change in a society. Therefore, a question may be posed: What is the basic structure of a people's worldview? Is it possible to identify common characteristics in worldviews? Hiebert (2008:31) observes that "although worldviews, as amorphous wholes, are hard to examine, they do share common characteristics" which are examinable by an enquiring mind. In this section the researcher will investigate worldview traits to learn how they shape behaviour, how they can be affected by external influences, and

seek to understand whether cultural communication can aim at worldview transformation to change the behaviour of its adherents.

3.4.1 Worldview Depth

The first characteristic of worldviews can be discerned from such expressions as ‘core culture’ and ‘deep structure’. These expressions suggest the notion that worldviews lie beneath the more overt facets of a culture. In this connection, it is useful to look at a culture as having several levels (see figure 3.3). The surface of culture constitutes the visible elements like cultural products, patterns of behavior, and speech. At the invisible/deep level of a culture are myths and rituals—enacted cultural dramas—which express the conscious beliefs, emotions, and values of a people’s culture.

Edward T. Hall (Hiebert 2008:32) explains the conception of ‘worldview depth’:

There is an underlying, hidden level of culture that is highly patterned—a set of unspoken, implicit rules of behavior and thought that controls everything we do. This hidden cultural grammar defines the way in which people view the world, determine their values, and establish the basic tempo and rhythms of life....One of the principle characteristics of PL [primary level] cultures is that it is particularly resistant to manipulative attempts to change it from the outside. The rules may be violated to bend, but people are fully aware that something wrong has occurred. In the meantime, the rules remain intact and change according to an internal dynamic of their own.

The term “depth” is potentially misleading as it has connotations of foundationalism—the idea that worldviews are the foundations of cultures, with behaviour as the superstructure. Foundationalism seems to overemphasize worldviews as a means of causality, meaning that worldviews

establish the shape of the surface cultures. However, causality in cultural change dynamics can go in both directions. Changes which often happen in the overt sphere of a culture and can affect a people’s worldview (cf. Luzbetak 2000). For instance, new technologies, such as, cars and the internet have emerged, and have transformed the underlying worldviews of many people in profound ways. It is the researcher’s view that worldview transformations can happen, but they broadly do so to maintain equilibrium with the changes occurring in surface culture (Luzbetak 2000). Hiebert (2000) and Kraft (2005) agree that worldviews usually act as preservers of tradition than as innovators of new patterns.

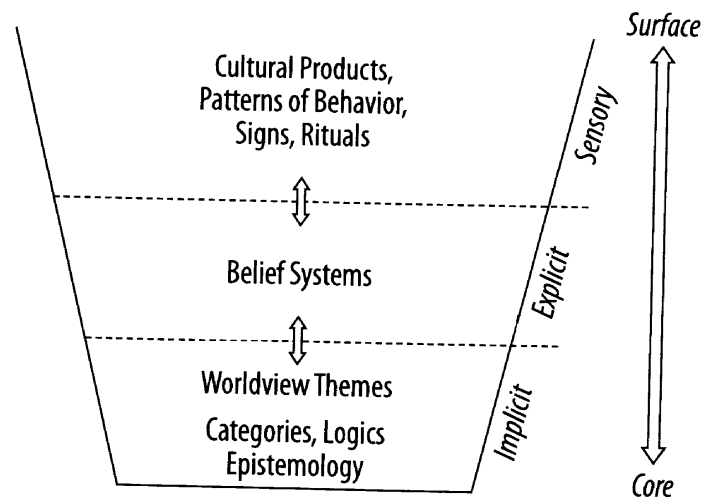


Figure 3.3—Levels of Culture
[Source: Hiebert 2008:33]

Shorter (1998:25) usefully posits that understanding the issue of cultural levels is significant to the process of cultural change as the various aspects of culture (represented by the levels) point to people’s reticence to change in varying degrees. By implication, enduring change at surface culture level will happen if it is supported by change at the worldview (deep-culture) level. The present researcher will demonstrate that understanding the trait of “worldview

depth” in behaviour change is crucially important to incepting enduring behavior change in any society.

3.4.2 Worldviews Are Not in the Genes

Worldviews are hereditary in the sense that they are passed on from previous generations together with their assumptions. These worldview assumptions or premises are learned from a people’s elders, not thought through, but assumed to be true without prior proof. In a word, worldviews are not in a people’s genetic makeup—they are taught. Futrell (2006) explains,

Since ...the “flesh” of *customary behavior* is hung on the “skeleton” of assumptions and images in the worldview, there are stakeholders in the process of any youngster’s development. Whoever most controls a child’s early environment will likely be most influential in directing the developmental course and bringing about desired ends. Stakeholders can hope to produce a preferred outcome by exposing a youngster to selected experiences and instructing him or her by way of narratives and rituals (along with related plaudits, censure, etc.). A conformist indoctrination process also may involve screening out of alternative worldview narratives and experiences, or at least careful managing of a youngster’s acquaintance with them. Even a broad-minded approach, one which does not seek to restrict exposure to alternate assumptions or images, will involve instilling certain “interpretations” and offering up “guidelines.” Conveyed as “helpful” (for understanding the universe, living life well, gaining meaning of it all, etc.), the intent is that they frame the child’s outlook thenceforth.

Futrell’s view is evident that a person’s worldview is received from “stakeholders”, in this case the elders, who even ensure that a ‘right’ worldview is perpetuated. This observation is true to the Zambian context where parents teach their young cultural values, norms and traditions affecting every area of life (cf. Chondoka 1988). For example, although there is a taboo on the discussion of sex and sexuality among most Zambian men the very behaviour of the elders in this realm of social life sanctions particular

lifestyles—such as stealthy multiple concurrent sexual partnerships⁶¹. The researcher has identified some of these values and norms in the preceding chapter concerning factors fuelling the growth HIV infection.

Kraft also points out that it rarely occurs to people of any particular worldview that other groups of people do not share their assumptions (2004:387). Hence, in cross-cultural communication the problems which emerge out of differences in worldview are the hardest to unravel because they relate to people's highest allegiances (cf. Kraft 2004). The present researcher posits that the absence of enduring HIV-risk behaviour change in Zambia is chiefly attributable to a 'communication complication' at the worldview level, where a conflicting message is being heard in relation to sex and sexuality.

3.4.3 Worldviews Are Implicit

Due to the fact that worldviews are deep-seated; they are usually unexamined and for the most part implicit. Worldviews like a pair of spectacles shape how people see the world, but they are seldom conscious of their presence. Arguably, it is outsiders who often notice better other people's worldview deficiencies than the owners of a particular worldview. For instance, language structure is implicit in a people's worldview. When people speak, they think of the ideas and feelings they want to say. They do not pause to think about how they will make sounds with their mouths, the specific sounds their culture uses to make words, or how they thread words together to make sentences.

⁶¹ The Bemba proverb "**Ubuchende bwa mwaume tabulusha**" (literally translatable as "a man's adultery is not nauseating") justifies men's adulterous behaviour. Hence Zambian society generally acquiesces in adulterous behaviour of men to the point that if a wife complains of her husband's infidelity she's is perceived as traditionally "stupid" –uncultured.

In fact, if they stop to scrutinize the phonetics and morphological structures of their speech, they might forget the message they wanted to communicate. When they learn another language, they simply use the sounds of their language to vocalize the words of the new language because they take for granted that all languages use the same vowels and consonants they do (cf. Hiebert 2008).

Similarly, individuals are usually unconscious of their own worldview and how it works. Other people are similarly largely unaware of their own worldview and how it shapes their thoughts and actions. They simply take for granted that the world is how they perceive it and that others see it in the same manner. People, however, only become aware that their worldviews are different from those of others when they are challenged by external situations which they cannot explain. The other way people's worldviews become 'visible' is by consciously exploring what lies beneath the surface of ordinary thinking. The researcher will discuss in chapter four that worldviews can be stimulated to change by examining them and by exposing them to other worldviews.

3.4.4 Worldviews and Causality

Whenever people struggle for a good life, and whenever they meet adversities, the majority of people aspire to do something about their predicament. This protective reaction of people is an indication that worldview change is not only a complex process, but one which also defies the easy grasp of causality. Consequently, people of any society when faced with a

novelty (or calamity) will attempt to make certain that they succeed and surmount their crisis. The first thing they would normally do is to find the correct belief system to explain their circumstance. When they have succeeded at this, they then would make a diagnosis of the situation and choose the proper way of handling it⁶².

Hiebert (2008:45) astutely writes,

Most cultures have a “toolbox” of different belief systems that they use to explain what is happening Some of these involve beings such as humans, spirits, demons, jinn, raskhasa, nats, and God. These explanation systems include shamanism, witchcraft, soul loss, ancestors, and moral judgments. Others concern impersonal powers, such as, magic, astrology, fate, luck, pollution, and biophysical factors.

Worldviews are thus understood as critical means of understanding life’s perplexities in a culture. It is interesting to note that quite a few African societies sometimes blame HIV infection on such phenomena as witchcraft (cf. Magezi 2005). The researcher posits that such a mindset may also be linked to the ideas of causality located in a people’s worldview.

3.4.5 Worldviews are Integrated Systems

Worldviews are integrated mental constructs. Kraft says that cultures “tend to show *more or less tight integration* around its worldview. Worldview

⁶² Luzbetak (2000) terms this aspect of the process of culture change as “reinterpretation.” He elucidates,

Reinterpretation is sometimes called reformation, contextualization, redesigning, reorientation, reworking, reconstellation, readaptation, recasting, and reintegration...as a general rule, a society will hesitate or refuse to adopt any new idea that it senses to be inconsistent with its cultural system or for which it feels no need. If, on the other hand, the new idea appears at least in some respect desirable, the society will... begin to reinterpret it so that it does fit into the symbolic system. It is, of course, possible for the unwary architects of the cultural blueprint [worldview], the individual members of the society, to allow a novelty to enter into their plans without realizing it. Reinterpretation would then also most likely take place unconsciously (Luzbetak 2000:309).

assumptions provide the ‘glue’ with which people hold their culture together” (2004:387, emphasis his). In other words, knowledge is not the sum of bits of information, but a system of interpretation which comes out of a plethora of relationships between pieces and gives meaning to the whole. Therefore, worldviews are concerned about patterns and perceive the entire system as greater than the sum of the parts. Hiebert (2008:48) explains that “worldviews are paradigmatic in nature and demonstrate internal logical and structural regularities that persist over long periods of time.”

Figure 3.4 below illustrates the paradigmatic or configurational nature of knowledge, a critical facet of worldview. Majority of the people looking at the dots attempt to give them meaning by organizing them into a larger “design” that links the dots together to give them ‘meaning’. Some may see a “star”; others might see two “circles”. The question posed is whether the stars or circles exist in reality, or are they merely created by the mind of the observer. Both answers are right because each individual observer interprets the dots as either a star or two circles. However, not one observer can see a star nor circles without the dots being arranged in a way which makes them interpretable in the manner they are viewed. For example, if the dots were placed haphazardly on the page observers would infer that there is no order in their arrangement. Hiebert thus concludes: “...the configurational nature of knowledge that gives meaning to uninterpreted experiences by seeing the order or the story behind them. Configuration gives to knowledge a coherence that makes sense out of a bewildering barrage of experiential data entering the mind. It helps people get a ‘picture’ of reality” (2008:49).

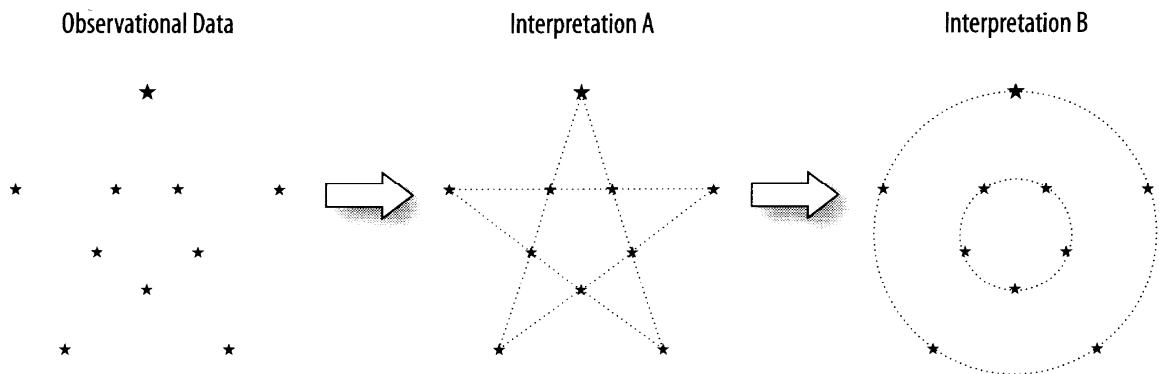


Figure 3.4—The Configurational Nature of Knowledge
[Source: Hiebert 2008:49]

3.4.6 Generativity of Worldviews

The idea of generativity in the study of worldviews speaks about the fact that worldviews do generate speech and behaviour. Hiebert asserts that “worldviews are generative” (Hiebert 2008:49). By this assertion he means that worldviews are not particular occurrences of human speech and behaviour, but do generate speech and behavior. Superficially, human activities are considerably diverse. People go to shops and purchase goods without reflecting on the rules that control economic behaviour in their community, for instance. This is possible due to the reality that the vast diversity of social and cultural interactions which people experience can be made understandable by explaining them in terms of some characteristics and by a set of laws which control the relationships between them. The worldview modulates these set of rules for the generativity to happen.

Language is a good example of the concept of generativity. In any language, people are able to say unique sentences and listeners are able to understand them. This is possible because people can generate an almost endless

number of sentences by making use of the sounds, words, and rules of language. Generativity partially gives complexity to worldviews. Arguably it is because of this characteristic that no simple worldview or culture has ever been found (Kraft 2004:387).

3.4.7 Worldviews are Constructed and Contested

It is possible to assert that human knowledge is made of mental constructs; models which assist individuals make sense of their experience. For worldviews to be useful, they must somewhat correspond to reality. They are not replicas of reality but approximate models of experience which people can choose as acceptable. With the passage of time worldviews turn out to be increasingly adequate and 'compatible'. In effect people construct alternative models and select some over others on the basis of fit, sufficiency, and convenience.

Worldviews, however, are also contestable since they are created by human beings and different groups in a community may have vested interests in advancing worldviews which give them advantage. Knowledge is power, and the powerful always try to preserve their vested interests through controlling the main worldview. They suppress opinions and seek to impose their culture on 'foreign' communities, who often threaten the way they see the world. According to Hiebert (2000:48), this tension between differing social groups partially explains why worldviews are continuously changing. It is precisely at this point of constructing and contesting worldviews that a window of

opportunity exists toward changing behaviour in HIV and AIDS preventive work (cf. PWG 2008).

3.5 Worldview Transformation Dynamics

In the preceding sections, the researcher has explored the concept and model of worldview. He has also given a succinct definition of the concept of worldview—the cultural core of human societies—and discussed its origins, characteristics and functions. The research thus far has posited that the concept of worldview fundamentally consists of the underlying presuppositions, valuations, and allegiances that enable human communities to function ‘properly’.

At this juncture, the researcher will explore the dynamics involved in transforming a worldview. Two critical questions come to the fore: How are worldviews changed? And what are the broad patterns of worldview transformation? These two questions are motivated by the realization that at the heart of doing theology amidst an HIV/AIDS epidemic, it is important not to merely seek change of the external characteristics and institutions of a culture. It is rather crucially important to grasp the modalities of behaviour transformation from the core of a culture—the worldview. The researcher will now look at a basic model of worldview change and survey patterns of worldview transformation to set a foundation for the role of worldview change in behaviour change.

3.5.1 An Elementary Model of Worldview Change

As noted in the foregoing discussion worldview is at the core of a culture and is made up of the paradigmatic presuppositions, valuations, and commitments which underlie a people's culture. Based on these presuppositions, people in a society interpret and understand their world and make strategies to function effectively within their world. From these interpretations and evaluations, they rationalize, make life commitments, make rules for interrelationships, and cope with their environment. A people's worldview, hence, furnishes them with designs for decision making, thought patterns, behavioural motivation, and structures their basic assumptions. In a basic sense, then, this is how a worldview functions (Kraft 1996).

Ideally every society desires to function in a healthy manner, that is to say, in a situation where worldview functions operate well and the whole community is suffused by a sense of balance and cohesiveness—community wellness. This community wellness in turn provides a people group with a sense of security whereby they perceive that their sociocultural life is peculiarly 'real' and is meant to persist. However, such an ideal state never occurs, although it is ever a worthwhile goal to pursue. The reality is that societies and their cultures are dynamic. They are constantly changing. A most unsettling reality is that in contemporary times these changes occur rather too rapidly and at a seismic scale which disrupts a society's sense of security and satisfaction in their way of life. The resultant disturbance often produces sociocultural upheavals which lead to breakdown and the society may either regroup and return to equilibrium or disintegrate and go into extinction (cf. Luzbetak 2000;

Kraft 1996). In the ensuing section, the researcher spotlights this process with particular reference to what occurs at worldview level. Kraft [1996:435, after Anthony Wallace (1956)] helpfully presents an elementary model of the process of worldview transformation consisting of three idealized states: the old steady state, the crisis situation, and the New Steady state.

Old Steady State \rightleftharpoons **Crisis Situation** \rightleftharpoons **New Steady State**

The first state, the “*Old Steady State*”, stands for the idealized equilibrium the researcher has been recounting above. In this condition all systems in a society are properly functional, steady, and durable. The second state, the *Crisis Situation*, shows the entry of some radical challenge into a society’s stable state, perhaps, occasioned by the imposition of foreign customs, values, and worldview, a war, or a natural tragedy. In this phase, a growing number of customary valuations and allegiances begin to be queried due to the novelty. As a result of this upheaval, a lot of well-known rules and guidelines, particularly in the realm of social control, no longer function properly and many conventional presuppositions become unsatisfactory. The third state, the “*New Steady State*”, stands for the ideal outcome of the crisis. The society survives by adapting to the novelty and formulates a new way for existing. It is important to note that although such a steady state often takes considerably long to happen, if at all, it is also the ultimate goal which is arduously pursued by any society. The researcher will show below that there are more than a few possible directions in which a people group can progress in tackling the upheavals that take place in the second state.

Anthropologists (cf. Kraft 1996; Luzbetak 2000; Hiebert 2008) are agreed that worldviews are transformed due to pressure—pressure which originates from within the society but often triggered by outside influence. In a word, although it is insiders who sense the pressure to change and implement such changes, more often than not it is the case that they were influenced first and foremost by their contact with outside factors and advocates (Luzbetak 2000; Hiebert 2008). The (new) outside influences also tend to produce dissatisfaction with traditional presuppositions and approaches to life. As a result, the society is pressurized to develop new ways of understanding and adapting to new circumstances. This situation generates new presuppositions concerning the world and formulates new strategies for handling the novelties. New values and allegiances also emerge in the community. As a general rule, societies strive toward and hope that a new steady state will soon be actualized.

Furthermore, the generation of new assumptions, valuations, and allegiances—the new worldview—entail the simultaneous rejection of old assumptions, valuations, and allegiances—the old worldview. However, the new presuppositions and strategies will not be completely new as the new is still influenced by the old strategies with radical changes at critical points. The issue is that even though new ideas and ways of perceiving the reality would have impacted on old strategies to produce transformation at crucial junctures, many traits of the old will persist into the new, albeit in adapted form.

3.5.2 A Worldview Change Model

In the discussion of section 3.5.1 the researcher hinted that there are various possibilities or results for worldview transformation. In this section the researcher will survey these possibilities of worldview change and the concomitant outcomes. Figure 3.5 below is a diagrammatic description of the process of worldview change and its results. Figure 3.5 starts at the ideal steady condition. A novelty then emerges from inside or, as often, from outside, which produces significant stress in the worldview. The stress accumulates and yields “a reservoir of tension” (Kraft 1996:437). According to Kraft a “reservoir of tension ...may be an intellectual, emotional, or spiritual build-up, or a complex of them all. This reservoir of tension may be a feeling of expectancy or an intense passion for emancipation.” Kraft (1996) adds that though the community might be experiencing this accumulation of tension with the attendant explosive capability for radical cultural transformation, it will still maintain its sociocultural cohesion which is the essential glue that unites and keeps a people a people. However, at some instance, an event may occur which will ‘ignite’ the built-up tension to precipitate radical transformation and innovation, followed by conversion or submersion, yet without destroying the essential configurational designs which bind the people together so that its sense of identity and security is also preserved.

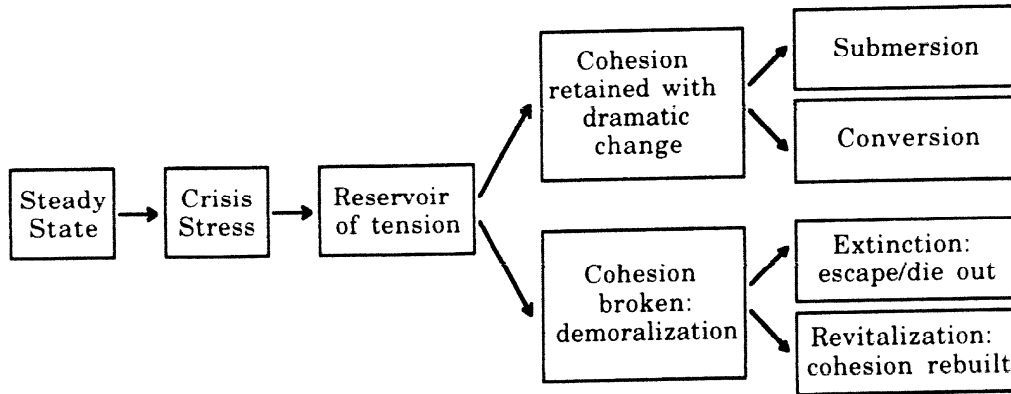


Figure 3.5—The Process of Worldview Change and Its Results (Source: Kraft 1996:437)

Once this reservoir of tension has sufficiently accumulated in a community, that society may react in one of a number of ways, depending on whether their cohesion is sustained or destroyed. If their cohesion is maintained, a community will often progress toward either a state of submersion or conversion. If, on the other hand, the cohesion is damaged or severely impaired, the community tends to progress into a situation of sociocultural demoralization. The latter state may result either in that community's extinction or revitalization.

The state of submersion represents a scenario where the people's cohesion is conserved and their traditional worldview configurations persist, but submerged under a facade of the new. Submersion is basically a cultural defence or coping mechanism. When customary worldviews are threatened with extensive external changes, their only chance for survival may be to hide "behind" the changes. Submersion of culture is that tendency to adopt the peripheral (overt, external) form of the change and at the same time keeping essentially the same worldview inside. The researcher is of the opinion that submersion has been the result of much of the existing HIV prevention efforts

in sub-Saharan Africa. The obvious outcome of this 'survivalist' response to HIV-risk reduction efforts is that authentic behaviour change seems to be the proverbial mirage in the desert.

Conversion also keeps the essential patterns of the sociocultural structuring of a people, but in different ways. Cultural conversion is the approach of those who convert to a new worldview, while maintaining the rest of the social structure more or less unbroken. It is the view of this researcher that culture conversion can result from any pressure on a people's worldview (including natural catastrophes and epidemics, like the current HIV/AIDS epidemic in our sub-region). The researcher envisages a situation where pressure for transformation is brought about by the HIV/AIDS crisis and a message to change is relevantly communicated at the deep-culture level to precipitate a new perceptual paradigm. Therefore, the worldview conversion fundamentally alludes to a complete and radical transformation at the level of a people's assumptions, values, and commitments.

Demoralization occurs when the ethnic cohesion of a people group is broken, that is to say, when the worldview of a cultural group is severely impaired such that it is impossible to rescue it. This is a situation where neither the customary nor new adaptations to life and solutions to problems are perceived as effective. Even though a society may survive its experience of a crisis such as an epidemic or a war, it may allow itself to enter into demoralized reasoning which damages what might be left of its sense of security. Demoralization quickly ramifies through a whole society impairing its will to

survive. The end result can either lead to the extinction or revitalization of a society. Extinction happens if a demoralized people group does not recover its cohesion. There are a number of routes through which a demoralized society can arrive at extinction.

A society may attempt to escape their culture by completely aligning themselves with another culture. Such a route may take place suddenly and dramatically or gradually over generations. For instance, the more gradual way may happen by intermarriage or through the natural processes of assimilation which come with large scale emigration or invasion and colonization. In Zambia intermarriages between the 73 tribes are so common that a significant portion of children born after the 1980s in urban centres are unable to speak their mother tongue (original ethnic languages). A society may also become extinct because people are no longer willing to reproduce. When a group has abandoned the search for security and cohesion and is overtaken by hopelessness, procreation may completely cease (cf. Kraft 1996). Fortunately, not every demoralized community progresses to extinction. Chances are good that when there are deliberate efforts to restore ethnic cohesion that revitalization of a cultural group can work. Revitalization, like the other responses, may emanate from the attitude of the people, not only from the outside pressures. If a people group reacts to demoralization with an attitude which resolutely says, "This cannot be happening to us. We will not let ourselves and our way of life to collapse and disappear," and initiates steps to restructure and reorganize it can revitalize. This resoluteness impels a society to search for a thing around which to remake their culture

amidst an unsatisfying anomie. They realize that their way of life has become dysfunctional and intentionally seek to recreate a more stable (and satisfying) cultural system. If it happens that the society becomes aware of the inaptness of their system to solve the crisis at hand, and if they are determined to change the situation, then the stage for revitalization is ready. With such a posture of determination the people will have the capability to discover a new paradigm around which to restructure their culture. Frequently the new paradigm (the impetus and design for restructuring) will be supernaturalistic in character (cf. Kraft 1996). The new paradigm thus sets the stage for change that transforms a particular behaviour from the cultural core—the worldview.

3.5.3 Transformational Culture Change

Anthropologists are agreed that human cultures are susceptible to change in response to a wide array of conditions. Some catalytic conditions which precipitate cultural transformation may be explosive ones, such as political instability, war or serious epidemics like the current HIV/AIDS epidemic in the sub-Saharan. Other catalytic culture change circumstances may be more subtle like the gradual erosion of values when new generations oppose and modify the perceptions of their forebears. It is undeniable that cultures are changing constantly in a wide range of ways.

Regardless of the precise catalyst of transformation, the researcher will delineate transformation which affects culture at its crucial core—at the worldview. This is a type of culture change which Kraft terms as “transformational culture change” (1996:440). Kraft (1996:440) defines

transformational culture change as “the change that takes place within a society and its culture due to a change in worldview. It is change that begins at the worldview heart of culture and courses, as it were, throughout the many veins and arteries of the surface-level subsystems, until it has touched everything and altered, to whatever extent necessary, whatever needs changing to accommodate the new assumptions.... [Transformational culture change] assumes that change introduced at the deepest level of culture, at the level of worldview, will ramify through every surrounding subsystem, effecting integral change throughout.”

The researcher is of the view that only transformational culture change is capable of translating into significant HIV-risk behaviour change in Zambia (and the rest of sub-Saharan Africa) where the HIV and AIDS epidemic is seemingly unrelenting. Having examined this model of culture change, the question may be posed: What exact role does worldview play in HIV-risk behaviour change? The researcher attempts to address this crucial question in the following section.

3.6 The Role of Worldview in HIV-Risk Behaviour Change

Kraft unequivocally asserts that “Solid culture change is a matter of changes in the worldview of a culture” (1996:65). Since people’s worldview influences their behaviour, the researcher posits that HIV-risk behaviour is intricately linked to their worldview. Therefore, in order to change HIV-risk behaviour in people there must be a fundamental transformation of their worldview. Kraft (1996) elucidates that in the same way as anything that affects the roots of a tree influences the fruit of the tree, so anything that affects a culture’s

worldview will affect the whole culture and the people who function in terms of that culture. The Lord Jesus thoroughly understood this link between worldview and behaviour change. For example when He wanted to communicate important issues, He targeted the worldview level for impact. During His earthly life, some Jews asked “Who is my neighbour?” He answered by telling them a story and then asked who was being a good neighbour (cf. Luke 10:25-37). Here Jesus was primarily leading them to rethink and change a fundamental value deep down in their cultural system.

Jesus also taught, “If someone strikes you on the right cheek, turn to him the other also. And if someone wants to sue you and take your tunic, let him have your cloak as well. "You have heard that it was said, 'Love your neighbor and hate your enemy.' But I tell you: Love your enemies and pray for those who persecute you...” (Matt 5:39-40, 43-44 NIV). The researcher views Jesus’ statements as an act of sowing seeds for change at the worldview level.

Moreover, when change takes place at the worldview level, it often throws things off balance, and any disequilibrium at the centre of a culture tends to cause hardships throughout the rest of the culture whole (Luzbetak 2000, Kraft 1996). But there are also changes that flow the other way round. These are usually made in response to coercion, or simply “forced’ changes, in the peripheral behaviour or customs and cause people to automatically change their worldview assumptions connected to that area of life. Kraft exemplifies this dynamic by pointing to people who, in the name of Christianity, change from using traditional medicines to scientific medicine. If they get deeply

enough into secularized medicine and endorse it they may even deduce that (as do most medical personnel, including some Christians) that God is irrelevant to the healing process. The researcher sees that the most difficult effect of worldview change by coercion (“forced”) is that it frequently becomes a formidable hindrance to the very change being sought for in society as its people will resent the ‘domineering’ attitude. Such changes mostly result in being short-lived and hypocritical. The researcher posits that this could be the case for African people south of the Sahara and the lethargic HIV prevention progression. Therefore enduring HIV-risk behaviour change in Zambia is a matter of transforming worldviews.

3.7 Conclusion

What are the pastoral implications of transforming worldviews on changing HIV-risk behaviour in Zambia? The researcher in the foregoing chapter has shown that the worldviews of any people profoundly influence their culture (all of explicit behaviour including sexual expression). Christians, therefore, must take the worldviews of other people seriously, not because they agree with them, but because they seek to understand the people they want to effectively reach with a message of behaviour change.

Arguably, Zambian Christians have no chance of facilitating behaviour change to curb the growth of the HIV/AIDS epidemic unless they are willing to become serious students of their own worldviews. The researcher posits that lasting HIV-risk behaviour change will only occur when HIV/AIDS information in Zambia (and the rest of sub-Saharan Africa) aims at transforming the worldviews

pertinent to sexual expression imbedded in their socio-cultural beliefs and customs.

The researcher further posits that studying worldviews is critically important to transforming them for HIV-risk behaviour change in the context of a growing HIV/AIDS epidemic. Too often HIV prevention conversation occurs at the surface levels of behaviour and beliefs; but if worldviews are not transformed, the message for behaviour change will be misinterpreted and hence rendered ineffective. Dwelle precisely makes the same conclusion when he asserts that traditional public health messaging and social marketing fail to achieve lasting behaviour change because they ignore cultural communication (cf. Dwelle 2006). Dwelle understands “cultural communication” as communication which engages worldviews with the aim of changing them to produce “permanent changes of high risk behaviours” (see figure 3.6). The much popularized Social Marketing does not mind what its target people think or feel, but merely wants to see behaviour change. Dwelle (2006) argues that cultural communication is that communication which will address people’s values, ideology, cosmology, and worldview⁶³.

⁶³ The present researcher posits that values, ideology, and cosmology facets are included in the idea of “core culture” of a people group and hence are synonymous to the broad definition of the concept of worldview (cf. Noebel 2001).

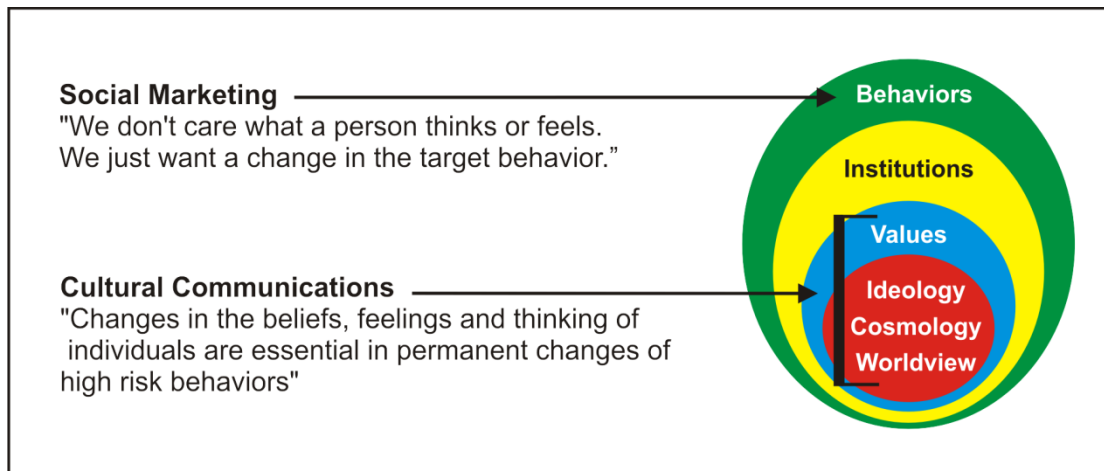


Figure 3.6—Traditional Public Health and Social Marketing (Source: Adapted from Dwelle 2006)

Dwelle's (2006) standpoint is fundamentally similar to Kraft's view that enduring behaviour change can only happen when change occurs at the worldview level. The researcher suggests that the basic appeal for conceptual transformation for HIV-risk behaviour change must be made at the worldview level.

Although worldview is a fascinating, and sometimes a confusing concept, the researcher has in the foregoing discussion not only described its fundamental shades of meaning, but also shown that the notion of worldview has been investigated toward understanding peoples' cultures and how behaviour change can happen through transformation at the worldview level. The foregoing chapter has also established that worldviews can be impacted and changed to facilitate enduring behaviour change in HIV and AIDS. Arguably, the very possibility of transforming people's worldviews opens the door to securing enduring behaviour change toward curbing the HIV/AIDS epidemic in Zambia. But, how exactly are worldviews transformable for HIV-risk behaviour change? The researcher attempts to answer this crucial question in the ensuing chapter.

CHAPTER FOUR

TRANSFORMING WORLDVIEWS⁶⁴ FOR HIV-RISK BEHAVIOUR CHANGE

4.1 Introduction

Colson and Pearcey (2000) assert that Christian ministry is intricately connected with the task of cultural renewal that we cannot neglect the one without failing at the other. They write, “Turning our backs on culture is a betrayal of our biblical mandate and our own heritage because it denies God’s sovereignty over all of life.... Evangelism and cultural renewal are both divinely ordained duties” (Colson and Pearcey 2000: x). Colson and Pearcey (2000) basically imply that the evangelistic mandate and cultural renewal are two sides of the same coin. It follows, therefore, that the issue of worldview transformation is a crucially important element for enduring HIV-risk behaviour change.

A critical observation of chapter two was that whereas some modest gains toward decelerating HIV incidences may be happening among the minority well-educated sections of Zambia, similar gains are not occurring among the most deprived and less-educated, the majority. This situation seems to be unabating due to adherence to deep-rooted cultural and traditional influences, values, norms and practices by most sub-Saharan Africans (Kapolyo 2005, Phiri 2008; Moyo 2009). Chapter two consequently established that interventions to check the continuing growth of the HIV/AIDS epidemic should

⁶⁴ The researcher is dependent on Paul G. Hiebert (2008: 307-333) for most of this chapter. In his book Hiebert has presented a lucid and erudite treatment of the task of transforming a worldview from an anthropological standpoint which perspective the researcher applies to the issue of changing HIV-risk behaviour. The reader is hence referred to Hiebert for broader coverage.

not only target individuals, but also aim at changing those facets of cultural and socioeconomic factors which heighten vulnerability to HIV infections (cf. Buve et al. 2002, Inungu et al. 2006). The researcher thus posited that the heart of HIV-risk behaviour change in Zambia significantly lies in transforming people's worldviews responsible for HIV-risk behaviour—the sociocultural and traditional influences, values, mores, norms and practices that predispose Zambians to HIV infection.

In chapter three the researcher concluded that the worldviews of any people group profoundly influence their culture (that is, all of explicit behaviour including sexual expression). This is not to say that the converse is not true. Surface culture too can impact the worldview toward change, but when change to the worldview emanates from surface culture it is usually through a very slow process of integration or diffusion (cf. Luzbetak 2000; 1975). The researcher admitted that this type of change is already happening in view of the HIV/AIDS epidemic but all too slowly. The researcher agreed with Kraft's (2005:46) explanation that worldviews do change in response to various change pressures in the surface culture over a lengthy period of incremental conceptualization process. He writes, "A group's worldview is not so structured that the perceptions of all its members are completely determined for all time. Though there is characteristically a very high degree of conservatism to such conceptualization, there is change in this as well as in all other areas of culture. ... Ordinarily such conceptual transformation takes place slowly" (Kraft 2005:46).

Kraft hence makes the crucial point that enduring cultural change, and for that matter any behaviour change, can only happen when a group's worldview is fundamentally transformed. Kraft admits that interplay of change influence between a people's culture and their worldview exists, but also points out that the worldview is the locus of enduring behaviour change. The researcher has discussed the dynamics of culture change in the preceding chapter (see 3.5 above) and the point being made here is that for HIV-risk behaviour change processes and programmes to be effective, change agents should strategically work toward effecting deep-culture (worldview) transformation (see Kapolyo 2007 for a Zambian perspective). Kraft writes:

Christians are anxious that culture change be effected by the infusion of Christian concepts into the cultural context. Note that the key factor that paves the way for any change is the development of some alteration in a person's or group's perception (model) of reality. This may be a change either in the perception of reality itself or of the understanding of what reality could be. Ordinarily we perceive reality in terms of our culturally governed conceptions (worldview) of what that reality ought to be (Kraft 2005:59).

Kraft's view is in agreement with that of Hiebert (2008) that in order to have a better comprehension of the people targeted with the message for transformation, change advocates should not underrate their worldview. Consequently, the researcher observed in chapter three that Christians must, take the worldviews of other people seriously, not because they agree with them, but because they seek to understand the people they want to reach with a message for HIV-risk behaviour change.

Kraft recommends that for effective transformational change to happen change advocates "should try to encourage a minimum number of critical

changes in the worldview rather than a larger number of peripheral changes.” He cautions, “Peripheral changes ...are more likely to prove hindrances than helps to true Christian transformation—because of the way the changes are brought about, not because the changes themselves are undesirable. In a word, changes forced at the periphery of culture cause unhelpful “ripples” of influence into the recipient worldview, core of the culture (Kraft 2005:283). A more effective approach toward enduring behaviour change should sensitively appeal directly to the people at the worldview level for more essential changes first to minimize antagonistic influence ripples into the cultural system (cf. Kraft 2005; Dwelle 2006).

Furthermore, from a pastoral standpoint, HIV-risk behaviour change entails more than cognitive transformation, which has been unduly emphasized in most contemporary approaches to HIV-risk behaviour interventions. The researcher suggests that enduring HIV-risk behaviour change be rooted in transformation at the deep-culture level—the worldview. This implies that when authentic deep-culture transformation is absent, enduring behaviour change will not happen. Hence, chances are good for HIV-risk behaviour relapses (Kelly 1995) to happen when the message for transformation is either dissonant with the recipients worldview (Luzbetak 1975) or change is forced on the existing surface culture (Kraft 1996). Kraft argues that it is futile to attempt at securing enduring ‘transformative change’ by effecting changes at the periphery of culture as that will be resented by the recipients, misunderstood to be a domineering attitude, and, hence, become a formidable hindrance to change (Kraft 2005:283-4). The researcher is also

aware that the human understanding of Scripture is also affected by the cultures and societies of its readers (Klein, Blomberg, & Hubbard 2004; Hiebert 2008). With this fact in mind, the researcher will approach the discussion with humility and a readiness to learn from the social sciences and the Bible. What, then, is meant by worldview transformation and how does the transformation of one's worldview impact on the quest for HIV-risk behaviour change? Asked differently, how can human beings change people's HIV-risk behaviour through transforming their worldview? In the current chapter the researcher will attempt to answer these critical questions.

4.2 Understanding Worldview Transformation

What, precisely, is meant by worldview transformation? To adequately tackle this question, it is imperative to have a clear understanding of the nature of transformation. Hiebert (2004) proposes that when analyzing transformation from a human perspective, it is necessary to examine the worldviews the students themselves bring to the study. The researcher will, therefore, examine some of these assumptions to discern how they shape our understanding of transformation. In a word, every student of any worldview already has a worldview with which he or she studies another worldview. Therefore, a student of any worldview is obligated to understand how his or her own worldview operates to have a chance at a fair and accurate assessment of the target worldview (cf. Kuhn 1975). The researcher therefore expresses humility as the study attitude for the rest of this discussion.

The researcher will start the enquiry toward understanding worldview transformation by exploring the link between transformation and cognitive⁶⁵ categories.

4.2.1 Transformation and Cognitive Categories

According to Hiebert (2008:308) “Concepts and definitions are at the core of every worldview.” These ideas and definitions aim to give meaning and rationality to the experiences of people of a particular culture. The concepts and definitions do differ in their categories and also in the manner in which these categories are created. Two questions emerge: What is transformation? And, “To what degree is the definition of ‘transformation’ influenced by a society’s ways of creating categories?” Hiebert suggests two principal ways of comprehending transformation, namely, through what he terms the “Intrinsic and Relational sets” and the “Digital and Ratio Sets” (Hiebert 2008:308-9). The present researcher will employ Hiebert’s approach toward understanding the nature of transformation.

4.2.1.1 Intrinsic and Relational Sets

According to Hiebert (2008), humans create two types of categories—namely, intrinsic and relational categories. Intrinsic categories are created by putting similar types of things together to form distinct categories. Therefore, according to the intrinsic approach, people who share one set of beliefs and practices are grouped together and called “Christians” to distinguish them from “Buddhists”, “Hindus,” or “Muslims.” In this way of thinking, it is vital to

⁶⁵ Cognition here alludes to the ideas and definitions which give meaning and rationality to the experiences of a society. This category is about the thought patterns and assumptions which constitute a worldview of a society (cf. Kraft 1996).

define precisely what is meant by “Christians” in intrinsic terms (what people are in themselves) as the definition should distinguish those who are Christians from those who are not. For instance, when conversion is defined in intrinsic terms, people are then defined by characteristics which they must have to be a part of the group. In which case, Christians are defined in terms of their beliefs. So it can be said that Christians are those who believe particular things, such as, the virgin birth, the deity of Christ, Scripture as divine revelation, and so forth. This type of categorization is also termed as creedal orthodoxy. The researcher thinks that creedal orthodoxy is not enough criteria as people who are truly converted to Christianity should also portray changed lifestyles.

However, If conversion is defined in relational terms, the criterion becomes whether people make Jesus the Lord of their lives—the one they follow, worship, and serve—or not. In this sense then conversion is understood as a turning from following one god to following another. Two relational phases become operative in conversion then. First, a person must reject his or her old gods, turn around, and follow another. Secondly, having turned, he or she must move closer to him through learning to know and serve him more fully. In this regard, making Christ the Lord of one’s life is not a single decision. It is the first step which leads to more decisions to submit to him. According to Grudem (1994) and Erickson (2002), these two phases cannot be separated from each other. They form two sides of the same coin called conversion.

Furthermore, in relational terms, sin is essentially understood as idolatry (the deification of self, or of something other than God, and a fractured relationship with God resulting in fractured relationships with humans. Transformation, therefore, implies repentance (turning from other gods) and turning to God, who forgives and opens the door for a new and growing relationship between the 'sinner' and Himself. In relational terms, then, transformation can be both an event and a continuing process.

4.2.1.2 Digital and Ratio Sets

Transformation can, however, be viewed differently when looked at through the "Digital/Ratio Set" perspective. Transformation from Buddhism to Christianity becomes a process through which change may occur instantaneously or progressively. It is possible then in this process to see the individual as three-quarters Buddhist and one-quarter Christian, half and half, one-quarter and three-quarters, and finally 100 percent Christian. The stages of conversion in this case may be identified either in terms of the degree of acceptance of Christian beliefs (orthodoxy) or changes in life (orthopraxy). But a Digital/Ratio approach to transformation raises immense theological complications. The issue which immediately arises in the "Digital/Ratio Set" approach has to do with whether or not there is a precise time when a person begins to experience transformation. From a human perspective it is hard to set the point of conversion, but what about God who sees the hearts of all human beings? Chances are good that what is unclear (and unknown) to human beings is known to God who is able to look into the heart (cf. 1 Samuel 16:7). Hence, when dealing with the issue of transformation and behaviour

change should efforts be directed toward seeing a single decision or progression of decisions?

Kapolyo (2007:36), discussing the complexity of conversion in African perspective, emphasizes that conversion in African perspective happens for reasons quite different from the desire to follow another religion. The processes of conversion are so intricate and fluid that they usually also involve processes of reconversion to religious practices socially adhered to in epochs before the advent of world religions. This situation may be attributable to the reality that core values transform slowly at the level of philosophical presuppositions. By implication, then, a considerable amount of time lapses before the 'real' religion of the heart comports with what occurs at the surface level culture.

Kapolyo (2007) basically understands transformation as a time-consuming process which is fundamentally straitened by the deep-level culture assumptions. Consequently, attempts toward transformation should take into account the African perspective. The tardiness toward transformation may be connected to a complication at the deep culture level where the proposed changes seem to conflict long-held assumptions. The researcher hence posits that enduring behaviour change efforts must not ignore the continuing need to alter the core values of target communities.

4.2.1.3 The Bible's View of Transformation

What then is the biblical view of worldview transformation? In modern and postmodern times the definition of things and ideas are often done using intrinsic and digital sets, stressing accurate definitions with unambiguous boundaries (Hiebert 2008). Consequently transformation is often understood on the basis of what a person is of himself or herself. This approach, however, is greatly susceptible to the danger of conceiving transformation as something a person does or believes. The risk with this approach lies in the possibility of ignoring the reality that transformation is beyond human work alone, even though it may be asserted that salvation is an act of God's mercy (cf. Ephesians 2:8-9).

The Bible views transformation neither in intrinsic nor digital terms. It views transformation in relational terms. It places emphasis on what things are in relation to other things and to history (extrinsic terms) rather than on what things are in themselves (intrinsic terms). For instance, the Hebrew word for repentance **shuv** means to turn in the opposite direction and connotes the thought of turning, turning away, and turning back (Brown, Driver & Briggs 2001:996; Vine 1996:203-204). According to Vine (1996:203) the verb **shuv** occurs about 1060 times in biblical Hebrew and roughly 8 times in biblical Aramaic. The essential meaning of **shuv** is movement back to the point of departure (unless there is evidence to the contrary). The first time the verb **shuv** is used in the Bible, God told Adam that he and Eve would “eat your food until you return (**shuv**) to the ground, since from it you were taken; for you are dust and to dust you will return (**shuv**)” (Genesis 3:19 NIV).

In the instance of ‘spiritual returning’ (figuratively) to the Lord, **shuv** can mean “turning away” from following Him (Numbers 14:43), “turning from” pursuing evil (1Kings 8:35), and “to return” to Him and obey Him (Deuteronomy 30:2) [cf. Vine 1996]. The fundamental import of **shuv** is that a person departs from the way he or she has been walking and changes into a new, opposite direction. It can also mean a return to a former place or state. Kasdorf (1980:42-43) lucidly illustrates these usages of the word **shuv** (all instances alluding to the idea of either turning away or turning toward) in his translation of Jeremiah 8:4b-6:

If one turns away (**shuv**) does he not return (**shuv**)? Why then has this people turned away (**shuv**) in perpetual backsliding (**shuv**)? They hold fast to deceit, they refuse to return (**shuv**) in perpetual backsliding (**shuv**). I have given heed to and listened, but they have not spoken aright; no man repents of his wickedness, saying ‘What have I done?’ Everyone turns (**shuv**).

The prophets in the Bible persistently called the nation of Israel to turn away from its worship of false gods and return to the worship of *Yahweh*, the true and living God. The prophets’ message entailed transformation on the part of Old Testament Israel. In this case the researcher understands transformation as basically a departure from a particular way of life to a new and opposite way of living. In a word, transformation is about repentance for that is what the Hebrew word **shuv** fundamentally means. Erickson (2002:948) helpfully explains,

The type of genuine repentance that humans are to display is more commonly designated by the word... [shuv]. It is used extensively in the prophets’ call to Israel to return to the Lord. It stresses the importance of a conscious moral separation, the necessity of forsaking sin and entering into fellowship with God.

Likewise, in the New Testament the terms for repentance and transformation, *metanoein*⁶⁶ and *epistrephein*⁶⁷, means “to turn around,” “to proceed in a new direction”. Luke used dynamic terms such as *epistrephein* nearly twenty times to show physical movement (e.g. Lk 22:32; Acts 3:19; 9:21; 14:15; 15:19; 26:20; 28:20) with the fundamental import of transformation (cf. Thayer 2000). Paul employed words like *apostrephein* and *anastrephein* (Eph. 4:22; 1 Tim 4:12), to communicate the notion of turning and then walking in a totally opposite direction from that previously pursued. Consequently, Hiebert astutely proposes a re-conceptualization of the meaning of transformation (by returning to the Scriptural view of repentance) to secure enduring behaviour change. He writes:

We need to return to a biblical view of transformation, which is both a point and a process; this transformation has simple beginnings (a person can turn wherever he or she is) but with radical, lifelong consequences. It is not simply a mental assent to a set of metaphysical beliefs, nor is it solely a positive feeling toward God. Rather it involves entering a life of discipleship and obedience in every area of our being and throughout the whole story of our lives (Hiebert 2008:310).

The question may be posed whether there is a connection between transformation, as described in the Bible, and HIV-risk behaviour change. Put differently, does transformation as taught in the Bible possess the capability of effecting enduring HIV-risk behaviour change? Or, more precisely, Is Christian conversion and discipleship capable of effecting HIV-risk behaviour change

⁶⁶ The word *metanoia*, according to Thayer (2000:405-406), means “a change of mind: as it appears in one who repents of the purpose he has formed or of something he has done (Heb 12:17),...especially the change of mind of those who have begun to abhor their errors and misdeeds, and have determined to enter upon a better course of life, so that it embraces both a resignation of sin and sorrow for it and hearty amendment, the tokens of which are good deeds.” Thayer sees repentance and transformation as two inseparable realities. There cannot be repentance without transformation and vice versa. The two are different sides of the same coin.

⁶⁷ The word *epistrephein* is derived from the verb *epistrephoo* which means “to turn to”, “to return, to bring back; (fig)...to the love and obedience of God (Lk. 1:17)” [Thayer 2000:243-244].

and is Christian ministry a potent approach toward HIV-risk behaviour change? The researcher posits that the biblical idea of repentance invariably anticipates transformation. Repentance and transformation (behaviour change) are two different sides of the same coin. In a word, then, biblical transformation presumes and anticipates repentance (cf. 2 Corinthians 3:16-18).

4.3 Transformation and HIV-Risk Behaviour Change

The researcher posits that the manner in which a person defines transformation largely determines how he or she will go about achieving behaviour change for HIV-risk reduction. If a digital approach is assumed transformation will merely imply possessing a mental agreement to certain truths or obtaining some amount of knowledge, but how much of each is required? In the case of the HIV/AIDS epidemic, it has already been noted that mere HIV education does not necessarily induce behaviour change (King 1999, PWG 2008, etc). This, again, is not to say that HIV awareness is immaterial in as far as behaviour change is concerned. The researcher agrees that HIV education is an elemental minimum needed to facilitate profound and enduring behaviour change. However, the researcher contends that enduring HIV-risk behaviour change is rooted in a transformed worldview. Furthermore, the researcher posits that a transformed worldview will only be possible when HIV/AIDS education occurs in tandem with authentic biblical transformation. Moreover, from an evangelical Christianity standpoint, HIV-risk behaviour change must be seen as an essential outcome of the transformation alluded to in Scripture (see 4.2.1.3). The goal of the Christian ministry of our Lord

Jesus Christ is to produce transformed lives. The Apostle Paul wrote to emphasize the importance of worldview transformation as an integral part of Christians' work in society thus:

Therefore, I urge you, brothers, in view of God's mercy, to offer your bodies as living sacrifices, holy and pleasing to God—this is your spiritual act of worship. Do not conform any longer to the pattern of this world, but be transformed by the renewing of your mind. Then you will be able to test and approve what God's will is—his good, pleasing and perfect will (Romans 12:1-2 NIV).

Bruce commenting on Romans 12:1-2, writes “Instead of living by the standards of a world at discord with God, believers are exhorted to let the renewing of their minds by the power of the Spirit transform their lives into conformity with God’s will” (1983:224). Bruce sees behaviour change (ethical behaviour) as a key outworking of worldview transformation (cf. Walsh and Middleton 1984).

The Bible anticipates changed behaviour, including the realm of sexual expression. The researcher contends that Christian Ministry has ethical implications for the whole of life, including behaviour change for HIV risk reduction. The question may be posed, however: How does worldview transformation affect other cultural dimensions in a society? What benefits would worldview transformation confer on a society?

4.3.1 Worldview Transformation and Cultural Dimensions

In the preceding discussion the researcher has shown that transformation according to the Bible has ethical implications embracing every area of his/her life. A further question concerning transformation is about its dimensions.

Every culture has three dimensions, namely, the cognitive (beliefs), the affective (feelings), and the evaluative (moral judgements) dimensions (Kraft 1979, Kraft 2004, Luzbetak 2000, Hiebert 2008). Worldview transformation entails changes occurring in all these three dimensions.

4.3.1.1 Cognitive Transformation

Contemporary Evangelical Christians have followed the example of protestant reformers in stressing the vitality of cognitive transformation in as far as transformation is concerned. Evangelicals emphasize the significance of defending the faith against heretical teaching as an essential element of genuine transformation (cf. Jude 3, 1 Timothy 4:16). Unquestionably knowledge of Bible truths plays a critical role in spiritual transformation, but is that all there is to it? Furthermore, Evangelical Christians are concerned not with transformation in broad terms but with transformation to Jesus, and not only to Jesus as a good person but to the Jesus of the Bible—the Christ, the Son of God, who became flesh, died, and rose to save people from their sins (cf. Romans 10:9-11). But mere knowledge of these truths alone is not enough.

The Bible attests to the fact that Satan has immense knowledge about Jesus and yet is not transformed because he is not willing to obey Him (cf. James 2: 14-19). The researcher sees a similarity between the case of a person with appreciable knowledge on HIV and AIDS and does not practice corresponding HIV-risk behaviour reduction and a person with knowledge about Jesus but is not spiritually transformed. Consequently, any form of knowledge which is not

used (or not applied in practical-real-life experience) is 'impotent' for behaviour change. Hence, genuine transformation should occur in the cognitive dimension of a culture if change in behaviour has to happen and persist. This is only possible when cognitive transformation at worldview level has occurred.

4.3.1.2 Affective Transformation

In order for enduring transformation to happen it is not sufficient for a person to have a full head (the cognitive dimension), but also a full heart (affective dimension). Recently, the Pentecostal and charismatic movements have reminded evangelical Christianity of the vitality of the affective dimension of transformation. In the past the sense of awe and majesty before the infinite, transcendent God as Lord and Father was the classical emotion associated with the 'high church' together with its liturgy, gestures of kneeling and bowing, cathedrals, organs, chants, and classical music. Evangelical Christians, tend to emphasize the presence of Christ amidst his people, and feel the tranquillity and joy a person experiences from intimate fellowship with God and other people. This is shown in their stress on meditation and silence, order, congregational hymns, restoration of personal relationships to Christ, and admission into the fellowship of a local congregation. Pentecostals and charismatics, however, have concentrated on 'ecstasy' expressed through freedom of expression, uplifted hands, dancing, speaking in tongues, and the presence of God the Holy Spirit within believers.

Hiebert (2008) says that those emotions usually provide the stimulus to transformation. People often feel welcome in a church and are attracted to the gospel from fellowship with Christians. However, it should be borne in mind that it is difficult to change people's feels with respect to the issue HIV-risk behaviour change partly because advocates tend to focus on cognition. Furthermore, feelings like knowledge feelings are an important part of the quest for behaviour change.

Similarly, in tackling HIV-risk behaviour change feelings play a critical role. People with HIV-risk behaviour will be 'attracted' toward behaviour change if proponents of the message are not portraying feeling of HIV/AIDS stigma. Chances are good that people with HIV-risk behaviour are being repelled from changing their behaviour by the stigmatizing affective attitudes of Christian ministry.

4.3.1.3 Evaluative Transformation

Although transformation may start with change at the knowledge (cognitive) level and through the affective dimension, for enduring behaviour change to occur, it must include the moral aspects of cultures and their worldviews. The Bible calls Christians not only to be acquainted with the truth and experience beauty and joy, but also to exhibit ethical behaviour issuing from a transformed life (cf. 1 Peter 1:14-16; 2 Peter 3:17-18). The researcher thinks that moral transformation must be the natural outcome of biblical (spiritual) transformation. At the centre of moral transformation is decision making. People think about things, feel about them, and then evaluate them, decide, and act on them. Some decisions people make are founded on rational

thinking, accompanied by minor emotional and moral consideration, for instance, solving a mathematics question or purchasing the cheapest garments available. But, other decisions emanate from intense feelings supported by scanty cognitive or moral contribution. Still other decisions concentrate on moral issues, like fighting corruption, deciding on abortion, and euthanasia. People also differ from one kind of choice to another, from individual to individual, and from culture to culture. The reason for these diversities between people groups choices (behaviour patterns) is attributable to their evaluation repository/criteria located in their worldview which processes decisions and mores.

The evaluation dimension of worldview transformation has two fundamental implications toward behaviour change. First, it means that when communicating messages toward behaviour change due care must be taken that the communication is made with sensitivity to the recipient culture (cf. Luzbetak 2000; Kraft 2005). The communication should not be done with a “holier-than-thou” attitude, but with an empathetic attitude which will invite the culture to bring to surface the structure of evaluative criteria. Chances are good that a people group might have a rationale for a particular risk behaviour which is rooted in their worldview. For example, Mbiti (1973) describes polygamous marriages as a culturally accepted practice pervasive in most African cultures. He argues for the case of African men having more than one wife on the basis that a woman may not be satisfying her husband conjugally. Mbiti (1973) portrays the picture that polygamous relationships have a critical part to play in the African’s worldview. Contrary to encouraging self control in

the area of sexual expression, he upholds the idea of partners' multiplication. The Bible is definitely against such thinking, but it must not be dispelled as a nonevent. Therefore, when advocating for HIV-risk behaviour change, such as reducing the number of sexual partners in a polygamous setting, it is necessary to engage the respondent culture in an evaluative process. In the evaluative process, specific issues which predispose the respondent culture to HIV infection should be targeted at the deep-culture level.

And secondly, the transformation being proposed entails more than making choices as mere acts of the will. More precisely these choices must be able to transform human lives and behaviour. Mere head knowledge, good emotions, verbal decisions will not be adequate. Fundamentally this evaluative process entails that enduring transformation is much more than intellectual acquiescence in some right beliefs and far more than an emotional release about sexual expression. Transformation is then about initiating a process of change of moral values and beliefs of a cultural milieu.

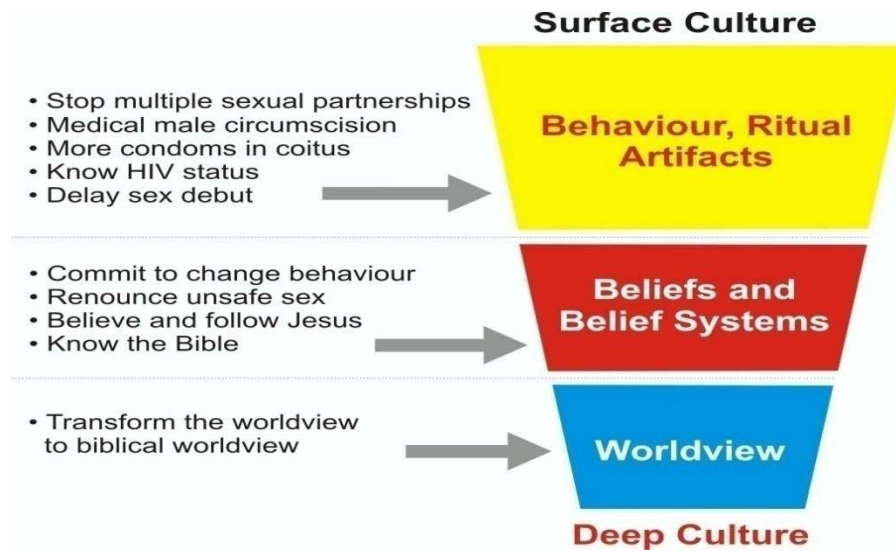
4.3.2 Levels of HIV-Risk Behaviour Transformation

When a people group receives communication on the need to change behaviour in the face of the HIV and AIDS epidemic it is always a welcome observation on the part of HIV educators to see even minuscule signs of positive results (cf. Kelly 1995). The established norm is to want to see people report starting to engage toward safer sexual activity, such as, using condoms during sexual intercourse, reducing the number of sexual partners, delaying sexual activity, or submitting to Voluntary Counselling and Testing. Such

changes are vital for the cause of HIV-risk reduction, but this does not mean that the underlying beliefs and worldviews, with the fundamental HIV predisposing traits, have necessarily changed. People usually say what they want others to hear. But how do we close this gap, which in essence, seems to be majorly responsible for perpetuating an epidemic whose route is now common knowledge?

The researcher has shown in chapter three that beneath explicit beliefs lays a deeper level of culture that shapes the categories and logic with which people reason and how they see reality. Authentic behaviour change will only happen if and when transformation encompasses all three levels of culture: behaviour and rituals, beliefs, and worldview. Unless the worldview of any people is transformed a relapse to riskier behaviour will happen. Kapolyo (2007:36-37) notes that African Christianity has been ineffective as far as changing behaviour is concerned because it has failed to appreciate the importance of securing transformation at the worldview level. Arguably, African Christianity has failed to take root into the foundational cultural level of host cultures, the case for Zambia, where surface cultural changes—such as taking on ‘Christian’ names, forms of dress, participation in communion, undergoing baptism, etc.—have been adopted and misunderstood for true conversion. Kapolyo (2007) blames the failure to transform deep-level culture assumptions as the cardinal reason for the lack of depth in Zambia’s Christianity. The researcher posits that effective behaviour change will only happen when transformative efforts aim at transforming the worldview.

Figure 4.1
Three Levels of Transformation
(Source: Adapted from Hiebert 2008:316)



At the heart of worldview transformations is the human search for coherence between the world as it is viewed and the world as it is experienced. Zambians culture, like any other sub-Saharan African culture, seek meaning by searching for order, symmetry, coherence, and non-contradiction. Learning is ‘meaning-making’—“a process of making sense or giving coherence to our experiences....” (Hiebert 2008:315). At the surface level people achieve this by categorizing their beliefs into religion, science, entertainment, and so forth. At a deeper worldview level, people look, usually without thinking about it, to incorporate these into a logical structure and story which makes sense of reality. On the other hand, the deep patterns or orders that come into view influence their surface domains. Overman (2009) succinctly writes, “Cultural assumptions [worldview] are like the ground-level foundation of a home, very important to the home”, affect the integrity of the structure. Overman (2009) argues that to change behaviour the change must happen at the deep culture level--the worldview. In Zambia, sexual activity is compartmentalized as

religious, social, and economic. Hence, sexual activity is something that is shaped by a deep-seated worldview (cf. Mbiti 1989). For instance, Mbiti (1989:145) points out that in African settings sexual intercourse is not used for biological purposes alone, but also for religious and social uses. Mbiti insightfully explains the significance of sexual intercourse to most African societies:

For procreation and pleasure, sex plays an important and obvious role in any marriage and in any society of the world. There are African people among whom rituals are solemnly opened or concluded with the actual or symbolic sexual intercourse between husband and wife or other officiating persons (1989:46).

Mbiti (1989) compares the religious use of sexual intercourse in African setting to a solemn seal or signature whereby sexual intercourse is employed as a sacred deed, a 'sacrament' indicative of internal spiritual values. Furthermore, Mbiti (1989:47) proposes that it is the religious attitude towards sexual intercourse which has brought about the social uses of sex in African context.

In the Zambian context, the kinship system includes, among other issues, relationships where in physical avoidance between individuals is strictly practiced. For instance, this is the case between a man and his mother-in-law or a wife and her father-in-law, where physical contact is taboo including a simple handshake for a greeting. Conversely, there is the opposite 'joking relationship', in which people have an obligation not only to socially intermingle but to also have physical contact which may entail 'easier' or casual sexual activity outside one's immediate marriage setting (cf. Mbiti 1989). There are tribes in Zambia, like the Kaondes of North-Western

Province, which use sexual intercourse for hospitality purposes. This custom of hospitality is practiced when a male relative or friend visits another. The host is required to 'surrender' his wife (or daughter or sister) to the visitor for him to have (sexual) company during the time he is away from his home.

Among the Namwanga tribe of Zambia's Northern Province, an elder sister's husband is, under some circumstances, permitted to have sexual intercourse with younger sisters of his wife including taking them for additional spouses. This too is an example of a custom which points to the intricacy of social use of sexual intercourse. Mbiti (1989:47) asserts that the religious and social uses of sex are considered sacred and respectable in many African settings.

Mbiti's standpoint implies that sexual activity/intercourse in an African cultural milieu is propelled from age-old deep-seated commitments and assumptions in the worldview, which transcends procreative and pleasure motives. It is this very locale of sexual activity in the worldview domain which further complicates not only the procreative, religious and social value, but has also made HIV-risk behaviour change difficult to achieve in Africa. Consequently, the researcher suggests that enduring sexual behaviour change will be realized when authentic and profound transformation occurs at the worldview level. But, what type of worldview transformation must be aimed at to secure enduring behaviour change with respect to HIV and AIDS? To respond to this question, it is imperative to explore the varieties of worldview transformation.

4.3.3 Varieties of Worldview Transformation

Anthropologists are unanimous that all cultures are dynamic in nature (Luzbetak 2000; Kraft 2005). That is to say, cultures are constantly changing and these changes usually lead to changes in their worldviews. However, worldviews often change more slowly as they are at the subconscious level. Worldview changes are essentially radical since they produce changes of an enduring nature.

Worldviews change in two principal ways. First, worldviews may change through gradual growth and, second, through radical shifts—also called “paradigm shifts” (cf. Kuhn 1975). Ordinarily, worldview transformations are brought about by surface incongruities, life’s paradoxes, and new experiences which cannot be merely resolved by getting additional information, increasing problem-solving adeptness, or by using a person’s capabilities. Frequently, the resolution of the dilemmas needs a transformation in a people’s worldview. The researcher will hence discuss how the two fundamental types of worldview transformation may occur—a normal worldview transformation and paradigm shifts.

4.3.3.1 Normal Worldview Transformation

The first type of worldview transformation is the ordinary one, or better called the “Normal Worldview Transformation”. Because culture is dynamic, there are “tensions between surface ideologies and between these ideologies themselves and the underlying worldview” which often precipitate imperceptible changes in ideologies and worldviews (Hiebert 2008:316). For

example, the emergence of new understandings of pharmacology produces new medicines and medical procedures which revolutionize the way people handle illnesses. Another example is from the construction of freeways in contemporary times. The construction of freeways has changed the way people do commerce as goods are transported more quickly by road than rail (cf. Crouch 2008). Worldviews are continually changing in reaction to changes at the levels of surface culture. Normal worldview transformations are comparable to remodelling and adding to an existing building. The edifice is remodelled without a lot of changes to the main structure. In a similar sense worldviews ‘unconsciously’ change without major alterations to the existing main structure or pattern of the worldview. This type of transformation may happen through a process Luzbetak (1975) terms as change by “diffusion,” where a new idea percolates throughout society, almost imperceptibly, to become part the main perceptual structure of that society. This is the normal way by which worldviews are transformed.

4.3.3.2 Paradigm Shifts

The second main type of worldview transformation is radical in character. It involves a deep-seated restructuring of underlying elements of culture. Thomas Kuhn called changes of seismic proportion, “paradigm shifts”⁶⁸. Accordingly, Mezirow (1978:104) explains,

When a meaning perspective can no longer comfortably deal with anomalies in a new situation, a transformation can occur. Adding knowledge, skills, or increasing competencies within

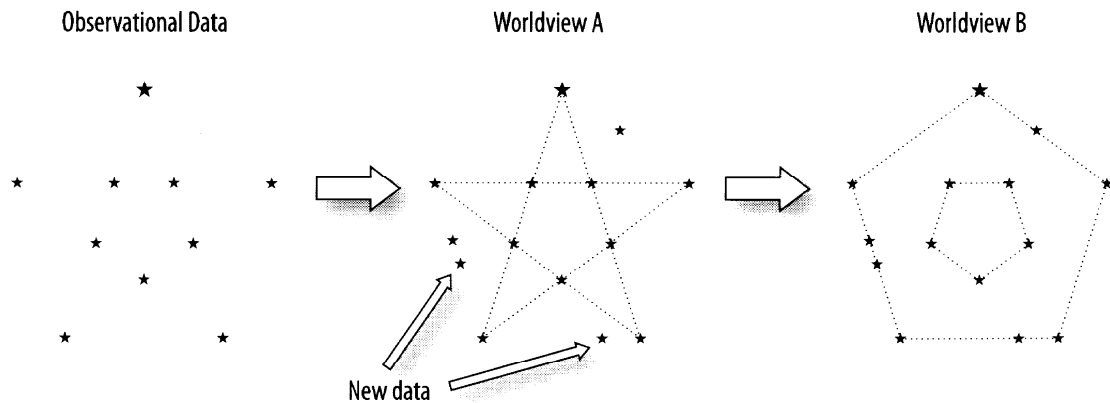
⁶⁸ In 1963 Thomas Kuhn published a book titled *The Structure of Scientific Revolutions*. In this work, Kuhn coined the idea of ‘paradigm shifts’ with the central argument that scientific developments do not take place gradually, but happens through revolutions interspaced by periods of relative calm. The revolutions which Kuhn described stand for periods during which one worldview is replaced by another worldview. Periods of relative calm stands for times when the current worldview is left unchallenged. These changes in worldviews are what Kuhn called paradigm shifts (Kuhn 1970).

the present perspective is no longer functional; creative integration of new experience into one's frame of reference no longer resolves the conflict. One not only is made to react to one's own, but to do so critically.

Mezirow is alluding to the second type of worldview transformation which results in radical perceptual transformation in order to change an undesirable behaviour or a situation. The resultant radical perceptual transformation entails fundamental changes of a people's deep-level assumptions and commitments and ensues in drastic behaviour change. The researcher holds that change which will result in enduring HIV-risk behaviour change must be paradigmatic in nature.

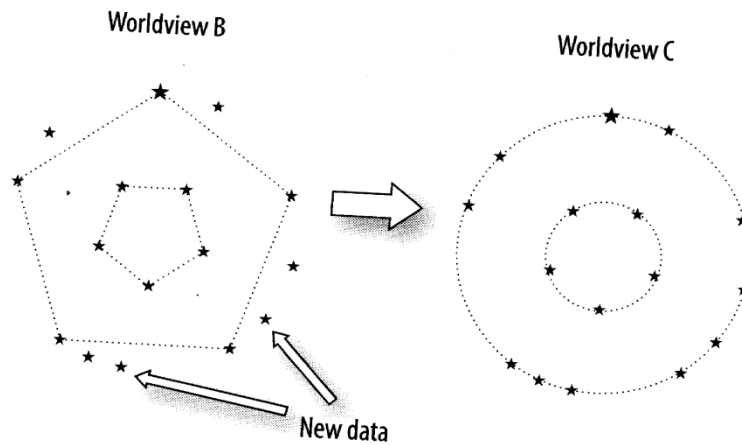
As pointed out in the foregoing section, the nature of this type of worldview transformation (or paradigm shift) is so deep-seated that they often go unchallenged. To assist with an accurate understanding of the nature of paradigm shifts, Hiebert (2008) refers to the configurational nature of worldviews. He posits that various "worldviews can be imposed on the data of our experiences." For instance let's observe a set of dots in Figure 4.2. Certain people may see a star, but when new experiences add new points to the knowledge base, which may be located outside the already perceived star pattern (model) of reality a new view may emerge. In this case a person might suggest an entirely different way of understanding the data. He may suggest an arguably true shape of a pentagon (Worldview B in figure 4.2). However, one may pose the question: which of the two paradigms is nearer to reality?

Figure 4.2
The Nature of Worldview Shifts
(Source: Hiebert 2006:318)



With the addition of new experiences more points of information may be added to observable data which again alters the model that the pentagon “joins” with more of the dots than the star. The end result is a paradigm shift where an observer sees a pentagon as the reality. However in the process of time, with additional data the pentagon does not fit into the model of reality. A whole new way of perceiving reality, therefore, emerges where another observer proposes that the dots can be joined in such a way that concentric circles are created instead of the pentagon (see Worldview C in figure 4.3) which assumes joining the dots in a straight line. Thus this radical proposal incorporates more bits of observable experience and data that in time another worldview shift occurs. At this stage observers see and think in terms of joining dots by arched as well as straight lines. Up to this point a ‘consistent’ worldview presupposition will hold that order is observable through joining dots in straight lines. But, at some point it may be more sensible to draw arched lines around the dots rather than joining them. When this thought emerges it will demand for an even far greater configurational shift.

Figure 4.3
Further Worldview Shifts (Source: Hiebert 2006:319)



However, two critical questions may be posed: What value does a configurational understanding of the nature of worldviews bring to pastoral efforts toward changing HIV infection predisposing behaviour? Asked more precisely, 'Are evangelical pastors not being pedantic by assuming that spiritual transformation as taught in the Bible can induce HIV-risk behaviour change?'

First, a configurational understanding of the nature of worldviews assists Christian workers to understand the nature of transformation. Some people contend that transformation must include traits/elements from the old worldview in the new. By implication, the inclusion of old elements in the new amounts to contamination of the new. However, if meaning is located more in the configuration that orders elements than in the elements themselves, old elements may be kept if they fit into the configuration of the new paradigm because they take on new meaning in it (see Kraft 1996 on Form and Meaning).

Additionally, not every fact must be present, or even totally complete, to perceive the bigger pattern. Hiebert says that incomplete and estimated data is often enough to understand what is happening and thus suggesting that it is possible to use traditional elements in creating Christian responses in specific cultural contexts on condition that they are explicitly given new meanings (2008:318). The researcher proposes that nothing short of a paradigm shift, catalyzed by (biblical) transformation, can produce enduring HIV-risk behaviour change in Zambia. Zambia has a lot of men and women who claim to be Christians, but continue to engage in risky sexual behaviour, because their old ways and beliefs have not undergone paradigmatic transformation.

Lastly, it is critical that Christians offer a trustworthy alternative to current paradigms of the world. It is not enough to preach the gospel, but the lives that Christian workers live out must be exemplary so that they will draw people to an obedient relationship with God which in turn will alter their ethical perceptual worlds. Authentic worldview transformation from a Scriptural standpoint starts with repentance which in turn affects all behaviour—including effecting HIV-risk behaviour change. The paradigm shift sought for in Christian work is spiritual transformation. In other words, the researcher suggests that spiritual transformation (radical worldview transformation) is a critical foundation toward securing enduring HIV-risk behaviour change.

4.4 Ways of Transforming Worldviews

How then can a worldview be transformed? The researcher has shown in 4.3.3 above, that worldviews are transformable in two fundamental ways, namely, normal worldview change and a paradigm or worldview shift. In the normal worldview change, transformation of a worldview takes place when changes occurring on the level of conscious beliefs and practices over time percolate and precipitate change at the worldview level. This is the ordinary way by which a worldview is transformable. We have thus far termed it as normal worldview transformation.

The second way a worldview transformation happens is through radical change termed as a paradigm shift. Paradigm or worldview shifts occur when there is a radical restructuring in the internal configurations of the worldview itself to harmonize with the tensions between surface culture and the worldview. Consequently, paradigm or worldview shifts restructure the surface culture. The interaction between surface culture and worldview is two-way: conscious beliefs restructure worldviews, and worldviews shape conscious beliefs (Kraft 2004, Hiebert 2008). Ordinarily, transformation in Scriptural terms is thought as a radical paradigm shift. In the transformation described in the Bible, old sets of beliefs and practices are replaced with new ones. This kind of transformation entails turning from an old way of life and starting on a new way of life (cf. Romans 12:1-2; 2 Corinthians 5:17; Ephesians 4:17-24 etc.).

At the worldview level transformation alters the primary ways in which people arrange their view of reality. However, the majority of worldview

transformations are a continuing process in all individuals and societies. As emergent technologies are developed, people meet new experiences, and new concepts emerge, which affect subliminal worldviews. The researcher suggests that it is critical to see worldview transformation as a point, conversion⁶⁹, and as a process, unending deep discipling⁷⁰. Christian ministry therefore must seek radical worldview transformation to get enduring HIV-risk behaviour change in Zambia.

The researcher has surveyed the basic types of worldview transformation (normal worldview change and a paradigm shift), but what are the means through which a worldview can be transformed to effect enduring HIV-risk behaviour change? Hiebert (2008:318-320) proposes three primary means of transforming worldviews, namely, by examining them, by exposing them to other worldviews, and by creating living rituals. The researcher will evaluate these three means of worldview transformation against the backdrop of HIV-risk behaviour change in Zambia.

4.4.1 Transformation by Examining Worldviews

The first way of transforming worldviews is by examining them. Because worldviews are often subliminal the very first step toward transforming them is by 'surfacing' them (Hiebert 2008). Surfacing worldviews means that worldviews are consciously examined at the deep-culture level. Ordinarily the deep-seated assumptions are implicit and remain unexamined because they

⁶⁹ The researcher does not necessarily mean conversion to Christianity, but the process of cultural transformation whereby a society's worldview assumptions, values, and allegiances are changed both as a work of God and biblical education.

⁷⁰ This refers to the continuing ministry of Bible teaching (and obedience to that teaching) which begins at the point of conversion and continues for the rest of a person's life.

are regarded as givens. Examination of a society's worldview makes it possible to make explicit its underlying presuppositions, evaluations, and allegiances. Arnold (2005: viii) helpfully remarks:

Cultural assumptions are insidious, not necessarily because they are wrong, but because they are hidden and affect the way members of a culture see and interpret the world. Cultural assumptions affect what we see and what we believe is true, right and proper without question. They are so obvious to us that they seem universal and are seldom questioned unless they come in conflict with a set of assumptions from another culture. More frequently than not, we fail to recognize that the values and assumptions that drive our culture are not in the Bible....

Arnold makes an important observation on the dilemma of how to transform worldviews. The predicament with worldviews is that they are chiefly undisclosed, unexamined, and incontrovertible. It is especially hard to examine one's own worldview as it is difficult to think about what one's own criteria of evaluation. However, the researcher thinks that Arnold posits a crucially important starting point for worldview transformation.

Minority groups may be more knowledgeable about their own worldviews because they often stand in distinction to the dominant worldview (cf. Luzbetak 2000). It is not uncommon for dominant communities to deny that they possess a constructed worldview. They acknowledge without difficulty the established ways in which they live. They think well in their worldview but are unable to do so outside or against their worldview as they do not possess any other worldview through which to express their thoughts (see Hiebert 2008). Thus surfacing a worldview begins the process and act of examining a worldview toward paradigmatic change.

Worldviews provide people with an undeniable logic that things are truly the way they view them. The very absence of the knowledge of alternatives also entails that any challenge to a worldview threatens to bring chaos, and consequently, stirs up extreme anxiety. Through presenting dominant people groups with conscious alternatives which are reasonable, the legitimacy of the prevailing worldview is not only seen as less absolute, but also makes it lose something of its hold. Similarly, a challenge to the worldview is no longer a huge risk of chaos.

In Zambia, Christians must start by examining the worldview of their cultures in which they themselves live and how it shapes their thoughts. They need to compare their worldviews against a biblical worldview⁷¹ so as to transform theirs in light of the Bible. This worldview examination has not been happening in Zambia with the effect that Christianity seems to have become captive to Zambian culture. Kapolyo writes,

[African] processes of conversion are truly complex and when they occur they do so for a variety of reasons quite apart from the straightforward desire to follow another religion... African processes of conversion are fluid, and they also include processes of reconversion to religious practices socially present in the eras preceding the world religions... Fear, opportunities for commercial and political advancement, desire to create cohesion around a tribal identity, economic survival, all can play significant parts in the decision made especially by groups of people to convert from traditional beliefs to a world religion. Since core values change very slowly at the presuppositional philosophical level ... it takes a long time before “true” religion of the heart corresponds with what takes place at the expressive or surface level culture. In the intervening period we can expect to see a kind of localization of the new religion as expressive culture forms superficially change to correspond to the new-found faith. This is the case in much of Africa, where Christianity appears as a veneer thoroughly affected by the original African core values. “The Christian spiritual import,

⁷¹ Kraft (1996) doubts whether there is such a thing as biblical worldview, but the researcher uses the term to allude to a situation where a society has begun to subject their worldview to biblical values and commitments.

with its aim at bringing men to their ultimate goal in heaven may be a mere overcoat over traditional deep seated beliefs and customs leaving them undisturbed” (2007:36-37).

Kapolyo goes on to conclude that

This I believe is the reason why so often the church in Africa has been compared to a river two miles wide but a mere two inches deep! This is an admission of the failure of African Christianity to root into the foundational or deep cultural level of the host cultures on the African continent. Instead it has adopted surface cultural changes, such as singing Christian hymns (for a long time these could only be Christian if they were in the traditional western linguistic forms and idioms), meeting on Sundays, reading the Bible, adopting “Christian” names, forms of dress, taking communion , undergoing baptism and so on. I am suggesting that it is only by such attempt to take more fully into account African tradition perspectives on the human condition that Christianity in Africa will be able to live out a truly effective and enriching demonstration on biblical values within our African setting (2007:37)

Kapolyo thus pithily suggests that enduring worldview transformation in Africa will occur only if Christian ministry attempts to examine worldviews. In that sense, then, for as long as the in-depth perspective transformation is a none-event HIV-risk behaviour change will not occur. Kapolyo’s point is that for Christianity to take root in Zambia true change needs to happen at core values level (worldview). Kraft calls this type of change as “transformation cultural change” (1996), a sort of change which profoundly affects the worldview of a society and in turn affects all behaviour.

It is the researcher’s view that authentic Christian transformation demands a paradigm shift where God is known through Christ. Christ also replaces humanity or any other god as the focal point of people’s lives. Spiritual transformation is thus a radical shift, with far-reaching consequences which will take a lifetime to be completed. However, the starting point of this

transformation is when one makes Christ the Lord and centre of his or her life. However, a plethora of disparities between the new worldview and the old worldview must be worked out by examining the worldview.

4.4.2 Transformation by Exposure to Other Worldviews

Another way to transform worldviews is by exposing them to other worldviews. Kraft helpfully asserts, “In terms of its worldview, *a people organizes its life and experiences into an explanatory whole that it seldom (if ever) questions unless some of its assumptions are challenged* by experiences that the people cannot interpret from within that framework” (1996:56, emphasis his). People usually have their worldviews challenged when they are exposed to other worldviews. When people become aware of such a challenge in a realm they consider very important, the upshot can often be widespread demoralization (Kraft 1996:57). For example, Old Testament Israelites assumed they were “the People of God” (implying to them that God would always protect them, irrespective of how they related to Him). They were therefore demoralized when they were defeated in war and went into the Assyrian and Babylonian captivities (cf. 2 Kings, 2 Chronicles). They were only able to survive by developing a broader understanding of the close relationship between their faithfulness to God and His assistance in war. Thus, for the ancient Hebrews a process of worldview transformation begun to happen.

The process of exposure to other worldviews will inevitably involve a people’s stepping outside its own culture and viewing it from the outside so as to have

an outsider's perspective. Mezirow (1978:109) explains "Transformation in meaning perspective can happen only through taking the perspectives of others who have a more critical awareness of the psychological assumptions which shape our histories and experience. Cultures vary greatly in the opportunity for perspective taking."

The journey toward learning to see one's own culture is a long and hard one, but once entered upon; the initial reaction is to examine another culture through the lenses of one's own cultural presuppositions. When a person begins to study a culture and begins to discover, as an outsider, facets of people's worldview which they themselves do not know about. These facets are merely taken for granted as the way things are. Consequently, as people learn to view the world through the eyes of others and return to their culture, they return as "outsiders" and start to view their own culture with a new perspective (Hiebert 2008).

Since seeking HIV-risk behaviour change is a quest for deep-culture transformation it is important that worldviews are exposed to alternative worldviews. This process entails the examination of not only the worldview of people requiring behaviour change but also the messengers' own perceptual world. In one sense, the messenger must learn to view reality through the eyes of others, which will happen with exposure to other worldviews.

One other critical dimension of exposure to other worldviews is that Christians globally should endeavour to articulate a biblical worldview (Walsh and Middleton 1984). The church in any one culture appears to find it nearly

impossible to articulate a biblical worldview because it views the dominant worldview through one set of eyes. It is crucial that change agents (missionaries, theologians and church leaders) in any local culture engage in mutual dialogue to learn to see their own worldviews and also recognize alternative Christian responses and, in the process, to read the Bible in a new perspective aimed at transforming all worldviews. Chances are good that change agents will not be able to effect change in any worldview if they are not willing to examine them through dialogue with Christians of other cultures.

Through this dialogue all participants need to listen carefully to other Christians who tell them how they understand them. Although each group's first reaction will be to perceive that they are misunderstood, on more reflection each group will discover that others' views assist them see more clearly and helps examine their own worldview in the light of Scripture. This dialogue will entail sharing in love concerns about others worldview assumptions and requesting that they are re-examined in the light of Scripture. Together Christians in any locale need to develop credible biblical alternatives to the specific worldviews in which they find themselves. And in the process Christians become a transcultural community consisting of transcultural people, that is to say, people who can live in different cultures but whose real identity is progressively more that of an "outsider-insider" in all of them (cf. Hiebert 2008: 321-322).

By implication, then, Christians are to be salt in their locale, challenging human systems which are against the kingdom of God. Newbigin (Hiebert 2008: 322) astutely writes:

If I understand the teaching of the New Testament on this matter, I understand the role of the Christian as that of being neither a conservative nor an anarchist, but a subversive agent. When Paul says that Christ has disarmed the powers (not destroyed them), and when he speaks of the powers as being created in Christ and for Christ, and when he says that the Church is to make known the wisdom of God to the powers, I take it that this means that a Christian neither accepts them as some sort of eternal order which cannot be changed, nor seeks to destroy them because of the evil they do, but seeks to subvert them from within and thereby to bring them back under the allegiance of their true Lord....

The researcher posits that for Christians in Zambia to be able to transform their worldviews, they must engage in critical re-examination of their worldview with an outsider-insider view. This approach will assist in changing HIV-risk behaviour so intricately tied to their HIV infection predisposing sexual behaviours rooted in their worldview.

4.4.3 Transformation by Creating Living Rituals⁷²

A third approach for worldview transformation is by the “creation of living rituals” (Hiebert 2008:322). Contemporary Evangelicals in Zambia have a tendency of being anti ritual. The term “ritual” has negative connotations—meaning “dead meaningless forms of idolatry and magic.” However, in this connection, the question may be posed: “Are we not in danger of divorcing realities, forms, and meanings from signs and of reducing these elements to simple verbal communication?” :

⁷² Luzbetak (2000) when discussing how cultural change can occur through the diffusability of ideas accedes that creating rituals aids the process of change in a people's worldview. He writes, “Anthropology tells us that most easily diffused is the form, the symbol minus the meaning; less diffusible is the second level of culture, the function or meaning; most difficult is the third level of culture, the underlying premises, values, and drives” (Luzbetak 2000:358). Luzbetak (2000; 1975), thus, sees the notion of creating rituals as a possible means of aiding worldview change in order to achieve behaviour (cultural) change.

Given the anti ritual bias of contemporary Evangelicals, Christians in Zambia frequently fail to notice the significant role rituals play in worldview transformation. In the past, conversions took place at evangelistic meetings where new believers publicly declared that they were transformed in response to the Christian ministry. These public declarations might be seen as rites of transformation indicating the occurrence of radical paradigm shifts in their worldview. In New Testament period, conversions were followed by public baptisms where new believers professed their commitment to Christ before the world (cf. Acts 2). Currently the practice in many churches is that baptisms happen long after conversion and, in some cases, some pastors de-emphasize it such that their converts do not even seek it.

Consequently, the unfortunate emphasis being made in Zambian Evangelical circles is that conversion is “a private, individual matter—a change in heart in which there are few outward social and public symbols” (Hiebert 2008:323). In this connection, Christianity has been so ‘privatized’ that it has become of no public use. Hence, people ‘become Christians’ without knowing that their conversion has both moral and practical implications (Bruce 1983; Kapolyo 2005). The researcher posits that this overly internalized perception of conversion resonates with a Zambian worldview trait of maintaining clandestine multiple and concurrent sexual partnerships, also pervasive in sub-Saharan Africa. In turn, this culturally accepted trend has become a significant conduit of HIV transmission as the researcher has shown in chapter two above.

The researcher posits that Christians rethink the importance of suitable rituals to assist model and articulate their worldviews. For instance, Sunday worship services, Easter, and Christmas can serve as rites of intensification where Christians remember and reaffirm their worldviews. There is a pressing need to conquer Evangelicals' phobia for rituals. The solution to dead traditions and idolatrous rituals is not to shy away from all rituals, but to continually evaluate and re-create current Christian rituals to keep them alive, with the consequence that through their participation transformation will take place. In the absence of living rituals, there will be no appropriate means of affirming the deepest beliefs, feelings, and morals, which facilitate entry into a new lifestyle in a renewed society.

4.5 Conclusion

Having discussed the dynamics of worldview transformation for behaviour change, the researcher now summarizes the key findings and recommendations of chapter four. It is Imperative to note that cultural systems are merely a part of the system in the total comprehension of human beings. Cultural transformations do not happen in isolation. There is interaction between worldview transformations and other human systems. However, the basic finding of the chapter is that worldview transformation is essential to enduring HIV-risk behaviour change.

First, the researcher concludes that worldviews are 'storehouses' of profound shared assumptions and ways of viewing reality. As the expressive culture of a people group changes, the worldview (usually over a considerably long

period of time) is reshaped to conform to their beliefs and customs. This phenomenon is perhaps the most usual cause of worldview transformation. But, worldviews also profoundly affect cultures and the manner in which they change. Thus worldviews and surface culture are in constant interaction, and either can be the cause of change. This means then that worldviews and their expressive cultures are in constant conflict and change.

Second, enduring HIV-risk behaviour change occurs when change is in tandem with transformations in people's worldview. When HIV-risk behaviour change advocacy ignores the need for worldview transformation, the recipient culture will resist the proposed changes by a process of submersion (cf. Kraft 1996). As explained in section 3.5.2 above, submersion of culture is that tendency to adopt the peripheral (overt, external) form of the change and at the same time keeping essentially the same worldview inside. Submersion is an undesirable result of the transformation process since it means that the basic assumptions and commitments which fuel HIV-risk behaviour will be unchanged to the effect that people will persist in HIV predisposing behaviour all be it covertly. The researcher posits that behaviour change by submersion will be ephemeral as has been the case with most contemporary behaviour change theories and approaches in Zambia.

Third, since worldview transformation occurs in a human systems context, where every other area of people's milieu is impacted, Christian ministry toward HIV-risk behaviour change must aim for holistic transformation. The researcher thus posits that anything short of worldview transformation will not

suffice for enduring HIV-risk behaviour change as that will amount to mere outward modifications of people's old lives. Christian transformation is rooted in the biblical understanding that the Christian ministry aims at transformed lives. This transformation is both radical and entire. It entails changes at all tiers of cultures and their worldviews. More precisely, the message of the gospel is about human beings being transformed. Paul wrote to the church at Rome:

Therefore, I urge you, brothers and sisters, in view of God's mercy, to offer your bodies as living sacrifices, holy and pleasing to God—this is your proper worship as rational beings. Do not conform to the pattern of this world, but be transformed by the renewing of your mind. Then you will be able to test and approve what God's will is—his good and perfect will (Romans 12:1-2 TNIV).

The Evangelical practice of theology, in the context of a growing HIV epidemic, should not flinch from speaking of those transformed by the power of the gospel demonstrating to the world a new worldview. This will be a worldview with an eternal perspective to human behaviour and manifests itself in Christlikeness in this present world.

Fifth, and finally, Scripture teaches that Christians live in the world, but they are not to be of the world (cf. John 17). They are those who are transformed by the power of the gospel to illustrate to the world a new worldview. They are not called to fight the world or to flee from it, but to be like salt and yeast, bringing about transformation in the world (cf. Matthew 5:13-16; 13:33). Obviously, the 'Salt and Light' role of the church entails that the church is an advocate of HIV-risk behaviour change in Zambia.

One perpetual temptation Christians have faced over the centuries is to withdraw and create ‘Christian communities’ which have little or no impact on the world. On the other hand, Christians face the risk of becoming captive to the prevailing culture (worldview) that they lose the gospel and its transforming mission in the world (cf. Crouch 2008)—including a context of unrelenting HIV/AIDS epidemic. The church in Zambia has a crucial role to play in HIV-risk behaviour change through transforming worldviews of its peoples who are being decimated by the HIV and AIDS epidemic.

CHAPTER FIVE THESIS SUMMARY, PROSPECTIVE ISSUES, AND CONCLUSION

5.1 Introduction

This thesis set out to investigate how to change risky behaviour through transforming worldviews as a pastoral intervention to the spread of the HIV/AIDS epidemic with specific reference to Zambia. The study found that HIV-risk behaviour in Zambia is not merely attributable to limited knowledge of HIV transmission, but more due to deep-culture assumptions and commitments which support and facilitate the spread of the HI virus. The researcher contends that a society's worldviews regulates all its expressive behaviour including sexual expression. The researcher has posited that Zambia's deep-culture assumptions are largely responsible for its people's risky sexual behaviour. Therefore, for enduring HIV-risk behaviour change to happen, Christian ministry should aim at effecting change at the deep-culture level--the worldview.

Current research has found that the HIV/AIDS epidemic in Zambia has continued to grow chiefly through the heterosexual intercourse route (UNAIDS and WHO 2009; UNAIDS 2008; CSO et al.2002, 2003) entrenched in pervasive HIV Infection predisposing worldviews (Phiri 2008; Kapolyo 2007; Moyo 2009⁷³). Therefore it is undeniable that sexual behaviour change is

⁷³ Moyo (2009) in her PhD thesis entitled *'The influence of cultural practices on the spread of HIV/AIDS on the Zambian'* has shown that various rites of passage associated with birth, puberty, marriage and death may or may not increase the spread of HIV/AIDS in Zambia. Moyo urges the church to facilitate dialogue within society to devise culturally sensitive options to these detrimental cultural practices. The present researcher, however, posits that

central to winning the fight against the growth of the HIV/AIDS epidemic in Zambia.

According to the Zambia 2007 Demographic and Health Survey findings, HIV/AIDS awareness in Zambia is almost universal at 99 percent (CSO et al. 2009a:189), but knowledge of HIV prevention is lower at 69% (CSO et al 2009b:14). It seems that the lower HIV prevention knowledge level is attributable to deep-culture convictions which have resisted HIV-risk behaviour change. For instance, a study to assess health workers' (that is, physicians, nurses, clinical officers, and paramedics) HIV-risk taking behaviours and status awareness in five Zambian hospitals found that HIV behaviour was the same as in the general population (Kiragu et al. 2007). Kiragu and colleagues (2007) found that in spite of Zambian health workers' scientific knowledge and training, their cultural beliefs, attitudes, and practices toward HIV were the same as the general population and influenced their sexual risk-taking behaviour. Kiragu and colleagues (2007:131, emphasis added) write, "Even though they may be a somewhat privileged group, health care professionals are still products of the communities they reside. They are women and men first, and as such experience *the same cultural values*. ...as the clients they are expected to counsel or treat." Kiragu and colleagues' (2007) findings establish the preponderance of the influence of worldview over mere HIV knowledge in HIV-risk taking in Zambia. Kiragu and colleagues, however, do not see the importance of transforming worldviews for behaviour

Zambia's intra-society dialogue has been inadequate to stem the spread of the HIV/AIDS epidemic. Rather concerted efforts should be made to transform worldviews in order to secure enduring HIV-risk behaviour change.

change as an intervention to the spread of HIV/AIDS Zambia. They merely conclude that health professionals in Zambia “too should be an important audience for behavior change intervention and HIV/AIDS services” (2007:135). The present researcher, however, contends that enduring HIV-risk behaviour change will happen when interventions aim at transforming worldviews—the deep-culture level—which support HIV-risk behaviour in Zambia. Therefore it is indubitable that the battle against the spread of HIV and AIDS in Zambia will only be won when radical changes in sexual behaviour occur at the worldview level.

The Global HIV Prevention Working Group (PWG) unequivocally asserts the centrality of behaviour change to the eventual reversal of the HIV/AIDS epidemic in these words:

Wider delivery of effective behavior change strategies is central to reversing the global HIV epidemic. The availability of new biomedical HIV prevention modalities, such as vaccines and microbicides, is still many years away. Even when these tools finally emerge, human behavior will remain critical, as new prevention strategies are unlikely to be 100 percent effective in preventing transmission....Human behavior is complex; widespread behavior changes are challenging to achieve; and there are important gaps in our knowledge about the effectiveness of HIV prevention. Yet the research to date clearly documents the impact of numerous behavioral interventions in reducing HIV infection. We also know that in all cases in which national HIV epidemics have reversed, broad-based behavior changes were central to success (PWG 2008:4).

As long as behaviour change does not happen, the HIV/AIDS epidemic will be with us for a long time to come. However, PWG rightly acknowledges the existence of a wide variety of effective behaviour change strategies. The question now is whether or not these strategies are working.

Another key aim of this study has been to investigate how the Church in Zambia can effectively facilitate behaviour change by transforming worldviews as a pastoral intervention to the growth of the HIV/AIDS epidemic. No doubt the church in Zambia has been known to care for PLWHA, but its' contribution to preventive work appears not to have received much international support (Green 2003). The present study intends to encourage churches in Zambia to be more involved in HIV prevention work through engaging Zambian cultural worldviews.

Consequently, the researcher sought to design a praxis model to engage cultural worldviews from a biblical standpoint to alter intrinsic cultural traits which predispose many Zambians to HIV infection. The researcher argued in chapter three that authentic and enduring HIV-risk behaviour change in Zambia is feasible when transformation occurs at the worldview level—the seat of sexual beliefs, attitudes, and practices. The present chapter of this work summarizes and concludes the arguments and findings of chapters one to four and seeks to make suggestions for doing transformative theology against a backdrop of a growing HIV and AIDS epidemic in Zambia. Hence, the researcher will summarize salient findings of the thesis, highlight prospective issues for further investigation, and state the critical conclusions of the study.

5.2 Synopses of Chapters

5.2.1 Synopsis of Chapter One

Chapter one hypothesized that the message for HIV-risk behaviour change in Zambia is not succeeding because it seems to be ignoring the need to change culturally entrenched sexual beliefs, attitudes, and practices of most people. The researcher argued that key traditional (sexual) practices and customs, supported by a pervasive worldview, have not helped the cause to decelerate the growth of the HIV/AIDS epidemic (NAC/Zambian MoH 2002; HRW 2002; Loosli 2004; Ndhlovu 2007; etc.). The study is cognisant of the fact that it is not these practices and customs in and of themselves which are flawed, but the values, assumptions and beliefs (worldview) underlying them 'defy' behaviour change as contemporary HIV messaging in Zambia aims at changing the surface culture (Kiragu et al 2007; Dwelle 2006; Ntseana & Preece [Undated]).

This researcher argued that in order to contribute to the success of efforts toward the deceleration of the HIV/AIDS epidemic in Zambia, evangelical Christians doing theology, should aim at transforming worldview assumptions which rationales HIV predisposing behaviour. That HIV/AIDS education is a worthy and beneficent factor to the cause of HIV-risk reduction in Zambia is indisputable. However, although HIV/AIDS knowledge is almost universal in Zambia, it has not induced ample HIV-risk behaviour change to beat back the spread of the epidemic. This research presupposes that behaviour change is not happening in Zambia, in spite of multispectral, concerted, and often well meaning efforts, because of conflicting messages for behaviour change at the

deep-culture level. In short, chapter one of the research hypothesized that a significant solution to the dilemma of HIV-risk behaviour change in Zambia lies in the Church embracing a praxis which aims at the transformation of worldviews.

5.2.2 Synopsis of Chapter Two

Chapter two established that doing theology in the context of a growing HIV/AIDS epidemic entails that Christians interface with contemporary theories and models of HIV-risk behaviour change to inform praxis. This is based on the premise that Christians will acquaint themselves with the existing behaviour change theories in the quest for enduring HIV-risk reduction.

Chapter two also established that whereas some modest gains toward decelerating HIV incidences were happening among the minority well-educated sections of Zambia, similar gains were still not taking place among the majority, that is, the most deprived and less-educated groups of the populace. The researcher observed that this state of affairs, where HIV-risk behaviour is persisting among the poor majority, integrally seems to be attributable to a subtle adherence to deep-rooted cultural and traditional influences; values, norms and practices which they find hard to relinquish (Kapolyo 2005, Phiri 2008). Additionally, due to the fact that most contemporary HIV reduction interventions in Zambia, such as the social marketing of condoms, appear to be in haste to change surface behaviour, the deep culture has remained unchanged. The researcher posits that the

‘neglect’ of worldview transformation in the quest toward HIV-risk behaviour change in Zambia has severely impaired the cause for reducing the spread of HIV infection.

As a consequence, chapter two suggested that interventions to check the growth of the HIV/AIDS epidemic in Zambia should not only target individuals, but also aim at changing those facets of cultural and socioeconomic factors which heighten vulnerability to HIV infections (cf. Buve et al. 2002, Inungu et al. 2006).

Four crucial conclusions emanated from chapter two. First, doing theology amidst a generalized HIV/AIDS epidemic in Zambia implies that Christians should not remain passive and indifferent toward initiating HIV-risk behaviour change. This inference posits that the task of doing theology amid a growing HIV/AIDS epidemic in sub-Saharan Africa entails advocating HIV-risk behaviour change. It is also 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 (such as HIV education which fails to change worldviews) are inadequate to produce authentic HIV-risk behaviour change. Enduring HIV-risk behaviour change will only happen when it comes from “inside out” (Crabb 2006) i.e. first the transformation of individuals’ worldview on sex and sexuality will produce enduring HIV behaviour change. The researcher concludes that authentic HIV- risk behaviour change is essentially a change of heart (cf. Proverbs 4:23)—the seat of a person’s emotions, knowledge, conscience and moral

character (Vine 1996:108-109)—all crucial aspects of an individual's worldview.

Second, chapter two found that cultural, economic, and historical factors do converge to accelerate the spread of HIV/AIDS in Zambia. The present researcher holds that while the effects of HIV and AIDS in sub-Saharan Africa are overwhelming, the fight toward HIV-risk behaviour change is not a lost cause. As PWG astutely state,

To be more effective in the 21st century, the HIV prevention effort must confront several challenges of perception: misplaced pessimism about the effectiveness of behavioral HIV prevention strategies; unfortunate confusion between the difficulty in changing human behavior and the inability to do so; and misperception that because it is inherently difficult to measure prevention success—a “nonevent”—prevention efforts have no impact.... (2008:4).

The researcher agrees with the PWG's (2008) position that HIV-risk behaviour change is achievable no matter the challenges of misunderstandings associated with it.

Third, chapter two of the thesis has also discussed and demonstrated that the social theories of behavioural change have recorded laudable successes and are not in fundamental conflict with the task of doing theology amid a growing HIV/AIDS epidemic. The researcher is of the opinion that the social theories of behaviour change are valuable and that Christians should not ignore them in their quest for enduring HIV-risk behaviour change, but must constantly remember that they are surface culture level efforts at best.

And fourth, chapter two has established that HIV prevention knowledge in Zambia is higher among those with higher levels of education (CSO et al. 2009:14; cf. Fylkesnes et al. 2001; Buve et al. 2002), which poses an HIV risk-reduction conundrum since the poor happen to be 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 majority Zambians, who also happen to be stricter adherents of traditional values, customs, and practices. These traditional ways of life are supported by deep-culture assumptions (worldview). Chapter two discussed examples of HIV infection predisposing cultural and socioeconomic practices in Zambia (see Section 2.4.1 above). The researcher holds that HIV-risk behaviour in Zambia is mainly being fuelled by deep-culture level values, norms, and convictions (all held together by the worldview). Therefore, it is the researcher's opinion that the quest for lasting HIV-risk behaviour change will integrally entail strategic interventions to effect worldview transformation.

5.2.3 Synopsis of Chapter Three

Chapter three of the study explored the connection between a people's worldview and HIV-risk taking behaviour to discern the pastoral implications of worldview transformation on behaviour change. The researcher found that the worldview of any society profoundly influences their expressive behaviour (including culturally-prescribed sexual behaviour). The researcher noted that the sexual behaviour of majority Africans is strongly connected to their

worldview (cf. Mbiti 1989). Consequently, the Christian worker should consider the worldviews of Zambians seriously, not because they concur with them, but because they want to understand them (Hiebert 2008) and hence have a better chance of effectively reaching them with a message of behaviour change (Dwelle 2006) which will translate into enduring HIV risk reduction. Kraft (2004:388) ardently holds to the position that “Significant culture change is always a matter of changes in the worldview.” The researcher posits that this is the case for HIV-risk behaviour in Zambia: to change HIV-risk behaviour changes must occur in the worldview.

The researcher contends that evangelical Christians in Zambia have little or no chance of facilitating enduring HIV-risk behaviour change unless they are willing to become serious students of their people’s worldview. It is from this vantage point that a relevant and effective approach to transforming the now pervasive HIV-infection predisposing worldview. Therefore, the researcher posits that lasting HIV-risk behaviour change will only occur when HIV/AIDS prevention in Zambia aims at transforming worldviews which support HIV-risk behaviour.

The researcher further noted in chapter three that often HIV prevention conversation occurs at the surface-culture levels (where efforts are made to ‘force’ change of behaviour without paying attention to people’s core culture—values, norms, and assumptions), but if worldviews are not transformed, the message for behaviour change will be misinterpreted and hence rendered ineffective for behaviour change. Dwelle precisely makes the

same point when he asserts that traditional public health messaging and social marketing fails to effectively achieve lasting behaviour change because it ignores “cultural communication” (cf. Dwelle 2006). Dwelle understands “cultural communication” as communication which engages the worldview with the aim of changing it to produce “permanent changes of high risk behaviours.” The much popularized Social Marketing for HIV prevention seems not to mind what its target people think or feel, but merely want to see ‘behaviour change’ whether or not the change is consistent with their core culture. Cultural communication is that communication which targets to transform people’s core culture (the worldview) to change expressive (surface) culture. Kraft insightfully asserts;

A worldview is seen as lying at the heart of every cultural entity (whether a culture, subculture, academic discipline, social class, religious, political or economic organization, or any similar grouping with a distinct value system). The worldview of a cultural entity is seen as both the repository and the patterning in terms of which people generate the conceptual models through which they perceive of and interact with reality. I suggest that the basic appeal for ...whatever conceptual transformation... is to be made at the worldview level (Kraft 2005:43).

The researcher contends that the very possibility of transforming people’s worldviews opens the door of possibility to securing enduring behaviour change toward curbing the growth of HIV and AIDS in Zambia.

5.2.4 Synopsis of Chapter Four

Chapter four of the thesis investigated the nature and necessity of worldview transformation which is able to lead to enduring HIV-risk behaviour change in Zambia. The researcher established that there are chiefly two types of worldview transformation: the normal worldview transformation and “paradigm

shifts” (Kuhn 1975). Because culture is dynamic, changes in any worldview are constantly occurring (Luzbetak 2000; Kraft 1996; Hiebert 2008). Therefore, in a constantly changing culture tensions between surface beliefs (and between the ideologies themselves) and the underlying worldview cause incremental changes in ideologies and worldviews. This incremental dynamism of worldview/culture change often occurs imperceptively—with subliminal disturbances in the culture since integration happens within minimal lapses of time (cf. Luzbetak 2000). As a consequence new understandings lead to new ways of looking at life. For instance the development of new understandings of pharmacology may lead to new medicines and medical procedures and the way people handle illnesses (Hiebert 2008).

The researcher agrees that worldviews are constantly changing in tandem with the changes happening at the surface level of culture. This dynamic is what is termed as normal worldview transformation. The researcher further notes that normal worldview change has been happening in response to surface culture changes from the impact of the HIV/AIDS epidemic. For example, the Tonga speaking people of the Chakankata area in South Zambia have modified their widow inheritance rituals by excluding sexual intercourse and the ritual itself is becoming rarer (Lucas 2004). But HIV-risk behaviour, such as polygamy and the subtle multiple and concurrent partnerships, are still alive and well across all Zambian tribes (Kiragu et al. 2007; CSO et al 2009). Some tribes like the Tonga of Southern province are more open about it while other tribes (including the Bembas to which the

researcher belongs) are very clandestine about it (Phiri 2008, Kapolyo 2007, Kiragu 2007).

The second type of worldview transformation is what Thomas Kuhn coined as “paradigm shifts” (Kuhn 1970). Paradigm shifts are worldview changes where radical reorientations of underlying assumptions occur. Mezirow (1978) calls this type of worldview change as “perspective transformation.” In a paradigm shift people not only react to their own reactions, but they do so in a radical way in order to change an anomaly in their context.

In a word, a paradigm shift is a type of worldview change of colossal nature which transforms the way a person or community sees life and conducts itself at the surface culture level. The researcher has observed that nothing short of a paradigm shift can change HIV-risk behaviour in Zambia. Therefore, the researcher posits that only the second type of worldview transformation (“paradigm shifts”) would amply effect HIV-risk behaviour change.

Additionally, chapter four investigated ways of securing worldview transformation in Zambia. The researcher (after Hiebert 2008) proposed that the Zambian worldview is transformable by three crucial ways: first, through examining them, second, by exposing them to other worldviews, and third, by creating living rituals to entrench a biblical worldview. The researcher also posited that the only transformation able to yield enduring HIV-risk behaviour change is the transformation as envisaged in the Bible. The Bible’s view of transformation is basically relational—that is to say—a person or a nation (cultures) may either stand in obedience towards God or against Him (see

4.2.1.3 above). There is no middle ground when relating to the God of the Bible. Hence the researcher thinks that when the Bible speaks of transformation it anticipates a changed worldview in which repentance has taken place and a relationship of allegiance to God in all of life is being actively pursued (cf. Romans 12:1-2). In a word, then, the concept of transformation in the Bible fundamentally means genuine repentance on the part of an individual or an entire society. Erickson (2002:948) supports this idea when he writes:

The type of genuine repentance that humans are to display is more commonly designated by the word... [shuv]. It is used extensively in the prophets' call to Israel to return to the Lord. It stresses the importance of a conscious moral separation, the necessity of forsaking sin and entering into fellowship with God.

Moreover, it is the researcher's view that Biblical transformation is both instantaneous and progressive as Paul explained to the Corinthians,

But whenever anyone turns to the Lord, the veil is taken away. Now the Lord is the Spirit, and where the Spirit of the Lord is, there is freedom. And we, who with unveiled faces all reflect the Lord's glory, are **being transformed** into his likeness with ever-increasing glory, which comes from the Lord, who is the Spirit (2 Corinthians 3:16-18 NIV, emphasis added).

The plain meaning of this Bible passage is that transformation has occurred in an individual's life at conversion ("...whenever anyone turns to the Lord...") and that individual is continuing in the way of obedience ("...are being transformed into His likeness...") to the Lord. The sentence "But when anyone turns to the Lord, the veil is taken away" is referring to a person (Jew or Gentile) who repents and believes in the Lord. By implication, Paul is saying that when a person becomes a Christian, he or she is transformed at the worldview level and embarks on a life-long path of transformation as he or she

continues being a disciple of the Lord Jesus. The way of obedience to the Lord is a process of ongoing transformation in the Christian's life becoming more Christlike. As Kruse rightly elucidates, "Believers, those who have turned to the Lord, have the veil removed from their minds (16), and so *with unveiled faces* they reflect (or perhaps contemplate) the glory of the Lord, and in so doing *are being transformed into his likeness* (18)" [2004:1196, emphasis his]. Thus the present researcher holds that, from a biblical standpoint, worldview transformation is both an instantaneous and progressive experience in a person's life.

However, it is imperative to note that worldview transformation does not happen in a vacuum. Worldview systems are merely a part of the system in the total comprehension of human beings (Kraft 1996). As a consequence, worldview/culture transformations do not happen in isolation. According to systems thinking⁷⁴, "change in one part produces change in another part, even the whole" (Steinke 1996: 4). Undoubtedly, there is interaction between worldview transformation and other human systems. How precisely, then, does cultural transformation affect personal, social, biological, and physical realities? Most importantly, in which way does cultural transformation affect spiritual realities?

⁷⁴ Steinke says, "Systems thinking is basically a way of thinking about life as all of a piece. It is a way of thinking about how the whole is arranged, how the relationships between the parts produce something new" (1996:3). The researcher understands worldview transformation for HIV-risk behaviour change from a systems approach perspective where Christian ministry proactively intervenes in the HIV infested milieu to curb the spread of the epidemic.

Arguably, then, worldview transformations do not happen in isolation from other human systems, but often may occur when surface culture changes are ‘imposed’ on any people group. In such a case of “forced change” (Kraft 1996) worldview changes tend to be ephemeral and the recipient culture latently resents the ‘interruption’. Kraft perceptively cautions that “effective transformational change should try to *encourage a minimum number of critical changes in the worldview*, rather than a large number of peripheral changes. Peripheral changes...are more likely to prove hindrances than helps to true Christian transformation” (Kraft 1996:282, emphasis his).⁷⁵

Since, any people group’s culture and worldview can be impacted by changes from other human systems; the present researcher argued that when people experience the transformation recommended by the Bible there will be a good chance of succeeding at effecting HIV-risk behaviour change (cf. Ezeokana et al. 2009). Therefore, the present researcher posits that enduring HIV-risk behaviour change will only occur when pastoral interventions aim at holistically transformed lives, not merely some modifications of people’s ‘old lives’.

When chapter four of this thesis alludes to holistic individual or societal transformation, it anticipates spiritual transformation from a Biblical perspective. Spiritual transformation is rooted in the biblical understanding that the gospel aims at transformed lives—changed relationships with God

⁷⁵ One example of a ‘forced’ change in the Zambian cultural ‘wiring’ on sexual behaviour has been the social marketing of condoms which has been misunderstood to aim at curtailing procreation and sexual pleasure (see discussion in chapter two on cultural misunderstandings on the condom).

and others in tandem with a life-view which seeks to honour God. That Biblical transformation is both radical and total. It entails changes at all tiers of expressive cultures and their worldviews. The Evangelical practice of theology, in the context of a growing HIV epidemic, then, should not flinch from speaking of those transformed by the power of the gospel demonstrating to the world a new worldview. This will be a worldview with an eternal perspective to human behaviour and manifests itself in Christlikeness in this present world.

5.3 Prospective Issues

The social theories of behaviour change have recorded commendable successes, especially in developed countries where they were formulated (cf. King 1999). However, the generality and progress of the HIV/AIDS epidemic in sub-Saharan Africa makes much of these theories difficult to implement, monitor, and evaluate for effectiveness. Theoretically, they do provide a point of departure for formulating context-specific responses toward HIV-risk behaviour change, such as was the case for Uganda where HIV-risk behaviour change occurred to reverse HIV prevalence. The researcher recommends that the task of doing theology against the backdrop of a growing HIV/ AIDS epidemic be done without ignoring insights from behavioural sciences. However, more study is required to discern how most of these theories can work in an African context (and Zambia in particular).

The researcher further recommends the transformation of HIV/AIDS predisposing cultural practices. The real task of transforming HIV predisposing

socio-cultural and traditional practices will be accomplished when the owners of the cultural practices are first transformed and equipped with a biblical worldview to guide them in the process of changing their worldview. At the end of the day, the researcher posits that Christians in Zambia must begin to own the responsibility of transforming their worldview which is the bedrock of HIV-risk behaviour. Therefore, the call to worldview transformation is a call to humility because all people judge others' cultures through their own. So when behaviour change agents are confronted with the flaws of their own culture/worldview, they tend to want to 'defend' it. Hence there has to be humility both on the part of the change agents and the recipients of the novelty (Kraft 2005; Crouch 2008).

The researcher posits that when pursuing transformation of worldviews a very important precaution must be taken so that transformation agents do not fall into the downside of foundationalism—that school of thought which simplistically holds that worldviews are the 'engines' which drive people's expressive culture. On the contrary, this study has shown that worldviews are people's 'storehouses' of profound shared assumptions and ways of viewing reality. As the expressive culture (behaviour) of a people group changes, the worldview (usually over a considerably long period of time) is reshaped to conform to their beliefs and customs. The case in point for the change of behaviour in HIV/AIDS is that it is already known that certain worldview assumptions are responsible for Zambians' 'moral hesitancy' to embrace HIV-risk reduction initiatives. It is imperative, therefore, that these worldview assumptions are examined (exposed) and targeted for transformation with

intentionality. The researcher contends that evangelical Christians be encouraged to speak out on the reality of spiritual transformation as crucial to enduring HIV-risk behaviour change. Green (2003) supports such an evangelical approach. Green (2003:19) astutely notes that “although FBOs have been encouraged to play a stronger role in HIV prevention in the last several years, a conflict remains in many countries between taking a medical or ‘realistic’ approach to AIDS prevention (and to behavior change specifically), and taking a religious or “moral” approach.” The conflict envisaged by Green is equally ideational (perceptual) and presupposes that Christians are ever condemnatory in their approach to HIV prevention.

However, the researcher accedes that the legitimacy of the link between dirtiness, sin, and an HIV positive status appears to be unsettled (cf. Hlongwana and Mkhize 2007; van Wyngaard 2006) and doing practical theology in a context of the epidemic will require a lot of sensitivity to this issue. The researcher’s view here is that people living with HIV/AIDS should not be stigmatized with the perception that being HIV positive means being the ‘worst of sinners’ (cf. Romans 3:9-12, 23). Rather, the quest for behaviour change as an HIV preventive approach is not typically an accusation of promiscuity. The researcher recommends that further study be done on the relationship between HIV-risk behaviour change and the biblical teaching of humans’ sinfulness.

5.4 Conclusion

The nature of the Church prescribes the mission in any particular context. Hughes (2010:44) pithily describes the church as “a transformed and

transforming society.” Therefore, the nature of the church as a transformed community means that its members have experienced radical transformation in their way of life, including HIV-risk behaviour change.

The Christian church has the dual task of reconciling people to God (Matthew 28:16-20; 2 Corinthians 5:19f), the evangelistic mandate, and exercising stewardship of His creation (cf. Genesis 1:26-27), the cultural mandate. The church, therefore, has no option but, along with spreading the gospel, to show compassionate care of people in affliction—including PLWHA. It is the researcher’s view that preaching the gospel without exercising mercy ministry is a contradiction of terms (cf. Matthew 25:31-46).

The task of preaching the Gospel is about transformed lives. The message of the gospel is basically an invitation to a whole new life-way, not merely to some adjustments of people’s old lives. The change given through the gospel is radical and entire. It entails changes in all spheres of culture (physically, biologically, psychologically, socially, and spiritually)—including people’s worldviews. God does this transformative work in all people who choose to follow Him.

But also the gospel is concerned with the transformation of the lives of the messengers—the agents of change. Paul wrote to the Christians at Rome emphasizing the centrality of this issue to Christian service: “Therefore, I urge you, brothers and sisters, in view of God’s mercy, to offer your bodies as living

sacrifices, holy and pleasing to God—this is your proper worship as rational beings. Do not conform to the pattern of this world, but be transformed by the renewing of your mind. Then you will be able to test and approve what God's will is—his good, pleasing and perfect will” (Romans 12:1-2 TNIV). Transformation is therefore a continuing characteristic of being an HIV-risk behaviour change advocate.

Finally, the Bible is unequivocal in teaching that although Christians live in the world; they are not to be of the world (cf. John 17). Christians are those who are transformed by the power of the gospel to illustrate to the world a new worldview. They are not called to fight the world or to flee from it (Crouch 2008), but to be like salt and yeast, bringing about transformation in the world (cf. Matthew 5:13-16; 13:33). It is an inescapable observation of church history that one unending temptation Christians have faced throughout the years is to cloister and create ‘Christian communities’ which have little or no impact on the world. On the other hand, Christians face the constant danger of becoming enslaved to the prevailing culture (worldview) that they lose the gospel and its’ transforming mission in the world (cf. Crouch 2008). The researcher posits that the task of decelerating the spread of HIV/AIDS in Zambia (and the rest of sub-Sahara) is also a call to encouraging HIV-risk behaviour change through transforming the worldviews which have entrenched all HIV predisposing behaviour.

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