Empowering Church-Based Communities

For Home-Based Care: A Pastoral Response to

HIV/AIDS in Zambia

Mulenga, K.C.

EMPOWERING CHURCH-BASED COMMUNITIES

FOR HOME-BASED CARE:

A PASTORAL RESPONSE TO HIV/AIDS IN ZAMBIA

BY

Kennedy Chola Mulenga

Submitted in partial-fulfilment of the requirements of the degree

MAGISTER ARTIUM

In the Faculty of Theology, University of Pretoria
The study was done through the Cape Town Baptist Seminary

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

November 2007

DECLARATION OF AUTHORSHIP

I declare that the thesis which I am submitting to the University of Pretoria for the degree Magister Artium has not been submitted by me to any other university for degree purposes, and I am aware that, should the thesis be accepted, I must submit additional copies as required by the relevant regulations at least six weeks before the next graduation ceremony, and that the degree will not be conferred if this regulation is not fulfilled with.

SIGNATURE: _____DATE: _____

ACKNOWLEDGEMENTS

Table of Contents

List of Figures

List of Tables

List of Acronyms

AIDS	Acquired immune-deficiency Syndrome
ANC	Antenatal Clinic
ART	Anti-retroviral Therapy
ARV	Anti-retroviral
CHBC	Community Home-Based Care
DOTS	Directly Observed Treatment Short-Course
HIV	Human Immunodeficiency Virus
HRW	Human Rights Watch
MAP	Multi-Country HIV/AIDS Program for Africa
MoH	Ministry of Health
MTCT	Mother To Child Transmission
NAC	National HIV/AIDS/STD/TB Council
NGO	Non-Government Organization
NIV	New International Version
PLWHA	People Living With HIV/AIDS
PVA	Poverty and Vulnerability Assessment
SARPN	Southern African Regional Poverty Network
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on AIDS
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
ZDHS	Zambia Demographic and Health Survey

Chapter One
Introducing the Research

1.1 Formulating the Problem

1.1.1 Introduction

As a pastor in Lusaka, Zambia, the researcher often came across HIV/AIDS related deaths affecting members of his congregation both directly and indirectly. The researcher served a community where HIV/AIDS related afflictions and deaths were not uncommon. In the early 1980s the majority of evangelical Christians in Zambia perceived HIV/AIDS as a disease exclusively affecting non-Christians, especially people who were deemed sexually promiscuous. HIV/AIDS carried such a strong stigma that it was a subject which was not openly talked about in evangelical Christian circles in Zambia. This stigmatization tended to make many evangelical Christians shy away from people afflicted by HIV/AIDS. HIV/AIDS was understood as a problem for non-Christians alone.   It is, however, lucid today that HIV/AIDS is a disease that knows no religious identity. Christians and non-Christian alike are affected (being infected and affected) by the disease. Undoubtedly HIV/AIDS is present in the church as well. Further it is generally accepted as fact that HIV/AIDS is not just a moral issue, but a critical health problem needing practical and relevant interventions to check both its spread and alleviate the suffering of over of 1.1 million people living with HIV and AIDS in Zambia (UNAIDS/WHO 2006 report on the Global Epidemic: 487). Since a cure for HIV/AIDS is not in sight yet, evangelical churches in Zambia have no option but to be involved in mitigating the impact of the epidemic. It is the position of this researcher that evangelical Christians in Zambia are optimally gifted to ameliorate the affliction of Christians and non-Christians living with HIV and AIDS[1].

---

[1] Evangelical Christians in Zambia are erroneously deemed to assume a position of non-involvement in HIV/AIDS interventions because they do not support the manner in which the public media promotes condom use as a 'foolproof' method of preventing HIV infection.

1.1.2 A Brief History of Zambia

Dzekedzeke and Mulenga (ZDHS 2003:1) say that history and archaeology show that by the year 1500, much of modern Zambia was occupied by Bantu-speaking horticulturalists. These farming people are identified as ancestors of Zambia's present inhabitants. By the end of the nineteenth century, diverse parts of what was to become Northern Rhodesia were administered by the British South Africa Company[2]. In 1924, the British Imperial Office took up the onus of administering the region, and in 1953, Northern Rhodesia (Zambia) and Southern Rhodesia (Zimbabwe) united with Nyasaland (Malawi) to form the Central African Federation of Rhodesia and Nyasaland, despite the opposition of Northern Rhodesia's natives. This Federation disbanded in 1963. In October 1964, Zambia became a politically independent republic and adopted a multiparty system of government. However, for what was to be a threat to national unity and peace in December 1972, Zambia embraced a one-party style of governance. In November 1991 multi-party politics were restored through a popular vote by Zambians. Currently Zambia is a multiparty democratic state (ZDHS 2003).

1.1.3 The Geography of Zambia

Zambia is a landlocked country covering an area of 752,612 square kilometres (approximately 2.5 percent of Africa). It is surrounded by eight other countries. It shares borders with the Democratic Republic of Congo (DRC) and Tanzania in the north; Malawi and Mozambique in the east; Zimbabwe and Botswana in the south; Namibia in the southwest and Angola in the west. Zambia

---

[2] The British South Africa Company was founded by Cecil Rhodes (and granted a royal charter) in 1889 to facilitate the colonization and economic exploitation of most of south-central Africa as a part of the "Scramble for Africa" (http://en.Wikipedia.org/wiki/British_South_Africa_Company, Accessed on 25 Oct 07).

has nine provinces (Lusaka, Copperbelt, Central, Eastern, Northern, Luapula, North-Western, Western and Southern) and 72 districts. Two of these nine provinces are predominantly urban, namely Lusaka and Copperbelt. The rest of the provinces—Central, Eastern, Northern, Luapula, North-Western, Western and Southern—are primarily rural provinces. More than a quarter of Zambia's estimated population of 11,668, 000 (UNAIDS/WHO 2006 report on the Global Epidemic: 487) live in two of these urban areas. The rest of Zambia is very sparsely populated, especially the west and the north-east regions of the Country.

The country lies between 8 and 18 degrees south latitudes and between 20 and 35 degrees east longitudes. Zambia has a tropical climate and vegetation with three separate seasons: the cool dry winter from May to August, a hot dry season during September and October and a warm wet season from November to April. Zambia has four main rivers—Zambezi, Kafue, Luangwa and Luapula. The country also has major lakes such as Tanganyika, Mweru, Bangweulu and the man-made Kariba. Figure 1.1 below is a map of the republic of Zambia showing the country's neighbours. The small square insert below the map shows the location of the country on the
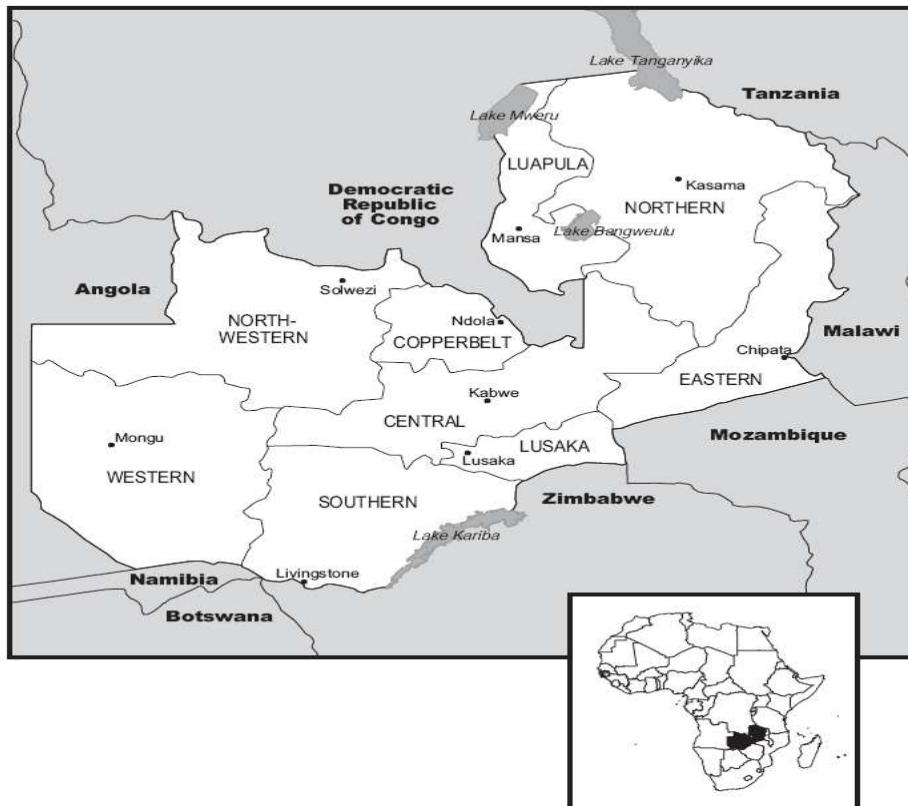
ZAMBIA

Figure 1.1 Map of Zambia [Source: ZDHS 2001-2002 2003: xxvi]

1.1.4 The Economy of Zambia

Zambia has a mixed economy made up of two sectors: a modern urban sector that, geographically, can be found along the line of rail traversing the country from north to the south, and a mainly rural agricultural sector. For a long time, the modern sector was operated by government controlled corporations, while private businesses had dominance in the construction and agriculture sectors. However, with the country's return to multiparty politics in 1991, a liberal market-oriented economy was incepted. Government owned enterprises were sold into private hands and, in some instances, liquidated. Copper mining is the country's main economic activity, accounting for 95 percent of export earnings and contributing 45 percent of government income during the first decade of

independence (1965-1975). But in the mid-1970s following a sharp decline in copper prices and a sharp rise in world oil prices, Zambia's economy deteriorated. Efforts to reduce reliance on Copper exports by diversifying the economy through the formation of import substitution government-owned business enterprises did not check the economy's 'free fall'. In the 1980s the International Monetary Fund (IMF) and World Bank sponsored Structural Adjustment Programmes (SAP) were introduced in a stagnating economy. The structural adjustment programmes did not yield economic prosperity, but only increased the poverty of majority Zambians (see Weeks & McKinley [2006]). Today Zambia is said to be one of the poorest and least developed nations on earth[3]. Poverty has been identified as a serious hindrance to the fight against the HIV/AIDS epidemic (ZDHS 2003).

1.1.5 The HIV/AIDS Epidemic in Zambia

HIV/AIDS has rapidly spread throughout Zambia since the first reported case of AIDS in 1984 (Haworth, A et al. 2001:11, NAC/Zambian MoH 2002). Today there is virtually not a part of Zambian society which remains unscathed by the epidemic. The most vulnerable groups to the HIV/AIDS epidemic are young women and girls (NAC/Zambian MoH 2002, WHO 2005b, etc). It is also significant to note that the disease has worst struck men and women in their most productive years (15-49 years). As families have disintegrated, many have been left destitute as their breadwinners have succumbed to the scourge. The adverse economic impact of AIDS has been felt by virtually every household in Zambia[4]. Every community is affected and every area of public and economic life has been weakened by the HIV/AIDS epidemic. Consequently, national

---

[3] The SARPN *Poverty Vulnerability Assessment Report* of June 2005 states that "Zambia is one of the world's poorest countries. The 2003 Human Development Report ranks Zambia's Human Development Index at 163 out of a total of 175 [poorest] countries" (2005:197).

[4] 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).

development has been squelched. Responses to the HIV/AIDS epidemic in Zambia was slow at the beginning, but has significantly changed with the government of the day now playing a leading role.

Since the first AIDS diagnosis in Zambia in 1984, a rising trend has been the norm. By 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/WHO Epidemiological Fact Sheet - 2004 Update, Zambia). Haworth et al (2001:11) underscore this tragedy by pointing out that "AIDS is a serious problem in Zambia [which] has spread though out the country. They further suggest that the HIV/AIDS epidemic could be worse than is officially reported: "[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). Chapter 2 below makes a situational analysis of the HIV/AIDS epidemic in Zambia and glimpses the context of neigbouring southern African countries. It is the researcher's opinion that Haworth et al (2001) are not overstating the HIV/AIDS scenario in Zambia when they assert that the country has one of the highest HIV prevalence rates in the sub-region.

At the end of 2005, it was estimated that 17% of Zambians aged 15-49 years old were living with HIV or AIDS. 57% of the estimated 1.1 million HIV infected adults were women (UNAIDS/WHO 2006 Report on the global AIDS epidemic). In Zambia young women aged 15-19 years old have about six times more chances of being infected with the HI virus than their male counterparts (Noble 2006a). The estimated lifetime mortality risk from HIV/AIDS posits that for a Zambian

population with an HIV prevalence of 17%, more than half of all youth now aged 15 will die of AIDS by age 25 years (Country Profile: HIV/AIDS Zambia). Approximately half of Zambia's population is under 15 years old.

It has been said that HIV/AIDS is integrally a disease of the poor in most developed countries such as the USA or Western Europe, but in Zambia infection rates are quite high among the wealthier and the better educated. Admittedly, it is the poorest that are least able to protect themselves from HIV or to cope with the impact of AIDS who are hardest affected. It is further noteworthy that 54% of all adults living with HIV /AIDS live in urban areas (UNAIDS/WHO Epidemiological Fact Sheet - 2004 Update, Zambia). Table 1.1 below shows HIV/AIDS prevalence rates, knowledge levels, and condom use for various age groups, based on findings of the Zambia Demographic and Health Survey 2001-2002 (ZDHS 2003).

Table 1.1 Selected HIV/AIDS Indicators for Zambia—2001/02

Background	HIV Prevalence Rate (%)			Knowledge of AIDS (%)		Use of Condoms (Spouse or Cohabiting Partner) (%)		Use of Condoms (non-cohabiting Partner) (%)	
	Female	Male	Total	Female	Male	Female	Male	Female	Male
Characteristic									
Age									
15-19	6.6	1.9	4.6	98.4	94.7	9.5	17.8	28	32.5
20-24	16.3	4.4	11.4	99.4	99.4	8.5	16	36	51.9
25-29	25.1	15	20.4	99.6	100	6.7	15	39.7	46.7
30-39				99.8	99.8	5.1	9.9	31.8	49.3
30-34	29.4	20.5	25.1						
35-39	22.6	22.4	22.5						
40-49				99.3	100	2.2	5.3	15.4	40.1
40-44	17.3	20.5	18.9						
45-49	13.6	20.2	16.5						
Residence									
Urban	26.3	19.2	23.1	99.9	99.7	8.2	12.2	45.4	52.1
Rural	12.4	8.9	10.8	98.9	98	5.1	8	20.4	37.2
Province									
Central	16.8	13.4	15.3	99.8	99.6	6.1	7.5	25.5	44.8
Copperbelt	22.1	17.3	19.9	99.7	98.9	5.1	12.9	41.3	52.8
Eastern	16.1	11	13.7	99.4	98.8	6.5	10.5	34.7	54.7
Luapula	13.3	8.6	11.2	99.4	98.9	1.4	1.6	16.7	18.9
Lusaka	25	18.7	22	100	100	12.7	15.8	48.2	55.6
Northern	10	6.2	8.3	99.1	98.8	6.8	9.7	22.4	47.1
North-Western	8.8	9.5	9.2	99.3	99.6	4.1	6.3	26.6	40
Southern	20.2	14.6	17.6	99.4	99.5	3.8	5.5	30.1	33.7
Western	16.9	8.3	13.1	96.5	97.5	6	5.7	14.5	23.3

Source: Zambia Demographic and Health Survey, 2001-2002, Central Statistical Office, Central Board of Health Lusaka, Zambia and measure DHS+, ORC Macro, USA [Adapted from PVA Report June 2005:194 http://www.sapn.org.za accessed 27/11/2006]

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 nascent stages of the disease, the bulk of infections currently take place among women, especially in younger age groups. Only in the age brackets of 40 and above do we see prevalence of men's rates equalling and surpassing those of women. The highest HIV infection for women rates occur in the 30-34 age band, while the peak for men is found in the 35-39 age category. It is this researcher's opinion that a social trend in Zambia exists where older

men prefer sexual liaisons with younger women than with their peers. This preference appears to partially explain the higher infection rates among younger women and girls compared to their male counterparts.

The information in table 1.1 above also shows that, while knowledge of HIV/AIDS is almost universal in all ages, HIV/AIDS-related behaviour is unsatisfactory, at least as gauged by condom use as a protection method against HIV infection. The condom is rarely used among cohabiting partners, especially for women. The fact that fewer women in all age groups use condoms explicates why HIV prevalence rates among females are higher than those of males[5].

The UNAIDS 2006 Report points out that the national HIV prevalence rates for Zambia have somewhat stabilized around 13.5-20%. However, according to the Sub-Saharan Africa 2006 Epidemic Update (2006:10), this could only entail that the yearly new infections is approximately the same as the number of HIV/AIDS –related deaths. Noble (2006b) pithily points out that "falling prevalence among young people might well indicate lower incidence of infection, but a more general decline would not necessarily be a good sign. In fact, if more people receive antiretroviral treatment, and there is no great drop in the number of new infections, then fewer people will die of AIDS each year and prevalence may rise." He furthermore argues that in Zambia "AIDS had been a notifiable disease since 1986, but only a very small proportion of cases was ever reported" (Noble 2006b). Noble thus implies that the situation could be worse than currently and officially

---

[5] Recent trends, however, evidence some significant positive changes in HIV prevalence among young Zambian woman. There are signs of a general drop in prevalence among young urban women, although a dismal drop was seen in teenage women elsewhere. The largest drop in prevalence was observed among well-educated women, but prevalence rates among the poor and least educated women either remained unchanged or increased. It is deemed that the declining incidence levels point to a drop in the number of new infections attributable to behavioural change. This is obviously a heartening indicator that at least ongoing efforts to educate and empower young people are bearing some measure of fruit (Noble 2006a).

known. Even worse than that is the estimation that a dismal 9.4% of women and 13.8% of men have ever been tested for HIV (Country Profile HIV/AIDS Zambia). It's apparent, therefore, that the HIV/AIDS situation in Zambia could be more complex than is presently envisaged (see Haworth et al 2001).

1.1.6 A History of HIV/AIDS in Zambia

Rob Noble (2006b) in his concise and insightful paper titled *'HIV & AIDS in Zambia—History and Funding'* gives a brief history of the national response to the pandemic in Zambia. He writes that 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 activities. Sadly, though, much of what was known about HIV prevalence was kept secret by the authorities. He alleges that senior politicians were reluctant to speak out about the growing epidemic (with the exception of the first republican President Dr. Kenneth D. Kaunda who publicly disclosed that his son, Masuzyo, died of an AIDS-related illness). He maintains that by the end of the 1980s Zambians were in denial and thus stigmatization was rife and went unchallenged. The disease 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 marked change in the political stance towards the problem occurred. The National HIV/AIDS/STD/TB Council (NAC) was created in March 2000, but only became operational in December 2002 when parliament endorsed its formation (NAC/Ministry of Health 2002). It is clear that the fight against HIV/AIDS in Zambia had a slow start. Noble (2006b) supplies a useful timeline of HIV and AIDS in Zambia (see Table 1.2 below) highlighting the country's response to the HIV/AIDS crisis. Today the government has admitted that the need for a

multidisciplinary[6] approach to HIV/AIDS management is indispensable to the fight against the pandemic (NAC/Ministry of Health 2002).

Table 1.2 Timeline of HIV and AIDS in Zambia

1964	The British colony of Northern Rhodesia becomes the independent Republic of Zambia, with Kenneth Kaunda as president.
1984	The first case of AIDS in Zambia is reported. In all probability, HIV has been around in Zambia since the 1970s.
1985	In Lusaka, 17.5% of hospital patients are found to be HIV-positive; of those in antenatal care, 8.7% have HIV.
1986	The National AIDS Prevention and Control Programme and National AIDS Surveillance Committee are established.
1987	President Kenneth Kaunda announces to the world that his son, Masuzyo, has died of AIDS.
1987	A short-term emergency plan is invoked to ensure safe blood and blood product supplies. Meanwhile, a survey of pregnant women in Lusaka finds that 11.6% have HIV.
1988-92	The First Medium Term Plan coordinates responses to the epidemic. Frederick Chiluba is elected president in 1991.
1990	The Zambian ANC-based National HIV/STD Sentinel Surveillance System (NSS) is set up. The first attempt is made to survey the national epidemic, though initially only a few sites are included.
1992	In urban areas, 27% of pregnant women tested have HIV; elsewhere, rates are around half this level. These prevalence rates remain more or less unchanged in all subsequent years.
1994-98	The Second Medium Term Plan unifies the AIDS, STD and TB programmes.
1999	The Prevention of Mother to Child Transmission (PMTCT) Initiative is launched.
2000	The National HIV/AIDS/STD/TB Council (NAC) is created and develops the National Strategic Framework
2001	Levy Mwanawasa is elected president.
2002	The NAC becomes a legally-established body able to solicit funding.
2002	Public provision of ARV treatment begins at two trial sites in Lusaka and Ndola.
2004	The government declares HIV/AIDS a national emergency in a bid to boost treatment and prevention efforts. By the end of the year, around 20,000 people are receiving ARV drugs, of an estimated 149,000 in need.
2005	In February, it is announced that user charges for public sector ARV treatment will be dropped

(Source: Adapted from Noble 2006b)

1.2 Problem Statement

It is an undeniable observation that Zambia is one of the poorest nations on earth (see SARPN PVA Report June 2005:197)[7]. The HIV/AIDS epidemic has affected every area of Zambian life. Van Dyk (2005:259) notes well that "HIV and Aids (sic) makes tremendous new demands on health

---

[6] This is an approach that actively involves different sectors, e.g., agriculture, health and includes private enterprise, NGOs and other sectors to combat the spread of the HIV/AIDS epidemic.

[7] The UNAIDS 2006 Report on the Global AIDS Epidemic (487) asserts that 87.4% of the Zambian population have less than US$ 2 a day.

services that cannot be met by hospitals alone." The observation holds true for Zambia. Although the HIV prevalence rate is significant among the wealthy and well-educated, the poor are hardest hit. As the disease escalates in Zambia hospitals are finding it hard to cope. Government funding to run these institutions is tight and health professional staffing numbers are at their lowest in the sub-region's history (van Dyk 2005:260; Silomba 2002; etc).   HIV/AIDS—infected people are usually discharged from hospital to at die home as the hospital personnel can do little more for the patient or simply because they deem the meager resources are better used on patients with better likelihood of recovery. Additionally, some HIV/AIDS—infected people might choose to be at home with their families rather than in hospitals (van Dyk 2005: 259-60; Magezi 2005: 1; Silomba 2002; etc). Sadly, when HIV positive people are discharged to be cared for at home, the poor families who receive them do not have ample resources to give the much needed palliative care. Smart (in Magezi 2005:1) adeptly describes a situation which is true for Zambia when he points out that:

> In some developing countries, patients with HIV who have accessed primary care services from government-supported hospitals simply don't receive palliative care because linkages between these government institutions, community-based organizations and other potential care providers simply do not exist

In this scenario some searching questions emerge: How might the evangelical church in Zambia interface with society amid such immense affliction? What is the connection between the HIV/AIDS crisis and poverty in the Zambian situation? How can pastoral care contribute to providing a support network to poor families of HIV/AIDS affected people? How can this community of faith apply the home-based care model to minister relevantly to the needs of HIV/AIDS afflicted people who cannot access health care facilities? Is there any Scriptural warrant for such involvement by the Christian congregation?

This study is undertaken on the presumption that it has been said and written that majority evangelical Christians in Zambia are uninvolved in HIV/AIDS care and interventions. It is the opinion of this researcher that evangelical congregations are optimally positioned and hence should play a critical role in providing meaningful and relevant home-based pastoral care and support to HIV affected people in a country that is economically weak. The study further underscores the issue that pastoral care of People living with HIV/AIDS (PLWHA) is not a sole task for pastors, but that entire congregations play a critical role too. Therefore, a redefinition of pastoral care must be made in the light of the current HIV/AIDS epidemic in Zambia (Gerkin 1997). This researcher contends that whole congregations should be enlisted and empowered to facilitate checking the ghastly consequences of the HIV/AIDS epidemic in Zambia. It is the researcher's view that whole congregations should be enlisted and empowered to mitigate the ghastly impact of the HIV/AIDS epidemic. This study will show that the theological principle of fellowship in the church is germane to establishing a caring community and support system that will bring about spiritual development and lighten the burden of HIV/AIDS infected and affected people in communities.

1.3 Hypothesis

The challenge presented by HIV/AIDS cannot be the sole responsibility of the Zambian government or social workers alone. Evangelical churches, particularly in the realm of pastoral care, is inescapably expected to give support and hope to people living with HIV/AIDS (HIV/AIDS infected people and their significant others). However, for the evangelical church in Zambia to be able to provide a support system to people afflicted by HIV/AIDS, the pastoral ministry should move toward a wholistic congregational approach (where members are empowered to minister to

People living with HIV/AIDS) rather than the current complicated pastor-centered approach[8]. The congregational approach has the strength of not only concentrating on the congregation, but also on the needs and afflictions of the wider community, who in the current HIV/AIDS crisis in Zambia, constitute primary caregivers of HIV infected people. A home-based care ministry driven by the local congregation is thus suggested as an effective way of interfacing with a country facing the life-destroying plague of HIV/AIDS[9]. The premise for this congregationally driven home-based care paradigm is that the more one is exposed to HIV/AIDS afflicted people and its affinity to poverty, the more pastoral care should employ the resource of people within that community. Church-based communities should be empowered for home-based care if we are to stand a chance of mitigating the impact of HIV/AIDS in Zambia.

1. 4. Motivation

The HIV/AIDS pandemic is a serious crisis for all Zambians. There is hardly a person in this country that has not felt the impact of the disease through the loss of a loved one to an HIV/AIDS-related illness (Dube 2003b). 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: 10). Zambia is located right in the heart of Southern Africa. Magezi (2005:5) points out that "Sub-Saharan Africa being the second poorest after South Asia …, and leading in HIV/AIDS cases, the challenge is far from being the responsibility of only governments

---

[8] Evangelical scholars (e.g. Crabb 1979, Gerkin 1997, Louw 1997 etc) are unequivocal about the shift of pastoral care from the clergy to the laity. The community of faith should be a healing body.

[9] George Scriba in his article *'The 16th Century Plague and the Present AIDS Pandemic: A Comparison of Martin Luther' Reaction to the Plague and the HIV/AIDS Pandemic in South Africa,'* in the Journal of Theology for Southern Africa No. 126 November 2006, equates the HIV/AIDS epidemic to a plague (i.e. a highly infectious, usually fatal disease—a pestilence—where huge numbers are dieing because of the illness). The researcher holds that such a nuance is admissible in the context of the HIV/AIDS epidemic in Zambia. HIV/AIDS has reached a plague proportion requiring radical and unrelenting interventions.

and social workers." The connection between poverty and HIV/AIDS is a controversial one but it can not be discounted without doing violence to reality as at some stage in the development of the illness poverty adds impetus to the disease's progression (NAC/Ministry of Health 2002; Fernandez, J. 2003; etc). The UNAIDS 2006 Report on the Global AIDS Epidemic states, "The relationship between AIDS and poverty is a powerful but nuanced one….*AIDS tends to affect the poor more heavily than other population groups*" (2006:84 Emphasis added). The AIDS Bulletin October 2004 (in Magezi 2005:5) hints at this affinity between HIV/AIDS and poverty saying "We know that HIV/AIDS is the quintessential disease of poverty. The Pandemic has its greatest impacts on the poor and most unbearable populations: those with no access to clean water and sanitation; poor nutrition and overall health status—and those who are constantly challenged by a variety of other infections."

It is the opinion of the researcher that evangelical Christians in Zambia have a unique endowment of providing pastoral care and support to people suffering from HIV/AIDS. The evangelical church is expected to offer support, love, and hope to people living with HIV and AIDS. The theological premise of this study is that God is faithful in all circumstances of human existence, even in HIV/AIDS infection, because of His unending compassion for the afflicted. Pastoral care should thus be a way of demonstrating God's faithfulness to bring hope to people afflicted by HIV/AIDS (Louw 2006). The evangelical church, by giving pastoral care to people living with HIV/AIDS, will surely be demonstrating authentic practical Christianity (cf. James 2:14-16).

1.5 Purpose

This research aims at investigating how evangelical Christians in Zambia could effectively respond to the HIV/AIDS epidemic through a church-based home-based care approach. The work will be

done with knowledge of the impact of the HIV/AIDS pandemic within a Zambian setting. This entails that a Zambian perspective and mindset will have a critical bearing on relevant issues involved in evangelical Christianity's response to the pandemic. Zambian spirituality located in an African Spirituality will interface with this global crisis. The research will give guidelines on how to build the capacity of Zambian evangelical churches for home-based care of people living with HIV/AIDS as a pastoral response to the epidemic.

1.6. Methodology of Research

The research shall be based on literature review. Sufficient sources on the problem of HIV/AIDS and its relationship to home-based care in a Zambian setting faced with growing poverty are available for a literature approach. The method of participatory observation will also be employed because the context in Zambia will be evident in the approach and interpretations. The researcher is a native Zambian who has lived most of his life in Zambia and witnessed the suffering that the HIV/AIDS scourge has inflicted on his compatriots since its first incidence in 1984. As a pastor of a metropolitan church in Lusaka, the researcher experienced the pain of loosing church members to HIV/AIDS related illnesses. He has also experienced the loss of family members and friends to HIV/AIDS related illnesses. These experiences opened his eyes to see the magnitude and the issues inculcated upon Zambian evangelicals as a community of faith by the advent of HIV/AIDS. Finally, leaders and members of evangelical churches in Zambia involved in home-based care of PLWHA will be interviewed to ascertain the link between empowering church-based communities and pastoral care of PLWHA as a response to HIV/AIDS.

1.7 Description of Chapters

Chapter 2 is a situational analysis of HIV/AIDS in Zambia. The discussion will fall under the following topics: facts on HIV/AIDS issues such as definition and description, origin, infection, transmission; factors contributing to the rapid spread of the HIV/AIDS epidemic in Zambia; attempts so far made to address the HIV/AIDS pandemic in Zambia; socio-political- and economic challenges to the HIV/AIDS pandemic, and a Zambian worldview of sickness and how HIV/AIDS fits in that worldview.

Chapter 3 will look at the implications of being an evangelical church within a context of HIV/AIDS in Zambia. It will argue for the assumption that, for pastoral care to be meaningful and effective in addressing the plight of people living with HIV/AIDS, evangelical Christians should personify the biblical image of family, whose members have a duty to love and care for one another (John13:35; James 2:14; Gal 6:10 etc). The focus will no longer be placed on one individual [the pastor as sole pastoral caregiver] but on the community of faith to encourage, care and support one another. This approach will also empower the congregation to shift from a standpoint of apathy to one of empathy. Such a shift will entail a change in the attitudes of church-based communities' from non-involvement to active participation in the lives of people living with HIV/AIDS to mitigate their daily challenges. This chapter will touch on a few vital issues on the nature and mission of the church—the biblical definition and description of church (an outgoing community of practical faith), the link between the church as family and the Zambian extended family care system, the church's Scriptural injunction and model of care, and pastoral care of people affected by HIV/AIDS in Zambia. It will stand on the biblical teaching that the church is a body where every member is indispensable and when a single member is not well, then the entire body is unwell too (cf. 1 Corinthians 12: 12-27).

Chapter 4 will look at the topic of pastoral care of people living with HIV/AIDS in Zambia. It stands on the premise that pastoral care is the optimal way of healing and giving hope to PLWHA from diagnosis to death through the care of the faith community (Maldonado1990, Louw 2006). The chapter will define the concept of pastoral care as a response to the HIV/AIDS epidemic, discuss the need for evangelical Christians' involvement in this helping ministry in the face of HIV/AIDS, discuss pastoral care from an interdisciplinary view, describe a feasible model of pastoral care and counseling for the Zambian situation, and state strategies for empowering Christians toward alleviating the suffering of people living with HIV/AIDS.

Chapter 5 shares a plan for home-based pastoral care as a response to the HIV/AIDS pandemic in Zambia. The connection between pastoral care and home-based care will be demonstrated. The discussion will fall under the following topics: definition and description of home-based care, advantages of home-based care, origin and models of home-based care in Zambia, and design of a practical model for a home-based care for evangelical churches.

Chapter 6 will summarize, state conclusions and prospective issues arising from chapters 1 to 5 of the study. The section on prospective issues will highlight the salient findings of the study calling for an effective evangelical response to the HIV/AIDS epidemic in Zambia.

Chapter 2

A Situational Analysis of HIV and AIDS in Zambia

2.0 Introduction

Zambia is facing a devastating HIV/AIDS crisis. It is, therefore, vitally important that HIV/AIDS caregivers possess accurate information on all facets of HIV and AIDS infection. Evangelical Christians in Zambia are among the categories of caregivers needed to work toward the alleviation of the affliction of over one million people living with HIV/AIDS in the country. This chapter will give basic facts and information on HIV/AIDS which must be known by every caregiver since the care and needs of HIV-positive people calls for such knowledge. A definition of HIV and AIDS will be made with a concise discussion of the history of the HIV/AIDS epidemic. Some focus will be given to the disease's trends in sub-Saharan Africa where Zambia is situated. The research will also look at the distinctive traits of the HI virus and how it impacts the human immune system; the modes of HIV transmission and the link between HIV/AIDS and poverty; factors fueling the rapid spread of HIV infection in Zambia; a survey of HIV/AIDS interventions so far made, and the country's worldview of sickness. A study of Zambians' worldview of sickness will assist us formulate effective approaches towards sexual behaviour change which is essential to the prevention of HIV/AIDS infection.

2.1 Essential Information on HIV/AIDS

This study will demonstrate that it is undeniable that HIV/AIDS is one of the world's most vicious diseases ever known in human history. It is such a vexing plague especially that there is no cure or effective vaccine in sight yet (NAC/Zambian MoH 2002; van Dyk 2005). These realities entail that

everyone concerned with the care of HIV-positive individuals should have a good appreciation of the HIV/AIDS epidemic. This section will look at basic issues about HIV and AIDS awareness such as definition, modes of transmission, to name a few.

2.1.1 The Definition of AIDS

AIDS is an acronym for *Acquired Immune Deficiency Syndrome*. The disease is said to be *acquired* because it is not hereditary. A virus termed the Human Immunodeficiency Virus (HIV) causes this health condition when it gains entry into the human body from outside. The word *Immune* alludes to the human body's natural ability to protect itself against disease and infections. A *deficiency* is a lack or weakening of the immune system so that it does not protect itself against infections. A *syndrome*, in medical terms, is a group of signs and symptoms that collectively point to a specific abnormal condition (Van Dyk 2005:3). To say that AIDS is a 'disease' is actually a misnomer, although the word is employed when referring to it. AIDS is really "a collection of many different conditions that manifest in the human body (or specific parts of the human body) because the HI virus has so impaired the body's immune system that it can no longer fight the disease-causing agents that are constantly attacking it" (van Dyk 2005:3). AIDS is, to be precise, a collection of "opportunistic diseases[10], infections and some cancers" which together or singularly possess the ability to kill the infected individual in the terminal phase[11] of the illness (van Dyk 2005:4).

2.1.2 The History of AIDS

---

[10] "Opportunistic infections or diseases are caused by micro-organisms that do not normally become pathogenic in the presence of a healthy immune system (because a healthy immune system will kill them or render them inert). But when an immune system is unable to defend the body because it is being destroyed by HIV, opportunistic infections will 'take any opportunity' (hence the name) to attack the body successfully" (van Dyk 2005:43). The commonest opportunistic disease in HIV/AIDS in Africa (and Zambia) is TB (Haworth et al 2001; van Dyk 2005; etc).

[11] Section 2.4 below discusses the stages of HIV infection in greater detail.

The first documented cases of AIDS were seen in the USA in 1981 when an uncommon form of pneumonia (caused by a parasite called *pneumocystis carinii)*, cytomegalovirus infections, thrush and Kaposi's sarcoma[12] (a skin cancer) occurred at the same time in some patients. These patients were mostly young homosexual men (Barnet & Whiteside 2002:28). A little later a new disease which impaired the immune system, caused diarrhoea and weight loss was recognized in central Africa among non-homosexuals. At the start, scientists and doctors were unable to understand the cause and means of transmission of this new illness. However, in 1983 it was learned that the disease was caused by a virus which they at that point called LAV (lymphadenopathy-associated virus) and the HTLV III (human T cell lymphotropic virus type III). It was only in May 1986 that the virus responsible for this illness was called HIV (human immunodeficiency Virus) [Barnet & Whiteside 2002, van Dyk 2005].

Presently two types of viruses are associated with AIDS (HIV-1 and HIV-2). HIV-1 is known for the infections in Central, East and southern Africa, North and South America, Europe and the rest of the world. HIV-1 has high genetic variability, rapid evolution, and diversification. HIV-2 was found in West Africa (Cape Verde Islands, Guinea-Bissau and Senegal) in 1986. HIV-2 has a similar structure to HIV-1, but it is not as aggressive as HIV-1 (WHO 2005a: 36, van Dyk 2005:4).

The history of how the HI virus was discovered is shrouded in controversy. Dr Lue Montagnier of the Louis Pasteur Institute in Paris France, first discovered HIV-1 in 1983. In 1984 Dr Robert Gallo of the United States promulgated to the world that he was first to discover the virus. What ensued was a protracted legal battle on the alleged theft by Gallo of Montagnier's virus given to him in

---

[12] In Zambia, it was a significant rise in the number of Kaposi's sarcoma cases by 1984 which pointed to the presence of the HIV/AIDS in the country (Barnet & Whiteside 2002:28).

good faith for research. It was ultimately held that a compromise be struck recognizing both Montagnier and Gallo as equal-discoverers of the virus. Montagnier is now credited with the original isolation of the HI virus, and Gallo for propagating the virus in cell culture. Gallo, however, developed the much needed diagnostic tests for HIV (Barnet & Whiteside 2002:35-38; van Dyk 2005:4).

2.1.3 What is a Virus?

Van Dyk (2005:9) defines a virus as "a very small organism, and unlike other life forms (e.g. human cells) they cannot replicate themselves (or make copies of themselves) within their own cores, because they do not have the chemical 'machinery' to do so." A virus carries its genetic material into living cells and then employs the 'facilities' of the host cells to replicate itself. A virus is parasitic in nature. It can not survive outside the host cell. The HI virus (like other viruses) has genes that make it possible for it to replicate itself. It has RNA instead of DNA in its nucleus. This RNA in the nucleus is called a retrovirus[13].

The HI virus is made up of two parts—the nucleus housing the genetic material and the shell or capsule protects the nucleus and is the external layer of the virus (see figure 2.1 below). The shell has spike-like protein projections which it uses to attach itself to specific binding sites (receptors) of a host cell that it infects. The protein projections on the virus and the binding sites on the host cell are comparable to a lock and key. The projection on the virus will fit into a specific lock (the host cell's receptor). The HI Virus also has a third part called a viral envelope. The viral envelope is a

---

[13] According to van Dyk "'Retro' indicates that HIV does the 'reverse' of what other viruses do. The normal transcription of genetic information in cells is from DNA to RNA to proteins. But the genetic information of HIV (and other retroviruses) is contained in RNA (rather than in the DNA-as in ordinary viruses). All retroviruses (including HIV) contain a unique enzyme (reverse transcriptase) which the virus uses to transform its viral RNA into viral DNA in order to produce more viruses" (2005:19).

loose and fragile membrane which covers the capsule. In this membrane (envelope) are embedded glycoproteins (antigens). A unique trait of viruses (including the HI virus) is that they infect only particular cells. A particular virus can only attach to a very particular binding site on the host cell (see the lock -and- key interaction discussed above). The defending function of the immune system is founded on this particularity of viruses. The immune system produces antibodies that attach themselves to the outermost proteins of the virus. This stops the virus attaching itself to the host cell. An antibody functions as a barrier between the virus and the host cell, and thus checks the attachment of the virus to the cell's receptor sites. The immune system malfunctions when the structure of the antigen[14] (or foreign substance) changes (as in the case of the HI virus) and the antibody cannot attach to it.

2.1.4   The Structure of HIV (Human Immunodeficiency Virus)

The HI virus causes AIDS. B. D. Schoub (in van Dyk 2005:10) says that HIV was the first retrovirus to be found in humans. Prior to the mid-1970s, retroviruses were chiefly found in animals. The crucial difference is that HIV is the most complex of all retroviruses. HIV has the ability to rapidly evolve into different strains such that a plethora of mutants of the virus can be found in one infected person. As a consequence, the HI virus has a unique ability of evading the immune system of the individual it infects. Figure 2.1 is a model illustrating the structure of the HI virus. Its' nucleus has a cone shape which is a key trait to recognition under an electron microscope. The nucleus houses two strands of RNA and the reverse transcriptase enzyme.

---

[14] 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."
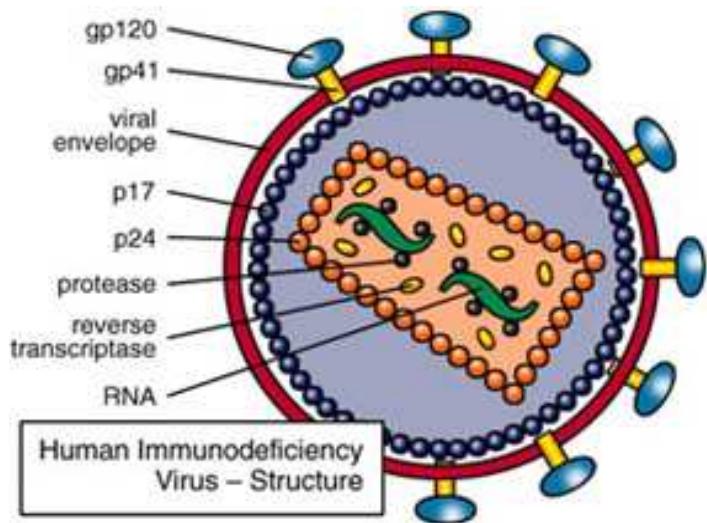
Figure 2.1- A Model of the HI virus
[Source: www.avert.org/HIV_structure_ and _life _cycle.htm, accessed 20/02/07]

The key protein of the nucleus is the p24 antigen which also plays a critical role in the diagnosis of HIV infection. The nucleus is enveloped by a viral membrane in which is anchored two critical viral proteins or antigens (also called glycoproteins). These glycoproteins, gp120 and gp41, work as attachment and penetration points into the host cell where the HI virus begins to replicate itself. Additionally, the HI virus, like other viruses, replicates itself by being a 'parasite' in a living cell. The HI virus cannot survive and multiply outside the human cell. The HI virus is further more complicated and dangerous because it does what no other known virus has ever done: it directly attacks the CD4 or T helper cells which are critical to the human defense (immune) system and turns them into HI virus 'factories'. As the viruses multiply the human immune system weakens. HIV is so effective in destroying human lives for, as far as is known currently, the defenders of the human immune system (the CD4 or T helper cells) do not have a way of defending the human body against the HI virus (van Dyk 2005:10-11). This phenomenon leads to a gradual impairment of an individual's protection system against all infections and diseases until he or she dies from one of the infections/diseases.

2.1.5 The Impact of HIV on the Immune System

One of the complexities of the HI virus is that it directly attacks the CD4 cells—the cells which play a key role in the defence system of humans. Figure 2.2 illustrates the life cycle of the HI virus and shows how HIV 'heists' CD4 cells and uses them to 'produce' more viruses. These CD4 cells (key defensive cells of the immune system) are turned into "efficient virus factories to manufacture perfect replicas" of HI viruses (Barnet & Whiteside 2002: 30-31, van Dyk 2005: 17-18). Consequently, the CD4 cells cease stimulating and coordinating the body's defences against the HI virus.
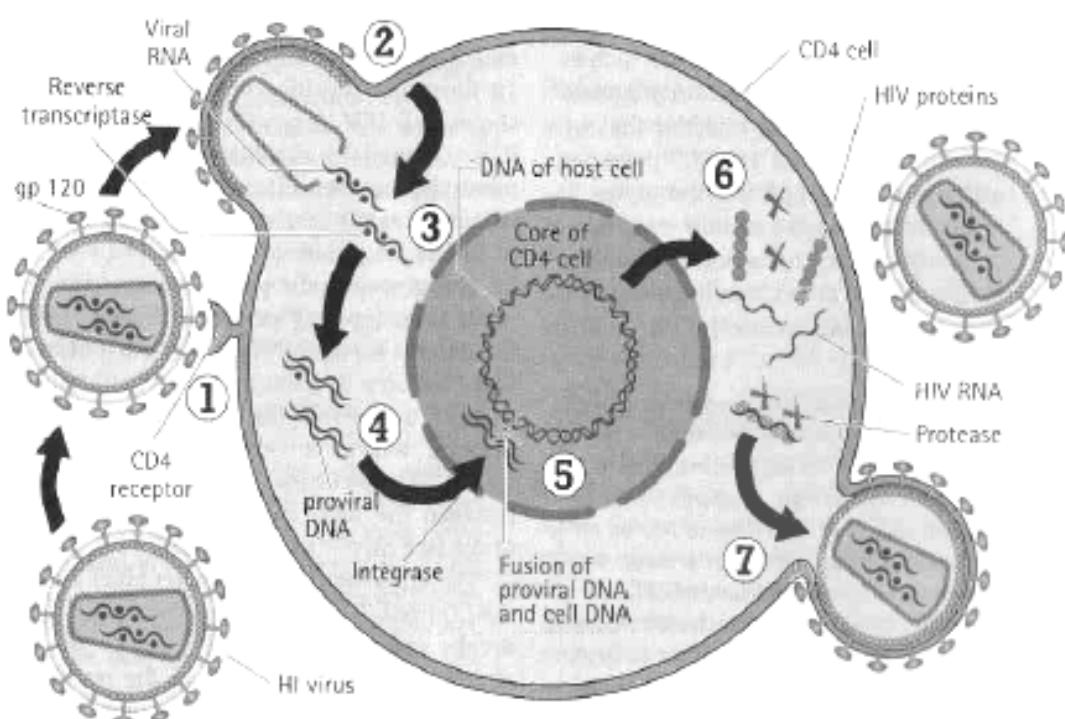
Step 1: The HI Virus attaches to the CD4 cell's receptors
Step 2: The CD4 cell and HI virus join membranes
Step 3: The HI Virus injects its RNA (as well as reverse transcriptase) into the CD4 cell.
Step 4: Viral RNA is changed into proviral DNA through a process called reverse transcription.
Step 5: The proviral DNA joins with the cell's DNA in the core of the cell, causing it to produce more viral RNA and viral proteins.
Step 6: The viral RNA and the viral proteins assemble into more HI viruses.
Step 7: The new viruses break free from the cell, killing it and infecting more cells
Figure 2.2 How the HI virus invades a CD4 Cell [Source: van Dyk 2005:18]

They now start reproducing "the very carriers of death against which they are meant to defend the body" (van Dyk 2005: 19) until the human body is entirely unable to protect itself from all illnesses. But, how does the HI virus enter the human body?

2.2 Modes of HIV Transmission

HIV infection is mainly transmitted in three ways—by sexual intercourse, by HIV-infected blood passing directly into the body of another person, and by an infected mother's blood passing to her baby during pregnancy or child birth, or the virus may be passed to a child through an infected mother's breastmilk. It is noteworthy that the HI virus has been identified in various body fluids—such as saliva, tears, sweat, and urine—but its highest concentration is found in blood, semen, vaginal fluids, and breast milk (van Dyk 2005: 23) and it is through these media that the highest risk of HIV infection is present.

2.2.1. Sexual Intercourse

In this mode of transmission HIV infection mainly occurs through unprotected (that is, without a condom), penetrative vaginal or anal sexual intercourse. It can also be transmitted through oral sexual contact under certain conditions, such as when there are wounds in the mouth. The transmission of HIV happens when the virus enters an individual's bloodstream through the body fluids of an infected person. Van Dyk (2005: 24) points out that for the HI virus to enter into the body it must attach itself to CD4 cells receptors. Many of the cells in the lining of the genital and anal tract have just such receptors, which makes it easy for HIV to enter into the body when having unprotected vaginal or anal sexual intercourse. The mucous membrane of the genitalia has a rich

presence of antigen-presenting cells such as *Langerhans*[15] cells that are ready to carry the HIV antigens to CD4 cells. Sexual intercourse accounts for the bulk of HIV infections in sub-Saharan Africa (WHO 2005a) including Zambia (NAC/Ministry of Health 2002; Central Statistical Office/Central Board of Health [Zambia] 2003; Haworth et al 2001; Mbewe 2005; etc).

2.2.2. Contact with HIV infected Blood

HIV is also transmissible when a person receives HIV contaminated blood in a blood transfusion; or when he or she uses contaminated needles, syringes and razor blades, and other skin piercing instruments; tissue transplant and organ transplants, including blood products used for treating blood disorders such as haemophilia (Haworth et al 2001:15; van Dyk 2005: 27-31). Alan Haworth et al. (2001:15) say 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 transfusion is, it must be noted that there is no such thing as 'risk-free blood' (WHO 2005a; van Dyk 2005). To avoid such incidences, the World Health Organization (WHO) stipulates that all donated blood be screened for HIV, hepatitis B and syphilis (and hepatitis C where facilities are available)[van Dyk 2005:28]. The issue of the 'window period' (the period after infection but before antibodies are formed to an ample level for detection) gives problems to blood transfusion services.

---

[15] "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).

The sharing of syringes, needles and other sharp objects also have 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. The HI virus can also be transmitted through ear piercing, tattooing, contact with infected blood at an accident scene, the ritual of circumcision or scarification in some African tribes. It is vital therefore, that persons carrying out these practices—such as traditional healers and their clients—are educated on the vitality of using sterile instruments when performing these procedures.

2.2.3. Mother-To-Child Transmission of HIV

Mother-to-Child transmission (MTCT) or vertical transmission of HIV is a major cause of HIV infection in children. Van Dyk (2005:31) aptly notes that "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 (cited in 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 breastmilk during seroconversion[16]); and if
- she has advanced, symptomatic HIV disease with
  - a high viral load (>50 000 viral particles/ml);
  - a low CD4 cell count (>200 cells/mm3);
  - symptoms of AIDS.

---

[16] "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).

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 infection in children in Zambia (NAC/Ministry of Health 2002) followed by the sexual abuse of girls (Human Rights Watch 2002).

2.3 Stages of HIV Infection

HIV infection progresses through a number of phases until a person dies. It is, however, important to note that these phases are not clearly demarcated into distinct stages with easily noticeable boundaries. Overlaps of these stages happen and thus it is best to view the phases as a progression of the illness. These phases are the primary HIV infection Stage (or acute seroconversion illness), the asymptomatic stage, the minor symptomatic stage, the major symptomatic stage with opportunistic diseases, and the severe symptomatic stage: AIDS-defining conditions (Haworth et al 2001: 23-24; van Dyk 2005:36; etc).

Since HI viruses attack and kill the CD4 cells to impair the HIV positive person's immune system, a CD4 cell count serves as an accurate indicator of the condition of the immune system at any given time. The more CD4 cells there are in a persons body the stronger the body's ability to fight infection by (opportunistic) diseases. This is means that there will be fewer HI viruses in the body when the CD4 cell count is high. The converse is true as well. When the CD4 cells are depleted in the body of an HIV infected person have more HI viruses will be present and the person's immune system will be more impaired to fight opportunistic infections. Thus a vital relationship between the viral load and the CD4 cell count helps to monitor the disease process of an HIV-positive patient,

and, if considered together, can envisage whether a person's progression towards the final stage of AIDS will be rapid or slow.

Van Dyk (2005:38) observes that "Viral load and CD4 cells have an inverse 'see-saw' relationship." This entails that a higher viral load points to a lower CD4 cell count, as the HI virus kills the CD4 cells. A lower viral load points to a higher CD4 cell count, since when there are fewer viruses in the blood the immune system has a chance to rebuild CD4 cells. Disease progression (the degree to which an HIV-positive individual gets unwell with opportunistic diseases and infections) is tied to the quantities of viruses and the CD4 cells in the blood. The journey to the final stage of AIDS (and death) will therefore be much quicker with a higher viral load. Conversely, an HIV-positive individual with a high CD4 cell count and a low viral load might be healthy for a number of years, as the immune system is still strong to defend the body against infections.

Figure 2.3 illustrates the relationship between the person's CD4 cell count, viral load and the stages of HIV infection. Note, however, that this pattern may differ from one person to another and other factors can influence the viral load or CD4 cell count from time to time. For instance, the CD4 cell count may increase with effective antiretroviral treatment or drop in response to infections such as flu or herpes, stress, smoking or menstruation (Van Dyk 2005:39-40).

1. The primary HIV infection phase (or seroconversion illness)
2. The asymptomatic phase
3. The minor symptomatic phase
4. The major symptomatic phase with opportunistic diseases
5. The severe symptomatic phase: Aids-defining conditions
   Note: This pattern may differ from individual to individual.
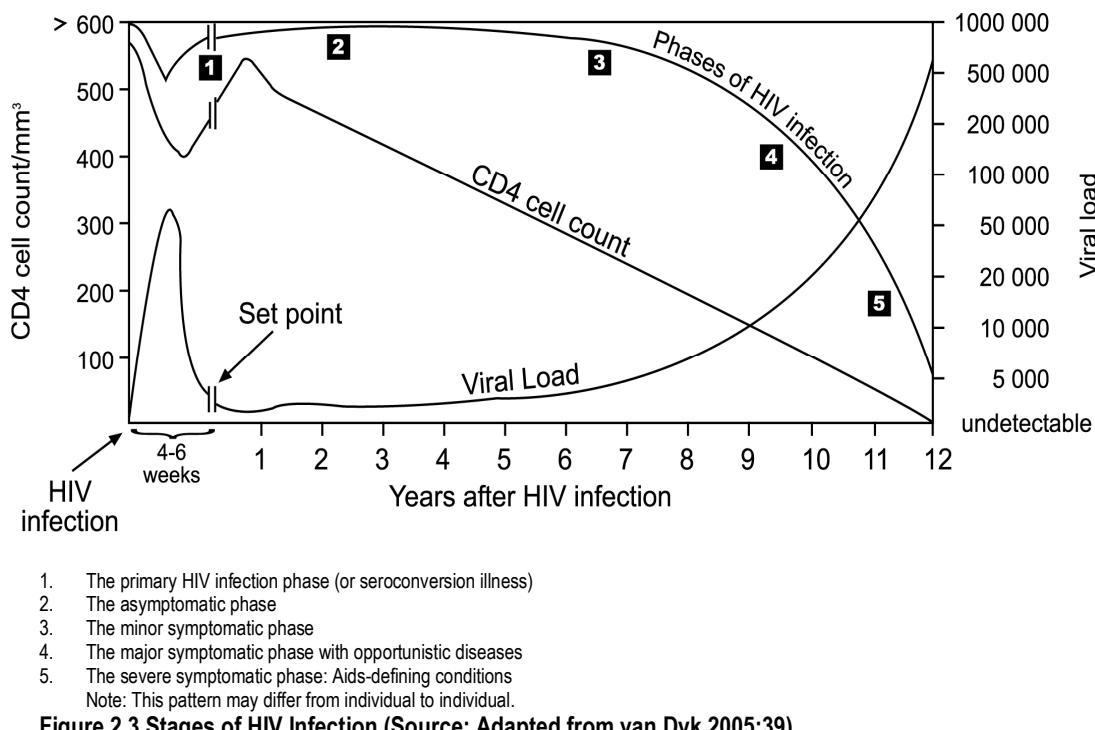
Figure 2.3 Stages of HIV Infection (Source: Adapted from van Dyk 2005:39)

2.3.1. The acute seroconversion illness (or Primary HIV infection phase)

The primary infection stage begins at the point when the HI virus is detectable in the blood of the person. This stage is called the acute seroconversion illness as at this point an individual's status converts or changes from an HIV negative to HIV positive status. The so called 'window period[17]' ends at this point. Seroconversion often happens from four to sixteen weeks after the HI virus's entry into the person's body. Van Dyk (2005:40) says that about "30-60% of individuals infected

---

[17] Van Dyk (2005: 66-7) explains that "The window period is the time between HIV infection and the appearance of detectable antibodies to the virus (when antibody tests will give positive results). In case of the most sensitive HIV antibody tests currently available, the window period is about 3-4 weeks. For less sensitive tests, the period can be longer (approximately 6 weeks). In some cases the window period can be as long as 12 weeks or (in rare cases) as long as 6 months, and any HIV antibody tests conducted during this window period may give false negative results. This means that, although the virus is present in the person's blood, antibodies can not yet be detected. The tests will indicate, incorrectly, that the person is not infected. Remember that an antibody test will become positive only after the host has mounted the initial immune response—namely to develop antibodies. The window period is usually much shorter for tests that detect the presence of the virus itself. Such tests do not have to wait for the immune system to form antibodies, but respond to the presence of the actual virus particles. During the window period the individual is already infectious and may unknowingly infect other people. People who are exposed to or who practice high risk behaviour are well advised to arrange for a repeat test after 3-6 months, and to practice safer sex (for example by using condoms) while waiting for their results".

with HIV will develop an illness similar to glandular fever at the time of seroconversion, and the symptoms of this fever will usually last a week or two. This seroconversion illness is often mistaken for a 'flu-like' viral infection, and it is characterized by symptoms such as a sore throat, headache, mild fever, fatigue or tiredness, muscle and joint pains, swelling of the lymph nodes, gastrointestinal symptoms, rash, and (occasionally) oral ulcers." The person will have a high viral load during this stage because since infection, a very rapid multiplication and replication of the HI virus will occur in the first weeks. The HIV positive individual will be especially infectious at this stage. The viral levels stabilize 16-24 weeks post infection. This is called the set point and coincides with the acute seroconversion illness (see figure 2.3 above).

2.3.2 The Asymptomatic Latent Stage of HIV Disease

In this stage an HIV infected individual shows no symptoms. Majority of infected persons are even ignorant that they are carrying the HI virus, and may unpremeditatedly infect new sex partners. The presence of the virus can not be denied even though the individual is unaware of it, as it is still active and continues to damage the individual's immune system. The only sign of infection during this stage is a positive HIV antibody test. So the HIV person can stay healthy for a considerable period of time with no symptoms of infection. Evans (in van Dyk 2005:41) says that "the CD4 cell count usually decreases by 40-80 cells/mm3 per year during the asymptomatic latent or silent phase."

2.3.3 The Minor Symptomatic Phase

In this phase of infection, early symptoms of HIV disease usually start to appear. The symptoms may include mild to moderate swelling of the lymph nodes in the neck, below the jaw, and in the armpits and groins; occasional fevers; herpes zoster or shingles; skin rashes, dermatitis, chronic

itchy skin; fungal nail infections; recurrent oral ulcerations; recurrent upper respiratory tract infections; weight loss up to 10% of usual body weight; and malaise, fatigue and lethargy. This stage is usually associated with a CD4 cell count of between 350 and 500cells/mm3 (van Dyk 2005:42).

2.3.4 The Major Symptomatic Phase

In this stage opportunistic infections and illnesses start to take hold as the person's immune system continues to deteriorate. The CD4 cell count drops considerably while the viral load rises (see figure 2.3 above). Signs of more severe HIV-related diseases begin to appear. The following symptoms are usually an indication of advanced immune deficiency: persistent and recurrent oral and vaginal *candida* infections (or thrush)—*candida* or thrush in the mouth is a common sign of immune deficiency and it does not usually occur unless the CD4 cell count is decreased—usually to less than 350 cells/mm3; recurrent herpes infections such as simplex (cold sores); recurrent herpes zoster (or shingles); acne-like bacterial skin infections and skin rashes; intermittent or constant unexplained fever that lasts for more than a month; night sweats; persistent and intractable chronic diarrhoea that lasts for more than a month; significant and unexplained weight loss (more than 10% of the usual body weight); generalized lymphadenopathy (or, in some cases, the shrinking of previously enlarged lymph nodes); abdominal discomfort; headaches; oral hairy *leukoplakia* (thickened white patches on the tongue); persistent cough and reactivation of Tuberculosis. The start of oral or vaginal *candidiasis* (thrush) and recurrent herpes infection, such as *simplex* (cold sores) or *herpes zoster* (shingles) are usually the first clinical signs of advanced immune deficiency. This stage is commonly associated with a CD4 cell count of between 200 and 350 cell/mm3 (van Dyk 2005:42-43). At this stage the HIV positive person will be bedridden 50% of the day.

2.3.5 The Severe Symptomatic Stage

This stage is sometimes called the "AIDS-defining conditions" (van Dyk 2005:43) or "full blown AIDS" (Magezi 2005) and it's the last stage of HIV infection. It usually takes about 18 months for the major symptomatic phase to develop into AIDS. At this stage the patient will have a severely depleted CD4 cell count, i.e. below 200 cells/mm3, and the viral load will be enormous. In the final stage of AIDS, the symptoms of HIV disease become more acute: patients become infected by relatively rare and unusual organisms that do not respond to antibiotics; the immune system deteriorates exponentially; and more persistent and untreatable opportunistic conditions and cancers begin to manifest. HIV-related organ damage is also common at this stage of AIDS.

The World Health Organization has given a clinical AIDS case definition called the *Bangui* Case definition (Haworth, A. et al 2001: 24; Magezi 2005:28). According to the Bangui Case Definition, AIDS in adults is diagnosable by the presence of at least two major symptoms and a minor sign in the absence of other familiar cases of immune-depletion. The Ministry of Health in Zambia adheres to the delineated "AIDS-defining criteria" (Haworth et al 2005:24).

Major Symptoms

- Weight loss of more than 10% of body weight within a short period.
- Chronic diarrhoea persisting for more than a month.
- Chronic fever lasting for over a month

Minor Signs

- Persistent cough for over one month.
- Generalized itchy lesion (dermatitis).

- Recurring shingles (herpes zoster).

- Thrush in the mouth and throat (candidiasis).

- Chronic, spreading and severe cold sores (herpes simplex).

- Generalized lymphadenopathy (swelling of lymph nodes for example in the armpits, groins, and neck).

- Dementia (loss of memory and intellectual capacity).

- Peripheral nerve damage.

The Zambian Ministry of Health counsels that the mere presence of Kaposi's sarcoma or cryptococcal meningitis on their own is enough for an AIDS diagnosis (Haworth et al 2001: 24).

2.4 HIV/AIDS in Southern Africa—A Gloomy State of Affairs

The WHO/HIV/AIDS Africa Region Update says that the current situation about HIV infection levels in Africa is primarily generated by Antenatal Clinics (ANCs) sentinel surveillance in the period 2003–2004 (2005:33). It points out that a direct comparison of HIV prevalence among women attending ANCs with HIV prevalence among both men and women combined in the same group of the population-based survey showed that the two sets of data were close, indicating that HIV prevalence among pregnant women can be used as an alternative pointer for HIV prevalence levels and trends in the general population in countries with generalized epidemics. Figure 2.4 below helps us to see and compare trends of HIV prevalence in four African sub-regions—Central, Eastern, Southern, and Western Africa. Southern Africa shows a markedly rising trend during the period from the 'advent' of the scourge thus pointing to the seriousness of the epidemic in this region where Zambia is located.
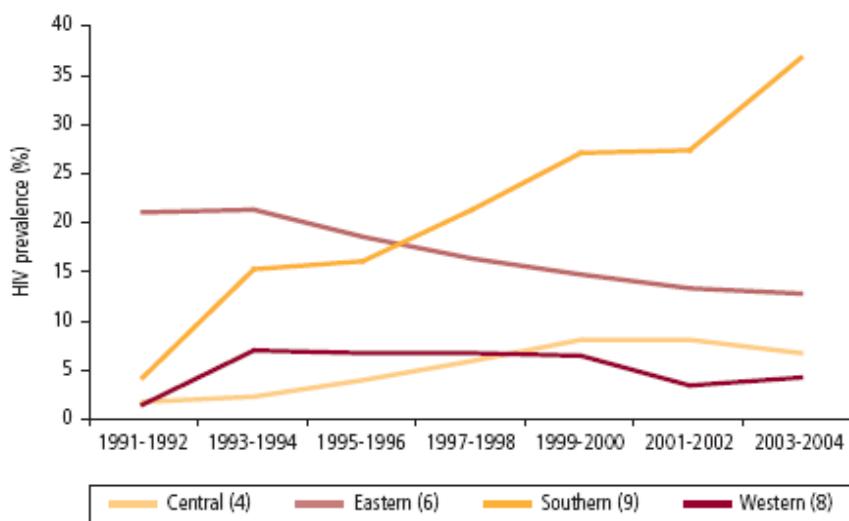
Figure 2.4 Trends in median HIV prevalence among pregnant women aged 15-49 years attending ANCs in four subregions 1991-2004 (Source: WHO/HIV/AIDS Africa Report 2005: 27)

The HIV/AIDS crisis in sub-region home to Zambia is so huge to that only a multisectoral[18] approach would help to check the further spread of the pandemic. HIV prevalence figures among antenatal mothers in nine cities in southern Africa showed a rising trend in HIV prevalence in nearly all Southern African cities from 21.3% (1997–1998) to 36.9% (2003–2004). Small declines have been observed in Harare (Zimbabwe) and Lilongwe (Malawi). WHO (2005a:27) points out that the current HIV prevalence rate (36.9%) in the southern Africa cities is almost three times higher than that for the capital cities in eastern Africa (12.8%), for instance. It is the researcher's opinion that this is an alarming state of affairs as after over two decades of the first AIDS diagnosis the trend should have been had a down turn considering preventive efforts made so far by various stakeholders in the sub-region.

---

[18] A multisectoral approach to combating HIV/AIDS is one that "actively involves different sectors, e.g., agriculture, health and includes private enterprise, NGOs and other sectors" (NAC/Ministry of Health 2002).

Michael Sidibe[19] (2006), in his Radio interview with James Butty on the 2006 World AIDS Day eve, said unequivocally that Africa has failed to tackle the HIV/AIDS pandemic. Sidibe (2006) asserted, *"Let us be very clear. We are not winning the war. What is happening is year after year we are seeing an increase in new infections. This year we had more than two point nine million new infections in Africa alone, which is representing probably 60 to 70 percent of all new infections worldwide. But what is really alarming is that 50 percent of those new infections is occurring among young people between 15 years old to 24 years old"* (emphasis added).
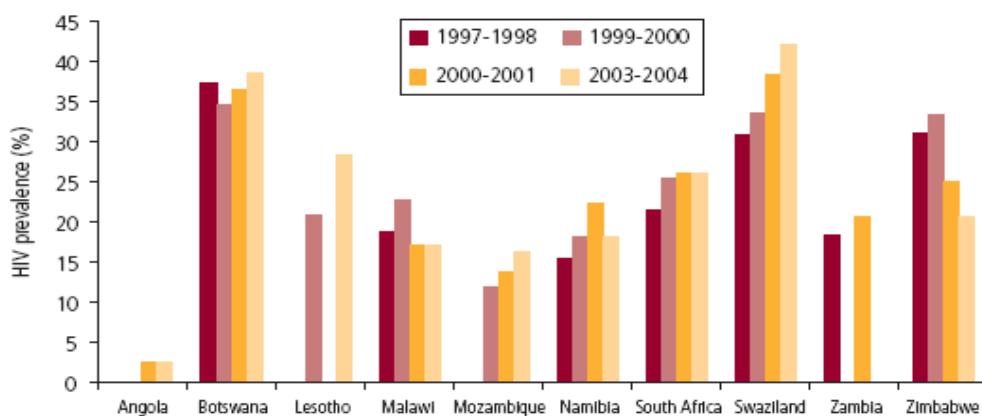
Figure 2.5 Trends in median HIV prevalence among women aged 15–49 years
Attending ANCs in southern Africa by country, 1997–2004
(Source: WHO/HIVAIDS Africa Report 2005: 42)

The southern African subregion, made up of ten countries (Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe), has an estimated population of 121 million of which 42% lives in urban areas and 58% in rural areas. More than 90% of all pregnant women in southern Africa attend ANCs. Data on HIV prevalence among expectant women attending ANCs show that southern Africa is most affected by HIV and AIDS (see Figures

---

[19] Michael Sidibe is head of country and regional support for the United Nations Program on HIV/AIDS.

2.4 and 2.5 above). Half of these countries have HIV prevalence rates of over 20%. HIV prevalence levels vary widely in the subregion, ranging from 2.4% in Angola to 16.2% in Mozambique to 42.2% in Swaziland. In 2003–2004, HIV prevalence levels among pregnant women attending ANCs were 42.2% in Swaziland, 37.4% in Botswana, 28.4% in Lesotho, 27.9% in South Africa, 20.5% in Zimbabwe, 18% in Namibia, 17% in Malawi and 16.2% in Mozambique. Zambia did not submit a report to WHO during this year, but according to van Dyk (2005:7) prevalence rates are said to have stabilized at 16% since 1999.

Antiretroviral treatment (ART) coverage still remains low in this subregion. For example, the Zambian government has only managed to cater for 75,000 people out of 149, 000 who urgently need ART (Magande 2006 National Budget Speech). This undoubtedly is a gloomy picture for the sub-region and Zambia in particular. This researcher believes all stakeholders must be asking one crucial question "What is fueling the spread of HIV/AIDS epidemic in the sub-region and our country?"

2.5 Factors Perpetuating HIV transmission In Zambia

DJ Louw (Magezi 2005:30) in his article, *'Pastoral Care for the Person with AIDS in an African Context'*, highlights the following critical 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 contraceptive advice as a political maneuver supporting white engineered intentions" (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's observation accurately describes Zambia's situation. The Republic of Zambia National HIV/AIDS/STI/TB Policy (NAC/Ministry of Health 2002:9-10) identifies similar factors contributing to the rapid spread of the HIV/AIDS pandemic in Zambia. These factors fueling the HIV/AIDS epidemic in Zambia are outlined below:

2.5.1 Social-cultural beliefs and practices

NAC points to social-cultural beliefs and practices, which look down on women in society, as a potent cause of rapid HIV infection in Zambia. For instance, in traditional premarital and post-marital counseling women are taught never to decline their husbands sexual intercourse even when it is clearly known that they are having extra marital sexual liaisons, or are suspected to have

HIV or indeed any other STI (NAC/Ministry of Health 2002; HRW 2002; Haworth et al 2001). Another practice commonly upheld among Zambian traditionalists is the practice of dry sex traditionally believed to heighten a man's sexual pleasure. Dry sex[20] facilitates HIV transmission via the laceration/bruising of genitalia during coitus, particularly in women. The traditional practice of widow/widower cleansing[21] also facilitates the transmission of HIV, although this practice has been fundamentally transformed among many tribal groupings in Zambia due to the advent of the HIV/AIDS epidemic. Many people were (are being) infected with the HI virus via this custom of sexual cleansing.

Adverse socio-economic conditions also impel women to exchange sex for money or gifts. Dr. Gordon Bolla (HRW 2002:16), the then director general of Zambia's National AIDS Council, aptly emphasized the link between HIV/AIDS and poverty: "Poverty is a big issue. People say, do I live now, or do I go into the street and earn a living? A person who is so poor, who will die if [s]he doesn't eat, will do bad things to survive." The "bad things" alludes to commercial sex work. This behaviour (commercial sex work) has made a significant contribution to the escalation of the HIV/AIDS epidemic in Zambia (NAC/Ministry of Health 2002; HRW 2002; Haworth et al 2001).

2.5.2 Mobility of groups more vulnerable to HIV

This factor mostly relates to populations who spend a considerable amount of time away from their (matrimonial) homes such as long distance truckers, migrant workers, cross-border traders, fishing and fish mongers. People involved in this trade often tend to have a 'second home/wife' in the

---

[20] Having sex where the vagina has been dried by the use of drying agents such as herbs and chemicals.

[21] 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.

areas where they go to work or do business for prolonged time spans. They, therefore, increase their vulnerability to HIV infection as usually no assurance that their 'second spouses' will be faithful to them is certain.

*Then, we have 'Uniformed Personnel'. T*his group includes the military and service personnel, such as police officers, who are often required to go away from their homes on duty for extended periods of time. Although there has been no prevalence of HIV study among uniformed personnel because of their tour of duties, this group is considered vulnerable to STD and HIV infection in part as a result of their high mobility, which keeps them away from their spouses and partners for extended periods of time (NAC/Ministry of Health 2002).

Prisoners—there were approximately 13,000 men and women in Zambia's prisons in 2002. Male prisoners are especially susceptible to HIV infection because it's not a rarity that unprotected, penetrative anal sex occurs in prisons either in the form of rape or as mutually consenting partners. The high prevalence of STDs and very low and inconsistent use of condoms also perpetuate the rapid spread of HIV/AIDS among prisoners. Presently Zambian Law does not allow the distribution of condoms in prisons. Penetrative anal intercourse is not uncommon in men's prison which is done without any protection measures at all. In many cases Prisoners delay in accessing medical services, as a result delaying the timeous diagnosis and treatment of STDs (NAC/Ministry of Health 2002).

2.5.3 Poverty

The HRW (2002) reported that a close interaction between poverty and HIV/AIDS in Zambia existed. This is now an irrefutable truth in sub-Saharan Africa where poverty levels are some of the

highest in the world. According to this researcher, it is now a well-worn observation that HIV can bring poverty and poverty can promote HIV/AIDS. A little over 80% of Zambians fall below the poverty level and majority of these are women (HRW 2002 etc.). A rising proportion of female-headed households are emerging in Zambia mainly due to, the HIV/AIDS epidemic. Child headed homes are not a rarity any more. Rising poverty has in some cases forced households to give their girl children into "sex for survival" (HRW 2002:35). The HRW Report (2002: 37), citing the National AIDS Council, highlights this unfortunate scenario as an implication of poverty on HIV/AIDS as follows: "In order to cope, households pull their children, particularly girls, from school, reduce their food intake and in some cases [they] resort to begging. In these circumstances, some women and girls are forced to engage in sex for money to meet their household expenses." The high poverty levels limit the enjoyment of social and economic rights such as education, health care, employment and social services by households. Magezi (2005: 57) succinctly describes 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…." Figure 2.6 below is a diagrammatic illustration of the relationship between poverty and HIV/AIDS. It demonstrates how a household giving home-based care to a person living HIV/AIDS can be impacted by HIV/AIDS and how poverty might heighten susceptibility to HIV/AIDS.

Figure 2.6-The Poverty and HIV/AIDS Interplay (Source: Magezi 2005:58)
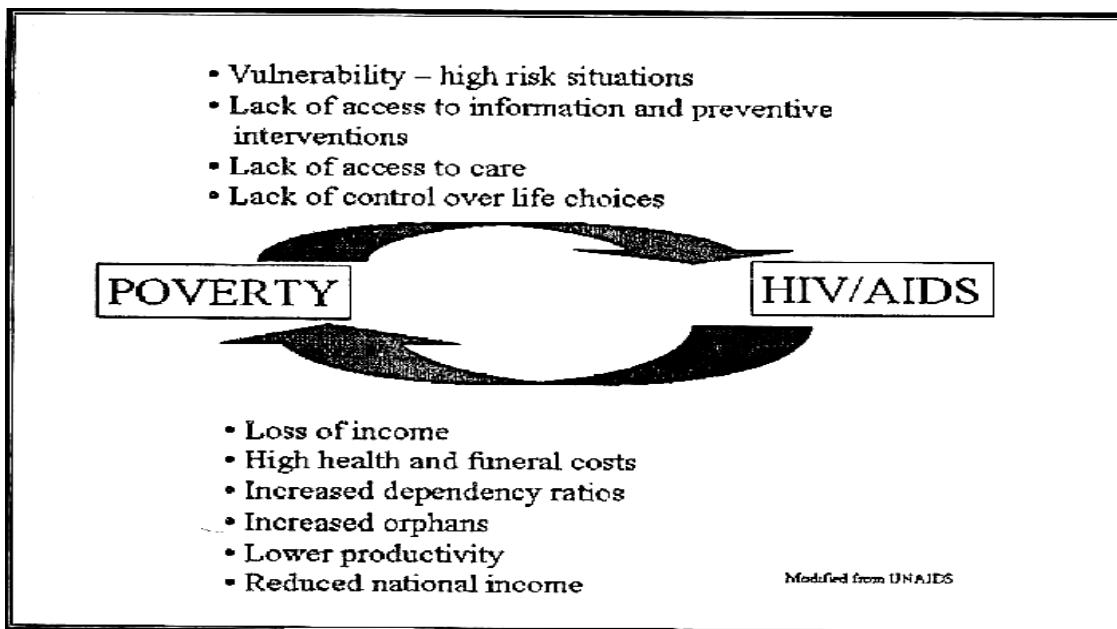
C. Greyling adeptly summarizes the interplay between poverty and HIV/AIDS thus:

- Poverty reduces children's chances of attending school; this in turn lowers their chances of gaining employment and increases the risk of HIV infection. Children often have to drop out of school to care for the sick family members, for their young siblings or to look for work. Children lose the chance to "children" because of these additional responsibilities.

- Poverty increases the likelihood that young women (and men) turn to commercial sex work, selling their bodies to survive, to gain an income to support younger siblings, to secure their next meal, to gain shelter, money for school fees, etc.

- Young people living in poverty often have low levels of self esteem and desire the material things their friends have, which may put them at risk of HIV/AIDS infection through becoming involved with "sugar daddies", taxi drivers, etc.—people who can give them material things they wish for. "Gift sex" is not seen as prostitution and is extremely common in many societies.

- As parents fall ill with AIDS, they afford no time to parenting their children, leading to risk-taking behaviour among young people due to the lack of attention and guidance they receive. Risk behaviour often leads to unsafe sexual activity, and in turn, to HIV infection.

- Some children are intentionally neglected and abused or forced to take on household tasks when they are taken in by relatives or other families due to the illness of their parents—they are also at risk of HIV infections as their own self-esteem plummets due to this abuse.

- According to home-based care providers, many AIDS-related patients die of malnutrition and not primarily of AIDS-related illnesses—people simply do not have sufficient food, leading to premature death even in the face [of] AIDS.

- As a person progresses from HIV infection to AIDS, they suffer many bouts of illness for which they seek treatment. In the process they spend money on medical care, traditional healers, etc. as well as on nutrition and supplements to help them remain healthy for a long period of time.

- Those members of the household who are in the weakest positions suffer the most—in affected households, health expenditure for the infected person increase while spending on food and other essentials decreases, impacting on women and children.

- Burial costs are increasing due to shortage of grave space in urban cemeteries.

- Funerals are very expensive but important elements of cultural tradition and a great deal of money is spent on food and drink for the duration of the funeral. Funerals extend over a number of days and are attended by family, extended family and the community at large. Therefore funerals continue to be costly and consume valuable resources, which could have been used by the surviving family members. The impact of death is most serious on proper households (cited in Magezi 2005:64-65, 70).

Greyling's analysis of the poverty and HIV/AIDS interaction cited above is logical, but does not mean that the interplay of poverty and HIV/AIDS is simplistic. It is more intricate than it appears and the situation calls for a cautious stance toward its perception. It should however be noted that poverty intrinsically exacerbates HIV/AIDS and HIV/AIDS raises poverty levels (Barnett & Whiteside 2002).

2.5.4 The Gender Dimension

In the Zambian situation women still have limited access to productive resources such as land, credit, skills, capital, technology and information. Consequently, most of them are economically

reliant on men. This situation contributes to their inability to negotiate for safer sex and sometimes impels them to engage in commercial sex to earn a living. Girls from poor families are sometimes enticed into early marriages, prostitution, and hence become vulnerable to HIV infection. Agatha T's (a pseudonym) story below is an example of a sad and subtle gender linked causative of HIV infection in Lusaka, Zambia:

> My stepmother treated me like an animal—and Daddy said "you're just a liar." He said there was no money for school (I was in grade three), so I started selling fritters for neighbors. Then I met a group of people—prostitutes. They all stayed in a one-room house. They said they'd buy all my fritters if I would cook and clean for them. Then [they] said [I] should join them. So I ran away, and started living with them. They brought me men to sleep with. . . . They bought me clothes and shoes so I could go to the street. I went looking for men. I'd come back at 5:00 or 6:00 in the morning. Sometimes I met some savages. They grabbed my money and ran away, or they'd hit me and take me to the bush far away and leave me there. The queen mother was twenty-one—us, we were young, about ten or twelve. The youngest one was nine. One day I got pregnant, and didn't know who the father was. The queen said I have to abort it. She took a stick and entered me until I aborted. I got sick with STDs. I was tested at the clinic. The doctor there insulted me. The queen brought me herbs—traditional medicine. Even though I was sick, she said I have to work. When I asked men to use condoms, they refused. Sometimes, sex with condoms was cheaper. One night, I was in a nightclub with a friend, and we met two men. They said they'd give us 200,000 [U.S. $46.50] each. We went to the bush, and they said they were going to kill us. I started crying. So the man felt pity, and he told me to runaway. I ran until I reached the road, and I got into a car that brought me home. I told the queen mother what happened. Then my friend came back, crawling. The man had taken a stick, pushed it inside her, and left the stick in. We took her to the hospital, but she died. She was ten years old. We didn't know where her parents were. The queen said we have to go to work to buy a coffin. That day, I started thinking—what next? Maybe I'll die.
> —Agatha T., former sex worker, now eighteen (HRW 2002:35)

The Human Rights Watch (HRW) report further observes that "Increasing poverty in Zambia has contributed to a rise in the sexual exploitation of girls" (2002:37). The story above partly explains the higher HIV prevalence levels among young women and girls than their contemporary males. An NGO, Women in Law & Development in Africa (WILDAF)-Zambia (HRW 2002:21) noted: "HIV/AIDS has a special gender dimension. First, women who are married are at the greatest risk of infection because of male promiscuity which is tolerated by social and cultural norms. …Traditionally, men cannot commit adultery except with another man's wife. Safe sex is rarely

practiced within marriage." Besides women's subordination, traditional practices (highlighted in 2.5.1 above and elaborated in 2.7.1 below) heighten their susceptibility to HIV/AIDS infection.

2.6. Interventions to the HIV/AIDS pandemic in Zambia

The Zambian government has shown a high level of political commitment to tackle the HIV and AIDS pandemic. A number of national support structures have been set up. For instance, as soon as the first AIDS diagnosis was made in 1984, within two years (1986), Zambia formed the National AIDS Surveillance Committee and the National AIDS Prevention and Control Programme. In 1987, an emergency plan was established to take care of the safety of blood supply. In December 2002, the National HIV/AIDS/STI/TB Council (NAC) was formed to coordinate the national multisectoral response, which included a health sector response. A Cabinet Committee on HIV/AIDS has also been created to give policy leadership and to frequently report to the Cabinet on HIV/AIDS matters. In 2002 a comprehensive national HIV/AIDS policy was finalized[22]. A Country-wide plan for reducing HIV/AIDS and sexually transmitted infections has been put in place. This plan stresses the scaling up of HIV/AIDS care and treatment. Furthermore, Zambia has been strengthening the capacity of the health sector's response to HIV/AIDS through several initiatives, namely, the Poverty Reduction Strategy Programme, the Highly Indebted Poor Country Initiative, the Zambia Social Investment Fund, the Zambia National Response to HIV/AIDS Project (funded through the World Bank Multi-Country HIV/AIDS Program for Africa) and the Global Fund to Fight AIDS, Tuberculosis and Malaria grant from Round Table 1. These government initiatives seek to expand voluntary counselling and testing services (VCT), provide free antiretroviral therapy, develop home-based care, manage opportunistic infections, strengthen laboratory capacity, ensure blood safety,

---

[22] The policy is currently being reviewed and will soon be finalized.

manage sexually transmitted infections, and encourage behaviour change (NAC/Ministry of Health 2002, WHO 2005b).

Zambia, however, is facing a critical challenge in the area of scaling up antiretroviral treatment due to a low rate of disbursing pledged funds to finance the procurement of medicines and other essential supplies (WHO 2005). A scarcity of trained human resource is another challenge. Dissemination of modes of HIV transmission (especially in rural areas) is insufficient. VCT is being hampered by the stigmatization still associated with HIV/AIDS (WHO 2005). Furthermore, many socio-cultural factors hinder the tackling of HIV-related issues in Zambia. For instance, deep-rooted cultural taboos inhibit parents from discussing sex with their children. This trend checks effective sex education. It is the position of this research that in order to tackle the HIV crisis strategic efforts must be made to transform the worldview of Zambians in which high risk behaviour (responsible for the proliferation of the HIV/AIDS pandemic) is inextricably implanted. Short of this worldview transformative approach, all interventions will bear little fruit.

2.7 HIV/AIDS in Zambian Worldview

That some traditional practices and customs have significantly contributed to the rapid growth of the HIV/AIDS crisis in Zambia cannot be overemphasized. It is not the practices and customs in and of themselves that are faulty, but the presuppositions and beliefs (worldview) that underlie the behaviour. It is the position of this researcher that in order to win the fight against the HIV/AIDS scourge through facilitating behaviour change (which is chiefly responsible for the proliferation of HIV infection in Zambia), Zambian Culture and worldview must be engaged with a view to transform it. Authentic change can only be from inside out and not the reverse.

2.7.1 Culture & Worldview

Paul G Hiebert (2004: 30) defines culture as the "integrated systems of ideas, feelings, and values and their associated patterns of behaviour and products shared by a group of people who organize and regulate what they think, feel, and do." He aptly demonstrates that culture and its concomitant worldview determine the way people behave. Behaviour is essentially rooted in people's worldview (mind-set). Charles H. Kraft (Winter & Hawthorne 2004:385-387) says that culture is "people's way of life, their design for living, their way of coping with their biological, physical and social environment." Kraft further concludes that culture is essentially founded on worldview. He points out that "worldview is not separate from culture…. [Its] assumptions provide the 'glue' with which people hold their culture together" (Winter & Hawthorne 2004:385-387).

Joe M Kapolyo (2006: 119-122) uses the picture of an onion (see figure 2.7 below), with its layers of skin, to show the complex cultural make up of any specific group of people. The concentric circles are numbered 1-6, starting with the core or the heart. In the first circle (1), is located one's religious beliefs, essential vision of life, the world and his/her place in it, including values and norms that constitute one's worldview. The next circles 2-6 represent "material and spiritual creations such as marriage, initiation rites, work, family, healing, customs, behaviors, habits, and others" (Kapolyo 2006:119-120) The first circle (worldview) is invisible, but completely percolates and controls all outward behaviour, speech, and products. "The inner deeper cultural layers determine and direct the outward layers" (Kapolyo 2006:120).
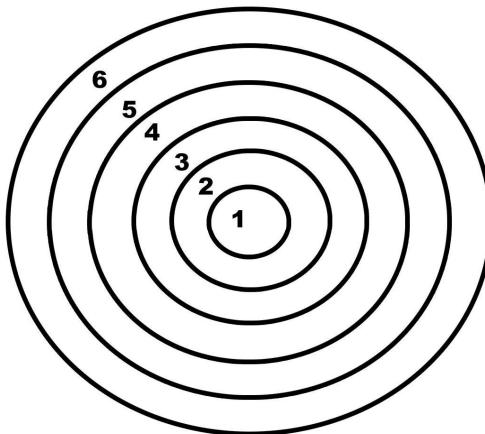
**Figure 2.7—Culture and Worldview Structure
(Source: Kapolyo 2005:120)**

This truth may also be shown by using the biblical metaphor of a tree (roots below the ground support and feed the stem, branches, leaves and fruit above the ground). In addition, Kapolyo pithily established that every culture is 'supported and fed' by an aggregate of invisible fundamental assumptions and beliefs whose locale is in the worldview. For authentic transformation to happen in any culture the change must start with the worldview. If the worldview is not changed all change at the culture level will be superficial and short-lived. What, then, are the issues to be addressed for transformation at the worldview level?

2.7.1.1 Concepts of sex and sexuality in Zambia

Sexuality occupies a pivotal role in Zambian society. However, sex is inexplicably perceived with mixed emotions. On one hand sex is surrounded with fear, but on the other associated with pleasure (Rasing 2006). Sex is deemed as a need for physical and emotional wellbeing of both men and women. Among the Bembas[23] sex in marriage is viewed differently from sex outside

---

[23] Bembas are a tribal grouping originally from Northern and Luapula provinces of Zambia. The Bemba language is widely spoken in Zambia perhaps second only to English—the country's official and business language. This

marriage. Marital sex, *ukucite cupo* (literally to create a marriage), is accepted as normal and legal. Sex outside marriage (both premarital and extramarital), *ukwangala*, literally 'to play', is regarded as not serious and illegitimate. An individual who indulges in illicit sex becomes 'polluted' and is considered to be harmful to others. This pollution is so serious that a woman involved in illicit sex is not allowed to cook food for other innocent people as that might cause them to suffer from inexplicable illnesses. Consequently, adultery is regarded as hazardous to the wellbeing of the community, especially of close relatives. Sexual immorality is also dangerous to the person indulging in it because he/she risks contracting *icifuba*[24] (a long-known illness believed to be caused by illegitimate sexual contact). It is believed that the blood of the adulterer intermingles with the blood of the third person and also with that of his/her spouse. This is seen to be very dangerous and there is a taboo on "mixing blood" (*wisankanya mulopa*). Blood is linked to the ancestral spirits in the Bemba worldview. This worldview places a very close connection between sex and blood. It is especially dangerous to commit adultery when one's wife is pregnant, or when a woman herself is pregnant, because (it is believed) adultery during pregnancy will harm the baby and the faithful spouse[25]. If a woman dies during child-birth or if a newly born child dies soon after its birth, the husband will be accused of having been unfaithful to his wife (*ncila* or *ncentu*). In ancient times, such a man had to sacrifice his sister by killing her for causing the death of his spouse. This custom has, however, disappeared, but it still happens that men are blamed and punished by their in-laws if a wife or child dies in labour or soon after birth.

---

researcher belongs to this tribal grouping, but the concepts and practices discussed here are generally common in most Zambian tribes.

[24] Among the Bemba speaking people of Zambia *Icifuba* is a disease presenting the same symptoms as AIDS such as weight loss, diarrhoea, and coughing, and is incurable. This illness is believed to be contracted by a person who has had illicit sex especially with a widow/widower who has not been customarily cleansed by having sexual intercourse with a close relative of the dead spouse.

[25] This custom partly supplies the rationale for polygamy so that the man (who during his wife's pregnancy is not allowed to have sexual intercourse with her until after child birth) can still legitimately have sex with another wife he is legally married to under customary law.

2.7.1.2 Sex education

As intimated in the foregoing section, sex in traditional Zambia is considered to be important. Since sex is considered important, sex education is given to children at an early age, but not by their parents as it is a taboo for parents to talk about sexual matters to their children. Sex education is thus given by grandparents to their grandchildren. Grandmothers will teach their granddaughters and to a lesser extent their grandsons. Grandfathers give sex education to their grandsons only—they are not permitted to give sex education to their granddaughters. This sexual guidance is usually given in an indirect manner using stories/tales (*inshimi*). Customarily, it is forbidden to discuss sexual matters with a member of the opposite sex (except a spouse, but even then sex is almost not discussed). Grandparents, however, are allowed to talk about sexual matters with their grandchildren.

Although the taboo to talk about sexual issues with one's own children customarily exists, in recent times (especially among middle and working class people in urban areas) women consider it their duty to openly talk to their daughters about sexual issues. This is attributable to the fact that contemporary adult children and their families usually live far away from their villages, where their parents live. Additionally, with rising pregnancies and a high HIV prevalence among the youth in Zambia (especially in urban centers) mothers see the need for 'accurate' sex education. This information/education given by mothers still remains superficial often consisting of warnings against premarital sex and avoiding friendships with members of the opposite sex. Mothers also teach their sons because, for some unclear reasons, fathers refrain from fulfilling the role of their grandparents who are usually at the village. Particularly among men in Zambia, a shame culture to talk openly about sexual matters with their children is pervasive. A spin-off of this 'silence' is that

youngsters get wrong sex education from wrong sources often leading to risky sexual behaviour which ultimately exposes them to HIV infection. This trend should also be transformed so that fathers a didactic role in this vital matter.

2.7.1.3 Initiation rites

Nearly all ethnic groups in Zambia have an initiation rite for girls, while some ethnic groups have an initiation rite for boys too. Young men and women are given traditional sex education during initiation ceremonies. Though initiation rites are ancient, they still play a vital role in traditional Zambia today. It is significant to observe, however, that these rites relegate HIV/AIDS information to the peripherals in as far as these institutions are concerned. The initiation, being a rite of transition from childhood to adulthood, sets a foundation for adult life by creating a new adult identity. It prepares a maturing young person with a plethora of social attributes (and skills) that an adult is expected to have for the rest of her/his life. "Norms and values concerning gender, production and reproduction, and cosmological ideas are passed on…. [And] ethnic identity is stressed. Symbols and rituals contribute to the creation and maintenance of an inclusive cosmology" (Rasing 2006).It is the researcher's position that ingrained sexual behaviour (values that fundamentally affect sexual expression) is partly inculcated during these ceremonies. Furthermore, I believe that a transformation of the didactic content of initiation ceremonies can assist change sexual behaviour toward safer sex ("Traditional Cultural Practices of Imparting Sex Education and the Fight against HIV/AIDS: The Case of Initiation" 2006).

2.7.1.3.1 Female initiation rites-In Zambian, and many other South Central African societies, females' initiation rites normally occur at puberty. Among the Bembas the young lady is taught by respected and initiated senior women (*nacumbusa*), usually a paternal aunt. Instruction is done

through cryptic songs, dance, and display of clay models (*mbusa*) which express traditional values. The *nacimbusa* (instructor) is tasked to explicate these modes of instruction. From this point on the girl has passed from childhood to womanhood and is expected to behave accordingly, even though she is told to refrain from premarital sex. Nevertheless, she is taught that adulthood incorporates the joy of sexuality. She is taught that she too can initiate sexual relations with her husband and actively participate in coitus (Rasing 2006). However, lacking in this 'coaching' is the topic on HIV/AIDS prevention. Often HIV/AIDS seems to be understood as the disease of sexual pollution contracted by breaking a taboo, such having sexual intercourse with a widow/widower who has not been customarily cleansed after the death of a spouse (Raising 2006).

*2.7.1.3.2 Male Initiation-*Male initiation rites are rarer than female initiation ceremonies in Zambia. Only the north-western province of Zambia strictly practices initiation for boys. Initiation for boys is usually done in a group setting with other boys, but not necessarily of the same age. Initiation for boys stresses manhood, that is, strength, perseverance, independence and solidarity with other males. Usually, male initiation will include circumcision, showing that to become a male adult a man must not only undergo a ritual, but bodily changes occur as well. The painful ordeal of circumcision and the secrecy of the rite 'differentiates' between the initiated and the uninitiated. Starkly absent too from the male ceremony is HIV/AIDS awareness training.

2.7.2 An African view of sickness and HIV/AIDS

Van Dyk pithily points out that "[I]f education and prevention programmes are to be successful in Africa, it is important for us to understand and appreciate the traditional African world-view." This understanding is crucial to changing people's sexual behaviour, which is primarily the reason HIV/AIDS is rapidly spreading in sub-Saharan Africa. In Zambia there seems to be a denial of the

link between risky sexual behaviour and HIV/AIDS infection. As in most African countries a belief that sickness (including HIV/AIDS infection) has a personalistic cause still persists. Berinyuu (Magezi 2005:35-36) asserts that to an African, sickness is viewed as "personalistic". He explains:

> A personalistic medical system…is one in which disease is explained as being due to the active purposeful intervention of an agent, who may be human (a witch or sorcerer), non-human (a ghost, an ancestor, an evil spirit), or supernatural (a deity or other very powerful being). The sick person is viewed as a victim, the object of aggression or punishment directed specifically against him. This view of sickness is in contrast to the western naturalistic system that explains sickness in terms of impersonal terms, systemic terms. Disease is thought to stem, not from the machinations of an angry being, but rather from such natural forces or conditions as cold, or an upset in the balance of basic body elements. Thus supernatural causes are perceived as the causes of sickness in Africa, while in the west it is due to non-supernatural causes

The point made here is that sickness in an African's perspective occurs as a sanction or punishment for an 'abomination' committed by a person. Kasambala (Magezi 2005: 37) says that for an African, health is a sign of right relationship between the person and the supernatural world and breaking from the delicate balance can cause misfortune and sickness. He writes,

> One could not possibly fall sick unless there is a disturbance within the systematic rhythm of life, which includes; the breakdown of harmony in personal and communal relationship, disrespect for cosmic existence within the cosmology of an African spirituality and, or lack of adherence to African health values (in Magezi 2005:37).

Van Dyk (2005:116) reiterates this same personalistic perception of illness in an African mindset when she writes,

> "When bad things happen, traditional thought does not simply attribute it to bad luck, chance, or fate. Instead there is a belief that every illness is directed by an intention and a specific cause. In order to fight the illness, it is therefore necessary to identify, uproot, punish, eliminate, and neutralize the cause, intention behind the cause, and agent of the

cause and intention. In an attempt to understand illness, traditional Africans will always ask the questions 'why' and 'who?'…. There are beliefs that mental as well as physical illness can be caused by disharmony between a person and the ancestors, by a god or spirits, by witches or sorcerers, by natural causes, or by a breakdown in human relationships"

A similar personalistic worldview is found in most of Zambia. Kapolyo (2005:127), writing on the Bemba tribe of Northern Zambia, says that "an illness … is never considered, let alone treated, in isolation. Contrary to normal biomedical practice, an illness is treated as part of the person suffering within a context of community, which includes both the people alive, and the spirits of the ancestors." For instance, witchcraft is blamed for HIV infection, AIDS and death in many African countries, particularly rural communities where education levels are usually lower (van Dyk 2005). In a study done in Zambia above a quarter of respondents attributed STI to witchcraft. *"Why else,"* *they argued, "will one man become infected and the other remain uninfected when both men have* *had sexual contact with the same woman?"* (van Dyk 2005: 117 emphasis added). Van Dyk admits that traditional beliefs do not attribute all illnesses to evildoing.

> "Traditional beliefs accept that some diseases (such as colds, influenza, diarrhoea in children, STIs and Malaria) are caused by natural causes such as 'germs'. Although witches may sometimes use germs and sexual intercourse to cause illnesss, it is accepted that the immediate cause of STIs is germ related; that they are transmitted through sexual intercourse; and that they can be prevented by behaviour change….Unfortunately, the connection between STIs, Aids and sexual behaviour change is often not made in Africa. People often cannot understand why they have to change their sexual practices to prevent HIV infection, because HIV attacks everything except their sexual organs. They believe that the place where a germ or disease enters the body is the body part that becomes ill (the genitalia are usually affected in the case of syphilis, but not in the case of HIV infection)" [van Dyk 2005:120].

A connection between the AIDS message and STI prevention in Africa is needed. Van Dyk also emphasizes the need for a strong link between the AIDS message and STI prevention. I believe

that the misunderstanding of the HIV/AIDS message can partially be ascribed to a matter which only a change at the worldview level can bring about.

2.8 Conclusion

Four critical conclusions emerge from this chapter. Firstly, evangelical Christians involved in giving pastoral care to HIV/AIDS patients must have accurate information on HIV and AIDS—such as definition, origin, transmission, statistics, stages of HIV illness, etc—if they are to be effective caregivers. This observation points to the importance of equipping church members in HIV/AIDS pastoral care-giving (Dube 2003b: iv; van Dyk 2005).

Secondly, the nature of the poverty and HIV/AIDS interaction is double-pronged. Poverty increases the poor's susceptibility to HIV infection as a 'push factor' toward risky behaviour. HIV/AIDS also hastens the destruction of an individual's immunity due to things such as malnutrition caused by diminishing resources (meaning that poorer people might die earlier than the well-to-do). Conversely HIV/AIDS accelerates the 'journey' to poverty as the previously productive person in the home is slowed down by the illness and begins to spend his/her savings. Household funds are depleted by high medical and funeral expenses leaving survivors of the deceased with meager resources to live on and educate their children. At the national level, economic performance is adversely affected. For instance, a research done among the agricultural community of Zambia showed that agricultural production drastically dropped due to the HIV and AIDS epidemic (see Drinkwater M, McEwan M and Samuels F 2005).

Thirdly, evangelical Christians in Zambia have an incalculable advantage when it comes to helping HIV/AIDS positive individuals. Evangelical Churches are strategically placed to disseminate

information. Churches are found in all corners of the country and still fulfill the function of an opinion leader—influencing their constituency on issues affecting them. This implies that evangelical Christians have a pivotal role to play toward empowering church people for effective care of HIV/AIDS positive people via education and other life-skills training.

And fourthly, in order to effectively reduce HIV/AIDS prevalence in Zambia, socio-cultural changes must be made, especially in the area of sexual behaviour. Changes at the traditional practices and lifestyle levels will help stem the spread of HIV/AIDS infection. Evangelical Christians involved in HIV/AIDS interventions are to be aware of a personalistic worldview of illness and designing support systems. The following question can be posed: "What should be the relationship of evangelical Christians to a society plagued by HIV and AIDS?" Chapter three tackles this issue.

Chapter 3
The HIV/AIDS Epidemic: A Challenge to Evangelical
Practice of Theology in Zambia

3.0 Introduction

The preceding chapter gave a concise situational analysis of the HIV/AIDS epidemic in Zambia. It delineated essential facts and knowledge on HIV/AIDS which every caregiver in Zambia must have such as, the definition of HIV and AIDS, modes of transmission, factors fueling the spread of the epidemic, challenges to the fight against the scourge, the impact of the disease on the country, and concluded that evangelical churches in Zambia have a critical role to play in the fight against the scourge. The current chapter will show that Zambian evangelical Christians have no option but to be involved in the fight against the HIVAIDS epidemic. So far non-evangelical churches in Zambia have led the way in church-based HIV/AIDS interventions, while evangelical churches have been uninvolved preferring the proclamation of the Gospel to direct interventionist work. This research will show that evangelical churches can make an invaluable contribution toward alleviating the suffering of people living with HIV and AIDS in Zambia.

Or wrote in a *Christianity Today* article *'Zambia Faith Leaders Unite to Tackle HIV/AIDS'* (2005) that the mother body of evangelical churches in Zambia (Evangelical Fellowship of Zambia [EFZ]) had joined efforts with other faiths (under the auspices of the Zambia Inter-faith Networking Group [ZINGO[26]]) to tackle the HIV/AIDS epidemic. This move by ZINGO went as far as signing a communiqué of commitment to 'respond favourably' when approached for help and support by

---

[26] ZINGO is currently made up of seven organizations namely, the Council of Churches in Zambia (CCZ), the Evangelical Fellowship of Zambia (EFZ), the Independent Churches of Zambia (ICOZ), the Zambia Episcopal Conference (ZEC), the National Spiritual Assembly of the Bahai's (NSAB), the Hindu Association of Zambia (HAZ) and the Islamic Council of Zambia.

"their members, societies, and communities" afflicted by the HIV and AIDS epidemic. The decision by Zambian faith leaders to unite against a common enemy of humanity such as HIV/AIDS is commendable, but, for what evangelicalism is, some critical question must be answered to justify this 'unity of convenience'. Important questions emerge, therefore: what is the responsibility of evangelical churches in Zambia in such a somber HIV/AIDS situation? How can evangelical Christians respond adequately to the HIV/AIDS pandemic? Is there any Scriptural warrant for involvement in HIV and AIDS 'work'? This chapter will contend that HIV/AIDS is such a pressing issue that Evangelical Christians in Zambia can not afford to relegate it to the peripherals of their social agenda. The chapter will demonstrate the premise that for the church to be germane to the sufferings of PLWHA, it must become a channel of God's love and compassion to them instead of embracing a non-engagement position. It will highlight the pressing need for the Zambian evangelical church to "change its position of apathy to one of empathy[27]" (Magezi 2005:77).

3.1 Understanding Evangelical Churches in Zambia

What is an evangelical church in the Zambian situation? This section is based on the premise that the mission of the church, in a context of the HIV/AIDS epidemic, issues from the nature of the church. Steve de Gruchy (2006:2) in his editorial notes well, "The silence that pervades the church whilst so many die—inside and outside the church—is a profound challenge about what it means to be church in a time like this." This section will explore the biblical understanding of church in order to inform the practice of theology in our current crisis of HIV and AIDS. A feasible model of ministry

---

[27] This researcher has been involved in evangelical ministry in Zambia for the past decade and it's sad to note that most church-based HIV/AIDS work in Zambia is being done by non-evangelical Churches (notably the Roman Catholic Church). Evangelical Christians have assumed a suspicious stance towards HIV/AIDS work and PLWHA which at best has only served to perpetuated stigma and apathy (cf. Parry 2005).

to people living with HIV and AIDS informed by a Scriptural depiction of the Church will be suggested.

3.1.1 Definition of Church

What is Scripture's definition of church? Erickson (2002: 1036) observes that there is a lot of confusion regarding the definition of the term "church" when he writes, "The church is at once a very familiar and very misunderstood topic". In Zambia the term church is also susceptible to misunderstanding. This researcher will use the term "church" in Zambia to allude to that stream of Christianity called "evangelical churches" most of whom are members of the Evangelical Fellowship of Zambia (EFZ). But, again, the word "evangelical" is fast becoming a difficult term to define in our times.

What is evangelicalism? Pierard and Elwell (Elwell 2001:405) define evangelicalism as "the movement in modern Christianity, transcending denominational and confessional boundaries, that emphasizes conformity to the basic tenets of the faith and a missionary outreach of compassion and urgency." According to this definition, an individual who identifies him/herself with this movement is called an "evangelical"—i.e. someone who believes and promulgates the gospel of Jesus Christ. In this work, therefore, the term "evangelical churches (Christians)" will allude to a wide array of denominational and independent churches in the republic of Zambia who adhere to the following core theological tenets:

i. the Bible as the divinely inspired record of God's revelation, the infallible, and authoritative guide for faith and practice,
ii. the total depravity of humanity (that all the goodness that exists in human nature is tainted by sin , and no dimension of life is free from its effects),
iii. God has provided the way out of the human dilemma by allowing His Son, Jesus Christ, to assume the penalty and experience of death on humanity's behalf,

iv.   Salvation as an act of God's unmerited grace received through faith in Christ alone (not through any kind of penance or good works),

v.   Preaching of the Word of God as the vital means of bringing people to the Christian faith, and

vi.   the visible personal return of Jesus Christ to set up His kingdom of righteousness, a new heaven and earth, and consummate the judgment upon the world and the salvation of the saints(Elwell 2001: 406).

The foregoing points are the essential distinguishing marks of evangelicals in Zambia, but note too that evangelicals share many tenets with other orthodox Christians, such as, the Trinity, Christ's incarnation, the virgin birth of Christ, His literal death and bodily resurrection; the reality of miracles and the supernatural realm; the Church as the body of Christ; the practice of the sacraments (believers' baptism and holy communion[28]); baptism in the Holy Spirit[29]; etc. The essential characteristic of these churches is that they adhere to the central beliefs of historic Christianity (especially those listed above) as opposed to liberalism.

Wayne Grudem (1994:853) in his *Systematic Theology* defines the term "church" as "the community of all true believers for all time". He explicates that the church comprises of all the people of God for all time, both Old and New Testament believers. This definition sees the church consisting only of those who are genuinely saved. Erickson (2002:1041) explains that the word church is derived from the Greek *kuriakos*, meaning "belonging to God", but the word is to be understood in the light of the New Testament term *ekklesia*. The Greek word *ekklesia*, translated in the New Testament as "church", is the word which the Septuagint (Greek Translation of the Old Testament) most often uses to translate the Old Testament term *qahal*, the Hebrew word for the "assembly" "convocation" or "gathering" of God's people (e.g. Deut 9:10; 10:4; 23:23:1-3 etc)

---

[28] Some churches include the washing of feet as a sacrament based on Jesus' discourse in John 13.

[29] It is noteworthy that many Pentecostals and Charismatic churches (who believe in the baptism in the Holy Spirit with the initial evidence of speaking in tongues) have since the early 1980s been admitted to membership of the EFZ as evangelicals too.

[Brown, Driver & Briggs 2001: 874]. The church in both New and Old Testaments perspective is made up of all people who are truly saved from all walks of life, ethnic groups, and (to use Pauline terminology) includes "both Jews and Gentiles" (Eph 2:19). An individual becomes a member of the church or of the people of God by accepting Jesus Christ through faith in His propitiatory death on the cross (Acts 16:31; Rom 3; Eph 2:9-10; 1 John 5:11-13; etc). In this sense "the church is a community of all true believers for all time" (Grudem 1994:853). Grudem (1994:855-6) points out that the "church is both visible and invisible". In its spiritual essence as the fellowship of all authentic believers, the church is invisible since we cannot see the spiritual condition of people's hearts—only "The Lord knows those who are His" (1 Tim 2:19). In short, the invisible church alludes to the church as God sees it. However, the true church of Christ can be seen as Christians on earth see it—i.e. all who profess faith in Christ and produce fruit of that faith in their lives. This visible church then is the church as Christians on earth see it.

However, the researcher's interest in this thesis is to understand the function of the church and how it functions in a context of HIV and AIDS infection? To help us understand the function of the church, the Bible describes the church in characteristic terms of relationship and vitality using a number of metaphors[30].

3.1.2 Description of Church

To assist us understand the nature of the church, the Bible employs a number of metaphors and images of what the church is like. For instance, the church is portrayed as the *family of God* (1 Tim 5:1-2; Eph 2:19; 3:14; Matt. 12:49-50; 1 John 3:14-18 etc), the *bride of Christ* (Eph 5:32; 1 Cor

---

[30] The New Webster's Dictionary and Thesaurus defines a metaphor as "a figure of speech which makes an *implied* comparison between things which are not *literally* alike" (1992:242 emphasis original).

11:2; etc), *branches on a vine* (John 15:5), an *olive tree* (Rom 11:17-24), a *field of crops* (1 Cor 3:6-9), a *building* (1 Cor3:9), a new *temple of "living stones"(*1 Pet 2:4-8), the *body of Christ*(1 Cor 12:12-27; Eph 1:22-23; 4:15-16; Col 2:19), and the *temple of the Holy Spirit* (1 Cor 3:16-17) [Erickson 2002:1044-1051; Grudem 1994:858-859]. All these depictions of the church are vital to our understanding of the nature and function of the church. However, this researcher will employ the metaphor of the church as the "family of God" and compare it to the Zambian extended family system to formulate a model of effective pastoral care of people living with HIV/AIDS (PLWHA).

Erickson (2002:1044) aptly observes that these biblical images of the church help us grasp the nature (qualities and characteristics) of the true church. The nature of the church entails (anticipates) the function or purposes (mission) of the church. Grudem points out that the church has three purposes—"ministry to God, ministry to believers, and ministry to the world" (1994:867).

First, *"Ministry to God: worship"* is about the church's relationship to God. In this sense the purpose of the church is to worship God. Grudem (1994:867) pithily says "Worship in the church is not merely a preparation for something else: it is in itself fulfilling the major purpose of the church in reference to its Lord" (Col 3:16; Eph 1:12; 5:16-19; etc.).

Secondly, *"Ministry to Believers: Nurture"* is about the church's duty to develop those who are already Christians toward maturity in the faith. "We proclaim him, admonishing and teaching everyone with all wisdom, so that we may present everyone perfect in Christ", says the Apostle Paul (Col 1:28; see Eph 4:12-13 etc).

And thirdly, *"Ministry to the World: Evangelism and Mercy"* is about the church's principal ministry to the world—that of promulgating the gospel (evangelism). In saying that evangelism is the church's principal ministry to the world, it does not mean that evangelism is of greater importance than worship and nurture, but merely that it is the church's basic ministry towards the world.[31] The point being made is that a corollary (but equally vital) ministry to evangelism is mercy—caring for the poor and the needy. It is crucial to note that mercy ministry is to be directed to both those inside and outside the church, even when the latter do not respond with gratitude or acceptance of the gospel message. In this sense then the church is to imitate Jesus Christ who was kind to the ungrateful and the selfish too (Luke 6:35; 4:40 etc).

What, then, should be the function of Zambian evangelical churches in the context of the HIV/AIDS epidemic? How should the church relate to the world in the context of the HIV/AIDS pandemic and poverty?

3.2 Being and Doing Church in A Growing HIV/AIDS Epidemic— the Imperative to Care

The church has a social responsibility to care for the sick (cf. Matt 25: 31-46). In Matthew 25 the Lord Jesus paints a picture of the great assize where it will not be so much of wrong-doing that will evoke the severest censure, as the utter failure to do what is good (cf. Matt 25:44-45). Evangelical Christians in Zambia seem to have forgotten that caring for PLWHA is a good thing to do and a practical implication of the great commission. I think that failing to pastorally care for PLWHA is a sin of omission. Tasker (1983) equates Christians' failure to take care of the sick (including

---

[31] Grudem also points out that all the three purposes must be continually emphasized in a healthy church otherwise a situation where any of the three is emphasized at the expense of others will result in a church that will malfunction (1994:869).

PLWHA) as sin of omission. In Matthew's account of the great judgment, the unrighteous on "*the left hand*" are severely punished for failing to notice the opportunity for showing kindness which had been given them" (Tasker 1983:239 emphasis his). I believe that caring for PLWHA is showing kindness to the Lord. Those on the "right hand" of the Lord are said to be righteous because they showed kindness to the Lord's brothers and are admitted into heaven[32]. It is the researcher's view that Matthew 25:31-46,   and other passages which encourage Christians to love both fellow-Christians and non-Christians (e.g. Lk 6:35; Gal 6:10; 1 Thess 5:15; etc), provides a sound warrant for Zambian evangelicals to take care of PLWHA.

Magezi (2005) points out that Practical Theology is not merely a theoretical or academic exercise. It is about engaging real life issues and providing Christian responses to the challenges posed. He argues that the authentic challenge of Christianity is "not to be a sterile objectivism, a transcended dimension that excludes the realities of being human. It should interpret and understand the Christian truth in terms of human experience in the world" (2005:79). Magezi explicates that practical theology is "the cutting edge of Christianity's encounter with important aspects of the modern culture….it covers the wide spectrum of those practising ministry to the ordinary members concerning ecclesial issues of living out the life of faith" (2005:80). We saw in chapter 2 that the HIV/AIDS epidemic is a serious life issue in Zambia. The Church in Zambia surely cannot afford to turn a blind eye to the HIV/AIDS epidemic without being like the proverbial ostrich that buries its head in the sand to hide.

---

[32] This is not to say that such acts of mercy qualify a person for salvation as a person is saved by grace alone (Eph 2:9-10). The point Jesus is making in this passage (Matt 25:31-46) is that caring for the sick will be a critical criterion in the final judgement. France aptly comments, "the criterion of judgement is not mere philanthropy (good as that is), but people's response to the kingdom of heaven as they have met it in the person of Jesus' 'brothers'" (2004:938).

John Stott (1999:409) unequivocally urges Christians to respond pastorally to the HIV/AIDS crisis. Using the words of American Roman Catholic Bishops, Stott (1999:409) counsels evangelicals everywhere to give pastoral care to HIV/AIDS infected persons and their significant others: "Stories of persons with AIDS must not become occasions for stereotyping or prejudice, for anger or recrimination, for rejection or isolation, for injustice or condemnation. Instead they provide us with an opportunity to walk with those who are suffering, to be compassionate towards those whom we might otherwise fear, to bring strength and courage both to those who face the prospect of dying as well as to their loved ones." Stott further points out that "the AIDS crisis challenges us profoundly to be the church in deed and in truth: *to be the church as a healing community*. Indeed, because of our tendency to self-righteousness, 'the healing community itself will need to be healed by the forgiveness of Christ" (1999:410 emphasis his). The evangelical church in Zambia should be unmistakable about this timely challenge by Stott in the face of an escalating HIV/AIDS crisis. The church's involvement through practical care for people living with HIV/AIDS can surely make a difference.

Hendriks (2002:57) posits that the church is a people called by God living in a specific time and place where they are called to witness within the confines of their world. This entails that faith communities need to have a prophetic and analytical ability to comprehend contemporary issues in the light of the Church's missional calling. It is hence unmistakable that evangelicals in Zambia have a contemporary issue at hand in the HIV and AIDS epidemic to appropriately and effectively respond to pastorally without necessarily watering down the task of proclaiming the gospel. But where and how can we make the connection between pastoral care and church-based interventions? Richardson puts it well, "As an integral, responsible and caring part of the body of

politic, the Christian community must operate proactively and collaboratively in seeking improved structural provision for people living with HIV and AIDS" (2006:50).

3.3 The Extended Family and Church-Based HIV/AIDS Interventions

The extended family plays a critical role in African communities. A person who has no extended family is a rarity and viewed as unfortunate (Kapolyo 2005; Magezi 2005). In the Zambian context the extended family is central to tackling life's perplexities. The extended family is the essential support structure during life-straits of all sorts. Kapolyo, a native of Zambia and current Principal of the UK-based All Nations Christian College, astutely points out that the extended family in Zambia is an amalgamation of "all the benefits of a fully-fledged social security without any bewildering red tape. 'The family is a refuge in both urban and rural areas, and the only institution providing some form of social security'… " (2005:131).

The issue at hand is how the church can harness this time-tested psycho-social support structure to contain the ravages of the HIV/AIDS pandemic in Zambia. Where can we make the link between the nature (mission) of the church and the extended family systems toward achieving effective pastoral care for people living with HIV and AIDS in our communities? Is there a model for family life in Scripture which can instruct our practice of theology in a context of HIV/AIDS? Magezi and Louw (2006: 64-79) pertinently posit that "merging the African family and church family systems" can effectively meet the urgent need for pastoral care in the context of HIV/AIDS and poverty in Africa. However, to successfully and synergistically merge the two systems—the African extended family and church family—that Magezi and Louw propose, a good grasp of both at which must be arrived. What do we learn about family in Scripture and in Africa?

3.3.1 The notion of family in Scripture

The Old Testament does not have a word which corresponds exactly to the modern English sense of 'family', as consisting of father, mother, and children. There are three different Hebrew words which inform the idea of family in the Old Testament, namely, *sebet (matteh or mattah), mishpaha*, and *bet 'ab*[33] (Wright 1992, Mitchell 1982, Vine 1952). These Hebrew words are usually translated into English as 'tribe', 'clan', and 'family' (or 'household') respectively.

According to Wright (1992:761), Israelite nomenclature gives us the clearest picture of kinship structure in Old Testament Israel. Israel's classification significantly informs the idea of family in Scripture. For example, the search for the guilty individual blamed for Israel's failure at Ai in Joshua 6 narrows down from "tribe" (*sebet*) to "clan" (*mishpaha*) to "family" (bet 'ab) and finally to the individual, Achan (Josh 7). These three major units are repeated in reverse order when his full name is given: "Achan son of Carmi (his own father's name), the son of Zimri (his grandfather and head of the bet 'ab), the son of Zerah (name of his *mishpaha*), of the tribe of Judah, was taken" (Josh 7:16-18). The same three levels of kinship are found in other Bible passages where names of individuals are used or chosen. Other examples showing the three levels of Israel's kinship structure (tribe, clan, and house) are the selection of Saul (1 Samuel 10:20f), Saul's the self-depreciating formulas (1 Sam 9:21), Gideon (Judges 6:15), etc (see Caverno 1996).

The Hebrew word *sebet* (*matteh/mattah)* is translated as 'tribe' in most English versions of the Bible. It alludes to a larger social unit that provided the major geographic and kinship organization

---

[33] Mitchell (1982: 370), says that the closest word with a meaning of family is *bayit* (house) [the KJV renders as 'family' in 1 Chron 13:14; 2 Chron 35:5, 12; Ps 68:6], which stands for the group of people, perhaps alluding to the residence. From this word (*bayit*) we get the Hebrew phrase *bet 'ab* (father's house).

for ancient Israel. The tribes bore the names of the twelve sons of Jacob, with Joseph divided into Manasseh and Ephraim. The tribe fulfilled functions for societal organization such as settling disputes between clans, spoke the same language, shared traditions and practices of law and customs, practised a common religion, and offered the means for mustering a citizen armed defense force (Magezi 2005:91-92). Wright (1992:761) notes that although one's tribe was important, it was "the least significant of the circles of kinship within which one stood".

The second Hebrew word for family is *mishpaha* ("clan"). The word is difficult to translate, but English versions of the Bible (e.g. the Revised Standard Version) renders it as "family", but this can be misleading since the word could mean a large number of families. The word more accurately points to a wider scope of application such as a kinship. Its most precise meaning is an inhabited kinship group of a number of families or extended family. The *mishpaha* is demonstrated as a unit of identifiable kinships on the census lists of Numbers 1 and 26. The *mishpaha* is also known for the territorial identity (for instance it is used in Joshua 13-19 when Joshua was allocating land to the Israelites). In short, *mishpaha* consisted of farm households related by kinship and marriage, clans held together by language, economic cooperation, common traditions of law and custom, ancestral stories and a common religion. When an Israelite gave his full name including his house, clan, tribe, it not only stated his kinship network but practically served as a geographical location of origin as well (Wright 1992).

The third Hebrew word which informs our understanding of family in Scripture is *bet 'ab* (father's house or household). The word *bet 'ab* is a combination of two Hebrew words *bayit,* for house, and *'ab*, for father. Literally *bet 'ab* means "house of (the) father" (Kelly 1992:6) and is commonly rendered "father's house". This was the third level of kinship structure in Israel and is (probably) the

one to which the individual Israelite felt the strongest sense of inclusion, identity, protection and responsibility. Interestingly, however, the *bet' ab* did not consist of a nuclear family as in the modern understanding of a married couple and their offspring, but were several generations (up to four generations) and included the social arrangement of several families, related by blood and marriage, who occupied at least two houses architecturally connected. The Old Testament is replete with examples of individuals belonging to the *bet 'ab* (Gen 12:1; 36:6; Josh 7:16-18; Judges 6:11, 27, 30 etc).

Wright (1992) says that the *bet 'ab* was made up of the head of the household (the father) and his wife (or wives), his sons and their wives, plus any unmarried sons or daughters in the generations below him, together with all the non-related dependents. Most interestingly the *bet 'ab* arrangement portrays the extended family living in a residential area of several associated private residences. In this way the *bet 'ab* consisted of an environment where the extended family had a good knowledge of what was happening in the next home which made it possible for other members of the *bet 'ab* to swiftly intervene in members' lives during times of crises. There were usually strong familial ties in the *bet 'ab*.

Wright (1992:768-769) says that the *bet 'ab* fulfilled vital social and religious functions in Israel. The *bet 'ab* for the Israelite was the place of inclusion, authority, and spiritual continuity (by its role in teaching and preserving the faith and traditions). The same three traits are seen in the household church of New Testament Christianity. When Paul describes the inclusiveness of the gospel in Ephesians 2, he uses kinship language of the Old Testament. In Christ, gentiles are no longer "foreigners and aliens" (whose only way of sharing in Israel was to reside within an Israelite household). Gentiles have become "members of God's household" (an expression used to

describe Israel), and "fellow heirs" (Eph 2:19ff). Furthermore, this inclusion into the family of God produces a strong commitment to an individual's "kin" in the faith. It demands a life of mutual support and sharing with fellow members of the household of faith.

The social and ethical demands of this familial inclusion are prominent in the New Testament (Acts 2:42,44; 4:34; Rom 12:13; 15;26f; 2 Cor 8:4; 9:13; Gal 6:6; Phil 1:7; 4:15ff; 1 Tim 6:18; Heb 13:16 etc). Wright (1992:769) points out that "The emphasis on sharing, meeting needs, equality, and generosity strongly recalls the economic ethic of the OT and has roots in its household ethos." In this way, the "household of faith" ("the family of believers," Gal 6:10, NIV) has priority in the general injunction to "do good to all." Within this injunction, the duty to support one's own relatives is stoutly reaffirmed (cf. 1 Tim 5:4-8).

Therefore, Wright (1992:769) is not far fetched in concluding that "with all this wealth of familial characteristic and their OT background, it is not surprising that the early Christians also took over the metaphorical use of family as a picture for the whole church." The same as Israel could be called the *bet-Yahweh*, "house/family of Yahweh" (Num 12:7; Jer 12:7; Hos 8:1; Mic 4:2), the church is called the *oikos* of God (Eph 2:19; Gal 6:10; Heb 3:2-6; 1 Tim3:15; 1 Pet 4:17).

Of the three Hebrew words translatable as family in English, *bet 'ab* has the closest resemblance to the African extended family concept. In the Zambian worldview family does not merely entail a western nuclear family; it is larger than that. Whereas the nuclear family is vital in a Zambian setting, the extended family seems to be preponderant. The Zambian extended family is a family with extensive interconnections and interdependencies in as far as mutual care is concerned. The Bible portrays the church as the "family of God" made up of brothers and sisters saved by grace

and God is our heavenly Father. The church family is further enjoined by the Bible to be a caring community especially for those of the household of faith (cf. Gal 6:10). But that's not all—Christians are urged to care for non-Christians too emulating Jesus Christ, who did well to all, including the ungrateful and unrepentant (Mk 7:37; Mt 5:45-48 etc).

3.3.2 The Zambian Extended Family and the Church Family Metaphor

How does the extended family idea assist the church do missional theology in the context of the HIV/AIDS epidemic in Zambia? How can the church empower its members to become effective supporters and helpers of people living with HIV and AIDS in Zambia? This researcher holds that church leaders can empower church members to be pastoral carers by helping them rediscover the family metaphor of the church where mutual care will occur whenever a crisis emerges. Thus the link between the extended family system in Zambia and the church family metaphor is intimated at this point of caring for the needy.

Kapolyo (2005:129) points out that a core cultural value of the Bemba[34] tribe of Zambia is "commitment to the group". For Bembas isolationism is unthinkable. The extended family plays a pivotal role in the total existence of a Bemba in Zambia. Taylor in his book '*The Primal Vision: Christian Presence amid African Religion*' (cited in Kapolyo 2005:130) says of Africans 'commitment to the group':

> The sense of the personal totality of all being, and of a humanity which
> embraces the living, the dead and the divinities, fills the background of the

---

[34] Bemba is a tribe that is predominantly found in Northern Zambia and in this paper fairly represents majority of Zambia's 73 tribal groupings' cultures at this point of the extended family as in the rest of Africa. The researcher is a member of Bemba tribe as is Kapolyo.

primal world-view. But the foreground in which this solidarity becomes sharply defined and directly experienced is the life of the extended family, the clan, and the tribe. This is the context in which an African learns to say I am because I participate. To him the individual is an abstraction; Man is a family.

In the Zambian context too family is not made up of only parents and children. At best what Western society calls a nuclear family Zambians may merely say 'those of one house'—meaning they have one father and one mother. The real family among the Bembas is called **ulupwa** (the extended family) and this word basically correlates to the extended family or kinship group. Kapolyo rightly points out that this Bemba extended family concept provides a simple form of social security system. For instance in Bemba culture, children needing school fees appeal to extended family members who will always oblige. Children needing to be housed for any reason will find a home in the house of a member of the extended family. Elderly people, parents or uncles and aunts, who need to be looked after will not normally be 'shoved' to old age home but will be cared for by their own 'children' at home. "The system is flexible, efficient and user friendly," Kapolyo (2005:131) writes.

The extended family system in Zambia is not without difficulties, however. Kapolyo (2005) cites some pertinent issues that relate to the church family. He highlights two issues which could be problematic for Zambian Christianity, namely, the issues of fellowship and the priority of relatives. First, Kapolyo (2005:133) makes a factual comment pointing to how the priority of the extended family interferes with authentic fellowship in the Zambian Christianity:

"One would have assumed that the similarity in attributes between the African extended family and the body of Christ, the church, would make it easier for the

African church to live out the concept of fellowship more fully. But sadly the reality in many places is that the experience of 'fellowship 'in the natural family is so real and exclusive that it hinders and discourages fellowship in the church. The sense of solidarity stemming from common ancestry is so strong that it acts as a barrier to the idea of extending the same sense of community to total strangers. Tribal churches thrive on this weakness.

In Zambia relatives always assume a place of priority over others to the point that more often than not Christians find it hard to assist a fellow Christian in financial trouble (for instance) even when they have the ability to do so just because he/she is not a blood relative.

This is a second negative spin-off of this priority of the extended family. A lucid example of this undercurrent is observable in public life where nepotism is a blot on the political and social landscape of Africa. This priority of the extended family also distorts a proper sense of justice and fair play. But worst still, and especially in marriage, this idea of the priority of relatives has had a damaging effect on family units and essentially negates the teaching of the Bible on the marriage covenant. For instance, there is a saying in Bemba **"Umwanakashi: mwina fyalo"** (a woman [wife] is always a foreigner) which implies that a wife must never be allowed to assume a place of importance in relation to her husband prior to his relatives. The woman on the other hand will not allow her sisters in-law to take a place of importance in relation to her brothers. This mindset has damaged many a household of imprudent husbands/wives who have chosen to be insensitive and cruel to their spouses to please their extended family members.

An unfortunate show of this fact, common in Zambia and Zimbabwe, is what is called "the dispossession of widows" (Kapolyo 2005:134) or 'property grabbing'. In the event of a husband

dying before his wife, the husband's relatives move into the house and dispossess the widow and her children of all assets and share them among themselves. It is not an uncommon trend in Zambia to find widows and orphans wallowing in poverty after the death of the man (usually the bread winner) of a home (Kapolyo 2005:131-132). Thankfully, for Zambia, this bad practice has been considerably depreciated with the passing of legislation[35] which makes it a criminal offense to strip a widow and her children of household effects after the death of a husband and father of a home (Hypponen & Banda [2005], Pubmed).

Having described these 'negative' traits about the Zambian extended family system, we must be careful that we do not throw away "the baby" with the proverbial "bath water" by dubbing it as wholly bad and therefore good for nothing. The system has strengths which can be harnessed for effective HIV/AIDS work in the country. The church has a task to transform the extended family system from inside out through constant biblical teaching and lobbying. Kietzman and Smalley

---

[35] The Intestate Succession Act 1989 (no. 5 of 1989) of Zambia spells out how the estate of a person who dies without a will is to be appropriated. This Act is applicable

"…only to those to whom customary law would have applied if the Act were not in existence. The Act has no bearing on land held under customary law, family property, or Chieftainship property. [The Act] holds that the property of the deceased is to be divided with 20% assigned to surviving spouse (s) (distributed according to duration of marriage and other factors); 20% to the parents of the deceased; 50% to the children to be distributed proportionately and according to educational needs; and 10% to other dependants in equal shares. The law makes provisions for the distribution of the various shares if there are no survivors in that category. If no spouse, children, parents, or dependents survive, the estate is distributed to near relatives. If there are no near relatives, the estate devolves upon the state. In the case of a monogamous marriage, a surviving spouse or child shall receive equally and absolutely the personal chattels of the intestate. If the estate contains a house, the surviving spouse(s) shall have a life interest in the house until the spouse remarries. Widows and children are entitled to the homestead property of the intestate and equal shares in the common property of the intestate. If the estate does not exceed a designated amount, the entire estate will devolve upon the surviving spouse or child or both or if there is no spouse or child, upon the parents. The court may appoint an administrator of the estate and guardians of the minor" (Pubmed).

Although this Act does not fully 'favour' widows and orphans it does reduce flagrant property grabbing by relatives of the deceased, which was rife in Zambia prior to the Intestate Succession Act 1989. With continuing civic education many widows and orphans are being protected by this law.

(2004) astutely point out that in a case where a particular people group has bad cultural traits the Church must become a cultural change agent in that culture. They write:

> The Church (the body of believers) is the real agent of the Holy Spirit for cultural change in any society (not necessarily the organized church of any particular denomination). The church is the salt working through the whole dish. It is that part of society which has a new relationship to God yet reacts in terms of the attitudes and presuppositions of society. The body of Christ understands intuitive, unanalyzed motives and meanings in a way the missionary cannot. The church must make the decisions (Kietzman & Smalley 2004:482).

The church in Zambia (and elsewhere) has in the past been able to transform unbiblical cultural practices through Christian education. This researcher holds that the two negatives (i.e. fellowship and the priority of relatives) rightly identified by Kapolyo in the Zambian extended family system are correctable via Christian education which will help evangelicals[36] understand, embrace, and practice the church family metaphor of mutual care as taught in Scripture. In this regard evangelical Christians can successfully live as channels of God's kingdom by personifying the family metaphor. This entails that Christians can change non-Christian society in Zambia and be able to exploit the positive traits in the extended family structure to provide care for those afflicted by HIV and AIDS. The positive traits in the extended family system which can be exploited are as follows; compassionate care of members in times of crises, pooling of resources to help the needy among them, rendering support when a member is threatened by an illness, etc. The church can emulate

---

[36] Marshall & Taylor (2006: 367) in a study on 'Tackling HIV and AIDS with faith-based communities' in Burkina Faso, Zimbabwe and South Africa' found that evangelical churches were pivotal in facilitating transformation of culturally entrenched beliefs and practices. Evangelical churches in Zambia are key opinion leaders who can serve as agents of change in an issue as the priority of relatives.

these good traits in the Zambian extended family system and apply them in the care of PLWHA both inside and outside the church community. Furthermore Jesus used the salt and light metaphors to describe the church as a change agent (cf. Matt. 5:13-16). An application of the salt-and-light metaphors is that Christians can change society as both salt and light are effective natural elements. Christians change the environment in which they are placed. When one puts salt on fish or meat, the bacterial decay is checked. When one turns on light something occurs; darkness is dispelled. Thus both salt and light are effective. They change the environment. Christians in Zambia too can bring change to the extended family system and use its positive traits of care, compassion, support, etc to check the ravages of the HIV/AIDS epidemic.

3.4 Conclusion

This chapter has argued that for the church to be an effective instrument of God's love and compassion to the HIV/AIDS infected people, it must personify the biblical metaphor of family which encourages care. This will entail a change in church members' attitudes from apathy to empathy and care for one another. It is vital to note by way of emphasis that the term church **ekklesia**—lit. '*called out ones'*) alludes to a community of believers who profess faith in Jesus Christ. A function of the church is responsibility to care for one another especially in the context of HIV and AIDS. The church in Zambia should move away from apathy and stigmatization and affirm (as Zambia faith leaders affirmed as members of ZINGO) "all members of our communities suffering from HIV/AIDS and their families shall forever remain our brothers, sisters, sons, and daughters" (Or 2005).

The church in Zambia should harness the extended family system, which is similar to the Hebrew **bet 'ab**, and link it to the church family metaphor to ameliorate the ravages of HIV and AIDS. The

Zambian extended family is central to the provision of support and care to the sick and needy members of the family. It provides healing in times of crises; assists with practical care in sickness and death; provides structure for orphan care, adoptions and integration when parents die; and numerous other care and support functions. The church too is described as a family of God and by implication the church too is to provide care and support to needy people (both members and non-members) including those afflicted by HIV and AIDS. But how is pastoral care to be used to give hope to PLWHA in Zambia? What elements are included in pastoral care when interfacing with PLWHA? Whose job will it be to give pastoral care to HIV/AIDS infected and affected people? These questions are addressed in the next chapter on the Pastoral care of PLWHA in Zambia.

.

Chapter 4
Pastoral Care of People Living With HIV/AIDS in Zambia

4.0 Introduction

Chapter 2 presented a situational analysis of HIV/AIDS in Zambia outlining pertinent issues impacting on the epidemic. Chapter 3 described Zambian evangelicals' response to the challenges of the HIV/AIDS epidemic. Chapter 3 also posited that evangelical churches have a unique capability to minimize the ravages of HIV/AIDS by harnessing the intrinsic strengths in the Zambian extended family system (essentially similar to the New Testament concept of fellowship, *koinonia*). The present chapter will describe and discuss the nature and vitality of pastoral care of people living with HIV/AIDS as a response to the HIV/AIDS epidemic in Zambia.

Van Dyk in her book, *HIVAids Care & Counseling: A Multidisciplinary Approach,* sagaciously points out: "HIVAids (sic) has forced us to think of *caring* rather than *curing*." She further counsels, "Because we have no *cure* for HIVAids (sic), we must focus on *caring* for the psychological and mental welfare of people living with HIVAids (sic)" (2005:174 emphasis hers). The current chapter will, therefore, look at the care of people living with HIV and AIDS in Zambia from an evangelical standpoint. Zambian Evangelical Christians have ample endowments (e.g. human resource, presence, and a message of hope) to give meaningful pastoral care to PLWHA. In this chapter the researcher will describe pastoral care and counseling, posit an interdisciplinary perspective to pastoral care and counseling, highlight the role of psychology in pastoral counseling, locate the place of spirituality as a unique contribution of pastoral care, and recommend a feasible evangelical pastoral approach to HIV/AIDS counseling. In other words, a pastoral care and

counseling approach that is both evangelical and germane to a Zambian worldview[37] will be the focus of this chapter. To begin with the concept of pastoral care from an interdisciplinary standpoint is presented.

4.1 Pastoral Care: An Interdisciplinary Perspective

4.1.1 Definition and Functions: Maldonado (1990:17) makes a pithy distinction between the ideas of pastoral care and pastoral counseling with HIV/AIDS affected persons. He notes that pastoral care is like a larger "umbrella that encompasses all the actions that the church is called to undertake in relation to the physical, spiritual, economic, social and even political needs of those who are affected by the virus." He clarifies that pastoral counselling is a component of the same umbrella, which is a sort of focused type of action. He views counseling in this sense as a temporary helping relationship between a pastoral counselor and counselee(s) seeking help.
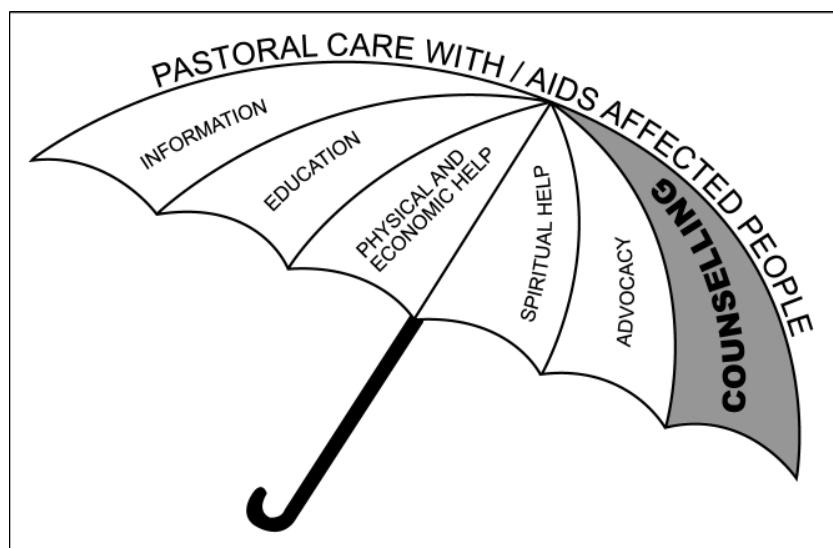

Figure 4.1 Pastoral Care of PLWHA (Source: Maldonado 1990:6)

---

[37] This approach is based on the assumption that when pastoral care does not transform the counselee's worldview it will not be effective. The counselee will see it as an intrusion in his/her way of life and will resent and reject it as irrelevant.

Figure 4.1 above diagrammatically presented Maldonado's idea of pastoral care of PLWHA within which pastoral counseling falls (cf. Marshall 1995).

Pastoral care, according to Gerkin, is the "caring task of the pastor in relation to individuals and communities" (1997:11). "Communities" in this usage allude to families living together, especially communities of faith, who have a common fellowship and want to be faithful disciples of Jesus Christ in the world. Gerkin (1997:19) asserts that pastoral care has "application to the broadest range of pastoral and communal practices in the life of the church and the world." In Gerkin's view pastoral care is not limited only to person to person encounters, but also to the caring of the church family and its community ('environment' or wider community in which the church is located). According to Gerkin (1997) pastoral care to the 'environment'[38] of the community of faith entails the fulfillment of the church's evangelistic task to the world at large. Thus the terms "pastoral care" and "pastoral counseling" are often used interchangeably, although a distinction can be made, as shown in figure 4.1. So it can be said that in talking about pastoral care, pastoral counseling is implied or assumed. A person cannot be a pastoral caregiver without being a pastoral counselor. It is the standpoint of this researcher that these activities constitute what in theological terms is called the *cura animarum* or 'cure of souls'. Pastoral care is a unique activity of caring for human life because it is created by God and belongs to Him (Louw 1997).

---

[38] Wikipedia (http://en.wikipedia.org/wiki/Pastoral_care, 01/06/07) says **"Pastoral care** is the ministry of care and counseling provided by pastors, chaplains and other religious leaders to members of their group (church, congregation, etc). This can range from home visitation, to formal counseling by pastors who are licensed to provide pastoral counseling." This researcher finds this definition sufficiently descriptive, but wanting in the sense that it excludes the laity from the task of practising pastoral care. Pastoral care in this work is about care the community of faith (clergy and laity) gives to each other and those who are not members of the church family. I believe in the tenet of the priesthood of all believers as lucidly taught in the Bible (see 1 Pet 2:4-9; Matt. 28:19-20; Mk 16:15-20; John 20:21; etc). Zambian evangelicals believe in the priesthood of all believers.

According to White (198:99-103) pastoral care involves five tasks, namely, spiritual nourishment, herding (i.e. to collect and keep together), protecting, healing, and leading God's people to their eternal destiny. The pastoral responsibility of spiritual nourishment relates to teaching, preaching, and explicating Scripture in the context of life experiences and challenges. The pastoral task of herding alludes to the preservation of the family and community of believers. Protecting the flock is closely implied in the spiritual nourishment motif, but vitally points to checking destruction that erroneous teachings introduce into the lives of Christians. The healing task of "pastoral care is that it follows up distress with practical mercy and kindness" (White 1998:102). It is this healing task of pastoral care that takes center stage in the care of people living with HIV/AIDS.

Magezi (2005:137), however, identifies seven functions of pastoral care—namely, healing, sustaining, guiding, reconciling, nurturing, liberating, and empowering. The first five functions are the same as White's functions, while the last two (liberating and empowering) are Magezi's. The later two purposes of pastoral care is the focus of this work in as far as care for people living with HIV/AIDS is concerned. Both Maldonado (1990) and Magezi (2005) point out that pastoral care is an age-old activity dating back to c.2800 BC. Table 4.1 is a summary of Magezi's understanding of the seven functions/tasks of pastoral care from a historical perspective.

Table 4.1—Summary of Pastoral Care Functions & Expressions (Source: Magezi 2005:137)

Pastoral Care Function	Historical Expression	Contemporary caring and counselling expressions
Healing	Anointing, exorcism, saints and relics, characteristic healers	Pastoral psychotherapy, spiritual healing, marriage counseling and therapy
Sustaining	Preserving, consoling, consolidating	Supportive caring and counseling, crisis counseling, bereavement caring and counseling
Guiding	Advice-giving, devil-craft, listening	Educative counseling, short-term decision-making, confrontational counseling, spiritual direction.
Reconciling	Confession, forgiveness, disciplining	Marriage counseling, existential counseling (reconciliation with God).
Nurturing	Training new members in the Christian life, religious education	Educative counseling, growth groups, marriage and family enrichment, growth-enabling care through development crises
Liberating	-	Raising awareness about sources of oppression and domination in society.
Empowering	-	Encouraging one to develop one's own/alternative base

It is the view of the researcher that pastoral care is a composite process of caring for individuals and communities with the goal of meeting a need which has emanated such as the need for healing, sustaining, guiding, reconciling, nurturing, liberating, or empowering (to use Magezi's terminology). Pastoral care implies pastoral counseling with a view of enabling the counselee to tackle his or her challenges more effectively. It must be noted further that counseling is the salient manifestation of pastoral care especially as it relates to the care of PLWHA (van Dyk 2005; Louw 1997; Maldonado 1990). Therefore it is imperative that every pastoral carer is equipped as a pastoral counselor. The researcher believes that this is what Gennrich's phrase "being there" means when she says that care involves much more than counselling: "Care involves really understanding a person's many social, personal, physical, cultural, spiritual needs and understandings, and responding to them in an integrated way. But above all, it simply means *being there*. Others call it accompanying a person, or walking life's journey (or part or it) with them." Gennrich adds "This is akin to the African traditional value of *ubuntu* - doing whatever is necessary to care for the sick person because their sickness affects everyone in the community and in the

family, and working hard to ensure that life flows on as normal" (2004:47 emphases mine). Gennrich captures the essence of pastoral care in an African setting—that is, the community orientation of pastoral care. Effective pastoral care in an African setting is certainly not individual oriented, but group/community oriented (Couture & Hunter 1995, Louw 1997).

Now, if it is true that African pastoral care is not person-centered as is western care and counseling, what is it that makes pastoral care African? Louw (1997:393) aptly asserts that "Pastoral care becomes African when it reflects the philosophy or life view of the African culture." Citing Mtetwa, Louw (1997:401), describes the defining trait of African pastoral care as follows:

> "One of the most remarkable and tangible dimensions of African Spirituality relates to the unique notion of communality and collective solidarity that the African society exhibits in all spheres of life. There is a profound sense of interdependence, from the extended family to the entire community. In a real sense, everybody is interrelated, including relations between the living and those who have departed."

It is the argument of the researcher that the evangelical church in Zambia should harness this characteristically African life-view of community in fellowship[39] and 'integrate' it with the metaphor of the church as a family of God's people where authentic fellowship translates into care of those affected and afflicted by HIV/AIDS. This approach does not mean that pastors in Africa must do away with the insights of other disciplines such as psychology, medicine, etc. These disciplines have a vital relationship to pastoral care which when neglected will do a disservice to the care of PLWHA. The question may be posed as to where and how pastoral carers would maintain a sound relationship between the Bible (Christianity) and the scientific discipline of psychology, for

---

[39] This does not mean to say that I am urging Christians in Zambia to have fellowship with their departed, Christian or non-Christian. Even in harnessing the strengths of an African concept described by Mtetwa care must be taken that African Christians do not revert to ancestral worship.

instance. Are the two disciplines antithetical and irreconcilable? What benefits can be drawn from the "tension" between them? Put simply, what is the value of psychology in pastoral care?

4.1.2 The Role of Psychology in Pastoral Care

It was found in the foregoing section that for Africans counseling is a community and extended family issue, but now it is necessary to know whether psychology is germane to pastoral counseling in African context. To help answer this matter it may be vital to ask another question: 'Why is the question of the connection between psychology and Christianity (the Bible) relevant to pastoral counseling?' First, psychological counseling seems to dominate the relationship. For instance, most NGOs who provide HIV/AIDS care and counseling in the sub-region prefer to employ staff with psychological training to pastorally trained persons. Van Dyk (2005) also presupposes a psychological approach to care and counseling of HIV/AIDS affected people as the most effective when she says that:-

Counselling must always be based on the needs of the client. Counselling has   a   dual purpose (Egan 1998):
- to help clients manage their problems more effectively and develop unused or underused opportunities to cope more fully; and
- to help and empower clients to become more effective self-helpers for the future (van Dyk 2005: 175).

Van Dyk's goal of counseling—"to help clients manage their problems…and become more effective self helpers…" seems to be only partially accurate. That goal of counseling becomes trite when the HIV/AIDS sufferer is at the brink of death and needs more reassurance and comfort than

anything else. The researcher is of the view that something much more than the two facets posited by van Dyk must be targeted in the pastoral care of PLWHA. A specific "pastoral or hope therapy" (Louw 2006) should be given at this point in the life-journey of PLWHA. It is the researcher's opinion that pastoral care (and counseling) is more holistic than any other approach as it not only aims at facilitating the clients ability "to explore and discover ways of living more fully, satisfyingly, and resourcefully" (van Dyk 2005:175), but seeks to impart hope (Louw 2006) beyond HIV/AIDS infection. Basing his argument on the fact of Christ's resurrection as the wellspring of hope beyond suffering for PLWHA (cf. 1 Cor. 15:10ff), Louw aptly asserts that "…one can view the resurrection of Christ as the final critique of God on death, suffering and stigmatizing. Resurrection hope is about the death of death, about the fact that every form of rejection, stigmatization and isolation has been finally deleted by God. People suffering from HIV should therefore be empowered to start to live despite the reality of the virus" (2006:104). This is a more holistic approach to the care of PLWHA as it not only points to positive living here and now, but also addresses the issue of hope in the afterlife when all pain will be no more (cf. Rev 21:4-5; Rom 8:18-25).

White (1998:97) sums it up this way: "The fact is, only the Christian carer is engaging with the whole of a person: a body-soul-in-community, with an eternal destiny. This is our confidence: he may expect to reach areas which no other carer can touch." It is precisely at this point (hope impartation) at which pastoral care of PLWHA differs from other approaches to care. This observation, however, does not mean that psychology has not made any meaningful contribution to pastoral care and counseling. There are two ways one can look at psychological and biblical approaches to counseling. There are two schools of thought on this matter: Psychology against the Bible and psychology 'integrated' with the Bible.

The 'Psychology against the Bible" school of thought holds that psychology has no relevance to the spiritual (pastoral) care of persons. Jay Adam's book *Competent to Counsel* (1976) categorically condemns the use of psychology in pastoral care and counseling and serves as an example of this school of thought. Adams holds that since the Bible is inerrant it is the only standard for faith and practice. He sees three elements in his nouthetic[40] approach to counseling. Firstly, he contends that when something is wrong some sin or some problem needs to be acknowledged and resolved. Secondly, *nouthetic* contact is personal conference and discussion aimed at bringing change toward greater conformity to biblical principles and practices. Thirdly, *nouthetic* confrontation changes that which in life hurts counselees head-on by verbal means. Adams infers that some of the causes of people's sicknesses are that they are not living as God requires and are not doing what they should be doing. In short, Adams sees psychology as anti-Bible and to be avoided by Christians.

A second school of thought contends that biblical and psychological counseling can be integrated. Integration in this instance does not mean to merely blend the Bible with psychology "half-half". From the onset it must be noted without hesitation that a danger exists in uncritically accepting any model of pastoral counseling. Integration in itself can easily become syncretism[41]. Psychology has some value, however. Miller and Jackson (Magezi 2005:146) give clarity to the issue when they helpfully observe that "God also has given to humankind the gift of reason and through it the marvelous techniques of modern medicine and psychology." They add, "We view such secular technology as a set of tools, to be employed within any system that does not exclude it." In what, then, way can psychology be used in pastoral counseling?

---

[40] Adams (1976) terms this method of counseling as *nouthetic* counseling (from the Greek word *noutheteo,* to admonish, warn, instruct). He out-rightly condemns psychological counseling as an enemy of the Bible.
[41] Syncretism is an admixture of paganism and Christianity resulting in inauthentic (anti-biblical) Christianity.

By implication, psychological insights can be used in pastoral care and counseling as long as they are not opposed to any biblical teaching. It might also be asked, 'How would Christians harmonize the inerrant, inspired Word of God and the science of psychology without being syncretistic?' Christianity insists on the centrality of Christ as revealed in the Bible, but psychology holds to humanism—a teaching which ardently maintains that humans are the highest beings and at the centre of all things. It seems there is no meeting ground for the two. To resolve this apparent incongruity, Crabb (1979) proposes four options, which he terms the "Separate but equal", "Tossed salad", "the Nothing battery" and the "Spoiling the Egyptians".

To start with, the *"Separate but equal"* view argues that the Bible is not a textbook of psychotherapy or medicine; therefore, if a person has a problem he should visit the right profession. Fields of legitimate concern, like medical, dental and psychological disorders are outside the area of Christian responsibility and professionals must handle them (Crabb 1979:34). This school of thought contends that the Bible is not a textbook of any other discipline except religion alone. Proponents of this view presuppose that emotional problems (for instance) do not have a bearing on spiritual issues. However, this inference seems to ignore the fact that certain psychological malfunctions are rooted in emotional problems such as guilt, anxiety, resentment, a poor self esteem, etc. The Bible is replete with instances when these emotional issues have had to be confronted or resolved by asking for God's help. The Psalms, for instance, address these issues (see Ps 34; 51; etc). Thus such a simplistic separation between scripture and psychology (as the 'separate but equal" proposes) is untenable and a misapprehension of the Bible.

Secondly, the "*Tossed Salad*" (Crabb 1979:35) approach seeks integration in the way a "tossed salad" is prepared by mixing a number of ingredients together in a single utensil to make a "tasty blend." This model says that Christianity offers great truths that are vital to good living. Psychology too has truths that are beneficial to humanity. So when the cream of biblical and psychological insights is mixed, effective Christian psychotherapy will be the outcome. Opponents of tossed salad model do not depreciate psychology, but caution Christians against careless acceptance of secular notions which may compromise Scriptural teaching.

Thirdly, there is the **"*Nothing Battery*"** model (Crabb 1979:40). According to Crabb (1979) this model is a reaction against the above two models. The "separate but equal" model refuses to recognize the pertinence of Scripture to psychological problems. Whereas the "tossed salad" model compromisingly mixes Scripture with 'secular' psychology. The basic premise of the nothing battery model is "Nothing but grace, nothing but Christ, nothing but faith, nothing, but the Word." Jay Adams' *nouthetic* approach is an example of the "nothing battery" model. Adam's *nouthetic* approach maintains that psychology is a foe of the Bible. Adam's approach, however, must be noted for its high view of Scripture because no person can claim to be a Christian carer or counselor if he/she does not obey biblical teaching. So Adam's approach has immense value to pastoral care except it that seems to ignore that man is a psychological being whose complex emotional mechanics play each other in day to day life.

Fourthly, there is the **"Spoiling the Egyptians"** approach. The carefulness of the "separate but equal" towards psychology, the permissiveness of the "Tossed Salad", and the overreaction of the "nothing battery" obliges a fourth school of thought to embrace the "Spoiling the Egyptians" standpoint. The expression "Spoiling the Egyptians" is derived from the occurrence in Exodus

chapter 11, when God ordered the Children of Israel to take with them articles (as spoils) as they left the slavery of Egypt. This view critically evaluates psychology and picks some truths not I dissonant to the Bible for use in counselling. Crabb (1979:49-50) is quick to point out that the "Spoiling the Egyptians" approach has an inherent risk of taking with it a mixed multitude which can eventually cause problems as was the case with Israel in the desert. The rebellion in the desert is blamed at the mixed multitude from Egypt. This approach looks at psychology through the eyes of Scripture and not vice versa.

Crabb (19979:49-50) prefers the "Spoiling the Egyptians" standpoint and gives principles to govern a truly evangelical integration of Christianity and psychology. Firstly, for evangelicals psychology must come under the authority of Scripture. Where the two contradict each other, the Bible is accepted as the truth. Secondly, the Bible is God's infallible, inspired, inerrant revelation in proposition. Thirdly, Scripture should have functional control over our thinking. Fourthly, functional control of the Bible can be achieved over psychology by spending much time studying the Bible systematically to understand overall content and to equip the Christian for a competent helping profession. Crabb's thoughts are useful toward the understanding of the role of psychology in Christian counseling. But the "Tossed Salad" and the "Spoiling the Egyptian" approaches are hard to distinguish and one may easily confuse the one for the other. Therefore this approach is also inadequate.

Fifthly and finally, Magezi (2005:151-55) embraces the **"Convergence Model"** (following Louw [1998] in A Pastoral hermeneutics to Care and encounter) as a balanced solution to the debate on the integration of the Bible and psychology. He handles the dilemma of integration between psychology and pastoral counselling as a tension. He says that the tension between the two is

healthy (Magezi 2005:150).The convergence model views pastoral care and counseling from an eschatological standpoint. Eschatology points to the essence of the Christian's 'already but not yet' existence by virtue of being a new being in Christ. Magezi (2005:151) asserts "Eschatology is not only a description of the end of history, but also reveals the essence of our new being. Eschatology defines the theological stance of pastoral care in terms of the cross and resurrection." In the convergence model an inevitable implication of pastoral care is hope. Hence, the practice of pastoral care is "a sign of hope to the world. This hope is the fountain of peace and the motivation to live in this life, even with HIV/AIDS infection" (Magezi 2005:154). Eschatology entails that pastoral care is essentially linked to hope and confers the task of care on the community of faith. The convergence model recognizes that the tension exists between the "already" of our salvation and the "not yet" of the coming kingdom.

The researcher prefers the convergence model as it scrutinizes psychological information on the basis of Scripture without depreciating the need for repentance as a prerequisite to salvation. The complementarism of the "Tossed Salad" should be avoided. The separation of the "Separate but equal" makes life unreal. It is the researcher's view that pastoral counseling should integrate the Bible and psychology on condition that the uniqueness of pastoral counseling is preserved everytime. But the integration must be healthy, without compromising biblical Christianity.

4.2 Pastoral Counseling within an African Setting

Another fundamental question may be posed in this connection: 'What is the nature of pastoral counseling that makes it uniquely suited to address the dilemma of PLWHA in Africa?' Whenever a person in an African context encounters a difficulty such as an illness or a calamity the why

question is posed. Why me? Why am I suffering in this way? HIV/AIDS infection elicits this question too. HIV/AIDS infected individuals in an African setting invariably ask themselves—why should I be HIV positive when there are many others who exhibit similar risky behaviour like me and do not get the HI virus?   The African worldview seems to believe that HIV infection is something that occurs as a misfortune when a taboo is broken either by the individual or his close relative. Sometimes an HIV positive diagnosis is attributed to a punishment for an abomination committed or to witchcraft. So HIV/AIDS carries a lot of stigma partly due to this mindset. Magezi (2005:190) says that when an African asks the 'why?' question (cause and effect); he or she receives an answer from the witchdoctor or diviner. So the witchdoctor or diviner is the therapist in this setting. Quoting Berinyuu, Magezi (2005:190 emphasis his), describes African therapy thus:

> Your sickness, misfortune, or condition can be traced to either an inappropriate action by one member of the family or a conflict that existed among members of the family who may be dead. *The purpose of the therapy is to say to the offender, you have done wrong or wrong was done by someone else; we have accepted responsibility, confessed the guilt/shame/damage by an appropriate ritual.* If it was a past conflict, descendents of the parents who gave rise to the conflict do the confession on behalf of the dead.

This African frame of reference necessitates that a biblical (Christian) worldview or understanding be adhered to in Christian therapy. Therefore, Christian therapy addresses a fundamental transformation of worldviews through Bible teaching. Otherwise the age-old decry that Christianity in Africa is superficial and profoundly misunderstood will persist as we seek to have a germane pastoral care of PLWHA.

What makes pastoral care and counseling unique and apt to give spiritual healing? Meier et al. (1991:134), identify the following principles which are distinguishing traits of Christian Counseling

that make it apt to give spiritual healing in any perplexing life situation including an HIV/AIDS positive diagnosis:

- Christian counseling accepts the Bible as the final authority. Christians are not tossed back and forth and do not rely on their conscience, but they have the word of God that is valid and defines men's *telos* and purpose.

- Christian counseling does not only depend on the human will to be responsible, but they have the Holy Spirit that assists them.

- Although human beings, by nature, are selfish and ignore or hate God, through faith they receive the Holy Spirit who gives them victory in overpowering their sinful nature.

- It deals effectively with the counselee's past. Because people's past guilt is forgiven (1 John 1:9), they can look to the future (Php 3:13-14).

- It is based on God's love. God loves us and his love flows through us as we care for others (Ro 12:9-21). A Christian counselor feels a spiritual relationship to others and helps them grow in Christ as they solve their problems.

- Christian counseling deals with the whole person. It recognizes that the physical, psychological, and spiritual aspects of humans are intricately related (Meier et al. 1991:134, see Minirth 2003).

Crabb (1979) focuses on the ultimate aim of pastoral counseling to demonstrate its uniqueness. He points out that when people have problems, they ordinarily emphasize finding happiness as of primary significance more than "becoming Christ-like in the middle of problems". It should be noted, however, that the goal should not be happiness (as psychology may claim), but to live a life in obedience to Scripture by putting God first (Matt 6:33). In other words, it will be as we devote ourselves to becoming what Christ wants us to be that God fills us with unspeakable joy and peace, outside of what the world can give us. Crabb (1979:22) thus helpfully summarizes the ultimate aim of Christian counseling as "to free people to better worship and serve God by helping

them become more like the Lord. In a word, the goal is maturity." Pastoral counseling of PLWHA should also should aim at helping them grow toward spiritual maturity.

Crabb (1979:24ff) further explains that maturity is both spiritual and psychological. For a person to become psychologically sound and spiritually mature, he/she must grasp the fact that his acceptability before God is not based on his behaviour, but rather on Jesus Christ's behaviour (cf. Tit. 3:5). He says, "The foundation of the entire Christian life then is a proper understanding of justification." Christian counseling, according to Crabb, is thus about whether the individual is responding biblically in whatever situation he/she experiences. "A counselor must help the client to move OVER to the pathway of obedience" writes (Crabb 1979: 26). "Moving over" involves getting rid of barriers in the way, such as "I can't" or "I won't". This change of position ("moving over") is about behaviour change. Christians, however, should experience much more than change. He points out:

> Attitude must change, desires should slowly conform more to God's design, and there must be a new style of living…. The change must not be only external obedience, but also an inward newness, a renewed way of thinking and perceiving, a changed set of goals, and a transformed personality. I call this second, broader objective the up goal. People need to move not only OVER but also UP (Crabb 1979:27 emphasis his).

Psychological counseling does not consider as essential this reality of moving OVER to biblical conformity and rising UP toward an attitude of Christ-like submission to God's will. Pastoral counseling on the contrary pays scrupulous attention to this issue which underscores its characteristic contribution to the helping 'profession'. In HIV/AIDS care where death is imminent and the individual experiences anger, guilt, and despair, a carer should stress God's acceptance

and unconditional love of the person. This means that HIV/AIDS carers (and counselors) are therefore to be sensitive to spiritual needs which are only met in sharing and accepting the message of grace in the gospel. PLWHA will stand a better chance of being healed spiritually when they see themselves as acceptable before God, and entrust themselves to His care. At this point PLWHA would have 'moved over' (i.e. started to think biblically) and begun 'moving up'. The 'moving up' (spiritual maturity or faith development) will not happen in isolation but in an environment of authentic fellowship, mutual support, and encouragement).

Meier et al (1991) point out that the environment of pastoral counseling is the community of faith. God's love flows through the believers as they mutually take care of each other (cf. Heb 10:24-25). A Christian counselor has a spiritual relationship to others and helps them to grow in Christ as they solve their problems (Meier 1991). Pastoral counseling therefore implies that believers who experience God's love and grace share it with others. PLWHA are also accepted and become part of the church family. Thus individuals involved in HIV/AIDS counseling should, in the course of their work, have the desire to allow PLWHA to experience salvation since works of mercy are not an end in themselves but a means of God's saving mission. The experience of conversion by a person living with HIV/AIDS is a facet of care of Crabb's (1979) calls "moving over". It is the opinion of the researcher that it is important for a pastoral carer of PLWHA, at some point in the relationship, to share the message of salvation[42] and encourage them toward growth in as disciples of Christ.

---

[42] This is not to say PLWHA got infected because they are not born again, but rather to stress the biblical teaching that salvation is about having eternal life after death (cf. John 3:16; 5:24; 1 John 5: 11-12; etc) through faith in the propitiatory work of our Lord Jesus Christ, which is a central tenet of evangelicalism (see chapter 3 above). This point also assumes that the pastoral carer is helping an HIV positive individual who at the beginning of the relationship is not a Christian.

Crabb astutely points that because pastoral counseling is the responsibility of every Christian, Christian leaders have a dual function—"to equip the body and offer back-up resources" (1979:16). He sees pastoral care and counseling in three senses. Firstly, there is the counseling by every Christian through encouraging, empowering and loving one another. Secondly, pastors, elders and church leaders teach biblical principles of loving one another to the community of faith. And thirdly, specially trained people deal with counseling and exploring deeper and complicated issues, as the role of Christian professional counselors. Crabb's model of congregational care is practical and germane to African HIV/AIDS pastoral care (cf. chapters 3). The wider community of faith would be involved in home care, as their ability permits, but pastors, elders or specialists from outside should equip those who commit themselves to the ministry of home-based care (see chapter 5).

In short, pastoral care and counseling is characteristically different from psychological counseling in the following four points—its context, means, goal, content, and target group (counselees) (Crabb 1979, Meier et al 1991, Louw 1997; Magezi 2005). The context of pastoral care is the community of faith; it is accomplished through Christians' mutual care; its ultimate aim is spiritual maturity (and faith development) motivated by unconditional love (agape) enabled by the Holy Spirit; its content is God's promises in the Bible, and the target group (counselees) are church members and all in need of help (e.g. PLWHA both Christians and non-Christians). Since pastoral care and counseling of PLWHA is the focus of this thesis, we will point out critical issues in HIV/AIDS care and counseling in Zambia beginning with HIV/AIDS counseling.

4.3 HIV/AIDS Counseling in Zambia

<u>Pre- and Post-HIV Test Counseling</u>

There are two basic phases of HIV/AIDS counseling, i.e., pre-and post-HIV test counseling, normally done through Voluntary Counseling and Testing (VCT). The purpose of pre-HIV test counseling is to find out why counselees want to be tested, assess the nature and extent of their current and past high-risk behaviour, and advise on prevention of HIV transmission (van Dyk 2005:202-213). Pre-HIV test counseling is critically vital as it provides an excellent opportunity to educate people about HIV/AIDS and safer sex because some counselees may choose not to return to collect their results. VCT is an entry point to prevention and care for HIV and AIDS. Figure 4.2 summarizes the various opportunities VCT presents to counselees. Furthermore it is recommended in HIV/AIDS counseling that the same person who gives pre-test counseling should give the post-test counseling because the latter is a continuation of the former (Haworth et al 1991, van Dyk 2005, Magezi 2005, etc).
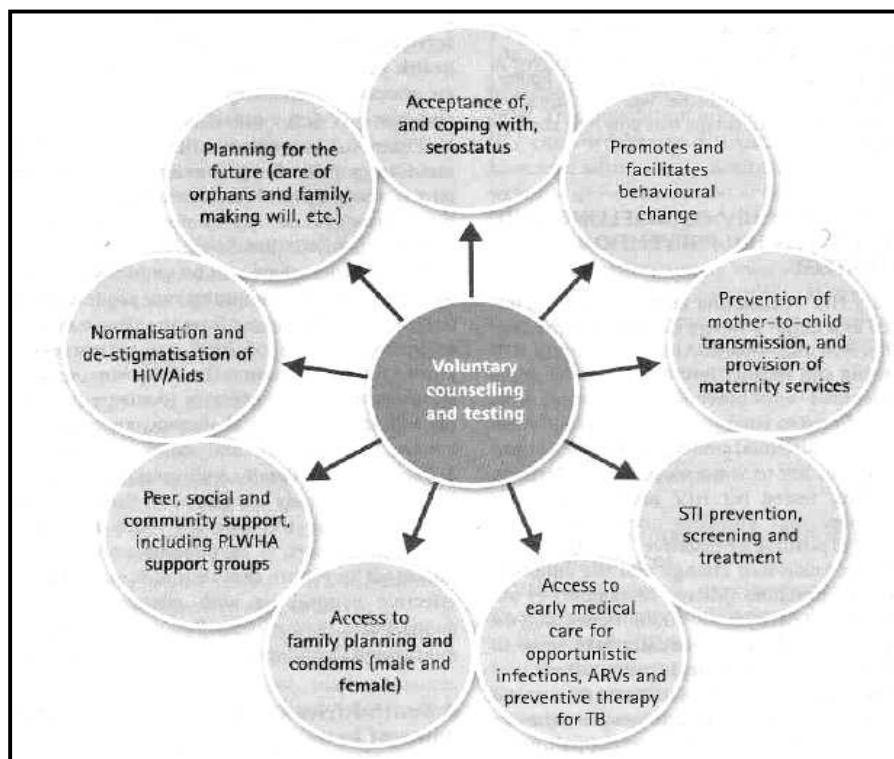

Figure 4.2 Voluntary counseling and Testing as an entry point for HIV prevention and care [Source: van Dyk 2005:104]

HIV/AIDS counselling is very important since PLWHA usually experience psychological, spiritual and socio-economic needs. Fear, grief, denial, anger, anxiety, low self-esteem, depression, suicidal behaviour and thoughts, obsessive conditions, spiritual concerns and socio-economic issues are intensified after an HIV positive result. A further intricacy of an HIV positive result is that it adversely affects significant others, such as family members and friends. These people too should be helped to come to terms with the situation through counseling. The aim of counseling the significant others of a person infected with HIV is to empower them to become a care and support base for the person. Pastoral care is crucial to giving acceptance and sustained support of the infected person and his or her significant others (the affected). Post-test counseling creates a challenge and opportunity for the church to accept and care for the person in the context of fellowship (*koinonia*) where there is mutual and unconditional love. We may, however, ask the questions: 'How HIV/AIDS pastoral care should be done in a Zambian context?' How does one talk to or counsel a person living with HIV/AIDS? What is to be the attitude of the caring community toward PLWHA? The following section responds to these questions.

4.4 HIV/AIDS Pastoral counseling in Zambia

Van Dyk calls HIV/AIDS pastoral care/counseling "spiritual counseling" (2005) and does not mind even if the counseling or care is non-Christian. She acknowledges the need for pastoral care of PLWHA. She asserts, "Researchers often refer to the importance of dealing with the spiritual and emotional needs of HIV-positive clients and their loved ones, but this process remains one of the most neglected aspects of counseling, especially within the HIV/Aids (sic) context" (van Dyk 2005:249). Her observation is valid for the Zambian HIV/AIDS counseling situation where until very recently the training of ministers paid 'little' attention to HIV/AIDS counseling (Dube 2003a; Chirwa

2005[43]). It was seen as a specialty of health professionals alone. Van Dyk advises HIV/Aids counselors not to ignore the religious needs of PLWHA, but cautions that counselors must not "force" their religious convictions on their counselees." She holds that in the HIV/AIDS situation any religion can help PLWHA come to terms with their predicament and find some peace. However, the researcher's view is that Christian counseling is the most appropriate form of care to people living with HIV/AIDS because it does not only impart positive living now, but also gives hope for eternal life in heaven. But one may ask the question: 'why are many pastors in Zambia so uncomfortable counseling people living with HIV/AIDS?'

Van Dyk (2005: 249) rightly posits that "many clergy find it difficult to counsel HIV positive properly because they are themselves ignorant about the disease and its ramifications….[and] many HIV-positive people avoid approaching their religious leaders for advice or consolation because they fear that they may well be condemned rather than supported." Both these two points are valid obstacles to effective pastoral care of PLWHA in Zambia. It is an aim of this researcher to come up with means of overcoming these impediments to effective evangelical pastoral care PLWHA. Chapter two showed that it is critical for pastoral carers to have a good understanding and

---

[43] Chirwa's (2005) findings of the lack of emphasis on HIV/AIDS counselling training in ministerial and theological colleges in Malawi agrees with the situation in Zambia where pastors-in-training have little or no training in HIV/AIDS. The researcher's first formal theological training in Zambia had little emphasis on HIV/AIDS counselling. The researcher's class was merely given a two-day HIV/AIDS awareness seminar and yet one of the pressing pastoral challenges in the researcher's country and sub-region is tackling the HIV/AIDS epidemic. Parry (2005:61) in a mapping study on 'the responses of Churches to HIV/AIDS in South Africa,' found that much of the apathy among evangelical Christians in south Africa was due to lack of pastoral leadership. She pointed out;

> "The major problem seems to lie with the Pastors, who lack a theological perspective on HIV and AIDS, as they concentrate their efforts on evangelism. Many still believe that HIV/AIDS is retribution for sins committed. It is acknowledged that Pastors can play a critical role in changing people's perspectives, and need to be well engaged and positively interactive with PLWHA…Others receive only a one-day course on HIV/AIDS ….Affluent Churches tend to do more, not only because of the additional resources but because they have the supportive infrastructure. There are few support groups for PLWHA" (Parry 2005:61).

This apathetic posture from evangelical pastors in South Africa is not so different from their counterparts in Zambia. It is the opinion of the researcher that it wouldn't be far fetched to claim that Parry's (2005) observation is valid for all evangelicals in the Southern African sub-region. We need to change.

knowledge of the HIV/AIDS pandemic, chapter three proposed that when the church in Zambia embraces the family metaphor taught in the Bible it will become a channel of inclusion, acceptance, and compassion to PLWHA. But how can evangelical HIV/AIDS pastoral carers in Zambia achieve this much needed ministry?

Firstly, pastoral carers must be relationship builders. It has been shown above that counseling is a relationship (counselor-client) which facilitates the client's growth. In this instance, the relationship is between the pastoral caregiver (who can be the pastor or congregation member committed to the task) and the HIV/AIDS affected person or people. A good relationship with PLWHA is necessary for them to open up. The counselor will in this way facilitate the growth of the HIV-positive individual. Facilitation means to create a favourable environment toward positive growth in the person living with HIV/AIDS. Growth here means that the pastoral counselor will aim at enabling the client to make changes toward living positively with the HIV/AIDS status.

Secondly, the pastoral carer should not have a condemnatory attitude toward PLWHA. Even if the person thinks that he or she has sinned (for all people do sin) emphasis should rather be placed on acceptance, forgiveness and reconciliation to God and His people. This researcher pastored an evangelical church in Lusaka and witnessed how individuals diagnosed with the HI virus were 'feared' and isolated by fellow believers. This was partly attributable to the lack of information on HIV/AIDS on the part of congregants and a shear 'holier than you' attitude towards PLWHA. The pastoral carer has a task to communicate grace, forgiveness, and acceptance to PLWHA. He/she should embody a gracious posture of compassion. The Bible is replete with examples of people who sinned and were subsequently forgiven by God. Some of them are heroes of faith such Abraham (Gen 20) and King David (2 Sam 11-12; Ps 51). The prostitute in John chapter 8 can also

be used as an example of God's desire to pardon those who come to Him in repentance rather than punish and condemn them (cf. 1 John 1:8-9).

Thirdly, the pastoral care giver should become a "companion on the journey[44]" (see Muller 1999) PLWHA. It's not sufficient to show acceptance and compassion to PLWHA. There will always be a need to console and practically help them as they have to grapple with a lot of uncertainties and declining physical health as the disease progresses (see chapter 2 for phases of HIV/AIDS progression). The experience in Zambia is that when people are in their 'terminal' stages of the disease, they are shunted to their extended family for care. It is the hypothesis of the researcher that evangelical churches in Zambia can walk alongside the HIV/AID afflicted by giving consolation and practical home-based care[45].

And fourthly, pastoral care, which is germane to the needs of PLWHA, should not be ashamed of the belief in the afterlife. Evangelical belief in the afterlife is about hope. This hope has two implications. First, it is a belief in the "final hope" (Yancey 1990:213) i.e. the hope of the resurrection. Yancey (1990:245) puts it this way: "For the person who suffers, Christianity offers one last contribution, the most important contribution of all….The resurrection and its victory over death brought a decisive new word to the vocabulary of pain and suffering: temporary." He points to the afterlife when the pain and sufferings of PLWHA will be no more. The Bible is unequivocal about such a day. Secondly, faith in the afterlife for a Christian, means that something good lies ahead. PLWHA need constant encouragement to have hope for a better day. This is not the same

---

[44] Muller (1999:1) describes narrative counselling as a journey of equal companions—counsellor and counselee. He writes, "Life is a journey. If you are alive, you have departed and you are on a journey…. We journey both separately and collectively. We come from somewhere and we are on our way to somewhere. We have a past and a future and with our stories we try to link these two—our past and our future—with each other."

[45] Chapter 5 defines/describes HIV/AIDS home-based care and recommends a model which a congregation can adopt to give pastoral care of PLWHA in Zambia.

as optimism or wishful thinking. It is about faith in God's compassion toward all people in trouble/suffering (Ps 46:1 etc). Paul says that hope is an expression of faith in God's faithfulness (cf. Rom 8:24-25). Christians believe that no matter how bleak things look at present something good does really lie ahead. Therefore, the pastoral carer should not be embarrassed to lead PLWHA to a place where they too can own the assurance of a better day in the afterlife through faith in the Lord Jesus Christ. This hope is about a day when HIV/AIDS will be no more. Scripture's statement on the matter of hope should be used to inspire PLWHA to hope for God's final day. Paul describes this hope in glorious terms when he writes: "…our citizenship is in heaven. And we eagerly await a Saviour from there, the Lord Jesus Christ, who, by the power that enables him to bring everything under his control, will transform our lowly bodies so that they will be like his glorious body" (Phil 3:20-21). Even a body with HIV/AIDS (here on earth) will be transformed to be like that of the Lord Jesus Christ—There will be no HI viruses in the after life. PLWHA can live positively in the light of this anticipation. This hope is an implication of the Lord Jesus' resurrection from the dead (cf. 1 Cor 15:51-55).

4.5 Conclusion

This chapter has argued the position that pastoral counseling is the best approach which adequately and meaningfully deals with the predicament of HIV/AIDS affected people. It has also posited that pastoral care of PLWHA can be performed by both clergy and laity. It has shown that a crucial element of the 'professional' pastor's care is to equip members of the community of faith to be carers of HIV/AIDS afflicted individuals. In conclusion, the key findings are as follows:

- Pastoral care and counseling (*cura animarum, 'cure of the soul'),* is a classical expression for pastoral work, designating the special process of caring for human

life because God created it and all people are His. PLWHA belong to God and they too must receive pastoral care.

- The pastoral care and counseling task has shifted from the professional' pastor to the mutual care of believers (koinonia). This mutuality of care in the church family will entail relationship building (counselor-client) where the counselor will facilitate the client's faith development. The mutually beneficial relationship will not only aim at faith development in the counselee, but will also facilitate the improvement of the counselee's "capacity and ability to cope with and manage … presenting problems in order to enable [him or her] live a more personally satisfying life" (Haworth et al 2001:3) in spite of an HIV-positive status.

- The shift of pastoral care from the professional counseling room to the faith community is very significant for African pastoral care of PLWHA. It creates a vital link between *koinonia* care and the community and the extended family care. Christians are encouraged in Scripture to care for one another through fellowship (*koinonia*). It has been shown above that pastoral care in an African setting is arguably the only structure that can replace the extended family if it collapses or is strained since the two share similar traits.

Finally, the foregoing chapter has highlighted that pastoral care and counseling is uniquely able to address the plight of HIV/AIDS-infected people in Zambia. The community of faith is the means for providing this much needed pastoral care to PLWHA. A question may, however, be raised as to how a model of HIV/AIDS ministry can be designed where members of the congregation are equipped to tackle the HIV/AIDS epidemic both within and outside their congregations. How can the home-based care model be designed to empower the congregation in germane pastoral care of PLWHA? The next chapter will address the issue of church members' empowerment to care for PLWHA.

Chapter 5

Empowering Church-based Communities for Home-Based Care

5.0 Introduction

Chapter 2 made a situational analysis of the HIV/AIDS epidemic in Zambia. Chapter 3 discussed the church's inherent capacity as a family of God's people to care for PLWHA by showing that clergy and laity alike are to be channels of God's compassion and care for PLWHA. Chapter 4 focused on HIV/AIDS pastoral care within an African setting. It underscored the primary role of the faith community (koinonia) in pastoral care. The preceding chapters thus delineate the African context for effective pastoral care of PLWHA. However, the question we may now posies: "How are we to empower church-based communities to practice care for people living with HIV/AIDS?

The current chapter is based on the assumption that a care gap exists in evangelical communities of faith integrally attributable to a serious lack of empowerment. It also hypothesizes that empowerment of church-based communities in Zambian evangelical circles will significantly contribute toward the mitigation of the impact of the HIV/AIDS epidemic. The researcher holds that a church-driven home-based care approach could strengthen the extended family system[46] which is an age-old crises intervention mechanism for many African communities (Zambia included). But how can church-based communities become empowered to care for PLWHA?

---

[46] Ogden et al (2004) in their study 'Expanding the care continuum for HIV/AIDS: focusing on the caregivers" found that the African extended family system has been severely stretched by the impact of HIV/AIDS that a new care gap is emerging. This researcher holds that the church can play a mitigating role through empowering church members for home-based care (see Silomba 2003, Magezi 2005, et al).

This chapter will describe issues which will enable church-based communities become effective caregivers of PLWHA through home-based care training. However, for a congregationally driven HIV/AIDS home-based care ministry to be successful, the notion of the church as family must be taught and practiced. Church members will have to link (and work) with informal home-based care providers (Magezi 2005:210) and involve PLWHA (Cornu et al 2003) for effective intervention.

This approach to HIV/AIDS intervention is further necessitated by the fact that the church is a subsystem within the community. The church family is made up of individual family systems. Church members who meet for worship on Sundays and other days come from a culture of relationships (including their extended families). Magezi (2005:212) points out that the church is a subsystem of the community and the community is a subsystem of society. These systems always influence and borrow from each other. The church in this sense has the ability to influence its environment. Conversely, the church can harness godly elements of the community such as the idea of the extended family in Africa to teach mutual care and support during times of crises. How then does a systems approach connect with the concept of home-based care? To answer this question, this chapter will define the concept of home-based care, sketch its' benefits and challenges, highlight present models of home-based care, and propose how Zambian evangelicals can empower its constituency for home-based care as a response to the HIV/AIDS epidemic.

5.1 Definition of Home-Based Care

The Gaborone Declaration on Community Home-based Care 2001 (Mohammad, N & Gikonyo, J 2005:7) defined home-based care as **"The care given to an individual in his/her own environment by his/her family and supported by skilled welfare officers and communities to meet not only the

physical and health needs, but also the spiritual, material, and psychosocial needs." Van Dyk similarly says, "Home-based care is the care given in the home of the person living with HIV/Aids (sic). It is usually given by a family member or friend (the primary caregiver), supported by a trained community caregiver" (2005:260). Van Dyk usefully adds that in an ideal situation home-based care should be done by a "multidisciplinary team" to meet the precise needs of the individual and family. This team is usually made up of people involved in care and support, which may include "a medical practitioner or professional nurse, a social worker or trained counsellor, a pastor or spiritual leader, volunteers, a traditional healer[47], friends and neighbours, and community members" (van Dyk 2005:260). This definition of home-based care surely includes the church's participation in the care of PLWHA.

Home-based care provides services similar to pastoral caring, specifically, general care and concern for human life, and counselling. Therefore, the church cannot comfortably refrain from such an opportunity to show mercy and compassion to PLWHA (cf. Matt 25:31-46) through home-based care. Home-based care, therefore, should be a concern of both Christians (*koinonia*) and non-Christians. Additionally, the church is the Christian family and should care for each other as members of the same community of faith. This is not to say that Christians should neglect their blood family, but that Christians must not forget that through their common relationship with the Lord Jesus Christ a brotherhood/sisterhood has been incepted (Gal 4:5-7; Eph 1:5; 2:19 etc), which calls for mutual love and care when in various kinds of affliction (including HIV?AIDS infection). Paul's injunction to the Galatians is instructive in this regard: "Therefore, as we have opportunity , let us do good to all people, *especially those who belong to the family of believers*"

---

[47] Van Dyk includes traditional healers in her team as she is writing from a perspective that is not solely Christian/evangelical. A church driven home-based care ministry will not have them on the team.

(Galatians 6:10 emphasis added). Home-based care should target three groups of people: PLWHA themselves (Cornu 2003), primary caregivers (either family or neighbours/community) [Ogden 2004] and children of the household affected by HIV/AIDS (van Dyk 2005, etc). But before we can show the nature of care work toward these three groups of individuals it would be useful to state the benefits of home-based care.

5.2 Benefits of Homed-Based Care

Many contemporary studies (WHO 1993, Haworth et al 2001, Silomba 2003, etc) have shown that home-based care is the best way to look after someone with HIV/AIDS in a poverty context as in most of Zambia. Van Dyk (2005:260) [citing Frohlich 1999; Uys 2003; WHO 1993] lists the following reasons why home-based care is preferable to hospital care:

- Good basic care can be successfully provided in the home.
- People who are very sick or dying often prefer to stay at home so that they can spend their last days in familiar surroundings—especially when they know that they cannot be cured in a hospital.
- Sick people are comforted by being in their own homes and communities with friends and friends around them. The ambience of home prevents the patient from feeling isolated and rejected.
- Home-based Care allows the patient and the family time to come to grips with the illness, and prepare for the impending death of the patient.
- Home-based Care promotes a holistic approach to care. This means that the physical, social, cultural, psychological, emotional, religious and spiritual needs of a patient can all be fulfilled by the family and the health team.
- Home-based care can be comprehensive if it includes rehabilitative, preventative, promotive, curative and palliative care.

- It is usually less expensive for families to care for someone at home. The cost of hospitalization and transportation to and from a hospital can be financially crippling.

- If the sick person is at home, family members can attend to their other responsibilities more easily. It can become very difficult to cope with one's own life if a loved one is in hospital and the caregiver has to make frequent trips to and from the hospital.

- Because the pressure on hospitals is reduced by home care, doctors , nurses and other health care professionals can use their time more effectively to care for other critically ill patients in hospitals ,

- Home care reduces the enormous pressure on provincial and national health care budgets (which are already strained to breaking point).

- The Network of health services available in the home-based care programme enables family members to gain access to counselling support for themselves.

- Family and community involvement in the care of their own members creates general Aids (sic) awareness in the community and this helps to break down fear, ignorance, prejudice and negative attitudes towards people with Aids.

- Home-based care is sensitive to the culture and value systems of the local community—a sensitivity that is often missing in clinical hospital settings.

- The intervention to home-based care is proactive rather than reactive.

- Home-based care puts Aids care providers in touch with potential orphans and people who really need help desperately.

- Home-based care is empowering. This means that people take responsibility for and control of their own lives and communities.

- Home-based caregivers are also in a position to identify the needs of children who are affected by the illness of parents or siblings. They can assess issues such as whether the child is involved in the care of the parent and to what extend; whether the child is immunized; whether the child needs health care; and whether the child has time to play. The home based caregiver is also in a position to know who supports the child psychologically and emotionally; whether the child understands what is going on in the family; and who will look after the child after the death of the parent (van Dyk 2005:260-261).

These benefits are credible ones, but what use would they have if there is no equipped and compassionate human resource to practice home-based care. Furthermore, home-based care has faced a number of challenges in most African countries.

5.3 Challenges of Home-Based Care

Home-based care has a long history in Africa. It was practised long before the advent of the HIV/AIDS pandemic to care for ailing family members. However, care that was given can be said to have been safe. People could provide nursing care without any worry of contracting an incurable illness such as HIV/AIDS today. On the contrary, HIV/AIDS home-based care is different. Caregivers themselves are at risk of infection. Beside the risk of infection, home-based care faces challenges to service delivery. A research conducted by Mohammad and Gikonyo (2005) for MAP in eight Sub-Saharan countries—Burkina Faso, Cameroon, Malawi, Mozambique, Nigeria, Senegal, Tanzania, and Zambia—found four critical challenges to home-based care, namely, providing pain relief, poor nutrition, the scarcity of properly trained care providers, and the burden of care integrally falling on older women and girls.

First, many home-based care initiatives experience challenges in **providing pain relief** to PLWHA because of the problem with drug availability and cost, transportation, and lack of trained personnel to administer drugs (Mohammad & Gikonyo 2005: 4). The Zambian scenario is no exception, although this constraint is receiving active attention. Mohammad and Gikonyo report that "ART adherence[48]" support is especially difficult in the wake of counselling, monitoring, stigma and discrimination, and social economic constraints.

---

[48] The PLWHA acquire these drugs from an external facility, often a public hospital, and return to this same location for their refills. The role of the care provider is therefore to help the patient in complying with the strict drug regiment (Mohammad & Gikonyo 2005:14).

Secondly, in a poor context like Zambia, many PLWHA do not have access to adequate amounts of **nutritious** foods. This situation poses a serious limitation toward the efficacy of medication (Mohammad & Gikonyo 2005:4). This is an area in which the church gives assistance through home-base care ministry by proving food parcels and identifying vulnerable families.

The third challenge has to do with the **scarcity of adequately trained caregivers** to tackle the epidemic. Mohammad and Gikonyo's (2005) research found that properly trained caregivers were scarce in all the countries under study. In Zambia too caring for PLWHA is often done by family members ('primary caregivers') and by members of the community recruited and trained to provide care as 'volunteers'. Sadly these caregivers experience poverty, social isolation, stigma, psychological distress, and, in many instances, lack basic care giving education.

And fourthly, **older women and girls are by far the majority responsible for home-based care**. This entails that the load of caring for PLWHA is disproportionately borne by women. The study found that men infrequently help with care giving to PLWHA. A study in Zambia reported older women feeling overwhelmed with the magnitude and array of tasks they had to carry out in caring for PLWHA (Mohammad & Gikonyo 2005). Young girls frequently missed school. They were sexually and physically abused, sexually exploited and depressed (Human Rights Watch 2002; Ogden 2004, etc).

Arguably, home-based care cannot entirely be the responsibility of health professionals, especially in Africa where medical resources are in short supply. It should also be deemed as a community

function. The community of faith is particularly in focus here. When care work is deemed as a community task, many more people will own the responsibility of providing care. Such a mindset will transform people's view of HIV/AIDS care as an expression of mutual care and support in the family and community (i.e. both congregation members and wider community). This is not to say that home-based care negates the vital role of health professionals, but rather calls for a close link to exist between the two for referrals and expertise. Van Dyk rightly says that an effective home-based care programme must work as a team (2005:263). She asserts, "A well-functioning network and referral system should connect the home-based care team with hospitals, hospices, clinics and other community-based health care institutions. Government support in terms of recognition, education, financial support, supplies and staff is indispensable" (van Dyk 2005:263). The model being proposed here will take this collaborative (teamwork) element into consideration, but will be largely congregationally impelled. But before proposing a workable model for a faith community, let's look at the various home-based care approaches (models) available.

5.4 Models of Home-Based Care

Van Dyk (2005:262) identifies three home-based care models, namely, the integrated home-based care, the single-service home-based care, and the informal home-based care models.

- The *Integrated Home-based Care* model works by linking all service providers with patients and their family in a continuum of care. The person living with HIV/AIDS and his/her significant others draw their support from a network of services, such as community caregivers, hospitals, clinics, support groups, non-governmental organizations (NGOs), faith-based organizations (FBOs), and the wider community. Van Dyk rightly notes that a salient advantage of this model is that it permits for referral between all players and

partners for a mutual confidence is established and ensures that caregivers are empowered through regular training, support, and supervision. Magezi's critique of this model is that it is "highly theoretical and hypothetical" (Magezi 2005:219) to be feasible in an African context in which poverty is pervasive. Notably, this model may face immense challenges in Zambia (see Mohammad & Gikonyo 2005) where resources are already scarce (see Chapter 2 above).

▪ The ***Single Service Home-based Care*** model is organized by a single service provider (often a clinic, hospital, an NGO, or a church) by enlisting and training volunteers, and connecting them to PLWHA and their families in the homes. An advantage of this approach to home-based care is that it can be started in situations of little resources such as in most parts of Zambia where hospitals and clinics are often a considerable distance away from most villages and transportation costs are high. Churches can utilize this model with some modification to embrace networking and capacity building strengths of the integrated home-based care approach. Magezi and Louw (2006:64-79) in their article entitled '*Congregational Home-based Pastoral Care: Merging the African Family and Church Family Systems for HIV Ministry'* rightly contend for this model as the most feasible and sustainable in most impoverished African contexts. This researcher holds that a church-based home-based care approach is feasible when church-based communities are empowered for the care of PLWHA.

▪ In the ***Informal Home-based Care Model*** family members care for PLWHA at home with the informal help of their own social networks. This is done without any training or external support, and there is no formal organization or supervision (van Dyk 2005:262). In fact, Informal Home-based Care is practised in most Zambian families affected by HIV/AIDS. Family members carry out this care with little or no education and management skills for

HIV/AIDS. Sadly, some family caregivers have been unwittingly been exposed to HIV infection in the process of showing practical compassion through this care. This is a main disadvantage of this model.

Though van Dyk (2005:262) concluded that the integrated model is optimal, I think that the model is, paradoxically, 'self-limiting' in the sense that there are not many entities that can handle the complexities of a start up integrated home-based care service. The single service approach is more feasible and must not necessarily be viewed as fragmented and weak. The perceived weakness of a congregationally driven home-based care is adequately compensated for in the systemic nature of the church. The church functions and is existentially a body with every part indispensable to the wellbeing of the whole (cf. 1 Cor 12, Rom 12, etc). Therefore, it is the researcher's opinion that church-based home-based care is intricately connected to the systems approach of being and doing church. To help us appreciate the researcher's preference for a single-service approach to home-based care the model is now presented from a congregational systems perspective.

5.5 Home-Based Care—A Congregational Systems Approach

To begin with, it would be helpful for us to understand the idea of a congregational systems approach to home-based care. A systems approach in a congregation alludes to members who do not function independently of one another but as a unified whole. The parts are connected by a central sense of oneness. Steinke pithily elucidates the essence of systems thinking to church life when he writes that:

Systems thinking is basically *a way of thinking about life as all of a part*. It is a way of thinking about how the whole is arranged, how the relationships between the parts produce something new. A systems approach claims that any person or event stands in relationship to something….All parts interface and affect each other (1996:3 emphasis added).

A systems approach sees the congregation as a composite whole with each member dependent and indispensable to each other. Steinke's view is in perfect agreement with the Bible's view of the church. The Bible compares the church to a human body whose parts indispensable to each other (1 Cor 12:12-31; Rom 12:4-5). Paul speaking of the vitality of unity in the church compares it to one loaf of bread (1 Cor 10:17) which typifies unity. These passages of Scripture support systems thinking in a congregation. In systems thinking church members become a caring and supportive community of faith. Scripture further underscores the essence of unity in the church through familial language such as a "family of believers" (Gal 6:10). This unison in African context is evident in the extended family network (alluded to in Chapter 3). The church of Christ is portrayed in Scripture as a community where its members are interdependent, care for and love each other as a characteristic quality of being followers of Christ (cf. Jn 13:35; 15:12 etc).

Furthermore, Christian love (Agape) has critical implications for mutual care and support in the church. Central in the community is mutual care and service of believers (Rom 12, 1 Cor 12). Each member does not merely seek to please himself or herself but looks out for the interests of others (Phil 2:4; 1 Cor 10:24; 13:4-5; Jam 2:8 etc). The unity of 'the body of Christ' is in this way kept as a complete system. This communal fellowship is much more than sharing doctrine but also includes mutual material care towards one another. The Bible lucidly speaks against a faith which is not practically helpful to those needing material help (cf. James 2:14-17). Thus a systems approach

means that Christians should accept and embrace one another unconditionally and any uncaring attitude renders the whole body unhealthy. There is, therefore, no room for stigma and discrimination of anyone (including PLWHA) in the church. Everyone is welcome in God's family.

But, what do the systems approach and the biblical model imply for the care and support of PLWHA (both within and outside the church)? People afflicted by HIV/AIDS experience a lot of crises such as physical, emotional, spiritual and are in constant need of support. In the course of all the vexing problems related to HIV/AIDS infection, the systems approach –i.e. faith community care—necessitates that Christians' involvement (presence) to support PLWHA emotionally and materially. In deep emotional crisis, for instance, the Christian community should be 'companions on the journey' (Muller 1999) of PLWHA through the excruciating process of denial, anger, guilt, loneliness, depression and acceptance. Christians are to be present as an emotional buffer to PLWHA and their significant others

The mutual care and interrelationships of members of the family of believers calls for the unconditional acceptance of all believers (PLWHA included). Stigmatization and discrimination in all their manifestations are thus rendered incongruous to the nature of the church (chapter three). The systems approach, therefore, dispels stigmatization and discrimination. The healthy congregation deems a person living with HIV/AIDS as a part of the system. In this way the Christian community speaks for God through practical love (koinonia) and serves others, which are both critical dimensions to home-based care. What, then, is meant by the expression "empowering for home-based care" and how can a congregation capacitate its members to reach out to PLWHA?

5.6 Empowering Church-Based Communities for Home-Based Care Ministry

The Concise Oxford Dictionary has several definitions of the word *empower*, namely, "to authorize, license, give power to, or make able" (Allen 1992:384). Empowerment, therefore, is a process and act of giving ability to someone to do something. In this usage 'empowering church-based communities' is about making members of a congregation able to effectively care for PLWHA and their significant others in a home environment. A critical finding of the research on the 'Operational Challenges to Community Home Based Care (CHBC) for PLWHA in Multi-Country HIV/AIDS Programs (MAP) for Sub-Saharan Africa' by Mohammad and Gikonyo (2005) was a serious human resource shortage and low volunteer motivation among caregivers. Mohammad and Gikonyo's (2005: vii) findings were that:

- The **human resource** is a key challenge faced by CHBC programs and requires immediate attention in the areas of training, capacity building and technical expertise;
- **Volunteers**, who are essential to the sustainability of the CHBC, need to be encouraged and motivated… (2005: vii).

The churches, being part of the communities affected by HIV and AIDS and seeking to find solutions to the many challenges posed by the epidemic through home-based care, will arguably have to grapple with those two issues. In other words, part of the answer to these issues from a church perspective will undoubtedly involve mobilizing a volunteer team and empowering them to give home-based care to PLWHA. This section is about how the church can empower its members to effectively give care to PLWHA in their home contexts. The section will be broken into four subsections, namely, home-based pastoral care, building a church-based home-based care ministry, training church-based communities for home-based care, and guidelines for pastoral counseling in home-based Care.

5.6.1 Home-Based Pastoral Care in Zambia

A salient feature of pastoral care and counseling in Africa is that it is more often than not "unstructured" (Louw 1997; Magezi 2005). That is to say that pastoral care and counseling in Africa (Zambia included) sometimes does not have clearly defined duties/responsibilities especially as it is being practiced in a context poverty. The poor, many of whom are uneducated and have little or no exposure to westernization, very often work with what is alluded to as "African concept of time: meaning a clock does not control the individual's activities but the 'event'" (Magezi 2005:233). This reality entails that a pastoral caregiver in Zambia should devise his/her model of care with an awareness of a pervasive concept of time. Thus, devising an effective home-based pastoral model in Zambia requires that the following points[49] be taken into consideration.

First, the pastoral leadership of a congregation must model and teach compassion for PLWHA (Marshall & Taylor 2006). It has been said (axiomatically) that "as church leadership goes, so goes the church". Church leaders must be foremost in showing compassionate care to PLWHA. This means that pastors will have to influence church members toward a godly posture of love, acceptance, and care of PLWHA in the church and their community. We noted in chapter four above that the context of pastoral counseling is the community of faith (the congregation). Crabb (1979) posits three levels of pastoral care and counseling in any congregation. First, the whole church is involved in giving pastoral care. In this sense, all Christians mutually care for each other pastorally as they show agape love and compassion to one another. This is especially germane to HIV/AIDS care, where PLWHA need unconditional acceptance from the church family. The second level of pastoral care comes from selected and trained church leaders or elders. This category of

---

[49] The points are not given in order of importance for they are all of equal vitality.

care givers functions as resource persons for the larger congregation giving encouragement and guidance to the 'flock of God'. The third level is for intricate, most profound, and sensitive care issues that call for in-depth training. This is where the pastor of a congregation will be located. This fact reinforces the need for church leadership (especially the pastor) to be knowledgeable about HIV/AIDS issues and their theological ramifications (see chapter two). Owing to the dynamic nature of HIV/AIDS research, knowledge on HIV?AIDS issues is not a 'once-for-all' affair, but entails that pastoral leaders assume an unending learning posture to ensure effectiveness and relevance in HIV/AIDS care delivery.

Secondly, the pastor should help the church community make networking relationships with other HIV/AIDS stakeholders such as government agencies, non-governmental organizations (NGOs), business houses, families and individuals, and other churches. These stakeholders might already be involved in HIV/AIDS care and prevention in which case it will be unnecessary for the church community to reinvent the wheel in practical start-up matters.

Thirdly, to facilitate pastoral care in home-base care it will be critical to identify opinion leaders in the target community. Opinion leaders in African cultural context are critical influencers since they are highly respected and will usually be skilled at mobilizing their community toward a known goal. They will also help community participation in home-based care ministry.

And fourthly, a pastoral caregiver in home-based care should have a good understanding of his/her identity. This point calls into focus the "being functions of the pastor are more important than his/her knowing function" (Magezi 2005: 235). The issue here is that the pastoral caregiver must avoid double talk. His/her lifestyle (conduct) must reconcile with his/her teaching. This matter is

about the issue of a Christian's integrity. The community should view the pastor as reliable, responsible and having the people's interests at heart. The congregational/pastoral caregivers are not be perceived as pursuing their own selfish interests, such as doing ministry merely for pecuniary gain rather than compassionate care. When the community views him/her in this way, it will be more open to him/her and will partner with him/her in the vital task of care giving. Additionally, HIV/AIDS care and counseling is all about relationship building. When a pastoral caregiver succeeds at relationship building with PLWHA and the affected families he/she will have the opportunity of communicating the message of hope without being seen as doing the work for selfish gain. Relationship building is fundamentally vital for both clergy and laity in the care of PLWHA as it is through the daily relationships and contacts that they will be able to mediate God's healing grace.

In short, care for PLWHA is the responsibility of all believers, although not every church member will be a 'front-liner' in service delivery[50]. Members of the congregation should be equipped for this ministry (Eph 4:12ff) by the church leadership in a similar way as they are prepared for other works of ministry. It goes without saying, therefore, that church members living with HIV/AIDS should be included in this care ministry. This will help put a human face to HIV/AIDS crisis and underscore the unconditional acceptance of PLWHA (Amos 1988; Silomba 2002; Cornu 2003). Having highlighted the connection of pastoral care to home-based care we can now itemize some critical ingredients needed to build a church-based home-based care ministry.

5.6.2 Building a Church-Based Home-Based Care Ministry

---

[50] Every church member can do something to help people living with HIV/AIDS live more positively. Not every church member will do the actual care work (such as giving a bed bath, doing home visits, etc.), but others can give financial support; help children of PLWHA with school work, etc.

Starting a home-based care ministry demands critical self-evaluation. It is a great challenge and requires ardent commitment on the part of the church family, especially its leadership. The following are critical issues to ponder and put in place for a successful home-based ministry (based on van Dyk 2005; Magezi 2005; Silomba 2002):

- Perform an environmental scan to establish the needs, resources, and networks within a specific community. "For a home-based care programme to be successful, it is important to talk to, listen and collaborate with community leaders and with the people living with HIV/Aids and their families (because they are the people directly affected by the programme)" (van Dyk 2005:264). Although the ministry will be church-based, the community must identify with it and not view it as using it (community) to further its own unclear motives.[51]

- Compile a church membership inventory. A church inventory will involve listing member's specific skills and areas of specialization which can be employed in the church-based care ministry. For instance, a member with community development/mobilization skills can be helpful to set up the home-based care ministry (Magezi 2005:233).

- Establish a dedicated leadership team to spearhead the home-based care ministry. Magezi (2005:229) points out that home-based care ministry require a lot of courage. Therefore, would-be caregivers and leaders should be courageous so that they may be a good influence on other parishioners toward the acceptance and assimilation of PLWHA into fellowship of the congregation. Ministry to PLWHA is often resisted from within

---

[51] Silomba (2002) in her paper describing a successful home-based care programme run by the Salvation Army Hospital at Chikankata in Zambia notes that home-based care will be effective only when target communities have significant ownership of the programme. If it is viewed as a 'foreign' imposition to disrupt their lives it will be rejected.

churches. Courage to persevere is indispensable. A good and bold ministry leadership would be an asset in this regard.

- Enlist caregivers from the community of faith and give them thorough training[52] in home-based care (section 5.7.3 below delineates the essential elements of the curriculum on training church-based communities).

- Access resources to support the home-based care ministry. For instance, there are financial implications to starting this ministry. Volunteers[53] will require logistical support like transportation and equipment to use in their course of duty. Equipment needed for proper care will be things like soap, towels, bedpans, etc. (van Dyk 2005:265).

- Establish a support group for home-based caregivers where they can reflect on their work, share their problems, and receive counseling and guidance. In the precincts of the support, group caregivers can receive educational talks, mentoring, supervision, socializing and participation in income generating projects (van Dyk 2005:265). Ogden et al (2004) stress the importance of caring for caregivers as critical to the survival of a home-based care programme. In this connection the congregation will need to care for the carers.

Finally, it is vitally important to note that all the foregoing issues must be pursued and implemented prayerful manner. The need for unrelenting prayer for God's help in building a church-based pastoral ministry to people living with HIV/AID cannot be overemphasized (cf. Prov 16:3; Ps 37:4-5; 1 Peter 5:7 etc). Having built a church-based home-based care ministry, the next step will be to empower parishioners for home-based care.

---

[52] Magezi (2005:234) calls the aspect of training caregivers as "sensitizing compassion and in-depth training." An essential component of this training will be explaining the biblical warrant for the care of PLWHA. Caring for PLWHA is caring for the Lord Himself (cf. Matt 25: 31-46).
[53] Mohammad & Gikonyo (2005) admit that remunerating volunteers helps to motivate them in the long-term. A church too might look at this possibility.

5.6.3 Empowering Church-Based Communities for Home-Based Care

The training of home-based caregivers is a critical dimension of empowering church based communities for home-based care of PLWHA. Van Dyk (2005:266) aptly points out that "It is important to train home-based caregivers properly and thoroughly to provide a high standard of holistic care". Church-based communities are certainly not excepted from this critical requirement. It is a premise of this research that for church-based communities to be effective home-based carers of PLWHA, regular training for empowerment has to done. A trained body of believers will surely be an empowered team of HIV/AIDS caregivers. Cameron, S in the article '*Training Community caregivers for a home-based care programme*' (cited in van Dyk 2005:266) recommends that a good training programme for home-based caregivers of PLWHA should include the following critical elements:

- Background to home-based care (definition, purpose, team members and the health care system).
- Ethical principles of home-based care: confidentiality at all times; respect for the patient's wishes about disclosure; the autonomy of the patient to agree or disagree with treatment; and respect for the patient's choice on issues such as abortion[54].
- Basic facts about HIV/Aids and other sexually transmitted infections.
- Knowledge of the signs and symptoms of TB as well as an understanding of DOTS.
- Teaching and facilitation skills, especially adult education.
- Communication skills. Including communication with children.
- Basic counselling skills (attending, listening, emotional support, how to deal with feelings and problem solving skills).
- Promotion of positive living.
- Spiritual and religious issues[55].

---

[54] There is no biblical warrant for abortion. The Bible regards all the unborn as persons from conception (Psalm 139:13-15; Job 10:9-11; etc) and thus proscribes abortion at any stage of pregnancy. This researcher considers it as unethical behaviour for caregivers to encourage abortion.

- Gender and cultural issues.

- Infection control in the home-based care situation.

- Basic nursing care principles and the management of common illnesses.

- Practical procedures to help patient, for example lifting, wound dressing, mouth care, feeding, bathing in bed, shaving, and using a bed pan.

- Nutrition and problems influencing nutrition.

- Incorporating palliative care principles into basic nursing care in the home.

- Social support, community support and referral possibilities.

- Care of the caregiver to cope with a very demanding task.

An assessment or evaluation process should be built into the training programme, with ongoing education, support and supervision for caregivers (van Dyk 2005:266-267). Pastoral leaders should also ensure that all pastoral caregivers are maturing in their discipleship so that they too can help PLWHA grow toward a mature faith. I believe that Paul's to Timothy be a discipler of disciplers are applicable to PLWHA (cf. 2 Tim 2:2).

5.6.4 Guidelines for Pastoral Counseling in Home-based Care.

In chapter 2 above we learnt that people living with HIV/AIDS progress through various phases of HIV disease from seroconversion stage (HIV-positive diagnosis) to full-blown AIDS stage. Caregivers should, therefore, be conversant with the appropriate pastoral response as the person experiences different crises as the disease progresses. The patient will experience varied psychosocial, spiritual, socio-economic, and emotional needs as the disease progresses towards the full-blown AIDS stage and ultimately death. It is vital for the pastor and church members involved in home-based care to be familiar with the appropriate pastoral response at each stage of the disease progression. Table 5.1 below summarizes van der Walt's (2004:33-38) guidelines on

---

[55] An evangelical theology of HIV/AIDS will be clearly taught to caregivers and issues of personal eschatology will constitute the care and counselling (see chapters 3 and 4). The fact that HIV/AIDS is not the end of life, that is to say, there's an afterlife (cf. John 3:16; 5:24; etc) for those who accept God's offer of redemption in Jesus Christ, will be a central tenet of pastoral care and counselling. The ministry will be all abou giving hope because of the resurrection of Jesus Christ (cf. 1 Cor 15; John 5:24; Rev 22:1-6; etc).

how church-based caregivers can be involved with PLWHA at each phase of the HIV disease process (see Magezi 2005:237).

Table 5.1 Counselling and the Different Progressive Stages of HIV/AIDS (source: Magezi 2005:237)

Progression Stage	Counseling Focal Issues		Pastoral Counseling Response
Diagnosis/ Seroconversion	When a Person is diagnosed HIV Positive there is shock That often leads to **denial, anxiety, fear, and suicidal behaviour or thinking**	**Denial**-At the breaking of the news, it is a defence mechanism to temporarily reduce emotional stress. Denial gives a breathing space, but if it continues it hampers positive thinking.	When a person is at this stage, not much talking should be done. Presence with the person is necessary, but if the denial persists it should be confronted so that the person may accept the reality and live positively. The counsellor should be empathetic, assure God's love, trust and commitment to support the person.
		Anxiety-uncertainty of the progress of the HIV infection, the risk of infection with other diseases, fear of dying in pain, inability to change things, etc. create anxiety	Correct information should be communicated to the person. Counseling of the person to accept the situation and progress with life is vital. Focus on life in Christ is the controlling factor.
		Fear-HIV-infected people have experienced the pain and death of loved ones by AIDS, so they fear wait awaits them, or they fear because they lack knowledge of how one can live with AIDS	The person should be educated about the facts and information regarding HIV/AIDS. The Christian hope of the resurrection should be shared with the person. Death is not the end for a Christian.
		Suicidal behaviour or thinking-Self-blame, knowing that one is living on borrowed time, shame, and fear of losing control of one's life may lead the person to commit suicide.	The Pastor should aware that there is a high risk of suicide in HIV-infected people, especially when they have just been told that they are HIV-positive. More time should be spent with the person.
Asymptomatic Phase	At this stage the person appears healthy like other people, though he/she carries the HI virus. The person may have emotional ups and downs as he/she remembers that he/she is carrying the HI virus. This person needs normal living guidance and continuous support. They could be in danger of obsessive conditions and hypochondria as the person becomes so preoccupied with the smallest physical changes or sensations, and this causes obsessive behaviour or hypochondria (van Dyk)		The counsellor should always be available when the person needs him/her. Counsellor should strengthen the person's faith and relationships in preparation for the later terminal stage. To avoid obsessive behaviour or hypochondria, the person should be encouraged to accept the HIV-positive status, which would lessen this phenomenon as the person adjusts to cope with the situation. The correct information should be

			communicated.
Symptomatic Phase	The HIV/AIDS-infected person at this stage feels emotionally isolated, loneliness and mourning, sense of loss, guilt, anger, grief and socio-economically deprived.	Isolation and loneliness-HIV-infected people's self-esteem is threatened as friends abandon them, leaving them feeling unworthy. The inability to continue in a career or having children also contributes. The person needs contact with others.	Emphasize human worthiness as defined by a relationship with Christ, not material or profession. The person should be encouraged to feel self-sufficient in Christ. The faith community should come alongside for comfort, which makes koinonia care crucial. The person should be accepted in the community to belong and get healing.
		Mourning and sense of loss-Often HIV positive people experience a loss of their hopes, dreams, sexual relations, independence, and importantly, loss of life and many other things.	The counselor should experience a process pf grief with them. Be patient and show compassion and encourage the celebration of life. Encourage wholeness through union with Christ.
		Guilt-Guilt may be intense for someone who has contracted the disease through promiscuity. One feels guilty about the wrong choices of a sexual partner. He/she feels guilt that he/she has let down the family, friends, relatives, etc.	The pastor should be supportive and dispel the guilt. The person should be helped to realize that the circumstances of HIV infection are not the problem. He/she should be aware of a gracious God who accepts and forgives the guilt through His great love in Christ. The pastor should encourage reconciliation with God and other people, where possible.
		Anger-HIV positive people are often angry with themselves for being irresponsible, angry with people who infected them; angry that there is no cure; angry at society's reaction of hostility and indifference.	The pastor's warmth and love often soothes the anger as the person realizes that there are people with his/her interest at heart. Acceptance of the person plays a vital role.
		Grief-Grief is more like loss. If the person is a parent he/she grieves for the children who will remain behind.	The art of listening is critical as the person grieves for loss. The pastor's presence is important, although he be silent.
		Socio-economically deprived-some companies dismiss workers when they are diagnosed HIV-positive, though this is illegal. Therefore, loss of employment, discrimination and stigma, and the need to buy anti-retroviral medication drain the HIV+ person's financial resources.	Social support through the community of faith (koinonia) should be encouraged. Where possible, food parcels and financial assistance provided to the person.

Serious Illness	The person may have serious depression. The feeling that he/she has lost much in life, feeling of powerlessness and knowing that many have died of AIDS and they will die , cause their depression. They may also experience self-rejection, hopelessness and worthlessness. These people need value, respect and dignity.	The counsellor should encourage the celebration of life. Resurrection hope as the final destiny should be emphasized. Hope and meaning as found in Christ should be emphasized.
Terminal stage	The people at this stage are fragile, uncertain and in extreme fear. The people need peace, acceptance and security for those left behind especially children. These people are confronted with death and loneliness. They ask spiritual questions about death, sin, guilt, forgiveness and reconciliation. They ask the theodicy question: why does god allow HIV/AIDS and death?	God's unconditional forgiveness of sin and guilt, and reconciliation in Christ should be shared. Resurrection hope should be emphasized. The counsellor should assist with succession planning and be with the person through the process of dying. The counsellor should be aware of Kubler Ross's stages of the dying (denial, anger, bargaining, depression, acceptance, and resignation). Eschatological hope should always be emphasized.
Grieving	Grief counselling normally is focused on family members who were the caregivers who also witnessed their loved one dying. There is depression, sadness, feelings of loneliness and abandonment, etc. They mourn the loss.	Since the pastor/counsellor would have been involved with the family for a long time over the period that the HIV/AIDS person was still alive, it becomes easier to encourage peace with what has happened. The counsellor should always minister by his presence even in silence. But it is important to encourage people to go on with life.

Pastoral caregivers can also help people living with HIV/AIDS come to faith in Christ and disciple them toward spiritual maturity.

5.6.5   Discipling People Living with HIV/AIDS—A Goal of HIV/AIDS Pastoral Care

Arguably, a goal of pastoral care of PLWHA is to "make disciples" of Jesus Christ (cf. Matt. 28:19-20). It is the view of this researcher that PLWHA should become followers of Christ who are growing in their personal walk with God toward themselves becoming disciplers of others (including PLWHA). PLWHA can be empowered and enlisted as caregivers to others living with HIV/AIDS (Cornu 2003, van Dyk 2005, Magezi 2005, etc). Magezi (2005: 239) well notes that "A well-counselled person should be a resource to the community of faith and should be active in bringing

healing to other people, as a model of Christian therapy." Kubler Ross (in Magezi 2005:239) points out that "Of all the thousands of patients I have seen literally all over the world, I have never seen such mutual support and solidarity as I have among AIDS patients themselves and their partners." In the model of home-based care posited in this work, PLWHA are to be involved in care work and designing prevention and support programmes. Ultimately, PLWHA are disciples of Christ and will be used by the grace of God to help others in the HIV/AIDS predicament. They too become encouragers in the faith community. That is a goal of HIV/AIDS pastoral care.

5.7 Conclusion

This chapter recommends a single service church-based home-based approach to care for people living with HIV/AIDS. The chapter has noted three ways (models) of HIV/AIDS home-based care—namely, integrated, single service, and the informal home-based care models. I have argued that the integrated model (which links service providers, PLWHA, families, and other stakeholder), though ideal, is infeasible in most African contexts due mainly to scare health-care resources. Single service home-based care is provided by single service entities, for instance, hospitals, NGO or church. However, since churches are the most strategically located entities in most of sub-Saharan Africa and have a plethora of contacts with many people on the ground, she should play a critical role in providing home-based care.

This chapter has further contended that church-based communities, when appropriately trained and supported, are capable of actively participating in the ministry of care for PLWHA and thus provide support and healing. Church-based communities have been identified as a potent and cogent role-player in HIV/AIDS intervention through a home-based care ministry inspired by the

theological belief that God is faithful and compassionate toward PLWHA. Pastoral care has been noted as key to successful home-based care. The chapter has further pointed out that to effectively do home-based care, church-based communities must be empowered for the task through appropriate training and ongoing support. Smart (van Dyk 2005:268) is right in asserting that "home-based care can become 'home neglect' if appropriate planning, capacity building, community participation and support [for caregivers] are not in place." This chapter has been about how to build care capacity of church-based communities through equipping for home-based care. It is the conclusion of this researcher that empowerment of church-based communities will only happen when evangelical church leaders give serious attention to planning, capacity building (e.g. through suitable training), and continued support of caregivers.

Chapter 6

Summary, Conclusions, and Prospective Issues

6.0 Introduction

This research has investigated the empowerment of church-based communities for home-based care of people living with HIV/AIDS as a pastoral response to the HIIV/AIDS pandemic in Zambia. The study has argued that an urgent need exists for evangelical church-communities in Zambia to be involved in the combat of the HIV/AIDS pandemic and the pastoral care of people living with HIV/AIDS. The study has further noted the care gap of PLWHA is integrally attributed to a lack of empowerment of church members for by their pastoral leaders, who often seem to be apathetic to HIV/AIDS issues (Marshall & Taylor 2006). In this work the task of empowerment has been understood as that process and act of giving ability to evangelical church-communities to give pastoral care to PLWHA and their significant others. Home-based care has been identified as a germane approach to the mitigation of the effects of the HIV/AIDS epidemic in the Zambian scenario where health-care resources are scarce (Silomba 2002, van Dyk 2005). The current chapter thus makes a synopsis of the preceding five chapters' arguments and conclusions. The chapter also highlights prospective issues emanating from the study for application and further investigation.

6.1 Chapter Synopses

Chapter one of the research hypothesized that Zambian evangelical churches have the capability of mitigating the impact of the HIV/AIDS pandemic by empowering church-based communities for home-based care of people living with HIV/AIDS (PLWHA). The advantages of home-based care

provide a fitting solution to the problem of HIV/AIDS and its challenges in the Zambian context. Chapter one also posited that a serious gap care exists (and is escalating) because evangelical church-communities are not empowered to provide care for PLWHA.

Chapter two made a situational analysis of the HIV/AIDS epidemic in Zambia. The chapter made four important deductions on the HIV/AIDS situation in Zambia. Firstly, church-based communities giving pastoral care to HIV/AIDS patients must have accurate information on HIV and AIDS—such as definition, origin, transmission, statistics, stages of HIV illness, etc—in order to do effective care work. This observation points to the importance of equipping church members in HIV/AIDS pastoral care-giving (Dube 2003b: iv; van Dyk 2005).

Secondly, the interplay between poverty and HIV/AIDS is double-pronged. Poverty increases the poor's vulnerability to HIV infection as a 'push factor' toward risky behaviour. HIV/AIDS also accelerates the destruction of an individual's immunity due to things such as malnutrition caused by diminishing resources. By implication, the chapter held that poorer people might die earlier than the well-to-do who are able to access better nutritional and medical care. Conversely HIV/AIDS accelerates the 'journey' to poverty as the previously productive person in the home is slowed down by the illness and begins to spend his/her savings. Household funds are depleted by high medical and funeral expenses leaving survivors of the deceased with meager resources to live on and educate their children. At the national level, economic performance is adversely affected as previously productive people are unable to work. The researcher therefore suggested that HIV/AIDS prevention and care work has a close connection to the task of social Upliftment.

Thirdly, evangelical Christians in Zambia have a tremendous advantage toward assisting people living with HIV/AIDS. For example, they are strategically placed to disseminate information. Churches are found in almost all areas of the country (i.e. including the remotest rural parts). Since churches function as opinion leaders, they can help people living with HIV/AIDS live positively, especially when they give unconditional love and acceptance to them (PLWHA).

In the fourth instance, Chapter two established that in order to reduce HIV/AIDS prevalence effectively in Zambia, socio-cultural changes must be made, especially in the area of sexual behaviour. It was posited that changes at the traditional practices and lifestyle levels could stem the current rapid spread of HIV/AIDS infection rooted in a personalistic worldview of sickness. The personalistic view of sickness has often discounted risky sexual behaviour as a mode of HIV/AIDS transmission. Because of a personalistic worldview of illness not a small section of traditional Zambian society hold that HIV/AIDS is either a misfortune or downright witchcraft. This inference points to the need for the transformation of worldviews as a way combating HIV/AIDS in Zambia.

Chapter three noted that the advent of HIV/AIDS in Zambia has brought a major challenge to evangelical Christians' practice of theology. Whereas for the most part evangelical Christians in Zambia assumed an attitude of noninvolvement in HIV/AIDS mitigation, chapter three has shown that the nature and mission of the church necessitates a shift from apathy to empathy. The Lord Jesus' injunction to look after the sick (cf. Matt 25: 31-46) inescapably obliges evangelical Christians to care for people living with HIV/AIDS (Richardson 2006). Chapter three further argued, from the biblical metaphor of the church as "family of believers" (Gal 6:10; Titus 3:8; Heb 13:16 etc), that, by nature, the church should be a caring and supportive community of love for all God's people (including people living with HIV/AIDS). The notion of family in the Bible was discussed at

length showing that a close resemblance between the *bet 'ab* (father's house) of the Old Testament and the African extended family network (system) exists. The researcher therefore posited that evangelical Christians in Zambia can harness the strengths of the extended family system to give care to people living with HIV/AIDS. Even in situations where extended families are failing to cope, church-based communities were to stand as an authentic family to care for people afflicted by HIV/AIDS. The New Testament emphasis on the church as the family of God which should care for its members out of love was emphasized. The notion of the church being a family means therefore that the church should lead the way in doing away with stigma and rejection of people living with HIV/AIDS so rampant in Zambia.

Chapter four argued for the idea that pastoral care and counseling is the best approach to tackling the predicament of people living with HIV/AIDS. The chapter noted that pastoral care and counseling has shifted from being the preserve of the 'professional' minister to the community of believers where mutual care (koinonia) and love of believers in the varied circumstances of life's journey occurs (Crabb 1979; Gerkin 1997; Louw 1997; etc). It was shown that ministers alone could not handle the care work of people living with HIV/AIDS. Pastoral care and counseling (*'cure of the soul')*, was defined as the special process of caring for human life because God created it and all people belong to Him. The shift of pastoral care from the professional counseling room to the faith community is very significant for African pastoral care of PLWHA where care and counseling is a communal matter (Louw 1997).

The researcher also noted in chapter four that pastoral care is the optimal response to the HIV/AIDS crisis in Zambia as it not only sought to ameliorate the psycho-social problems of PLWHA, but also imparts a resurrection hope (Yancey 1990, Louw 2006). This is not to say that

pastoral care has nothing to do with psychological counseling. Rather, a health tension between pastoral care and psychological counseling should be maintained without compromising biblical Christianity.

Chapter five discussed the mode of empowering church-based communities for home-based care as an intervention to the HIV/AIDS epidemic in Zambia. The chapter defined the term empowerment as the process or act of building the capacity of church-based communities to respond to the HIV/AIDS epidemic through home-based care. The Chapter also gave a definition of HIV/AIDS home-based (care of people living with HIV/AIDS in their home environment) and identified the three approaches to HIV/AIDS home-based care, namely, the *Integrated*, the *single service* and the *informal* models (see van Dyk 2005). This researcher preferred the single-service home-based care model to the other two as optimal mode for empowering church members for home-based care of PLWHA in Zambia. The argument is premised on the fact that the integrated model is infeasible in the majority of churches in Zambia (due to the scarcity of healthy-care resources in the majority of poor communities). The integrated home-based care model was perceived as the preserve of a few 'wealthier churches'. But it must be noted that the single service home-based care model supported in this research will need to network with other stakeholders for such essential services as referrals, caregivers support and ongoing training needs. The *single service model* of home-based pastoral care holistically addresses the interplay between HIV/AIDS and poverty in the Zambian scenario (see Magezi & Louw 2006). In the *single service model* of home–based care the understanding of church as family can be integrated in a sound manner with the African extended family system where fellowship will entail mutual care.

6.3 Prospective Issues

This study has brought to the fore some issues pertinent to pastoral care of people living with HIV/AIDS in Zambia. First, the study has demonstrated the existence of a vital connection between pastoral care (*koinonia*) and Zambia's extended family care. Arguably in the Zambian extended family setting, family members care for each other during times of crises such as illness, bereavement, etc. The researcher is of the view that the church can harness positive traits of the extended family to give home-base care to people living with HIV/AIDS as the family of Christ. The care function of the church family is emphasized in the Bible as a norm—an indispensable trait of biblical Christianity. No one can claim with a clear conscience that he or she is a Christian without demonstrating practical care of the afflicted (cf. Matt 25:31ff; James 2:14-17, etc). The church is by nature a caring community. Church-based communities therefore have an excellent opportunity to give pastoral care to PLWHA through home-based care.

Secondly, because the HIV/AIDS pandemic has had such profound and debilitating effects on the Zambian extended family system, to the point that even this de facto social safety net seems to be failing as families abandon their sick, evangelical Christians should become proactive in HIV/AIDS care work functioning as a family to PLWHA. It is the researcher's view that home-based care in HIV/AIDS ministry can help keep supportive family ties alive in the face of a growing epidemic (see Silomba 2002).

Thirdly, a salient conclusion of chapter three was that Zambian evangelical Christians should harness practical care strengths in the extended family system to establish a church-based home-based care ministry to PLWHA. The church, therefore, should embody care and compassion to

PLWHA since it (church) is a family akin to both the Old Testament *bet 'ab* and the extended family systems. In the church, therefore, unconditional acceptance, compassion, and love are to replace stigma, rejection, and discrimination on the basis of HIV/AIDS infection. Stigmatization, rejection, and discrimination on the basis of HIV/AIDS infection are still very high among evangelical Christians in Zambia. A need exists for new and growing strategies of eliminating these negative traits.

Fourthly, arising out of the need for pastoral care givers to be well versed on the fundamentals of HIV/AIDS, it is essential that theological education in Zambia include HIV/AIDS psycho-social counseling as part of its core curriculum.

And fifthly, the study has shown that culture/worldview has an intricate bearing on sexual behaviour with reference to most tribal groupings in Zambia (see chapter three). The implication of this finding is that a way of combating the HIV/AIDS pandemic is to effect cultural/worldview transformation which in turn will foster change toward safer sexual behaviour/practices. Christians in Zambia have this particular task of engaging cultures to change behaviour rooted in tribal worldviews. It is the opinion of the researcher that worldview transformation will not only result sexual behavioral change (currently responsible for majority new HIV/AIDS infections), but will ameliorate the stigmatization, rejection, and discrimination against people living with HIV/AIDS. Arguably, worldview transformation is a work from the inside-out of any recipient culture and it goes without saying that Zambian evangelicals must abandon a culture of shame which often seems to shy away from issues of sexuality and HIV/AIDS. Albeit, more study should be done on the topic of worldview transformation as a means of combating HIV/AIDS in Zambia.

6.4 Conclusion

Finally, the focus of this research has been on the issue of empowering church-based communities (i.e. church members) for home-based care to assist evangelical Christians' in Zambia effectively respond to the HIV/AIDS epidemic, which has affected virtually every family. It is the researchers' view that empowering evangelical church-based communities for home-based care of people living with HIV/AIDS will go a long way toward mitigating the impact of the HIV/AIDS epidemic as church-based communities are significant opinion leaders in Zambian Society. Empowering church-based communities will be achieved through HIV/AIDS training, rediscovering authentic koinonia care, and reaching out to people living with HIV/AIDS through home-based care. Evangelical communities in Zambia can in this way give pastoral care to people living with HIV/AIDS and participate in HIV/AIDS prevention.

7. Bibliography

1. Adams, JE 1976. *Competent to Counsel.* Presbyterian & Reformed Publishing: New Jersey

2. Allen, RE (Editor) 1992. *The Concise Oxford Dictionary of English* Eighth Edition. Clarendon Press: Oxford

3. Amos, WE 1988. *When AIDS Comes to Church.* The Westminster Press: Philadelphia

4. Barnett, T & Whiteside, A 2002. *AIDS in the Twenty-First Century: Disease and Globalization.* Palgrave Macmillan: New York

5. Brown, F, Driver S, & Briggs 2001. *The Brown-Driver-Briggs Hebrew and English Lexicon.* Hendrickson Publishers: Peabody

6. Butty, James (Interview with Sidibe, Michael) 2006. "*Africa Not Faring Well on World AIDS Day, UN Official Said*" http://www.voanews.com/english/africa/2006-12-01-voa11.cfm , 01/12/2006

7. Caverno, C 1996. "Family" in *International Standard Bible Encyclopaedia.* Electronic Database, Biblesoft.

8. Central board of Health & Ministry of Health [Zambia] March 2004. *Antiretroviral Therapy: A Reference Manual for Health Workers.* Ministry of Health: Lusaka

9. Central Statistical Office [Zambia], Central Board of Health [Zambia], and ORC Macro. 2003. *Zambia Demographic and Health Survey 2001-2002.* Calverton, Maryland, USA: Central Statistical Office, Central Board of Health, and ORC Macro http://www.zamstats.gov.zm/dload/zdhs.asp, accessed on 26.2.2007.

10. Chirwa, Vincent 2005 *'The Need for Counseling As A Major in the Pastor's Scope of ministry and Theological Education in Malawi in Light of HIV/Aids'* in The South African Baptist Journal of Theology Vol. 14, pp 82-99

11. Country Profile: HIV/AIDS Zambia. Online article: http://www.rhap.org.za/zambia (PDF) accessed 28/11/2006

12. Cornu, C & Attawell, K 2003. *The Involvement of People Living with HIV/AIDS in Community-based Prevention, Care and Support in Developing Countries—A Multi-Country Diagnostic Study.* The Population Council Inc. & The International HIV/AIDS Alliance: New York

13. Couture, PD & Hunter, RJ (Eds.) 1995. *Pastoral Care and Social Conflict,* Abingdon Press: Nashville

14. Crabb, LJ 1979. *Effective Biblical Counseling.* Baker books: Grand Rapids, Michigan

15. De Gruchy, S (ed.) July 2006. Journal of Theology for Southern Africa—Special Issue: Church, HIV and AIDS in Southern Africa Volume 1 number 125, UKZN Pietermaritzburg

16. Mitchell, TC (1982) in Douglas, JD et al 1982. *New Bible Dictionary Second Edition.* Inter-Varsity Press: Leicester

17. Drinkwater, M McEwan, M & Samuel, F "The Effects of HIV/AIDS on Agricultural Production Systems in Zambia: A Restudy 1993-2005" http://sarpn.org.za/documents/d0002149/index.php, accessed 27/11/2006

18. Dube, MW (Ed) 2003a. *HIV/AIDS and the Curriculum: Methods of Integrating HIV/AIDS in Theological Programmes.* World Council of Churches Publications: Geneva

19. ------- (Ed) 2003b. *Africa Praying: A Handbook on HIV/AIDS Sensitive Sermons Guidelines and Liturgy.* World Council of Churches Publications: Geneva

20. Essay.com.2002. '*The interaction of poverty and HIV/AIDS'.* Online article: http://sarpn.org.za/refionalpovertypapers/April262001/page4, accessed 27/11/2006

21. Elwell, WA (Ed) 2001. *Evangelical Dictionary of Theology* 2nd Edition. Baker Academic: Grand Rapids, MI

22. Erickson, MJ 2002.*Christian Theology 2nd Edition*. Baker Books: Grand Rapids, MI

23. Essays.com 2002. '*HIV/AIDS and Poverty'.* Online http://www.unfpa.org/swp/2002/english/ch6 accessed 11/10/2006

24. Fernandez, J. 2003(May) '*Poverty and HIV/AIDS'* online http://www.drugtext.org/library/articles/fernandez.htm accessed 11/10/2006

25. France, RT 2004 in Carson, DA et al (Eds) 2004. *New Bible Commentary.* Inter-Varsity Press: Leicester

26. Gennrich, D 2004. *The Church in an HIV+ World: A Practical Handbook,* Cluster Publication: Pietermaritzburg

27. Gerkin, C V 1997. *An Introduction to Pastoral Care.* Abingdon Press: Nashville

28. Grudem, W 1994. *Systematic Theology: An Introduction to Biblical Doctrine.* Zondervan Publishing House. Grand Rapids: Michigan

29. Haworth, A, Chiboola, H & Kwapa, P (Editors) 2001. *HIV/AIDS Counselling: A Generic Training Manual,* Zambian Ministry of Health: Lusaka

30. Hendriks, HJ 2002. *Doing Missional Theology in Africa*. University of Stellenbosch: Stellenbosch

31. Hiebert, Paul G 2004. *Anthropological Insights for Missionaries*. Baker Book House: Grand Rapids

32. Human Rights Watch (2002). *Suffering in Silence: the Link between Human Rights Abuses and HIV transmission to Girls in Zambia*. Online Article http;//www.hrw.org/reports/2003/zambia/zambia1202pdf, March 20, 2007

33. Hunter, RJ 1996. *Dictionary of Pastoral Care & Counseling*. Abingdon Press: Nashville

34. Hypponen, E & Banda, H [2005]. Legal Reform-Key to Social Change? Experiences from Rural Zambia. Online Article http://zambia.ded.de/cipp/custom/pub, accessed May 17, 2007

35. International Center for Research on Women (2003). *Disentangling HIV and AIDS stigma in Ethiopia, Tanzania and Zambia*. Online Article www.icrw.org/docs/stigmareport093003.pdf accessed 20/11/2006

36. International Monetary Fund [2005] "Zambia: Poverty Reduction Strategy Progress Report-July 2003-July 2004". Online Article http://sarpn.org.za/documents/d0001196/index.php accessed 27/11/2006

37. Intestate Succession Act 1989 of Zambia (No. 5 of 1989) [14 May 1989]. http://www.ncbi.nlm.nih.gov/entrezlquery.fcgi?cmd:Retrieve&db-Entrez PubMed, accessed May 17, 2007

38. Kakwani, N [2006]. *"What is Poverty?"* Online article http://sarpn.org.za/document/d0002176/index.php accessed November 27, 2006

39. Kapolyo, JM 2005. *The Human Condition: Christian perspectives through African Eyes*. Inter-Varsity Press: Leicester

40. Kietzman, DW & Smalley, WA 2004. "The Missionary's Role in Culture Change" in Winter, RD & Hawthorne, SC (Eds) 2004. *Perspectives on the World Christian Movement—A Reader 3rd Edition*. William Carey: Pasadena

41. Kraft, CH 2004. "Culture, Worldview and Contextualization". In Winter, RD & Hawthorne, SC (eds) Perspectives on the World Christian Movement—A Reader 3rd Edition, William Carey, Pasadena

42. Laws of Zambia Chapter 59. The Intestate Succession Act No. 5 of 1989 (and Act no 13 of 1994).

43. Louw, DJ November 2006. *"The HIV Pandemic from the Perspective of a Theologia Resurrectionis: Resurrection Hope as a Pastoral Critique on the Punishment and Stigma Paradigm"* in the Journal of Theology for Southern Africa, Number 126, pages 100-114

44. ----------November 1997. "*Pastoral Care in an African Context: A Systematic Model and Contextual Approach"* in Missionalia Volume 25 No. 3, pages 392-407

45. Magezi, V/Louw, D July 2006. '*Congregational Home-Based Pastoral Care: Merging the African Family and Church Family Systems for Effective HIV Ministry*.' Journal of Theology for Southern Africa, Vol. 1 Issue # 125, pp 64-79

46. Magezi, V Dec 2005. *'Life beyond Infection: Home-based Pastoral care to people with HIV-positive status within a context of poverty.'* Unpublished Dth Dissertation, University of Stellenbosch

47. Maldonado, JE (Ed) 1990. *Guide to HIV/AIDS Pastoral Counseling.* World Council of Churches: Geneva

48. Marshall, JL 1995. *Pastoral Care with Congregations in Social Stress* in Couture, PD & Hunter, RJ (Eds) 1995. *Pastoral Care & Social Conflict*. Abingdon Press: Nashville

49. Marshall, M & Taylor, N 2006. *"Tackling HIV and AIDS with faith-based communities: Learning from attitudes on gender relations and sexual rights within local evangelical churches in Burkina Faso, Zimbabwe, and South Africa"* in Gender & Development Vol. 14, No. 3, November 2006, Oxfam GB

50. Mbewe, Conrad 2005. *HIV Testing Prior to Marriage.* Unpublished Mphil Mini-Thesis, University of Pretoria

51. Meier, PD, Minirth, FB, Wichern, FB & Ratcliff, DE 1991. *Introduction to Psychology and Counseling: Christian Perspectives and Applications* 2nd Edition. Baker Book House: Michigan

52. Minirth, F 2003. *The Minirth Guide for Christian Counselors*. Broadman & Holman: Nashville

53. Mohammad, N & Gikonyo, J (August 2005). *"Operational Challenges to Community Home Based Care (CHBC) for PLWHA in Multi-Country HIV/AIDS Programs (MAP) for Sub-Saharan Africa"* http:// worldbank.org wp88.pdf community home based care, accessed 01/12/2006

54. Muller, JC 1999. *Companions on the Journey: The Art of Narrative Counseling*. Logos Books (www.logos-sa.com)

55. -----1997. *Intercultural Exchange: A Discovery of Being Different. In Intercultural Pastoral Care and Counseling*. No. 2, pages 4-8

56. Muller, JC & Stone, HW 1998. *Intercultural Pastoral Care and Counseling: Resources from Narrative Therapy and Brief Pastoral Counseling.* In Skrif en Kerk, Jaargang. 19(2), pages 325-341.

57. Muller, JC & Van Deventer, W 1998. African Cosmology and Pastoral Family Therapy. In Missionalia August 1998 Volume 26 No. 2 pages 260-271.

58. National Aids Council/Ministry of Health 2002. Republic of Zambia National HIV/AIDS/STI/TB Policy online document: http://www.youth-policy.com/policies/zambia_national_HIV_STI_TB_policy.cfm accessed 28/11/2006

59. New Webster's Dictionary & Thesaurus 1992. Ottenheimer Publishers Inc.: New York

60. Noble, R (June 6, 2006a). "HIV & AIDS in Zambia—the epidemic and Its Impact" http:www.avert.org/aids-Zambia.htm accessed 27/11/2006

61. ------ (October 20, 2006b). "HIV & AIDS in Zambia: Prevention & Care" http://www.avert.org/zambia-aids-prevention-care.htm accessed 01/12/2006

62. ------ (2/11/2006c). "HIV & AIDS in Zambia: History & Funding" http://www.avert.org/zambia-aids-history.htm, accessed 02/12/2006

63. Ogden, J, Esim S, & Grown C 2004. *"Expanding the Care Continuum for HIV/AIDS: Bringing Carers into Focus." Horizons Report.* Population Council and International Center for Research on Women, Washington DC Online: http: http://www.popcouncil.org/pdfs/horizons/xpndngcrcntnm.pdf, accessed 04 Jul 07

64. Or, E. October 20 2005. 'Zambia Faith Leaders Unite in Efforts to Tackle HIV/AIDS' Online Article: http://www.christianitytoday.com, accessed 24th April 2007

65. Parry, S 2005. *Mapping Study: Responses of Churches to HIV and AIDS in South Africa.* WCC Ecumenical HIV/AIDS Initiative in Africa (pdf) www.wcc.coe.org, accessed 01 Jun 2007

66. Rasing, T [2006]. *HIV/AIDS and Sex education among the youth in Zambia: Towards behavioural change.* Online Article http://asc.leidenuniv.nl/pdf/paper091022003.pdf accessed 20/11/2006

67. Richardson, Neville July 2006. '*A Call for Care: HIV/AIDS Challenges the Church*' Journal of Theology for Southern Africa, Vol. 1 Issue # 125, pp 38-50

68. Silomba, W (March 2002). '*HIV/AIDS and Development: the Chikankata Experience*'— Draft paper prepared for UNRISD project HIV/AIDS and Development (PDF), Online article http://www. Unrisd.org, accessed 05/02/2007

69. Steinke, PL 1996. *Healthy Congregations—A Systems Approach*. The Alban Institute: VA

70. Stott, JRW 1999. *New Issues Facing Christians Today*. Marshall Pickering: London

71. ------ [2007] in Tim Stafford *'One to One Interview John Stott'*. NewFrontiers Magazine January-March 2007 Volume 3 Issue 2

72. Tasker, RVG 1983. *Matthew—Tyndale New Testament Commentarires*. Inter-Varsity Press: Leicester

73. The Times of Zambia (Ndola) Opinion 29/11/06 *"Zambia: World AIDS Day"* http://www.allafrica.com/stories/200611290925.html , 01/12/2006

74. "Traditional Cultural Practices of Imparting Sex Education and the Fight against HIV/AIDS: The Case of Initiation" [2006]. Online article http://www. Codesria.org , 28/11/2006

75. USAID (2003). Country Profile HIV/ADS Zambia http://www.usaid.gov/pop_health/aids/countries/africa/zambia.html , August 21, 2006

76. USAID (September 2004) "Home Based Care for People Living with HIV/AIDS: A Reference Manual for Caregivers" PDF http://pactworld.org Accessed 28/11/2006

77. UNAIDS 2006 Report on the Global AIDS Epidemic http://www.unaids.org/en/HIV_data/2006GlobalReport/default.asp accessed 5/02/2007

78. Van der Walt, H 2004. *HIV/AIDS in South Africa: A Synopsis of the Epidemic and How Congregations Can React to It.* CLF Publishers, Bloemfontein

79. van Dyk, Alta 2005. *HIVAids Care & Counselling: A Multidisciplinary Approach* 3rd Edition. Maskew Miller Longman: Cape Town

80. van Niekerk, R, Samson, M & Green (2001) AIDS, Poverty, and Malnutrition: A Review of the Household Survey Literature, EPRI (PDF) http://www.sarpn.org.za accessed 27/11/2006

81. Weeks, J & McKinley [2006]. "Does Debt Relief Increase Fiscal Space In Zambia? The MDG Implications" http://sarpn.org.za/documents/d0002183/index.php accessed 27/11/2006

82. White, P1998. *The Effective Pastor: Get the Tools to Upgrade Your Ministry*. Christian Focus Publications: Ross-Shire

83. World Bank Report (2005a) Chapter 7 *"The Impact of HIV/AIDS on Poverty and Vulnerability in Zambia."* Online http://www.sarpn.org.za/documents/d0001457/index.php accessed 27/11/06

84. ---------- (2005b). Zambia: Poverty & Vulnerability Assessment Report No. 32573-2M Online Article: http://www.sarpn.org.za/documents/dooo1457/index.php, accessed 5/02/2007

85. World Council of Churches 2002. *Facing AIDS: The Challenge, the Churches' Response.* WCC Publications, Geneva

86. World Health Organization (2006). *Sub-Saharan Africa AIDS Epidemic Update.* Online Article: http://www.int/hiv/mediacentre/04_sub_saharan_African_2006_EpiUpdate-engpdf accessed 27/11/2006

87. ----------- 2005a. *HIV/AIDS Epidemiological Surveillance Report for WHO Africa Region 2005 Update.* Online Article: http://www.who.org , 27/11/2006

88. ----------- 2005b. Zambia: Country Profile for HIV/AIDS Treatment Scale Up. Online Article http://www.who.org, accessed 27/11/06

89. Wright, CJH 1992. *"Family"* in Freedman, DN (Ed.) 1992. *The Anchor Bible Dictionary: Volume 2 D-G.* Doubleday. New York

90. Yancey, P 1990. *Where is God When It Hurts? A Comforting, Healing Guide for Copping With Hard Times.* Zondervan, Grand Rapids, Michigan

91. Zondervan NIV Study Bible (Fully Revised) 2002. The Zondervan Corporation: Grand Rapids, MI