

**UNIVERSITY OF PRETORIA
FACULTY OF THEOLOGY**

DISSERTATION TITLE

**THE ROMAN CATHOLIC CHURCH AND THE UNITED CHURCH OF
ZAMBIA CHALLENGED BY HIV AND AIDS, WHICH RESULTS IN
CREATING POVERTY AMONG ZAMBIAN PEOPLE.**

BY

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DECLARATION

I hereby declare that this dissertation is my own work, and that all sources I used have been indicated and duly acknowledged by means of complete reference.

Richard Chimfwembe

Date:.....

Sign:.....

DEDICATION

To my children, Mwila, Bwalya, Chimfwembe and Kangwa, and to the rest of Africa's children living with HIV and AIDS who are orphaned and living in poverty.

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ABSTRACT

The writing of this thesis is to investigate the role that the church play for the people living with HIV and AIDS and are poverty stricken. This investigation takes us both into the role of the Roman Catholic Church of Ndola Diocese and the Copperbelt Presbytery of the United Church of Zambia are doing in the fight against HIV and AIDS and poverty.

The problem of HIV and AIDS in Zambia, as well as Africa in general, represents an economic, social, moral, and spiritual problem of great magnitude. Never before in the history of the world have we faced such a pandemic which results in creating poverty among Zambian people. It knows no boundaries, leaving a path of death and destruction to all that treat it lightly. HIV and AIDS have touched every community within the global village. There is not a person that has not pondered on this terrible disease. The researcher's question through this thesis is to find out the role of the church as it seeks to care for those infected and affected by the HIV and AIDS pandemic. Can the church rise to embrace the enormous economic and social need that HIV and AIDS and poverty presents, can it make a difference in an environment of suffering as it seeks to become a healing community?

This thesis is to enhance the response of churches in Zambia to the fight against HIV and AIDS and Poverty. Pastorally, churches have the duty and task to address issues of stigma, discrimination, judgmental tendencies and give pastoral care to people living with HIV and AIDS. This thesis has attempted to explore new theological perspectives and utilise the available ones, which have already been dealing with issues that address HIV and AIDS prevention and care. The study also seeks to encourage church ministers, pastors and lay leaders to provide the much needed leadership in the fight against HIV and AIDS and its accompanying social problems of poverty, injustices, culture and gender inequality.

The church has a central role to play in the fight against poverty and impoverishment. As part of the civil society, it has the pastoral responsibility for ensuring that all citizens in Zambia enjoy their full rights. Far from being powerless victims of HIV and AIDS and poverty, the poor in Zambia must be treated with respect and dignity. Nevertheless effective therapy and pastoral

care normally transcends all stigma and cultural barriers as it seeks to address the problems of people living with HIV and AIDS. Human beings respond to love, care and shelter, as basic needs. Ross reminds us that “It is only when the church becomes the leading symbol of healing in a situation of HIV and AIDS and poverty then it will be a blessing to all those who are living HIV negative lives and those who struggle to bring care, support, love and comfort to the orphans and widows and more especially to all those living with HIV and AIDS” (Ross 2002:vi). The church should not lag behind, but it should set the pace of showing the love and care for all people with HIV and AIDS and are living in poverty.

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
BNA	Basic Needs Approach
CHAZ	Churches Medical Association of Zambia
DOTS	Direct Observer Treatment Short course
HIV	Human Immunodeficiency Virus
HBC	Home Based Care
OVC	Orphaned and Vulnerable Children
NGO	Non Governmental Organisation
PQLI	Physical Quality of Life Index
LCMS	Living Conditions Monitoring Survey
STD	Sexually Transmitted Disease
NAC	National AIDS Council
CBoH	Central Board of Health
UNAIDS	United Nations – AIDS
UNICEF	United Nation International Children’s Emergency Fund
WHO	World Health Organisation
WCC	World Council of Churches
UCZ	United Church of Zambia
UNITA	National Union for the Total Independence of Angola
CSO	Central Statistics Office
GDP	Gross Domestic Product
GNP	Gross National Product
HDI	Human Development Index
IMF	International Monetary Fund
SAP	Structural Adjustment Programme
ESS	Epidemiological Sentinel Surveillance
ZDHS	Zambia Demographic Health Surveys
ANC	Antenatal Clinic

INTRODUCTION

Many people to day will agree that September 11th 2001 marked a turning point in our world's history. The terrorist attack on the Twin Towers in New York warned us that we cannot take peace for granted. The response to this callous act of mass murder has been to go to war, and physically try to wipe out those judged responsible for the action of violence. While people want to see the culprits brought to justice, they also know that force does not reform people and does not bring lasting peace. Violence will provoke more violence, death and fear will spread with the threat of more open war.

In our day there has been another turning point in modern history. This cannot be dated as accurately as the terrorist attack on New York, but it has had and is having more terrifying consequences. This has been the discovery of a mysterious sickness, which began to be noticed in the early 1980s, which has turned out to be a plaque, which has no cure. This plaque is known as AIDS and is claiming millions of lives of men and women; old and young, rich and poor, white or black. This plaque respects no tribe or race or national boundary. It is true that poorer countries are much more vulnerable and are experiencing much large number of casualties. Let us note that poverty does not cause AIDS but creates an environment, which militates against treatment and alleviation of suffering. Poverty means lack of proper food, clothing, shelter, proper sanitary condition and sufficient medicine. Clearly this poverty brings deterioration and death more quickly. Further, it destroys human and economic resources for development, which promotes further poverty. AIDS is a new disease in the world. The acronym stands for “Acquired Immune Deficiency Syndrome” and is caused by a virus called HIV (Human Immuno deficiency Virus). It depletes the immune system cells of the human body thereby making it susceptible to opportunistic infections, e.g. Tuberculosis and Pneumonia. HIV affects the human body by attacking the body defence mechanism (the immune system making the body unable to fight of infections). HIV is viral infection caused by viruses that are parasitic in nature because they do not live on their own. HIV lives and survives in human cells. The HIV virus has the ability to turn itself into a human cell once it attaches itself to one. Infections with HIV are life long and infected persons remains infected and infectious for life.

The human toll of AIDS is a tragic reality being experienced by families, communities and the nation at large. There is no aspect of life that has not directly or indirectly been affected by the AIDS epidemic. AIDS has become the major cause of illness and death among the young and middle aged adults, depriving households and society of critical human resource base and thereby reversing the social and economic gains made since independence in Zambia.

In Africa when you talk of HIV and AIDS, it automatically links you to poverty. That is why in this study the researcher has to deal with both HIV and AIDS and poverty. As noted above poverty does not cause AIDS but creates an environment which militates against treatment and alleviation of suffering. There is a strong correlation between the incidence of poverty and HIV and AIDS. Recent studies in developed countries have shown that AIDS incidence to be highest among the very poor. At the moment, there is no data to access the precise proportion of poor and non poor people who are infected in developing countries, but if trends for developed countries are replicated worldwide, the poor will likely become more infected than the non-poor. AIDS deepens and spreads poverty among African countries. Poor households are more adversely affected by an AIDS death of a prime-age adult than other households, because they have fewer assets to draw on to cope with medical expenses, and the loss of income and services that a prime-age adult typically provides. AIDS is also likely to increase poverty although the rise in the number of children who lost one or both parents. Evidence shows that orphans have significantly lower enrollment in school and are more likely to be malnourished than non-orphans. Lack of schooling and inadequate nutrition will make it more difficult for orphans to escape poverty. AIDS in southern Africa as well as in Zambia is not just a medical dilemma, but also a political and social crisis. In other words, on top of the massive political and social economic problem countries in the sub-region have to deal with, HIV and AIDS has proven to be partially difficult to contain.

In the study proposed here, the researcher will explore through documentary study the problem of poverty and HIV and AIDS in Zambia. To some extent, the purpose of this

study is to give some comparative perspective on how the church in Zambia is generally responding to the problem of poverty and HIV and AIDS. As it has been observed the problem of poverty and HIV and AIDS is a moral question that falls within the social and spiritual responsibility of the church. In fact, scripture provides the church with issues of justice, especially it's biblical emphasis on pastoral care and social ethics. Since we are living in a world of rising international inequality and deep persistent of poverty and HIV and AIDS, it is imperative that the church should fight against poverty and HIV and AIDS, and seek to give proper love and pastoral care to those living with HIV and AIDS and those affected by it. Hence in this study, an attempt is made to answer the question why poverty and HIV and AIDS is significant, and how the church can find a role to play in the process of reducing the infection rates and alleviating poverty and caring for those infected or affected with the virus. Can the church rise to embrace the enormous economic and social needs that poverty and HIV and AIDS presents? Can it make a difference in an environment of suffering as it seeks to become a healing community? This study will bring out the importance of care in communities through pastoral care. It will also help church communities to realize that by its very nature as a body of Christ, should call its members to become healing communities. Despite the extent and complexity of the problems raised by poverty and HIV and AIDS, churches can make an effective healing witness towards those infected and affected.

A Brief History of Zambia

Politics, Land, Demography and Economy

Zambia was a British Colony until 24th October 1964 when the country obtained self-rule following 74 years of colonization. Before independence, Zambia was known as a Northern Rhodesia, a part of the federation of Rhodesia and Nyasaland from 1953 to 1963. Since independence, the country has undergone three major political phases of governance. From 1963 to 1971, the country had experienced multi-party politics. From 1971 to 1991, the country introduced a one party state. This second system of

governance was brought to an end when Zambian people decided to revert to multi-party politics in October 1991. Administratively Zambia is divided into nine provinces being Central, Copperbelt, Eastern, Luapula, Lusaka, Northern, North Western, Southern and Western, with 73 officially recognized local languages. Lusaka is the capital city of Zambia and the seat of government. The government consists of central and local government. The local government is administered through the current 72 district councils, which are classified as townships, municipal and city councils.

Zambia is a land locked country meaning it is surrounded by other countries and has no direct access to the seacoast. Although it is landlocked, the country has relatively good transport links with her Southern African neighbours. Zambia lies in the Southern tropics of Sub-Saharan South Central part of the continent, sharing borders with eight other countries: Tanzania in the North-east, Malawi to the east, Mozambique to the South-West, Zimbabwe to the South, Angola to the west, Botswana and Namibia to the South West, and Democratic Republic of the Congo to the north. On the world map Zambia lies between 8 degrees and 18 degrees South and longitudes 22 degrees and 33 degrees east. Zambia has a total area of 752, 641 square kilometers (290,586 Square metres).

Zambia is about 2.5 percent of the African continent's total area and the sixteenth largest state in Africa. Zambia's furthest points on a north south or east-west axis measures nearly two thousand kilometers apart. Such vastness of territory coupled with low population densities pose serious problems in national development efforts. The country lies on the Central African plateau between 1,000 and 1.600 metres above sea level. This gives Zambia a moderately cool subtropical climate, with a hot and cold season each year.

Zambia has considerable natural resources, although until now these have been only partly exploited. While soils and climate conditions in many parts of the country are favourable for arable agriculture, only about one fifth of the tillable land is actually farmed, albeit, much of the better land. The combination of relatively good soils, water

and climate provides the country with a great potential for crop and livestock production, however one cannot understand why Zambians continue to be poor people. By far the most important crop is maize. Other crops include groundnuts, millet, sorghum, cotton, tobacco, sunflower and cassava. Zambia's many lakes and rivers support a rich and diverse resource of fish. Thus, fishing is another important supplementary economic activity in rural areas, mainly to supply urban consumption requirements (Republic of Zambia and United Nations 1996:19).

Over the past three decades Zambia's population has more than doubled in size. The de jure population rose from 3.5 million in 1963 to an estimated 9.5 million in 1996, representing an increase of 171 percent over 33 years (Zambian Human Development Report 1998:5). Other factors include low education especially among women, low contraceptive use, high levels of infant and child-mortality, and low socio-economic status especially that of women (CSO 1996:24-25). By the rule of numbers, it implies that Zambia's population will double by the year 2021 (i.e.: if the current population growth were to continue).

Zambia has its main economic activities (mixed) concentrated along the line of rail, while agriculture sector is most concentrated in the rural parts of the country. At independence, Zambia inherited a dualistic economy that was heavily dependent on the mining sector for employment, foreign exchange earnings and government revenue. The Zambian government based its development strategy on copper earnings, which accounted for 90 percent of all earnings and nearly 50 percent of the gross domestic product (Bonnick 1997:48). This government policy was focused on this sector, with a view to use the earnings to create a manufacturing sector in a highly protected environment. During the first decade of Zambia's independence, a relatively advanced manufacturing base was developed through import substitution. Also during this period the country achieved significant progress in the provision of social services.

The mid 1970s marked a sharp discontinuity in the development of Zambia. The country's terms of trade fell sharply following the 1973/74 oil crisis and the subsequent

world economic recession. After 1973 the Zambian economy contracted because of the massive decline in copper prices and the doubling import prices (Bonnick 1997:49). The 1979/80 oil crisis resulted in another sharp decline of copper – petroleum terms of trade (Anderson 2000:16). Bonnick (19997:49) notes that a sharp drop in copper production after 1980 also contributed to the shortage of foreign exchange, in turn causing the under utilization of industrial capacity and the postponement of maintaining and rehabilitation infrastructure. Although Zambia joined the IMF in 1965, but because of the economic boom the country was enjoying in 1960s, it saw no point in using the IMF's resources until in the 1970s, when the international copper prices continued to be depressed, Zambia's economic strategy became impracticable. In 1980 the government accepted the need for reform and turned to the IMF. This has not helped the situation, the economy of Zambia has gone down, and the people of Zambia live in poverty. As at now, Zambia is one of the poorest countries of the world.

The above brief history of Zambia and its economic activities over the years show how Zambia has ended to be one of the poorest countries of the world. This state of being one of the poorest nations in the world has contributed to the exceedingly high of HIV and AIDS prevalence, since it was first detected in 1984. Because of the gravity of the pandemic it is very difficult for the government of such a poor nation as Zambia to fight the scourge single handedly. This therefore calls all sectors of society including the church to put the resources and fight together to mitigate the impact of HIV and AIDS that has put the Zambian people in a crisis.

CHAPTER ONE

1.0 SETTING THE SCENE

In setting the scene, the researcher will discuss his personal experience with people living with HIV and AIDS in his family and work as a pastor.

1.1 The Topic Story

In April 1990, the researcher was ordained as a minister in the United Church of Zambia at Mbereshi Mission Station in Luapula Province of Zambia. The same year he was appointed acting Chaplain for Mbereshi Mission Hospital. It was at this hospital that the researcher first experienced a case of HIV and AIDS. A sick man named “Kabungo” (fictitious name) came from the city to live with his parents at home, and was then taken to hospital for treatment. In confidence the Doctor told the researcher that Kabungo was HIV positive and that needed to be counselled. Two years in the ministry the researcher had never encountered a person living with HIV and AIDS, as a result stigmatised him because the researcher was afraid of the sickness. However, the researcher tried his best to be good to the man, but he ended up discriminating and judging him, saying he was a sinner and that his sickness was a punishment from God. Not only did the researcher show this negative attitude to “Kabungo” but also to other persons suspected to be HIV positive. His theology informed him that such people were promiscuous or loose in morals.

In January 1991, the researcher was transferred to Kitwe in the Copperbelt Province of Zambia. It was in this town, that God exposed him to real experience of negative attitude towards people living with HIV and AIDS. It all began in 1993 when his own brother “Machushi” (fictitious name) became sick, lost his job and came to stay with him and his family. Looking at his condition, the researcher knew that he had to be with him most of the time, and from the experience he had at Mbereshi Hospital, he concluded he had been infected with HIV. Due to the little knowledge he had on HIV and AIDS from the Chaplain’s experience, he really feared that his children would contract the disease and so he discriminated against him. After one year, his brother did

not get any better and even though he loved him, he really encountered discrimination and stigmatisation not only from the researcher, but his family as well. Furthermore, The researcher totally agrees with the English adage “little knowledge is always dangerous”. Unfortunately enough, his brother died from AIDS related illnesses and his death marked the researcher’s turning point in his life and ministry. The researcher’s negative attitude to people living with AIDS was challenged by his brother’s death and he felt guilty because of his negative attitude towards his own brother. This experience caused him to search for a way of ministering to people living with HIV and AIDS.

The researcher therefore worked very hard to give his brother a decent burial. Apart from his brother, he managed to take care of his niece who died in his care from AIDS, and another brother who also died of AIDS related illness. From that time, the researcher came to understand that AIDS could not be contracted by sharing the same toilet, drinking from the same cup or bathing an infected person. This challenge caused him to stop judging people. The practical experience the researcher had by staying with his sick relatives under the same roof was a big lesson for him. This helped him get involved in the caring ministry in his congregation, such as; running a home based care in Mulenga Compound as will be discussed in Chapters four and five. The researcher drew inspiration to work and care for people living with HIV and AIDS from the death of his relatives, especially the death of his brother “Machushi” whom he failed to give love and good care. But that failure became a good lesson and turning point in his life as a minister of religion ordained to give pastoral care to people who are in need and those who are neglected like people living with HIV and AIDS. From his experience at Mbereshi Hospital, his brother’s sickness and death, the researcher has come to learn that no one has the right to condemn others. Unfortunately, People Living With HIV and AIDS (PLWHA) often have been looked upon with prejudice and shame, another reason to conceal their HIV status. They do not dare to tell anyone for fear of being rejected. Sometimes people living with HIV and AIDS have felt alienated and condemned by Christians, friends, leaders and relatives as it was with his case. Because the spread of HIV is so closely related to sexual behavior, churches often tend to judge infected people as greater sinners than others. They are likely to misjudge “innocent people” who

are not themselves responsible for their infection. However, even in a case where someone got infected through sinful behaviour, who has the right to condemn another person? In the Gospel of John we hear about some religious leaders that brought a woman caught in adultery to Jesus. She was guilty, and according to the law such people should be stoned to death. But Jesus' way of judging was different from what they expected.

The teachers of the law and the Pharisees brought a woman caught in adultery. They made her stand before the group and said to Jesus, "Teacher, this woman was caught in the act of adultery. In the law Moses commanded us to stone such women." Now what do you say? They were using this question as a trap, in order to have a basis for accusing him. However, Jesus bent down and started to write on the ground with his finger. When they kept on questioning him, he straightened up and said to them, "If any one of you is without sin, let him be the first to throw a stone at her." Again he bent down and wrote on the ground. At this, those who heard began to go away one at a time, the elder ones first, until only Jesus was left, with the woman still standing there. Jesus straightened up and asked her, "Woman where are they? Has no one condemned you?" "Then neither do I condemn you," Jesus declared. "Go now and leave your life off sin." (John 8:3-11).

Jesus was the only one without sin; He had the right to condemn her. He could have thrown the stone at her as the law required. Instead of condemning her, he forgave her. Instead of death he gave her the gift of life. What right has the researcher to condemn Kabungo and his brother "Machushi?" The above story challenged the researcher's method of caring for people living with HIV and AIDS. It also caused him to examine his theology of serving others. His attitude of discrimination and condemnation was changed to the loving and caring attitude to people living with HIV and AIDS, and those in need of care and help. This is how the researcher's topic story was clothed, but the seed that germinated it all was a spirit of love, care and concern for the people living with HIV and AIDS.

1.2 The Positioning of the Research

The researcher is writing this dissertation as an ordained minister of the word and sacraments in the United Church of Zambia. Moreover, working as a pastor in Mulenga

unplanned settlement for five years now, living and dealing with the poverty stricken people of this shanty compound, the researcher also has a privilege to work for the Theological Education by Extension in Zambia since 1996, when he was seconded as Training Coordinator. In his work he has had a privilege to travel around the country and seen and proved how HIV and AIDS and poverty have become serious health and developmental problems. People in Zambia are in a crisis due to HIV and AIDS and poverty, which to the researcher are intertwined in spreading the virus. The researcher will deal and justify this relationship between HIV and AIDS and poverty.

The researcher is also writing from his own experience of living and caring for people living with HIV and AIDS. As stated in the topic story the researcher gives a living testimony of stigma and discrimination, which he was involved in as a church leader and chaplain of the hospital. However his experience has changed his perception towards people living with HIV and AIDS. The researcher's personal experience and his involvement in HIV and AIDS programme in Mulenga community, somehow, substantiate why he has to remember Campbell's description of pastoral care as he reminds us that "In pastoral care we are speaking of meditation of steadfastness and wholeness, not the offering of advice at an intellectual level. Our bodily presence is better than our counseling techniques. There is no need of the stress on competence" (Campbell 1998:15).

The researcher commences this work as a pastor working in one of the poor congregations of the United Church of Zambia where he has physically experienced poverty and how it contributes to vulnerability to HIV and AIDS. Given the effects of poverty and HIV and AIDS as challenging the pastoral care of the church, the researcher feels obliged to study and contribute to the effective church response to the challenges posed by the HIV and AIDS pandemic.

1.3 Statement of the Research Problem

Twenty-two years after HIV and AIDS was medically discovered it has become clear that it is more than just a medical issue. It pervades all spheres of our lives, be they social, economic, political or cultural (UNAIDS 2000:26-33). It is also more than just an individual problem, for it affects families, communities, nations, continents, and the whole world.

Statistics have proven that 40 million people are living with the virus in the world. 28.5 million of them live in Sub-Sahara Africa. Since its outbreak, HIV and AIDS has killed 22 million people worldwide, 17 million of which are from Sub-Saharan Africa. UNAIDS and UNDP 2001 Reports states that in Sub-Saharan Africa, South Africa has the highest number of people living with HIV and AIDS, while Botswana has the highest infection rate.

Zambia is one of the countries in the Southern Africa, which has also been hard hit by the HIV and AIDS epidemic. The National AIDS Council citing the 2001/02 Demographic and Health Survey states that 16 percent of the adult population aged 15 to 49 are HIV positive (NAC, Living Positively; No. 10, December 2004). For many years the statistics of people infected by the HIV virus had been at 20 percent (NAC 2003:16). However, the recent reduction from 20 to 16 percent is still alarming, and it calls for effort from all sections of life to join together in the fight against the HIV and AIDS epidemic.

In recent years some Christians and church-related institutions in Zambia have been active in the education and prevention programmes and in caring for people living with HIV and AIDS. Still the response of churches has been inadequate and has in some cases made the problem worse. For instance, in 1987 the WCC Executive Committee noted that, “through their silence, many churches share responsibility for the fear that has swept our world more quickly than the virus itself” (WCC Study Document 1997:99). This is a true picture of the church in Zambia. Sometimes churches have

hampered the spread of accurate information or created barriers to open discussion and understanding about the epidemic. This situation continues to challenge churches in Zambia to respond effectively to the fight against HIV and AIDS and poverty.

The Church as a body of Christ is a community of healing and compassion (WCC Study Document 1997:77-92). By preaching the good news of Jesus Christ, the church espouses the message of social, individual, national, and international wholeness. For the church, all people, regardless of their gender, class, ethnicity, race, age and religion are created in God's image and life itself is God's will for humankind and creation as a whole (Genesis 1-2). This is further underlined by Jesus who said he came that all may have life and have it in fullness (John 10:10). Jesus Christ' ministry was centred around healing of diseases unconditionally (Mark 1:29-34), forgiving sins (John 8:1-12) breaking the stigma associated with leprosy by touching lepers and restoring them back to physical and social health (Mark 1:40-45), denouncing self-righteousness among believers (Luke 18:9-14), taking sides with the poor and the socially marginalized (Matthew 9:10-13) prophetically denouncing oppressive social structure (Luke 4:16-22) and triumphantly defeating the power of death through his resurrection, thus conferring upon all believers the privilege to live in the resurrection hope.

In short, biblical teaching, the gospel of Christ and church traditions provide adequate framework for the church to serve God's people in the HIV and AIDS era. However the church's close connection with individuals, families and the community; its availability even in the most remote areas, has put it in the center of HIV and AIDS care. The church ought to be there for the sick, the dying, the bereaved, the orphaned and widowed, offering care and hope in the gospel of Christ. Besides, as a community of compassion and healing, the church is a pool of human resources, who are willing to reach out to God's people. This thesis seeks therefore to examine the response of the two mainline churches in Zambia, the Roman Catholic Church and the United Church of Zambia to the challenges of HIV and AIDS and poverty, which have adversely impacted on the country's population.

1.3.1 Statement of the Research Question (Hypothesis)

The problem of HIV and AIDS and poverty presents an economic, social, moral and spiritual problem of great magnitude. The question through this thesis is what is the role of the church, as it seeks to care for those infected with the virus? Can the church rise to embrace the enormous economic and social needs that HIV and AIDS and poverty presents? Can it make the difference in an environment of suffering as it seeks to become a healing community?

1.4 The Aim and Purpose of the Study

The main aim and purpose of this study is to help the church, in particular the Roman Catholic Church and the United Church of Zambia, to enhance their pastoral role in the fight against HIV and AIDS and poverty in Zambia.

The specific objectives are as follows:

- a) To analyse the interplay between HIV and AIDS and poverty.
- b) To assess the role the church is playing in the fight against HIV and AIDS and poverty.
- c) To ascertain the gap between theory and practice, that is, in terms of the strategies the church has developed in responding to the challenges between HIV and AIDS and poverty.
- d) To examine how the Roman Catholic Church and the United Church of Zambia are applying the theology of caring to people living with HIV and AIDS.
- e) To provide information to church leaders and members, and others working to improve the status of those infected and affected by the HIV and AIDS pandemic and poverty.
- f) To make recommendations to churches that will help their effective participation in the fight against HIV and AIDS and poverty.

1.5 The Significance of the Study

The significance of the study is to help the Church to evaluate how it is responding to the HIV and AIDS pandemic and its role in preventing the spread of HIV and AIDS among adults and youth, finally alleviating its impact in our communities. This study will also remind the Church that it is the only institution that can command a gathering of people of different sexes, age, races and walks of life at one time to care for one another. Is it using this opportunity to respond to the HIV and AIDS pandemic and poverty that have put Zambian people in deep crisis?

This thesis will help Churches and church leaders to take up their pastoral role in the fight against HIV and AIDS and poverty in Zambia. The pastoral role of the Church can make a difference in addressing the issue of HIV and AIDS and poverty as it leads the Christians to be the healing community. Lastly this study will enable churches and church leaders to be informed about HIV and AIDS and the extent of poverty in Zambia.

1.6 Preliminary Conclusion

The chapter sets up the scene beginning with the topic story of the research and gives the researcher's personal experience with HIV and AIDS cases. The researcher has positioned himself as a minister of religion working in an interdenominational lay training Institution known as Theological Education by Extension in Zambia. His work has helped him to travel around the country and see how HIV and AIDS and poverty have become a serious health and developmental problem in Zambia. The chapter continued to address the statement of the research problem, the specific research question and determined the progression of the research report. The chapter ended with specific aims and objectives of the study and its significance; how the church can become a healing community to people living with HIV and AIDS regardless of their sex, age, color, race and social status.

CHAPTER TWO

2.0 Methodology used in the Research

In chapter one the researcher dealt with the topic story outlining his personal experience with people living with HIV and AIDS. He also positioned his research by outlining the research problem, research questions, the significance of the study and the motivation. In this chapter the researcher will deal with the research methodology used in this thesis.

2.1 Scope of the Research

Because the researcher was looking at “Church’s response to the challenges of HIV and AIDS and Poverty in Zambia”, there were various approaches the researcher could take in terms of his focus or target for his research. One possible approach was to select churches to research on. The researcher hoped to go for a possible and economic approach of selecting churches to research on. The sampled churches represented the many churches scattered all over the country. It is hoped that this method will give a balanced state version and consequently the perceived role of the church in the fight against HIV and AIDS and poverty in Zambia.

The researcher picked on the Roman Catholic Church of Ndola Diocese, because of its outstanding response to the fight of HIV and AIDS and poverty on the Copperbelt Province of Zambia. The other thing is that, The Roman Catholic Church has a well-coordinated programme to respond to the challenges of HIV and AIDS and poverty. The researcher then, aims at comparing his church; the United Church of Zambia (UCZ), and the Roman Catholic Church and discusses the two churches in order to see what the UCZ can learn from the Roman Catholic Church. Therefore the two churches were considered as case study for this research.

2.2 Methodology

The researcher has based his methodology on the work of Charles Gerkin's work on pastoral care, especially the shepherding element. Gerkin shares a very interesting concept of caring for the people through a method called shepherding. After looking at a pastor, pastoral care and pastoral work, the researcher was inspired by Gerkin, because to him Gerkin wears the poet's eyes' and paints' the practical pastoral work. Reflecting on all the good images he brings forth about the pastor inherited from ancient Israel, he sees the pastor as a shepherd of the flock. He states:

More than any other image, we need to have written on our hearts the image most clearly and powerfully given to us by Jesus, of the pastor as the shepherd of the flock of Christ. Admittedly, this image originated in a time and place which the shepherd was a common place figure, and we live in social situations in which shepherding is a scarcely known, even marginalized vocation. Nevertheless, the New Testament depiction of Jesus as the good shepherd who knows his sheep and is known by his sheep (John 10:14) has paid a meaningful, normative portrait of God's people. Reflection on the action and words of Jesus as he related to people at all levels of social life gives us the model sine qua non for pastoral relationship with those immediately within our care strangers we meet along the way (Gerkin 1997: 80).

As the researcher read this, he made a mental evaluation of his church: the United Church of Zambia does, by way of caring for people living with HIV and AIDS and those living in poverty. The researcher found himself failing to come up with any meaningful gesture towards pastoral care on this aspect. He still has to do more, and learn more from the Roman Catholic Church. When he looked at the suffering and the complications that HIV and AIDS has brought in his country and the level of understanding by the church leaders concerning the epidemic, he realized the level of incompetence in this subject. However, going through Campbell talking about steadfastness and oneness in pastoral care, he got some courage as he said, "the care and the cared for are not on two sides of a divide which must be bridged by some of expertise. It is possible because we share a common humanity with its entire splendor

and all fallibility that is implied. In pastoral care no need to stress on competence” (Campbell 1981:26). All this is harmonized perfectly when he further said:

In order to revitalize the imagery of pastoral care we must restore to it a much neglected quality courage. Anyone who has entered into the darkness of a detached professionalism will know the feeling of wanting to escape, of wishing they had not become involved. Caring is costly, unsettling, even distasteful at times. The valley deep shadow in another person’s life frightens us too and we lack the courage and constancy to enter it. One of the most vivid aspects of the biblical image of shepherding (from which the term ‘pastoral derives) is risking one’s own life. This young David, anxious to convince Saul that he his capable of fighting Goliath, use as testimonial his experience as a shepherd boy (1Sam. 17:34-37 TEV) (Campbell, 1981:26).

This inspired the researcher to search for the meaning of pastoral care. The dictionary of pastoral care and counseling defines pastoral care of the congregation as “The ministry of oversight and nurture offered by religious community to its members, including acts of discipline, support, comfort and celebration” (Hunter J. et al., 1990:850). Armstrong stressed the same when he talked about “a twofold mission” of the servant church. He writes, “the first part is to develop and nature one another. The Bible says, “exhort one another (Hebrews 1:13), comfort one another (1 Thessalonians. 4:18), bear one another’s burdens,” (Galatians 6:21). This what is meant by Christian fellowship. (Armstrong, 1979:41).

All of the above conquer that pastoral care and the image of the shepherd with all images about it is historically referring to the solutions of concern expressed within the religions community for persons in all troubles or distresses. It includes care for souls. Taking into considerations this pastoral concern as may be related to people living with HIV and AIDS who might be silently suffering under all the effects of this problem, and very often only hearing comments from the very close friends who only reminds them of their faith, and comments which are clearly not helpful to them except discouraging and stigmatizing them. It is therefore important to examine more closely what a congregation is and does. To provide caring leadership for a community of Christians, the pastor needs not only a clear vision of what a congregation should be, but also the

capacity to think and act with clarity in relation to the realities of a given congregation. The researcher fully agrees with Gerkin (1997:122) when he said, “It is useful to think of the life of the congregation as having five dimensions”:

1. Community of language
2. Community of memory
3. Community of inquiry
4. Community of mutual care
5. Community of mission

As for the researcher, a caring pastor is one who gives leadership to the congregation’s exercise of all five of these dimensions of its life. The whole image (Shepherding) is connected to the African concept of caring as shepherding is important for Africans who grow up caring animals. Gerkin touches and reminds the researcher of these traditional shepherds as follows, “They are people who care for the life of the flock, i.e. the flock depends on their safety for its life in general. A shepherd must first know their flock and the pasture and also be known by the flock” (Gerkin 1997:122).

Shepherds in general must be excellent observers and reliable interpreters, sharp listeners and very able to use the inter-relatedness of life around them to simplify the surfacing problems and to the advantage of the flock. The researcher has seen all these incorporated in the shepherding method.

The researcher also feels that church leaders and churches need to extend the concept of shepherding beyond the fences of their own churches. The concept of shepherding as Gerkins suggests was well understood in primitive society. The modern church finds these concepts as shepherding hard to understand, but the principles are reinforced by the teaching of Jesus Christ, Jesus was a perfect shepherd. He gave us the perfect example that if a sheep wanders off and is in danger, the shepherd leaves the flock in safety and finds the one that is in danger. He picks the lost sheep up in his arms and reunites it back to the safety of the flock.

What do you think, if a man owns a hundred sheep, and one of them wanders away, will he not leave the ninety-nine on the hills and go to look for the one that wandered off? Moreover, if he finds it I tell you the truth, he is happier about the one sheep than about the ninety-nine that did not wander off. In the same way your father in heaven is not willing that any of these little one should be lost (Matthew 18:12-14 NIV).

Such is the philosophy of shepherding set and exemplified by Jesus as explained in the parable of the lost sheep, so should the church model this concept of care and healing. It is this compassion that will inspire and challenge churches become healing communities.

The lost sheep here means the people that are rejected and marginalized because of HIV and AIDS need to be picked up by the shepherding churches and brought into healing communities. As stated in chapter one, HIV and AIDS is an incurable disease. When the researcher speaks of healing in this context, may it be interpreted in a way that people will be cared for, and through this care dignity and self-worth restored.

This image of shepherd in pastoral care is important in the context of Zambia for it seeks to shepherd people who are experiencing difficulties in communities. Using this method will help the researcher to investigate how the church could become a powerful instrument of mediation and inspiration in matters of HIV and AIDS and poverty and in reconciliation. It is this caring process that the church can bring which forms the praxis of this thesis. This research is based and reinforced by some research methodology from Pieterse and Campbell. For example Pieterse provides a clear inspiring and provoking understanding into the world of poverty that fits very well in Zambia's context. When he says:

Poverty in this country is horrific. The inescapable question for the Christian church, and more specifically its preachers, is how to deal with this problem. Preaching, in its very essence, is situational and topical: it seeks to communicate God's word to people in their particular context. It is impossible to ignore the poor in the country and merely preach about faith as a private spiritual affair. A positive approach to the church's

preaching and praxis is to face this problem squarely, preach it continually and focus the church's witness on it. Hence the paramount question in this book is what role can the churches and more particularly their preaching play in offering inspiration and vision to the poor as to empower them to improve their own situation and thus enjoy liberation from poverty? (Pieterse 2001: ix)

Although Pieterse said this basing on the situation in South Africa, this also applies very well to Zambia's situation of poverty, which is also horrific.

Churches ought to be there for the broken and suffering people in need of healing and love. Something drastic needs to happen for many churches in Zambia to come to the realization that they grieve the very heart of God. These churches need to be challenged on their shortcomings. A thesis like this one and other such writings need to be made available to motivate and challenge main line churches into playing a meaningful role within the greater church community in Zambia.

This church practice is well summarized by Pieterse, when he said:

Present-day practical theologians are largely agreed that their discipline is an action science (Zerfass 1974; Geinacher 1974...). The actions studied are performed by all believers in every sphere. They are performed by pastors, preachers, parishioners and Christians outside the church-by everyone who performs any act in the service of the gospel-among individuals, in the congregations and in society. These acts are communicated not just in language but also in deeds (cf. Ricoer 1991; Keaney 1996). They are intentional acts aimed at transforming issues happening in accordance with the value of God's kingdom in the lives of individuals, in the church and in society. It happens through the proclamation of the gospel and through living and acting in accordance with that gospel- with a view to liberation. Practical theology studies these acts in order to improve them against the background of theological theory and the realities of the context and society in which we live and work. (Pieterse, 2001:9)

Pieterse highlights the process so well. Unless church leadership is in the process of communicating the needs for social action, transformation will never become a reality. When the redemptive communities involve themselves with deeds, not only are we

communicating the language of love but in-fact healing our prejudice. This is a challenge that faces our church's ministry in Zambia.

Within the redemptive community of the church the researcher sees the process forward as being threefold; this will help focus the ministry of the churches in Zambia.

1. To communicate in such a way that the hearts of congregation are touched. There is a great deal of information out there, we don't just need information, but stories that touch the heart. If a heart is touched, the hand finds it easy to open and touch the afflicted, poor and needy:

Then the righteous will answer him, 'Lord, when did we see you hungry and feed you, or thirsty and give you something to drink? When did we see you a stranger and invite you in, or needing clothes and cloth you? When did we see you sick or in prison and go and visit you? The King will reply, 'I tell you the truth, whatever you did for one of the least of these brothers of mine, you did it for me (Matthew 25:40, 41 NIV).

2. To develop a theory for praxis, which can help churches to begin small yet highly effective methods of caring for the community of people around their churches within Zambia. In Chapter 4 of this thesis the theory of praxis is discussed as a model that has been developed by the Roman Catholic Church Diocese of Ndola in Kitwe and other towns on Copperbelt Province in Zambia.

The researcher will discuss this praxis, as model that he believe is functional and highly feasible within Zambian context that can help the researcher's church, the United Church of Zambia to be more effective in its response in the fight against HIV and AIDS and poverty.

3. To discuss and illustrate the effects that poverty has on people suffering with HIV and AIDS. The mortality rate is very high within the poor Zambian communities. They cannot afford the expensive medication required to help the immune system combat secondary infection. Poverty is also the main cause of the spread of HIV and AIDS in

Zambia because women are involved in prostitution as a job for food. As long as poverty continues to affect our people in Zambia it will be difficult to fight the pandemic. People are unaware of the dangers of HIV and AIDS simply because they cannot read. They are totally dependant upon healing from family and friends, this has on more occasion led to their demise.

2.3 Methods Used to Collect Data

The methodology that the researcher employed in order to collect the necessary data pertaining to HIV and AIDS and poverty in some of the communities in Kitwe included, the research approach, methods, sources, types and treatment of data, population and sample and limitations. For the purpose of this research project, interviews were conducted in some communities in Kitwe, Roman Catholic Church Diocese of Ndola HIV and AIDS Desk, Jesuit centre for Theological Reflection and the United Church of Zambia Copperbelt Presbytery HIV and AIDS Desk. In order to collect the necessary data the researcher used different strategies of collecting data such as interviewing ministers, youth, and people living with HIV in the community and caregivers.

For the purpose of this study the approach that was employed was mostly qualitative and descriptive one (Haralambos and Holbon 1995:814). In other words, in this approach, data was usually presented in words. The researcher employed this approach chiefly because it's greater richness and depth was more likely to present a true picture of people's experiences, sufferings, attitudes and beliefs. In this regard, interviews were conducted in order to extract simple factual information from the interviewees.

The sources of information used by the researcher were based on primary and secondary sources. Haralambos and Holbon (1995:828) defines primary sources as consisting of data collected by the researcher during the course of their work. Secondary sources as consisting of data that already exists. In this case, the primary data collected by the researcher from the field of work especially came from the interviews that were

conducted. The secondary data was collected through the review of literature such as: books, newsletters and paper, pastoral letter and press statements.

However the researcher did not depend on one particular data, neither did he investigate the topic using one single theory, but also some experiences from churches. For this reason, when it came to the treatment of data, the researcher was compelled to synthesize the data from the various sources through the triangulation method. This is a way that allows researchers to use a plurality of methods. Haralamos and Holborn (1995:856) claim that qualitative research can be used to produce hypothesis, which can be used together so that a more complete picture of the case (e.g. social group) being studied is produced.

The research methodology and collection of data provides a formula to follow in this research, which will help the researcher to progress well in his writing of other chapters of this thesis. The researcher will explore the concept of HIV and AIDS and poverty, the causes and the interplay in the next chapter and will subsequently figure out as to what can be the Church's response to the challenges of HIV and AIDS and poverty.

2.3.1 Interviews

As indicated earlier, the researcher used the interview method of data collection largely, but only as a way of supplementing as well as amplifying on the data from books and questionnaire research. Denscombe sees this as an acceptable combination and one legitimate way of using interview method. He notes that, "As an information gathering tool, the interview leads itself to being used along side other methods as a way of supplementing their data adding detail and depth" (Denscombe 1998:112).

Because it is not the main, though very significant, data collecting method, the researcher opted to use the "semi-structured interview". The semi-structured interview falls between the structured interview, which strictly follows set questions and order,

and the unstructured interview, which is too open-ended with a lot of emphasis on the interviewee's thoughts.

With the semi-structured interview the interviewer still has a clear list of issues to be addressed and questions to be answered. Though is prepared to be flexible in terms of the order in which the topics are to be considered to let the interviewee develop ideas and speak more widely on the issues raised by the interviewer (Denscombe 1998:113).

The suitability of open interviews in the researcher's case is that it provided a greater possibility of collecting data, which would be unlikely accessible using other techniques. One of the disadvantages of the interview method is that it is quite costly in terms of time and cost of travel if the informants are geographically wide spread. This affected the researcher to some extent in that, he had to travel between Kitwe and Ndola towns on many occasions and it became costly on his part. The researcher however did his best within the limitations to interview some key people.

2.3.1.1 Choice of Interviewee and the use of Questionnaire

Because of two factors expounded on earlier, namely, the purpose for the choice of the interviewees, the researcher had to be strategic in his method of selecting interviewees without compromising the effectiveness of the method. The researcher found random sampling as helpful, because he had many people who were willing to be interviewed. Although random sampling was used, the researcher was careful to balance as much as possible, so that the information obtained was balanced. The questionnaire was used for those who were able to read and write. However in both Ipusukilo and Mulenga compounds the researcher mainly used one to one interviews. The researcher therefore chose his informants on the purposeful or non-probability sampling. These were people he regarded to have a wealth of knowledge on the HIV and AIDS and poverty. For an example the care givers, those living with HIV and AIDS and the leaders of the Home Based Care programmes both in Ipusukilo and Mulenga communities.

2.3.1.2 General Conduct of Interviews

The researcher was unable to conduct group interview, as this would either take too long or leave some areas not adequately covered. So the researcher conducted one to one interviews generally lasting about 40 minutes to one hour for the initial interview for each informant. The researcher then had further one or two shorter follow-up interviews for some of the informants. The researcher interviewed a total of twenty-one informants. Six of these were clergy from the Roman Catholic Diocese of Ndola and the Copperbelt Presbytery of the United Church of Zambia. The rest were lay people involved in the running of the AIDS integrated programmes for the Roman Catholic Diocese of Ndola and the home based care members and community caregivers.

2.4 Preliminary Conclusion

The core discussion of this chapter is the methodology used in the research. The researcher has based his methodology on the work of Charles Gerkin on pastoral care, especially the shepherding element. The researcher has also based and reinforced some of his research methodology from H.J.C. Pieterse and Alastair V. Campbell, because Hennie Pieterse provides a clear and provoking understanding into the world of poverty in South Africa, which the researcher found to fit in Zambian context. Alastair Campbell provided a slightly different stance on pastoral care for us to consider. The researcher has not elaborated much on this method, but it does challenge one.

The researcher continued to give the scope of the research, which explains how limited this research is. It specifically gives the place where he did his research and the reason why he did it in those areas only. The chapter ended with the methods used to collect data and how this was done. The researcher has used mostly the qualitative and descriptive approaches. This approach was used because its greater richness and depth was more likely to present a true picture of people's experience, suffering, attitudes and beliefs. In this regard interviews were conducted in order to extract information from the interviewees.

CHAPTER THREE

3.0 HIV and AIDS in ZAMBIA

This chapter will discuss the question of HIV and AIDS and poverty in Zambia. However, the researcher would like to start this discussion by positioning Zambia as a country. The Republic of Zambia is a large country at the heart of sub-equatorial Africa. More than a quarter of its 10.5-11 million people live in two urban areas near the center: in the capital Lusaka and in the industrial towns of the Copperbelt. The rest of Zambia is very sparsely populated: particularly the west and the northeast. The majority of people make their living as subsistence farmers.

In its four decades of independence the republic has found peace but not prosperity. Zambia is today one of the poorest and least developed nations in the world and has a crippling national debt, around two-thirds of the population lives on less than a dollar a day.

3.1 HIV and AIDS Definition and Description

HIV stands for Immune Deficiency Virus. HIV is a virus that causes AIDS. It destroys the biological ability of the human body to fight off opportunistic infections such as Tuberculosis. A person can be infected with HIV for a long time without showing any symptoms of the disease. Nevertheless, during that period before a person develops symptoms, he or she can transmit infection through sexual contact to uninfected people. An infected woman can also transmit the disease to her infant during pregnancy or delivery or while breastfeeding. HIV can also be spread by transfusion of contaminated blood and by sharing needles used for injections and drug use (CBOH 1993:3). AIDS stands for Acquired Immune Deficiency Syndrome. The Human Immuno-deficiency virus or HIV causes it. It acts by weakening the Immune system, making the body susceptible to other diseases and unable to recover from these diseases when infected. AIDS itself is defined in terms of how much deterioration of the immune system has taken place as seen by the presence of opportunistic infections. Unless they pass away

from some thing else first, virtually all infected persons will eventually die from the disease. Most will be dead within ten years of infection and many will die even sooner (CBOH 1999:4).

The difference between HIV and AIDS is that; HIV is a virus that would eventually lead to AIDS. AIDS is a condition in which the body is susceptible to any infection, since it can't defend itself. From HIV infection to AIDS it takes 10 to 15 years or in some cases even longer, depending on the attitude that the person adopts and the availability of antiretroviral drugs.

3.1.1 Origin

The origin of HIV virus is not conclusive even at now. There are some speculative theories regarding the origin of HIV, but there is scientific evidence that HIV 1, which is more virulent and widely spread throughout the world, originated from a chimpanzee. A particular kind of Chimpanzee is known to carry a virus quite similar in structure to HIV. HIV 2 is less virulent and found in West Africa; it originated from the sooty Mangaby Monkey.

The HIV Virus was first recognized in 1981 among gay people in United States of America (U.S.A) the virus was identified in 1983 – 84. In 1982 it was detected in some parts of Africa. Today it is a pandemic covering the whole world (WCC Study Documnet1997:7)

HIV affects the human body by attacking the body defence mechanism (the immune system) making the body unable to fight off infections. HIV is a viral infection; Viruses are parasitic in nature they cannot live on their own. HIV lives and survives in the human cells. The HIV virus has the ability to turn itself into human cell once it attaches itself into human cell. Infection with HIV is life long and infected persons remain infected and infectious for life (Smith 1988:2).

3.2 HIV and AIDS - Global Trend

It is a well-known fact today that HIV and AIDS epidemic and pandemic is a health problem but also development problems, the economic struggles of Zambia clearly share a good example. The HIV and AIDS have negatively impacted on all areas of human development: political, socio-economic, cultural, religion, environment. According to the preliminary report of the National HIV/AIDS/STD/TB Council: costing the Zambia National HIV and AIDS strategic framework 2002-2005 so far over 50 million people are infected with HIV and AIDS worldwide; more than 16 million have died from the virus; over 15,000 are infected everyday (NAC 2002-2005:16)

According to Nelson Mandela, as broadcasted on Zambia National Broadcasting Corporation television network news on 29th November 2003, the HIV and AIDS catastrophe killed 2.3 million people in Africa in the year 2003.

Sadly the majority of persons attacked by this scourge are found in the Sub-Sahara Africa especially in Southern Africa where Zambia is also situated. This unpleasant scenario is well documented in the Government of the Republic of Zambia-Ministry of Finance and National Planning: Advocacy for Action: Zambia's response to HIV and AIDS: a reference manual-volume one which states that:

Africa with 11% of global population is the site to 70% of all HIV infected individuals. Thus the affected are more. Africa has accounted for 75%-80% of global AIDS deaths, and 95% of the world's orphans are in Africa. Over 6.5 million AIDS orphans are in sub-Saharan Africa; and by 2010 this will have increased to 15.3 million among an overall orphan population of 21.8 million. In 16 African countries, 10% or more adults live with the infection; and the Southern African region, 1 in 4 women aged 0 to 29 is infected. (Ministry of Finance 2001:12).

The HIV and AIDS pandemic has not spared Zambia. Though the national HIV and AIDS prevalence has dropped from 20% at the close of 2003 to 16% in 2004. The 16% rate is still a concern to Zambians given that the inhabitants are only about 10.5 million.

This work out to be 1.7 million persons countrywide are infected by this deadly scourge. Most of the HIV and AIDS cases are between the ages of 15-49 (18% women and 13% men). In Zambia the HIV prevalence rates differ according to age, and gender, characteristics, geographical areas and by social economic status.

Ever since the first AIDS case was noted in Zambia in 1984, much effort has been made to monitor the HIV and AIDS situation in Zambia. Zambia has put in place different systems for providing information on the magnitude and trends of the HIV epidemic and how this relates to changes in risk behaviours. These systems are used to generate knowledge of critical importance for improving prevention and care intervention. The epidemiological sentinel surveillance (ESS) system among antenatal clinic attendees (ANC) was established mainly to monitor changes in HIV and AIDS prevalence over time and to provide community level insights into the dynamics of the epidemic. This system has been operational since 1990, but was rather limited in geographical coverage up to 1993/1994. It is still the main tool to monitor trends. Other systems that inform us about the HIV epidemic are those surveying the entire general population at various points in time, population based surveys, and systems that collect on going operational information regarding health services. These different systems complement each other. Each source of information has its own strengths and weaknesses, but when used together they provide a much more complete view of the epidemic, with both national overview and local details.

3.3. HIV and AIDS Statistics in Zambia

Zambia's first reported AIDS diagnosis in 1984 was followed by a rapid rise in HIV prevalence (that is the proportion of people who are living with HIV). By 1993 surveys of pregnant women had found infection rates of 27% in urban areas and 13-14% elsewhere. These levels have remained relatively stable ever since (UNAIDS/ WHO 2004). At the end of 2003 UNAIDS/WHO estimated that 16.5% of people aged 15-49 years old were living with HIV or AIDS. Of these 820.000 adults, 57% were women

(2004) Young women aged 15-19 are around six times more likely to be infected than are males of the same age (WHO/UNAIDS 2004).

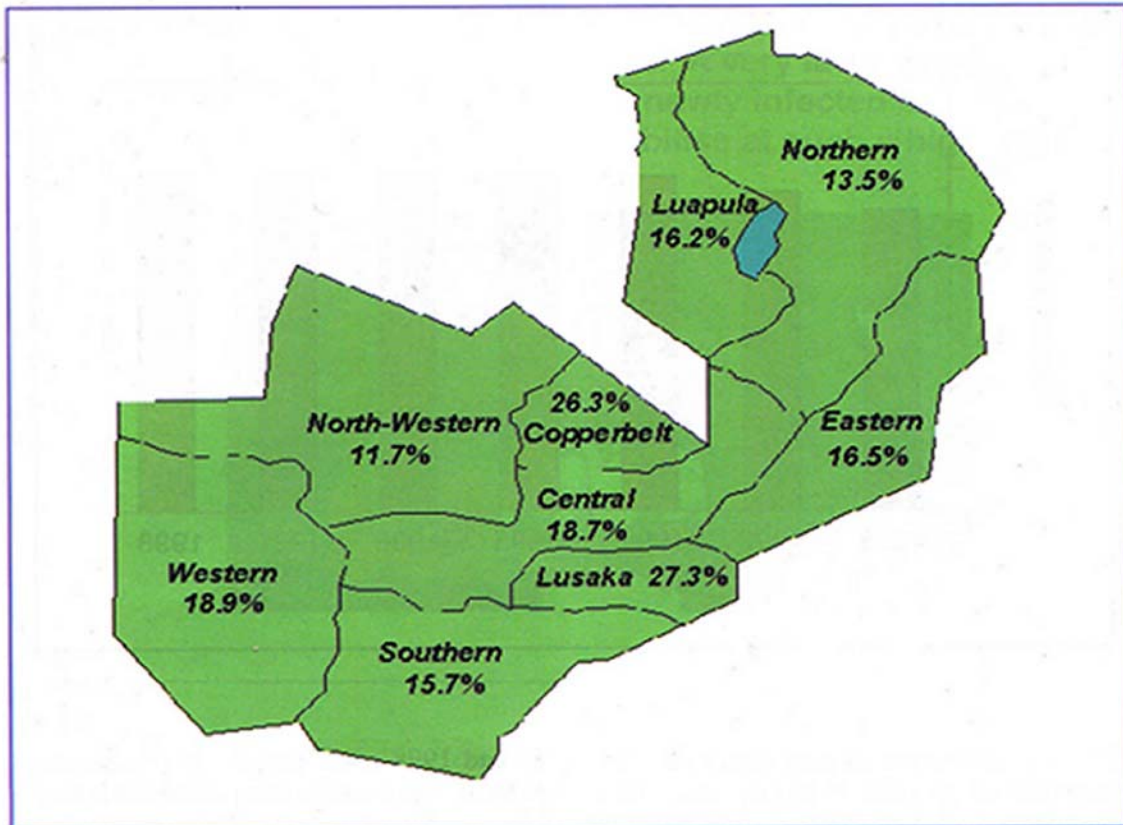
Nearly half of Zambia's population is under 15 years old. According to UNAIDS/WHO, 85.000 of these children were living with HIV and AIDS at the end of 2003. Unlike in the USA or Western Europe, HIV in Zambia is not primarily a disease of the most underprivileged. Infections rates are very high among wealthier people and the better educated. However it is the poorest that are least able to protect themselves from HIV or to cope with impact of AIDS.

It has been estimated that 52% of Zambians live in towns or cities. HIV prevalence is considerably higher in these urban areas than elsewhere. Among pregnant women, the highest rates have been recorded in the capital Lusaka (home to 10% of the population); the industrial towns Kabwe and Ndola; Western province's capital Mongu; and the cross border trading center's Chipata and Livingstone (Livingstone is also a tourist resort). It has been estimated that urban areas contain 54% of all adults living with HIV or AIDS (NAC 2003: 8)

Prevalence data on HIV in Zambia come from testing pregnant women at antenatal clinics and population- based surveys in selected areas. Since 1990 some 39 sites have been included in national antenatal surveillance on at least one occasion. It should be noted that this does leave substantial gaps that includes some of the larger towns. Another way to look at HIV in the country is to consider prevalence in different regions of the country. By the year 1998, estimated HIV prevalence was highest in Lusaka and Copperbelt provinces, where more than one out of every four adults in the 15-49years old age groups were HIV infected. Prevalence rates are in the 15-19% rate in five of the remaining provinces-Luapula, Eastern, Central, Southern and Western. Prevalence is moderately lowering the 11-14% range in the two remaining provinces, Northern and Northwestern. The provincial differences are not the most important story, however much more important is the fact that reported rates are very high everywhere in the

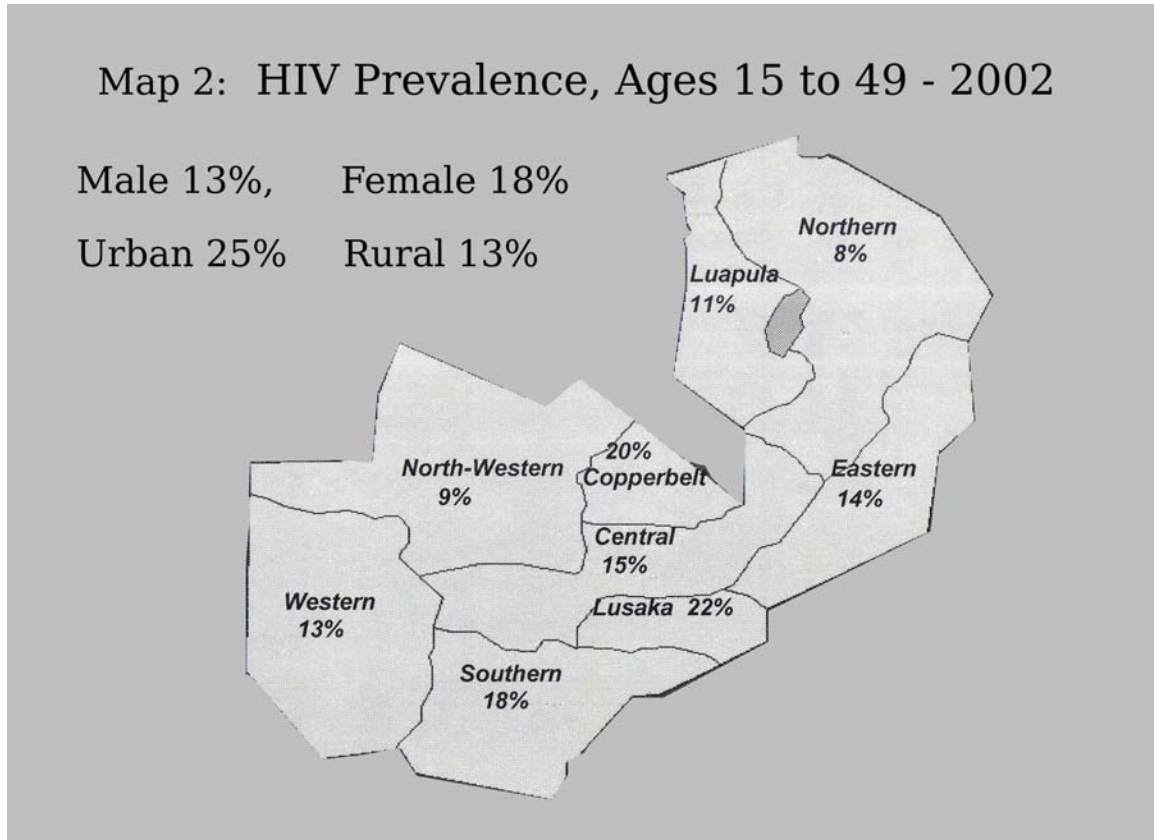
country. The HIV and AIDS epidemic has left no corner of Zambia untouched. Below is the map indicating estimates of HIV prevalence by provinces.

Map 1: HIV Prevalence, Ages 15 to 49, by Province: 1998



There is good evidence of a significant fall in HIV prevalence among young Zambian women in the 1990's. The most dramatic finding concern pregnant women aged 15-19 years surveyed in Lusaka. Among this group the proportion living with the virus almost halved from 28.4% in 1993 to 14.8% in 1998. Over the same period, there appears to have been a general decline in prevalence among young women in urban areas and to have a lesser extent among teenage women in rural areas. The greatest reductions were found among well-educated women. While prevalence among the least educated remained stable or increased it is thought that the falling prevalence levels indicate a drop in the number of new infections. Possibly as a result of behaviour change. This is

an encouraging sign that efforts to educate young people about avoiding HIV have had some success as shown in map 2.



The reduction in the infection (as shown in map 2) can also be attributed to the efforts made by the church and NGOs in the fight against the HIV pandemic; especially in the area of advocacy and sensitization. The infection rate could further go down if churches can be actively involved in the fight of the HIV and AIDS Pandemic.

The above statistics shows that the infection rate is going down due to the involvement of the Church and the Non Governmental Organisation in the fight against the HIV pandemic. From the researcher's point of view, the Church became active in the fight against HIV and AIDS three years ago; however, in the same period we have seen the situation according to statistics improving. If the Church could do more than what it is doing, we are likely to see more reduction in HIV and AIDS prevalent rate. This is due

to the privilege that the Church has in dealing with all types of people, rich and the poor. The Church is able to give effective information about HIV and AIDS to people of different sectors of life.

3.4 HIV Transmission

In Zambia most HIV infections are the result of unprotected heterosexual sex. People who have many sexual relationships increase the risk to both themselves and their partners. A number of factors can greatly increase the risk of HIV transmission disease (STD) in one or other partner. STDs are very common in Zambia: it is estimated that around a million cases occur each year (CBOH 2003: 20). The high-risk traditional practice of “dry sex” is also wide spread. During dry sex, plants extracts are used to reduce lubrication. Often causing genital ulceration’s through which HIV can more easily enter the body. Many thousands of sexual transmissions could be avoided if many people consistently used condoms. However, for a lot people to do so require overcoming substantial practical cultural or religious obstacles.

Most non-sexually transmitted HIV infections are passed from mother to child. Without access to preventive drugs. Nearly 40% of HIV positive mothers give birth to infected babies. An estimated 30.000 infants contract the virus each year in Zambia. Either during pregnancy, at the time of birth or while breast-feeding. Most of these children die before the age of 5 years old. Around half of all transmissions during pregnancy and birth could be avoided if every mother received a short course of antiretroviral treatment. Other mechanisms of transmission such as contaminated blood and re-use of needles are thought to have been relatively insignificant but are non-the-less important. All district provincial and central referral hospitals have blood transfusion facilities that screen for HIV. However, it is not certain that safety can be absolutely assured out side of the capital Lusaka. People might also be put at risk by some traditional practice such as tattooing.

3.4.1 People at the High Risk of HIV Infection.

In any discussion of Zambia's HIV and AIDS epidemic. The significance of gender inequality cannot be overstated. Men play a dominant role in relationships, while women and girls are generally expected to be submissive. Females have also had less access to education and mass media. As a result women can lack the confidence, skills and knowledge necessary to negotiate safe relationships with men and to independent lifestyle choices. Usually a woman is taught that she must obey her husband and that it is wrong to refuse sex with him. Less two-thirds of adults (of either gender) believe that a woman can refuse sex if she suspects that her husband has HIV.

Various aspects of traditional Zambian culture make women more vulnerable to HIV infection. Not least among these is sexual cleansing – a very common ritual in which a deceased mans relative has sex with a surviving widow. In the belief that this will dispel evil forces. The HIV status of either person involved is not taken into consideration. Various alternative, risk-free rituals do exist. And traditional leaders in some areas have saved lives by encouraging change. Most Zambians become sexually active at quite a young age. In 2003, among young people 15-19 years old. 28% of boys and 44% of girls reported having had sex within the last twelve months. The average age for first sex is around 17 in females and 17.5 in males (NAC 2003: 12).

It is normal for men to be older than their partners: the average age difference is around 5 years. For many girls their first sexual encounter is with an older boy or an elderly man. Some of who entice them with money or gifts. This is one reason why girls aged 15-19 are six times more likely to have HIV than are boys of the same age.

Many of the most tragic stories connected with HIV transmission involve the sexual abuse of children. The high prevalence of HIV has increased the level of sexual violence and coercion. And not just many of the victims are vulnerable AIDS orphans. Men are targeting increasingly younger sexual partners whom they assume to be HIV negative. And the “virgin cure” myth (which claims that sex with a virgin cure's AIDS) fuels

much of the abuse. An increased proportion of the abusers are HIV-positive and many transmit their infection to their victim.

Like most countries, Zambia does have laws against child abuse. However orphans fail to report such abuses because if they report they risk abandonment or violent punishment and families will often go to great lengths to conceal what is going on. It is no surprise that the vast majority of perpetrators go unreported, unpunished and free to abuse again. As observed by the Human Rights Watch, “to report a crime of sexual violence or abuse, a girl will face a police department that is rarely child- or gender – sensitive. Health service provider’s that may scold for being promiscuous. A court system lacking any facilities for youths. And societal structure that teaches girls to be submissive to men. Even if she did report abuse, chance’s that officials would act against the abuser are minimal” (Human Rights Watch 2002). Police handled more than 200 cases of child rape in the quarter of 2003. And some experts believe that for a very case published another 10 go unheard ([http www.aegis.com](http://www.aegis.com) 2003)

There are thousands of female sex workers in Zambia and men pay a premium to engage in unprotected sex with them. The limited data available suggest that around two-thirds of such women are HIV-positive (UNAID/ WHO 2004).

Besides regular sex workers many other women are compelled by poverty to occasionally accept money or gifts in return for sex. According to a 2003 survey, 19% of women and 29% of men have taken part in commercial sex (NAC 2003:8). There is a saying among desperate women in Zambia: “AIDS may kill me in months or years. But hunger will kill me and my family tomorrow”.

Much of Zambia’s population is mobile. Risk of infection is often higher among these people and among those whom they contact. Truck drivers, hundreds of who regularly pay for sex, carry infection along the main transport routes. The Zambia association of truck drivers is very aware of this problem. And is running awareness campaigns to try to counter it. In some places in Zambia, large numbers of seasonal workers and

fishermen/women during long periods away from their regular partners they engage in short-term relationships and “temporary marriages”. Thus spreading the virus from pockets of high prevalence into the general population. Women and girls involved in cross-border trading may exchange sex for transport or other favours, and are very vulnerable to exploitation.

Homosexuality is a taboo subject in Zambia. No one knows how many people are infected through homosexual sex, which is officially illegal. What is known is that sex between men occurs frequently in prisons, yet the government refuses to lift its ban on distributing condoms to prisoners.

3.5 HIV and AIDS Stigma.

Because HIV can be sexually transmitted, it is often presumed that those living with the virus have brought disease upon themselves by having many sexual partners, and moral judgments are made. Women are especially vulnerable to this prejudice. And they may also be blamed for infecting their children (even when the father is often the first to be infected). Victims of stigma suffer physical and social isolation from their family, friends and community: they are made to feel guilty, ashamed and inferior. Those associated with people living with HIV also suffer from stigma. As do those thought to be responsible for spreading infection. Such as sex workers, traders and migrant workers (even if they are not themselves known to be infected) (BOND 2003).

Stigma does not just cause pain to individuals. It also hampers prevention and care programmes. Those who fear becoming stigmatized will be unwilling to volunteers for an HIV test: even purchasing condoms or discussing safer sex may be seen an indication of infection and so is stigmatized. People who know or suspect that they are HIV-positive are generally reluctant to reveal their status – even to their partners and family or to come forward to treatment. Tragically some of the worst discrimination occurs in clinics and hospitals. Patients known or suspected to have HIV are sometimes given

very low priority and may be subjected to degrading and breaches of confidentiality, they may even be denied drugs and treatment (PANOS 2001).

3.6 The Impact of HIV and AIDS

The majorities of people who develop AIDS are in their productive years and are often the sole breadwinner in their households. When an adult falls ill, other family members, particularly children, are home from school – in order to raise money or tend crops as well as looking after their ailing relative. Much of the cash they are able to obtain is spent on medical care and ultimately funeral costs when a parent dies; survivors are left destitute. People in need have traditionally been supported by their extended families, but the roll of the epidemic is now so great that family structures can no longer cope. Stigma compounds the problem. As many of those affected by AIDS become socially excluded. To make matters worse, when the male head of a household dies, it is common for his entire property to be “grabbed” by his relatives (despite laws meant to prevent this), leaving his widow and children with nothing. Desperate people will inevitably turn to risky occupations or to migration.

Thousands of children are abandoned due to stigma or to simply lack of resources. While others run away because they have been mistreated and abused by foster families. Many such children congregate in the big cities where they live by begging, stealing and prostitution. As noted by Dr. Manase Phiri (2003), “In the days before the full impact of the HIV and AIDS pandemics, street children were a very rare sight in Zambian cities and towns; now they are very everywhere... sleeping under bridges, behind walls and in shop corridors.”

In 2003, it was estimated that 630,000 surviving children had lost at least one parent to AIDS (UNICEF 2004) (around one in every 5 children). It is projected that the number of AIDS orphans in Zambia could rise to 974,000 by 2014 ([http: www.aegis.com](http://www.aegis.com) 2003).

The crippling effect of AIDS on Zambia's health care system is perhaps the greatest problem the government faces. In some hospitals patients with AIDS-related illnesses occupy more than 50% of beds. Not only has the epidemic increased the number of people seeking medical services but it has also greatly increased costs, as most AIDS-related conditions are especially expensive to treat. There is consequently less money available to treat other conditions (NAC 1999:16).

Zambia's health system, having suffered years of under-investment has now been brought to the brink of collapse. Almost all health facilities lack adequate personnel, drugs, and/or equipment, and physical infrastructure is deteriorating. Under such conditions, care struggle to cope with the rise in demand, just as their own number is being depleted by illness and AIDS deaths.

In 2001, a national wide survey found that just two thirds of primary-school-age children attended primary school because a parent or guardian was suffering from AIDS or had died from AIDS (CSOZ 2003). In 1999, the government launched a programme called BESSIP, which envisages education for all by 2015. However, it is acknowledged that the global spread of HIV and AIDS may make the attainment of some of the BESSIP goals difficult if not impossible" (hivaidsclearinghouse.unesco.org 2000).

Teachers have been disproportionately affected by the epidemic and are now in short supply: more than two thousand teaches died in 2002, while teaching colleges produced less than a thousand new graduate's (Lewis 2003). Rural postings are unpopular and those who accept them tend to move away when they become ill in order to be closer to clinics (UNDP 2003). Those children and teachers who are able to attend school face further challenges. As AIDS-related illness, stress and malnutrition make learning very difficult.

The AIDS epidemic has severely damages every sector of Zambia's economy. In the first place employers bear the direct costs of absenteeism and medical care. Funerals and extra recruitment: according to the Zambia Business Coalition, 82% of known causes of

employee deaths are HIV related and 17% of staff recruited are to replace people who have died or left because of HIV-related infections. (allafrica.com 2004). But what is even more significant is that, as AIDS kills people in the prime of life, the workforce is stripped of valuable skills and experience. The situation becomes yet worse as there are fewer people to teach the next generation. All this means that production costs rise. While at the same time consumer spending falls because people affected by AIDS have less money to spare. Zambia has been one of the world's poorest countries since the late 1970's, and AIDS has made a bad situation even worse.

Agriculture, from which the vast majority of Zambia's make their living. Is also affected by AIDS. In particular, the loss of few workers at the crucial periods of planting and harvesting can significantly reduce the size of the harvest. AIDS is believed to have made a major contribution to the food shortages that hit Zambia in 2002, which were declared a national emergency (UNDP 2003).

Negative trends in the economy and food production fuel the epidemic that helped to create them. Poor nutrition makes HIV-positive people more vulnerable to infections. And hastens the progression of AIDS: and when people are poor they are more likely to turn to risky occupations and are less able to pay for medical care or school fees. As Zambia's poverty reduction strategy paper acknowledges. "The epidemics are much likely to affect economic growth as it is [to be] affected by it" (PRSP 2002). Clearly an epidemic on such a scale demands a powerful and wide ranging response from all sectors of life, however, for this study the researcher is more interested in the response of the church. Chapter five of this thesis will discuss the Churches response to the challenges of HIV and AIDS and Poverty.

3.7 Ethics Associated with HIV and AIDS

The WCC study Document Facing Aids defines ethics as "the systematic study of moral reasoning in theory and practice. It clarifies question about right and wrong, but also demonstrates their complexity, most ethical theories and many moral judgment are

contestable.” (Facing AIDS, WCC 1997:50). In short, the researcher would say ethical perspectives are principles that govern behaviour of community, as well as human beings who live in communities.

HIV and AIDS confront Christians and non-Christians and present the church with many difficult ethical questions to answer. This thesis is focused on the Christian Church and its healing ministry. How should the church respond to their own members that are living and affected with HIV and AIDS? Some relevant questions that the church leadership needs to ask themselves, are as follows:

- Can a church actively promote measures to prevent the spread of HIV?
- Does the church have a vision to involve itself with such a project?
- What church resources should be used in order to care and help the affected people within the congregation and in the community where the church is placed?
- What do churches say about such matters?
- What is the individual responsibility of a Christian in this area?
- How can churches and Christians cross the denominational boundary in unity with a common cause to help this great humane need?

The above questions bring the researcher back to the weakness he had when his brother shared with him about his status. The researcher’s lack and failure to care for his brother ‘Machushi’ during his sickness helped shape his ethical character on how he viewed people living with HIV and AIDS. Ethical character of the individual and collectively in what we term the church is shaped by information, fears, prejudice, and how we act upon these views. For many, their fears keep them inactive, for others they are motivated by their passionate value on how to show Christ’s love towards their neighbour, to save lives, to work for reconciliation and see justice be done. The researcher was inactive towards his own blood brother for two reasons:

- 1) Fear of Aids.
- 2) Ignorant, about the sickness he was experiencing.

3.7.1 Ethics Applied to Some Issues Raised by HIV and AIDS

When it comes to complex ethical issues, praxis for decisive decision making within the broader Christian Community is needed. Most ministers and priests need guidance and clear defined boundaries, which will help to unite leadership to map a way forward especially for ministering to people infected and affected by the HIV and AIDS pandemic. There are a number of ethical issues that, the researcher would like to address in this paper. The researcher is sure there are more but he will endeavor to cover the most important issues that the church leadership will confront when dealing with HIV and AIDS. For example, discrimination, isolation and rejection.

3.7.2 Stigma and Discrimination

Before we discuss in detail, it is important to define stigma and discrimination. Stigma refers to the isolation, rejection and labeling of people living with HIV and AIDS, their families and friends. Stigma is fueled by many factors. Sometimes it is spurred by fears of infection, misunderstanding on how infection occurs, the misleading association of HIV with immorality and the fear of death, which becomes associated with the infected, once more, because of the mistaken assumption that infection equals death. The researcher feels the UNAIDS definition of stigma and discrimination in the booklet, “A Conceptual Framework Basis for Action”, would be helpful to the readers of this thesis. UNAIDS gives the following definition of stigma:

Stigma has ancient roots. It has been described as a quality that significantly discredits an individual in the eyes of others. It also has important consequences for the way in which come to see themselves. Importantly stigmatization is a process within a culture or setting, certain attributes are seized upon and defined by others as discreditable or unworthy. Stigmatization therefore describes a process of devaluation rather than a thing. Much HIV and AIDS-related stigma builds upon and reinforces negative thoughts, people with HIV and AIDS are often believed to have deserved what has happened by doing something wrong.

Often those wrong doings are linked to sex or to illegal and socially frowned-upon activities, such as injecting drug use. Men and women who become infected may be seen as homosexuals, bisexual or having had sex with prostitutes. Women with HIV and AIDS are viewed as having been promiscuous or having been sex workers. The family and community often perpetuate stigma and discrimination, partly through fear, partly through ignorance and partly because it is convenient to blame those that have been infected first (UNAIDS 2002: 8).

HIV and AIDS discrimination is when stigma is put into application, for example, when people living with HIV and AIDS and their affected are thrown out of the family, work, denied medical attention and in some extreme instances, stoned to death. As the voices of people living with HIV and AIDS as noted above stigma and discrimination frustrates efforts to prevent the spread of HIV and AIDS and the offer of quality care to people living with HIV and AIDS and the affected. Given the magnitude of the epidemic and the fact that we all affected, what we need most is compassion towards one another than stigma.

Discrimination against people living with HIV and AIDS occurs in all societies and communities. In the researcher's experience of people living with HIV and AIDS at Mbereshi Hospital and some congregations in communities in Kitwe, discrimination was rife. Families rejected their own, as it was with the researcher's own experience with his brother 'Machushi' who was discriminated and rejected. It is also true to say that, churches often neglected congregants because of stigmatization. The researcher rejected the cry for acceptance and love from 'Kabungo' the patient in 'Mbereshi' Hospital, he did not possess the God given revelation that all people are created equal, even though he was a chaplain and minister of the gospel. The New Testament calls Christians to be the example (witness) to the world. It needs to start within the church. The researcher's experience during his research and visitations is that churches in Zambia can now truly hold their heads up high. The majority of people are serious about the fight of HIV and AIDS and they aim at transforming it into the images that brings glory in the kingdom of God and all people are to be treated as equals.

Discrimination compounds the problem of AIDS prevention. Churches need to inform communities that HIV and AIDS is not ancestral curse, but it is a disease that can be prevented through moral values. This is especially true within rural communities. Some traditional healers have done considerable harm through misinformation. They have used this to further their own means, and destroyed spiritually, mind and soul of the entire communities. Political correctness wants to avoid confrontation, but if some traditional leaders and healers continue to use HIV and AIDS as a level to further their own means, the researcher believe then that the government must act accordingly. The church on the other hand needs to take a lead in educating people.

In Zambia discrimination against people living with HIV and AIDS, unfortunately occurs in all societies and communities, and it has become an important obstacle to effective means against the further spread of the pandemic. Discrimination makes the whole community both those who discriminate and those discriminated against more vulnerable to the spread of HIV. People become angry and sick to revenge because of discrimination in a situation of stigmatization, prejudice and gossip. Both groups are less likely to accept the presence of HIV and AIDS sickness in the community, and to co-operate in prevention of the factors which lead to increased vulnerability to HIV resistance to discrimination against people affected by this virus. Again, justice demands that people be treated equally and fairly so that they receive the care and attention they need.

3.7.3 Confidentiality

According to the WCC Study Document, confidentiality means that information which persons wish to keep to themselves or share only with a person they trust (such as a doctor, pastor or counselor) in fact remains secret. Such a relationship of mutual trust is protected by special obligations. Confidentiality of personal health information is implied by the principle of respect for persons, and required by traditional medical ethics of privacy inhibits responsible decision making (WCC Study Document 1997:58). Confidentiality is a very important ethical principal for pastoral counselors;

especially pastors and ministers who are working in communities where they are held in high esteem.

A relationship of mutual trust must be protected by special obligations or by virtue of our calling in ministry. We are seeing this more and more with patients with AIDS. Where confidentiality and trust is kept, there is a greater opportunity of a positive influence into their lives. The researcher need to remind the reader that confidentiality is an effective tool in psychosocial and pastoral counseling it can build or break trust if not handled properly. In the researcher's work as a community counselor in Mulenga this positive influence experienced has reduced sexual behaviour, there by reducing the risk of the transmission of HIV and AIDS to others. There have existed situations however where a spouse refuses to reveal his or her status. This places their partner in a situation of contracting a fatal disease; men are the most problematic part in sharing. In this situation, what does the pastor, doctor or counsellor do? Do they respect the infected partner's autonomy or breach confidentiality in order to avoid potentially fatal harm to the other partner? From the researcher's experience in community and church work, there are many people who know that they are positive, yet they are still sexually active without disclosing their status to their partners. The issue of confidentiality is challenged when confronted by the above issue.

The researcher's personal view and conviction as a minister who is a counselor believes in the sovereignty of life of all people created in the image of God. Life is a gift from God and as ministers of Gods word our theology must always be to obey God's word. "Thou shall not kill" as the researcher believes, life is an absolute right for all humanity to have as an important roadmap in civilized communities and societies.

3.7.4 HIV and AIDS and Sex Education

The researcher believes in the protection of life, as a result he is challenged by those men who continue spreading the virus by using their male dominance within marriage, it is important to note that sex education is an effective tool that will help us fight against HIV and AIDS epidemic. However, it has to be recognized that there are cultural

barriers of stigma and silence, which inhibit the delivery of effective sex educational programmes in Zambian context. Hence there is need for a highly focused effort by the church, before people will have access to the information.

In Zambia especially in rural area people need sex education to break through the source of cultural practices that promotes the spread of HIV and AIDS. The churches have enormous influence, particularly in the most heavily affected areas of Zambia, and it is critically important that they find effective ways of openly addressing the issue of sex education. Part of the major problem in African communities is that sex education is taboo among adult and young people. Hence in some cultural environments, especially in parts of Africa, people refuse to talk about sex, HIV and AIDS and other aspects related to sexually transmitted diseases. People that are traditionally conservative fear that open sex education and talk of condoms, at school or homes encourage promiscuous behaviour. The researcher does not subscribe to such fears because sex education will help the people to know the basic facts about HIV and AIDS. Adults have the responsibility to educate the young people. Here the researcher thinks it is the opposite to what others think as the promotion of promiscuity. Clearly the church has a responsibility towards moral generation.

In spite of understandable reservations, the researcher has revealed that education about sex, HIV and AIDS and health in general, particularly with children does not result in increased sexual activity. The responsibility of the church in facilitating sound well-resourced education is thus necessary.

The Roman Catholic has taken sex education seriously in communities in Kitwe and other towns on the Copperbelt. They have promoted what is known as AIDS Teen Peer Training programme. Peer is used in this sense to mean people of equal status or people who are alike. Because young people are always prone to peer influence and peer pressure, The Roman Catholic Diocese of Ndola has successfully used this method to reach out to many in terms of sex education, as Fr. Ng'andwe the Diocese Administrator confirmed. The researcher saw in Ipusukilo community some excellent drama production where the message of sound morality was conveyed very effectively. The

leader needs to know that the Catholic Church is highly involved in the area of HIV and AIDS.

Going by the researcher's experiences in the field, it can be argued that teen peer sex education proved to be an effective tool of equipping people to deal with the HIV epidemic. It is important that clergy and lay leaders are offered appropriate training in this area. The capacity to offer effective education in a group context and individuals counseling to those who are directly affected is more urgently needed than anything else in Zambia at the present time. A relatively modest investment in this area could have a major effect for good. Other churches like United Church of Zambia have much to learn from the Roman Catholic in this fast changing field. Providing the structures for the sharing of successful models and good practice would be a very effective resource, which could be offered to our communities.

3.8 Theological Perspectives

The theological issues that touch this subject are very large and could in themselves form the basis for their own study. For this study the researcher would like to address mainly two theological areas that touched his life as well as his involvement with HIV and Aids community projects. These are:

1. God's creation an expression of His Love and Care
2. Biblical boundaries of 'Human Sexuality'.

3.8.1 Theological Perspectives in Relation to God's Love

As HIV and AIDS continue with the devastation of destroying lives of people, some people are asking about the existence of God and whether He is in control. A question that is often raised by people who are in pain is, "How can a God of love allow this suffering which comes as a result of HIV and AIDS to happen"? A theological perspective is analyzed to help readers who are challenged by this question. This is not a new phenomenon, there has always been human suffering and tragedy, and it is how

we react within tragedy that determines our relationship to God. There are two consequences, it either brings us back to God, or it propels us away. This general rule can be applied to many areas in life. God created human beings in His own image primarily to have a relationship with them. God is a relational God; we see this in the Trinity, in human society as well as in the natural world that God created.

Nothing is more fundamental in the Gospel than the love imperative. This was the way Jesus lived, and it is the way in which he calls his disciples to follow. When one asked which is the most important commandment, Jesus' reply made it clear that the first and second are inseparable. To love God is to share in God's unconditional love for humankind. When we relate to our neighbour, whether near at hand or far away we are subject to Jesus' command! "Love one another as I Love you" (John 15:17). It is in this context that our relationship to the communities and churches most affected by the spread of the HIV and AIDS epidemic must be understood. Our loving relationship thrives within the confines of freedom. As soon as force or manipulation is applied to any relationship, it dies or it turns to dominate the other. In other words it does not treat the other as an equal. This is not by chance; it is God's design that we relate to each other. God gives humanity the freedom to love him or reject him. Love is expressed through obedience, when we obey God we express our love. As we express our love in freedom, we can also as humans reject God's love and choose to love and exalt self. This is where sin enters our being and evil rules our lives. In our freedom, of course, it is possible to reject relationship with God and act as if this did not exist. It is equally possible to reject or disrupt relations with other human beings. Such distortion of being in relationship is sinful. Sin outworks itself through selfish actions.

Suffering in the world is direct result of sin. Human beings chose to rebel against God and live by their own decisions. These choices either result in blessing or curses. Sin has also affected the natural world, disease, national disaster etc. Nature waits for the day of redemption when Jesus will restore all things. Just as God has chosen not to interfere with the man's freedom, God chooses not to step in when natural disasters occur such as floods, earthquakes etc. This theology explains why disease such as

malaria, cholera and HIV and AIDS occur. The above factor does not prove that God is not involved in our lives. God is a God who came to live among us.

The researcher's relationship with his brother "Machushi" and 'Kabungo' at Mbereshi Hospital, expressed his own theology at that time. He was so involved with himself that he could not be an expression of God's care and love to others. He has now realized that selfishness is the root cause of so much wrong in the world today. The Bible portrays a God of love who loved the world that he gave his only Son that whoever believes in Him will never perish but have eternal life (John 3:16). God the Father saw the suffering of his people in the world just as he had seen the suffering of his chosen people in Egypt. In Egypt the oppressor was Pharaoh. Today the oppressor is the sin in people's hearts, a human selfishness that often refuses to go out in love to others. Men and women seem trapped in their human weakness and failure. They are alienated from God and each other. Because of guilt, fears in the human heart also contribute in alienating them from their own best selves. People could not save themselves, and could not heal themselves. God so loved his people that he sent his son to them in their predicament. They could not believe in themselves and were losing a sense of their own identity. The Son came to help people to believe in themselves, to heal them by helping them rediscover their true identity.

All the people created in the image God desires to be in community and therefore belong within a relationship with other people. This relationship is expressed first towards God and then towards each other. Jesus expressed openness towards people of all kinds, without barriers of class or tribe or race or gender. Just as God through his love accompanied all creation, so did Jesus do by living among the poor, telling them that God loved them.

When people in our congregations live out of a relationship with God and follow Jesus they open themselves up to others, not just those in the church but even those outside the church, making a loving and caring community. The Church must not be inward in

nature, withdrawing into a closed community but embracing all like Jesus demonstrated to all humanity.

Alastair Campbell in the researcher's opinion is a great thinker who explores many of the dilemmas that plague modern society. Not only does he assess the needs of the people but provides very practical steps of remedy. This is explored in his book, "Rediscovering Pastoral Care." In his book he entitles a chapter, "Communal Rediscovery" which the researcher has seen happening in his own congregation as well as in other churches in Zambia. He says:

Just as vital as an individual's rediscovering of pastoral resources within the self is the renewal of the pastoral ministry of the church as community of those who care. This communal dimension of rediscovering will be aided by two development: the revitalization of theology so that it springs once more from situations of real human need encountered in pastoral care; and the recovery of the ancient insight (Micah 6:6-8) that spirituality and the seeking of justice are inevitably intertwined, giving pastoral care a necessary political dimension (Campbell 1998: 107)

3.9 A Revitalized Theology

According to the above quotation, Zambian pastors are challenged to revitalize their own theology of caring. This can be supported by Campbell who notes that:

The rediscovery of pastoral care depends upon the formulation of a common language by which individual Christians can both communicate with each other and explain to the world outside the church what they are trying to do in their caring acts. Yet there has been a death in recent times of the kind of reflection upon praxis which creates a living theology. The emergence of such a theology depends upon an escape from the excessive rationalism and disavowal of the emotions which has characterized traditional theology. In a world of abstract categories the ill-organized world of emotional and bodily reaction has no place, yet this is the world in which most people encounter their greatest problems. Small wonder that what churches say seems largely irrelevant to the majority of people in modern times (Campbell, 1981: 108).

The researcher agrees with Campbell, because people do not see the practical part of it. A way to such rediscovery seems to live in the development of a viable 'hermeneutic' of

what Anton Boisen called the living human documents of pastoral care, especially referring to people as living documents. Seward Hiltner's preface to Pastoral Theology was an early attempt to achieve this through the creation of what he called "inductive theology, but Hilner lacked a clear methodology for achieving this desirable aim. The researcher's main aim is to journey with the living human documents (people living with HIV and AIDS) as they unfold their stories.

The praxis of expressing and touching people with HIV and AIDS in such a way that they could be lovingly absorbed into the community of the Church. This dimension within the Zambian context will be the greatest challenge that the church has ever faced. Out of this pandemic we face a need of loving and caring for approximately 800,000 orphaned children (NAC 2004:17). The magnitude of this exercise has to touch the heart of every church in this country if we are going to have a meaningful impact in the society. If these innocent little children can be adopted into loving Christian homes, can you imagine the positive impact it will have on the next generation? This would imply caring for the flock.

The researcher would like to highlight a number of dimensions within this community that we call the congregation. Charles Jerkin's in his book, "An introduction to Pastoral Care". Clearly defines these dimensions and how they interconnect within the community. This methodology is very helpful in dealing with communities affected with HIV and AIDS. He says:

To speak of pastoral care as involving the care of the congregation as a Community that expresses its loyalty to the Christian tradition requires that we examine more closely what a congregation is and what it does. To provide caring leadership of a community of Christians, the pastor needs not only clear vision of what a congregation should be, but also the capacity to think and act within clarity in relation to the realities of a given congregation. It is useful to think of the life of the congregation as having five dimensions. I will therefore speak of the congregation as:

- a community of language
- a community of memory

- a community of inquiry
- a community of mutual care
- a community of mission

(Gerkins, 1997:121)

The researcher will highlight the relevant points that Gerkins seems to stress in order for the church community to be effective.

3.9.1 A Community of Language

The Christian Church communicates the language of the Bible. The Bible provides the language through which communication takes place in the church. James Gustafson asserts that for Christians there is a normative way of thinking and speaking meaningfully to one another that is rooted in an appropriation of biblical images and themes. In other words, to speak to one utilizing the imagery of the Bible is to communicate in the native language of the Christian community. This kind of language helps Christians to help each other as the body of Christ.

3.9.2 A Community of Memory

This is “to remember the stories that come down to us from the history of the people called Christians. It means the retelling of those stories and the celebration of events and symbolic acts that remind God’s people of who they are. It is simply the passing on the Christian tradition. The retelling of Christian stories that were passed from generation to generation.

3.9.3 A Community of Inquiry

To be the pastoral leader of a Christian community means to be engaged in persons lives, both individually and as a community, a mood and habit of inquiry, most particularly inquiry into the ultimate meaning of their actions and the actions of others upon them. To care deeply for persons is to inquire with them, answers to questions

about what the events of their lives mean at the deepest level. A pastor is expected to interpret human situations from a Christian reference point and dispense pastoral care and advice. The inquiry part helps the counsellor to work with the client in such a way that they understand their own stories.

3.9.4 A Community of Mutual Care

A primary function of the Christian community is that of creating and maintaining a climate of relationship within which all members of the community are understood and cared for. Mutual Care must be offered to all people within the church community. It is from this fact that my study is based on Christian community care, to make this practical, it is the only way forward in the way of joining the fight of HIV and AIDS. To experience such a community is to overcome loneliness that pervades contemporary culture.

The Dictionary of Pastoral Care and Counseling defines pastoral care of the congregation as “the Ministry of oversight and nature offered by a religious community to its members, including acts of discipline, support, comfort and celebration.” To be a member of the Christian community thus means to give and receive a variety of forms of care.

In the postmodern world we live in there is a tendency towards alienation rather than drawing close into community. This alienation affects church life as well as society at large. The role of the pastor or a pastoral care giver is to encourage this mutual care within the community. The church that embraces this role becomes a sign of hope within any community. Churches can facilitate and lead community projects that promote care, empowerment skills and social needs into the wider community. In this regard would the care community become involved in poverty eradication projects and in HIV and AIDS programmes?

3.9.5 A Community of Mission

The church is the extension of Jesus Christ into the world. The church is called to have a positive influence into the world. As H. Richard Niebuhr said, “of the influence of biblical faith on Christians, the church loses its character as church when it concentrates on itself, worships itself and seeks to make love of the Church the first commandment” (Niebuhr 1922: 127). Gerkins further uses the example and principle from Niebuhr. He says that people who call themselves the ‘redemptive community’ are to be faithful to the God of the church and to Christ, who is the head. The ultimate objective of the Christian community is to increase the Love of God among all people and his neighbour. This can be done through therapy. What Gerkins points out is that Christians are to be true to the Christian tradition, they need to extend love and care past the physical walls of their churches.

Gerkins makes the point that Dieter Hassel’s research reinforces in his own interpretation of what pastoral care must be. When we study the history of pastoral care, you cannot separate pastoral care and the social ministry of the church.

Since God is radically social, all modes or dimensions of ministry are special in ways that encompass both personal growth and political responsibility. Congregations must develop the modes of ministry with internationality and competence, so that ministry contributes to social transformation as well as human fulfillment, to health of community and country as well as to human fulfillment, to congregational renewal, to local/global action as well as to church growth. (Gerkins, 1997:128)

3.10 Theological Perspective in Relation to Human Sexuality

Zambia is not unique in that its population is made up of 73 different tribes. Each tribe has their own custom and values that are placed on human sexuality, although in some tribes they have similar customs, but sexuality plays an integral part in their identity. It is not the focus of this thesis to bring commonality in view of sexuality, but rather that each tribe’s culture and custom is placed under Christian doctrine when it comes to sexuality.

Christianity has traditionally expressed the understanding that sexuality is a gift of God for both procreation and a wonderful intimacy between husband and wife in marriage. The Bible clearly states that sexual intimacy outside of marriage is sinful in the sight of God. Postmodern society that does not embrace the fundamental interpretation of human sexuality in terms of biblical interpretation becomes confused as to the acceptance or rejection of non-heterosexual identity.

Due to the fact that humans are sexual beings by nature and the major cause of the spread of HIV and AIDS virus is through sexual intercourse, this increases vulnerability to this disease. People that have multiple partners are at a highest risk such as prostitutes (sex-workers) or drug users. Sexual activities among teenagers in Zambia are at high and alarming phase. It is estimated that seventy five percent of teenagers have engaged in sexual activity before marriage, of that percentage at least twenty percent have had five different partners. The old fashioned ways of being a virgin at the altar seems an archaic, teenage girl are teased and ridiculed if they remain sexually inactive (Bowa 2005:3). We find ourselves in the middle of a sexual revolution. Young people today under the age of twenty, have a liberal view of sexuality compared to people born in the fifties and sixties. The sexual revolution is like throwing petrol onto a fire. The high percentages of young Zambians are positive with HIV and AIDS.

In summary the moral and theological understanding of human sexuality the researcher strongly agrees with John Habgood, Archbishop of York at the WCC Conference on HIV and AIDS in 1987. This extract from his presentation clearly defines our human frailty within the context of human sexuality and HIV and AIDS.

And there is an interesting connection between intimacy and vulnerability. Every intimate contact makes us vulnerable in all sorts of ways, not only through transmission of infection but also psychologically and in our personal identity. This is why every civilization has in various ways surrounded intimate relationship with rules, with structures, with ceremonies with taboos. These have, as it were, protected the relationships. What I see the AIDS epidemic is teaching us is that we

can no longer treat these intimate relationships lightly. That is where the world has lost its sense that close contact between an ordered framework. This, it seems to me, is a moral and theological understanding which can be expressed in ways which are accessible not only to those with Christian commitment but to all those who think seriously about our human nature and our contacts with one another (WCC Facing AIDS, 1997:31).

The researcher agrees with Habgood, because in Zambian context this is a reflection of what happens. History proves that society looks to the Church for moral guidance, even political leaders. The church determined for society what was sexually moral and what was sexually immoral. This trend worldwide no longer exists in reality. Post modernism places paramount importance on individual 'human rights'. A person chooses for themselves their own sexual identity and orientation.

However, the researcher believes that there is a golden opportunity within Zambia, to reverse this trend. History records those all-great cultures and civilizations cracked down when they embraced immoral behavior. Christian faith and churches clearly have an important role in influencing positive moral behavior within communities. Young people are looking for answers that are real. They look for direction from trusted mentors. Within the church, because the church is a redemptive community, people are no longer governed and directed by world forces, but submissive to the influence and direction and power of God must become the agent in which we can touch a broken world through pandemic of HIV and AIDS. The researcher now analyses the issue of homosexuality, an issue that troubles Zambians to the extent of blaming them for the pandemic.

3.10.1 Homosexuality

Taking into consideration the theological perspective towards homosexual is important within the context of this thesis. Although the percentage of the gay community is very small and in most cases private. Many of the few gays in Zambia are HIV positive. From the researcher's own observation the issue of gays in Zambia has started growing

and in near future it will be big and a concern to communities. The teaching of the church in relation to gay as an ethical issue should be sound and clear.

What the researcher sees as a great problem with modern society is that we deviated away from God's order. God created us in His image, male and female. The scriptures tells us that, a man leaves his father and mother and become one with a woman, who becomes his wife through the sacred union of marriage (Genesis 2:24).

We have to refer back to a point of reference, a blue print of God's design. For the researcher, that is the only way to keep true to the original plan of God for human beings. Man has always had the propensity when intoxicated with sin to interpret and justify his or her wrongful action, his or her own way. When we feel automatically justified and begin to proclaim his justification.

The world has looked to modern science and medicine because they no longer look to God. Modern science and medicine have reached no consensus about the causes of homosexual orientation. Among, the factors proposed as possible causes are; genetic determination, Pre-natal hormone levels, disturbances in family relationship (absent-father, dominant mother).

The researcher argues here that the causes of homosexuality are none of the above but plain old sin. When the inhabitants of Sodom did great evil in the sight of a holy God, God sent his angels recorded in Genesis 18:20 (NIV) that this great evil was Sodomy, a practice that God does not condone but condemns. They called Lot, "where are the men who came to you tonight"? Bring them out to us that we can have sex with them." (Genesis 19:9, NIV) In that same chapter it says that all men from every part of the city of Sodom – both young and old – surrounded the house. The reference to gender here is most certainly male. Other biblical texts that reinforce this theology is Paul's writings. In his letter to the Romans we find the following about homosexuality:

Therefore God gave them over in the sinful desires of their hearts to sexual impurity for the degrading of their bodies with one another. They exchanged the truth of God for lie, and worshipped and served created thing rather than the Creator – who is forever praised. Amen. Because of this, God gave them over to shameful lusts. Even their women exchanged natural relations with women and were inflamed with lust for one another. Men committed indecent acts with other men, and for one another, and received in themselves the due penalty for their perversion (Romans 1:24-27, NIV).

Liberal theologians will argue that this view is too narrow and biblical evidence given to homosexuality is little. The God of the Bible is heterosexual, as seen in human kind and in the animal kingdom that God created.

In sum of this sub-section on homosexuality and its ties with HIV and AIDS, we need to communicate God's principles on these human issues and not our own. God's reveals himself to us through the Holy Scriptures. Here are other clear scriptures, for example, "Do not live with a man as one lives with a woman's that is detestable. Do not have sexual relations with an animal and defile yourself with it. A woman must not present herself to an animal to have sexual relations with it; that is perversion" (Leviticus 18:22-23, NIV).

The above quotations have caused conservative Zambians to fight homosexuals and accuse for introducing the virus among human beings.

3.10.2 Human Sexuality in Relation to Child Abuse

The researcher now comes to an issue that has disturbed Zambians of late and this is the issue of child abuse. Child abuse within the context of this thesis is necessary. It is prevalent in Zambia at a high level and the church needs to take a more proactive stance against this violent act against innocent children.

A great deal needs to be done against abuse in Zambia before the situation gets out of hand. Children are at risk not only from unscrupulous individuals, but also from highly sophisticated organization trading in child pornography, child prostitution, and child

labour and using children to fight in dirt wars. In Zambia some traditional healers cheat people that if they have sex with a young child they can be healed from AIDS. This false information has contributed greatly to child abuse both in rural and urban communities.

In this disturbing scenario, it is vital that the true basis of a child's right to protection is fully grasped and also promoted and acted upon by the Christian Church. Children are the most vulnerable within society and as such children have a special right to protection. They must be seen not just as property to their parents or guardians, but as individuals, unique human beings who are themselves responsible to God and who are entrusted to the care of their parents for a time. As such, children must be accorded the dignity, which is richly and equally deserved by every human being, created in God's image and likeness.

Jesus words in Matthew 18:5 and the severe warning which follows against harming little children must be echoed by the church. This fundamental right must transcend cultural practices. Parents selling their young daughters, as sex workers for economic reasons must be strongly condemned by the church. The dilemma of how to protect children effectively when they are found to be at risk is a continuing one, particularly as increasing incidences of children being abused by other children or by adults in residential or care homes comes to light. The importance of the Church's role in preventive work and in family support cannot be overestimated.

Having dealt with HIV and AIDS in Zambia, ethics associated with HIV and AIDS and theological perspectives. The researcher will conclude the chapter by analysing poverty in Zambia and the HIV and AIDS and poverty interplay. In this section the researcher will discuss the interplay of HIV and AIDS, the main question is what is the relationship between HIV and AIDS and Poverty?

3.11 Poverty Problems in Zambia

In the last section the researcher gave an overview of HIV and AIDS information and the issues related to the pandemic in Zambia. This section deals with the poverty

situation in Zambia and also it attempts to unravel the intricate nature of the poverty-HIV and AIDS relationship in Zambia. The researcher therefore, attempts to address the issue of the interplay between HIV and AIDS and poverty in Zambia. However, before embarking on a detailed discussion of the poverty situation in Zambia and HIV and AIDS relationship, there should be a working understanding of what poverty means. Secondly, since our subject focus is pastoral care, which is a theological enterprise, it is pertinent also to briefly explore the biblical meaning of poverty. Hopefully in so doing the Church in Zambia would seriously and critically reflect on its role of mediating God's Kingdom in situation where people are entangled with HIV and AIDS and poverty. The Church ought to ask a critical question: what does it mean to be Christ's disciple in the context of poverty and HIV and AIDS?

Therefore, to begin the discussion, several questions could be asked. What is poverty? How is the poverty situation in Zambia? What is the Biblical meaning of Poverty? But the central question remains; what is the nature of the poverty and HIV and AIDS interplay in Zambia?

3.11.1 Poverty: Definition and Description

Poverty is not easily defined. It has many meanings, and many facets. It is composed of a variety of individual and collective experiences, changing in structural significance and features with time. It is for this reason that those who study poverty contend that there is no one correct, scientific agreed definition, because poverty is inevitable a political concept, and this inherently a contested one. Although poverty is a contested phenomenon it is generally agreed that it is a problem and one thing that there is no disagreement over is that something must be done about it.

The Oxford Advanced Learner's Dictionary simply defines poverty as "the state of being poor" (2000:910). From this definition one still needs to define "poor" in order to have a clear understanding. In a simplified way again the dictionary (2001:910) defines "poor" as having very little money or not having money for basic needs. Hence,

poverty means a state of not having or having very little money for basic needs. However, restricting poverty to money as the definition does is not informative enough. What about material assets? This definition accommodates assets since they can be converted to liquid money and purchase goods. But this definition can be extended further: what are the needs and who determines them? For instance, a Congo forest pigmy does he need a house?

Pieterse citing May and Govendor's definition, said, "Poverty is the inability of the individuals, households, or entire communities, to command sufficient resources to satisfy a socially acceptable minimum standard of living" (2001:30). This definition underscores the same idea as the World Bank that poverty is the inability to attain a minimal standard of living. However, this understanding of poverty also does not state who determines the living standard for the people. Could someone from New York or London say that the people in Chiundaponde (one of the rural villages in Zambia) are poor because they cannot afford a Mercedes Benz? Therefore the World Bank, in attempting to clearly underpin the definition of poverty, outlined some descriptive aspects that embrace the various facets of poverty ([http: www.worldbank.org/poverty/mission/upl.ht](http://www.worldbank.org/poverty/mission/upl.ht), 2004:1).

The above description of the various aspects of poverty clarifies it. The description captures the person's context and experience. In that sense, then, poverty is contextual and experiential, which is consistent with its relative nature. Pieterse offers a guideline for understanding poverty that also echoes poverty's experiential nature in agreement with the World Bank's description. He wisely states that "what poverty means is the poors' own experience" (2001:30). He goes further to apply the experiential dimension of poverty to the South African context where he says, to a South African poverty means not knowing where the next meal is coming from, or fearing eviction from their meager dwellings because they cannot pay the basic rental. There is also fear that the breadwinner will lose his job (Pieterse 2001:30).

Myers in his article, ‘What is Poverty Anyway?’ introduced a spiritual and relation dimension to poverty. He argues that we should move beyond understanding poverty as the absence of things and knowledge. The heart of poverty, he argues, is a spiritual issue and relationships that don’t work, and power that is misused (Myers1991:580).

However, though poverty is experiential and contextual, as Pieterse and other writers rightly argue, it is important to develop indicators to determine it, otherwise donors won’t be able to fund poverty-alleviation projects. Therefore, focusing on the objective aspects of poverty, Burkey described it in concrete and measurable terms. He defined it in terms of basic needs, which are those things that an individual must have in order to survive as a human being. These needs include clean air and water, adequate and balanced food, physical and emotional security, physical and mental rest, and culturally and climatically appropriate clothing and shelter (Burkey 1993:34). He further says that the human race does not depend on the survival of a single individual, but on the survival of communities; hence the individual needs should include those of the community. These community needs are defined as: sexual regeneration, a system of communication, a belief and educational system for cultural continuity, physical and cultural security, a political system defining leadership and decision-making, and systems of health and recreation for maintaining the well being of sufficient numbers to maintain the community (Burkey 1993:3).

Poverty is determined, firstly, by measuring the Gross National Product (GNP), i.e. the total value of a nation’s annual output of goods and services, thereby classifying countries as low-, middle- or high-income countries. Secondly, it is determined by measuring the Physical Quality of Life Index (PQLI), i.e. the state of people’s health and welfare and the standard factors are: life expectancy, child mortality and adult literacy. Thirdly, it is measured by means of the Basic Needs Approach (BNA), in which the presence or absence of minimal basic human requirements for life, as well as essential service, indicate the degree of poverty, or the level of standard of living. The basic requirements are: adequate food, safe drinking water, suitable shelter and clothing, as well as basic household equipment; and the services measured are:

sanitation, public transport, health and educational facilities (Burkey 1993:4-5). With reference to poor HIV and AIDS affected people, they are always at the bottom of whatever poverty measuring scale is used.

However, it is important to emphasise that, of all the poverty measuring approaches, none can completely identify and quantify poverty. But for a working definition of poverty, it would be necessary to indicate that the poor referred to in this research are people who fall below the generally agreed minimum scales, as above. Furthermore, these people should be perceived in their communities (context) as poor.

In wrapping up the section, it is crucial to highlight that pastoral care givers should have a clear contextual working definition and understanding of poverty. Though there are poverty indicators, one should be warned about the possible dangers of such global indicators. If the income indicators are employed in many rural communities, very few or none would be above the poverty line in countries like Malawi, Zimbabwe, Zambia, or Mozambique (just to mention a few). However, these people would be clear among themselves about who are the needy in the area. In such situations it would be unwise to rigidly stick to global indicators, since none would care and assist the other. In fact, in many cases in Zambia, relative poverty may be the best way to measure poverty and to mobilize interventions. Communities are aware of the orphans and needy widows that require handouts among them. Therefore pastoral care givers in poor communities should be sensitive about this fact. The community and the church should define their poor and then jointly intervene. Thus, poverty should be viewed as a local and community issue in mobilizing interventions.

Notwithstanding the importance of doing something about poverty the advance made in various parts of the world since 1960's, particularly in refining the definition and measuring the extent of poverty are extremely important. These have shaken the dominant mainstream concepts (the western concepts in particular) about poverty, rectifying the situation and bringing in conceptual thinking of poverty that is representing local context.

It is not within the scope of this study to discuss all dominant western concepts although it must be acknowledged that most debates about the conceptual problem of poverty, and its measurement have relied heavily on western theoretical and conceptual perspectives. The implicit intention of this study is to assess that poverty is a problem and it contributes to the spread of HIV and AIDS epidemic in Zambia. A lot is known about the effect of poverty, how it squanders human resources, and how it undermines the development potential of countries. For instance, in most developing countries there is correlation between insufficient basic health services and poverty, school enrolment and poverty, between gender discrimination and poverty, and between lack of access to credit opportunities and poverty. Therefore, poverty is defined and measured hunger, poor shelter and inadequate clothing frequently accompanied by ill health and illiteracy, are features that would assist us make judgment about what the real problem is. In trying to answer the question, "is poverty a problem?" Alcock (1997:3) cites Oppenheim and Harker (1996:4-5) who argue that poverty means going short materially, socially and emotionally. It means spending less on food, on heating and on clothing than someone on the average income. Above all, poverty takes away the tools to build the blocks for the future, your life chances. It steals away the opportunity to have a life unmarked by sickness, a decent education, and a secure home and a long retirement.

On the other hand as Christians, we see and experience the need for others in the community and this has an effect on us. It is at all possible to define poverty by considering the criteria we apply. Perhaps the UN definition on poverty could be helpful: "The denial of opportunities and choices most basic to human development to lead along healthy, creative life and to enjoy a decent standard of living, freedom, dignity, self-esteem and respect from others." Within this section on poverty the researcher will bring to the reader's attention that within Zambia, poverty has contributed generally to the spread of the HIV and AIDS pandemic.

3.11.2 Poverty Situation in Zambia

This section provides a brief assessment of Zambia's present poverty situation. Zambia's present poverty situation is the result of more than two and half decades of decline in the economy, in public services, and virtually in all major indicators of human development (see Zambia Human Development Report 1998). At independence in 1964, Zambia was one of richest countries in Africa. The Zambian government was able to provide free and almost universal social services to its citizenry. Today Zambia is classified as one of the poorest countries in Africa. In fact the transition from being one of the richest countries in Africa to one of the poorest took less than a generation. As pointed out by Anderson (2000:9), much of Zambia's economy decline is attributed to the failed past policies that led to an unbalanced and unsustainable economic structure within the country.

A recent Zambia poverty study conducted by the United Nations Children's Fund states that the immediate manifestation of poverty in Zambia have grown to such an extent that the country can be said to be experiencing a social crisis (UNICEF 1998:33). According to this study, among the most critical symptoms of this social crisis are worsening problems of the public health, and life expectancy, which has deteriorated due to the coming of the HIV and AIDS pandemic. The study adds that under these circumstances the ability for people to cope day-to-day has been drastically diminished, and many people have unnecessarily adopted unhealthy lifestyles that seriously threaten their present and future well being.

The study also goes on to state that roughly six million people, equivalent to a poverty line is employed as a measure of poverty, that line is constructed based on the food basket approach. The food-basket calculates the cost of acquiring basic food items that provides a basic minimum caloric requirement for an individual per month (Central Statistics Office 1998:11). Most Zambian poverty studies argue that if the poverty line is reduced to cater only for basic nutritional needs, most Zambians will fall below the line (World Bank 1998: 2).

Zambia's economic decline coupled with the subsequent implementation of a vigorous Structural Adjustment Programme referred to from now on as (SAP) in 1991 had led to the stagnation and collapse in people's livelihoods and in available forms of social support. A general argument is that the incidences and intensity of poverty in Zambia have increased with the implementation of the SAP. The social and economic costs of SAP were massive job losses due to retrenchment and redundancies in the public and private sector, decline in real wages, increased taxation, and reduced access to economic resources among people.

Despite some partial and half-hearted attempts at adjustment since the 1980's the situation worsened, the reforms were neither systematic nor sustained. Precisely, it is clear that in Zambia the structural adjustment programme has not worked for the majority of the people, as we experience drastic decline in school enrolments, disturbing rises in mortality and mobility rates and so on (see Zambia Human Development Report 1998).

Since mid of the 1970's the living standards have declined in Zambia. A study by Bonnick (1997:48) states that a 1994 internal consultative group report noted that the deterioration in nearly every social indicator reflects Zambia's deepening poverty. A point, which is also observed by Chisanga (1999:37) who claims that in Zambia, all major indicators of human development are largely negative. In other words, the broad reform programme, which includes Zambia's poverty strategy, has not produced the desired results in the long term, but rather it has led to the deterioration of quality, and access to social services. Those who have been hit the largest are the poor, both in urban and rural areas, although the living standards of the middle and high-income groups have been eroded as well.

A study conducted by the World Bank (1998) shows that in 1991 about 69 percent of all Zambians lived in households with expenditure below a level of sufficient to provide for basic needs. The same study maintains that poverty prevalence stood at 76 percent, and

was more pronounced than urban poverty, and especially severe in the remote districts of provinces where people engage primarily in semi-subsistence farming. In fact, recent studies indicate that the poverty levels in Zambia have risen since 1996. The latest figure from the Central Statistics office's Living Conditions Monitoring Survey (LCMS) 2004, suggests that the total poor people in rural areas is 86 percent, while in urban areas is 56 percent. The study further states that there is 17 percent of people above poverty line in rural areas, while the figure in urban areas is 44 percent see table.

Table 1: Incidence of Poverty by Rural/Urban.

	Total Poor %	Extremely poor %	Moderately poor %	Above poverty line %	Total population
All Zambian	73	58	15	27	10,168,00
Rural	83	71	12	17	1,344,000
Urban	56	36	20	14	3,824,000

Source: http://www.ccjp.org.zm/sap_mon_23.htm.

Most of urban poor live in unplanned squatter settlements (commonly known as shanty compounds) on the periphery of urban centers, where lack of legal status and provision of basic community services, for example, clean water and electricity, constrains their productivity. Related to this is that most squatters do not possess title deeds on houses, and hence they cannot use them as collateral. Many of the urban poor survive by engaging in the informal economy, through unregulated street vending and illicit activities. The researcher's case study is based on two of the unplanned settlement in the town of Kitwe. In sum the level of poverty in Zambia and the plight of the poor struggling to survive is vividly illustrated by the UNDP Human Development Index. Zambia is ranked 163 out of 173 countries, with inadequate health and educational services, with shocking social indicators of life expectancy, maternal and child mortality, etc. HIV and AIDS the poverty induced and poverty-causing pandemic, effects and affects all of us in the country.

3.11.3 Analysis of Some of the Causes of Poverty in Zambia

Some of the causes of poverty in Zambia are lack of access to basic services. Others refer to public and macroeconomic policies adopted by the Zambian government during the years of prosperity, immediately after independence. Also the harsh impact of SAP as several studies on poverty in Zambia seem to agree that inappropriate policies served to undermine much of the basic social, and cultural fabric of the Zambian society and the weakened Zambia's capacity to help itself (see UNICEF 1996:24). For example, an important common main feature post-independent Zambia was the belief that the state should take care of every Zambian (Graham 1994:164). In other words, the traditionally self-help method was replaced with a culture of dependence on state.

At the time of independence, when funds were readily available, this precept did certainly lead to better living conditions, and access to services for a large majority of Zambians. However, when the economy started to decline and the effects of misguided government policy were finally felt these improvements all but evaporated. These factors lead to a situation of overall incapacity and lack of initiative, one, which Zambia is still trying to break free from. However, the decades of party and government handouts have all but destroyed Zambian's tradition of self help, with the result that grass roots movements of Non-Governmental Organisations (NGOs) and the Church are finding it difficult to blunt the negative effects of poverty. As UNICEF puts it, "the attainment of independence regrettably overshadowed the need to think through policies and guard against their possible detrimental consequences" (UNICEF 1996:24). The philosophies of 'humanism' and 'nationalism' are examples of strategies that later proved disastrous for a government that wanted to transform the country into an industrial modern economy.

Humanism became a national philosophy of Zambia. It became a basis of all policies and programmes of the ruling party and government. All the development efforts during UNIP's reign were based on humanism. It is a way, which emphasised the importance of 'man' as the centre of all activities. Zambia humanism provided the moral basis for

all human activities in the country whether it is political, economic or social. UNICEF notes that “Zambian humanists experience was presented at a grant venture that would remove the injustices of the colonial past, redistribute wealth, improve the welfare of the people, and rapidly transform the country into a modern industrial power” (UNICEF 1996:24). However, in the absence of realistic strategies for accomplishing this, the policies led to huge consumption, which only stopped when the countries reserves had been depleted and enormous debt had been incurred. By that time, Zambia was impoverished, it had become much more difficult to invest in the people and help them improve their livelihood based on exploiting the countries resource strength.

To make matters worse, the Mulungushi reforms of 1968 implemented a policy of nationalising ownership of the economy. The mining industry together with a number of foreign owned firms active in manufacturing, transport, retail and whole distribution, and newspaper publishing were all nationalised. Nationalisation was seen as the only way to avoid the majority of the countries productive base continuing to be owned by foreign interests. The UNICEF study notes that “a common experience shows that African countries that attempted to nationalise their economies, the parastatals proved to be disastrous inept at running business (UNICEF 1996: 25).

Under these circumstances, little attention was given to the role that the market or private sector could play in economic development. In the longer-term, this extension of Zambian control over the Zambian economy, has had some considerable benefits, yet in the shorter-term, some disruption particularly in the private sector, followed by the economic reforms have adversely affected the performance of the Zambian economy. From the beginning political interference has indeed engendered unfavourable condition for economic and social development endeavors in Zambia. It is argued that governments reluctance to diversify and restructure the economy immediately after independence, and it’s failure to sustain the economic reform programmes has contributed to the manifestations, and causes of poverty that Zambia is experiencing today.

Zambia also played host to a number of liberation movements in Southern Africa such as the African National Congress (ANC), Zimbabwe African Peoples Union (ZAPU), National Union for the Total Independence of Angola (UNITA) and other political groups. Thus, Zambia's support for these liberation movements was done at a great economic cost to the country and its people. The country became an obvious target for countries sub version by urgent of white regimes in southern Africa. On several occasions, Zambia suffered military offensive attacks, including air raids in Lusaka in 1978 and 1979. The argument here is that some of the disruptions to Zambia's economic performance were partly as a result of political and security situation in the sub-region. However it is important to note that the political and security factors observed here were merely the symptoms and not the underlying causes of poverty in Zambia. As Chakaodza rightly points out, that the above factors were simply contributory to an economic situation, which started sliding as far back as the early 1970s. (Chakaodza 1993: 33).

The other cause of poverty that should be noted is SAP, which most Zambians today hold capable for the countries economic disarray. SAP has contributed to poverty in Zambia. Because of the implementation of SAP Zambia eliminated tariffs on foreign goods, weaned farmers off practically all government support and sold more than 300 state owned enterprises, including copper mines which since 1992 has shed off nearly 100,000 jobs. According to the international newspaper the mining giant Anglo American Cooperation withdrew from Zambia copper mines in January 2002, putting 4000 jobs at peril. Mr. Mulima Kufikisa-Akapelwa lecturer at the University of Zambia, in his presentation at the Economic Association of Zambia in Lusaka in 2001, observed, "the initials SAP became infamous in each household in Zambia." Every man, woman and child put all blame for his suffering on SAP. The local name was 'Satana alipona', meaning the devil among us depicting a very negative impression in people. This was so because of SAP policies, which included devaluation of the currency, reduction of restriction on amounts of foreign investments including removal of price controls, privatization of state owned enterprises, labour reforms including removal of minimum wage controls, among many others issued things. Akapelwa further observes that

adjustment policies worsened the situation. It entails loss of income, inability to access health and education, environmental degradation as those who lost jobs were forced to rely more on environment for lively hood; as well as enhanced intense suffering:

The multilateral always claimed that there would be short-term pain in the process. From the onset of these reforms in Zambia the impact has been heavy especially on the poor. Peasants for men's could no longer have subsidised inputs, they had to organise marketing of their crops overnight, parastatal workers lost their jobs, fees were introduced to health and education. Out break of diseases such as cholera became almost annual as consequence of changes in financing the public sector, particularly of public health. The observation of a Finish economist, Marko Nokkala, is worth noting: "the effect of the structural adjustment Programmes since have been various. Most alarming is the fact that the status of the poor in Zambia has not improved, more likely it has worsened (Nokkala 2001: 6).

According to Akapelwa, poverty levels rose drastically, mortality, malnutrition and non-attendance of school levels shot up. The reduction in the public expenditure was made worse by the fallen income of the country and the value of currency. Through redundancies the already small formal sector was reduced further, rise in the already high unemployment level.

To many Zambians International Monetary Fund (IMF) and SAP were synonymous and representative of misery and there are strong sentiments against SAP related issues. Scores of anti-international monetary fund (IMF) protestors were dispersed by armed riot police in Zambia's capital Lusaka after attempting to picket outside the hotel where IMF and Zambia's officials were meeting. Protesters brought together by leading women rights group opposed to IMF fund World Bank policies which attempt to price open markets-accused the fund of bringing misery to poor countries by imposing strict conditions on their economies, which benefit only the rich. IMF policies are killing us, especially women and children (Jere 2000: 4).

One reason for the anti SAP-IMF sentiments lies in Nokkala's remark: "First of all, historically there is evidence that past policies and SAP have contributed to increasing

poverty”. This fits in well with what other economists have observed that, “studies conclude that although past government policy contributed to poverty the structural adjustment programme that began under the Kaunda regime, which was continued and deepened following election of the Movement for Multi-party Democracy (MMD) government, could have negative impact on the poor” (Alwang and Siegel 1996:8). The reader now can understand why people resort to selling their bodies in order to earn a living.

3.11.4 Poverty: A Biblical Concept

Post-modernism, which is pluralist in thinking, has permeated many societies, including those in Africa especially in cities. Though some African people are still tenaciously holding onto their values, the ripples of the movement are evident. Theology is no exception. Therefore, in this culture where epistemology is contested, it is crucial for any theological endeavour to appeal to the Christian epistemological foundation (i.e. Scripture). Failure to do so means that a theological pursuit could risk being indistinct from the social sciences. The value of drawing from the Christian normative source is that people would not deviate from God’s mission or kingdom focus, though interpretation remains contested. Furthermore, by centering this pursuit on Scripture, we allow ourselves to be haunted by the reflective question: what does Scripture say? This continuously shapes our thinking and actions. In this light, therefore, it is paramount to explore the biblical concept of poverty.

3.11.4.1.1 Poverty: An Old Testament Concept

Poverty in the Hebrew Bible denotes (1) lack of economic resources and material goods; and (2) political and legal powerlessness and oppression (Pleins 1992: 402). Poverty as lacking material, legal power and oppression is a notion shared by other scholars like Mott (1985:807) and Braaten (2000:1070). However, to grasp the Hebrew conception of poverty, it may be useful to consider the Hebrew words translated as “poverty”. They are ‘ebyon, dal, mahsor, misken, ras’, ‘ani and ‘anawim’ (Brown 1971: 820; Pleins

1992:403). In analysing the meaning of these words Pleins (1992: 414) agrees with other scholars that:

- *ebyon*- refers to a person who is economically or legally distressed, destitute, beggar, i.e. it generally refers to the beggarly poor,
- *dal*-means poor, weak, inferior or lacking. And in many cases it alludes to the plight of the beleaguered peasant farmer,
- *mahsor* – denotes lack of or need for material goods. It occurs 13 times in the Hebrew Bible and mainly in Proverbs. Its rarity in other parts of the Hebrew Bible suggests that it is a wisdom term;
- *ras* – refers to someone who is politically and economically inferior, frequently referring to someone who is last;
- *ani* – refers to economically poor, oppressed, exploited, suffering, and is the common term in the Hebrew Bible for poverty;
- *anawim* – is not a common word for poor, but is believed by scholars to be a conjunction of poverty and piety, i.e. poor, pious, humble.

These various Hebrew words translated as “poverty” do not mean much to a reader apart from their context. Therefore, in his analysis Pleins, like Wittenberg (1986), discourages an etymological approach to the study of words but encourages a consideration of context and usage. He states that:

It is important to note the distribution of the vocabulary throughout the Hebrew Bible: no one Biblical writer or text uses all the Hebrew terms for poor/poverty. In fact, the distribution reveals selectivity on the part of the biblical authors: *ras*, for example, is a wisdom word and not a prophet word. This selectivity should also alert us to the fact that even when the various blocks of the biblical text make use of the same Hebrew term, the writers may not mean the same thing by that term. In proverbs, for example, the *dal* is a lazy person, whereas for the prophets, the *dal* is an object of exploitation (Pleins 1992:403).

However, while it is undoubtedly difficult to represent the various “poverty concept” denoted by the above words in their contexts and usages, there is an insightful trend that

may be adopted. Braaten (2000:1070-1071) discovered this trend and commented that Old Testament traditions emphasise different aspects. The legal texts regulate the treatment of the poor, seeking to protect the poor, widows, orphans, or strangers (Lev 19:9; 25:25,35). The prophets show a concern for those economically exploited (e.g. Isaiah and Amos). The wisdom traditions view poverty from different perspectives. Proverbs sees poverty as one's own fault (e.g. Proverbs. 6:10-11; 10:4; 13:18), while for Job poverty results from political and economic exploitation (e.g. Job 29:12, 16; 30:25; 31:16). The Psalms present God as the defender of the poor (e.g. Ps 22:26; 35:10). The narrative literature of the Pentateuch and Deuteronomistic history show little interest in the poor, but are concerned more with critiquing the kingship.

As highlighted above, the various strands of Old Testament traditions have different focal points. "Nevertheless, the legal, prophetic, wisdom, and liturgical traditions all see poverty as a matter of grave significance to the community" (Pleins 1992:413). The legal and the prophetic traditions present the harsh situations of poverty, hunger and thirst, homelessness, economic exploitation, legal injustices and lack of sufficient farmland. The liturgical tradition (Psalms) presents a God who assists the poor in their distress. In the wisdom tradition, the wise in Proverbs view poverty as either laziness or as representing judgement of God, but by contrast Job views the poor as victims of economic and legal injustices.

All in all, the Old Testament in its various descriptions denotes the poor as the needy, without power, and abused by those with greater power. They (the poor) may also not have the capacity to provide the essentials of life for themselves. Their deficiency in life-supporting power is understood to exist in relation to the rest of the community, which also alludes to poverty as contextual and relative as argued in the previous section.

3.11.4.2 Poverty: a New Testament Concept

The New Testament has two Greek words that are translated “poverty/poor”. The words are *ptochos* and *penes*.

- *Ptochos*- is the most common term in the New Testament. It appears 34 times. *Ptochos* literally means beggarly poor (Hanks 1992:45; Brown 1971: 821). Brown added that this word signifies utter dependence on society. The person would be so helplessly poor that he/she is at the mercy of other people.
- *Penes*- is only used once in the New Testament (i.e. 2 Corinthians 8:9). It refers to the person who cannot live on his property or one who has little and must live frugally (Hanks 1992:415). Though this word is barely used in the New Testament, it was the most common word in ancient Greece.

Much as words translated as “poverty” in the Old Testament should be understood in their context and usage. The New Testament words should be understood in the same way. As mentioned above, *ptochos* occurs 34 times – 24 times of these occurrences in the gospels (and mostly in Luke). In the gospels *ptochos* is used in various ways, for example in the literal sense (Matthew 10:21; cf. Luke 18:22) and in a spiritual sense in (Matthew 5:3). While doing a detailed analysis of the usage of *ptochos* could shed more light on poverty, it is not our main interest. Our interest lies in developing a general understanding of the way that the New Testament presents poverty in order to view this idea in relation to the above discussion.

What could precisely be stated in this discussion is that the words for poor in the New Testament cannot be defined exhaustively and statically. However, what is apparent is that poverty generally designates a person(s) and group(s) lacking (totally or in some degree) the necessities of life: food, drink, clothing, shelter, health, land/employment, freedom, dignity and honour, etc (cf. Job 24:1-12) (Hanks 1992:415). Furthermore, it is also clear that some kind of option for the poor is represented in most New Testament literature (e.g. Luke).

Finally, in the previous discussions (3.2; 3.3.1; 3.3.2), it emerged that poverty is experiential, contextual and relative. The poor's experience of their condition is an important indicator that reveals poverty. Secondly, the people in the community are aware of the poor people around them, though organizations may use global indicators. Thus poverty is relative. These community people share a common idea of poor people designated as needy, without power, abused by those in power, and lacking the necessities of life (e.g. Job 24:1-12). The most striking experience for the researcher was to see people in Mulenga Compound dividing a 1kg sugar to give an old widow whose sons are not employed and living in the compound. Poverty is not an abstract concept. It applies strikingly to people in whatever context they are. They see, feel and experience it. Therefore, whether by rules, principles, paradigms or symbols (Hays 1996), the Scriptures instruct the more privileged to care for the less privileged.

3.12 Interplay: Poverty and HIV And AIDS

Poverty in biblical times was sometimes caused by natural disasters, oppression (e.g. in Prophets) or laziness (e.g. in Proverbs). However, in our time there are many other factors including HIV and AIDS. Therefore, the following related questions could be posed. How does poverty increase HIV and AIDS? How does HIV and AIDS in turn cause/increase poverty?

The connection between these two issues (i.e.. poverty and HIV and AIDS) works in two directions. Poverty increases vulnerability to HIV infection and plunges the family into deeper poverty and HIV and AIDS exacerbates poverty as the potentially productive person becomes powerless and draws from savings. Consequently, poverty trickles down to the whole family ([http://www.irc.nl/page.php/130 pp.1](http://www.irc.nl/page.php/130_pp.1) and <http://www.sarp.org.za/reegionalpovertypapers/april262001/page4.php>)

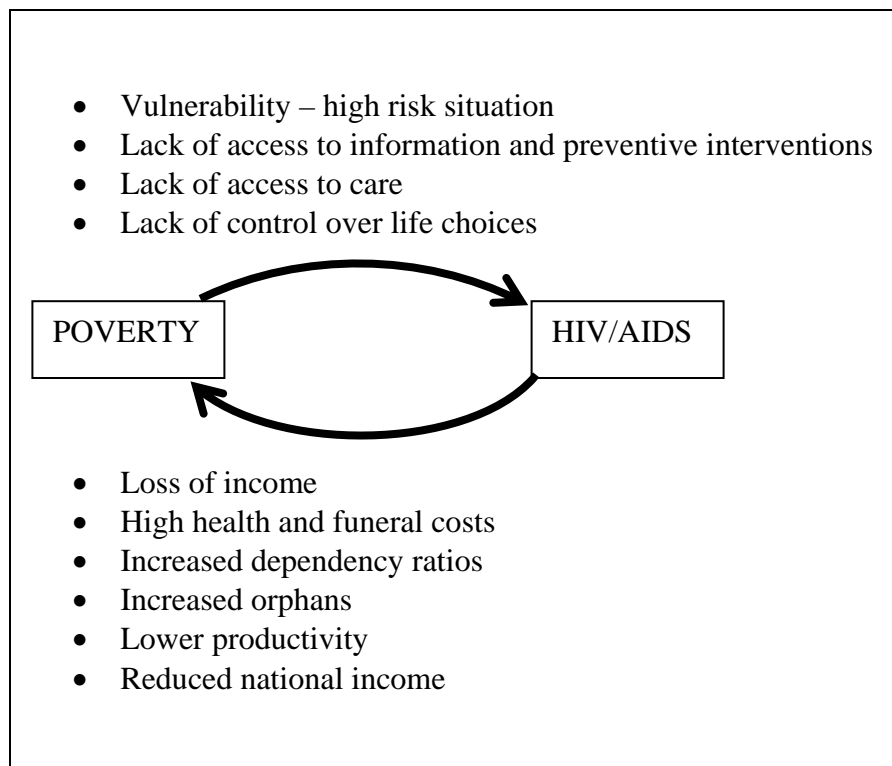
However, this does not mean that HIV and AIDS is the only factor that causes poverty. There are many other factors as highlighted above. There are also other factors that increase HIV and AIDS in Zambia.

However, though it is a fact that there is a link between HIV and AIDS and poverty, the interactions are myriad, complex and not fully understood. “HIV is not confined to the poorest even though the poor account absolutely for most of those infected” (Cohen 2002:2, *Poverty and HIV and AIDS in Sub-Saharan Africa*). Therefore, regarding the intricate nature of the poverty and HIV and AIDS relationship, UNFPA wisely comments that:

The relationship between poverty and HIV transmission is not simple. If it were, South Africa might not have Africa’s largest epidemic, for South Africa is rich by African standards. Botswana is also relatively rich, yet this country has the highest levels of infection in the world. While many people with HIV are poor, many others are also infected (www.unfpa.org/swp/2002english/ch6 pp.2).

In saying this, UNFPA is not denying the link between HIV and AIDS and poverty, but is warning people not to adopt a reductive understanding of HIV and AIDS as being increased only by poverty. The diagram below (Fig.3.1) summarises the relationship between HIV and AIDS and poverty. It illustrates how a family that provides HIV and AIDS home-based care can be affected by HIV and AIDS and how poverty in turn may increase vulnerability.

Figure 3.1: Poverty and HIV and AIDS Interplay



(<http://www.sarp.org.za/reegionalpovertypapers/april262001/page4.php> and <http://www.irc.nl/page.php/130> pp.1)

3.12.1 Poverty to HIV and AIDS

There are many issues that contribute to vulnerability of people to HIV and AIDS but in Africa poverty has been sighted by many researchers as the major contributing factor.

Below is a discussion on how poverty contributes to the vulnerability of people to HIV and AIDS.

3.12.1.1 Vulnerability – High-Risk Situations

Poor people are vulnerable to HIV and AIDS and are often in high-risk situations, for example, homelessness and migration. These situations leave them with little choice but to participate in risk behaviours.

The first group of the homeless who live on the streets have very little or no education, hence they have very little or no prospects for a better life. Life to them is meaningless. The multiple sexual partners and the drug-using culture of these people expose them to HIV and AIDS. In Zambia an attempt to stop or discourage them from engaging in risky activities is often met with the response ‘Icishili imfwa cinshi’? (What is not death?). By saying this they mean that life and death to them are not different. They argue that they may die today or tomorrow of hunger, so they can do whatever they feel like doing. In fact, they argue that HIV and AIDS is better than hunger because it prolongs your life rather than dying of starvation in few days. HIV and AIDS prevention is not a priority. A plate of food is more valuable than worrying of HIV and AIDS. They sell sex to anyone who offers them money. Fernandez simply summed it as follows: “Many of these people participate in informal activities, such as prostitution and intravenous drug use, which has implication for HIV” (www.drugtext.org/library/articles/fernandez.htm pp.1).

The second group of the homeless living in informal settlements also engages in high-risk activities such as selling sex as a means of survival. National AIDS Council report revealed that in Zambia the highest number of HIV and AIDS cases 28 percent are in urban informal settlements, followed by 14.8 percent in urban settlements, and the rural areas have the lowest figure of 12 percent in the 15-49 year age range. Apart from the economic reasons, some engage in sex for entertainment (NAC 2003:24).

Another strand of poverty’s implications for increased risk behaviour in HIV and AIDS transmission is rural urban migration. Poor people in rural areas migrate to cities expecting to find formal employment, but they usually are employed in low-skilled jobs, as farm labourers, and some fail to find employment and end up in high-risk behaviour such as prostitution and drug peddling. A study that was done on women and HIV and AIDS by (Tasinta) revealed that the majority of women in the sex trade are the unemployed from poor minority groups. (NAC 2004:16)

Another clear and insightful dimension in understanding the risky activities was noted and emphasized by Bowa (2003). They observed that the system of migrant labour in the Zambia's mining industry and sugar plantation in Mazabuka facilitates the spread of HIV and AIDS. Separations from their wives and families for long periods of time, poor conditions in mining compounds that are isolated from others coupled with low wages, conspire to make life quite miserable for the migrant workers. In discussion with these men, they described how contact with prostitutes offered not only sexual satisfaction, but allowed them to enjoy female company and receive some measure of comfort and relief from the harsh reality of the existence. Therefore the need for satisfaction push (males) and the ready cash pull (prostitutes) stimulates the sex market – hence the spread of HIV and AIDS.

3.12.2 Lack of Access to Information, Preventive Interventions and Access to Care

The HIV and AIDS awareness programmes conducted through radio and televisions sometimes do not reach to the poor. This crucial information that they need to know is hampered by inappropriate dissemination methods. The (NAC 2002:21) report revealed that the media are a powerful influences that makes people take HIV and AIDS seriously, (i.e. television, radio, billboards and leaflets). The programmes are often in English, yet the poor majority's education level is very low. Besides, many poor people cannot afford televisions and radios. Hence the report emphasizes that “lower levels of access to mass media channels in rural communities and poor households should be noted” (NAC 2002:20). Thus Akapelwa (2001:1,5) “Notes that poverty and the lack of knowledge are also linked”.

Another factor that has contributed to these problems is that, at national level government resources are thinly spread since many of the African governments cannot meet the cost effectively. The few government resources often target the privileged of the country, neglecting the country's poor. Scarcity of resources has further implications in poor countries in that very little research has been done to identify the factors that lead to the spread of HIV and AIDS. Hence the poor are often overlooked.

Greyling states that, epidemics of other sexually transmitted diseases (STDs) increase the likelihood of HIV and AIDS (Greyling 2001:4). Untreated STDs make sexual organs' surface environments favourable for transmission. Poor people's communities have fewer health facilities than the rich communities, which make it difficult for STDs to be treated. More so, the lack of funds to buy medication. In March 2002 in Zambia, due to the economic crisis, government hospitals that used to cater for the poor were not getting sufficient medication to treat infections, hence they were failing to cope. Furthermore, the hospitals were understaffed. It is only the expensive private hospitals, which were providing effective care and medication, which is far beyond the reach of the poor. These private hospitals were charging up to K500 000 (or \$120) upfront before patients are attended to. In such situations the poor infected people do not even bother to seek medication, hence making HIV and AIDS transmission highly likely. However, the distribution of condoms as a preventive measure is being done through NGOs in many different countries.

The vicious cycle of poverty and HIV and AIDS is also evident when parents die and the children have no one to take care of them. They end up engaging in high-risk HIV and AIDS behaviour. Therefore, home-based care should focus seriously also on orphans. In summary, poor people are affected by a host of factors: under-nourishment; lack of clean water, sanitation and hygienic living conditions; generally low levels of health, a compromised immune system, a high incidence of other infections, including genital infections, exposure to diseases such as tuberculosis and malaria, inadequate public health services, illiteracy and ignorance, and pressures that encourage high-risk behaviour (National AIDS Council 2003:2). Furthermore, the situation worsens when the children are orphaned.

Lack of control over life's choices, especially regarding sexually, in Zambia is sometimes misinterpreted and in other instances not explained. For instance, the CBOH (2002: 26) report revealed the following prevalence:

Table 2: Figures taken from the CBOH Report for 2002

Age Group	15-19	20-24	30-34
Males	4%	8%	24%
Females	7%	17%	24%

Figures taken from the CBOH report for 2002, but my own presentation explanation and easy interpretation

The report does not explain this trend. Nonetheless, one possible explanation to account for the differences could be poverty. Zambian men prefer female partners younger than them. In that case older men who have resources scout for younger women say in the 15-19 or 20-24 age group. For financial benefits these women are attracted to these men, leaving men of their own age who are still working towards establishing themselves professionally. However, as they get to the 30s they become stable. Another factor that may cause this scenario is the need to save money to pay lobola (bride price). The man has to work for some years, hence he delays marriage and by the time he has enough money he prefers a younger woman. This has two implications; Firstly the man would be involved in Sexual relations, while he delays marriage and, secondly, the helpless young women who are the prey for men are normally not in a position to bargain for safe sex due to cultural values, age gap and material privileges. It is easier to control a sexual relationship with someone of the same age than with an older person, especially a man in Zambia. Young women, therefore, become more vulnerable than young men. This could be a possible explanation to the above case. Women sometimes can't control their life choices.

The issue is not so much abuse of power due to the hierarchical structure as some writers claim. Gift sex is not seen as prostitution and is common in many societies. In addition, often the men who can afford gift sex are the older who are relatively stable financially and can spare money for gift sex to the young women. It is untrue simply to say Zambian or African women have no control over sexual matters. This may be evident by the high resistance expected of women over sexual matters in some African

communities. How can they resist if the social structure does not support them? In fact, among the Bemba tribe of Zambia to which the researcher belongs, women are referred to as key holders to sex not men! The poverty factor, however, comes to play in the sense that older men are the ones with money to attract the poor young women, thereby reflecting the above scenario.

3.12.3 Summary and Critical note: Poverty to HIV and AIDS

In summing up on how poverty increase the risk and worsen the impact of HIV and AIDS in African families, Professor Nkandu Luo, a former Zambian Minister of Health, in the Post Newspaper dated Tuesday, January 20, 2004, outlined in a simplified manner ways that are complimentary to the ones discussed above. They are as follows:

- 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 or death of their parents they are also at risk of HIV infection as their own self esteem plummets due these abuse.
- According to home based care providers, many AIDS patients die of malnutrition and not primarily of AIDS related illnesses, people simply do not have sufficient food, leading to premature death.

These explanations are sketchy, but they also underline some of the issues discussed above. They should be read in conjunction with the above discussion.

It is also important to note from the discussion that, though there is a correlation between poverty and HIV and AIDS, as mentioned earlier, the interactions are complex and not fully understood. A simplistic approach should be avoided. Pieterse (2001:36)

and many other scholars agree that poverty is highest in rural areas. Hence from the poverty – HIV and AIDS relationship discussed, the possible trend could be expected to be: high poverty levels in the rural areas, therefore higher HIV and AIDS cases, and fewer HIV and AIDS cases in the urban areas (because there is less poverty). However, the contrary is true. The Zambia National HIV and AIDS Council Estimates show that the urban areas have 27.5 percent cases (i.e. more) and the rural areas have 16.4 percent (i.e. less). The NMH (2002:2) in South Africa shows a similar trend as in Zambia i.e. 15.8 percent in urban (higher) and 12.4 percent in rural (less).

As mentioned earlier, Botswana is richer than many African countries, but it has the highest number of HIV and AIDS cases in the world. In fact, the Halperin and Allen (2002) research report in ‘AIDS Analysis Africa’ revealed that rapid economic growth in Botswana resulted in a breakdown of traditional ways of life, which in turn fans the epidemic further. South Africa is also fairly rich by African standards, yet has the fastest growing rate of the HIV and AIDS pandemic in the world (UNAIDS 2002).

These international organizations such as UNAIDS and WHO are correct according to the global indicators that rural people are poorest. However, the approach cannot explain the poverty and HIV and AIDS scenario. The probable explanation could be that, though rural people may not have wage income or enough money to pay their children’s fees up to high school and University, they often have enough food for the family through subsistence farming. For urban people, when one is unemployed and does not have money to meet one’s daily needs, the situation is desperate. Furthermore, the rural communities/villages’ settings allows for one to get handouts from the neighbours, which is not the case in cities. The urban poor then are pushed by their desperate poverty circumstances to engage in risk behaviours leading to HIV and AIDS infection. In fact, many African people’s wages are barely enough to meet all their needs, hence some engage in risk activities or sell goods to supplement the wages. A typical example is that of a Ndola female teacher who was reported in the post-daily newspaper The Post Tuesday 5th August 2001 that she was engaging in prostitution. In defending her actions she argued that the salary was not enough to meet all her needs.

Though this woman's case may be an extreme one, it illustrates how desperate people could become in the cities. Many examples could be cited from College and University students in the urban who engage in risk activities as alternative means to supplement their allowances. These poverty situations cause higher HIV and AIDS infections.

Another important factor that may account for the low HIV and AIDS cases in rural areas, though they may be poorer, is the strong socio-cultural fibre. Many communities still uphold cultural moral values. It is an embarrassment to the family and community for a man to have multiple girl friends. If a man loves a woman, he is expected to marry and settle. Moreover, it is the same with women. It is socially unacceptable for women to change partners, even though it is one at a time. Moving from one partner to another shows loose moral values. The community ensures that the values are upheld.

This strong moral fibre and cultural conservation reminiscent of many rural African communities reduces HIV and AIDS infections in comparison to the urban communities. However, this does not imply that all rural practices reduce HIV and AIDS, since some actually fan it, as discussed above. Therefore, though the rural communities may be poorer in terms of global indicators, the people are likely to survive even with little or no cash. Hence high morality coupled with livable environments reduces the prevalence of HIV and AIDS, which is not the case in cities.

To close the discussion, the initial question could be posed again: how then does poverty increase or cause HIV and AIDS? The answer is twofold: Firstly, from the discussion it emerged that poverty increases poor people's vulnerability to HIV and AIDS (i.e. poverty is a push factor). It leaves poor people with little or no alternative but to indulge in risky HIV and AIDS activities. Secondly, it accelerates immunity depletion due to poor nutrition (i.e. the poor infected person dies sooner). Having seen how poverty causes/increases HIV and AIDS, how then does HIV and AIDS increase poverty in turn?

3.12.4 HIV and AIDS to Poverty

Poverty is a factor that facilitates the spread of HIV and AIDS, as it has been discussed in the previous section. Poverty pushes one to engage in risk behaviour leading to the contraction of HIV and AIDS. HIV and AIDS in turn cause poverty by directly draining the resources of the affected people.

However, while our interest lies in the impact of HIV and AIDS on the family/home, it is also important to note that the home/family exists in a web of other macro factors as outlined above. Okonmah (2003:8), therefore, in agreement with Danziger (2000:41-55), International Water Sanitation Centre on Poverty alleviation, and Colvin & Sharp (2001) On HIV and AIDS, succinctly sums the poverty facets caused by HIV and AIDS.

HIV and AIDS have impoverished individuals, families, communities and governments. Individuals and families are constantly faced with an exorbitant medical cost, depleting all their savings and even forcing them to dispose of their assets such as land, houses, etc. with government funds and household savings being diverted to purchase health and health related goods and services, less capital is available for investment and ultimately resulting in a significantly stunted growth in the economy (GDP, GNP and employment). Erosion in the human resource base, due to HIV and AIDS deaths, has also resulted in a reduced growth in productivity, capital generation, and labour industries. Agriculture, mining and crude oil extraction account for a significant proportion on the GDP in most of the African countries where they also serve as the major sources of employment for the people (Okonmah 2003:8).

The above summary by Okonmah is useful as a starting point to focus specifically on how the pandemic impacts on individual families.

3.12.4.1 Loss of Income

Some employers require a medical report from employees. If one is HIV positive then they may be reluctant to employ him/her. Greyling (2001: 5) notes that many employers seeing the impact of HIV and AIDS on their workplaces are not employing staff with full benefits, but rather take them on as temporary staff with no benefits such

as medical aid, etc. This then means that pensions, etc. will not be available to meet family needs when they are most needed and payouts will no doubt be consumed as they are received, not invested or kept until all other resources have been exhausted. Loss of income can also be extended to include agriculture. Families that rely on family labour (subsistence), especially healthy parents will be severely affected when parents are bedridden.

3.12.4.2 High Health and Funeral Expenses

An HIV-infected woman appeared on ZNBC-TV news (19:00h) on 15 June 2004 explaining that she was spending K450 000 on antiretroviral drugs before the government intervened. This is example of how HIV and AIDS can drain a family's savings. In other poorer African countries, proper medical care is only offered in private hospitals because government hospitals have no drugs and are understaffed. This means HIV and AIDS- infected people have to incur huge medical expenses in these hospitals. The researcher's brother had to sell his two cars in order to meet medical costs before he eventually died in 2002. It is a heart-rending experience to see a person becoming poorer each day as HIV and AIDS drains family resources.

Luo, Kasochi, Bowa, and many other writers on HIV and AIDS agree on how health and funeral costs impoverish a family; Luo (2001:5) sums this up in the following words:

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 infected person increases 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 a very expensive but important element 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 a death is most serious on poorer households.

3.12.4.3 Increased Dependency Ratios and Orphans

One of the advantages of Africa's extended family structure in the wake of HIV and AIDS pandemic is the close-knit relationship- network. It allows for easy orphan adoption. However, in many communities this is a fading practice. Nonetheless, even in places where it is still the case, there has been a shift from chiefly being agrarian to wage living. In many cases the few young and active parents are the ones employed in manual labour. However, with HIV and AIDS infecting young people, often grandparents are the ones left with the burden of caring for grandchildren. This scenario is clearly depicted in the story below narrated by a grandparent (Lucy) in Cohen's paper.

By the time my son became ill with AIDS, one of my daughters-in-law had already died for tuberculosis, and the other had become mentally sick. Therefore, I was the closest person to my son. I had to resume the role of a mother caring for her sick children. I was the only one who could ensure that their physical and emotional needs are met. It was very touching to nurse my sons again and watching them bed-ridden and deteriorating day by day. My heart shrunk whenever I thought of caring for my grandchildren after the death of their fathers. Their sickness had started encroaching on the savings I had made for my own welfare in old age. It was very painful watching them die. When I was a young girl of 17 getting married, I never dreamed that someday I would see three of my sons die. My sons left behind 6 orphans, and now I am once again a mother to children ranging in age from 8 to 15. Two of my grandchildren were also HIV infected. One has already died, and one is still living at age of 8, though she has started falling sick. I am taking care of them alone because in our culture, it is the family of the father who must care for orphans. This is a great challenge having to look after young children again after counting myself among those who had graduated from the responsibility of being a mother. Before my sons became ill, I had hoped that my role as a grandmother would be to care for my grandchildren occasionally during school holidays, but now I am alone in caring for them. In the old days, children were not exposed to so many outside influences, but now Uganda society has changed so much. I find that some of the tactics I used to instill discipline in my own children no longer yield the desired response from my grandchildren. I find the children less respectful and undisciplined in spite of my effort. I feel so sad that I have gone back to the beginning and I have to struggle to get resources to ensure that their basic needs are met, such as school fees, medical care, clothing and other needs. Lucy

When parents die as Lucy narrates in the above story and there are no people to look after the orphans, they become vulnerable. They easily become the poor of the next generation (i.e. generating a culture of poverty). Kavina's story below also from Cohen shows this situation clearly.

My names are Kevina Lubowa. I am 14 years old. I have 4 brothers and 3 sisters younger than me. I come from Uganda. I am studying in Primary six. I have come here to say something about AIDS and its problems. AIDS means acquired immune-deficiency syndrome. It's a terrible disease. It killed both my mother and father in 1992. It killed all brothers and sisters of my father. It has killed many men and women in Uganda. Some houses have been closed. However, our house was not closed because my father and mother left me with four brothers and two sisters. I look after them. I also look after my grandfather who lives near us, because his wife died and nobody was there to look after him. He is 84 years old. He lost his wife in 1992. The grandfather does not see. He has eye problems. It is me who looks after the family. From school, I go to bring water from the well. I take a jerrican on my head. I tell my brothers and sisters to go in the bush and collect firewood. Sometimes, when we don't have fire, we go and get it from our neighbours. We cook potatoes, matooke, pumpkins and cassava. However, my brothers do not want cassava; they want only matooke. Our banana plantation is now a forest. We dig in our plantation on holidays and on Saturday. Our food is not enough. Some days we don't get food. We eat cassava with boiled water as sauce. We don't have money to buy sugar or tealeaves. In the evening I make up beds for my young sisters and brothers. Every week we cut grass to use as our mattresses. We all sleep together and cover ourselves with blankets. Sometimes, we sleep in the corner of the house because our house is leaking. Our blankets get wet and we put them near the fire or in the sun to dry. There is the problem of diseases. We get sick and go to the dispensary. At the dispensary they want money but we don't have the money. They give only tablets. We foot from home to the dispensary. You cannot stop a car because they also want money. Old women help us and give us leaves and Mululuza to chew. This helps to get rid of fever. Because I am a girl people think I am weak. Therefore, they come home and steal our cassava and firewood. Because I am a girl even when I see them I can do nothing. Some people in the village are not friends. They shout at us, they don't give us advice; we don't have one to call father or mother, we feel sad when we see other children laughing with their father and mother. In short, this is how I find life. However, other orphans have the life. They don't have blankets; they don't eat meat; they don't have sugar, they sleep in huts. Some go to eat at the neighbours or they get one meal a day. At school, life is good. The teacher calls us orphans, but I don't want that name. Even other children don't want that name. We think we are animals. My friends, I am concluding by saying that the life of an orphan in Uganda is bad. Some people want us to work as their house girls and houseboys. Now we want good food, blankets, education and many other things.

We also want to live in good houses. Therefore, orphans need help. We need to grow and to be proud and happy. Let me stop here. Thank you very much.
Merci beaucoup
Kevina

3.12.4.4 Summary: HIV and AIDS to Poverty

Lucy and Kevina's stories are two examples of the many stories that people affected by HIV and AIDS can narrate. Many African people have experienced the HIV and AIDS death of either a close relative or friend and they can easily relate to them. The key points of this discussion could be summarized in various ways, but importantly what emerged either explicitly or implicitly from the discussion could be hinged on the following three assertions. HIV and AIDS causes poverty through:

- Draining households' income (also through unemployment) by increasing health and funeral expenses, which may lead to liquidation of assets such as land, livestock or goods like a car to cover expenses. Furthermore there is loss of subsistence labour.
- Consumption on family spending (e.g. food and general upkeep) in HIV and AIDS-affected households decline significantly, while medical care costs rise.
- Orphans are less likely to attend school (or at least get quality education), hence they are unlikely to be employed and are also vulnerable to seduction and infection, becoming the poor of the succeeding generation (poverty culture).

The issues discussed above are evident in many communities where churches are located in Zambia. The church, therefore, should be sensitive to people who are in such situations.

3.13 Preliminary Conclusion

Chapter three is the longest of this thesis, because it has covered the core issues of this thesis that is HIV and AIDS and poverty. The chapter has dealt with the overview of HIV and AIDS information and issues related to the pandemic in Zambia. The

information discussed in this chapter is to help churches and community leaders to be well informed about the situation of HIV and AIDS in Zambia.

The church people who are the pastoral care givers should have accurate HIV and AIDS information on definition and description, origin, infection, transmission and statistics in order to offer effective and informed care.

In Zambia HIV and AIDS prevalence has dropped from 20 percent to 16 percent. This rate is still a concern to Zambians. The ages mostly affected are 15 to 49, these are the productive ages in Zambia, that is why the situation is still alarming.

HIV and AIDS definition and description: the difference between HIV and AIDS should be emphasised. HIV is the virus that would eventually lead to AIDS. AIDS is a condition in which the body is susceptible to any infection, since it can't defend itself. From HIV infection to AIDS it takes 10-15 years or even longer, depending on the attitude that the person adopts and the availability of antiretroviral drugs. Therefore, pastoral care should emphasize that being diagnosed HIV positive does not mean that you will die tomorrow. There is still life beyond infection.

Infection, transmission and statistics: HIV is passed on from an infected person to the next through unprotected sexual encounters, through blood transfusion and mother to child. When the HIV enters the body it attaches itself to the CD4 cells (i.e. special type of white blood cells) and multiplies. The body's immunity system declines since the defence system is being destroyed. When the CD4 cells are less than 200 the person is diagnosed as having AIDS. In this condition the body can't defend itself and is open to any invasion, hence the person can die from any disease. When the HIV enters the body, it progresses through various stages, but poverty and negative attitude may accelerate the process to life.

The Zambian perception of HIV and AIDS has a psychological faction. The affected are considered innocent but victims of angry supernatural forces. The community, therefore,

view them as people deserving assistance. However, this interpretation has negative implication for people's sexual behaviour. People may not be held responsible. Pastoral care, therefore, should be aware of the Zambian worldview when erecting support systems.

The foregoing discussion of Zambia contextual understanding of HIV and AIDS attempted to highlight the basic HIV and AIDS information in the light of the Zambian context. The assumption of the chapter is that HIV and AIDS information on it's on to pastoral care givers and counsellors may not address the core difficulties, anxiety and despair associated with coping with the HIV and AIDS situation among Zambian peoples. Therefore, understanding the Zambian world view would allow pastoral care to further focus on deep complexities underlying the affected people rather than focusing on superficialities. One such complex feature underling the Zambian epidemic is the intricate link with Zambian poverty. Hence pastoral care, apart from focusing on HIV and AIDS information and Zambia worldview, should unravel the poverty-HIV and AIDS link for it to be relevant. The following question, which introduces us to the next section, can therefore be posed: what is the relationship of HIV and AIDS with poverty in Zambia?

The premise of this chapter is that poverty and HIV and AIDS are an inter-related phenomenon. Hence the following basic question was posed: what is the nature of the poverty and HIV and AIDS relationship in Zambia? In addition, from the main question, further questions were asked to illuminate the discussion. What is poverty? What is the biblical meaning of poverty? What is the nature of the poverty and HIV and AIDS interplay?

The following observations and conclusions emerged from the discussion:

- Poverty is a term that is difficult to define clearly. The World Bank and other International organizations determine or define it in terms of Gross National Product

(GDP), i.e. the total value of a nation's annual output of goods and services; Physical Quality of Life Index (PQLI), i.e. the state of people's health and welfare

Standard factors; and Basic Needs Approach (BNA), i.e. presence or absence of minimal basic human requirements for life. These approaches help to quantify poverty and determine the poverty line, which is vital to determine countries that require poverty alleviation funding. Nevertheless, importantly, poverty is experiential, contextual and relative. Communities are aware of the poor among them according to their standard. And it is this approach to understanding poverty that is crucial for home-based care. The church within its community in consultation with the church members should identify the community's poor people and assist where possible.

- Poverty in the Bible is denoted by various words. In the Old Testament it is denoted by *'ebyon, dal, mahsor, ras, 'ani and 'anwim*. However, though one could attempt to understand the meaning of poor from these various words' usages, contextual usage is the most enlightening method. The authors depending on the tradition and background may use the same word differently. For instance,

Dal means a lazy person in Proverbs, but in the prophets is an object of exploitation. In the New Testament *ptochos* and *penes* denote poverty. In all the various Old Testament and New Testament rendering of the term "poverty", what is apparent is that it is also experiential, contextual and relative. The Bible people shared a common communal idea of poverty. However the general designation of the poor is one who is needy, without power, abused by those in power and lacking the necessities of life (Job 24:1-12).

- The nature of the poverty and HIV and AIDS interplay works in two directions. Poverty increases poor people's vulnerability, for example through risk

behaviour (i.e. poverty is a push factor), and accelerates immunity depletion due to poor nutrition (i.e. poor probably die sooner than wealthier people). The chief risk behaviour among others is selling sex. Other factors also like lack of access to information and preventive interventions and loss of access to care account for poor people's vulnerability. HIV and AIDS in turn exacerbate poverty as the potentially productive person in the home powerless and draw from savings. Household income is eroded through high medical and funeral costs. Employers may also be reluctant to employ HIV and AIDS-infected people; thereby, they become more impoverished. Orphans may not attend school, thereby becoming the poor of the succeeding generation (poverty vicious cycle).

Though there is an apparently clear relationship between poverty and HIV and AIDS, a simplistic approach should be avoided. The interactions are myriad, complex and not fully understood. Therefore, one is encouraged to always do a contextual analysis to determine the specific factors responsible for fanning HIV and AIDS in that particular situation.

The discussion on the interplay between poverty and HIV and AIDS reveals that the poor are in need and they should be cared for. Therefore, the following questions should be posed: what role or function can the church play to the poor and HIV and AIDS affected people? What is the theological basis for the church to be involved with the poor and HIV and AIDS-infected people? The response to these questions will be discussed in Chapter 5.

CHAPTER FOUR

4.0 CASE STUDIES ON THE ROMAN CATHOLIC CHURCH AND THE UNITED CHURCH OF ZAMBIA'S INVOLVEMENT IN THE FIGHT AGAINST HIV/AIDS AND POVERTY

In dealing with the Church involvement in the fight against HIV and AIDS and poverty, the researcher will mainly look at what the Roman Catholic Church Diocese of Ndola and the United Church of Zambia in the Copperbelt Presbytery have done. The information in this section of the research is mainly from the interviews that the researcher conducted with people working in the Roman Catholic Church Diocese of Ndola Integrated AIDS Programme and the United Church of Zambia Copperbelt Presbytery HIV and AIDS Desk.

4.1 A Case of Roman Catholic Diocese of Ndola

The Catholic Diocese of Ndola was originally part of the prefecture Apostolic of Broken Hill (Kabwe) from which it became independent in 1938. In 1959 the Diocese of Ndola was established with the first Bishop Francis Mazzien. The late Bishop Dennis de Jong was the third Bishop of Ndola. He was appointed in 1975 and Died in 2004. He was the man behind the formation of the Ndola Diocese AIDS Integrated Programme (Mulenga 2003:14). According to Fr. Benedict Ng'andwe Diocese Administrator, the Diocese of Ndola covers the whole Copperbelt province, which includes Kitwe District. There are an estimated 750,000 Catholics. The Diocese has established a large network of Catholic organizations and trained a lot of lay people. There are 74 parishes and more than 180 outstations.

In responding to the challenges posed by the spread of HIV and AIDS and poverty in Zambia, the Roman Catholic Church Diocese of Ndola has come up with an effective response in the area of pastoral care, education for prevention and social ministry. This programme is known as Catholic Church Diocese of Ndola Integrated AIDS Programme. The Roman Catholic Church has coordinated a programme of both

material and expert assistance to many communities on the Copperbelt Province of Zambia. The theological and philosophical basis of this activity is found in the threefold mission from whom the church responds to all human realities – that is, of Teaching, Serving and Gathering people in Worship. The Roman Catholic Church Diocese of Ndola has participated, therefore, in the church’s response to the pandemic of HIV and AIDS from the ecclesial perspective. The loudest response of the Roman Catholic Church Diocese of Ndola to the pandemic has been in the area of pastoral care and teaching. The teaching role of the church, however, goes far beyond lessons in sexual ethics and moral theology.

Fr. Benedict Ng’andwe the Diocese Administrator stated that: “the challenge is to love as God loves, without distinction, without limit, for he loves those who are sick, those suffering from AIDS”. He continued to say, “the church has a very long pilgrimage ahead of itself. The fact is that many members of the church, because of their frailty, still try to distinguish between the “innocent” and the guilty persons with HIV or AIDS; they try to define the criteria for God’s unlimited mercy and reconciliation and close the doors of our communities of those whom they consider to be too “Unorthodox” “sinful”, or “unnatural” in their behaviour or orientation. In this context, the Teaching church is being obliged to re-examine the consistency and credibility of messages, which it communicates in both word and practice”.

The second aspect of the mission, which Christ entrusted to the church, is service or Diaconal. The Roman Catholic Diocese of Ndola Integrated AIDS Programme has expanded the vision of church-related HIV and AIDS services far beyond that of providing health care to a more holistic approach, including both social and Pastoral activities.” Fr. Ng’andwe quoted the words of Bishop Dennis de Jong who in one of his pastoral letter said, “from our Catholic community, we speak of a ministry of spiritual and practical assistance to all AIDS patients, and their families, and friends. We anticipate that AIDS will touch every parish in the same way, through individual sufferers, or their families and friends (De Jong 20 May 1997).

Due to the clear vision of the Roman Catholic Church Diocese of Ndola Integrated AIDS Programme, it receives special assistance from organization within and outside the country. The main focus of the programme is to work with communities through pastoral care, provision of social services facilities, supply of foods, medicines, and facilitating the HIV antibody testing to those who are willing to do so, and transportation for mobile home care teams; development of oriented orphan care programmes, and alternative income generating projects for marginalised groups, such as street children, and commercial sex workers.

A listing of such service programmes could never adequately capture vitality and dedication of women and men (many of whom are HIV – infected themselves) who are giving much but perhaps are receiving more as they reach out in Christ’s name to alleviate suffering and to bring hope to those whose lives have been so deeply impacted by HIV and AIDS. Those especially called to this service include trained volunteer nurses and community volunteer lay care givers, who visits people living with HIV and AIDS in their homes. They also provide food to the poverty stricken families in communities.

The third aspect of the Roman Catholic Church Diocese of Ndola’s mission is to gather people in worship in order to deepen their relationship with God on their journey through life. One might say that the Church is indeed unique in its ability to assist or accompany persons with HIV and AIDS in confronting the final realities of life.

Although this is said and done, it must be admitted, with much regret, that the Roman Catholic Church Diocese of Ndola faith community has not responded as fully as possible to this challenge. Many priests are still fearful of physical and social contact with persons with HIV and AIDS since they persist in their ignorance about modes of transmission. In some churches leaders are extremely uncomfortable with the issues related to sexuality, which are closely linked to the situation of HIV and AIDS. Others lack the “right words” in ministering to a young man or woman who is facing death.

In spite of their many human weaknesses, pastoral ministers are however offering spiritual accompaniment to persons with HIV and AIDS.

The Roman Catholic Church Diocese of Ndola has however responded to the HIV and AIDS pandemic at times with fear, ignorance and hesitation, but often from the fullness of its mission to teach, serve, and gather a community of worship. It has been a privilege and an enriching experience for the diocese to participate in this unfolding journey of the Church to work with and for those affected by HIV and AIDS pandemic. Let us pray that the Integrated AIDS Programme will touch many lives in our communities. With this hope in mind the researcher would like to share the work done by the Integrated HIV and AIDS Programme for the Roman Catholic Church Diocese of Ndola in Ipusukilo Settlement in Kitwe District.

4.1.1 Ipusukilo Community Settlement

Ipusukilo is one of 12 community settlements on the ragged edges of Kitwe. Ipusukilo is located in one of the unplanned settlements, known as Ipusukilo compound. “Ipusukilo community is situated in the eastern part of Kitwe and lies along the banks of Kafue River. It is approximately eight kilometers a way from the town center. The community has four thousand and one hundred housing units with an estimated population of 32,800 people (Kitwe City Council Upgraded Settlement Unit Document No. 22). Ipusukilo is one of the low-income settlements in Kitwe. Most of the houses in Ipusukilo are made of abode bricks and roofed with cut drums. People in this community consume unclean water drawn from shallow wells, which are in most cases constructed near pit latrines. As a result the prevalence of diarrhoea diseases is high. Residents have very little access to services such as health care, education and leisure. The majority of the people in this settlement are not employed. Many are widows, divorced women and those men and women who were retrenched from the copper mines, which were closed due to privatisation. Many of these people spend their time patronising noisy bars where they drink.

4.1.2 Ipusukilo Home Based Care.

The Ipusukilo Home Based Care is run by the Roman Catholic Church Diocese of Ndola integrated AIDS programme. The Co-ordinator is Miss Chazanso Ndaka a nurse by profession; they have other 5 full time workers and 85 volunteers. The key to the success of this home care is the 85 volunteers, who offer counseling, social, emotional support and basic medical and nursing care for people living with HIV and AIDS and their families. They also provide links between the local health centers and the community. Allowing people living with HIV and AIDS to receive care at home has helped to reduce congestion at the hospital.

Since the bed spaces at Kitwe Central Hospital are inadequate to take in all desperate sick people, the home care programmes in the 12 townships around Kitwe are helping to relieve staff at Kitwe Central Hospital of some of the pressures affecting their work. Dr. Cheswa Mporokoso from the hospital explained that, “before home based care was established, it was hard to discharge a patient because you didn’t know if they were going to be looked after at home. We had to keep them longer until we saw that they were a bit stronger, but sometimes we had to actually force people to go home. Now it’s easier to discharge them knowing that the help will continue when they go home.” This remark by a medical doctor show how important the home based care is in the fight against the HIV and AIDS pandemic.

Ipusukilo Home Based Care programme cares for and supports people living with HIV and AIDS. It conducts HIV and AIDS education and information dissemination on the pandemic. All home based AIDS clientele access free consultation and medication at Kitwe Central Hospital. They are driven to Clinical Pastoral Care Centre in home based care programme’s vehicles from Ipusukilo and other catchments areas for specialist clinics on Tuesdays and Thursdays every week. As confirmed by Miss Daka the Co-ordinator, whilst attending these clinics the sick and care givers accompanying them are given free food provided by Ipusukilo Home Based Care. Thereafter, pastoral

visitations, feeding and medical administration continue in their respective homes managed by the coordinator and other trained nurses.

In addition to medical administration Ipusukilo Home Based Care gives monthly rations, that is, mealie meal, Kapenta (small fish), beans or soya, salt, sugar, oils, detergents and soaps to the enlisted patients within the home based care. Commenting on this good gesture, during one of the interviews the researcher conducted in the area one of the beneficiaries Mary Musonda said, “Without the medical help of the home-based care programme, we would have died. Even the free medication and medicines and care we get from Kitwe Central Hospital and the Clinical Pastoral Care Centre workers help us to improve on our total health. May God continue giving ideas and innovation to the Roman Catholic Church so that they can serve us the vulnerable even much better.” This was said by this beneficiary in recognition of what the church was doing in caring for people living with HIV and AIDS.

The other important response to the fight against HIV and AIDS pandemic by the Roman Catholic Church Diocese of Ndola in Kitwe is the establishment of the Clinical Pastoral Counseling Centre at Kitwe Central Hospital, which is now serving as an Ecumenical Clinical Pastoral Care Centre (CPCC). The Centre was initiated by the Roman Catholic Church nun-cum-nurse, Sr. Amanda Neidhart, of the Sisters of The Holy Cross Order in the early 90s and supported by the late Bishop Dennis Dejong (Kasochi: 2002: 2). She envisioned then that the spiritual care alongside the medical one result in the holistic healing of a patient. Fortunately enough Sr. Amanda spent months in 2004 at the Clinical Pastoral Care Centre and the researcher was able to get more information on the CPCC from her. Asked about the genesis of the center, Sr. Amanda narrated that:

In the late 1980s working as a nurse and Chaplain at Kitwe Central Hospital I noticed the increased number of HIV and AIDS victims and their carers who needed special counseling and care. Therefore, I proposed to the Kitwe Central Hospital Management and the Roman Catholic Church Diocese of Ndola, the idea of the center, which was

well received by both. Their good will encouraged me to source funding overseas especially from my home parish Ramen in Switzerland and from Misereor, Aachen, Germany. The late Bishop Dennis De Jong officially opened the center on 26th December 1994. The Churches then gave it to Kitwe Central Hospital Board of Management for use. She further said that she was happy that the hardworking men and women at the center today are meeting the purpose of the center. According to Sr. Amanda the CPCC was aimed:

To provide holistic care spiritual, social and psychological support – in conjunction with the medical care of Kitwe Central Hospital to HIV and AIDS patients and their families. To provide both individual and group counseling which is the nucleus of the home based care programme. To make provision for care of AIDS victims and their families at home. In 2001 the Health Department of the Roman Catholic Church Diocese of Ndola commenting on the Clinical Pastoral Care Centre at Kitwe Central Hospital acknowledged that; “The Clinical Pastoral Care Centre is an interdenominational center providing HIV information, counseling and testing and pastoral care to out and in-patients at Kitwe Central Hospital and the general public. It represents also the link between the home care programmes in Kitwe and the hospital to assure continuity of care to the chronically ill, especially the symptomatic HIV infected. The center is part and parcel of the AIDS Integrated Programme co-ordinated by the AIDS department of the Roman Catholic Church Diocese of Ndola” (Newsletter: 2001:8). Certainly the response by the Roman Catholic Church to the fight against HIV and AIDS is commendable. They have spearheaded the home based care programme and other denominations are learning from them.

In sum the researcher would say the programme seeks to address the AIDS epidemic in its widest context. Because the fight against HIV and AIDS, as well as poverty cannot be fought using a single approach but rather by employing multi-faceted approach that takes into issues of care, prevention, community development and advocacy.

4.2 The Integrated AIDS Programme

The Roman Catholic Church Diocese of Ndola has established the programme known as The Integrated AIDS. The programme deals with issues of HIV and AIDS and poverty. The Roman Catholic Church Diocese of Ndola in Zambia mainly funds it with the help from donors outside the country. The programme seeks to address the AIDS epidemic in its widest context, through the provision of holistic care, prevention, community development and advocacy. The primary target groups are people with symptomatic HIV infection and their families.

According to Chanda Fikansa the Programme Manager, most of the work is done by volunteers and various groups of people living positively with HIV and AIDS in a wide variety of activities in which some of the programme beneficiaries have become actors themselves in preventing HIV transmission and caring for those affected by the AIDS epidemic. Because of the effectiveness of the programme most communities have benefited through the provision of quality home care for the chronically ill patients of whom 95 percent have symptomatic HIV and their families. The programme is working hard to improve the lives of orphans through the provision of a package of services to orphans and vulnerable children (OVC) and their caretakers. This has contributed to an improved quality of their lives.

One of the beneficiaries Mrs. Kabanda a widow of Ipusukilo said that, “the Roman Catholic Church Diocese of Ndola AIDS Integrated Programme had improved life skills for people with living HIV and AIDS, orphan guidance, home care volunteers, an improved income base for those living with HIV and AIDS and more active role in undertaking prevention activities in their communities also, improved awareness in society of human rights, a reduction in human rights violation and a reduction of stigma.” From the interview that the researcher conducted in this community of Kitwe, people have appreciated what the Roman Catholic Church Diocese of Ndola is doing in caring for the HIV and AIDS infected and affected people and those who are living in poverty. People see the hand of God through the response of the church. Many of the

churches in Zambia have a lot to learn from the Roman Catholic Church's response to the fight against the HIV and AIDS pandemic.

To achieve this, the Roman Catholic Church Diocese of Ndola Integrated AIDS Programme has tried to improve the economic security of households in communities by providing food to families who are infected and affected by HIV and AIDS pandemic. This research has revealed that women are especially had-hit because they carry the burden of the diseases and yet are expected to care for other members of the family who are also HIV positive. With the help from the Integrated AIDS Programme many women have been helped and their burdens have been reduced. For example, food is provided to them at least once per week, and medicine is given to sick members of the families. At this point, the researcher would like to share some stories gathered during his interviews conducted in the Ipusukilo Settlement.

The first story is from Royce (not real name) a volunteer caregiver in Ipusukilo. Royce has six children and her husband works as a driver. She was one of the first members of volunteers in Ipusukilo Home Based Care trained in 1993. She narrated her experience as follows:

What helps to motivate me is the recognition I get in the community as a care giver. I also find joy in caring for the sick. Besides, I never went to school. Before joining the home-based care programme I didn't know how to read and write, or to speak English. Now I can do these things, and I have two certificates of my own from the training courses I attended. At the hospital I used to be scared to ask for any information. Now with my identification badge I am regarded as one of the staff. Nobody ever asks me where I am taking a wheel chair to, or why I am in the lab. I have full support of my husband and all the members of my family. My children are quite proud of me. Being a volunteer has also helped me to care for my family. My brother fell ill with TB and I nursed him, but unfortunately he died. Then my first-born daughter lost a child and her husband died, she developed a lot of complaints, cough, loss of strengths, night sweats and loss of appetite. When I asked her why she was losing weight she said she was depressed from losing her child and husband, People were saying she had not kept the tradition rules of mourning unripe child, so the ghost of the baby turned on the parent. However, because I was familiar with signs of HIV and AIDS, I started

wondering if my daughter could be HIV positive. I started counseling my daughter and she agreed to get her blood test for HIV and her sputum for TB. She tested positive and started treatment for TB and went back to Lusaka. Soon she was admitted in the hospital, so I rushed down there to care of her. She had so many gadgets all over her body. I have never seen so many things on a sick person even the electrical company doesn't have as many wires on a single pole. I cared for my daughter until she died. I was strong and followed all the instructions from the nurses in the ward. This was due to training and experience that I had gained in the home based care. One of the nurses even asked me if I was a retired nurse. Oh! Me! A nurse? However, who knows may be one day in the future.

The second story came from Grace (not her real name). She is one of the living testimonies of the work of the Roman Catholic Church Diocese of Ndola's work in the fight against HIV and AIDS and poverty in Ipusukilo Settlement. Grace was one of the first young women to join the income-generating group at Ipusukilo Home Based Care Center. She is 28 years old and a mother of three, she is still an active member of the group, and she is also a living proof that TB treatment can be remarkably effective in people living with HIV. She narrated her story by saying:

I was married at the age of 16, but I left my husband after our second child because he was a heavy drinker and he was always out late. I was afraid of him, so I came here to stay with my mother. During my stay with my mother life became hard and I had no other ways of making money than by selling sex. However, when my second child was about six months old, I started having chest pains, my legs were hot swollen, and I had a cough, headache, fever and diarrhea. I had to give up breast-feeding and my mother started giving my baby foods. Home care volunteers visited me and I agreed to go on their register of patients. Sister Edith visited me and they took me to the hospital, where I was diagnosed as having TB. I came back and went on to TB treatment at home. The nurses from the home care project also counseled me about a blood test for HIV. They wanted to know how I would react if the result was positive. I assured them I could accept it because I knew my own background very well. When I had the test and I was told I was positive for HIV, I wasn't shocked. Sister Edith helped me and other patients who were HIV positive and those with TB to start an income generating project at Ipusukilo Homed Based Care Center. People told me that it was no use for me have a TB treatment because I was going to die of AIDS anyway. However, I finished the course and I made a complete

recovery. I even put on weight. Now I still go for meetings at the center, where we learn about how to look after our own health. I learned about why you should avoid sex if you are positive, because you can catch other STDs or be exposed to the HIV virus again and it could destroy your body immune system. I do have personal problems, especially when I am at home on my own. I think about my future. The home based care project has helped me a lot and I have to keep living a normal life. I have lived with the virus for more than eight years now and it is my prayer to live more years to come.

The third was from Mary (not real name). At the age of 21, Mary is looking after her unemployed husband, their three-year old daughter, three young brothers and two cousins. They live in a small mud house in Ipusukilo Compound on the banks of the Kafue River. She narrated her story as follows:

My mother and father were divorced in 2000 and all the children stayed with my mother. In 2003, she fell ill and died. Our relatives came but they were only interested in grabbing the property. No one wanted to look after the children. I took them all and came to live here. Then two of my aunts died and their children came to stay with me. Some of my cousins are working as house servants in town. They are two young but I couldn't stop them because they needed to earn money for food and other basic needs like soap. Two of my cousins have to go out into the street and sell sex. One has been very sick and now has herpeszoster. The other one has a baby that is sick, I don't know what to do. The home based care volunteers visits us. They pay the school fees, buy clothes, and buy some school requirements for my brothers. They also bring us food and soap, and sometimes cooking oil. When my aunt died the home care project provided the food, the transport and the coffin for burial. I want to start selling vegetable in the market but I need some capital to start. Sometimes I wonder about getting divorced. My husband's relatives are not happy about the young orphans I look after. They think we are spending too much money on them. One day, when only the children were at home, my husband's relatives came to the house and humiliated them. When I came I found them outside the house with a note saying I should leave my husband and go join our mother in the grave. I went and told Diana (not real name) a leader of the home care volunteers in Ipusukilo who I regard as my mother. I told her what had happened with my husband's relatives and she encouraged me to ignore them and accept the situation. Diana and other home based care volunteers have been so helpful to us, but still looking after orphans is not easy. Orphans really need help from groups like the home-based care project. If they do not get help, these children will end up on the street and they will become

sick. Then the home care project will have to look after them. So I strongly believe that support for orphans is needed to prevent sickness like HIV and AIDS in the future.

The stories above are testimonies by the care givers and those who are being cared and supported by the home based care project. They are living testimonies of what is really happening on the ground in the Ipusukilo Settlement. Having discussed what the Roman Catholic Church is doing in the Ipusukilo Settlement, the researcher now goes on to discuss the case of the United Church of Zambia Copperbelt Presbytery.

4.3 A case of the United Church of Zambia Copperbelt Presbytery

The Copperbelt Presbytery is one of the oldest presbyteries in the United Church of Zambia (UCZ), it has been a Presbytery since 1945, when the first union of two churches come into being. By then it was known as the Urban Presbytery of the Church of Central Africa in Rhodesia (UCCR) (Silungwe 1987:7). This was the Union of the Church of Scotland and the London mission society.

It remained a Presbytery when the United Church of Zambia came into being on the 16th January 1965. The United Church of Zambia incorporates the Church of Central Africa in Rhodesia (Itself a union of the Church of Scotland and the London Mission Society, Churches with the union of the Copperbelt), the congregations of the Copperbelt Free Churches Council, the Church of Barotseland and the Methodist church. After this union of the above churches, Copperbelt remained the largest and strongest Presbytery of the newly formed United Church of Zambia.

The Presbytery has ten (10) consistories and covers the area of the entire Copperbelt Province, including Lubumbashi in the Democratic Republic of Congo, it has 69 congregations and 77 preaching points. According to Bishop Committee Njanse, the Copperbelt Presbytery has 290, 000 members.

The Copperbelt Presbytery of the United Church of Zambia has responded to the challenges posed by the HIV and AIDS epidemic and poverty in the province as well as the country. The Presbytery has followed the United Church of Zambia HIV and AIDS Synod policy, which requires all the 10 presbyteries to form HIV and AIDS committees.

The task of these committees is to monitor and evaluate the fulfillment of the objectives of the United Church of Zambia HIV and AIDS policy, but due to the inadequacies in the system, nothing tangible has been realised. In other words, most consistories and congregations HIV and AIDS committees have failed to implement meaningful HIV and AIDS programmes to write about. Despite this failure, however, the HIV and AIDS committees both at consistory and congregation level are supposed to maintain the core value of the church and seek to share God's love in the midst of the HIV pandemic through education and practical assistance.

The researcher observed that in many congregations of the Copperbelt Presbytery of the United Church of Zambia, preaching is done quarterly to sensitize the members of the church about the HIV and AIDS epidemic. Practical implementation on the Synod HIV and AIDS policy is not done in many of the congregations, because the Copperbelt Presbytery has no well co-ordinated HIV and AIDS projects. Some Christian Volunteers, have joined the Roman Catholic Church Parishes who have well-coordinated HIV AIDS programme. Others have joined either the Faith Based Organisations (FBO) or local NGO's that are dealing with the HIV and AIDS and poverty in local communities. Some consistories and congregations are involved in isolation; they use their initiatives and carry on the work in the name of the Copperbelt Presbytery. The question is, where is the problem? The research will address this question in chapter 5 of this thesis.

The researcher will now discuss one project that has been involved in the home-based care programme in Kitwe, Mulenga settlement. This will serve as a case study of the other similar projects in other consistories.

4.3.1 Mulenga Community Settlement

Mulenga Community Settlement is situated in the Southern part of Kitwe Town center and lies along Ndola dual carriageway. It is 7 kilometers from town center. It has 3,000 housing units and has an estimated population of 14,000 people (Kitwe City Council Upgraded Settlement Unit Document No. 22 2003:6). Mulenga community settlement has the majority of people who are not employed. Most settlers are widows, divorced women and those men and women who have been retrenched from the Copper Mines and other parastatals companies which have closed due to privatization. The community is a well-known place for brewing local beers and prostitution. It was in this settlement where the researcher was inducted as a minister among the poverty stricken people. He managed to conduct pastoral visitations in most of the houses of the Christian members of the congregation, who are suffering because of poverty, some of them can just afford one meal a day and during some hard times they go without a meal.

The researcher now shares Mrs. Banda's (not a real name) story as an illustration of the situation of poverty and its effects on the people of Mulenga Settlement. One day the researcher visited a house of Mrs. Banda a widow. When he asked her where her two boys were, who are members in the researcher's church had gone, she told him that she sent them to the road side to pick the grain so that they could grind it into mealie meal and make Nshima (a thick local porridge). The children did this often. After the researcher explained who he was, she agreed to have a conversation. When he asked her what she did for a living, she looked at him for some time then looked down and sighed before she narrated her story:

“My husband was discharged in 1994”, she began. “He was our sole bread winner. I was a full time housewife and mother. I thought I would never have to earn an income. Food was never a problem and everything was well with us. We managed well with my husband's income”. Things changed after my husband left the army. He did not receive his benefits for two years, which meant the family had no income. My husband couldn't cope and died of depression in 1997. Though his benefits came before he died, most of the money went to repay the debits we had accumulated. We experienced serious food shortages. We often went

without a good meal for several days. My children always were hungry and sad faces. I tried to sell vegetables but everyone else sold vegetables, too. Whatever I sold didn't bring much." I had no choice but to send my children to beg in town and clean the maize that dropped from trucks passing along the road. But this is no solution I had to find food for my family." She paused, looked down with clenched fists, hit her chest, and said, "Against my own will minister, against my faith, I have become a walker. I sleep with men for money. At first it tormented me and I found it extremely hard to understand to day I do it with less difficulty." Don't ask me about sexually transmitted diseases," she said, "I may or may not be a carrier. But as long as I can afford a meal for my family, I am happy. I know that one day sooner or later I will die of AIDS," she said on the verge of tears. "But I can tell you that I find hunger more deadly than AIDS. AIDS kills in years. But hunger kills within days."

She never mentioned school, health, entertainment or clothing, but only food. The researcher then realized that when you have no food, you have no choice. This story explains the extent of the suffering of people in Mulenga community and why the researcher has said HIV and AIDS and poverty are intertwined in spreading the virus. However it should be noted here that poverty does not cause AIDS but creates environment, which militates against treatment and alleviation of suffering.

One day when the researcher came from the cemetery after the burial of his beloved and dedicated steward the late John (not real name) who died from HIV and AIDS related illnesses, the researcher sat in his small vestry office and looked in the direction of the main entrance of the Church building. He reflected on the story of Mrs. Banda, her suffering and that of many other members of the community, the researcher wept when he remembered all the terrible suffering in their midst caused by poverty and the deadly HIV and AIDS epidemic. The researcher thought of how his sisters and brothers in the community starved to death after trying any remedy they could think of, but alas all in vain. The rate of death they experienced in a week in their congregation is unbelievable. They could not bury according to their traditional customs, which required the funeral to be held for three days before burial, to allow all relatives from different places to come and witness the burial. But nowadays it is only held for just a day and burial takes place. The researcher discovered during his pastoral visits that,

people were abandoned by their relatives, who pretended not to accept that, HIV and AIDS was real. They left their dear ones without any care dying in their homes, and moved to other settlements and towns. The researcher imagined how his fathers, mothers, sons and daughters some as young as two years, were suffering from the disease, HIV and AIDS. As a result some die and were given to the congregation to take responsibility of the whole funeral arrangements, because of the economic hardships in the families. The researcher's prayer that day was:

O Lord what shall I do?
O God we are badly hurt and we have septic wounds in our hearts.
For all that is happening in our presence, we need to do something as a church.
God of love teach us to love and care for the need.

This was his turning point from that day the researcher committed his life to the care of people living in poverty and those living with HIV and AIDS. In 1999, he met Mr. Emilio Kunda a leader of Twafwane Home Based Care, which is an inter-denomination, with its membership mainly from the United Church of Zambia, the Roman Catholic Church and other churches within Mulenga Settlement. Mr. Kunda was very happy when the researcher pledged his support for Twafwane Community Home Based Care, the only one in Mulenga community settlement.

4.3.2 Twafwane Home Based Care

Twafwane Community Home Based Care is a group of Christian volunteers mainly from Mulenga U.C.Z congregation. (Twafwane) means "Let us help each other". It started in 1998 by some of the members from United Church of Zambia Mulenga congregation, then other members from different denominations joined in the programme, after seeing the good works the group was doing in the community. Twafwane Home Based Care has 56 members and is headed by Mr. Emilio Kunda the co-ordinator. It gives care and support to chronically ill patients who suffer from Tuberculosis (TB), HIV and AIDS and are poverty stricken in Mulenga Community. With inspiration from Emilio Kunda the Leader of the home based care, the group grew from 12 members in 1998 to 56 members in 2004.

So far Emilio has managed to recruit many volunteers from several local churches. At first a group of 28 volunteers from Twafwane Home Based Care were trained over a two months period, and began to visit families in their neighbourhood to identify people who had been sick for a month or more. The Home Based Care Programme developed slowly at first by 1998 only 32 patients were registered and visited. “Some people refused to be visited because they were afraid of being stigmatized by their neighbours as AIDS patients,” Recalls Rose Mwika (not real name) who is one of the first volunteers to be trained.

In 2000, another 100 patients joined, many of who had TB as well as HIV and AIDS related symptoms. To the great dismay of the volunteers, many people with T.B died. At this time T.B patients were kept in hospital for at least the first two months of treatment. After discharge they had to take their medication at home and return to the hospital regularly for fresh supplies and follow-up sputum analysis. As Chanda Bwembya (not real name), one of the volunteers narrates: We asked ourselves why many T.B patients were dying and we realized that they were not taking medicines. Therefore, we thought that if we went to the patients’ homes and watched them swallow their medicines, it could help. Therefore, that is what we did and many T.B patients started getting better and eventually cured.

This was not yet the fully developed strategy of T.B treatment known as DOTS (Direct Observed Treatment, short course) promoted by the World Health Organisation, which was introduced into, Mulenga compound in 2002. It demonstrated, however, that local volunteers had an understanding of the health behaviour in their own community, and that they were capable of creative responses to their own health problems. What they needed was training, guidance and resources to help them carry out the work effectively. It is because of this ability that communities have which makes the home based care an effective model of caring for people living with HIV and AIDS and chronically ill patients.

Twafwane Christian Community Home Based Care entered a period of accelerated growth in 2003 when the Church Health Association of Zambia CHAZ recognized it, and it was funded. The funds were used to train the 56 volunteers in counseling and Short Direct Observation Treatment (DOTS). The training also included volunteer Christian nurses from Ndeke government clinic. This helped all the trained volunteers with professional nursing care hints which are key factors in care giving to those who are infected and affected by HIV and AIDS and related problems.

The researcher has worked with Twafwane Home Based for three years now, and has participated in home visitation and offering counseling to the patients in the homes and at the church. His personal experience with the home based care has convinced him that the church is the best organization which can successfully carry out community home based care programme. This is because of the commitment of the Christian volunteers who work for the love of others and the well being of the community.

Although Twafwane home based care is spearheaded by the United Church of Zambia (U.C.Z) members, it receives no financial support from the Church apart from the spiritual guidance and the use of the church building where most of the things are done through the initiative of the members. In 2004 the government also funded the programme, through ZAMSIF to construct a center where volunteers could be meeting instead of using the church building. This building is now complete and it has boosted the interest of many more volunteers. According to Mr. Emilio Kunda, by August 2004, some 240 people were on the patients' register. A total of 982 people had been registered with the programme since its inception in 1998. Many had since died, some have left the township and a number of former TB patients had been removed from the register because they no longer need care and support. Twafwane Care Center is the base for 56 volunteers, who make home visits to chronically ill patients three days in a week. Each is equipped with basic drugs and medical supplies from Ndeke clinic; trained health volunteer workers accompany most of the time volunteers. The story below explains the experience that the home based care go through.

The story shared here was given by Ruth (not real name) a 48-year-old volunteer from Mulenga settlement and a member of Twafwane Home based care. Ruth is a widow and looks after six orphaned children; she narrated her experience as follows:

I am happy to tell you that we are united as Volunteers and we help each other, my fellow volunteers supported me a lot when I was nursing my only daughter who passed away after some time of nursing her leaving me with two grandsons aged five and ten. I have been trained as a health volunteer, so I knew my daughter was suffering from AIDS and the younger boy could be HIV Positive. I was to be trained as a volunteer because I was interested in getting more knowledge about health issues. We learned about how to care of the sick and protect ourselves. The community recognized us and respects us. However, sometimes I do think about giving up. For example, during the rainy season when my roof is leaking and am out in the community attending to patients and when I go home just to find that all my belongings wet. Moreover, sometimes the work is unpleasant. As for what happened one day, when I went to visit a house of a sick person in our community, upon reaching the house I opened the door and there was an overpowering smell like decaying corpse. There on a mat in front of me was this poor bundle of humanity, like a lamb waiting to be slaughtered. I opened the window and saw that the man's body was covered in sores and maggots. Moreover, the pain in his eyes, he was abandoned by his relatives. There I was alone with this burden. I thought, "Doctor" where are you? Sister, where are you? This is unbearable. O God how can I go on? Isn't there some one out there who cared about me, a volunteer with limited knowledge, left to do this work? What keep me going are my religious faith, and the support of the nurses and my fellow volunteers. I do appreciate the support I get from the project for orphans I look after. I like the meetings we have with volunteers from other places to share knowledge and interact with each other at times we exchange gifts. However, the volunteers need some kind of project to earn some money together to sustain us in our every day living. "Sometimes the situation seems hopeless because the number of people with AIDS keeps on increasing. However, people here are becoming more concerned about AIDS and more helpful to one another. Those who were afraid of people with HIV and AIDS are being educated and are gradually accepting them. Sometimes I wish there was some kind of reward for what we do. However, I can't stop now I am too deeply involved. My finger is woven into the basket.

Nevers (not real name) narrated the other experience. Nevers is 44 years old and a father of six, he has been a home based care giver volunteer in Twafwane Home Based Care in Mulenga settlement. He narrated his experience as follows:

I was recruited as a volunteer when the Home Based Care started here in Mulenga. At first there were three of us men and 42 women volunteers, but one man moved away and the other dropped out. Now I am the only man who is a volunteer. I work as a road technician for PUSH (Programme for Urban Self Help). I visit patients on Saturdays, with the other volunteers from our section. At the moment we have 36 patients. Each one of us visits about ten patients in a day. If someone is really sick the relatives call for me and I go right away to see them, and arrange for nurses to visit. When we visit a patient we ask how they are feeling. We also talk with the members of the family. Sometimes we find that the relatives are fed up with looking after the patient for such a long time, so we try to give them some encouragement. Some of the relatives want to leave everything to us, like washing the patient's dirty bedding. We explain to them that the patient isn't our relative but theirs. We are only helpers. What does encourage the relatives is when they can get food for patients. That really motivates them. TB patients sometimes give us problems they don't want to take their medicines. So we visit them everyday to make sure they do. The people in the neighborhood appreciate our work. Other men used to laugh at me and say I was wasting my time. These people have got relatives to look after them, they would say. I could only reply that I liked the work and found it interesting. Now some other men are interested too, and one wants to become a volunteer. I am still discussing the few things with him, and the other volunteers in our section have also agreed. When I go for a drink with my friends we talk about AIDS sometimes. I tell them that this is the situation we are in and that we ought to look after ourselves. We have to keep to one partner, we have to use condoms. What do I get out of this work? Well I have learned a lot that can help other people and my own family. Now I know how to attend to my children if they are sick. We do not get any money from Twafwane Home Based Care. When I first joined it was announced in church that volunteers would not be paid anything so I never expected any money. But the work has made me known in the community. People recognise and respect me. They know I work in home based care. I take my work as a call from God, and I do it for the community.

These stories challenge the church to look after the community volunteers, not to take them for granted. Community care givers need compassion, encouragement and support.

In chapter five the researcher will discuss the community care givers who gave the moving stories in this Chapter.

4.4 Preliminary Conclusion

The Roman Catholic Church Diocese of Ndola has a well co-ordinated programme in their response to the challenges of HIV and AIDS and poverty. A good example is the Integrated AIDS Programme, which is a working department of the Roman Catholic Church Diocese of Ndola. The programme aims at addressing the AIDS epidemic in its widest context for the most vulnerable people in society through: the provision of holistic care to people with symptomatic infections and their families, prevention of the further spread of HIV; community development, and advocacy. The case studies show how the Integrated AIDS Programme is providing home based care for people with symptomatic HIV infection and their families. The home based care has improved and strengthened the quality of service in communities.

Home Based Care consists of the provision of medical care, nursing care counselling, testing and prevention services to chronically ill people and their families through 11 established community based care programmes from which Ipusukilo was picked as a case study. The community volunteers and nurses carry the above duties through home visits of the bed-ridden patients within their homes and static clinics for ambulant patients at designated central places within the community. The stories documented in this thesis are a good example of what the volunteers do in communities. The community volunteers and nurses provide the spiritual care to the people living with HIV and AIDS including their families.

Although the response of the Roman Catholic Church Diocese of Ndola is commendable, the researcher's concern is the lack of clergy participation in the fight against the pandemic. Because of this concern the researcher feels that, the Roman Catholic Church Diocese of Ndola has not responded as fully as possible to the challenge of HIV and AIDS which result in poverty. Many priests are still fearful of physical and social contact with persons with HIV and AIDS; it might be due to

ignorance about modes of transmission. May be it is lack of interest or they do not just care. It is because of this that still the Roman Catholic Church Diocese of Ndola still is challenged to respond fully that with the participation of the clergy in the fight, then it will become a symbol of healing in community.

As already stated in this thesis the United Church of Zambia Copperbelt Presbytery has no coordinated programme that the researcher could site. The only programmes are from the congregations' initiatives. The good example sited in this thesis, as a case study is Twafwane Home Based Care in Mulenga compound, which is partly a congregation initiative and partly a community initiative, but receives no help from the Copperbelt Presbytery.

As observed during the field research, the United Church of Zambia has good plans on paper of what it intends to do as a response to the challenges posed by HIV and AIDS and poverty. Also its pastors and lay people seem to be willing fully participate in the fight, but they lack leadership in this area. Perhaps what the United Church of Zambia needs to do is to take leaf from the Roman Catholic Church Diocese of Ndola in terms of its programme formulation and implementation. And a good example in this regard could be how the Roman Catholic Church Diocese of Ndola has managed to coordinate its Integrated AIDS Programmes

From the case studies in this chapter the question, which introduces us to the next chapter, can therefore be posed: What is the response of the Roman Catholic Church Diocese of Ndola and the United Church of Zambia Copperbelt Presbytery to the challenges of HIV and AIDS which result in poverty.

CHAPTER FIVE

5.0. THE RESPONSE TO THE PROBLEM OF HIV/AIDS AND POVERTY BY THE ROMAN CATHOLIC CHURCH AND THE UNITED CHURCH OF ZAMBIA

In chapter four the researcher dealt with care givers who are involved in caring for chronically ill patients and the Home Based Care (HBC) totally depends upon these care givers.

In the case studies the researcher just mentioned them without explaining who they are and their primary functions. The following four questions will be discussed. Who are the caregivers? Why care givers? What does care giving entail? How can the Church become compassionate to care givers?

5.1 Care Givers

1. Who are the Care Givers?

It is important to know who the care givers are. A person who takes care of the sick is referred to as care giver. For example, these could be, mothers, grand mothers, sisters or aunts and other people with compassion to sick people in community. This leads to the question, why care givers in the HIV and AIDS era?

2. Why Care Givers?

The researcher is sure that within the community or church we have heard of care givers, some of who have chronically sick people in their families. In the HIV and AIDS struggle, care givers are central actors, as long as HIV and AIDS remains incurable. The chronically sick people need care and spiritual support. It is because of the need of care to people living with HIV and AIDS which has made the HBC a central strategy and therefore the researcher will examine what it entails.

3. What does care giving entail?

In Zambia the concept of HBC became a central strategy to the HIV and AIDS struggle in the mid nineties when more and more people began to move from HIV positive status to the stage of AIDS. That is many people who had been living with the HIV virus were beginning to get ill since their much immunity had been gradually depleted over the years. Hospitals, doctors and nurses became increasingly stretched and in some cases 65 percent of beds in the hospitals were occupied by people with AIDS related illnesses (NAC 2000: 6). It became clear that care giving could not be left to the hospitals alone especially since without access to Anti Retroviral (ARV) drugs most patients were unlikely to get significantly better, rather more likely to get worse with time.

HBC was thus programmatically designed particularly to meet the needs of the terminally ill. The National HIV and AIDS / STD / TB Council Report 1996 – 1998 states that:

Rapid increase in the incidence of HIV and AIDS clearly has implications for the National Health system's ability to cope with the provision of medical care to both HIV and AIDS and non HIV and AIDS patients. HIV and AIDS related admissions are beginning to dominate patients' admission at hospitals. Indeed, AIDS related admission at all central hospitals and University Teaching Hospital, in Kitwe, Ndola and Lusaka have increased by five fold in three years, with AIDS now being the most common diagnosis for the medical ward admissions, and accounts for 40 percent of the total death in the ward. If Zambia's medical system is to maintain or for that matter, to improve the quality of medical care, there is a clear need to address this new stress that is being brought by AIDS. As with most countries in the world, this solution has been found to lie with Home Based Care (HBC) programme. Zambia is suited for this programme for a number of reasons. First, the family in Zambia is traditionally the caring unit in the society and therefore the programme builds on it will most likely be successful and effective. Secondly, studies elsewhere have found that terminally ill patients prefer to die at home (NAC 1997: 10).

The above quote gives us the challenges that led to home based care in the mid-nineties. You will note that part of justifying HBC, the study holds that ‘the family in Zambia is traditionally the caring unit’ while this is true, the researcher is sure that you will agree with him in saying that with HIV and AIDS epidemic, the family, just like hospitals is over stretched in the demands of care giving. Thus it has become evident that ‘family care givers and members of the HBC team frequently experience burnout. “Burnout is the result of excessive emotional and physical strain without necessary care to support care givers” (WHO 2002: 43). We must underline that twenty-four years into the HIV and AIDS epidemic, compassion with and to care givers is therefore necessary. Is the Church called to care? How can the Church become compassionate to and with care givers? Before we explore these questions let us look on what does care giving involve?

Most probably some of us have been care givers to friends or family members at one point or another in our lives, even if it may not have been for a terminally ill person. If so, we have an idea about care giving and care givers. You may have received care from friends or family. In such times, care givers become our hands and feet, standing in for our low health. In their study on Community Home Based Care in Resource Limited Setting: A Framework for Action, WHO outlines four departments in care giving: basic physical, palliative care, psychosocial support and counseling and care of the affected and infected children. In physical care, the WHO study document notes that:

Basic nursing care includes positioning and mobility, bathing, wound cleansing, skin care, oral hygiene, adequate ventilation, and guidance and support for adequate nutrition. Symptom management depends on the ill person’s condition. However, basic symptom management includes: reducing fever, relieving pain, treating diarrhea, vomiting and cough, skin, mouth-throat, and genital problems and general tiredness and weakness and treating neuron physical symptoms. Palliative care is the combination of active and compassionate long term therapies intended to comfort and term therapies intended to comfort and support individuals and families with long threatening illness (WHO 2002: 35-36)

Given that most Aids patients on home based care are in fact terminally ill, the demands on care givers are constant. Some care givers can no longer go to work. However, since

the care is also medically and nutritionally demanding, when the care giver and the patient are both out of work, the circle of poverty is only bound to thrive, for the concerned family, especially because most AIDS patients are breadwinners. Compassion to care givers to avoid burnout and circle of poverty is central.

4. How can the church become compassionate to care givers?

To answer the above question the researcher begins by looking on the Biblical perspective on care giving (Luke 10:25-37). Is the church called to the ministry of care giving? According to Gideon Byamugisha, “The church with its members is called to the ministry of care giving. This means promoting the acceptance of people with HIV and AIDS, fighting against their discrimination and involving them in developing programmes which address the needs of the people” (Byamugisha 2000:31). We are aware of the story of the Good Samaritan in the Bible:

Just then a lawyer stood up to test Jesus. “Teacher” he said, what must I do to inherit eternal life? He said to him, what is written in the law? He answered, you shall love the lord your God with all your heart, and with all your soul and with all your strength, and with all your mind and your neighbour as yourself. He said to him, you have given the right answer. Do this and you will live. But wanting to justify himself, he asked Jesus, but who is my neighbor? A man was going down from Jerusalem to Jericho, and fell into the hands of robbers, who stripped him, beat him and went away leaving him half dead. Now by chance a priest was going down that road; and when he saw him he passed on the other side. So like wise a Levite, when he came to the place and saw him, he passed on the other side but a Samaritan while traveling came near him, and when he saw him, he was moved with compassion. He went to him and bandaged his wounds, having poured oil and wine on them. Then he put him on his own animal, brought him in an inn, the next day he took care of him. The next day he took out two denarii gave them to the innkeeper, and said, take care of him and when I come back, I will repay whatever you spend. Which of these three do you think was a neighbour to the man who fell in the hands of robbers? He said, the one who showed mercy. Jesus said to him, go and do like wise (Luke 10:25-37 NIV).

This story was given to answer the question of who is my neighbour! Jesus’ answer illustrates that a neighbour is one who is ‘moved with compassion;’ to enter your situation and to give care as long as you need it. A neighbour is one who does not spare

himself or herself in giving care. The man used his hands, oil, animal, money and time to give care to this almost half dead man. We must also note that Jesus gives the example of people who walked away. They refused to enter the situation of man who was left for half dead. They refused to be moved by compassion.

We also note that both of them were outstanding religious figures: a priest and a Levite. Why were they not moved by compassion to remember what the law said, “You shall love the Lord your God with all your heart, and with all your soul, and with all your strength, and with all your mind, and love your neighbour as you love yourself” (Mark 12:28-32). The moral aspect of the story is to warn all of us who are believers that our faith loses character when it lacks compassion. Perhaps it was not that, may be Jesus wants to underline that no matter what social class you hold in your society and faith community you should not ever think giving compassion to the sick through care giving is optional for you. Clearly Jesus is saying neighbourliness shall be measured by our compassion to others. Jesus said the sick and hurting must be given care, medicine and nursed back to wellness. He is also saying, where there is no compassion there is no neighbourliness and where there is compassion there is neighbourliness.

Lastly, the researcher thinks it is notable that Jesus featured men in a story that illustrates neighbourliness through care giving. In Zambia, men are not so involved in care giving. As we have already seen in the case studies, women in all the two churches researched on are the ones involved. Consequently women, grandmothers, mothers and the orphaned girl child are burdened by care and driven to poverty. The fact that Jesus featured a man as a care giver is instructive, which is also noted by many scholars. He featured a Samaritan as “the good neighbour as compared with Jews, the Priest and Levite”. Samaritans were despised by Jews (John 4:9). The researcher thinks the story is internationally subversive both at ethnic, race, and gender and class levels. It underlines that even men can give care: they can bind wounds, wash the sick, feed them, change them etc. The lesson that the churches in Zambia can learn from the parable of the Good Samaritan is that they too ought to respond to the ministry of care giving to the chronically ill patients and those living with HIV and AIDS. One of the tools that

churches can effectively use to respond to the problem of HIV and AIDS is that of pastoral care and counseling.

5.2 The Church and the Culture of Pastoral Care.

The late Catholic Bishop Dennis De Jong wrote in one of his pastoral letters dated 6th December 2001, that:

Our moral awareness and attitudes have stages towards a greater moral maturity. Perhaps the AIDS crisis is God's way of challenging us to care for one another, to support the dying, and to appreciate the gift of life. AIDS need not be merely a crisis. It could be also a God given opportunity for moral and spiritual growth, a time to review our assumptions about sin and morality. The modern epidemic of AIDS calls for a pastoral response.

The researcher agrees with De Jong's statement because it is an encouragement to the church to see, analyze and take up its pastoral role in the fight against HIV and AIDS. This statement is also a call and greatest challenge that the church has had to face in Zambia. The church needs to pick itself up and face this moral and pastoral challenge head on. Church critics have slandered the church, stating that churches are sick as the victim themselves. Little do they know that God's divine principles of sowing and reaping never fails. If we sow the seed of love and care, we will again reap an abundant harvest and the church will regain its respect and honour. Care givers within the broader church community can make and are making positive contribution in their congregations by helping to create an accepting and welcoming attitude to people who are HIV positive. This gives hope and communicates a message to all that are HIV positive that the Church does not judge, stigmatise or reject anyone. This is so crucial to the overall success of reaching infected people.

While doing research in Ipusukilo and Mulenga communities, the researcher encountered many incidences of stigmatization. What troubled him was that many church members feared rejection by their own churches. Where the church community

needed to accept and love those who are infected felt that they would be judged and rejected. The researcher was surprised that in 2005 people were still equating HIV and AIDS with God's punishment for the individual's sins despite the fact that not everyone who is infected and affected was as a result of immorality. This experience with some members of the Christian communities raises some theological and ethical challenges that need to be addressed through the strengthening of the culture of pastoral care, so that Christian leaders (ministers, pastors and priests), can lead the way in showing love to people living with HIV and AIDS.

The culture of pastoral care helps the Church to accommodate people living with HIV and AIDS who feel unwanted, neglected and lonely. It also enhances reconciliation and provision of support services. People helped in this way will look to the church as a place of refuge, acceptance, hope and healing. Caring brings about change in people's attitudes, behaviours and environment, and helps to prevent HIV and AIDS from spreading. Caring can take place whenever people feel safe, it can be in homes, in a hospital, when community leaders, neighbours, church members and pastors are involved. During this study, the researcher discovered the need for the church to encourage formation of discussion groups, which will help church members and communities to understand the full dimension and impact of the HIV and AIDS epidemic. Such groups will discuss and analyse information, find solution and inform the churches and the community about the HIV and AIDS scourge. Generally the church is a place where people look to for solutions. The researcher discovered that the two churches being studied have not yet done so, despite the need for it. During the research process, the researcher established that equipped with the right information and knowledge, the church would take the lead in facing the realities of every day life in caring for people living with HIV and AIDS.

The culture of pastoral care is important and is needed for those people who are infected and affected by the HIV and AIDS pandemic. This study has practically helped the researcher to discover the link between prevention and care, and the importance of care in the communities. His involvement and participation in Mulenga home based care

programmes has helped him to see the importance of the statement from the WCC study document, which states that, “the church by its very nature as a body of Christ, calls its members to become healing communities. Despite the extent and complexity of problem raised by the HIV and AIDS, Churches can make an effective healing witness towards those affected” (WCC Study Document 1997:77). Following this statement, certainly the church can make a big difference in the fight against HIV and AIDS, if pastoral care and counseling are taken seriously and supported by all churches. Churches could come up with co-ordinated programmes to train counsellors in psychosocial counselling and care giving to people living with HIV and AIDS and are poverty stricken. The Roman Catholic Church Diocese of Ndola Integrated Programme is the best example to support this argument, and details about this programme have been discussed in chapter 4.

A good Biblical example to explain the importance of the culture of pastoral care is the church as a body of Christ, which states that:

While our presentable parts need no special treatment. But God has combined the members of the body and has given greater honour to the parts that lacked it, so that there should be no division in the Body, but that its parts should have equal concern for each other. If one part suffers, every part suffers with it; if one part is honoured, every part rejoices with it. Now you are the Body of Christ, and each one of you is part of it (1 Corinthians 12:24-27).

This means that the church should love and care for all the members of the community, including those living with HIV and AIDS. Christians must care for one another. If one member suffers all suffer together. Through proper pastoral care to people living with HIV and AIDS, the church can be a healing community. Churches should be a safe place for sharing, telling and listening, this is helpful in dealing with pain that those living with HIV go through. That is why it is important for churches to create an atmosphere of openness, acceptance, love and continued concern to the needy in communities.

The researcher’s experience of what a caring community can have with a person living with HIV and AIDS is what the Christian caregivers are doing in Ipusukilo Community.

For example, when Leya (not real name) one member of the care givers revealed her HIV status to the group, she was received with overwhelming love and acceptance. She was given good care and support. She was reassured at times when fear seemed to overwhelm her. She was visited by many of her friends regularly so that she would never be left alone when she felt scared. It is such as this example of Christian care and love that made the researcher realize the importance of the culture of pastoral care in alleviating the suffering that is caused by HIV and AIDS and poverty in communities in Zambia.

Many people suffering from HIV and AIDS and those who are living in poverty feel not only rejected by humanity, but through ignorance feel rejected by God. The vacuum for the Church caregivers to fill is two-fold:

1. To provide a safe, loving and caring environment.
2. To bring the person to the truth that God loves them, forgives them prepares a place for them in eternity through Jesus Christ.

From the researcher's perspective, a positive church culture does not just happen, it is planned, communicated and then implemented by the church leadership. This can be at national level within the denomination, then filtering down to local churches. Where a culture grows, it can never grow in a vacuum. A culture of care within the context of the local church is a responsibility of the pastor. As he or she starts the culture of care and love, it grows as church members take ownership.

Churches in Kitwe as well as in Zambia need to have a culture of caring for the afflicted, a culture that extends beyond their walls into the surrounding communities, across denominational lines, across race lines that have undermined 'Church Unity' for a long time.

During this study, the researcher discovered that creating awareness in communities affected by HIV and AIDS is a great challenge facing the United Church of Zambia

(UCZ). At the UCZ Synod Executive meeting of 2001, the Church officially inaugurated the HIV and AIDS Synod Committee to make sure that the HIV and AIDS Policy Document of the Church was practically implemented to benefit the communities. Because of this monitoring committee, many UCZ congregations heeded the call, and have taken up the challenge to involve themselves in various HIV and AIDS projects. In so doing the UCZ has created a culture of caring for people suffering from this disease. Many congregations are now desperate for networking with stronger resource churches and NGOs to fulfill their obligation to care for the suffering people in their communities.

To fulfill the culture of caring for people suffering from the effects of HIV and AIDS the Roman Catholic Church Diocese of Ndola established the Integrated AIDS Programme (IAP) on the Copperbelt Province. The aim of IAP is to continue to seek to address the AIDS epidemic in its widest context, through the provision of holistic care, prevention, community development and advocacy. The primary target groups are people with symptomatic HIV infection and their families. The programme also provides medical and nursing care, counselling, psychosocial and pastoral support and the provision of welfare support, care of orphans and children in distress, and support to groups of people living positively with AIDS. If this trend could be extended to other denominations, a greater web of churches providing care would extend throughout Zambia.

5.3 Counselling as the Therapeutic Process.

Counselling has been defined as a process for empowering the person to make decisions about his or her own life. Beyond conveying information, the counseling process includes partnership in discussion and reflection about the specific problem and challenges the individual and his or her family are facing. In that sense, counseling may be concerned with many different areas of life of a person or a family, and may address physical, practical, psychological, social and spiritual needs (WCC Study Document 1997:85).

The goal of HIV and AIDS counseling is two-fold. To help the infected persons come to term with their situations and to promote coping strategies for the infected and affected, including preventing or reducing HIV transmission. The researcher has discovered that effective counselling is one way in which the churches can respond to the fight against HIV and AIDS. For example, the Kitwe Central Hospital Clinical Pastoral Center has helped many people who are HIV positive to live positive lives. Counselling as a tool in the healing process has also enhanced voluntary counseling and testing in many home based care centers and clinics in Kitwe communities.

Within the church, counselling has enhanced the culture of care. It has helped the church operate in the very nature as Christ designed it to be, a healing community. The culture of care is only complete when effective counseling takes place in churches. When the church begins to care for people living with HIV and AIDS, by caring for them and learning from their suffering, it will develop a model of therapy that will help them to express their stories and develop meaningful relationships of trust and love. Love is a requirement of the New Testament Church, not an option. In the Gospel of John the writer states:

Dear friends, let us love one another, for love comes from God. Every one who loves has been born of God and knows God. Whoever does not love does not know God, because God is love. This is how God showed his love among us: He sent his one and only son into the world that we might live through Him. This is love: not that we loved God, but that he loved us and sent his son as an atoning sacrifice for our sins. Dear friends, since God so loved us, we also ought to love one another. No one has ever seen God; but if we love one another, God lives in us and his love is made complete in us (John 4:7-12 NIV).

Love is key in counseling, as it becomes an effective tool in helping the church to become a healing community. Love speaks the language of acceptance, care and the willingness to help. Love makes people compassionate to others who struggle and suffer. Life is a gift from God and we never know what our future is like. It is this unknown factor that makes life so fragile. As noted by Gerkins:

We are most intimately aware of life's fragility in relation to individual and family life. The newspaper tells the story of a happy family of four on vacation with dreams of play in the sand, sailing and hours of leisure and new experiences. As if out of the blue, a drunken driver hits their car head-on, killing all but the father who is left alone in a sea of grief and bewilderment to put his life back together or we watch our neighbour. A young woman in her twenties struggles to make a life for herself while her mother slowly dies of Alzheimer's disease. Then the word comes that she herself has been diagnosed with – threatening cancer. Such stories as these are numerous in the ministry of any pastor. Such is our awareness of life fragility. Pastoral care as crisis ministry is by and large what is understood as ministry in life's fragile situations (Gerkins 1997:228).

The researcher totally supports Gerkin's illustration of pastoral care as a crisis ministry. That is why counselling is crucial in pastoral care because people in crisis need counselling, which is an effective ministry in the crisis healing process. Pastoral counselling is not an option to the church it is the church's vocation, as acknowledged by Gerkin. Similarly the WCC Study Document notes that:

As Christ identifies with our suffering and enters into it, so the church as a body of Christ is called to enter into the suffering of others, to stand with them against all rejection and despair. And because it is the body of Christ who died for all who enters into the suffering of all, the church can not exclude anyone who needs Christ, certainly not those living with HIV and AIDS (WCC Study Document 1997:44).

Knowing that you are HIV positive can be traumatic. In fact some people have committed suicide after hearing they are HIV positive. Counselling can help the infected persons to accept their life situation and to promote coping strategies both for the infected and the affected. Counselling can also help to prevent or reduce HIV and AIDS transmission. Counselling does not only convey information but includes partnership in discussion and reflection on problems and challenges the individual and his or her family faces. Counselling should be done in a conducive atmosphere where information sharing is not inhibited and confidentiality is maintained. When people test positive, heavy emotions are to be expected at this time. Talking to a pastor or a Christian counsellor can help the person deal with all the feelings and mixed emotions. Often counsellor help is needed to break the news to family or friends. Christian believers

particularly can be helpful in strengthening those whose family members are HIV infected or have AIDS. Love, care and ministry should be extended to those hurting from this disease.

The WCC Study Document challenges the church communities to create safe spaces for telling ones own story as a practical step through which congregations can become healing communities. Healing and care becomes more positive as one shares the story within an atmosphere of acceptance, love and continuing concern. As stated by the WCC study document, the task for those in the ordained ministry of the Church is to leave space in their own hearts to allow their own eyes to die in order that this potential source of healing can flourish. The only way to create an atmosphere of acceptance in which stories can be shared, and healing needs to happen among people of the church (WCC Study Document 1997:80).

The best example of counseling as a therapeutic process to those who test positive to HIV is the story told by one of the counsellors at the Kitwe Central Hospital Clinical Pastoral Centre who narrated his experience as follows:

In July 2004 I received a consultation form from a Doctor in Luapula Ward of Kitwe Central Hospital requesting me to go and counsel a patient. When I was taken to the patient's bedside, I introduced myself as a counsellor from the Clinical Pastoral Care Centre. She told me she was very weak and did not want to talk to anyone. After talking to her brother I requested the Doctor to refer her to the Clinical Pastoral Care Centre on the day that she would be discharged from the hospital.

Two days later she came to the Centre with her brother. I asked her how she was feeling and she replied she was feeling a bit better. When I tried to check her knowledge about "Voluntary Counselling and Testing" (VCT), she retorted sharply "I have not come for VCT, I am here because the doctor told me to pass through here on my way home." I then told her that her doctor wanted us to discuss her health and help her. "No I do not want. I am tired of this life, I just want to die. Let me just go home. At this point it

became difficult to follow the checklist for pre-test counseling. It was quite apparent that the case was not just HIV Counselling but also suicidal. I asked her why she wanted to die. She told me that for three months she has been thinking about committing suicide because she had suffered from a lot ailments including TB in the last one year. She was now frustrated because her health was getting worse. In order to assess the seriousness of her suicide intent, I asked whether she had discussed her plan with anybody. She told me she had discussed it with her brother and her best friend who was also a fellow teacher.

Her fears and concerns were that because she had HIV and AIDS, very soon she would be very thin and could not stand gossip and discrimination. She also pointed out that HIV and AIDS had no cure. She was convinced that she had HIV because two of her boyfriends died of TB. I allayed her fears by pointing out that HIV and AIDS was not the only disease without a cure. Diseases like Diabetes and High Blood Pressure had no cure but patients have to take drugs in order to prolong their lives. Her situation was not as hopeless as she thought because she can live positively and productively. Anti retroviral drugs were available to enable her prolong her life. I told her that taking her life was not the best solution to her problems. She was still young with many years of fruitful life ahead of her.

After a moment of silence she asked how long it would take her to know the result of her blood test. I told her the result would be ready the following day. Then I asked her how she would feel if the result were positive. She said, “the result would just confirm what I have been suspecting, I won’t be moved.” She agreed to be tested so I called the nurse to collect a blood sample from her. Thereafter she left looking somehow relieved.

Two days later she came for her result looking much better. She told me she was no longer thinking about suicide. I gave her the result and asked how she felt about it. She said, she knew she had HIV. “I just have to fight,” she added. We then talked about health maintaining behaviours such as avoiding unprotected sex, which could increase her viral load, good food, enough sleep and exercises. I referred her to the ART clinic

for further tests and ARV drugs. I encouraged her to seek early treatment for any symptoms. I also told her to visit us any time.

A month later she came to tell me that she had been put on Triomune 30 and she was getting on well. She confessed she had wanted to commit suicide because she blamed and hated herself. I asked her how she was coping with stigma and opportunistic infections. She said she was able to deal with her problems. She thanked me for the encouragement I gave her and told me she had joined a local support group for people living with HIV and AIDS. I congratulated her for taking a positive step, which enabled her to look at her life differently. We arranged to meet again after two months.

On her next visit, immediately we exchanged greetings she said “thank you very much for everything”. I asked her how she was keeping. She buoyantly replied “very well, as you can see the skin rash is gone”. What is bothering you now? I asked, “Nothing” she replied. She then went on to say, “My life had been very bleak, I never knew things could turn out this way”. I told her that information was a powerful tool and that should always seek advice when in doubt. Useful information will help you deal with situations in your life. She then told me she was going to the Anti Retroviral Therapy (ART) clinic for a check-up and a refill of ARVs.

This case was tricky. I had to do what I did in the best interest of the client even though it was against her wishes. I avoided confrontation but strengthened counseling relationship in order to bring healing to her. The client had been injured by stigma, sicknesses shame and self-blame so much that suicide was the best option for her. I gave her valuable information and helped her to deal with her world. Our relationship made her feel respected trusted and accommodated.

This is a living testimony of how counseling could change things, from a crisis to the healing situation and positive living. Certainly counseling is an affective tool in a healing process of people living with HIV and AIDS. This narrative challenges the

church, to be more involved in counselling in congregations, parishes, counselling would become one of the outstanding church responses in the fight of HIV pandemic.

However, the Roman Catholic Church in Zambia has responded very well to the care and counselling of people living with HIV and AIDS. For example, the Roman Catholic Church Diocese of Ndola through its Integrated HIV and AIDS Programme has and is still training its priests and lay people in counseling and care giving skills. The training is to equip them with skills in counseling and care giving to people living with HIV and AIDS. Many of the trained people are involved in psychosocial counseling in VCT Clinics and Community Pastoral Centres.

In comparison, the United Church of Zambia has not done well in equipping its ministers and lay people in the area of care giving. Learning from the Roman Catholic Church, it has slowly started training its clergy and the laity with counseling and care giving skills, but has a long way to go. However, during his research the researcher discovered that the UCZ had started training people both lay and clergy through Theological Education by Extension in Zambia (TEEZ). The training is to enhance the ministers and lay volunteers' with knowledge on facts about HIV and AIDS and related illness, as well as equip them with basic skills and techniques in HIV and AIDS counseling. It has been proved that counselling is a vital component of HIV and AIDS and STIs preventions and good clinical management and care of those infected and affected.

According to Mrs. Ngoi, the Copperbelt Presbytery HIV and AIDS Coordinator the UCZ is intending to embark on a long-term training programme, which will help it to effectively participate in the fight against the pandemic in Zambia. In doing this it hopes to strengthen pastoral care and counseling in most of the congregations. When congregations have skilled human resource, then they will work on opening voluntary HIV counselling and testing centres. She further added that this long-term plan would assist the church to deal with the issues of HIV and AIDS effectively. Although these are just plans of what the United Church of Zambia wants to do in responding to the

challenges of HIV and AIDS. For sure they ought to fulfill these plans, or else UCZ will be irrelevant in communities.

5.4 A Practical Pastoral Model for the Care of People Living with HIV and AIDS

In this section the researcher will deal with a practical pastoral model for the care of people living with HIV and AIDS in poor communities in the town of Kitwe, Zambia. The home care strategy is an effective practical pastoral model for the care of people living with HIV and AIDS in our communities. Like most other countries in Sub-Saharan Africa, Zambia faces the problem of how, with severely limited economic resources, to provide a basic level of care and support to everyone affected by the dual epidemic of HIV and AIDS and TB. This is one of the most daunting challenges facing governments through Sub-Saharan Africa.

Yet the challenges have also led to innovative church responses, in caring for the infected and affected through home care pastoral models. In the late 1980s, Zambia saw the emergence of a new strategy known as home based care. This strategy was not confined simply to medical treatment and nursing, but took a more comprehensive approach to the needs of individuals, families and communities affected by the HIV and AIDS epidemic.

In Zambia, the home care strategy was started by the church at Chikankata Mission Hospital in the Southern Province. The programme was first adopted within a home care setting model. This model provided both elements of palliative care, which are:

1. The model in providing for primary Health Care and Support.
2. Basic Techniques of Counselling.

The church, by its very nature as the body of Christ, calls its members to become healing communities. Despite the extent and complexity of the problems raised by HIV and AIDS, churches can make an effective healing witness towards those affected. The experience of love, acceptance and support within a community where God's love is

made manifest can be a powerful healing force. The church can be a healing community only if it is sanctity, a place where people feel safe. People need a place where they can come and share their pain, knowing that they will never be judged but rather accepted and loved.

Within a church community where people feel safe to share their stories, they heal as they confess; the church community is also healed as it learns from those that share their pain. From stories, we do not only learn about others but also about ourselves. Church culture must embrace a concept of value that communicates responsibility, sexual integrity, healthy relationships, human dignity and mutual respect. With this in mind the church in Zambia saw the need of pastoral care to the people living with HIV and AIDS by involving Christian community participation in caring for one another and so far the home care has proved to be an effective model for community pastoral care.

5.4.1 Home Based Care as an Effective Method.

Every year, throughout the world, the HIV and AIDS pandemic affect an increasing number of people, either directly or through someone they care for. People with HIV infection can remain healthy for some years, but it is assumed at present that all HIV infected people will develop AIDS in due course. AIDS is a chronic disease lasting months or years, and a person with AIDS may move several times from home to hospital and back again. Much of the care of those with AIDS therefore occurs in the home.

Home care means different things to different people, but whatever form it takes, it relies on two strengths that exist everywhere in Africa, that is the family and the community. It is with the hope of stimulating and utilizing the strengths of the family and the Christian community that this section of this thesis has been developed.

Care at home provided by family, friends or neighbours is not without problems. Very few of the people giving this care have had any training in looking after sick people.

Christian groups in Zambia have a long tradition of visiting the sick to provide emotional and spiritual support. It is this traditional strength that has helped the church to have effective home-based care. When the volunteers are trained in basic health nursing care, they become very effective in caring for the sick in the community. The readiness of families and community to provide care for persons with AIDS at home is important. It has been discovered that in early stages of the epidemic (when few people are noticeably sick) there is often a high level of stigma, fear and lack of acceptance of people with AIDS in their homes. This makes it difficult for health workers to involve families in learning about or providing care at home.

Research has proved that as more people are personally affected the tendency for hiding or denying the disease decreases. As people's knowledge and understanding of HIV increases, their attitudes towards caring for persons with AIDS are likely to become more positive.

Home care is often the best and effective way to look after someone with AIDS. The following are some of the reasons:

- Good basic care can be given successfully in a home.
- People who are very sick or dying would often rather stay at home, especially when they know they cannot be cured in hospital.
- Being in their own homes and communities comforts sick people with family and friends around.
- Home care can mean that hospitals will be less crowded so that doctors, nurses and other hospital staff can give better care to those who really need to be in hospital.
- It is usually less expensive for families to care for someone at home, for example they will not have to pay for hospital bills and transportation to and from hospital.

- If the sick person is at home, family members can meet their other responsibilities more easily. This can be difficult if they have to stay at the hospital, or have to travel frequently to help and to take food to the sick person.
- Sometimes hospital care is simply not possible.

Due to the above facts it is true and with good backing when we say, home based care is an effective method in caring for people living with HIV and AIDS.

In sum, the researcher would say the HBC programme seeks to address the AIDS epidemic in its widest context, through the provision of holistic care, prevention, community development and advocacy. The primary target groups are people with symptomatic HIV infection and their families.

5.5 Preliminary Conclusion

The conclusion drawn from this chapter is that:

- The care givers play a central role in pastoral care to those living with HIV and AIDS. The response of the Roman Catholic Church Diocese of Ndola through the Integrated AIDS Programme totally depend on volunteer care givers who are involved in the running of the home based care in communities. As already noted in this thesis, care giving is important in the fight against HIV and AIDS.

Church response to the challenges of HIV and AIDS and poverty would be meaningless without the culture of pastoral care. Pastoral care is important to the church's response in the fight against stigma and discrimination. Through pastoral care the church accommodates all the people regardless of who they are, including those who are living with HIV and AIDS. Pastoral care is a call from our Lord Jesus Christ who demonstrated how people created in the image of God should be cared for, the best teaching on this is the parable of the good Samaritan in (Luke 10:25-37) as discussed earlier in this chapter. The holistic care of the church to people living with HIV and AIDS mainly depends on the culture of pastoral care. Churches in

Zambia can make a difference in the fight against HIV and AIDS and poverty, if the pastoral care is taken seriously and supported by the clergy and other leaders of the church.

- The church response to the fight against HIV and AIDS calls the church to become a healing community. This statement brings us to counselling as the therapeutic process. This is to say that through counselling people receive spiritual healing. Counselling takes off the traumatic concerns that people experience in their lives. People living with HIV and AIDS and are poverty stricken need counselling. The demonstration of the Roman Catholic Church Diocese of Ndola Integrated AIDS Programme who supports the Kitwe central hospital clinical pastoral care center, where effective spiritual and psychosocial counselling is done to those who are infected and affected by the pandemic. This response by the Roman Catholic Church Diocese of Ndola in the fight against the pandemic is a shining example of what churches in Zambia can do for them to become healing communities. Knowing that you are HIV positive can be traumatic. In fact some people have committed suicide after hearing that they are HIV positive. Counselling can help infected persons to accept their life situation and to promote coping strategies both for the infected and the affected. This fact is discussed in this chapter and supported by the examples to qualify counselling as a healing process.
- The HBC has been cited in this chapter as the best pastoral model for the care of people living with HIV and AIDS. The researcher dealt with this practically, from his experience in the case studies in chapter four. That is why this chapter started with the discussion on care givers. It has been proved through this research that care givers are the key actors in the running of the home based care in both churches, the Roman Catholic Church and the United Church of Zambia, they all depend on volunteer care givers who have done the church a pride in Zambia. The researcher discovered that the clergy had mixed feelings about issues related to HIV and AIDS and their response is generally poor. Despite the poor response from the clergy the HBC have proved to be an infective church response in the fight against HIV and

AIDS and poverty. Because the programme seeks to address the AIDS epidemic in its widest context, through the provision of holistic care, prevention, community development and advocacy.

- The researcher has discovered that the response from the United Church of Zambia is still poor. Although they have good ideas on paper the implementation is lacking. However they have the opportunity of leaning from the Roman Catholic Church which has many successful projects dealing with HIV and AIDS and poverty. It is hoped that the research like this one can motivate the United Church of Zambia leadership to be serious in implementing programmes dealing with the fight of HIV and AIDS and poverty, for the church to be relevant to the people in communities.

Although the researcher has given an account of what the Roman Catholic Church Diocese of Ndola and the United Church of Zambia Copperbelt Presbytery are doing to respond to the challenges of HIV and AIDS and Poverty. The researcher has concluded that the response of these two mainline churches and other Christian denominations in Zambia has been inadequate. The researcher established that the following factors could help denominations to enhance their response to HIV and AIDS and Poverty. Personal experience of community or church members with the HIV and AIDS, Internal Advocacy and response from the church leaders attests to this.

- **Personal Experience:**

Direct Personal contact with the human consequences of HIV, for example, finding out that you or a friend is HIV positive or having a member of your family or faith community become sick and die of the pandemic, as it was with the researcher's personal experience with his brother and other members of his family.

- **Internal Advocacy:**

Those denominations that have become involved with issues relating to HIV and AIDS and poverty have often had within them someone or people who have lobbied

and advocated for greater involvement on HIV and AIDS effectively. The best example is what is happening in the Roman Catholic Church Diocese of Ndola AIDS Integrated Programme, community members who have become involved in the HBC programmes are always advocating for greater involvement in the caring ministry. As a result of this the programme is now people driven, hence its successes.

- **Response from Church Leaders:**

It has been established that church leaders, who acknowledge the challenge of HIV and AIDS and do not condemn those who are affected by it, but offer support and understanding. They can also motivate others within churches and religious groups to respond positively to those who are infected and affected by HIV and AIDS. The best example of the above argument is what late Bishop Denis Dejong did for the Roman Catholic Church Diocese of Ndola. His interest in keeping the needy in the poor communities of the Copperbelt Province motivated many people to develop interest and get involved in community projects to alleviate the suffering of the people who are infected and affected by the pandemic and are living in poverty. The researcher himself is one of those who were motivated by the late Bishop.

CHAPTER SIX

6.0 CONCLUSION

This study has attempted to analyse the extent of HIV and AIDS and poverty in Zambia. As noted in our discussion, critical research on HIV and AIDS has been done to determine the causes and impact of the pandemic on the communities in Zambia. Also numerous researches have been done on poverty, similarly, to examine its causes and effects on the general population of Zambia. In other words, this study has tried to give a general picture of the problem of HIV and AIDS and poverty in Zambia. As noted in this study, Zambia is one of the countries in Southern African that has been hard hit with the problem of HIV and AIDS and poverty. For a long time the HIV prevalence rate had been 20 per cent, although it now stands at 16 per cent, while about 70 per cent of the population live in abject poverty.

It has been argued that the economic environment prevailing in Zambia has contributed to high levels of HIV infections and poverty. To give a better understanding of the general picture of HIV and AIDS and poverty in Zambia, an attempt has been made to define HIV and AIDS and poverty. A brief profile of Zambia has been given to try to help clarify how these terms should be understood in this study. However, it is from the adverse effects and impact of HIV and AIDS and poverty on Zambia that the hypothesis of this thesis was conceived. That though some Christians and church-related institutions in Zambia have been active in the education and prevention programmes and in caring for people living with HIV and AIDS and also those affected by poverty, their response to challenges posed by the problem of HIV and AIDS and poverty has been inadequate and has in some cases made the problem worse.

Certainly, the problem of HIV and AIDS and poverty has raised considerable debate both at national and international levels. Questions to this effect have been raised as to whether HIV and AIDS cause poverty, or whether it is poverty that causes HIV and

AIDS. As argued in this study, poverty does not cause AIDS but creates an environment that militates against treatment and alleviation of suffering. Poverty as defined means the lack of proper food, clothing, shelter, proper sanitary conditions and insufficient medicines. As noted in this study, where poverty prevails, it impacts negatively on the social and economic development of a country, and this in turn destroys the human and economic resources for development, which further promotes poverty. In Zambia, AIDS has become a major cause of illness and death among the young and middle aged adults, depriving most households and the society at large of the critical human resource base and thereby reversing the social and economic gains made since independence.

The field research revealed enormous economic, health and social problems caused by HIV and AIDS and poverty. It is within this scope that we have tried to examine the role of churches in the fight against HIV and AIDS and poverty in Zambia. The church as one of the constituencies within the larger society is not exempt from the problem of poverty and HIV and AIDS. In fact this problem carries a moral question that falls within the social and spiritual realm of the church. In other words, the biblical teaching, the gospel of Christ and church tradition, provide adequate framework for the church to assert itself as a community of healing and compassion.

The case studies carried out on the Roman Catholic Church and the United Church of Zambia's involvement in the fight against HIV and AIDS and poverty clearly show why the church should be concerned with social and ethical issues. Facts on the grounds are that epidemics such as AIDS are likely to affect a country's economic status. Zambia, for example, has been one of the poorest countries in the world since the late 1970s, but with the advent of HIV and AIDS, the economic status of most people have been worsened. As earlier argued in this study, it is not easy for the government in a poor country like Zambia to fight HIV and AIDS and poverty single handedly. As this study has shown, scripture provides the church with issues of justice, especially its biblical emphasis on pastoral care and social ethics.

In an attempt to assess the church's response to challenges posed by HIV and AIDS in Zambia, some stumbling blocks to such responses were found to be evident, issues such as, lack of confidentiality, discrimination and stigma. The research findings in some sections of chapter 3 indicate that the three issues mentioned in the preceding sentence have had a negative bearing in the fight against the HIV and AIDS pandemic in Zambia. In Zambia, discrimination occurs both in the families and communities. Unfortunately this discrimination has also found its way into churches. A discovery during field research has shown that discrimination and stigma against people infected with HIV has compounded the problem of AIDS prevention.

As noted in this study, both HIV and AIDS and poverty have impacted negatively on the general population of the communities that have been studied in Kitwe, that is, Ipusukilo and Mulenga settlements. This been the case, it would be irresponsible for the church and the society in general to avoid the ethical questions that these problems have raised. Therefore, as this study has argued, it is common sense that the church should respond to the challenges posed by HIV and AIDS and poverty in a manner that would promote social justice. One unfortunate thing discovered during this study, is that some communities look at those infected with HIV and AIDS as being promiscuous, and their suffering is seen as a punishment from God. This kind of thinking has contributed to discrimination and stigmatisation.

From a biblical point of view, justice demands that people must be treated equally and fairly. That is, despite their social and health status, people should receive the attention, care and respect they deserve. Whether it is in the church or community, the problem of AIDS and poverty calls for a moral awareness that drives towards a greater moral responsibility. For the church which is the subject of this study, the crisis of HIV and AIDS and poverty presents it with an opportunity to revisit its pastoral responsibility in the community. No matter how critics view those living with HIV and AIDS, the church should be seen as a place where such people could share and tell their stories, and moreover, it should be seen as a place where people could find compassion, healing and love.

As established in this study, many church members (especially those living with HIV and AIDS)) conceal their HIV status because of the fear of being rejected by their own families and the community at large. Such an attitude, as this study has attempted to point out is contrary to the biblical concept of the church as the body of Christ, and by its very nature calls its members to become healing communities. Certainly the HIV and AIDS problem raises a moral and pastoral challenge for the church. However, one of the tools that the church can effectively use to respond to this problem is that of pastoral care and counselling. Therefore, in line with the discipline of pastoral care and counselling, the church should engage itself in people's lives both at individual and communal levels. In fact the primary function of the church is that of creating and maintaining an environment in which all of its members and all members of the community are understood and cared for. When we talk about pastoral care and counselling in Christian circles, we are referring to a holistic approach in matters that affect humanity. These matters could be cultural, economic, political, social or spiritual, but what is important is for the church to exercise its pastoral role, so that people who are infected or affected with such matters are helped to make well informed decisions for their lives. In short, the church should be seen as a symbol of hope in the community.

The Clinical Pastoral Center cited in this study is a typical example of a pastoral care and counselling institution where a lot of people diagnosed with HIV have been helped to accept their status. Certainly a well coordinated programme in the area of pastoral care and counselling, education for prevention and social ministry would definitely contribute to the reduction in the spread of HIV and AIDS. Both the Roman Catholic Church and the United Church of Zambia Mulenga Congregation should be commended for setting up Ipusukilo Home Based Care Center and Twafwane Home Based Care Center, respectively. Such centers have proved to be effective models for providing both elements of palliative care, that is, primary health care and support and basic techniques of counselling. Also these centers have been viable links between local health centers, allowing those infected with HIV and AIDS to receive care at their homes. The same

centers have been used as out posts for HIV and AIDS education and information dissemination.

As discovered during fieldwork, the Roman Catholic Church has gone into care for AIDS patients by providing medical care through a few hospices scattered in the country. However, given the gravity of the AIDS pandemic, the challenge for both the Roman Catholic Church and the United Church of Zambia is to enhance the home care strategy as a practicable pastoral model for the care of people living with HIV and AIDS. The goodness of this strategy is that it is not only confined simply to medical treatment and nursing, but it also takes into account the basic needs of individuals, families and communities affected by the HIV and AIDS epidemic.

Clearly both the Roman Catholic Church and the United Church of Zambia have the potential to respond positively to the challenges brought about by HIV and AIDS and poverty. The potential being referred to here is human and financial resources. In addition these churches have infrastructure that can be turned into voluntary counselling and testing centers, to supplement what the Clinical Pastoral Care Center is doing. We need more of such centers in Zambia where people can go for voluntary testing and counseling knowing that whatever they have given out will be kept confidentially, if we are to win the battle against the HIV and AIDS pandemic. In fact the question of health care provision by the two churches is not new, both churches have been involved in this ministry since the missionaries who came to Zambia established their first health centers. Perhaps the question the two churches have to ask themselves is have they set their priorities right in this era of HIV and AIDS and poverty?

Being diagnosed with HIV and AIDS can be a traumatic experience. This is why love, care and ministry should be extended to those hurting from this disease. The people hold the church in high esteem. Thus why the church should create safe space where people living positively could tell their own stories, as a practical example through which the church can become a healing community. In fact such an approach would definitely help those infected and affected with the HIV and AIDS and its related problems to be

socially and spiritually transformed. Churches should be seen to be serving communities. They should go out there, rather than wait for people to come to their courtyards.

Poverty reduction will be meaningless in Zambia if the HIV prevalence remains high. Such a challenge invites the church to make a meaningful contribution in the reduction of poverty. However, as at now the greatest challenge for the church in Zambia is to fight stigma and discrimination because there is nothing wrong with being HIV positive. Lepers, prostitutes and those who were demon possessed are a good example of people in the Bible who were discriminated against, but these were the same people Jesus Christ who is the head of the church showed compassion. Compassion and love are key when dealing with people who are infected with HIV and AIDS. This message could be difficult for people to understand, but using its position in society (i.e. its influence and trust), the church should educate people to understand issues surrounding HIV and AIDS.

As noted in this study, discrimination and stigma has in a way perpetuated the spread of HIV and AIDS because those infected are not able to come out into the open, and as a result continue to spread the virus. The challenge for the church in such circumstances is to conscientise the public that HIV and AIDS is a disease like any other disease. Therefore, people should not conceal it, but rather declare their status openly so that they can be assisted to access the required medical, social, and spiritual support. The other challenge for the church is to educate the masses on the importance of going for voluntary counselling and testing. If a person is found to be positive, it would be possible for that person to be helped to access the antiretroviral drugs which will prolong his or her life span. If people are able to live long enough, they would be able to contribute productively both to the church and society.

The church should be clear about the use of condoms as a means of prevention against HIV transmission. As much as the teaching about abstinence and remaining faithful to one sexual partner is a positive move towards controlling the spread of HIV and other

sexually transmitted diseases (STIs), the truth is that many people including Christians find it difficult to observe these principles. The facts on the ground are that the use of condoms would be second best after abstinence. Some Christians have not welcomed this proposition, but what is obtaining in the communities where this study was done is that many people are leading life styles that expose them to various STIs, of which HIV is one of them. In short, the church should face the issue of condom use squarely, it is better to call a spade a spade.

As clearly established in this study, the interplay between HIV and AIDS and poverty cannot be underplayed, especially in the settlements studied. Most people infected and affected with HIV and AIDS in these settlements were also poverty stricken, which was the major contributing factor to the deterioration to the ill health of those infected. In Zambia, fighting HIV and AIDS alone leaving poverty would be a futile exercise. This is what the researcher observed in Ipusukilo and Mulenga settlements. The Home Based Care programmes in these settlements are typical examples of how those who are living with HIV and AIDS but are poverty stricken have been assisted and cared for medically, economically and socially. In other words, the home based care activities have helped both the infected and affected to improve their living conditions.

This study would not be complete without commenting on the recent government pronouncements on the state of the economy. It has been reported in the media (the Post Newspaper 14th October, 2005) that Zambia's economy has shown an upward trend. Inflation has gone down and the country's currency has improved against some international currencies. These are good signs for the future, but as at now the government, the church and the non-governmental organisations should not be swayed in their fight against HIV and AIDS and poverty. Moreover, this said economic growth has not yet trickled down to the people, and as a result the poverty levels are still high in the country and also the HIV prevalence still stands at two digits. Though poverty does not cause HIV and AIDS, the high levels of poverty in Zambia have greatly contributed to the vulnerability of many people to diseases such as AIDS.

This study is not conclusive because HIV and AIDS and poverty are problems that cannot be solved overnight. What we have attempted to do is to bring out some of the pertinent issues surrounding HIV and AIDS and poverty, and simply suggest the role the church can play in a country that has been hard hit with such problems. In fact the moral and social implications of these problems challenge churches in Zambia to respond as expected by communities in which they serve. It is in this vein that this study leaves room for further research especially on the question of whether the Integrated AIDS Programme being run the Diocese of Ndola and the HIV and AIDS Desk of the Copperbelt Presbytery are sufficient to respond to the challenges of HIV and AIDS and poverty in poor communities of Kitwe. The other area that could be explored further is the home based care programme. Are these effective models that could be fully exploited by the church in the fight against HIV and AIDS and poverty? Have all sections of the church fully embraced what home based care programmes are doing? As discussed in this study the fight against the HIV and AIDS pandemic and poverty is a battle that should be fought by all sectors of society. However, the church should lead in this fight in order to fulfill its God given mandate through its pastoral care and counselling, and further sustain its position as a healing community to those who have been infected and affected by the HIV and AIDS epidemic and are poverty stricken.

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USE OF INTERNET RESOURCES

UNAIDS (www.UNAIDS.org) is a joint United Nations Program on HIV/AIDS, offering worldwide information on the epidemic.

AIDS Org (www.aids.org) provides updated information, especially treatment news.

AIDS Map (www.aidsmap.com) offers worldwide information and articles.

Bill and Melinda Gates Foundation (www.gatesfoundation.org)

Greyling Christo (Christo-greyling@wvi.org)

www.lutheranworld.org -Lutheran World Federation

United Methodist HIV/AIDS Ministries Network (www.gbgm.umc.org/health/aids)

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LIST OF INTERVIEWEES

Bishop Committee Njase	UCZ Copperbelt Presbytery Bishop
Dr. Alex Simwanza	Zambia National Aids Council Acting Director
Dr. Betty Maline	Former Lecturer at the UCZ Theological College
Mr. Benedict Ng'andwe	Catholic Diocese of Ndola Administrator
Mr. Chanda Fikansa	Catholic Diocese of Ndola Integrated AIDS Programme Manager
Mr. Chanzanso Daka	Coordinator For Ipusukilo Home Based Care.
Mr. Cosmas Mulenga	Catholic Diocese of Ndola Project Manager
Mr. Emilio Kunda	Coordinator Twafwane Home Based Care Programme
Mr. Jacob Kabila	Social Worker for UCZ Copperbelt Presbytery
Mr. Mutale Bowa	Community Programme Coordinator for CHEP
Mrs. Eunice K. Kasochi	Coordinator Trainer for Catholic Diocese of Ndola Home Based Care Programmes
Mrs. Mary Ngoi	HIV and AIDS Committee Coordinator, UCZ Copperbelt Presbytery
Rev. Kabwe Chikolwa	Kitwe Central Hospital Chaplain
Rev. Samuel Silungwe	UCZ Copperbelt Christian Training Convener