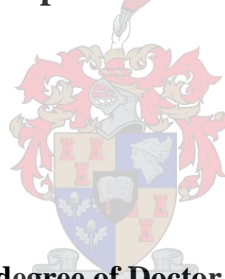


**COMBATING HIV:
A MINISTERIAL STRATEGY FOR ZAMBIAN
CHURCHES**

by

Japhet Ndhlovu



**Dissertation presented for the degree of Doctor of Theology (Practical Theology)
University of Stellenbosch**

Promotor:

Prof. H.J. Hendriks

March 2008

DECLARATION

I, the undersigned, hereby declare that the work contained in this dissertation is my own original work and that I have not previously in its entirety or in part submitted it at any university for a degree.

Signature: Date:

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EXECUTIVE SUMMARY

This work is about a missiological praxis for the creation of ‘Circles of Hope’ as an entry point for faith based organisations and, particularly, local churches in Zambia for an effective battle in the fight against HIV (Human Immunodeficiency Virus). The HIV pandemic is one of the worst tragedies to have befallen humankind in the 21st century. Lost to many people is the fact that it does not affect all regions of the globe equally. Figures show that over 70% of PLWHA (people living with HIV) are in sub Saharan-Africa while most affected are young and therefore, in theory, energetic. With an overall HIV prevalence rate of 16% and a life expectancy of 34 years, HIV has severely impacted the lives of Zambians across the country. Stigma remains one of the most significant challenges in Zambia across the prevention-to-care continuum. The wider environment of these effects and statistics has provided for us the wider contextual situation. The Church in Zambia and, indeed, in the entire sub-Saharan African region cannot afford to hide its head in the sand anymore. The impact of HIV is being felt at all levels of society. This has posed a threat to economic progress and human development by attacking the most economically productive age group and reversing gains in life expectancy and child survival. The increasing burden on health budgets has stretched national and community resources to the limit, leaving no room for complacency or pretence about the magnitude of the problem. Since some members of the Church are positively infected, we can safely say of the Church: the body of Christ has HIV. HIV is a national disaster. It cannot be managed without mobilising all the sectors within a nation. The Church in Zambia needs to make HIV prevention a matter of compelling priority. The Church is an instrument for the missional praxis of the triune God. Theology in this work is not so much a scientific endeavour that begins and ends with analysing contexts and texts, rather it is an imaginative way of finding new answers to the new situation brought about by the presence of HIV (Hendriks, 2004: 30).

In this work the researcher contends that measures are required to develop strong theological reflections and education which would result in the establishment of Circles of Hope in all local congregations. These Circles of Hope would act as a fountain for promoting behavioural change, support action for safer sexual behaviour, and combat stigmatisation and discrimination against people with known HIV infection.

There must be appropriate theological reflections that touch on the work of the reign of God. A relevant HIV theology will necessarily involve the laity, will watch out for fundamentalist views, will be biblical in nature and will draw from Trinitarian understanding. The basis of moving from a theology of punishment to that of care, truth, freedom, justice and peace is the theology of community and companionship. This reflection is an attempt to have constructive interpretation of the present realities brought about by a time of HIV.

One can only discern God's will for the present situation through critical and sensitive leadership in order to bring about genuine healing. The role of the local church and networking activities are essential commodities to realise a vision of a Zambia that is HIV competent. This then is the new ministerial strategy being spearheaded by the 'Circles of Hope' programme of the Council of Churches in Zambia. It is a challenge for Zambian churches.

OPSOMMING

Die navorsing handel oor 'n missiologiese begroonde praxis vir die skepping van “Kringe van Hoop” as 'n beginpunt vir geloofsgebaseerde organisasies en spesifiek die plaaslike kerk in Zambië in hulle stryd teen MIV (Menslike Immunitets Virus). Die MIV pandemie is een van die ergste tragedies wat die mensdom in die 21ste eeu getref het. Wat baie mense nie altyd besef nie, is dat dit nie oral in die wêreld dieselfde impak het nie. Statistiek wys daarop dat meer as 70% van alle MIV positiewe mense Suid van die Sahara woon. Die meerderheid van die geïnfekteerdes is jonk met baie potensiaal. 16% van die bevolking in Zambië is MIV positief en het 'n lewensverwagting van 34 jaar. Die uitwerking hiervan raak die land en al sy mense. Naas voorkoming en versorging bly een van die grootste uitdagings wat die gemeenskap in Zambië moet aanspreek stigmasering. Die groter konteks Suid van die Sahara vorm die agtergrond van elke land se spesifieke probleme. Ook Zambië en met name die kerk in Zambië sal die feite in die oë moet kyk. Die pandemie is 'n bedreiging vir ekonomiese vooruitgang en menslike ontwikkeling omdat dit die ekonomies mees produktiewe ouderdomsgroep afmaai, lewensverwagting verlaag en kindersterftes laat toeneem. Die toenemende las op die gesondheidsbegroting het die nasionale en gemeenskapshulpbronne grootliks uitgeput. Die omvang van die probleem kan op geen manier meer ontken en negeer word nie. Aangesien baie lidmate MIV positief is, kan 'n mens goedsikks verklaar dat die liggaam van Christus MIV het. Dit is 'n nasionale tragedie.

Die pandemie kan nie bestry word sonder dat al die sektore van die samelewing daarteen gemobiliseer is nie. Die kerk in Zambië moet die voorkoming van MIV as 'n uiters noodsaaklike prioriteit beskou. Die Kerk is 'n instrument vir die missionêre praxis van die drie-enige God. Die navorsing beskou teologie nie as 'n wetenskaplike onderneming wat bloot handel oor 'n analise van kontekste en tekste nie. Teologie is iets waarin jy handelend en verbeeldingryk toetree tot die aanspreek van 'n veelbewoë situasie en antwoorde probeer vind op die probleme (Hendriks, 2004: 30).

Die navorsing werk met die hipotese dat die probleem vanuit 'n teologiese hoek benader moet word sodat teologiese beginsels die praktykteorie van Kringe van Hoop in plaaslike gemeentes sal onderskraag. Die studie voorsien dat die Kringe van Hoop die hoof dryfveer sal wees wat gedragsverandering sal bevorder, veiliger seksuele gedrag sal aanmoedig, en die stryd teen die stigmasering en diskriminasie sal voer.

Gepaste teologiese refleksie oor die heerskappy van God is noodsaaklik. `n Revelante HIV teologie sal gewone lidmate insluit, sal bedag wees op fundamentalistiese sieninge, sal bybels wees en sal gebaseer wees op `n trinitariese godsbegrip. Die teologiese basis vir die wegbeweeg van `n teologie van straf/oordeel na een van versorging, waarheid, vryheid, geregtigheid en vrede, is geleë in gemeenskap en kameraadskap. Hierdie refleksie is `n poging om in `n tyd van HIV `n konstruktiewe interpretasie te gee van die huidige realiteite.

Kritiese en sensitiewe leierskap behoort in die huidige situasie te poog om God se wil te soek om die gebrokenheid van `n MIV siek gemeenskap aan te spreek. Die rol van die plaaslike kerk en netwerkingsaktiwiteite is onontbeerlik vir die realisering van die visie van `n Zambië sonder MIV. Die “Kringe van Hoop”-program van die Zambiese Raad van Kerke is `n bedieningstrategie wat die MIV pandemie wil aanspreek en wat die kerk in Zambië uitdaag om mee te doen.

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This work is dedicated to Joy Lubinga and all members of the Council of Churches in Zambia Circles of Hope. To them all I owe an immeasurable debt of gratitude for teaching me Christian hope and positive living as they struggled to fight the silence, shame and stigma associated with living with HIV.

This dissertation is dedicated to the memory of my late brother, Matthew Sailota Ndhlovu, whose death from AIDS would have been delayed if ARV therapy had been available to him.

A LIST OF ABBREVIATIONS USED

AACC	All Africa Conference of Churches
A B C D E	A Advocacy for (gender) equality B Attention to body and sexuality C Work with the community and in context D Dialogue for development E Empowerment for sharing of power
ABC	Abstain, Be faithful, Condomise
AFYA MZURI	A Kiswahili name meaning good health.
AIDS	Acquired Immune Deficiency Syndrome
AMROP	World Association for Public Opinion Research = Association Mondiale de Recherches sur l'Opinion Publique
ANARELA+	African Network of Religious Leaders living with or personally affected by HIV or AIDS
ANC	Antenatal Care
Aprodev	Association of World Council of Churches related development organisations in Europe
ARA	AIDS Research Alliance
ART	Anti-retroviral therapy
ARVs	Anti-retroviral drugs
AVERT	An international HIV and AIDS charity based in the UK, with the aim of AVERTing HIV and AIDS worldwide.
AZT	It was the first anti-HIV drug approved for use in the United States also called zidovudine.
BIGOCA	Bible Gospel Church in Africa
CBG	Community Based Groups
CCZ	Council of Churches in Zambia
CD4	Stands for cluster of differentiation. CD4 is a molecule on the surface of some white blood cells onto which HIV can bind. The immune cell that carries the CD4 on its surface is called a CD4 cell. A CD4 test measures the number of CD4 cells in a person's blood. The more CD4 cells there

are per millilitre the stronger is the immune system. The stronger the immune system the better the body can fight illness.

CHAZ	Churches Health Association of Zambia
Circles of Hope	The term refers to support groups of people living with HIV and was coined by the Northmead Assemblies of God congregation of Paseli Road in Lusaka under the leadership of Bishop Joshua Banda.
CMAZ	Churches Medical Association of Zambia
CMMD	Christian Men Making a Difference
CORE	The Communities Responding to the HIV/AIDS Epidemic
DANIDA	Danish International Development Agency
DDI	Didanosine, another anti HIV drug which can be taken together with AZT
EFZ	Evangelical Fellowship of Zambia
EHAIA	Ecumenical HIV/AIDS Initiative in Africa
ESD	Ethics Society and Development department
FBOs	Faith Based Organisations
FOCCISA	Fellowship of Councils of Churches in Southern Africa
HDI	Human Development Index
HIPC	Highly Indebted Poor Countries
HIV	Human Immunodeficiency Virus
ICASA	International conference on AIDS and STDs in Africa
IDA	International Development Association
IMF	International Monetary Fund
JMTC	Justo Mwale Theological College
LINGO	Lusaka Interfaith Networking Group
LWF	Lutheran World Federation
NASB	New American Standard Bible
<i>ng'anga</i>	A Chewa word that implies several types of traditional African medical specialists.
NGOs	Non Governmental Organisations
NPV	NET present value
NZP+	Network of Zambian People Living with HIV/AIDS
OVC	Orphans and Vulnerable Children
PACANET	The Pan African Christian AIDS Network

PEPFAR	President's Emergency Plan for AIDS Relief
PLWHA	People Living With HIV/AIDS
PRSP	Poverty Reduction Strategy Paper
RCZ	Reformed Church in Zambia
SAVE	Safer practices, Available medications, Voluntary counselling and testing, and Empowerment through education
STDs	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
TCCA	Theological College of Central Africa
UCC	United Church of Christ
UEM	United Evangelical Mission
UN	United Nations
UNAIDS	United Nations Programme on HIV/AIDS
UNDCP	United Nations office on Drugs and Crime
UNDP	United Nations Development Plan
UNESCO	United Nations Education, Scientific and Cultural Organisation
UNFPA	United Nations Populations Fund
UNGASS	United Nations Special Session on HIV/AIDS
UNICEF	United Nations International Children's Emergency Fund.
UNIFEM	United Nations Development Fund for Women
USA	United States of America
VCT	Voluntary Counselling and Testing
WARC	World Alliance of Reformed Churches
WB	World Bank
WCC	World Council of Churches
WFP	World Food Programme
WHO	World Health Organisation
YMCA	Young Men's Christian Association
YWCA	Young Women's Christian Association
ZAMSIF	Zambia Social Investment Fund
ZDHS	Zambia Demographic Healthy Survey
ZEC	Zambia Episcopal Conference
ZINGO	Zambia Interfaith Networking Group on HIV/AIDS

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CHAPTER ONE

INTRODUCTION

1.1 Problem statement

The scale and duration of the HIV pandemic presents a fundamental challenge to the world. Long term commitments are necessary to prevent the spread of HIV infection and mitigate the impact of HIV. Many ways are being found to live as long as possible and in good condition with HIV. What is lacking is basically the sharing of information. Hope is possible only if resources and efforts are mobilised to empower people living with HIV and care givers with useful information on HIV, and how to manage it with the most accessible and affordable means (Mombe, 2005: 15).

Throughout history faith based organisations (FBOs¹) have responded to human needs and this response is based on the moral teachings of their faith. The Church by its very nature and teachings is a caring community therefore should be involved in intervention strategies aimed at meeting human need. In this case it is about meeting the human need posed by the effects of the HIV pandemic. Like Jesus Christ, the church is called to be daring and different in the way things are viewed and done. In the light of the HIV pandemic, the Church is called to engage in the fight against the triple 'S' factor namely silence, shame and stigma against discrimination, prejudice, injustice and oppression. The WCC study document (1998: 15) on *The Nature and Purpose of the Church* has properly indicated that mission belongs to the very being of the Church. As persons who acknowledge Jesus Christ as Lord and Saviour Christians are called to proclaim the gospel in word and deed, they are called to live its values and to be a foretaste of that reign in the world. The Church is to be a representative of Jesus by encouraging care of, love and compassion for the sick and oppressed, an understanding of those affected and infected in the communities, taking responsibility, speaking the truth and living as the light of the world (Mathew 5: 13-16 NIV). The WCC study document on *The*

¹ In this study, FBOs are defined as organisations that have one or more of the following characteristics: affiliation with a religious community, a mission statement with explicit religious references, receiving financial support from religious sources, selection of board members or national leaders or staff based on religious beliefs, and use of religious beliefs in decision making. FBOs may operate out of individual Churches or other faith structures. They may also be independent organisations. Religious bodies or denominations are faith structures that are organised in one way or another at national and international level. In this work therefore the CCZ, EFZ, CHAZ, RCZ, ZINGO are all examples of FBOs. (Source of definition from *Journal for the scientific study of religion* 2003, 42 (3): 411). The emphasis in this study though, is largely on the Church.

Nature and Purpose of the Church (1998: 56) further gives us a better understanding of what the nature and purpose of the Church is. It says:

*The Church is the community of people called by God who through the Holy Spirit, are united with Jesus Christ and sent as disciples to bear witness to God's reconciliation, healing and transformation of creation. The Church's relation to Christ entails that faith and community requires discipleship in the sense of moral commitment. The integrity of mission of the Church therefore is at stake in witness through proclamation and in **concrete actions for justice, peace and integrity of creation**. The latter will often be undertaken with those outside the community of faith (emphasis mine).*

The contention of this study, then, is that the creation of HIV support groups as a Missiological² praxis³ in local faith communities is an appropriate vehicle to mobilise the local Church for greater involvement in concrete actions for justice, peace and integrity of suffering human beings in the face of the various challenges posed by this pandemic. The purpose of this study, therefore, is to investigate the nature and mission of Zambian Churches in as far as the scourge of HIV is concerned. Furthermore, the researcher will seek to investigate possible concerted efforts that can be contributed by the Church in the fight against this deadly pandemic. The Christian Church, by its very nature, should be involved in intervention strategies to save lives. The study will further propose that the Church in Zambia revisits its understanding of its own identity and God's mission in as far as the challenge of HIV is concerned. The creation of 'support groups' of people living with HIV in local faith communities is here proposed as one major challenge for the Church in Zambia to be seen to have fully embraced HIV. These support groups herein dubbed, as 'Circles of Hope⁴', are a new frontier that the Church in its missional nature needs to seriously consider. The HIV

² Missiology is the handmaid of mission, but mission is not always Missiological. Mission becomes Missiological when a process of critical reflection accompanies it. (See Costas, 1977: 90 – 91)

³ Freire developed this concept of 'praxis' in his classic, *The pedagogy of the oppressed* (1970). Theron (1995) reflects on Freire's relevance for theological education and summarizes Freire's view of praxis in regard to critical consciousness and liberation as follows: "it must lead to praxis, reflection and action, which will result in the transformation of society. The praxis must involve the denunciation of an unjust reality and the announcement of a new reality through word and action. Praxis is reflection and action upon the world in order to transform it" (Freire, 1972: 28). Reflection and action take place simultaneously and cannot be divided. If they are separated, and the one is emphasized at the cost of the other, then we will end up with either activism or verbalism (Freire, 1972: 60). According to Baranowski (1988: 68) praxis means 'reflection on life' which is 'learning by doing and learning from what we are doing... it is reflection and action combined... is a way of learning that begins by inviting people to reflect upon their own life experiences'.

⁴ The term 'Circles of Hope' referring to support groups of people living with HIV has been coined by the Northmead Assemblies of God congregation of Pseli Road in Lusaka under the leadership of Bishop Joshua Banda. Currently amongst the more than 14,000 points of presence for the Church in Zambia across denominational barriers only twenty known congregations have started implementing the idea of 'Circles of Hope'. It all started at Northmead Pentecostal Assemblies of God in Lusaka and the Trinity congregation of the United Church of Zambia based in Church Road, also in Lusaka. This work has seen expansion through a formalized creation of Circles of Hope as an arm of the CCZ – HIV work at Makeni Centre. The researcher has been instrumental in initiating that work.

pandemic has a wide scope. This then is one way in which the faith community in Zambia would contribute towards dealing with the current vexing problem (Hendriks, 2004: 28). UNICEF (2003b: 9) has observed that religious leaders are in the unique position of being able to alter the course of the pandemic. Why? When they speak their followers will religiously listen and follow them. Religious leaders can shape social values increase public knowledge and influence opinion; support enlightened attitudes, opinions, policies and laws; redirect charitable resources for spiritual and social care and raise new funds for prevention and for care and support and promote action from the grass roots to the national level. Pastors and Church leaders have a ready audience - their Church members. If a leader sees the importance and relevance of speaking about and sensitizing people to HIV, the audience is already there. On the other hand, Thairumn (2003: 25-27) warns that while some highlight the important roles religious leaders play in responding to the HIV crisis in their communities, others argue that religious leaders are largely silent on the issue and thus contribute to the worsening of the epidemic. What then is the problem and what are its social aspects?

In the next section the medical and social aspects of HIV will be examined.

1.2 Medical and social aspects

Muraah and Kiarie (2001: 119) have said that HIV is a major public health problem with a negative impact on development. While appreciating that HIV is not just a medical problem, under this section a medical definition of HIV will be given. The social aspects of how the disease is or not spread will also be examined. No known HIV cure is available; the current available anti-retroviral therapy will be mentioned. In order to appreciate the context from which this work is written, general data about Zambia will be provided before examining the statistical picture of the spread of HIV.

1.2.1 HIV⁵

According to the World Health Organisation's official website at <http://www.who.int/health-topics/hiv.htm>, AIDS (Acquired Immune Deficiency Syndrome) is the name given to the fatal

⁵ There is so much literature that defines what HIV is and how it is transmitted. The following is adapted from the *Zambian Central Board of Health definitions from the Sentinel surveillance of HIV/syphilis Trends in Zambia 1994-2002*" published by the Government of the Republic of Zambia; and from *Healing and wholeness: the global challenge of HIV/AIDS*, World Alliance of the YMCAs, 2003. Gordon and Klouda, *Talking AIDS: a guide for community work*, Sept 1988, *Facts for life*: 3rd ed. (2002).

clinical condition that results from long-term infection with HIV (Human Immunodeficiency Virus). There is no cure for HIV. It progressively damages the body's immune defence system, preventing the body from protecting itself against infection that it would otherwise render harmless. It can ultimately lead to death. These opportunistic infections include tuberculosis, Kaposi's sarcoma (a tumour primarily affecting the skin), Pneumocystis carinii (a form of pneumonia), diarrhoea and severe weight loss. Over time it weakens the immune system to the extent that several opportunistic infections are present at once, death is not caused directly by HIV but by one or more of these infections (Phiri, 2004; Catholic Bishops of Africa and Madagascar, 2004; Mellins and Ehrhardt, 1994; Premilla, 2004; Patterson, 1996; Dube, 2003b and Lwanga, 2005).

HIV is transmitted in semen, vaginal fluid and blood. Transmission of HIV can occur only in the following ways:

- Through unprotected (without use of a condom) vaginal or anal intercourse with an infected person. A few cases of HIV transmission have been attributed to oral intercourse.
- Through infected blood – in transfusion, blood products, the use of contaminated needles, syringes or other skin-piercing instruments in injecting drug use, medical and quasi-medical use.
- From an infected mother to her child before or during birth, the risk of transmitting infection is estimated at 30%. Recent evidence suggests that most transmission take place during delivery (Krivine, 1992: 1187). There is evidence that breast-feeding is also a route of HIV transmission (Van de Perre, 1992: 643).

According to Hubley (1995: 32) four critical conditions must be fulfilled if HIV is to be transmitted by a particular route namely that:

1. HIV must be present in a body fluid. In practice this means semen, vaginal fluids, blood or blood products and in breast milk.
2. HIV must survive during the period if it is out of the body. This can be a long time in stored blood but is quite brief in most other situations.
3. HIV must get into a person. Skin forms a barrier to HIV so the virus must enter where the skin is damaged or more delicate e.g. the mucous membranes of the anus and vagina. The acid in the stomach inactivates the virus.
4. Sufficient HIV must be transferred into the other person to make an infective dose.

HIV does not survive easily outside the body. It is not transmitted in everyday circumstances of the home, school, workplace, restaurants or any public place, on toilet seats, by hugging, kissing, or shaking hands, sharing eating or drinking utensils, by coughing or by mosquito or other insect bites (Hoffman, 1995: 102). Wilson (2002: 368) indicates that only those body fluids with an adequate concentration of HIV may cause infections. Weinreich and Benn (2004: 4) say that in Africa, HIV is transmitted mainly through vaginal intercourse (87%) while Hira and others (1989: 1251) talks about parent to child to be about 10%; blood products 2%; and skin-piercing instruments at about 1%. Onyango (2004: 35-36) has also observed that widow inheritance can be another vehicle of transmitting the HIV. It is a fact that when a person dies of AIDS the cause of death is often not revealed to the public. This is fatal because inheriting a widow whose husband died of AIDS could mean exposing the inheritor to the virus and eventually he could pass on to his wife or other partners. After this the chain could be endless, and the rates of HIV infections may not so easily be reduced.

Three types of treatment (*Sandford guide*, 2003: 2) exist for people with HIV:

- Palliative care to reduce pain or discomfort caused by opportunistic infections.
- Drugs to attack opportunistic infections.
- Anti-viral drugs such as Zidovudine (AZT) and ddi (didanosine) which attack HIV directly.

According to Stine (2005: 203, 406) treatment may alleviate symptoms and return a patient to temporary health, but even the most comprehensive treatment, including anti-viral drugs, can not eradicate HIV and cure AIDS⁶. Antiretroviral therapy is the treatment that uses drugs to suppress viral replication and improve symptoms (Fauci, Bartlett, & al., 2002: 3). According to the WHO guidelines there are currently sixteen approved Anti-retroviral drugs for treatment of HIV-1 infection in the USA (WHO, 2002a: 27). Many more new drugs are currently under development and still in critical trials and will be added to the list later. Only thirteen of them, however, have been mentioned in the WHO documents addressed to source-limited settings. Wilson (2002: 339-339) gives some information about side effects, drug interactions and monitoring. Mombe (2005: 58) says it is important to note that each Anti-retroviral drug has three names by which it is referred to, namely the research or chemical

⁶ Cf. 'HIV and its treatment: what you should know', 2nd ed, on the website: [http://www.aidsinfo.nih.gov/guidelines/adult/brochure/ Starting Antiretroviral Treatment](http://www.aidsinfo.nih.gov/guidelines/adult/brochure/Starting%20Antiretroviral%20Treatment), <http://www.avert.org/starttrt.htm> [2006, September 9th].

name, the generic or common name for all the drugs with the same chemical structure and the brand name given by the pharmaceutical company. Effective anti-retroviral therapy requires the simultaneous use of three or four anti-retroviral drugs as specified in WHO guidelines for a public health approach, scaling up anti-retroviral therapy in resource-limited settings (June 2002a).

The World Health Organisation at <http://www.answers.com/topic/who-disease-staging-system-for-hiv-infection-and-disease> has also developed a staging system for HIV infection. Staging is determining what point a disease has reached. In resource poor countries and communities, sometimes medical facilities and testing are unavailable and it is not possible to decide the appropriate time to begin treatment on the basis of the test results. WHO recommends that a person is put on ARVs at an early stage regardless of the CD4⁷ count (Watsetein and Stratton, 2003: 14–15).

There is some evidence that taking Zidovudine before symptoms appear delays development of HIV (Hamilton, 1992: 438; UNAIDS/WHO, 2000).

According to AVERT, a website on HIV in Zambia, the WHO estimates that at the end of 2005, 183,000 people living with HIV in Zambia were in immediate need of anti-retroviral (ARV) therapy. By tackling the virus itself, this treatment can revive a person's immune system and give those years more healthy life. However, until recently drugs could only be bought through the private sector and, at prices between \$200 and \$800 per month, very few could afford them.

State provision of ARV therapy began at two hospitals in Lusaka and Ndola in late 2002. Just a year later, President Mwanawasa announced that he planned to have 100,000 people accessing treatment by the end of 2005, as part of the global "3 by 5" initiative. To further boost treatment efforts, the government has declared HIV a national emergency, with effect from August 2004 to July 2009.

⁷ CD4 – CD according to Mombe (2005: 18) stands for cluster of differentiation. CD4 is a molecule on the surface of some white blood cells onto which HIV can bind. The immune cell that carries the CD4 on its surface is called CD4 cell. A CD4 test measures the number of CD4 cells in a person's blood. The more CD4 cells there are per milliliter the stronger is the immune system. The stronger the immune system the better the body can fight illness.

Zambia's treatment programme has been made possible only by an unprecedented amount of funding from the Global Fund, PEPFAR and other sources. The delivery of the programme relies on the involvement of many NGOs, churches and communities.

After a sluggish start the treatment programme made swift progress in the second half of 2004. It had expanded to 53 centres by the end of the year so that a third of Zambia's 72 districts had at least one site. According to the Central Board of Health, 13,555 people were receiving ARV therapy through the public sector in September 2004 and at the end of the year, an estimated 18,000 - 22,000 Zambians (13% of those in need) were receiving treatment (including those who paid privately).

Expansion continued during 2005, and by the end of the year around 45,000 - 52,000 people were receiving the drugs, representing 27% coverage, which is above the African average. Stringer et al., (2006: 10) in their recent research have found that death rates among antiretroviral patients in Zambia are as low as those found in the USA.

Peris (2004: 6) says many Zambian people are now wondering whether such a rapid rate of expansion can be maintained, and whether all groups will ever have equal access. Two major issues have dominated discussions of Zambia's ARV treatment programme: the cost to the patient and the shortage of health workers.

According to Kombe and Smith (2003: 13), a year's course of antiretroviral treatment in Zambia costs \$480-490 per patient, of which the drugs themselves make up 57%, and laboratory tests according to UNAIDS/WHO (2004) another 36%. Most of this cost has been subsidized always, but at the start of scale-up the government chose to charge each person receiving therapy around \$8 per month (only a few clinics in Lusaka were exempt). In addition, patients had to pay for tests and transport, which generally raised the cost to \$25-30 per month. Most Zambians live on less than a dollar a day, so could not possibly afford to pay this amount.

Justifications for the user charges included discouraging abuse of the system and encouraging adherence. However, according to Peris (2004: 7) the government more significantly was not at all sure that funding was sustainable, so they wanted to recover some of the cost. Attitudes changed when Zambia secured \$254 million from the Global Fund in June 2004, and in February 2005 the government announced the start of free treatment.

The Joint Review and Strategic Plan for 2002-2005 by the National AIDS Council (30th June 2004) confirms this development and goes on to point out that the cost of these drugs is high and not so easy for many poor people to manage without government subsidies. It must be admitted that the Zambian government recently resolved to supply ART for free to vulnerable groups within society. It must also be acknowledged that there are a number of scientific research efforts at finding a cure for HIV infection (*Times of Zambia*, October, 13, 2005).

One such an effort is by the AIDS Research Alliance (ARA) which is a national leader in fast-track leading edge AIDS research dedicated to identifying more effective treatments and a cure for HIV.

The AIDS Research Alliance uses private donations to speed up the translation of theoretical discoveries in the laboratory to their implementation in the clinic via human clinical trials. For example, ARA works with leading scientists in academia and government laboratories who have identified compounds that potently inhibit HIV in "test tubes". It also works to move these discoveries down the development pipeline and into clinical trials. The Alliance does this by designing and funding pre-clinical research and/or designing human clinical trials for those compounds that demonstrate safety and efficacy in pre-clinical testing. It focuses its attention on therapeutics that industry is not pursuing, including early-stage compounds, off-patent therapies and/or unpatentable natural compounds⁸. Djomhoue (2005: 132) has indicated that unlike other diseases, HIV currently remains incurable. This means that it affects many people whom it surely and progressively destroys. The Bible does not know HIV, but it mentions some sickness like the pestilence that made great devastations, while the physicians of Egypt watched helplessly (Exodus 9: 15, Lev 26: 25, Deut 28: 21).

1.2.2 General data on Zambia⁹

Figure 1 below shows where Zambia is located in Africa and the world.

Zambia is a landlocked country located in south-central Africa. It covers an area of 752,612 square kilometres. It is bordered by eight countries, namely: Tanzania and the Democratic Republic of Congo in the north, Malawi and Mozambique in the east, Botswana and Zimbabwe in the south and Angola and Namibia in the west. Zambia's terrain ranges from

⁸ Information accessed from <http://www.aidsresearch.org> [2005, October, 17th].

⁹ Most of the information from this section obtained via CD-ROM [online] Resource material for Churches and communities <http://www.wcc-coe.org> [2005, March, 29].

mountain peaks to the lowlands of the fertile Zambezi River Valley. The climate is tropical in the lowlands and cooler in the higher altitudes. The country is administratively divided into nine provinces and seventy-two districts.

The population of Zambia is currently estimated at 11,261,795 of which 51% are female and 49% are male (2005 est.). The annual growth rate averages 2.1%, crude birth rate 41.4/1000; crude death rate 20.2/1000; and infant mortality rate 88.3/1000, life expectancy: 39.7.

Almost 39% of the population live in urban and 61% in rural communities. The average national density is 10.4 persons per square kilometre, although the density range in heavily urbanized provinces of Lusaka and Copperbelt is much higher than in the predominantly rural provinces such as Western and North-Western. The majority of the population is Christian, followed closely by adherents to Islam, Hinduism, and other religions.

Figure 1: Maps showing where Zambia is located in Africa and the world



Source: <http://www.worldatlas.com/webimage/countrys/africa/zm.htm>

[Accessed: 2005, April 19]

1.2.3 Statistical picture of HIV in Zambia

Otieno and McCullum (2005: 60) report that by 2005 nearly 40 million people world-wide were living with HIV and some 25 million had died. Worst hit is sub-Saharan Africa and especially eastern and southern Africa where nearly 30 percent of all people have been affected with the virus and more than 14 million children orphaned. Countries especially hard

hit include Botswana, Kenya, Lesotho, South Africa, Swaziland, Uganda, Zambia and Zimbabwe. About 30 million people living with HIV infection, of whom 58% are women are found in sub-Saharan Africa, where Zambia is found. The last report of UNAIDS fact sheets on the situation of HIV in the world does not show any sign of improvement as far as Africa is concerned. As Mombe (2005: 30) observes, the high levels of new infections and AIDS mortality still persist.

Gilborn and others (2001: 100) show that the majority of newly infected adults are under the age of 25 years. These figures almost certainly suffer from under-estimation. Of equal importance to the figures are the rate and the range of growth. The former beliefs that this was a disease of gay men and intravenous drug-users (through their own fault according to some commentators) have had to change. This is due to the recognition that heterosexual intercourse is now the more common means of transmission and that no group of whatever class or race, gender or sexual orientation is immune to infection by HIV.

Zambia has used the antenatal care (ANC) sentinel surveillance data as a principal means of monitoring the spread of HIV for almost a decade (Fylkesnes et al., 1998: 18). The ANC sentinel surveillance system includes both urban and rural sites with at least two sites in each of the country's nine provinces. There has grown, over time, a need to expand the tools for monitoring HIV trends in the general population with population-based surveys. UNAIDS recommends carrying out population-based surveys in catchments of ANC sentinel surveillance sites to calibrate the results of routine surveillance systems (UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance, 2000).

A number of population-based surveys have been carried out in specific catchments of the Antenatal National Clinic sentinel surveillance system in Zambia in order to calibrate the results of the ANC system to the general population and to monitor HIV trends in the general population. However, the 2001-2002 Zambia Demographic Health Survey (ZDHS) is the first nationally representative population-based survey to estimate the prevalence of HIV in Zambia.

It is difficult to get reliable statistics on HIV. It is, nevertheless, clear that Zambia is facing a pandemic of major proportions. By June 2004 the National AIDS Council, in quoting the Zambia Demographic and Health Survey, reports that HIV has spread throughout the country, and cases have been reported in the entire 72 districts. There is much more to the pandemic

than the number of reported cases. Some cases are not reported. This is due to the fact that doctors do not see all patients suffering from HIV. Doctors sometimes fail to diagnose the disease, and the administrative and financial means are not always available to record all diagnosed cases. Some of the reasons for not having precise statistics according to the Zambian Ministry of Health/Central Board of Health (1999: 4) include:

- Some people never seek hospital care for HIV infection.
- Some physicians or nurses may not want to record a diagnosis of HIV infection because of the stigma attached to the disease.
- People with HIV infection do not die from the virus but from the opportunistic infections (such as tuberculosis) that invade the body with the breakdown of the immune system, consequently, many persons die from these evasive infections before they are ever diagnosed as having HIV.
- Most rural hospitals and district health facilities do not have the capability to test for HIV infection.
- Most private laboratories do not report their figures.

(These reasons were used in 1994, but they are still valid as things have not changed much by the time of writing this study).

1.2.3.1 Current situation of HIV in Zambia¹⁰

The population of Zambia continues to grow at an annual rate of 2.3%, (Zambia Demographic Health Survey 2002-2005). According to the observation made by Msiska (1992: 9), the context of the current HIV pandemic is far from satisfactory. More than 50% of the country's population is less than 20 years of age and they constitute the most vulnerable group to HIV. The discovery of the first HIV case around 1988 shocked the nation. It brought about devastating situations in various homes, and hospitals had nothing positive to offer. The seriousness and impact of the HIV was felt at the highest level of government. Many households lost bread earners and in some cases, both parents died. This resulted in these households being headed either by aged grand-parents or teenagers who were not in employment. It also brought about the mushrooming of homeless street children, a social problem which is threatening future generations and future national development prospects (National Aids Council Strategic Plan, 2002-2005).

¹⁰ This section with following diagrams is quoted from the National Aids Council 30th June 2004 *Strategic plan for the National HIV/AIDS/STI/TB Intervention*, published by the Government of the Republic of Zambia.

According to the Zambia Demographic and Health Survey¹¹, currently 16% of the adult population aged 15 to 49 or around one of every 6 individuals in this age group is HIV positive in Zambia.

Zambia is faced with a macro-economic situation which is a major challenge. Since Zambia embarked on structural adjustments in 1991, progress has been made in privatisation and budgetary reforms. Despite these developments, Zambia's debt burden remains astronomically high at US\$3.9 billion (as estimated after reaching the HIPC completion point as prescribed by the World Bank)¹². A substantial proportion of public funds are currently allocated for debt repayment. Zambia is still projected to experience huge debt repayment schemes. Particularly disturbing are the findings from a recent debt sustainability analysis for Zambia. The analysis concluded that even with strong financial policies, the avoidance of non-concessional borrowing, and full use of well established debt relief mechanisms, Zambia's external debt would remain high at unsustainable levels for at least five years. Therefore, Zambia's decision to seek exceptional debt relief under the Heavily Indebted Poor Countries (HIPC) initiative and to explore alternative debt swap mechanisms are essential for the government's overall ability to mount an effective and sustainable response to the current HIV pandemic.

The entire socio-economic context suggests the preponderance of conditions inimical to the effective control of HIV in Zambia. Furthermore, while the trend is of worsening health indicators, the high levels of poverty are likely to make control of the epidemic more difficult and they, too, are in part as a result of the pandemic. With this economically challenged context in mind Guest (2004: 98) suggests that the best hope for halting HIV would be that of

¹¹ Central Statistical Office 2001-2002.

¹² The international community has recognized that one of the major factors contributing to slow growth and persistent poverty in the poorest countries has been unsustainable external debt burdens, which significantly reduce the resources that can be used to improve conditions for poor people.

In April 2005, the International Monetary Fund (IMF) and the World Bank's International Development Association (IDA) agreed that Zambia has taken the necessary steps to reach its completion point under the enhanced Heavily Indebted Poor Countries (HIPC) Initiative. Zambia was the 17th country to reach its completion point. Under the enhanced HIPC Initiative, debt relief from all of Zambia's creditors will surpass US\$3.9 billion over time [or US\$2.5 billion in net present value (NPV)] terms as of the end of 1999. IDA will provide debt service relief amounting to US\$885.2 million to be delivered from 2001 through 2020; the IMF will provide debt relief of \$602 million in NPV terms on payments falling due to the IMF during 2001-08; and the remaining bilateral and multilateral creditors are also expected to provide their share of relief. In July 2005, the G8 agreed on a proposal to cancel 100 percent of outstanding debts of eligible HIPC countries to the IMF, African Development Fund and IDA. Given that Zambia has reached HIPC completion, Zambia has had debt relief and the full benefits especially in the health sector are yet to be seen.

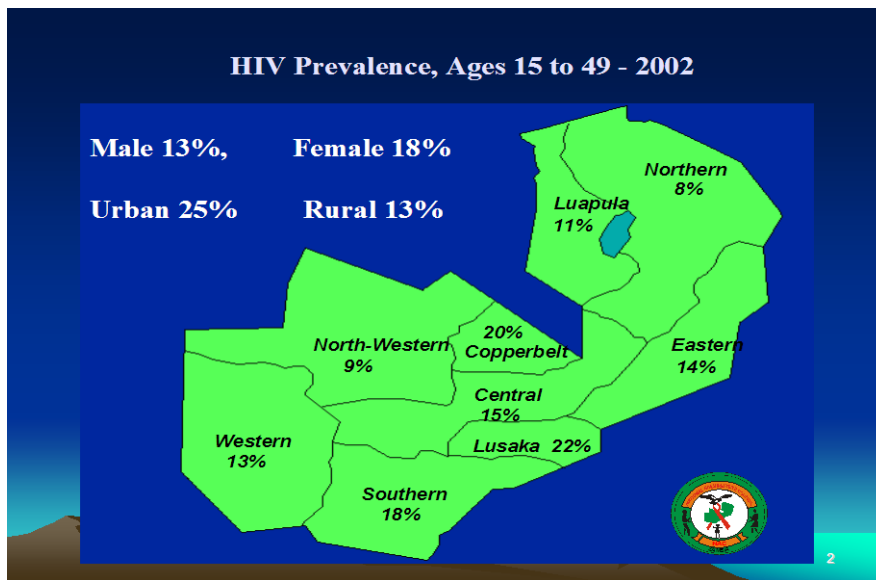
a cheap vaccine. Scientists are trying to find one, but that could take many years. Meanwhile HIV mutates rapidly, so it is hard to teach the body's immune system to recognise and attack it. Guest (2004: 99) goes on to say that in the short term, the only way to curb the epidemic in Africa is to persuade people to shun risky sex. This is hard for several reasons. Sex is fun. And many people feel that condoms make it less so. He quotes one popular phrase one is bound to come across in many African countries: "would you eat sweets with a wrapper on?"

Talking about sex is often taboo. Many traditional parents think it shameful to discuss the subject with their children. Some conspiracy theorists even argue that the whole discussion about HIV is a bizarre plot to make blacks appear immoral.

AIDS in Africa: three scenarios to 2025 (UNAIDS: 2005) was published in an effort to look at actions today and what the possible scenarios could be in 2025. Even though the purpose was not to project statistics, they nevertheless published numbers. The statistics generated the most international coverage. According to the publication the number of children orphaned in Africa by 2025 may be between 18.1 and 27.3 million, the estimated number of new infections between 2003 and 2025 may be between 46 and 89 million and the cumulative deaths from AIDS in Africa between 1980 and 2025 may be 67-83 million. The numbers themselves do not tell of the physical and emotional devastation to individuals, families and communities. They do not say anything about the effect on national economies.

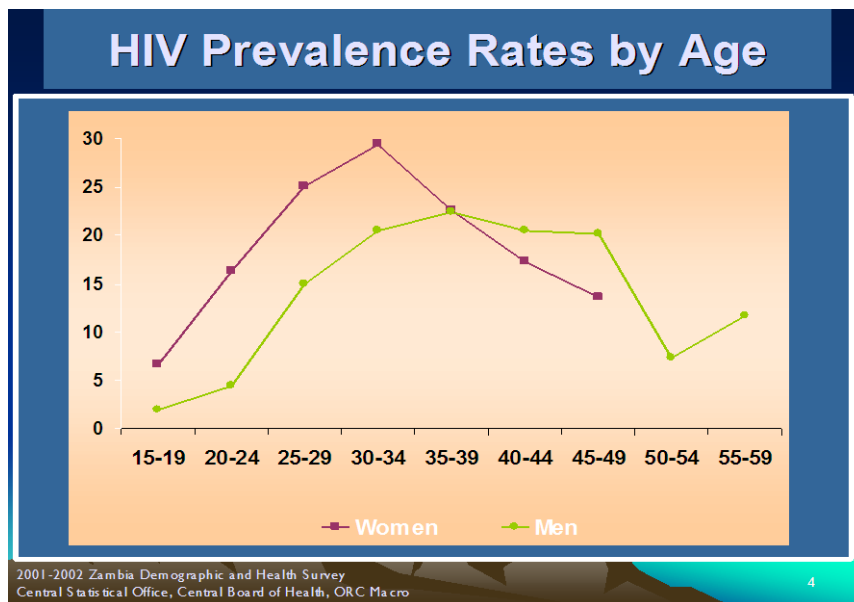
16% of the adult population aged 15 to 49, or as indicated above, one of every 6 individuals in this age group in Zambia, is HIV positive. The infection rate is substantially higher among women (18%) than among men (13%). Figure 2 below shows how the prevalence rate of HIV is distributed in the nine provinces of Zambia for people between the ages of 15 to 49. This is as reported by the National AIDS Council.

Figure 2: HIV Prevalence in the nine provinces of Zambia



HIV prevalence rises from a level of 5% among 15-19 year olds, to 25% among individuals in the 30-34 age group, before falling to a level of 17% among the individuals aged 45-49. Women have much higher infection levels than men in the group below age 35.

Figure 3: Graph showing HIV prevalence rates by age between women and men

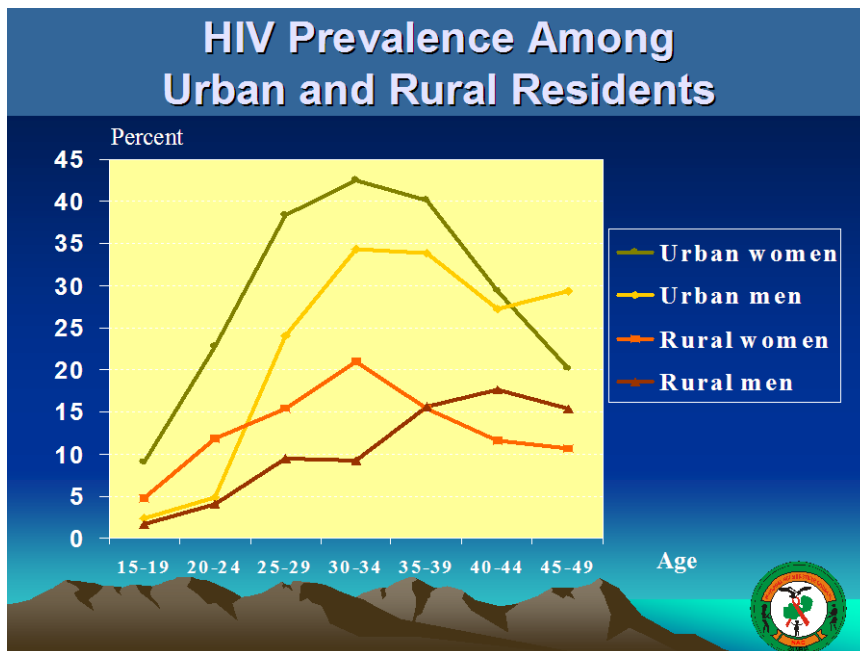


According to Figure 3 above, the difference is especially large under age 25: for example, the HIV rate among women 20-24 is 16%, four times that of men of the same age group. Among the population age 40 and older, HIV infection rates are higher for men than for women.

In Zambia, as shown by Figure 2, urban residents (Copperbelt, Lusaka and Southern) are more than twice as likely to be infected as rural residents (Eastern, Northern, Central, North-Western, Luapula and Western): 23% of urban residents were HIV positive compared to 11% of rural residents (ZDHS, 2002). The most worrisome finding according to Figure 4 below is that almost 50% of the women of 15-49 years in urban areas are infected with HIV. The HIV prevalence rates vary significantly according to geography, with ranges from a low of 8% in Northern Province to a high of 22 percent in Lusaka province.

Approximately 40% of babies born to HIV infected mothers are infected with the virus.

Figure 4: Graph showing HIV prevalence among urban and rural men and women



1.2.4 Poverty in Zambia

According to the 2004 *Human development report* published by UNDP, Zambia’s human development index (HDI) ranks 164 out of a total 175 countries surveyed. This reflects the status of the country as one of the poorest in the world both in terms of quality of life and income poverty. So many of the Zambian population live below the poverty line, with GDP per capita of around 280 dollars (Zambia Economic Report, 2003) and an inflation rate that averaged 30% in recent years. Zambia is the only country that has recorded a regression of the HDI from 0.448 in 1975 to the current figure of 0.427. Guest (2004: 100) indicates that due to poverty those who cannot afford television find other ways of passing the evening. Poor people often cannot afford antibiotics to treat other sexually transmitted diseases

(STDs). STDs can open sores on the genitals, which provide easy openings for HIV to enter a new host.

From a socio-economic perspective, 83% of the rural population is poor against a poverty level of 56% in the urban population. Formal sector employment has for a long time failed to exceed 20% and declined further to about 12%. Women head 20% of the households in Zambia.

In 2002, the Government developed a Poverty Reduction Strategy Paper (PRSP) for the period until 2004. The PRSP clearly notes the lethal link between HIV and poverty, and stresses the fact that poverty is one of the major underlying factors driving the pandemic. HIV, as elsewhere in the southern Africa region, has become an integral part of structural poverty, making its prevention and control a paramount development concern for all sectors of the economy.

Kelly J (2006a: 4) has rightly observed that there is no simple equation between HIV and a country's national wealth or poverty status. HIV is not a disease of the poor countries. Nevertheless, where wealth is concentrated in the hands of a few, if the majority are so indignant that they cannot satisfy their basic needs, society is fragmented and in a state of disarray and the scene is ripe for HIV to make significant inroads. This implies that social and economic measures that will bring about a more just distribution in the wealth of the world and within individual countries are by that very fact measures against HIV. HIV also has the effect of making the poor poorer. This is due to the way the pandemic causes costs to rise, reduces incomes and resources and necessitates the diversion of resources. Kanyandago (2002: 21) indicate that the cost of goods and services increases as industry raises prices to offset ways in which HIV affect its operations. Incomes and jobs are lost through sickness and death, farm production is reduced, loans cannot be repaid, households headed by the elderly or children produce less and the volume of sales decline because customers do not have resources to spare for anything but most essential purchases. The cumulative affect of these various situations is that poverty deepens and becomes more extensive. Muraah and Kiarie (2001: 120) show that poverty not only denies the communities and governments the resources needed to prevent HIV spread and treat infected individuals, it also creates a fertile ground on which HIV thrives. This creates a vicious circle. Poverty fans the spread of HIV and HIV in turn further increases the levels of poverty.

1.2.5 Who are dying?

Table 1: Adult (15-49) Summary, Zambia Total, Epidemiological Projections

1980-2010¹³

	1980	1985	1990	1995	2000	2005	2010
HIV population							
Total	0	33,827	261,171	572,195	741,501	773,539	756,082
Males	0	13,259	107,561	235,810	310,896	330,537	327,529
Females	0	20,568	153,610	336,385	430,605	443,002	428,553
Adult prevalence	0	0.78	10.41	16.72	15.78	13.93	11.85
New HIV Infections							
Total	0	14,534	74,864	82,922	79,782	73,993	73,126
Males	0	5,943	32,018	36,933	36,705	34,204	33,830
Females	0	8,591	42,846	45,989	43,077	39,789	39,296
Adult HIV Incidence	0.00	0.53	2.18	2.96	2.4	1.95	1.59
New AIDS Cases							
Total	0	530	7,423	31,286	57,199	67,854	67,676
Males	0	282	3,714	14,119	24,359	29,123	29,736
Females	0	248	3,709	17,167	32,840	38,731	37,940
Annual AIDS Deaths							
Total	0	240	4,682	25,092	50,353	65,572	66,096
Males	0	132	2,344	11,467	21,434	27,884	28,767
Females	0	108	2,338	13,625	28,919	37,688	37,329

¹³ Table taken from the National AIDS Council strategic plan 2002-2005.

The adult (15-49) summary of Zambia's total, epidemiological projections, 1980-2010 as shown in Table 1 above indicates that the pandemic will increase the death rate at almost all ages. Ndhlovu (1995: 8) says the impact will be most severe among adults in the prime working ages and among children under the age of five. The category of the age group most affected in Zambia is between the age of 15 and 49. People of all walks of life, races and religions are dying from the deadly disease but as observed above especially those in the productive years of their lives are dying in greater numbers. In 2001, Barret (2001: 28) observed that about 1.5million Christians die annually (around 4,110 daily) from AIDS. In the absence of reliable data, one can only assume that the situation of deaths has not significantly changed.

HIV must thus be regarded as a community crisis or as rightly described by Africa's Heads of States – a community disaster (ICASA-XI 2003: 9) and not simply an individual problem. The disease adversely affects entire communities by threatening their collective ability to cope. The *Panos dossier* (1992: 22) has observed that more than any other disease, HIV has the potential to undermine both the social and economic fabric of affected communities because it targets those in the reproductive and bread-winning ages, and because its spread is a factor of the way individuals relate to each other. This last characteristic means that the virus has often brought in its wake recrimination and stigma, but above all it implies that “HIV prevention and care requires a cultural sensitivity and community intimacy unparalleled in other health challenges” (McGuire, 1989: 279). The Africa alive, for youth and entertainment in preventing HIV at their website offers prevention ideas targeted at youth (<http://www.africaalive.org>).

1.2.6 Social implications

HIV affects a wide array of social and economic activities. However, for the purpose of this work the section which follows will only deal with brief analysis on the social effects on the family, women, orphans, education and economic implications. The section will then deal with the implications of all these for the life and mission of the Church.

1.2.6.1 The family

As Matthews (2003: 291) says, throughout history, the family has formed the fundamental social and economic unit on which most human societies have been based. The definition of family varies according to culture and ranges from the single household or nuclear family of

parent(s) and child(ren) to a broader kinship network, or extended family of grandparents, aunts, uncles, and cousins and other relatives and individuals (Czerny, 2005: 31 -34).

Flykesnes and others (1997: 339) in their article: *The HIV epidemic in Zambia: social-demographic prevalence patterns and indications of trends among childbearing women* have shown that in the Zambian society, the concept of extended family still exists but it is largely disrupted due to the influence of urbanisation, which has totally displaced the communal village life. While the status, number and obligations of parents and other adults may vary such extended households generally function as an economic whole. Although it is usually the adults between the ages of 20 and 50 who bring in the greatest income, all family members may contribute according to their abilities. A child of five can oversee livestock while her 70-year-old grandmother cooks the family meals.

It is not surprising that in some parts of Africa, HIV is known as the “family disease” (Panos, 1992: 46). Because the virus predominantly attacks the sexually active, most people who are HIV-positive live in a family with a partner and children. Duncan and others (1994: 12) have indicated that the long incubation period of the virus means that even those who contract HIV when single or childless are likely to have formed families by the time they fall ill. Furthermore, because HIV infection is transmitted between couples, and to offspring, there is a strong probability of multiple cases within a household, creating an even greater burden for its members. As the Kenya Episcopal Conference Commission for Education observed in its HIV/AIDS manual (2002: 105-106) the effects of HIV operate at three different levels: the individual, the family and the wider society. In any community, the greater the number of households affected by a disease such as HIV, the greater the strain on wider social coping systems. Families affected by HIV need support in caring for the sick. Muchiri (2002: 60) indicates that most problems associated with HIV can be managed at home with support from family members. More families find themselves asked to contribute to the funeral expenses of neighbours and relatives, assist in financing health care, to take on work in their fields, care for the sick or take in orphaned children. The arrival of two, three and often more orphans from other parts of the extended family obviously has dramatic effects on the survival strategies of rural households which are already under stress, although older children will be able to contribute extra labour and in some cases their parents’ land. Muchiri (2002: 69) says the family is a very important resource to persons living with HIV and to caregivers as well, and that in addition to the physical and material support which family members can offer,

they can also give emotional support, help the person to make plans for the future and offer a 'place' where the infected person never needs to hide his/her true feelings and worries.

1.2.6.2 Women

Fylkesnes and others (1998: 1227) have observed that women and girls are more susceptible to HIV than men and boys. Furthermore, the report on the Global Strategy Framework on the AIDS Epidemic (2004: 6) observed that in Africa, on average for every man infected, there are three women infected. There are a number of ways in which women are disproportionately affected by the pandemic. As Weinreich and Ben (2004: 26-30) have said, the social and economic status of many women makes them less able to protect themselves from infection. They go on to say (2004: 31) that HIV is transmitted easier from male to female; women are more likely in Africa to be sexually exploited; women are generally less educated; they have fewer rights; they have less economic independence; some traditions are harmful to women; and men determine sexual behaviour. If infected, they face the prospect of passing on the disease to any children they may bear. They also take on a greater share of the burden of caring for the sick. Finally, when they themselves fall ill, they face more problems than men do. Some husbands reject their wives, even though they are the source of the women's infection. Compounding all these restrictions and limitations is the heavy HIV burden that women must bear. The burden of care that they already carry is greatly increased by additional responsibilities in caring for the sick family members and for orphans from their own or their husbands' extended families (Muchiri, 2002: 64-67; Czerny, 2005: 31-35). Patient care, whether at home or in hospital involves women more than men. They provide more care, but receive less care as patients. Kelly (2006b: 7) has underscored that in African societies as in many other parts of the world, married women often face violence and abuse if they demand condom use or refuse sex from their husbands or long term partners. The insistence at times of initiation and premarital 'kitchen parties'¹⁴ that the prime responsibility of a woman is to please her husband at all costs, reinforce the message of her inferior status. Effectively this leaves many Zambian women psychologically powerless to take steps to protect themselves against possible HIV infection from their husbands.

¹⁴ Many young women in Zambia go through a modernized form of initiation ceremonies just before getting married where gifts to help the young bride start her kitchen are presented. Alongside the showering of gifts goes the instruction ceremony where the woman is taught to please her husband at all costs. These ceremonies are called kitchen parties and mostly attended strictly by women.

1.2.6.3 Orphans

An orphan is a child under the age of 18 years (or 15 years) whose mother (maternal orphan) or father (paternal orphan) or both (double orphan) are dead. As the 2004 UNAIDS/WHO report on the Global HIV/AIDS Epidemic says, distinguishing AIDS orphans from other orphans only increases the stigma and discrimination the child is facing today. This view is supported by Subbarao and Courey (2004: 3-4). Meanwhile, UNICEF has observed that (*UNICEF Zambia Report* 1998: 2-6) the increasing number of adult deaths from AIDS in Zambia leaves more and more children orphaned (missing one or both parents). Guest (2004: 98) indicates that in 2002 there were an estimated 11 million AIDS orphans living in Africa. Extended families have adapted heroically to the crisis. In Zambia, one study conducted in the parts of the country worst hit by HIV found that 72% of households had taken in one or more orphans. The national average is probably lower than this, but there is no doubt that such generosity is common.

The vast majority of orphans in Zambia indeed are still being absorbed by the extended family. Although the number of street children is estimated at 90,000 and growing, some 50% of these are orphans. Almost three-quarters of all Zambian families include at least one orphan. Their caretakers are predominantly women. A national study of poverty (Central Statistics, 2002: 12) in Zambia noted that poor women and children tend to have poorer nutrition and health status, and have less access to, and suffer discrimination at the hands of the educational system. Support for families assisting orphans comes primarily from the private NGO sector, which include an array of NGO's, community-based organisations, and Church groups. These are often linked to health facilities, public or private. Chronic malnutrition is pervasive in Zambia, and there is some evidence that infant and child health is declining, partly due to HIV infection and partly due to gaps in coverage of the health care system.

Children orphaned by HIV face many social and psychological problems, as highlighted by Ssekiwanuka (1991: 20) of the Save the Children Fund in Uganda. Orphans lose out economically when their sick parents use the family resources to pay for medical care, or when relatives take their land because they themselves cannot look after it. If taken by the extended family, their living conditions and diet are likely to be poor. This, together with lack of immunisation and health care, heightens their vulnerability to the disease. Their status is affected. As Kidd and Clay (2003: 15) observes, stigma reduces their chances of marriage. If

not taken by relatives, they may become 'street children' and highly vulnerable to HIV because of the need to sell sexual favours for cash or food or they may end up being institutionalised, which creates the problem of adapting to society when they come out of the institution (Lwanga, 1991: 308). UNAIDS as also seen above (2005) in its *Three scenarios to 2025* indicates that the future for many orphaned African Children does not look bright, by 2025 there will be between 18.1 - 27.3 million orphans due to HIV. When children become orphaned they may be deprived of their basic needs of shelter, food, access to health care, clothing and education. They may be targets of verbal, physical and sexual abuse. Their psychological needs for a loving and caring environment are taken away.

1.2.6.4 Education

The development aspirations of most countries depend upon increasing levels of education and literacy. Yet in the worst hit communities, HIV is already having an adverse impact on education. The Kenya Episcopal Conference (2002: 50) has stated that the problem of hundred of thousands of orphans unable to get adequate education or poor socialisation will impact on affected countries for years to come. This is very true as the researcher has observed that many Zambian families affected by the pandemic cannot afford to keep children in school, because reduced income mean that finding even small amounts of money for fees, uniforms, books or other items is no longer possible. Even where there is no question of school fees, children may be needed at home to look after sick parents or to do their work. This has a cumulative effect - the longer children stay away from school, the less likely they are to return. Homeless orphans are unlikely to attend school, while grandparents may not have resources or authority to enable children in their care to continue their education. Therefore, the impact of HIV on education can be profound and has both immediate and long-term effects. Sickness or death of family members - or the children themselves - takes pupils away from school. Yet these institutions could play a considerably bigger part in teaching children and the local community how to look after themselves, and how to help prevent the further spread of HIV.

On another dimension Kelly (2006a: 29) observes that education is also important in responding to HIV. Most countries, however, have been slow in organising their educational systems to work in the threefold area of HIV prevention, care and support for infected and affected persons and the mitigation of the impacts of the disease on the education sector

itself. Namibia and Zambia have had a head start in this regard, but even these countries still have a long way to go.

When countries think of responding to HIV through education, the first thing they usually think of is putting some form of HIV education into the curriculum. This is only natural, because ministries of education feel comfortable when they are dealing with curriculum and teaching matters. In fact, the impact of education on HIV seems to have very little to do with teaching about HIV. Subbarao and Courey (2004: 22-26) agree with Kelly (2006b: 30) that more education helps to reduce levels of infection. Kelly (2006b: 30-31) quotes an example of research done in rural Uganda where HIV testing was done over a period of ten years. What was found was that for those with secondary education, HIV prevalence fell steadily from 12% in 1991 to less than 2% in 2001, for those with primary education it fell from 12% to 6% and for those with no education, it did not fall, but fluctuated around 12%. This occurred at a time when the education being provided in schools was not very good and when the HIV did not receive very much attention in the school curriculum.

It seems that it was the fact of being at school that made the difference and not education about HIV as such. Something similar has been found in Zambia: a girl who dropped out of school was three times more likely to be HIV positive than her age-mate who remained in school. What seems to be happening is that school education somehow opens a person up to taking in and acting on information from other sources, including information about the disease and how to protect oneself. Kelly (2006b: 33) observes that in Zambia the percentage of those who know that a healthy looking person can have HIV rises steadily with the level of education. So also does the percentage of those who know more than one way of protecting themselves against HIV infection, the percentage of those who know where to go for an HIV test and the percentage of those who have actually had an HIV tests. On every measurement that has been taken, those with primary education come out better than those with no education, those with a secondary education better than those with a primary education and those with a tertiary education better than those with a secondary education. Clearly education counts and the difference is more than in knowledge, since being educated is linked with going for HIV testing, something that requires action.

1.2.7 Economic implications

Zambia's economy has been in decline for more than a decade, mainly because of depressed world copper prices and declining production. Copper was once the mainstay of the economy, to the detriment of the development of the agricultural sector. Foreign debt has grown steadily, and there is high inflation. Nearly 70% of Zambians lack basic human needs. 29% of children suffer chronic malnutrition, and a HIV pandemic poses serious health threats. Zambia has launched a number of economic reform programmes to try to diversify and reduce its dependence on copper. The government is focusing on agriculture - still the country's largest employer. Zambia has also privatised much of the economy, reduced public spending, and is attempting to attract more foreign investment. At the time of writing this dissertation, Zambia remains dependent on development assistance. The country also faces serious environmental problems, including deforestation, desertification, and cyclical drought.

Because it primarily targets the most productive members of the labour force, the HIV pandemic has profound economic implications. As the epidemic advances in Zambia, changes to the population profile will exacerbate existing skill shortages and create new ones, threatening productivity. Over time, as the young sexually active members of the labour force (20-40 years old) become infected, fewer will survive to form the older segment (40-60 years old) which has accumulated skills and experience through training and long service.

In addition to the loss of labour and skills, which takes many years to replace, HIV has implications for other aspects of employment such as training, sickness benefits, pensions and insurance. Absenteeism because of illness, caring for the sick and mourning¹⁵ the dead also affect productivity (Panos Dossier, 1992: 67-79).

A common image in Zambia, as also in other developing countries, is one of teeming cities, acting like magnets for millions of people in search of a better livelihood than what the rural areas can provide. The majority of these millions remain informally employed, making a

¹⁵ In Zambia ten or more visitors come and spend an entire day or several days at the house for a funeral. The labour of all these people is thereby lost. They need feeding, a direct cost. The whole funeral becomes an extra expense. Then there can also be travel costs and also, in some cases, transport of the body, mortuary costs, coffin costs, grave digging costs and so on. In Zambia burials take place every day so people are disrupted often from their work schedules. Night vigils take place until the day of burial, in some cases of up to four nights.

living in many different ways, working, for example, in small industries and businesses, as market traders and day labourers brewing beer, selling food and recycling waste.

Those in formal employment are in the minority. The service sector dominates the picture. It is made up primarily of commerce centred on the export and import of goods with even the banking, finance and transport industries geared to international trade. The government is the next main source of employment, with hiring policies designed to absorb large numbers of unemployed school graduates. The industrial sector is typically small, based in the cities to take advantage of infrastructure such as the airport, good transport and communication networks, financial services and government offices. In spite of the accelerating urbanisation over the last two decades, Zambia is still having a higher proportion of its population living in the rural areas. HIV with its initial disproportionate impact on urban areas, threaten the development prospects of the commercial and industrial enterprises, which are so vital to a country's economic growth (ICASA-XI, 1999: 17).

Kofi Annan (formerly UN Secretary General) aptly commented on the challenge which HIV poses: "HIV/AIDS has become not only the primary cause of death, but the biggest development challenge" (UNAIDS Peter Piot, 2003a).

1.2.8 The problem summarized: implications for the church

Summarising the problem, one can say HIV is a rampant pandemic, a sickness with no cure. According to the medical dictionary on <http://www.thefreedictionary.com/pandemic>; a **pandemic** is an epidemic (a sudden outbreak) that becomes very widespread and affects a whole region, a continent, or the world. By contrast:

- An **epidemic** affects more than the expected number of cases of disease occurring in a community or region during a given period of time. A sudden severe outbreak within a region or a group as, for example, HIV in Africa or HIV in intravenous drug users.
- An **endemic** is present in a community at all times but in low frequency. An endemic is continuous as in the case of malaria in some areas of the world or as with illicit drugs in some neighborhoods.

The word "pandemic" comes from the Greek "pan-", "all" + "demos", "people or population" = "pandemos" = "all the people." A pandemic affects all (nearly all) of the people. By contrast, "epi-" means "upon." An epidemic is visited upon the people. And "en-" means "in." An endemic is in the people.

HIV infection is thus extracting an accumulating staggering health toll especially amongst those in their productive years. The social, family, educational and economic implications are overwhelming. Not a single family and community is unaffected by the pandemic. Maluleke and Dube (2001: 120-124) sum this up very well:

HIV/AIDS is not only a matter for health professionals. Its impact encompasses individuals, families, communities, faith communities, entire nations and continents. In short it is a global phenomenon. HIV/AIDS has especially devastating social-political and economic effects on those countries with a high prevalence of the disease. This reality calls for a multi-sectoral approach to its prevention and care. For an effective fight against HIV/AIDS to emerge, all government departments, the private sector, NGO's and faith communities must make fighting HIV/AIDS part of their "core business". All of us everywhere must make it our business to reduce the spread of HIV/AIDS as well as to minimise its impact.

The lack of zest and strategic planning on the part of the Church and its educational institutions to confront the challenges, therefore, needs urgent attention. The lack of support groups at local congregational level provides the Church with a great challenge in the need to embrace HIV totally. Kidd and Clay (2003: 29) agree that the absence of support groups in local faith communities fuels the stigma of people living with HIV.

To a large extent the Zambian Churches have not yet adequately attended to the problem of HIV. A few seminars where medical personnel are invited to give a talk are held once in a while but no theologically motivated response has yet been made. Apart from the caretaker role played by most women members of the Church in the women's guild, the Church seems to be in a denial stage. The pulpit has done very little to address this human scourge. One will listen to more condemning and judgmental sermons (particularly in condemning the use of condoms in the prevention messages) than concrete proposals of how the pandemic could be tackled. Hendriks (2004: 29) is right in suggesting that faith communities need to be empowered to discern God's will for their own contextual situation like this one posed by HIV. The problem is further compounded by the fact that the theological institutions where pastors are trained have just recently (2003) introduced a curriculum dealing with HIV. This has posed a new challenge, namely, that those ministers who got trained prior to the introduction of an HIV curriculum are in the majority and there is need to scale up the re-training programme. Maluleke (2001: 127), in borrowing from Mbiti's (1969: 7) words, says there is some kind of "theological impotence" of African graduates in theology in respect of the acute challenge posed by HIV. Theological training in Zambia some five or more years

ago offered little or nothing in preparing pastors for meaningfully and constructively to face the challenge. Maluleke's (August, 2000: 105) words again are more appropriate in this light, namely that:

The HIV/AIDS pandemic constitutes a new *Kairos* for the Church in (Southern) Africa. The Church should overcome its theological impotence in the face of AIDS and learn from African Theology how to develop a contextually relevant theology to meet this new *Kairos*. Theology should reflect on its silence about HIV/AIDS and develop an advocacy theology in continuity with earlier 'third world' theologies that takes women's concerns seriously and highlights personal ethics. Out of this, theological educators should develop a curriculum that addresses all three its 'publics' and enables people to integrate what they say with what they do.

The fact that this constitutes a *new kairos* should enable a deliberate strategy to be devised to ensure that the silence, shame and stigma associated with the HIV infection is removed so that the Church can play its meaningful role in influencing a behavioural change for life in its fullness.

1.3 Research hypothesis

It is clear that HIV is rampant in Zambian society causing major social and economic disruption. In the light of the discussion of the problem, the researcher wants to pose the following hypotheses:

Hypothesis 1:

Churches in Zambia do not have in place an effective strategy that addresses the issue of HIV stigma in a holistic way at a congregational level where it effectively reaches and influences members¹⁶.

¹⁶ In coming up with such a statement as an hypothesis, the researcher takes the view as explained by Mouton and Muller (1997: 121) that when we first formulate a statement without knowing whether we have any empirical warrant to accept it as reasonably valid or even true, we call this a hypothesis. A hypothesis is a statement that makes a provisional or conjectural knowledge claim about the world. Furthermore, the Merriam-Webster (1996) dictionary says that a hypothesis is an assumption or concession made for the sake of argument or an interpretation of practical situation or condition taken as the ground action or indeed a tentative assumption made in order to draw out and test its logical or empirical consequences. In this first hypothesis, the researcher has used the meaning given by the Merriam-Webster dictionary that a hypothesis is the antecedent clause of a conditional statement. A good hypothesis is empirically testable, which means that we must be able to specify clearly what data would provide support or rejection of it. Mouton and Muller (1997: 122) further clarifies hypothesis into two main groups: Existential and relational hypothesis. An existential hypothesis is thus a provisional statement about a certain state of affairs, that is, it makes a claim that something is the case. The hypothesis of this work therefore makes a claim that there is no strategy that addresses HIV stigma in a holistic way. The primary argument of the hypothesis will be elaborated and its

According to <http://www.answers.com/topic/holistic?cat=health> (2007, May 20), “holistic” is described as a term describing an integral, inclusive approach, which regards each being, system, or object as more than the sum of its parts. Holism is often associated with medicine, nutrition, and lifestyle. The term can imply a pre-technological lifestyle which uses alternative healing practices vs. contemporary established western practices. Holistic practices deal with the whole person, in that one's entire well-being is analyzed - his/her physical, emotional, spiritual, mental, social and environmental factors, etc. HIV is a complex and multifaceted pandemic with a variety of interacting causes, sustaining factors and impacts. Therefore this pandemic demands a holistic response from local faith communities. HIV is a biological, behavioural, child and youth issue, gender, poverty and cultural, socio-economic, justice, deception and compassion issue. In this work, therefore, “holistic” means including all relevant parties that can play a role in this quest of building HIV competent communities.

Hypothesis 2:

A missional theology which promotes the praxis of the creation of ‘circles of hope’ at a congregational level is a basic presupposition for a holistic approach to combat HIV infection and its related stigma.

A circle is a symbol of unity and wholeness. The circle evokes sitting around the village fire or under a tree in the African culture. However it manifests itself, the circle is all about being a place for community to grow, about being face-to-face in basic need for freedom, love, truth and justice and it is about being knit together in a network of people that overcome silence, shame and stigma and share resources.

In the same way that black theologians in both South Africa and North America launched a concerted theological assault on pseudo-Christian racist heresies, the researcher contends that there is need to launch a similar campaign against the heretical self righteousness of those who discriminate against people living with HIV. If racism attacked the integrity of the children of God by making them doubt that they were indeed children of God, discrimination against HIV positive people essentially does that too. We share the same humanity and in the same human frailty as people living with HIV infection and to treat them otherwise is as

tested results shown in Chapters two and three. The existential hypothesis is more commonly used in exploratory research. Its main purpose is to establish what the matter is.

bigoted as being racist or sexist. Maluleke (2001: 135) wonders how those who were excluded from the communion table, from the ministry of Christ and from participating in the economic and political affairs of their countries - on account of their skin colour and gender - forget the pain of exclusion so quickly. The only way to counter this discrimination of people living with HIV infection is surely by creating support groups within local congregations. As Hendriks (2004: 221) says, in combating HIV infection, one needs co-operation from a number of disciplines that should be presented to local communities. Building networks and partnerships are crucial elements of the process and are part of the public dimensions of the Church's work and witness. These support groups which need networking and partnerships, are from within local communities. The researcher fully agrees with Hendriks (2004: 217) that an ideal community is a coming together of people who share physical and social space, in this case the social space of all people who are HIV positive, making them aware of individual, family and community strengths and needs. Furthermore, helping them to build informal social support networks in co-operation with professional helpers (in the case of circles of hope, these professionals would become psychosocial counsellors and caregivers) so as to manage resources in such a way that social problems (in this case related to HIV) are prevented at all levels.

This study, then, is an attempt to fashion a model for combating the HIV pandemic for the faith communities.

1.4 Aims of the study

This study will seek to develop a theological theory and an integrated strategy that addresses the problem of fighting HIV stigma in Zambia in a holistic way:

- With regard to theological theory, the study will describe what is meant by "missional theology" by using the literature produced by Network for African Congregational Theology as well as the Gospel and our Culture Network.
- The strategy that needs to be developed will require inter-organisational co-operation as well as a multi-disciplined approach (local government, local communities, non-governmental organisations, research institutions, churches and even other faith communities).
- The strategy will show that a full range of inter-related approaches are needed. Effective methods of prevention should include sexual abstinence, mutual fidelity, condom use and a safe way of dealing with blood and needles. Education, including education for responsible sexual practices, will help to stop the spread of the infection.

- The strategy implies participatory action research: those affected by HIV infection need to be involved in a praxis-oriented way of developing ministering theory and strategy. The creation of support groups for people living with HIV infection at local congregational level is a new frontier that needs to be embraced in this fight.
- The strategy involves developing supportive and healing communities as a means of fighting the silence, shame and stigma associated with HIV.
- The strategy depends on the ministry of women church groups who are in the forefront as care givers.
- The strategy depends on getting the co-operation of the Zambian churches to address the situation of HIV infection and this requires visionary and committed leadership.

1.5 Value of the research for the field of study

The study will develop a mission, vision, values and a strategy with which the Church can engage the pandemic of HIV. It is hoped that this study will contribute to contextualise a missional theology in Zambia in order to develop practical proposals for the intervention strategies of the Church in Zambia in tackling the HIV pandemic, which is claiming many lives and even threatening the entire community. *[I]f you do not warn, then I will hold you accountable for their blood* (a paraphrase of Ezekiel 3:18 NIV). *If one part of the body suffers, every part suffers with it* (1 Corinthians 12: 26 NIV). Furthermore, this study has contributed to the body of knowledge about social consequences of HIV particularly in Zambia by suggesting that the stigma is being effectively fought through the creation of praxis support groups called Circles of Hope.

1.6 Motivation for the study

The problem-statement should serve as an adequate motivation for this study. The impact and devastation caused by HIV infection has had major effects on the life and mission of the Church as well as the social and economic life of people in Zambia.

For many people, HIV infection has acted as a spotlight exposing and revealing the many iniquitous conditions, such as poverty and injustice in the communities' lives, which have been neglected. The Church is challenged to examine the underlying realities in the Churches and communities, which encourage the spread of HIV infection, and to work to address those realities in a way which can help to restore healthy, safe communities.

The Church by its very nature as the body of Christ is called to become a healing community. This community must be a safe space of openness and acceptance providing healing spaces, and for the sharing and telling of life and death experiences. Christ's community of care should be an environment of trust and commitment, in which risks can be taken and where all members acknowledge their mutual vulnerability. This study proposes an alternative paradigm which is evolving amongst the Zambian Churches on how to overcome silence, shame and stigma associated with HIV infection. The researcher contends that the creation of HIV support groups, called 'Circles of Hope', provides such an alternative paradigm.

The presence of HIV infection in the Zambian community and, particularly, but not exclusively, in the Church community, requires Christians to find out who they are and how they are responding to the urgent need to act for inclusiveness and justice. Christians are not simply called upon to offer charity to those whose physical bodies have the virus. The Church is challenged by its very belonging to this community to acknowledge that the virus has come into the body of Christ and thus needs to respond urgently with tangible and realistic intervention strategies.

1.7 Preliminary studies

The researcher wrote a Masters Degree thesis entitled: 'Some Missiological Challenges facing the Reformed Church in Zambia after Autonomy' (University of South Africa, 2000, *cum laude*). In that thesis the researcher mentions HIV as one such challenge that cannot be ignored.

In his dissertation for the Master of Philosophy degree in Ecumenics, submitted to the University of Dublin in Ireland (1995: 18–20) the researcher refers to HIV as one of the most serious problems facing young people in Zambia.

The researcher has also been involved empirically in combating the scourge in his capacity as Moderator for the Southern Africa Alliance of Reformed Churches. This has designed a project to mobilise member churches in the southern Africa region to address the pandemic with new strategies and with the mobilisation of youth and women participation. The creation of an HIV/AIDS Resource and Training Centre as well as the support groups called Circles of Hope under the leadership of the researcher is another empirical involvement in fighting the scourge.

The researcher was involved in a theological reflection group from the Nordic and some Southern African countries called the NORDIC-FOCCISA (Fellowship of Councils of Churches in Southern Africa) cooperation which resulted in the production of booklets entitled: ‘*One Body*’, produced by NORAD (2006) and available at <http://64.233.183.104/search?q=cache:rfsWhgNmBEEJ:www.norgeskristnerad.no/doc/OneBody-Vol2%2520-Eng.pdf+One+Body+Nordic+Foccisa&hl=en&ct=clnk&cd=3&gl=ke>.

One Body was an outcome of a close and collaborative dialogue between people from four countries: Mozambique, Zambia, Norway and Denmark. They were brought together by the NORDIC–FOCCISA Church Cooperation. The researcher was a convener of the said meetings. Their work was motivated by the call for ecumenical initiatives in response to HIV and AIDS both in Africa and elsewhere. It may be seen as a follow-up to an appeal from the World Council of Churches to work across regions in order to address questions of stigmatization. It was a group of lay and ordained, male and female, but came from a diversity of cultural, regional and denominational backgrounds. They came from churches, ecumenical and church related organizations and organizations of people living positively with HIV.

The researcher has also participated in forums of the All Africa Conference of Churches where he served as General Committee member until he joined the staff team at the Nairobi office in Kenya.

In Zambia the researcher has been a Reformed Church Synod Moderator and is currently serving as Vice Synod Moderator (2005-2009) where, in this capacity, he has been asked to participate in discussion forums on what the Church can do. In his recent previous office as National Co-ordinator responsible for strategic planning and capacity building, he was responsible in mobilising resources aimed at, among other things, how the Church could come up with a policy document on its mission and intervention strategies concerning HIV.

The researcher presented a paper entitled: “*Social Religious perspectives of HIV/AIDS and Sexually transmitted diseases*” at an Eastern Province of Zambia seminar organised by the Zambian Ministry of Health (Ndhlovu, 1998). He has also spoken at a number of Church organised meetings in Zambia, Kenya, Sweden, Denmark, Norway, Singapore, Hawaii, Ethiopia, Botswana and Malawi on the basic facts concerning the spread and prevention of HIV.

The researcher served as General Secretary for the Council of Churches in Zambia for five years (until March 2007) and helped in the establishment of a Resource and Training Centre for member Churches and other Christian organisations to help in addressing issues of HIV and also spearheaded the creation of support groups of people positively living with HIV.

As indicated above, the author was the Board Chairperson of the Zambia Interfaith Networking group on HIV/AIDS (ZINGO). This group brings Bahai, Muslims, Hindus and Christians of various theological persuasions together to work towards an HIV free Zambia.

1.8 Methodology

The practical theology methodology that is suggested by Hendriks (2004: 34) would be the basis of the methodology in this research. This methodology takes cognisance of the fact that theology is about showing good insight and making good judgements, which take place in a congregation of the faithful. This insight, then, leads to the involvement of the faithful in Church and society. This involvement is a response (praxis) to the presence of the triune and missional God who interacts with the faithful through the Bible and tradition in a particular given context and beckons the faithful to the future. The concept “missional” will be fully dealt with in Chapter 3.

The researcher used a purposive sampling technique to interview the Faith Based Organisations whose results form the basis of mapping chapter two of this study. This chapter discusses what is happening in creating HIV competent communities in the Zambian context. According to Mugenda and Mugenda (2003: 50), purposive sampling is a technique that allows a researcher to use cases that have the required information with respect to the objectives of the study. In this technique cases of subjects are therefore hand-picked through consultation with FBO`s and they are informative and they reveal what happens on the ground. This technique was preferred because the response to HIV by the faith-based community in Zambia can be better described and analysed through the work done by the umbrella bodies.

Furthermore, this study made use of data from both secondary and primary sources. Being a qualitative study, there was a deliberate restriction of the target group to the available faith-based umbrella bodies in Zambia.

1.8.1 Secondary sources

Initially, there was a deliberate consultation and recording of secondary data from books, reports, dissertations and newsletters from the libraries of Justo Mwale Theological College, in Lusaka (Zambia), Stellenbosch University in South Africa, the AACCC Library in Nairobi, Kenya, the AFYA Mzuri information centre in Lusaka and other relevant sources from the internet. In developing a theological theory to support the ministry theory and strategy that this study wants to pursue, the researcher studied literature from the Gospel and Culture Network. In order to appreciate the local analysis for members of the Zambian Churches, the researcher also endeavoured to look at literature by the Network for African Congregational Theology.

It was established that these centres and sources of literature had sufficient and relevant materials to lay a foundation of this study. Secondary sources of data were consulted to provide a starting point and obtain a contextual framework for the study.

Secondary data also provided support for primary sources, ground for comparison, benchmarking and perfecting the topic in line with what has already been done. Further, this information provided an update of knowledge on current HIV interventions, policies and programmes of FBO's in Zambia. This information indicated that there was little or no literature on fighting stigma through HIV support groups.

Finally, secondary sources revealed some unresolved issues, and assisted to refine the focus of the study. It spells out the uniqueness of the direction taken in the research and helps to avoid duplication. It also acts as a control measure for the validity of the research findings.

1.8.2 Primary sources

In the second part, data was collected from primary sources. These included the Council of Churches in Zambia, the Evangelical Fellowship of Zambia, The Churches Health Association of Zambia, The Zambia Interfaith Networking Group on HIV, the Zambia Episcopal Conference especially those directly or indirectly responsible for policy making, General Secretaries and Executive Directors. In some instances, feedback depended largely on a few write-ups that were made available from the organisation in addition to the respective individuals who were interviewed. The personal experience of the researcher in addressing the HIV scourge with the Council of Churches in Zambia where the researcher

was General Secretary, Chair of the Interfaith Network, initiator of the Circles of Hope programme and participant in several HIV related local and international conferences helps as a way of controlling data as well as extracting relevant data for the sake of contending with the arguments at hand.

Primary data were useful in contributing to the topic. It provided unbiased empirical evidence since it was directly obtained from the target group. This raw data often was of more value than secondary data. Therefore, the arguments in this study, particularly in Chapter 2 and 4, largely depended on these sources for the sake of adding more knowledge to the subject of a ministerial strategy for combating HIV.

Through interviews and structured questionnaires, information was obtained from the five faith-based umbrella bodies. A standard structured questionnaire with six questions was used in all cases and transcripts were used to compile data from interviews.

The researcher deliberately conceived the questionnaires to address the research problem and goal. Since the questionnaires were personally administered by the researcher, the return rate was 100%. The questions were not many in order to keep the respondents interested in providing answers. The six questions were meant to benchmark the organisations' HIV activities and inquire if they had programmes which supported the creation of support groups for people who were living with HIV. Chapter 2 begins with an overview of what has been happening in the global ecumenical church and compiles the responses to the questionnaire. Each organisation was introduced briefly before going into what they have done in their response to HIV in Zambia. The following questions were asked:

1. Give me a brief historical background of your organisation?
2. How is the structure organised?
3. What responses has your organisation made to the problem of HIV and to many deaths caused by AIDS in our country?
4. Do you have any HIV policy statements issued by your organisation?
5. Do you have any programmes that support people living with HIV? What are they called and what do they do?

6. Give me any further information of what your organisation is currently doing about the challenge of HIV?

The following steps for doing a survey were used as adapted from *The Survey System's Tutorial, revised July, 2006*

Establish the goals of the project - The goal was to find out how faith communities have responded to HIV in Zambia and look at gaps. The researcher embarked to find out if Churches in Zambia do have a strategy in place which effectively addresses the issue of HIV stigma in a holistic way at a congregational level where it effectively reaches and influences members. On the other hand the researcher wanted to find out if a missional theology which promotes the praxis of the creation of 'circles of hope' at a congregational level was available in the programmes or activities which were under the umbrella bodies described in this work. This was done by asking if they had activities which supported HIV positive people.

Determine your sample - It was determined to interview the executive officers of the umbrella bodies in question thus the Council of Churches in Zambia (which was done through participant observation, since the researcher was the executive officer of the Council of Churches in Zambia), the Evangelical Fellowship of Zambia, the Zambia Episcopal Conference, the Churches Health Association of Zambia and the Zambia Interfaith Networking Group on HIV/AIDS.

Choose interviewing methodology - The methodology was personal interviews.

Create your questionnaire - A questionnaire with six questions was designed and it was used as guide in all the interviews. The interviews were personal and according to *The Survey System's Tutorial, revised July, 2006*, an interview is called personal when the interviewer asks the questions face-to-face with the interviewee. These responses were complemented by the researcher's participation in several HIV related conferences organized by the bodies described in this work. These conferences took place between 1999 and 2006.

Conduct interviews and enter data - The questionnaire was administered by visits to the mother bodies' offices and data collected.

Analysis of the data - The collected data formed the basis of the discussion in Chapter 2.

Instead of only focusing on Scripture and tradition with the intent of making systematic and comprehensive interpretations, a missional praxis theology does theology by first focusing on local and particular issues with the intention of doing something about the reality and problems confronting the faith community, as well as society. It does this because God in his coming to us in and through Jesus Christ initiated something that changed people and formed them into a community of a people called to love God and their neighbour. Therefore, after listening to and researching the present or contextual reality affected by HIV as the main thrust of this work, a dialogue with the reality of the past and its normative content ensues. Theology tries to discern present and past realities hermeneutically in order to discern God's will in order to participate in his ongoing praxis towards a future anticipated eschatological reality. It does so in a vocational way. This active-reflective spiral leads to a new formulation of the truth and values that may be systematically expressed in theology in new creeds as shown in the formulation of the 2003 covenant on HIV by the All Africa Conference of Churches. Above all, these values are evidenced in the life and witness of the church. As such, aspects of the eschatological future are now realized, creating joy and hope even in the face of a life threatening disease such as HIV infection (Barth, 1958: 100).

A hermeneutical, correlative way of doing theology is expressed in this work. This section heavily relies on the work done by Hendriks (2004: 33) in *Studying congregations in Africa*. At least five levels of action for doing theology are mentioned in the book:

1. At a personal level, Christians are called to be followers or disciples of Jesus Christ. They are to grow spiritually towards maturity in order to portray Christ's image. In this process they discover the gifts bestowed upon them with which they are to serve God, their neighbour and their society. The indwelling power of the Holy Spirit touches and changes them in all facets of their lives, minds, bodies and souls or, to put it in another way, rationally, emotionally and physically they are formed and transformed by the power of God.
2. At an ecclesial level, within the faith community, they are the body of Christ: a missional church (Guder, 1998). Not only as individuals, but also as a community, they have to discern God's will at a particular time and place in order to act as an alternative community, within the wider society, in order to be a light and salt to the world. Therefore, the church's vision and mission will have a direct relationship to its identity, processes and programs. In its life as the body of Christ, the church has

different ecclesial practices or activities that evolve from its missional character. Circles of Hope are thus one such activity evolving from this missional character and saying HIV infection is not God's will and begin to look for ways of being a community in the face of silence, shame and stigma brought about by HIV.

- Worship and the liturgy are of crucial importance in this regard because that is where the most intimate and deep communication can occur. All Circles of Hope meetings start with prayer and worship.
 - *Koinonia*, or community in and through Christ and the Holy Spirit, may be experienced in all the church's activities in local or ecumenical relationships. There is a unique fellowship shared by members of the body of Christ who are HIV positive.
 - *Diaconia*, or the service or ministry of the church, has many forms such as taking care of one another, responding to those in need, ensuring that justice is done in all spheres of life, as well as caring for the earth. Circles of Hope are indeed an entry point for care and compassion instead of silence and stigma.
 - Equally, the witness of the church has many facets, from evangelism to witnessing about truth and justice in all walks of life. The truth of HIV infection and about positive living is dealt with in Circles of Hope.
 - The organization and strategic planning of the church, as an institution, the communication between, and regulating of, its life and ministries act as the skeleton and nervous system of the body and impart order and form to its many functions. The Circles of Hope are strategically planned as part of the church community, though their influence goes beyond the boundaries of the church.
3. At the level of secular society, the church also has an important role to play (Hauerwas & Willimon, 1989: 48). It must witness to the Gospel of Jesus Christ and proclaim prophetically that justice be done to all people, as well as ecologically to the earth (Rasmussen, 1997: 91). The body of Christ must be humble custodians of the creation.

In the process of doing theology, the church must unmask the pretences of secular value structures, unjust practices, ideologies, the seductive injustices of capitalistic market economies and the destruction of the natural habitat. Alternative stories, realities and hope should be proclaimed. The faith community should be an example of people capable of living and relating with an alternative set of normative biblical values. This communication should take place with an ethos of humble service in a language and style that can reach out to people with no Christian memory or commitments (Fowler, 1999: 84). It should be seeker-sensitive (Strobel, 1993: 11).

4. At the scientific level, on which the church should participate and which refers to the academic-intellectual aspects of theology. It is important that this aspect of theology should not be done alone in some sort of “splendid isolation” (Van der Ven, 1998: 23). Theology should be multi-disciplinary insofar as it should relate to other disciplines in addressing the issues with which persons, the church and society are confronted. This does not mean that theology has to compromise its normative element.

In this regard Kelsey (1992: 20) points out that academic theology should be done through the lens of the congregation and should be taken seriously.

5. At the ecological level, the body of Christ must be humble custodians of the creation (Rasmussen, 1997: 91).

Furthermore, this study is about a theology of Hope. Hope is an integral part of the theological methodology outlined and used in the research (see Chapter 1:11 on Missional Theology below and also Chapter 3). This hope is as explained by Jürgen Moltmann (1967).¹⁷

¹⁷ Since the publication of *Theology of Hope* in 1964, Moltmann has continued his long adventure of theological ideas with eschatological hope, that is, hope for the coming Kingdom of God, as his central theme. His adventure of theological ideas can be divided into two parts by a turning point in his theological path in 1978: the Mexico City Conference attended by liberation theologians, black theologians and feminist theologians. In this account we can meet two distinct series of his works: the early trilogy and systematic contributions to theology. Moltmann’s early trilogy - *Theology of Hope*, *The crucified God*, and *The Church in the power of the spirit* - represent three complementary perspectives on Christian theology. These are programmatic in style and content: and in each the aim of them is to look at theology as a whole from one particular perspective (Moltmann, 1981, xi). Though they are ‘one-sided,’ he could enter new territory, for which no maps yet existed in the theological traditions.

It is about this specific time and about Zambian Churches. In *Theology of Hope* (1964; English Translation, 1967), Moltmann (1967) understands Christian faith as an essential hope for the future of human beings and this world as promised by the God of Exodus and the resurrection of the crucified Jesus. Thus for him, eschatology expresses the attitude of expectancy that underlies all of faith. For him, however, Christian eschatology does not mean “the future as such”; it sets out from a “reality in history” and announces “the future of that reality, its future possibilities and its power over the future” (1967: 17). Moltmann (1967: 84) presents Christian eschatology as an active doctrine of hope in order to give hope for an alternative future to the oppressed and suffering of the present time. This hope for him acts as the motivating force behind liberation in the world. In re-examining the sources of eschatological thought, he finds that Christian eschatology looks toward the revolutionising and transformation of the present. This is why for him, “[t]he theologian is not concerned merely to supply a different interpretation of the world, of history and of human nature, but to transform them in expectation of a divine transformation”. Therefore, history is the reality instituted by the promise of God in God’s presence and experienced by human beings as the moving horizon of promise in anticipation. In this sense, his eschatology in *Theology of Hope* is different from the traditional theological eschatologies of the ‘hereafter.’ God is a God of hope and this work motivates the urgency of sharing faith, love and hope to all people infected and affected by HIV, regardless of whom they are. Paul wrote: “And now these three remain: faith, HOPE and love” (1 Corinthians 13:13).

Therefore, in order to do an appropriate local analysis for this study, literature describing the medical and other aspects of the HIV infection will also be used.

Part of the study will be descriptive and exploratory in nature while the other part will be about a normative approach (deductive and dialogical within a hermeneutical approach as described above). Empirical data is needed to describe the statistical situation of the Zambian HIV infection. Descriptive research as indicated above will be the entry point as there will be an investigation of the present Zambian reality in order to arrive at credible facts (Hendriks, 2004: 225). While obediently participating in transformative actions at different levels, the strategy here is to examine the existing framework of fighting HIV through the activities, public statements and programmes being undertaken at national level through the umbrella bodies of Churches. It will be shown that this has not been an effective strategy in addressing

the issue of HIV in a holistic way at a local church level where the effects of the pandemic are felt more persistently.

The study will explore, describe and explain the empirical aspects of the relations between present day HIV infection facts and their context in Zambian faith communities (Hendriks, 2004: 28).

The African traditional beliefs on ‘disease’ and ‘healing’ will be used to study the need to develop these healing and supportive communities. Consequently, there will be field visits to specific Christian (religious) organisations (CCZ, EFZ, ZEC and the Interfaith AIDS group) in order to assess their theological impact on the Zambian community.

Participant observation will play an important role in this study. The researcher was extensively involved in projects related to this research.¹⁸ Practising theology in this work is a praxis process; it means thinking, doing and evaluating as a process of reflective involvement (Hendriks, 2004: 203). The emphasis is on local congregations or faith communities because they can make a difference in Zambia’s harsh realities. The love and care that are typical of faith communities can be a sign of God’s presence and a sign of God’s reign. As such, the catastrophic problem of HIV can, as Hendriks (2004: 33) rightly puts it, be a great opportunity for and challenge to evangelism and mission:

The Church that embodies Jesus Christ’s coming to the world, reflects something of the God who reaches out to the sick and blind and to those caught in the fatal grip of the HIV virus. This point of our definition of *practical theology* concerns vision, mission, hope and eschatology (*emphasis mine*)

As such the study will be practical-theological in its nature. The researcher follows the definition of Fowler (1983: 4) that “practical theological in nature” means a critical and constructive reflection by communities of faith carried on consistently in the contexts of their praxis, drawing on their interpretations of normative sources from scripture and tradition, in response to their interpretations of the emergent challenges and situations they face, and leading to ongoing modifications and transformations of their practices, in order to be more adequately responsive to their interpretations of the shape of God’s call to partnership.

There will be an attempt at practising exegetics in respect of portions of relevant Scripture and faith resources as well as in respect of the contextual HIV situation in Zambia and also at

¹⁸ As alluded to below in the section entitled ‘Practical backdrop’ the researcher has been heavily involved in the projects mentioned in this text as part of his varied ecumenical portfolios.

deducting from this dialogue a theory and strategy of ministry to address the epidemic in Zambia. In the process of developing a praxis theory and strategy, a participatory action research methodology will be used. Osmer and Schweitzer (2003: 5), in commending James Fowler's great contribution to the discipline of practical theology, states that practical theology is viewed as carrying four distinguishable but mutually influential tasks: the descriptive, empirical, the interpretive, the normative and the pragmatic. Attention to all four of these tasks allows practical theologians to construct actions, guiding theories of contemporary religious practice. All these four are in mutually influential relationship along the lines of a hermeneutical circle.

Historically, practical theology has been oriented primarily to the tasks of the clergy or the life of the Church. Fowler (1987: 20), however, suggests that explicit attention be directed to religious praxis beyond the Church. It means moving from the clerical paradigm and ecclesiocentric models to religious praxis within the context of public life in its various dimensions. By addressing issues of public interest and importance, practical theology strives to become involved with social and political attempts at shaping the future of society or thinking of current debates and more appropriate for this work, the future and the challenge of HIV to the Zambian people and the role of the Church in that future.

1.9 Practical backdrop

This study is practical. It is so because the researcher is an African Christian. His father is an African herbalist and a retired copper miner. The researcher belongs to the Church. He is in full time Christian work, now serving with the All Africa Conference of Churches based in Nairobi, Kenya, an ordained minister of word and sacraments of the Reformed Church in Zambia. He served as General Secretary for the national ecumenical organisation, the Council of Churches in Zambia. This organisation plays a very influential role in Zambian society as an opinion maker on many national issues, including HIV infection. He also served as Chair for the Zambia Interfaith Networking Group on HIV. His own immediate young brother died of AIDS after being nursed in the author's house. A few years later three children of that young brother and his wife also all perished because of AIDS. The author has been agonising as to how best the Church can effectively respond to this great challenge. How is the Church to respond meaningfully, in a way that is true to its understanding of who God is? HIV questions the very fabric of the Christian faith, and its enormity easily traps people in a sense of powerlessness and hopelessness.

The researcher agrees with Nouwen (1995: 10) when he says that the HIV pandemic is probably one of the most telling symptoms of our contemporary brokenness. There, love and death cling to each other in a violent embrace. Young people, desperate to find intimacy and communion, risk their very lives for it.

The researcher has since then been actively involved in HIV related work in his ministry as a Church minister. He has been exposed to a variety of both local and international seminars and conferences that have dealt with fighting the HIV infection. In all this exposure, the great challenge has been to hear what God is saying through the HIV pandemic. Many have viewed the pandemic as a tragedy and have not seen it as an opportunity and a challenge. This crisis is a new opportunity for the Church in Zambia to bring Christ to a world that is increasingly being forced to recognise its brokenness and need for God. Moreover, in this lies God's challenge: to rethink how to bring Jesus' unconditional love, healing, wholeness and hope to this broken world. Many HIV positive people in Zambia have complained in a similar way to what an HIV positive woman complained at a PACSA¹⁹ workshop in South Africa (Gennrich, 2004: 42) on coping with HIV. She said that church groups always come when we are dying or even already gone, but when we are trying to live with HIV, when we really need them most Christians are nowhere to be seen.

This is further confirmed by what Greyling (2001: 11) says namely that:

The harsh reality is that HIV-infected and affected people experience the Church as silent and absent in their suffering. *Statements* reflect beautiful written resolutions, but no message of hope sounds from the pulpits. Religious leaders and Christians deny that Christians could be HIV infected. Expressed or implied, the following is very often the feelings expressed by congregation members and religious leaders: 'it is not our people', 'they brought it on themselves', 'they sinned!', 'they were sleeping around', 'it's God's punishment for a promiscuous life!' It is clearly a 'them' versus 'us' situation with a very judgemental undertone (emphasis *in italics mine*).

But God is doing something new. An increasing number of congregations are developing HIV ministries or more general caring ministries to the poor and HIV-infected and affected²⁰. This moment needs to be seized so that a strategy that promotes the praxis of the creation of circles of hope at a congregational level can be developed in a more holistic approach. The

¹⁹ PACSA stands for Pietermaritzburg Agency for Christian Social Awareness.

²⁰ The Reformed Church in Zambia, for example, has recently instructed all its congregations to devote the Sunday of the second week of February to care ministries to the poor.

researcher agrees with Kidd (2003: 31) that an effective way of breaking stigma and discrimination needs to be put in place.

The researcher has recently initiated a Resource and Training Centre for Churches in Zambia on HIV. Through this Centre, Church leaders, youth groups, women and others have all been trained in the basics of HIV prevention, care and support. It is from this background that the researcher has discovered a missing gap in the fight against HIV in Zambian Churches. This is the fact that local Churches have lacked a proper theological rationale as well as an ability to embrace HIV with the subsequent action of creating ‘Circles of Hope’ of people that are already infected with the virus within local congregations. God’s will, in the context of HIV, is to break stigma, shame, denial, discrimination and all those values that deny life. The practical experience of the researcher has taught him that Zambia has suffered a theological silence in many Churches. This is because when faced with it we have to confront two issues which our modern Churches and our inherited cultures, both Western and African, have been unable to handle openly and constructively; namely death and sexuality. How can this weapon of ‘mass destruction’ be so closely connected with the very instrument for the procreation of future generations?

How then have Churches in Zambia responded to what Hendriks (2004: 26-27) calls the ‘vexing problem’? How have they responded to what the living God is requiring of them in this time of HIV? The next section will give an overview of how that has been done by explaining the linkages of the six chapters in this work before dealing with mission theology as being the underlying key concept in this work.

1.10 Presentation of the dissertation – research outline

Chapter 1 of this dissertation looks at the problem, namely HIV and the subsequent challenge it has posed to the nature and mission of the Church in Zambia. God the creator, redeemer and sanctifier is concerned with this problem because it has affected the integrity of his creation. God works through his body, the faith community. Therefore the creation of HIV support groups as missiological praxis in local congregations is an appropriate vehicle to mobilise the local Church for greater involvement. The chapter covers the medical and social aspects of HIV. As part of the wider contextual situation, global statistics are examined while for the purpose of local analysis, current national statistics are equally analysed. HIV is thus seen as a crisis that has affected all people in Zambia. The research hypotheses of this study

are spelt out. Aims of the study are shown while time is taken to explain the practical theology methodology which is applied in this study as well as the multifaceted empirical research methodologies which included interviews for certain sections of the work and participant observation.

In Chapter 2 is largely the analysis of the personal interviews. It is also an attempt to discern what God is doing through the instrument of the ecumenical Church in the fight against life threatening HIV. Chapter 1 indicates the seriousness of the problem through startling statistics. Members of the Zambian Churches through their national umbrella bodies are involved in a vocationally based, critical and constructive interpretation of their present day HIV reality. HIV has very severe human effects on any society. HIV has touched the image of God in human beings. The triune God, creator, redeemer and sanctifier is concerned about the current situation and as such this research is a missional praxis. God's body, the apostolic faith community (the Church) has been making attempts to do something about the situation.

Chapter 2 further takes a look at activities/programmes and statements of the global ecumenical Church as well as policy documents that the Zambian Churches and the interfaith groups have issued with regard to the challenges posed by the HIV pandemic. Through guided questionnaires used during visits, a sample of which is shown in Appendix 1, the researcher collected the information from Church umbrella organisations and other faith based organisations.

Policy documents help to state in a much more focused way what an organisation stands for and what its core values are. Policy documents also indicate the level of seriousness attached to any given subject matter, in this case to HIV. There is, furthermore, an attempt to sketch the magnitude of the problem which has prompted the Churches in Zambia not to leave this issue as a medical problem alone. These efforts, however, have not been effective at congregational level where their impact is needed most.

Chapter 3 looks at the challenges faced in addressing the pandemic. Chapter 3 tackles the importance of leadership in the fight against HIV and the nature of the specific challenges that face leadership at this level.

The Church in Zambia is participating in the triune God's missional praxis and is the gateway to an effective involvement in the fight against HIV. This chapter, therefore, is of key importance to the first hypothesis, namely that the problem before us is that the Churches in

Zambia do not have an effective strategy in place that addresses the issue of HIV in a holistic way at a congregational level where they can effectively reach and influence members. It is at that point therefore that one needs a committed leadership which will facilitate an effective strategy and influence the desired change of a holistic approach.

In Chapter 3, therefore, the researcher looks at some of the challenges which face the Church leadership in Zambia. This includes the challenge of fighting silence, stigma and discrimination, the challenge of change itself, issues of the empowerment of women in the reduction of their vulnerability, the involvement of men in prevention, care and support, the involvement of people living with HIV, local congregation mobilisation and the unavoidable question of leadership and condoms.

A few theoretical models, based respectively on the characteristics of leaders, the behaviour of leaders and the situation in which leaders and followers function, will be applied in view of how they may help Church leadership to effectively form a strategy that will bring about transformative change in this era of HIV. The researcher shall also see how these analyses and theories of leadership provide insight into this complex component. Furthermore, the researcher shall consider how we can have a leadership that is sensitive to God's will in mobilising for change. Since God's concern is for the entire world, leadership for change in a time of HIV is surely on God's agenda. Bosch (1991: 392) states that to participate in missions is to participate in a movement of God's love towards people, since God is a fountain of sending love. The leadership which is sensitive in this way will develop and empower the laity for full participation in Church ministry (Hendriks, 2004: 14). This leadership should empower the congregation to grow towards spiritual maturity

Chapter 4 is an attempt to do a critical and constructive interpretation of some of the critical theological reflections prompted by encounters with HIV affected and infected people. Chapter four therefore makes an attempt to sketch out some of the theological themes which form the basis for the creation of the Circles of Hope concept. This includes some biblical and theological themes which touch on truth, freedom, justice and peace. Furthermore, the chapter looks at the Trinitarian and community concepts as underpinning themes. This is done to draw upon an interpretation of the normative sources of scripture and tradition, so that a strong basis upon which to engage in the missional praxis for the Circles of Hope may be formed. Missional theology, which promotes the creation of Circles of Hope at a

congregational level, is the basic presupposition in this work regarding a holistic approach to combat the HIV pandemic. A missional theology is therefore given a detailed explanation.

In expanding the missional theology mentioned above, **Chapter 5** will further build on the second hypothesis, namely, that a missional theology which promotes the praxis of the creation of ‘Circles of Hope’ at a congregational level is a basic presupposition for a holistic approach to combat the HIV pandemic. A missional theology as seen in Chapter four is sensitive to the local context of the people. As such, if there is to be an effective strategy in place that addresses the challenge of HIV in Zambia, there is need to understand how the people think and what their customs and traditions are. The researcher shall not do this in a general way but in a rather precise manner and will examine how the Zambian cosmological view on health and healing should be used towards building a holistic approach to combat the pandemic. That view does not support the western type of theology which promotes dichotomy in epistemology. The researcher shall also evaluate this Zambian perspective by drawing upon the interpretation of the normative sources of scripture and tradition. A holistic model must start with people and where they are. Due to the sociological position of the researcher, who is a Zambian (African), born and bred within the country, part of the work of this chapter will be, as indicated in chapter two, from a participant observer perspective. The way Zambian people think about illness and healing is partly a lived experience of the researcher whose father is a herbalist. Healing in this chapter is suggested as a conscious spiritual activity of people who are suffering from HIV participating in Circles of Hope for holistic healing. The way such support groups can be created will be examined with practical suggestions. Circles of Hope support groups in local congregations should be a sign of God’s kingdom on earth while moving forward with an eschatological faith based reality in view. The praxis of Circles of Hope support groups and the utilisation of a holistic theology for human dignity cannot have a transformative impact at a congregational level if the challenges are not analysed and questions of leadership are not examined. The role of leadership will be critically reviewed in Chapter 3.

Chapter 6 will seek to show that this work has clearly discerned that God’s will is the dignity of all people including those who are positively affected by HIV. The local Church has to be an embodiment of this will by being a sign of God’s kingdom on earth. The researcher shall therefore look at the vision and mission required for the Church to continue participating obediently in the transformative action of God in the Zambian society.

Chapter 6 will look also at responses to the HIV pandemic, where priorities have been and where they should have been. The researcher will argue that a theological, holistic model and strategy that effectively address the HIV crisis should involve a continuum of policy and practice, spanning the prevention and mitigation of the impact of the crisis. Care is an important component of both of these. A Church without pastoral care for the sick and dying would have lost its relevance in the world. Prevention responses have been inadequate and generally ineffective. In Zambia the spread of HIV continues, requiring planning for a decrease in its impact. More needs to be done in the area of local faith communities creating special support groups which in this work are called Circles of Hope. There is a need to address afresh the theological content of formation for ministry. This chapter will explore concepts that help understand the challenges of a response to the crisis. The need for networking and partnership will be emphasised as a new frontier for the ministry of the Church and, in particular, for partnership with the 'world'. The chapter will also briefly look at the role of Non-Governmental Organisations (NGOs) in this fight. It also underpins the ministerial challenges that this epidemic has posed to the Zambian Churches, namely that the Churches in Zambia need to have an effective strategy in place to address the issue of HIV in a holistic way at a congregational level where it will effectively reach and influence members. This can be done effectively by embarking on a holistic approach of a missional theology which promotes the praxis of the creation of circles of hope at a congregational level. Circles of Hope are that new frontier posing a ministerial challenge for combating HIV in Zambia.

1.11 Missional theology

Missional theology is a key concept used in this work. The question to be dealt with in this section is: How are we to practise missional theology? The researcher believes that the way we define and practise theology should be as a methodology. It is a practical, communal, holistic and contextual missiological perspective. Its purpose is to discern God's will and to faithfully participate in the *missio Dei*. In attempting to flesh out the *missio Dei*, Bosch (1991: 390) says in its new image, mission is not primarily an activity of the church but an attribute of God. To participate in mission is to participate in the movement of God's love toward people, since God is a fountain of sending love. Roxburgh (2005: 12) says missional activity expresses that God's mission is that which shapes and defines all that the Church is and does, as opposed to the expectation that the Church should be the ultimate self-help

group for meeting people's own needs and finding fulfilment in their individual lives. He goes on to say that the focus of the mission must be upon placing the God who has encountered people in Jesus Christ back in the centre of their communities of faith that shape and give meaning to people's lives.

The basic theological argument in this work, then, is that the starting point of how we do theology is about God - the triune God and his mission. Kritzinger, Meiring and Saayman (1994: 4) all agree that mission is not primarily the activity of men and women but that mission is God's work. They go on to say that mission as stated by the International Missionary Council has a trinitarian base, just as the Father sent the Son into the world, and as the Father and the Son together sent the Holy Spirit, so the Father, Son and Holy Spirit send the Church into the world. Guder (1998: 5) also agrees with this idea of the trinitarian point of entry and says our theology of the church necessarily shifts all the accents in our ecclesiology. He goes on to say that this leads us to see the Church as the instrument of God's mission. In respect of the term 'missional', the researcher agrees with Guder (1998: 11) that we emphasize the essential nature and vocation of the Church as God's called and sent people. This missional theology is biblical, historical, contextual, eschatological and practical. As Guder (1998: 12) puts it the basic function of all theology is to equip the Church for its calling. If that calling is fundamentally missional, then what we understand and teach about the church will shape God's people for their faithful witness in particular places. In this work we want to see the witness of the Church in Zambia in a time of the life-wasting disease of HIV. Theology is about discernment. The steps of practising theology will be metaphorically illustrated by a cross. These steps are interwoven, which means they cannot be separated. Hendriks (2004: 23) uses the illustration of the cross for this approach of practising a missional theology. He stated that:

The foot of the cross portrays identity. It says that the triune God is the source of our identity. The church is his body. The left side of the cross reflects the present world: the world to which God sent his son (John 3:16). In this world we find faith communities. The right side of the cross reminds us of the past, of the Bible and the faith tradition. The top of the cross reflects the future, the Kingdom of God, the eschatological reality that is already present in and through Jesus Christ on whom our hope is focused. In the centre of the cross we find the faithful struggling to discern the will of God (Philippians 1:9) in order to obediently engage in strategic action, realising God's Kingdom.

The illustration by Hendriks (2004: 23) is further amplified in the next section through the six points as shown below:

1. **The foot of the cross:** represents the first and second steps and deal with **identity**. This is about who we are. Our identity is not determined by what we do. We were formed to resemble the **Triune God**. The church should be the body of Christ.
2. **The left side of the cross:** refers to the world that is the third and fourth steps or points dealing with **the wider contextual situation** and **local analysis**.
3. **The right side of the cross:** refers to the Word, which is the fifth step that summarises our heritage or past. **Scripture** and **faith tradition** plays the central role here.
4. **The centre of the cross:** is the sixth step where our struggling to **discern the will of God** for the present situation takes place and where correlational hermeneutics comes together. Here we find a faith community in prayer, listening and discerning.
5. **The top of the cross:** is the seventh step which shows where we are moving or heading and deals with eschatology. The faith community is to be a sign of the Kingdom of God. It is about becoming what we received as our identity in Jesus Christ. This will lead to a **vision** and a **mission**.
6. **The movement from the bottom to the top of the cross:** focuses on what we do and is the eighth step. The movement from the Alpha to the Omega describes the doing of transformative theology. It involves obedience and developing a **strategy** which should be **implemented** and **evaluated**. The researcher believes that what we do, does not determine what we are but reflects who we are (identity). In the process of implementing, of being involved in missional praxis, the discernment continues, the correlation between the points of the cross continues, they inform the process, one adjusts and develops. It is a reflective engagement (praxis). So then God the creator created human beings as individuals and as community to complete his mission. Being created in his image and likeness implies that following the example and illustration thereof in Jesus Christ, we know who we are and what the purpose in life is.

CHAPTER TWO

HIV AND THE ECUMENICAL CHURCH

2.1 Introduction

Reid (1995: vii) says that the human immunodeficiency virus (HIV) pandemic has entered the human consciousness as an incomprehensible calamity, already laying claim to millions of human lives, inflicting grief and pain, causing uncertainty and fear, and threatening economic devastation. The global ecumenical Church has not been silent over this calamity. *In every situation, our faith seeks to comprehend what the living God requires of us* (Hendriks, 2004: 27). In this chapter, then, the researcher shall attempt to discern what God is doing through the instrument of the ecumenical Church in the life threatening fight against HIV infection. The researcher shall look briefly at how the global ecumenical movement has responded to this disease before concentrating on how the Zambian Churches have responded and look at gaps in those responses.

2.2 What has the global ecumenical church said?

The startling statistics in Chapter 1 have indicated to us the seriousness of the problem. The involvement of members of the Zambian Churches through their national umbrella bodies in vocationally based, critical and constructive interpretation of their present day HIV reality has already been acknowledged. The researcher has also shown that HIV has very severe human effects on any society. HIV has touched the image of God in human beings. The triune God, creator, redeemer, and sanctifier is concerned about the current situation and as such this is a missional praxis. God's body, the apostolic faith community (the Church) has been attempting to remedy this situation.

In this chapter, the researcher shall take a look at activities/programs, statements or policy documents that the global ecumenical movement has released and then focus on how the Zambian Churches and the interfaith groups have responded with regards to the challenge posed by the pandemic of HIV. As mentioned before, the researcher has collected the information from Church umbrella organisations and other faith based organisations through guided questionnaires used during visits, a sample of which is provided in Appendix 1. With reference to the methodology referred to in Chapter 1, this chapter focuses on the present

reality of what the faith community is doing. Participant observation accompanies the use of the semi-structured questionnaire and the use of the literature produced by the FBOs that have been investigated. The chapter is therefore descriptive in nature (Hendriks, 2004: 225).

Policy documents and pastoral statements also indicate the level of seriousness attached to any given subject matter and, in this case, HIV. The researcher will also attempt to sketch the magnitude of the problem, which has prompted the Churches in Zambia not to leave this issue as a medical problem alone.

This chapter outlines the response to date of churches and faith-based organizations in breaking the silence surrounding HIV and challenging the presence of HIV-related stigma within churches and faith based organizations as well as in the wider community. It will be shown that the early days of the pandemic, were characterized by silence, except in the few examples provided, and will document the tremendous commitments and moves in the last years by churches to break the silence surrounding HIV. UNAIDS (2005: 20) has said that HIV-related stigma and discrimination is a violation of human rights.

The response of churches and from members within churches to HIV has been variable. The following paragraph from Vitillo (2004: 24) summarizes both the ignorance and fear of some, and the humanity of others in responding to HIV in their midst:

Despite the fact that the rejection and scapegoating of people affected by HIV and AIDS finds no basis in theological scholarship, such incidents continue to occur. While visiting many different countries to facilitate HIV and AIDS workshops for pastoral personnel, I have heard the “horror stories” of pastors refusing to anoint HIV-infected people or forcing them to publicly confess the “sins” that caused them to be infected. I believe that members of the hierarchy, clergy, and laity alike have responsibilities to stop such poor pastoral practices as soon as they occur. I received much personal inspiration from an archbishop in a Caribbean country who, upon hearing that his priests were unwilling to visit a woman of supposed “ill repute” and suffering with AIDS-related illnesses went to visit her in the hospital and continued to do so on a daily basis, until the woman died. Then he celebrated her funeral Mass in his cathedral.

The World Council of Churches (WCC) has been deeply committed and involved in responding to HIV since 1986. It has assisted member churches in:

- sharing lessons learnt;
- developing policy guidelines;

- initiating and sustaining theological discussions on HIV;
- developing and applying strategies, methodologies and tools for education;
- mobilizing churches to action both internationally and regionally;
- mobilizing resources for churches for HIV-related work;
- advocating on HIV issues in the international arena; and
- mapping and monitoring the churches' involvement around HIV.

During 1986 the WCC gave serious attention to the escalation of the HIV pandemic and its implications for the churches. In June 1986, three WCC sub-units, namely the Church and Society, Family Education and the Christian Medical Commission, called a joint consultation at which the General Secretary, Dr Emilio Castro, in an opening address, (<http://upetd.up.ac.za/thesis/available/etd-01172005-145754/unrestricted/00dissertation.pdf>) challenged the view that disease is a punishment from God by saying that AIDS is a disease and should be treated as such because God, who loves all human beings, cares for the well-being and health of every one of his children, and does not inflict disease as a punishment.

The final statement of the June 1986 consultation, called for the Church to be the Healing Community, expressing its solidarity with those affected by HIV through pastoral care, education for prevention and social ministry:

In the mysteries of life and death, we encounter God; this encounter calls forth trust, hope and awe rather than paralysis and immobilisation. Those we cannot cure we can support and sustain in solidarity: "I was hungry ... thirsty ... a stranger ... naked ... sick ... imprisoned, and you fed ... clothed ... took care ... visited" (Matthew 25). The AIDS crisis challenges us profoundly to be the Church in deed and in truth: to be the Church as a healing community. AIDS is heartbreaking and challenges the churches to break their own hearts, to repent of inactivity and of rigid moralisms. Since AIDS cuts across race, class, gender, age, sexual orientation and sexual expression, it challenges our fears and exclusions. The healing community itself will need to be healed by the forgiveness of Christ. (<http://www.wcc-coe.org/wcc/what/mission/ehaia-html/executive-committee-1986-e.html>)

In January 1987, the sub-unit on Church and Society organized a hearing on the subject for the WCC Central Committee, which recommended that the Central Committee of the WCC urges all churches to make known the seriousness of the problem of HIV and to take every opportunity to cooperate with one another and with medical, social and educational agencies and the mass media in appropriate educational programmes.

Churches were largely silent in the first years of the HIV pandemic, but there were some notable exceptions. The World YWCA World Council passed ‘Resolutions on AIDS’ (1987) and ‘Women and HIV/AIDS’ (1991). At its General Assembly in 1987, Caritas Internationalis, the Vatican-based, global confederation of Catholic social service and development organizations operating (at that time) in more than 260 countries of the world, designated HIV as one of its priority areas of reflection and action. This commitment has continued to the present. Since that time, Caritas Internationalis has attempted to mobilize a non-judgmental and compassionate education-focused and service-oriented response to the challenges posed by this pandemic. According to McLaren (1996), Pope John Paul II made frequent and emotional appeals to avoid the discriminatory treatment of people living with HIV. In his visit to PLWHA in a Californian hospital in the United States in September 1987, he held out the unconditional love of God himself as the guideline to be followed:

God loves you all, without distinction, without limit ... He loves those of you who are sick, those suffering from AIDS. He loves the friends and relatives of the sick and those who care for them. He loves all with an unconditional and everlasting love.

According to the website on Church statements on HIV, McLaren (1996) says that the bishops of the United States were among the first to appeal to all the faithful to respond to those affected by the pandemic with compassion and without fear or prejudice. In *The Many Faces of AIDS: A Gospel Response* (1987: 136), the Administrative Board of the U.S. Catholic Bishops Conference mentioned the new services which should be considered by parishes and institutions sponsored by the Catholic Church and offered a litmus test for responding to the HIV pandemic:

Current programs and services need to be expanded to assist the families of those with AIDS while they are alive and also to support them in their bereavement. In addition, new programs, services, and support systems need to be developed to deal with unmet and poorly met needs.

Our response to the needs of persons with AIDS will be judged to be truly effective when we discover God in them and when they, through their encounter with us, are able to say, in my pain, fear, and alienation, I have felt your presence, a God of strength, love, and solidarity.

Messer (2004: 91) reminds us that in a subsequent pastoral letter issued by all the bishops of the United States in 1989, Catholics were reminded of the Gospel-based responsibility to affirm the dignity of those living with HIV and to care for them without hesitation:

Persons with AIDS are not distant, unfamiliar people, the objects of our mingled pity and aversion. We must keep them present to our consciousness, as individuals and as community, and embrace them with unconditional love. The Gospel demands reverence for life in all circumstances. Compassion - love - toward persons infected with HIV is the only authentic Gospel response.

Overberg (1994: 55) quotes Pope John Paul II at the Vatican AIDS Conference who said:

AIDS has by far many more profound repercussions of a moral, social, economic, juridical and structural nature, not only on individual families and in neighbourhood communities, but also on nations and on the entire community of peoples....Those who suffer from AIDS, even in their unique pathology, are entitled to receive adequate health care, respectful comprehension and complete solidarity, just like every other ailing person.

The Church, imitating her divine Founder and Teacher, has always deemed as fundamental to her mission assistance to those who are suffering. She now feels that she is called upon as protagonist in this new area of human suffering, aware as she is that suffering man is a "special way" of teaching and her ministry.

Brothers in Christ, who know the bitter harshness of the way of the cross, do not feel that you are alone. The church is with you as sacrament of salvation to sustain you in your difficult path. She receives much when you live your suffering with faith; she is beside you with the comfort of active solidarity in her members so that you never lose hope. Remember how Jesus invites you "Come to me all of you who are weary and tired, and I will give you complete rest" (Matthew. 11:28).

In Africa, the Bishops of Southern Africa proposed in June 1990:

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 also be 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 (Mc Laren, 1998: 4).

According to Ghana Bishops' Conference *Pastoral Statement on AIDS*, October 1990, Catholic Bishops in Ghana were also among the first voices to be raised in appeal for an unconditional and accepting response among Christians to the brokenness in human relationships that both precedes and results from HIV infection:

AIDS often involves alienation and separation between the person with the disease and every surrounding system. We are challenged to be reconcilers, helping to restore a sense of wholeness to broken relationships between the patient and those near to him or her. We must build a sense of trust and caring. This requires education, and a change of heart...If the yardstick of our faith is unconditional love, particularly love of those whom society regards as outcasts, then our response to people suffering from AIDS will be a measure of our faith (Mc Laren, 1998: 3).

The Lutheran World Federation, in a report *'Pastoral Work in Relation to AIDS'* (1988), stated:

The church should open its doors to all, unconditionally, just as Christ opened the door to all, irrespective of who they were or what they had done. Salvation is given to all by grace, through faith, not because of deeds or behaviour. By accepting everybody Christ gave access to his forgiveness and to a new life. Today in his church, we receive this new life through the Word and the sacraments. By excluding somebody from these sources of life, the church becomes guilty of the gravest form of discrimination that exists. (<http://www.oikoumene.org/en/resources/documents/other-ecumenical-bodies/church-statements-on-hiv-aids/lutheran-world-federation.html>).

The spread of AIDS is dependent on cultural, social and economic realities. The church should question seriously its own role in developments facilitating the spread of the disease, and challenge its own members and the society to take steps to remove discriminatory attitudes and actions prevailing in society (Pastoral work in Relation to AIDS, 1988).

The Lutheran World Federation members of Argentina, Uruguay, Paraguay, Chile, Brazil, Peru and El Salvador in the *Declaration of Buenos Aires* (1998), stated:

We are called to commit ourselves to such pastoral action. This call arises out of the recognition that a medical diagnosis has often been confused with a moral judgment affecting the dignity of many brothers and sisters. We are moved by the suffering of those persons exiled from family and social solidarity networks, and we are called to be facilitators of the reconstruction of these networks. We take seriously the profound meaning of the word "epidemic" (epi = over, demos = people) which reveals to us that it is a crisis installed in the midst of the entire society and in all churches.

Christ continues calling us to conversion today, by means of the excluded: the Samaritan shows us solidarity (Luke 10:25-37); the widow, generosity (Luke 21:1-4); the Canaanite woman, the certainty of faith when faced with the prejudices of belonging (Matthew 15:21-28); and persons in situations of prostitution and tax collectors show us the way of the reign of God (Luke 18:14). This pastoral ministry desires to contribute to the reintegration of those who have been exiled, due to our judgements, to the space which belongs to them by virtue of the Gospel: "Come to me" (Matthew 11:28).

We know that the cost of this identification with those stigmatized by our society and by our churches is always very high, but that in faithfulness to the Gospel we cannot avoid it. This price should be paid by all the faithful, and not only by those who are directly involved. We desire that this pastoral ministry be visionary, while we wait for the entire Christian community to assume it in the near future. (<http://www.oikoumene.org/en/resources/documents/other-ecumenical-bodies/church-statements-on-hiv-aids/lutheran-world-federation.html>).

The Seventh Day Adventist Church stated in 1990:

AIDS challenges the ministry of Seventh-day Adventist pastors and chaplains. They already have people with HIV infection in their congregations, communities and hospitals. The numbers will increase. They should not fear casual physical contact including shaking hands and baptizing. Pastors should continue to call on the sick at their homes or in the hospital. HIV infections should not change patterns of visitation or in any way limit ministry.

The fear of AIDS should not compromise our compassion or our witness. Those who test positive for HIV and who may be sick with the disease should find acceptance and fellowship in the local congregation. They should be comfortable in our church services and be welcomed to participate in all activities of the church: baptism, foot washing and the communion supper. The local church can find many ways to minister to those with AIDS. Church members can join or form a support group and become individually involved in a supportive role to meet the needs of persons and families impacted by AIDS (http://www.adventist.org/beliefs/other_documents/other_doc1).

In September 1996, the WCC Central Committee on the basis of the WCC Consultative Group on AIDS Study Process adopted a statement on HIV, the theological basis for a response and possible responses by churches, including:

1. The life of the churches: responses to the challenge of HIV/AIDS
2. We ask the churches to provide a climate of love, acceptance and support for those who are vulnerable to, or affected by, HIV/AIDS.
3. We ask the churches to reflect together on the theological basis for their response to the challenges posed by HIV/AIDS.
4. We ask the churches to reflect together on the ethical issues raised by the pandemic, interpret them in their local context and to offer guidance to those confronted by difficult choices.
5. We ask the churches to participate in the discussion in society at large of ethical issues posed by HIV/AIDS, and to support their own members who, as health care professionals, face difficult ethical choices in the areas of prevention and care.

In this period most churches (especially in Africa) were still either silent, or in denial, or condemnatory, with only a few examples of positive response to HIV. Since then there has been a massive change both at the individual and denominational level and at the ecumenical level - from 2000 to the present, in the work of the Anglican Communion (Anglican Church 2002), Lutheran Communion and of the Catholic Church to name but a few. Furthermore, in their work and that of United Evangelical Mission (UEM), United Church of Christ (UCC), the Ecumenical HIV/AIDS Initiative in Africa (EHAIA), All Africa Conference of Churches

(AACC), World Young Women's Christian Association (YWCA), World Alliance of Reformed Churches (WARC) and several National Christian Councils. These church bodies have made a great exodus from Egypt, crossing the Red Sea into the wilderness, where many have made a covenant with God to respond to the HIV crisis. Of course, some members of churches are crying “we were better in Egypt” and some still are building up calf idols. However, sadly, some churches are still in Egypt denying the reality of HIV, and their need to change and respond.

While churches have not entered the Promised Land in so far as the struggle against HIV is concerned, the church has crossed the Red Sea and is in the wilderness, struggling and working out their relationship with God. This analogy is very much dependent on which church and continent is being discussed. While many flaws remain, while the full potential and commitment of churches is yet to be unleashed, a great step forward has been taken. The greater Church, especially in the developing world, has heard God’s voice saying, “I have seen the suffering of my people, I have heard...I know...come let me send you to deliver my salvation to them” (Exodus 3: 7).

In 2001, church leaders of Africa, and international and African ecumenical organizations developed a coordinated Plan of Action to respond to the HIV pandemic in Africa, at a WCC “Global Consultation on Ecumenical Responses to the Challenges of HIV/AIDS in Africa”, Nairobi, Kenya. The Plan of Action (2001: 5) stated:

The Plan is part of the response, by these groups of partners, to the urgent challenge presented by the epidemic of HIV/AIDS: a challenge to which all religious organizations have been struggling to respond, which is depopulating Africa faster than any calamity since the slave trade.

It is notable that at this gathering the vision of the Plan of Action and the first commitment adopted by the churches centred on breaking the stigma and discrimination surrounding HIV. Since 2001, a number of churches and faith based organizations have stated their commitment to break the silence around HIV and challenge the stigma and discrimination faced by PLWHA.

Breaking the silence around HIV also involves respecting the rights of marginalized groups. For example, members of the World Alliance of Reformed Churches (WARC) have different views on homosexuality but Christians can agree that it is wrong to violate human rights because of sexual orientation. This view was conveyed to delegates to the WARC’s General

Council Meeting in Accra, Ghana in 2004 by WARC General Secretary, Setri Nyomi. WARC's Executive Committee has engaged in a study of where member churches stood:

While it is clear they have a variety of views on gays and lesbians, the executive committee came to the conclusion that we can together as Christians at least agree on the fact that it is wrong to violate the human rights of anybody for any reason - including sexual orientation", Nyomi said (Asling, 2004: 1).

In addition to such statements, actions have been taken by churches to break the silence around HIV within churches and to tackle HIV-related stigma. Some examples of churches' responses include:

- At the All Africa Council of Churches (AACC) 8th General Assembly, Yaoundé, Cameroon, November 22–27 2003, free, voluntary on-site testing for HIV was offered. More people than expected came for testing. Of the 800 participants at the Assembly's, 105 were tested with demand initially surpassing the availability of testing kits. "As far as we are concerned, this is war", said Mvume Dandala, General Secretary of the AACC. "We declare unequivocally that HIV/AIDS is not the will of God for Africa; we will try with all we have to resist it".

(Fouke, 2003. <http://www.wfn.org/2003/11/msg00282.html>)

- In November 2004, the Anglican Church in Tanzania, Dodoma Diocese, announced that 12 of its priests are HIV-positive. Three of those priests have declared their status to the public, while the remaining nine are to do so at an "appropriate" time (Okema, 2004: 13).
- Fifteen years ago Canon Gideon Byamugisha, an Anglican priest from Uganda, stunned his fellow clerics and parishioners when he revealed his HIV-positive status. He was supported by his local Bishop and made a canon in 2001. Now he travels the world and is serving as a global role model and urging churches in Africa to help develop the right attitudes, skills, services and supportive environment to roll back the pandemic. Canon Gideon is believed to have been the first religious leader in Africa to make public his HIV-positive status when in 1992 he announced he had the virus, at a time when churches were consumed by denial about the phenomenon²¹.
- Twenty-seven Zimbabwean pastors from various Christian denominations underwent a voluntary HIV test in a move aimed at removing stigma in the church against people living with HIV. The pastors

²¹AIDS calls for holistic response, says HIV-positive cleric, 1 December 2004, Nairobi/Bangkok, Ecumenical News International, <http://www.eni.ch/> [657 words, ENI-04-0784]. For more information on Rev Gideon, "Canon Gideon Byamugisha – the Anglican Church stands behind its pastors" in 4.3 Confidentiality of World Council of Churches, *Working with People Living with HIV/AIDS organizations: guidelines*, 2005.

from churches in the townships of Tafara and Mabvuku in Harare became the biggest group of church leaders ever to take an HIV test in Zimbabwe²².

In 2001a, at the United Nations General Assembly Special Session on HIV/AIDS (UNGASS), the WCC facilitated a statement on behalf of faith based organizations, which outlined the successes and challenges of faith-based responses as follows:

Faith-based organizations are joining many other actors in the global fight against this devastating pandemic and can offer our specific resources and strengths. At the same time we acknowledge that we have not always responded appropriately to the challenges posed by HIV/AIDS. We deeply regret instances where FBOs have contributed to stigma, fear and misinformation.

(<http://www.oikoumene.org/en/resources/documents/other-ecumenical-bodies/church-statements-on-hivaids/lutheran-world-federation.html>)

However, it is also fair to say that FBOs have often played a positive role in the global fight against HIV. Countries such as Senegal, Uganda, and Thailand which have involved religious leaders early on in the planning and implementation of national AIDS strategies have seen dramatic changes in the course of the epidemic. For example, religious communities in Uganda, working hand in hand with AIDS service organizations and the government, have championed peer education, counselling and home care programmes. A church leader has led the National AIDS Commission in Uganda since 1995. In Uganda, Zambia and Tanzania, prevention efforts have resulted in changed sexual behaviour including delayed sexual activity among adolescents, and a reduction in the number of sexual partners. These modifications of behaviour have been part of the message of many FBOs. In Thailand, Buddhist and Christian groups have introduced home based care services and have greatly contributed to the de-stigmatisation of the disease.

The follow-up report to the UNGASS Declaration, appraised faith-based organizations responses in the intervening period, stating that the importance of faith-based organizations in the response to HIV was well recognized, given their long history of service in communities, their moral authority and financial and organizational resources that they command. In addition, these organizations boast a reach that cannot be matched and are often present in even the most remote areas. Representatives of faith-based organizations were frank in admitting that they had, in general, been slow to react to the epidemic, usually because of the stigma and moral overtones associated with being HIV-positive. However, as more believers

²² Zimbabwe pastors take HIV tests in stand against prejudice, 2 December 2004, Geneva *Ecumenical news international*, <http://www.eni.ch/> [388 words, ENI-04-0787]

fall victim to the disease, the position of many religious leaders has evolved. In other regions, faith-based organizations considered health service provision to be beyond their limited resources and capacity and therefore something best left to others.

The Ecumenical HIV/AIDS Initiative in Africa (EHAIA) was established in 2002 as a joint undertaking of African churches, northern churches and agencies, and the WCC. This initiative has been strengthened by the involvement of PLWHA organizations and networks in governance and planning.

The experience of the WCC in being a partner in the Communities Responding to the HIV/AIDS Epidemic (CORE) Initiative²³ has also broadened the scope of faith based organizations involvement in working in partnerships with PLWHA organizations.

The WCC and some 30 related networks and member organizations signed the Code at the end of October 2004. Their signature makes these faith based organizations accountable to the norms contained in the Code. A focus on assisting member churches to work more closely with PLWHA in a measurable manner is an essential follow-up process after signature. This will ensure that the gains made by the churches in the realm of HIV prevention, HIV care as well as HIV advocacy will be owned by the whole community and will be rooted in the life of churches.

The lessons learned for partnerships from the above initiatives have been:

- PLWHA need to be part of both the planning and governance of initiatives in HIV.
- Faith based organizations have to be accountable not only to their own constituencies but also to governments, NGOs and international bodies. This means faith based organizations need to be transparent in their workings and open guidance from a broader of stakeholders.
- Specific measurable mechanisms, including for monitoring and evaluations, have to be in place to ensure that organizations are held accountable to the stated principles.

²³The Communities Responding to the HIV/AIDS Epidemic (CORE) Initiative <http://www.coreinitiative.org/> is a USAID-funded global program, whose mission is to support an inspired, effective and inclusive response to the causes and consequences of HIV by strengthening the capacity of community and faith-based groups worldwide. The main approach of the CORE Initiative is to leverage existing efforts, while catalyzing and encouraging new efforts through diverse and innovative partnerships in the areas of community-based prevention, stigma reduction, and care and support to PLWHA and their families. Leading this initiative is CARE International.

2.2.1 HIV and the church in Zambia

The Churches in Zambia do ‘speak out’, mainly through their umbrella bodies namely, the Council of Churches in Zambia, the Evangelical fellowship of Zambia, and the Zambia Episcopal Conference embracing the Roman Catholics²⁴. HIV activities of these umbrella organisations will be examined and used to understand how the Churches in Zambia have been/are responding.

Apart from these umbrella organisations, this chapter would be incomplete if it did not touch on the work done by the Churches Health Association of Zambia, another church-related organisation co-ordinating hospitals and rural health centres that belong to the member churches of the three mother church bodies in Zambia. In their efforts to respond effectively to the challenges posed by HIV the three church mother bodies have given birth to another organisation to enhance the fight: the Zambia Interfaith Networking Group on HIV/AIDS (ZINGO). These organisations will be examined, as they are an arm of the Church in Zambia in the fight against HIV. The chapter also will deal with the need for co-operative FBOs and government relations, the need for financial and technical support, the need for training and skills building, prevention support and the importance of communication and networking. An analysis of those areas that will need attention will be given towards the conclusion. This analysis shows to us that a missional theology which promotes the praxis of the creation of circles of hope at a congregational level which is a basic presupposition for a holistic approach to combat the HIV pandemic, has been absent in these efforts.

2.3 Epidemiology, magnitude and trends

Flykesnes and others (1997) in a paper entitled: *Dynamics and determinants of the HIV epidemic: a review of Zambian epidemiological, demographic and behavioural observations*, have indicated that HIV have spread throughout Zambia, and all its 72 districts are affected. The Ministry of Health/Central Board of Health has reported that 16% percent of the adult population is HIV-positive as indicated in Chapter 1 (HIV/AIDS in Zambia, 1999: 10). The

²⁴It is important to note that in the year 2001, Zambia went through an interesting political phase when former President Fredrick Chiluba wanted to stand for a third term as Republican President, against the constitution and the wishes of many people. During that time a new Church group emerged supporting President Chiluba and his bid to change the republican constitution to allow him stand for the Presidency for a third term beyond the constitutional requirement of two terms of five years each. This Church group called itself the ‘Independent Churches and Ministries’, and claimed to speak for those Churches who are not members of the three traditional Church mother bodies. Apart from their political alternative voice of supporting the powers that be, the group does not seem to be actively involved in social issues such as HIV.

prevalence of HIV in urban areas is twice as high as it is in rural areas with rates of 23 percent and 11 percent respectively. It is projected that the number of HIV infected persons will increase. Luapula, Copperbelt, Central and Lusaka provinces have high prevalence rates, while both North-western and the Northern Province have rates of less than 15 percent.

The situation as shown in Chapter 1 has necessitated the involvement of *Zambian Churches* in addressing the pandemic. The members of the *Zambian Church* community are involved at national level in their local analysis. They have drawn guidance from the interpretation of scripture and tradition to meet the challenging times. As the popular saying goes: *If one is not infected or afflicted one is surely affected*. Thus, this scourge has spared no single family or individual. The Church's call to care for the sick and dying has necessitated its heavy involvement in mitigating the spread of the virus. In God's design, the Church exists, not for itself alone, but to serve in God's work of reconciliation and for the praise and glory of God. The more the Church understands its own nature, the more it gets hold of its own vocation (*Faith and order paper*, no 181, WCC Study 1998: 8). HIV threatens the very foundation of human existence. It poses a serious threat not only to humanity's social and economic development but also to its very existence. It has wiped out the gains of development. HIV is virtually reversing all the advancements the world has made in the health sector. The above scenario is spreading fast, not just in Zambia but across all the nations in the developing world. The time surely has come to act now. Humanity and more particularly the Church cannot afford to be silent any longer (Byamugisha, 2000: 16). The silence must be broken. Many religious leaders, institutions and groups are extremely uncomfortable with issues related to sexuality. These issues are inextricably linked to the HIV situation (*Caritas training manual* 1997: 61).

It is clear that at least up to the appearance of the HIV pandemic, the Churches had made little or no impact against the traditions that encourage promiscuity in Africa. Most of the Church leaders never even discussed the looming disaster in their respective Churches. As a result many young people find their parents and teachers ill equipped or afraid to teach them about sexual issues (Shorter and Oyancha, 1998: 49, 52, 98).

In Europe, the need for the sexual education of teenagers was not felt until modern times. Sutherland (2003: 1) says when Christianity was brought to Africa the same pattern was followed and as a result, the whole Church (in Africa) has not dealt with sex education as it intends to do now.

AIDS is a silent killer. In the mission praxis of the triune God we see that Jesus Christ demonstrated his father's love to all human beings, coming to be present in the midst of human struggle. If God's body, the Churches, are to fulfil their mission, they must recognise that HIV brings the lives of many people into crisis and that it *is* a crisis, one which Churches must face. Religion and faith communities can become part of the solution in arresting the spread of HIV and in providing quality care (Dube, 2003: ix). The very relevance of the Churches will be determined by their response. The crisis also challenges the Churches to re-examine the human condition, which in fact promote the pandemic, and to sharpen their awareness of people's inhumanity to one other, of broken relationships and unjust structures, and to understand what? (WCC, 2002: 2–3). Denial, fear, betrayal, misinformation, exploitation and ignorance have been major hindrances in dealing with HIV (Njoroge and Dube, 2001: 235). The HIV and AIDS manual of the Kenya Episcopal Conference (2002: 105) has rightly noted that behavioural change is a central issue in respect of the HIV pandemic. This is supported by Siame (1998: 10) who says individuals and communities have the capacity to change attitudes and behaviour. The power to fulfil this capacity is often determined by the Church and is not exercised. This power must be recognised, called forth and supported from both those that are infected and affected and implemented. This will enable people to initiate change and sustain behaviour that promotes a healthy state of mind, body, spirit and environment. A critical component in this process of change in behaviour is a supportive response to those living with HIV from the Church.

2.4 The first church statement on HIV in Zambia

Here the researcher shall look at the first public statement to be issued by Churches in Zambia since the problems of HIV started. By looking at this statement, the researcher is underpinning the fact that Churches in Zambia do not have an effective strategy in place which addresses the issue of HIV in a holistic way on a congregational level where it effectively reaches and influences members. The examination of this statement will show the absence of a missional theology which would promote the praxis of the creation of circles of hope at a congregational level. This section is largely descriptive and exploratory in nature and thus reveals the empirical data needed to confirm the absence of a holistic approach needed to combat the HIV pandemic.

A watershed public statement on HIV by the three umbrella Church bodies was made in January 1988 entitled: *'Choose to Live- reflections on the AIDS crisis from the Christian*

Churches in Zambia' (Komakoma, 2003: 197-218). Before then, the Church had not spoken about the deadly pandemic in the manner they did in the 1988 statement. *Choose to Live* is a response of the Zambian Churches to the HIV crisis in the country, which was then just manifesting its devastating effects. It is addressed to Christians and non-Christians. The document identifies HIV as a world-wide problem of which Zambia has its share. The document gives scientific facts about HIV and how it is transmitted. The Zambian Churches through this document identified promiscuity as the chief cause of the rapid spread of HIV in Zambia. This promiscuity has been due to social changes, fostered by outside influences that teach that sexual intercourse can be separated from married love. It calls for the recognition that sexual activity has its true place in marriage between married people. The document first of all gives the Christian attitude towards HIV and then gives suggestions for combating the disease. Concerning the Christian attitude, it emphasises chastity before marriage and fidelity throughout married life. It further recommends that people should behave responsibly in their sexual behaviour by avoiding promiscuity. For those already living with HIV the document urges them not to infect others. It further recommends them to go on living fully and taking extra precautions against diseases of any kind. Even when they are sick and faced with death their life in the context of the cross and resurrection of Jesus Christ and the Christian understanding of suffering still has meaning and value. It calls for the education about HIV of young people and of those who depend on them. It urges all Christians to show love to those suffering from HIV.

The document further states that HIV is a problem for the whole community and therefore public authorities and every social force must be harnessed for solutions. It warns that condoms are not safe because they are known to have a high failure rate in preventing pregnancy. Therefore advising the use of condom gives people a false sense of security and encourages them to continue conducting themselves in ways that they might otherwise have abandoned.

The document also reflects on HIV as a sign of the times. It calls on people to reflect on human love and sex, its meaning and place in their lives. It asks how sex, which seems to becoming the means through which the human race may yet destroy itself, can be restored as a loving and life-giving force instead of being seen as a source of selfish gratification.

As regards suggestions for action, it calls for the intensification of education of people about the nature of HIV how it is contracted and how it can be avoided. Special attention must be

paid to youth education. The document further urges the proper treatment of people living with HIV, taking care of them preferably in a family environment, where the local community can be involved. They should not be isolated but be given medical, moral and spiritual support. Giving prostitutes occupations that will enable them to support themselves in an honest way should help them to rehabilitate themselves. Dependants of people living with HIV should be cared for by society by the provision of foster homes and institutions. The medical profession is encouraged to maintain their morale in despite of witnessing the death of many of their patients because of HIV. The document appeals for respect for the unborn even if there is HIV. Abortion is not allowed. Furthermore, it is probable that one in four babies born to HIV infected mothers will be free of the disease. Finally, the document recommends Voluntary Counselling and Testing (VCT) for couples contemplating marriage.

It was the result of this statement that Christian Umbrella Organisations in collaboration with their member Churches began to make some responses to practical interventions on the HIV crisis in Zambia. A brief look at their activities will provide a clear insight into their efforts to scale up strategies. It should also be observed that some actions came ten or more years later because of the stage of denial in which had existed among the Zambian Churches. A visit²⁵ to the three umbrella offices showed that while a lot of activities seem to be going on, there is a serious lack of documentation on what the Churches are doing in Zambia in response to the HIV crisis.

The next section will discuss what the Churches are attempting to do through their “mother bodies” and the institutions that they have created in responding to this challenge of the HIV virus.

2.5 The council of churches in Zambia (CCZ)²⁶ and the problem of HIV

The Christian Council of Zambia was formerly known as the Christian Council of Northern Rhodesia. This was the successor to the General Missionary Conference of Northern Rhodesia, which existed from 1914 to 1944, when the Christian Council of Northern Rhodesia was formed. Its main responsibility was to promote co-operation between the missionary societies in areas such as education, health and religious broadcasting. It later

²⁵ See Appendix 1 for the standard questions asked during the visits

²⁶The name was changed from Christian Council of Zambia to the Council of Churches in Zambia in July 2003. It has always been a Council of ‘Churches’ rather than a Council for all Christians in Zambia. Membership is open to denominational Churches that confess the Lord Jesus Christ as Lord and upholds the Trinitarian belief in God.

changed its name to the Christian Council of Zambia (CCZ) on the eve of Zambia's political independence in 1964. The CCZ now exists to bring together members of Churches and Christian organisations for consultation and discussion in order to form an enlightened Christian opinion on all issues affecting the spiritual, moral, social justice and physical welfare of all Zambians. It also promotes the study and investigation of problems relating to the progress of the reign of God and the development of the people of God. It serves as a representative body and may express the views of its constituent members on such issues. A seventeen member Executive Committee that acts on behalf of the General Conference spearhead the Council. The secretariat is headed by the General Secretary and has nine operational departments, namely, Administration, Projects, Development and Uprooted People Ministries, Women and Children's Work, Communications and Social Justice, Education and Scholarships, Youth and Chaplaincy, Accounts and, more recently, the inclusion of the Makeni HIV/AIDS Resource Centre.

Apart from attending several meetings around issues of HIV, the CCZ has with effect from January 2003 opened up an HIV/AIDS Resource and Training Centre in Makeni - Lusaka. This centre now serves as a focal entry point within CCZ's structures for HIV related work. Previously most of this work was tackled by the Women and Children's Department. The initial response to the HIV pandemic was to provide traditional care programmes. These were programmes designed to provide support and education for persons of families caring for HIV patients in their homes. Considerable efforts were made into addressing false perceptions and myths about how HIV was transmitted in order to reduce discrimination against infected people. Families have been helped to form support groups to sustain them through long term care experiences. The Women's Desk has also promoted the revival of local knowledge about the medicinal properties of available plants and traditional treatment methods, in order to deal with the associated illness that come with HIV such as fever, diarrhoea, and respiratory problems. Commercial HIV drugs are either not available or prohibitively expensive²⁷. Because of the connection between poverty and HIV, part of CCZ's approach has been to support activities that generate an income for women. Helping women increase the family income can alleviate the conditions that drive people into high-risk behaviour such as prostitution. The CCZ has thus been training women in small business management skills and has been offering training in tie-dye, batik, and flower arranging.

²⁷Most of the work of the CCZ on HIV has not been documented. The aforementioned details are from an article by Paula Butler interviewing the Head of Women and Children work in CCZ Suzanne Matala during her visit to Canada and published in *Mandate: a United Church of Canada Mission magazine*, February 2003: 21 – 23.

Flower arrangements for funerals have made flower business activity a viable small business for women. Training in methods of preserving food is another aspect of CCZ's holistic response to HIV. Once women learn improved techniques to preserve food, they have the benefit of both a more assured food supply during the dry season, when food is often scarce, as well as the possibility of selling some food to support their family's income. In addition to these very practical programmes the CCZ has identified the need to address the emotional and legal aspects of HIV-related deaths. The Council has therefore had to train women about their legal rights when their husbands die. For many years Zambian women have been struggling with traditional customs that deny widowed women the right to inherit marital property in the event of their spouse's death. Zambian law now protects women's rights to inherit such property, but traditional customs that give inheritance rights to the deceased husband's family remain influential. The CCZ tries to ensure that women going through the stress and grief of bereavement do not suffer additionally because they are not aware of their legal inheritance rights.

Children are dramatically affected by HIV, and the CCZ has integrated children's issues and needs in its overall response to HIV. The number of AIDS orphans, as indicated above, continues to grow. Zambian Churches have not wanted to promote the establishment of orphanages, but are working instead to keep orphans living in their own communities with as normal a life as possible. This is difficult because so many traditional systems have broken down as a result of the accumulated impact of long-term poverty, unemployment and early adult death. The CCZ has tried to be as creative as possible in addressing the challenges of dealing with huge numbers of orphans. One of its approaches has been to set up churches as facilitators, identifying locally available resources and organising and mobilising the community to maintain and care for orphaned children. Presently over ten churches in different communities are involved in pilot projects involving about two thousand orphans. Working with the community, the church co-ordinates the provision of school uniforms books and foster mothering for children.

HIV has much to do with social power and gender dynamics and the CCZ has had to work for the empowerment of women, girls and children as a basic aspect of the approach to HIV. The CCZ teaches women that they have a right to be in charge of their own bodies. Their bodies are made in the image of God and must be respected. Yet, incest and rape are on the increase in Zambian society, making children, and girls in particular, vulnerable. The CCZ, through its

women's desk, promotes education about child abuse and exploitation and tries to popularise an awareness of children's rights, making children themselves more aware of their rights.

In order to strengthen its education, advocacy and action work, the CCZ as indicated above has had to create a new centre called the Makeni HIV/AIDS Resource and Training Centre.

2.5.1 Makeni HIV/AIDS Resource and Training Centre

The Makeni HIV/AIDS centre was created by the Council of Churches in Zambia in order to concretize the Church's response to the challenges posed by HIV. It is a centre dedicated for empowering of Churches on how best they can competently respond to HIV. The section which follows then explains in brief about the rationale for such a centre.

2.5.1.1 The need for a HIV Resource and Training Centre

The churches need to be engaged in the field of HIV prevention and care. If the church leaders were empowered by the necessary facts and the Christian humane attitude of caring, their wholehearted effort could make a big difference in behaviour change in their congregations. Therefore, the Resource and Training Centre for HIV/AIDS has been created to provide training and necessary backup for church leaders to actively get engaged in this necessary attitude change.

At present, there are not many comprehensive, national Church centres for HIV related material existing and the need for this is obvious, since the authorities and NGO's develop a great deal of scientific and training material. This material, however, is not collected and made readily available in one spot. The Resource Centre is providing the necessary location to consolidate the huge amount of scattered material already in existence and facilitate its effective use.

The Council of Churches in Zambia has been involved in the provision of education, advocacy and training by itself and through its member churches. The Resource Centre is consolidating all such efforts especially in the fight against HIV. In the words of Kofi Annan (*Map international*, 1999: 6) the CCZ is helping to give people a chance to replace suffering with hope, to plan for life, not prepare for death.

The aim of the Makeni CCZ HIV/AIDS Resource and Training Centre is to contribute in the fight against the HIV pandemic by educating people of different age groups focussing

particularly on the youth. The Centre provides training in Psychosocial Counselling for Church leaders, Home Based Care, Life Skills for PLWHA, Youth Sexuality and Reproductive health, basic HIV facts and other related courses.

2.6 The Evangelical Fellowship of Zambia (EFZ)²⁸ and the problem of HIV

The Evangelical Fellowship of Zambia is a voluntary organisation of Christian denominations, local churches, missions, organisations and individual Christians operating in Zambia and of evangelical persuasions and convictions. The Organisation was formed on the 8th April 1964 in Lusaka. The EFZ is a service agency of the evangelical community in Zambia. It assists in a wide range of evangelical ministries through out the country by sponsoring seminars in Evangelism, Church Planting Planning, Church Growth, Leadership Training, Youth and Women Ministries. Through the Ethics Society and Development Department (ESD), several relief programmes and small-scale projects are pursued in bringing assistance to many less privileged families. EFZ is the mother body of the Theological College of Central Africa (TCCA) in Ndola, Zambia, where Theology is taught at a University degree level and in other study programmes.

2.6.1 Church leaders' national conference

In June 2001 the EFZ held a national conference for top Church leaders on HIV prevention and control. Over forty leaders from all over Zambia attended the workshop. The Church leaders who attended were sensitised on a number of important issues: HIV and its impacts and how the Church needs to get involved in the fight against HIV.

2.6.2 Orphans and Vulnerable Children (OVC) initiatives

The EFZ has established OVC initiatives in the following areas: Lusaka West, Livingstone, Mansa, Samfya and Mufulira. This is one of the ways of responding to the impacts of HIV. The OVCs in the above areas are not found in orphanages, some are with guardians and couples from EFZ member Churches who have adopted them, while some stay on their own in child-headed homes.

There are women who have volunteered to take care of these OVCs by visiting them, cleaning their homes, helping them materially and sometimes financially, and counselling

²⁸The Evangelical Fellowship of Zambia can be found on Kamloops Road, postal address: P.O. Box 33862 Lusaka. 10101, e-mail evafeza@zamnet.zm

and encouraging them spiritually. These initiatives are not exclusive to the orphans and vulnerable children as help is also extended to terminally ill persons in the above mentioned areas.

2.6.3 Training of volunteers

The EFZ identified the need for the training of the volunteers in all the project areas in various skills because of the nature of the work they do in society and the community. The EFZ volunteers have been trained in the following skills, Psychosocial Counselling, Nutritional Education, Basic Administration Skills and Resource Mobilisation.

2.6.4 Youth sexuality and HIV

EFZ has an ongoing youth programme which aims at encouraging and intensifying open discussions on sexual related issues. This programme targets young people between 13 and 20. These programmes are usually carried out in youth groups of EFZ member churches. This programme has been introduced in all the areas where Church leaders have been co-opted for the OVC care and support programmes.

2.6.5 Co-opting church leaders for OVC care and support

EFZ is currently co-opting church leaders (under a programme they call ‘envisioning Church leaders’) for care and support. This is in order to increase the Church’s involvement in support of OVC. The projects have taken place in Lusaka, Copperbelt, Central and Southern provinces. Several aspects under this project have been covered and these include:

- Integrating HIV in Sunday Worship Services and other Church ministries
- Biblical mandate on the Support of OVC
- Initiating on the OVC program at Church level
- Resource mobilisation
- Proposal writing
- Needs of children and need for advocacy (information supplied through responses to Appendix 1 as shown above)

Some Church leaders have caught the vision from the time the project started, and are now implementing some HIV related programs at local church level.

2.6.6 Parent child dialogue

This programme targets both the youth and the parent. It is the means by which dialogue between parents and youth is facilitated. Open discussions between parents and youth/children on sexual matters do not take place easily, but in the times of HIV, parents cannot afford to keep silent and must give guidance to their young ones on sex education. Parent-child dialogue is very important and it helps in HIV prevention.

2.7 The Zambia Episcopal conference (ZEC) and the problem of HIV²⁹

About 20% of the population of Zambia have been baptised into the Catholic Church. They are served by one cardinal; ten (10) bishops; nine hundred-and-forty nine (949) priests; about one thousand two hundred and fifty four (1 254) religious men and women as well as two hundred and ninety eight (298) catechists and lay co-operators (men and women). They are served in about two hundred and fifteen (215) parishes with an average of ten prayer centres and thirty active small Christian communities in each parish. Each parish has estimated one hundred and forty (140) volunteers. There are chaplaincies at the universities, the institutes of tertiary education, the secondary schools, the army, the airport, the Zambia Air force, the prisons and the councils of the laity. The number of recognised lay movements in the Catholic Church in Zambia is eighteen.

The Church was established in Zambia in 1891 with the White Fathers settling at Old Mambwe Mwela along the newly constructed Stevenson Road that connected Lake Malawi at Kalonga with Tanganyika at Mpulungu and that formed the border between Zambia and Tanzania. In 1895 they set up their first parish at Kayambi near the capital of Chief Makasa. Many of the first Christians were young people redeemed from slavery whose parents could not be traced. The Zambia Episcopal Conference (ZEC) is the central office of the Catholic Church, and it works under the college of Bishops. The Catholic Church in Zambia is involved in providing various services to Zambian society. They run twenty-nine secondary schools, twenty-three primary schools, eight special schools for the handicapped, two teacher

²⁹All the information regarding the history of the Roman Catholic Church in Zambia – from *The Catholic Church in Zambia – brief history*, by AMECEA, 1992.

ZEC secretariat offices situated at Kapingila House, number 6 Kabulonga Road, postal address; P.O. Box 31965. Lusaka. zec@zamnet.zm

training colleges, three institutes of tertiary learning and eight private schools. Since the beginning of the 1990's the Church has opened numerous 'Zambia Open Community Schools' to cater for those children who could not afford the school fees of the State schools.

The Church also runs a very strong Health Department, which looks after nineteen hospitals and twenty-five rural health centres, mostly situated in the rural areas of Zambia.

Having recognised that the HIV pandemic has reached an alarming stage, the Catholic Church began responding to the challenge in numerous ways in the area of health and home based care programmes as well as programmes for widows and orphans. In 1997, ZEC created a National HIV/AIDS desk to co-ordinate and evaluate the programmes, in order to guarantee support and sustainability of the different programmes and activities in the various dioceses. The religious woman who pioneered the desk was responsible for 'Behavioural Change Programme', which developed into 'Youth Alive Zambia³⁰', an NGO which had great success in the area of behavioural change. The National AIDS Desk of the Catholic Church works as part of their Health Department managed by an AIDS programme manager. This manager liaises and co-operates with Diocesan programmes. They have very strong home based care programmes where the sick are cared for within their homes. Home based care is provided to all terminally ill people regardless of age, race, sex, religion (it is unconditional care) and addresses the medical, emotional, spiritual, psychological and material needs of patients (it is holistic/integrated care). The beneficiaries of home based care are:

- a) the afflicted i.e. the dying disabled, diseased and destitute
- b) the affected family members, orphans, widows and the elderly (information supplied through responses to Appendix 1 as shown above)

The Catholic bishops have continued to issue pastoral letters addressing the HIV pandemic. After the joint statement issued by the three Christian umbrella mother bodies, they have gone further to refer to the pandemic in other pastoral letters such as: *You shall be my witnesses*, *The Church as caring family* and *Choose life* (Komakoma, 2003: 221-230).

³⁰The researcher and his wife since 2004 are respectively the current patron and matron of Youth Alive Zambia.

The latest Pastoral letter entitled: *Have life to the full* (November 2002) makes appeals and challenges that are worth noting as they have helped the shaping of all Roman Catholic Church efforts in fighting HIV. The bishops say:

Since the fight to eradicate HIV/AIDS cannot be won by any single group or institution, we appeal to various stakeholders as follows:

We appeal to the government to recognise that the Churches have the largest constituency in the country and their contributions can make all the difference. We appeal to government to include representation from the Christian Council of Zambia, the Evangelical Fellowship of Zambia and the Zambia Catholic Bishops on the National AIDS Council³¹.

2.8 The Churches Health Association of Zambia (CHAZ)

The Churches Health Association of Zambia (CHAZ) was created in 1970. It was first called Churches Medical Association of Zambia - CMAZ. Later it became Churches Health Association of Zambia (CHAZ), an umbrella organization to represent work done by church administered health institutions in Zambia. The medical committees of the Christian Council of Zambia and the Catholic Bishops Conference met regularly since 1950 to discuss matters of common interest and adopt common positions in dialogue with the government. With the assistance of the Christian Medical Commission of the World Council of Churches it was decided that one organ should be created to represent and provide support to all church administered health institutions in the country. There are at present 90 health institutions affiliated to CHAZ representing 16 different church and church organizations. Of the 90 CHAZ member institutions 30 are hospitals and 60 are rural health centres. Together these institutions are responsible for more than 50% of formal health services in the rural areas of Zambia and about 30% of health care in the country as a whole. The CHAZ fulfils the role of a facilitator in the provisions of health services in the country. Member church institutions implement health services and programmes. CHAZ provides support and representation to enable each member institution to provide adequate and effective services. The mission of CHAZ is to represent and provide for church related health institutions and programs to improve health in Zambia. The church health institutions were founded primarily on the Christian mission not to only preach the word of God to people but also to address their

³¹ This appeal has since been responded to and the three umbrella bodies have since nominated one person who serves on the National AIDS Council. Presently (2006) the officer is the Executive Director for the Evangelical Fellowship of Zambia. The position will be rotating amongst the Executive officers of the umbrella bodies.

health and other basic needs. The continued existence of church hospitals today is still to a large extent driven by that same religious conviction. Most of these institutions see their role as a direct response to the call of God to express his love and compassion through care for the sick and dying. Some workers in these institutions may be ready to make many personal sacrifices in order to accomplish what they perceive as God's high calling for them. CHAZ complements government efforts in the delivery of quality health care by bringing to the health sector, human, material, financial resources, innovation, and more importantly, Christian love and care. CHAZ member institutions are mostly situated in rural areas where government services are few or sometimes non-existent.

The priority interventions for the period 2003 to 2006 for CHAZ were as follows:

- Mobilisation of a multi-sectoral response
- Promotion of behaviour change: abstinence, mutual faithfulness or condom use
- Increased and improved STD prevention and control
- Reduction of high risk behaviours
- De-stigmatisation of HIV
- Increased voluntary counselling and testing
- Reduced mother to child transmission of HIV
- Improved Home Based Care and support for people living with HIV
- Community based support for orphans and vulnerable children
- Improved drug supply for the treatment of STD, TB and HIV positive clients
- Improved hospital level care (information supplied through responses to Appendix 1 as shown above).

The CHAZ AIDS program became fully operational in 1988 in order to contribute to the prevention and control of HIV infection, focusing on the rural areas of Zambia. The CHAZ AIDS Care and Prevention Programme focused on AIDS education, capacity building of institutions and communities, support to orphans and prevention of HIV infection through the screening of blood. From 1993 to 1999 the Community Care and Education Project was initiated through financial support from DANIDA/Dan-Church Aid. The project focused on

the need for establishment of home based care, counselling and health educational activities in the target districts. The rest of the CHAZ member institutions also benefited from the HIV testing kits and training programmes.

2.8.1 Overall objective

The overall purpose of the current project is to contribute to the prevention and mitigation of the impact of the HIV pandemic in Zambia. Mobilising, scaling up and strengthening the institutional structures helped to achieve this.

2.8.2 Specific objectives

The specific objective for the CHAZ HIV work has been to prevent the transmission of HIV, particularly among the youth and women and in situations providing risk for HIV transmission such as truck drivers, commercial sex workers and fishermen. This has included the need:

1. To reduce the socio-economic impact of HIV on individuals and families in rural Zambia.
2. To strengthen capacities of institutions and communities that contributes to the implementation of HIV related programs
3. To develop institutional capacity to conduct HIV and related research (information supplied through responses to Appendix 1 as shown above)

2.8.3 Target group

The main target groups for the CHAZ support are the communities in the rural areas, where the weakest of member institutions are found. The programme covers all CHAZ member health institutions and programmes. However, nine of the CHAZ member institutions in rural areas receive special attention. The primary target group is:

- The communities (the general population) in the CHAZ catchments
- Specific groups, such as youth, women, sex workers and truck drivers within the catchments
- Persons who are diagnosed with HIV and their families in the catchments areas of CHAZ institutions. (information supplied through responses to Appendix 1 as shown above)

2.8.4 The secondary target group

Health workers involved in the programme, such as community volunteers, community health workers, traditional birth attendants, traditional healers, and rural health centre and hospital staff, are all secondary target groups.

2.8.5 Main activities

The following are the main activities of the Churches Health Association of Zambia in their response to HIV:

- AIDS Education
- AIDS Educational Materials
- Relevant AIDS literatures including posters Leaflets in local languages are produced to intensify the HIV/AIDS Campaign.

2.8.6 AIDS Radio programmes

CHAZ has been running a series of radio programmes aimed at the church and other stakeholders who ‘speak out’ on relevant issues related to HIV. This programme has become very popular.

2.8.7 Condom promotion

CHAZ condom promotion has been targeted at discordant couples where one partner is an HIV positive or an STD patient. Condoms are made available to those institutions that request them. On the other hand, in respect of an institution that for one reason or another cannot distribute condoms; a smooth referral system is put in place to refer patients to other institutions.

2.8.8 Control of Sexually Transmitted Diseases (STDs)

Control of sexually Transmitted Diseases (STD’s) has been an integral component of the CHAZ AIDS Care and Control Programme. This has been done through training of health professionals at member institutions in STD Management.

2.8.9 Voluntary counseling and testing (VCT)

HIV counselling and counselling testing services are available in 60% of the member institutions. Clients are encouraged to know their HIV status. To strengthen this service CHAZ has had to train medical doctors, nurses, clinical officers and social workers in counselling. The need for more counsellors in the rural areas is growing.

2.8.10 Provision of protective materials and supplies

An important component of this project is to secure a steady supply to hospitals and clinics of HIV preventive supplies (like gloves) to protect health personnel, including traditional birth attendants.

2.8.11 Provision of HIV testing kits

CHAZ provides HIV testing kits to all church health institutions. Unfortunately the demand is higher than what the current budget can provide for.

2.8.12 Support to orphans and vulnerable children

Foster (2004: 4) in *Study of the response by faith-based organizations to orphans and vulnerable children*, projects that by the year 2010 there will be an estimated 1,145,892 orphans in Zambia. The main thrust of CHAZ has been on supporting education for orphans and vulnerable children through provision of school fees and supplies.

2.8.13 Home-based care (for PLWHA)

The overall objective of the CHAZ home care programme is to provide quality medical, nursing and psychological care to people infected and affected with HIV in the comfort of their own homes while decongesting the hospitals. Home Care also provides an entry point for AIDS education in the community and for orphan identification.

2.8.14 Activities in home care

Under the home care responses the CHAZ has a number of activities which include the following:

- Training the family in infection control, nutrition and basic nursing care

- Counselling clients and family members about the HIV disease
- Provision of pastoral support, prayer and, bible reading
- Linking patients with a health centre and hospital for specialised care
- Provision of material assistance (food, soap, disinfectant, gloves etc.)
- Provision of nursing services (bathing patients, dressing wounds)
- Housekeeping (washing up, laundry, doing shopping)
- Bereavement support (information supplied through responses to appendix 1 as shown above)

2.8.15 Development of micro-credit-schemes

In the year 2000, the AIDS Programme introduced a micro-credit-scheme pilot project as an integral part of the AIDS Care and Prevention Programme in the four target hospital/districts supported by DCA. Funds are administered by small Community Based Groups (CBG) under the supervision of AIDS field officers at the four target hospitals. The input of funds is a once off event, as the scheme is based on the principle of interest-free, revolving loans for members of selected CBGs. Loans are used for the establishment of income-generating activities and profits generated are for the individual members' and their families' own social support. The participants in the micro credit scheme, after accumulating a certain proportion of the surplus from the established income generating activities, then develop *a merry-go-round-scheme*, from which other Community Based Groups can borrow.

2.8.16 Capacity building

Both formal and informal training programmes have been conducted by CHAZ. The main target group has been the health workers. They have been trained with a view to impart their skills and knowledge to the community. The priority areas for this training have been:

- Counselling Training
- STD Management Courses
- Training in Community Based Approaches - with the emphasis on decentralising programmes
- AIDS Management Training (information supplied through responses to Appendix 1 as shown above)

2.8.17 Research

In order to assess the relevance and effectiveness of the various models of the innovative HIV interventions, the health system research component of the programme is essential. The CHAZ AIDS programme seeks to strengthen institutional and human capacities in health systems research and related operational research to adequately respond to the challenges of HIV.

2.9 Zambia Interfaith Networking Group on HIV/AIDS (ZINGO)³²

Faith based organisations (FBOs) have become extremely important contributors to the Zambian socio-economic development and its political process.

Faith, according to Burke and others (2005: 10-23) is the mainspring of the soul. Through faith, aims and desires, plans and purposes are translated into physical, social, economic, political, artistic and spiritual achievements. Over the centuries, positive religious faith has stimulated individual and collective actions for the improvement of people, collectively and individually, in many different spheres of life. History, however, also abounds with instances of religious faith applied negatively, bringing untold suffering, injustice and evil into the world. For many centuries, religious faith and spirituality have been major resources in promoting health and wellbeing, and in helping people to cope with the impact of disease. This is especially the case in Zambia, and for many African countries, where many hospitals and rural health centres as seen above (30% of all health facilities in the nation) were started by missionaries. It is also very true in a continent where religious beliefs play a major role in shaping people's personal identities, thought patterns and perceptions of disease and the decisions they make which affect their health. Faith communities in Africa, therefore, have the potential to play a pivotal role in determining how individuals, families and whole communities respond to the HIV pandemic, which is the greatest health and development challenge facing the continent today. The establishment of the Zambia Interfaith Networking Group on HIV is thus a very commendable step by the religious community in Zambia in the fight against HIV.

³²ZINGO office is situated at Plot Number 5505 Msanzara Road, Kalundu in Lusaka. Zingo@zamnet.zm. Information has been gathered through participant observation. As the researcher has indicated above he is the current chair of ZINGO. Part of the information is from unpublished ZINGO reports.

Since Zambia's political independence in 1964, FBOs have enjoyed a formal partnership with the government, sharing responsibility for the provision of education and health services. It is a pertinent and powerful truth that FBOs are often the only residential Non Governmental Organisations (NGO's) in remote communities, particularly those distant from the railway lines and therefore have had significant involvement and strong influence in the development and social wellbeing of these communities. Today, according to a World Bank urban assessment paper³³, FBOs are the most widely recognised non-governmental participants in development activities in urban townships. Despite a long history of advocacy on issues of moral and spiritual dimensions, FBOs have been less active in developing a collaborative response to HIV. While some religious communities such as the Catholic Church and Salvation Army, had responded soon after the first case of HIV was diagnosed, very few FBOs have comprehensive programmes that encompass the entire spectrum of prevention, home based and palliative care and treatment of opportunistic infections.

Religious faith can also play an important role in promoting safer sexual behaviour, and in motivating large numbers of volunteers involved in HIV care, support and prevention activities. Moreover, the personal testimonies of many people living positively and productively with HIV reveal a deep reliance on inner spiritual resources for strength and willpower.

The Interfaith Networking Group on HIV/AIDS was formed in 1997 to assist religious communities to become more involved in HIV prevention and mitigation. ZINGO consists of independent churches, umbrella Christian organisations (CCZ, EFZ, and ZEC) and representatives of the Bahai and Islamic communities.

ZINGO, also popularly referred to as "the Interfaith", provides a model for ecumenical collaboration through providing a unified platform from which faith based organisations (FBOs) can contribute and expand upon existing HIV prevention and care programmes. The interfaith model lends itself to a favourable environment for the development of approaches that will be recognised and supported by Government and other stakeholders. During the last National Interfaith Conference held in March 2002, religious leaders re-confirmed the

³³ World Bank 2000 *Annual report*

efficacy of a well co-ordinated HIV³⁴ response and called for the expansion of the interfaith model to all areas of the country.

Against this background and in order to strengthen its co-ordination of the HIV response by the religious groups, the following activities have been carried out:

2.9.1 Strengthening the interfaith secretariat

In order to establish itself nationally and scale up its activities, the Interfaith developed into a national network following a recommendation by religious leaders to scale up and henceforth changed its name from Lusaka Interfaith Networking Group (LINGO) to Zambia Interfaith Networking Group on HIV/AIDS (ZINGO). This enabled the network to gain NGO status and it is now a registered organisation. Furthermore, a part-time worker was engaged and was seconded to the Interfaith by Council of Churches in Zambia (CCZ) in order to administer the its day-to-day activities. To further strengthen the Interfaith, interim office bearers were put in place to assist in running the secretariat. The combination of the office bearers provides a very important illustration of people of different faiths co-existing and working together to combat the deadly HIV-virus. The member representatives of ZINGO are therefore Muslim, Christian, and Bahai believers.

2.9.2 Best practice documentation

As much as these religious responses are admirable, little has been done to document them. Today, few people if hardly anyone at all can comprehensively say what religious organisations are doing in regards to responding to the HIV pandemic. It is against this background that the Zambia Interfaith Networking Group on HIV/AIDS (ZINGO) embarked on a best practice documentation exercise. The exercise aims at documenting practices in existence that might not necessarily have been visited or known by the outside world, and subsequently proposes them to UNAIDS for documentation. Phase one of the exercise began in December 2002. During that phase 322 faith based organisations were visited and interviewed in Lusaka, Livingstone and Kitwe. The objectives of the exercise were to generate information on the type of activities carried out by FBOs in order to describe when, where and how they were being carried out. The exercise also aimed at mapping these FBOs as well as providing baseline information for monitoring and evaluation. Most importantly,

³⁴See ZINGO report for 2002 activities – unpublished. Zingo@zamnet.zm at 5055 Msanzara Road, Kalundu, Lusaka.

however, the exercise provided an opportunity for identifying which of the faith based responses deserve to be documented as ‘Best Practice’ for possible replication elsewhere.

Another great success of the network that deserves mentioning is the production of a manual entitled *Treasuring the gift: how to handle God’s gift of sex - sexual learning activities for religious groups*³⁵. This manual helps youth groups to gain knowledge, attitudes and skills they would need to treasure the gift of sexuality beyond their religious barriers. The book helps young people from various faith groups to put aside their doctrinal and denominational differences in order to work together in the fight against HIV.

All the activities and statements related to HIV conducted by the faith community have not given enough attention to the fight against HIV related stigma. None of the above programmes have any specific and focussed attention on dealing with the creation of support groups for those who are HIV positive. The holistic approach being advocated for in this work would entail attention of all aspects including support groups of HIV positive people. Furthermore, to show the impact of these programmes and activities, efforts should go beyond the mother bodies to local faith communities. A non-faith organisation called the Network of Zambian people living positively with HIV has some basic lesson to offer in terms of providing an agenda which takes concerns of HIV positive people.

2.10 Network of Zambian people living positively with HIV (NZP+)

In this section, the researcher briefly discusses this group, which is not a church or a religious group, but has much relevance to the substance of the current research work. This research work touches on people who are living positively with HIV.

This network, according to their website http://www.icomp.org.my/Inno_prog/inno-LR-zambia.htm#Propride NZP+, was established in Lusaka in 1996 to help improve the quality of life of people living with HIV by actively pursuing three issues which are communication, support and representation of people with HIV in issues affecting them.

They organize conferences and workshops for people with HIV in Zambia, an initiative that brings out solidarity and encouragement to live on and be part of efforts against HIV and in support of people with HIV. They conduct intra- and inter-country visits among members that help in sharing and acquiring new knowledge for an effective contribution in the response

³⁵ Published by the Lusaka Interfaith HIV/AIDS Networking Group

against HIV of people with HIV. They also work for the formation and strengthening of non-religious support groups of People with HIV. They are highly involved in advocacy and lobbying for the rights, interests and responsibilities of people with HIV in their efforts against the scourge. They also are involved in the production and promotion of information relevant to those with HIV and aimed at normalizing the attitudes of people in regard to HIV.

2.11 Conclusion

What the researcher has done in this chapter is to answer the question: ‘What is happening in the global ecumenical Church as well as in Zambia at the religious level in as far as the challenge of HIV is concerned?’ Methodologically, this is about discerning what is taking place globally as well as at the local situation in the faith community in Zambia before one looks at what the spirit is saying to the Zambian faith community. HIV has touched the image of God in human beings and so he is concerned about what is happening. Churches have attempted to respond albeit in a limited way. The researcher has looked at the major umbrella Christian organisations, namely the Council of Churches in Zambia, the Evangelical Fellowship of Zambia, the Zambia Episcopal conference and the way they have responded to this challenge. He also looked at the activities of organisations these umbrella bodies have created in fighting the scourge, namely Churches Health Association of Zambia and the Zambia Interfaith Networking group on HIV/AIDS.

Faith based programmes are especially renowned for their activities in the field of medical, pastoral and spiritual care, home based care and assistance to orphans. This is true for the Zambian mother umbrella bodies as well as for the Zambia Interfaith Networking group on HIV/AIDS.

Panos Southern Africa (2007, May 20, <http://www.healthcomms.org/rtf/PANOS-communication-in-Lusaka.rtf>) noted in their research that the Zambian context does not lend itself to a vigorous public debate on HIV because of the issues of stigma and shame around the virus, and the gender dynamics that prevent men and women from being open about HIV or sexuality. As indicated above by Vitillo (2004: 24), levels of stigma still abound in many countries - Zambia inclusive. From the statements from the World Council of Churches as shown above, HIV stigma has been clearly condemned. However, the first Zambian statement on HIV went on to indicate that HIV was a result of promiscuity. That is indeed entrenching stigma about the spread of the infection. One wonders about the children and

many faithful spouses who got infected with the virus? The statement however does admit that HIV was the problem for the whole community and needed every social force for solutions. That statement went on to condemn the usage of condoms in curtailing the further spread of HIV, another language promoting stigma.

Not until the work spearheaded by the researcher under the umbrella of the Council of Churches in Zambia, did all programmes, activities or statements began to deal with the issues of theological reflection around HIV stigma. Before the intervention of the researcher, they did mention a number of intervention programs but none had any theological reflection on the role of local congregations. This then enhances the researcher's hypothesis that Churches in Zambia do not have in place an effective strategy that addresses the issue of HIV stigma in a holistic way at a congregational level where it effectively reaches and influences members. There is clearly no inclusion of HIV positive people in creating such strategies. The very absence of HIV support groups in the form of Circles of Hope in local congregations indicates that gap. There is not an inclusion of relevant parties that can play a role in this quest.

Yet, many non church organisations and bodies have also developed policies, strategies and activities to prevent the spread of HIV and to fight stigmatisation and discrimination towards PLWHA. These have not reached local congregations where it would effectively touch many people. In this case, the researcher has mentioned the Network of Zambian People living with HIV. This is similar to what has happened during the last few years when HIV infected members of the clergy have openly attested their status and have organised themselves, which will prove invaluable in reducing stigma at community levels. A good example is the work of ANARELA+, an African network of religious leaders of all religions who are living with or personally affected by HIV. Increasingly, religious leaders advocate for human rights, address gender inequality and oppose harmful traditional practices. An important step is the recognition e.g. by the World Council of Churches (1997: 79-92) that any reference to *AIDS as a punishment of God* is incompatible with the Gospel. 'A *theology of compassion*' (WCC, 1997: 93-95) is needed to properly react to this pandemic to produce a conducive atmosphere to that holistic community based approach.

FBOs contribution to prevention is valuable in terms of broader development issues such as education and social services to reduce vulnerability. They help to cope with the emphasis on abstinence and faithfulness as exclusive strategies for HIV prevention. Here however, in view

of the reality of human sexual behaviour, prevention methods have been incompatible with the approach of secular stakeholders to HIV prevention. Indeed in amongst the Zambian religious groups as mentioned above, HIV strategies focussing on condom promotion have faced tremendous opposition from religious organisations. At the local level some clergy and FBOs have also felt constricted by these official church positions, and occasionally acted in pastoral situations according to their perception of social necessity.

FBOs have displayed a number of strengths compared to government institutions and development NGOs. In many parts of Zambia they are clearly the most effective in service delivery in relation to care and support for PLWHA. FBOs have a solid record in alleviating human suffering and potential for outreach to the poor in the most remote areas of Zambia, including humanitarian crises and conflict situations. Their limitations are manifested mostly in the areas of collaboration with other stakeholders in prevention issues, and in their lack of opportunities for participation in the design of national policies and strategies.

On the other hand, significant opportunities exist to enhance the debate and the involvement of local congregations and the effectiveness of their HIV related projects. To be able to expand and widen their programmes, they need support. They need information, training, opportunities for networking (Parry, 2003: 11), funding and technical assistance from international FBOs, international religious bodies NGOs, government and other actors. Tiendrebeogo and Buykx (2004) make recommendations from the 2003 desk review on the response of the faith sector in sub-Saharan Africa conducted by the Dutch Royal Tropical institute and these are:

Government-FBO relationship - The main priority is to create a better understanding between religious/FBO leaders and government policy makers at national and international levels. This would involve greater communication and more professional discussions. Also, the extent to which mechanisms are in place for effective the participation of FBOs in HIV programmes should be reviewed. This includes reference to the national and global AIDS control programmes` co-ordination, other institutional relationships and co-ordination around FBOs strategies and work.

Financial and technical support - If FBO projects are to be improved and scaled up, international FBOs and donors must show greater commitments to supporting local

initiatives. They should be supported in their very effective practical work at the grassroots level, regardless of differences of opinion on international levels over theoretical concepts.

Training and skills building - Training is needed to ensure increased skilled human and financial resources for the treatment, care and support activities in which FBOs have demonstrated strong commitment and potential. This would include support for skills training and initiating community development activities.

Prevention support - FBO care and support activities need to be complemented and not overruled by public health activities that support prevention. It should be acknowledged that not all FBOs are in a position to promote condom use. Their work in their areas of comparative advantage should be respected. In this way the work of other stakeholders may be adequately complemented and the deadlock over prevention methods overcome. Nevertheless, FBOs should be encouraged to give their young people access to HIV prevention services along with expressing their messages. In their own religious classes, FBOs should be supported in teaching young people how to negotiate sexual relations. Such life saving skills is especially important for pre-adolescents who want to practice abstinence.

Networking and communication - Religious leaders and FBOs should actively seek information and exchange and avoid isolation. They should pursue regional, national and international networks at every opportunity. Secular stakeholders should facilitate contacts and discussion with religious leaders. Communication at higher levels is important to keep religious leaders and FBO workers informed.

From the foregoing information on how the Churches in Zambia have responded to HIV thus far, it is very clear that they do not have an effective strategy in place that addresses the issue of HIV in a holistic way on a congregational level where it can reach and influence members effectively. Information on how the virus is spread has been shared in the statements but there is no clear holistic way of calling on all the necessary components in building HIV competent communities which remove shame, silence and stigma.

A missional theology, which promotes the praxis of the creation of 'Circles of Hope' at a congregational level, is basically absent and thus enhances the proposition for a holistic approach to combat the HIV pandemic from that angle. The above mentioned activities, programmes and statements, as well as later resolutions by various denominations and *ecumenical bodies* demonstrate an understanding and a theological commitment to the fact

that faith communities must become involved, yet at grassroots level, i.e. at congregational level, *this has not yet translated into concrete care and biblically based support programmes* (Greyling, 2001: 10). While there are many ways of approaching this pandemic, the author here contends that one of the most effective ways is a holistic community based strategy. In this way people will be encouraged to begin a journey which Njoroge (2001: 237) calls a journey of self-scrutiny, discovery, repentance healing and growth. People need to be involved in what Njoroge (2001: 241) again calls life transforming and life giving activities.

The researcher used the empirical data in Chapter 2 to benchmark the validity and appropriateness of the programmes, policies and strategies of these institutions and organizations mentioned.

The next chapter will look at some of the challenges faced in Zambia in addressing the HIV pandemic.

CHAPTER THREE

CHALLENGES FACED IN ADDRESSING THE PANDEMIC

3.1 Introduction

In Chapter 1 of this work the researcher has stated the problem statement, defined HIV and looked at the medical and social aspects of the life threatening disease. There is sufficient motivation from that chapter for the focus of this work. Chapter two has gone further to describe how the global ecumenical Church has responded to the problem of HIV. The chapter has further examined what is happening at the local scene in Zambia in terms of how the faith community has responded to the pandemic of HIV.

The researcher has been realistic about the situation in Zambia in Chapter 1 and 2 of this study. The Church in Zambia may participate in the triune God's missional praxis and leadership is the gateway to effective involvement. However, before realistically getting involved in participating in creating an alternative response to fight silence, shame and stigma associated with HIV, the current chapter will thus attempt to map some of the challenges involved in addressing the pandemic. It is when the challenges are understood and appreciated, that leadership will make an informed and appropriate response.

This chapter is of key importance to the first hypothesis, namely, that the problem before us is that the churches in Zambia do not have an effective strategy in place that addresses the issue of HIV **in a holistic way** on a **congregational level** where it effectively reach and influence members. Because of this, one needs a committed leadership, which will facilitate that effective strategy and influence the desired change towards a holistic approach.

Apart from what has been outlined above as the broader challenges of Africa some of the challenges that face the Church leadership in Zambia as it relates to HIV include fighting silence, stigma and discrimination, the challenge of change itself, issues of the empowerment of women in reducing their vulnerability, involvement of men in prevention, care and support, involvement of people living with HIV, local congregational mobilisation and the unavoidable questions of leadership and condoms.

The researcher shall then propose some church leadership skills that may be appropriate to effectively form a strategy that will bring about transformative change in this challenging arena.

There are several challenges facing Zambia as a country and in this chapter, the researcher shall attempt to look at only those that are related to the current subject of research. The researcher agrees with the picture painted by Manuel Castells (2000: 82-83) which demonstrates the rise of inequality, polarisation and social exclusion throughout the world and focuses on Africa's urban poverty and the plight of children. Castells (2000) further talks about how the information age and global capitalism have coincided with the collapse of Africa's economies leading to the disintegration of many of its states and the breakdown of most of its societies. As a result famines epidemic, violence, civil wars, massacres, mass exodus and social and political chaos are at this juncture of the millennium, common features of Africa. Udoh (1998: 129) shows that these misfortunes are a paradox for a continent endowed with so much human and natural resources. Castells (2004: 83) further elaborates on the decline of systems of support and the wide neglect of children and the collective responsibilities of household and family. In her book entitled: *Democratization and the protection of Human Rights in Africa: problems and Prospects*, Ambrose (1995: 15) points out that when the cold war ended, western powers insisted that authoritarian regimes embark on democratisation anchored in human rights and public participation. That was aimed at ending the increasing misfortunes of Africa such as endemic corruption, increasing poverty and human rights abuses. Nevertheless, the process which began in 1990 has shown few positive signs of real change to date. All of these and bad leadership styles are key elements as to why the pandemic of HIV cannot be easily stopped. This provides an appropriate backdrop for the discussions which follow in this chapter.

The researcher will briefly discuss some basic leadership styles before tackling those skills which may be helpful in ensuring that there could be a theology that promotes an environment of truth, freedom, justice and peace in dealing with HIV.

There are some critical issues in which the Zambian Church leadership from all congregations should seriously consider putting on their agenda in the fight against HIV. These areas will surely need a leadership which facilitates for truth, freedom, justice and peace.

3.2 The challenge of silence, stigma and discrimination³⁶

This is one of the challenges which, once overcome, will allow for the creation of Circles of Hope at local congregational level. Stigma is an absence of truth and it denies freedom to people who are infected to experience their rights in full. The biggest obstacle to HIV prevention is now generally acknowledged to be the stigmatisation of people living with or affected by HIV and the silence and denial this causes. Kaleeba et al. (2000: 10) has indicated that clergy with HIV have been dismissed from their jobs or shunned and forced to marry again if they are widowed. Religious leaders have “added to the misery of people living with HIV by condemning them as ‘wrong-doers’ or ‘sinners’” according to a Ugandan study. Brown (2004: 76-78) argues that it all begins with denial of the reality of the seriousness of HIV amongst many African communities. She says that there is denial at individual, group as well as at the international level.

Moloney (2005: 100) has observed that many churches in the early years disassociated themselves from the HIV pandemic. Those who were known to have the virus were to have committed immoral acts that put them outside the religious community. Although it is no longer politically correct to have these attitudes now and the Church preaches understanding and compassion for those living with HIV, the actions of many religious people fail to conform to the preaching. The tag of immorality which was so obviously associated with HIV in its early years is still present.

Patterson (2003: 13) has indicated that people living with HIV and their families have been excluded from churches, publicly exposed, refused pastoral care and funeral rites and in extreme cases have been killed. Without a word from the Church establishment, orphans have been thrown out of their homes accused of being cursed, and either excluded from school or made to sit separately with other ‘AIDS kids’. Few people are willing to state that a relative has died of AIDS. The situation which Brown (2004: 74) describes of people in a village in Malawi coming from a funeral but not willing to say what killed the deceased is identical to that in Zambia. The response is usually ‘they had pneumonia, malaria or TB. etc. and not

³⁶ Janet L Brown has completed an extensive dissertation on this in her Doctor of Theology dissertation entitled *HIV/AIDS Alienation: Between Prejudice and Acceptance* submitted to the University of Stellenbosch in April 2004. Part of this work may refer to hers because the focus in this section of the discussion is to show that stigma is one of the challenges facing leadership amongst the Zambian Churches. The creation of Circles of Hope is based on fighting silence, stigma and discrimination.

AIDS. One study³⁷ showed that less than one in ten home care volunteers would admit that the person they are caring for is living with HIV. One result is great suffering for people who are known to be living with HIV and their families. Another is massive reluctance, among people who fear they are HIV positive, to come for help or take steps to avoid passing the virus on. Even in a situation where antiretroviral treatment is available for pregnant women, mothers are often so afraid of stigmatisation that they would risk having an HIV positive baby rather than go for testing themselves.

The social effects of HIV are as dangerous and debilitating as its physical symptoms. Until the stigma and the discrimination suffered by people living with HIV and their families are addressed, the pandemic will continue to grow. Prejudice and fear prevents people seeking proper care. For those infected with HIV there is little incentive to be open about their condition if it results in hostility and their isolation. Ignorance, prejudice and fear help HIV spread. Openness, acceptance and support are essential for its containment.

Hillery (2002: 12) states:

Stigma and the fear it engenders both fuel the spread of HIV, since those with risky behaviour in the past may be reluctant to change that behaviour in case the change is interpreted as an admission of infection. Fear of acknowledging HIV infection can stop a married man from raising the subject of condom use with his wife. Fear of advertising her HIV status may prevent an infected woman from giving her baby replacement feeding to avoid transmitting the virus through breast milk.

Addressing the HIV pandemic requires a strong and co-ordinated response from all sectors of society - government, NGOs, Churches, communities and children, as well as the international community. Kelly (2006a: 29) suggests that the Church can contribute to making a difference in the area of HIV by bringing the healing power of love into the lives of those afflicted by this sickness. Nevertheless, this response has to incorporate changes in attitude and behaviour at the personal level if it is to be successful. Moloney (2005: 93-97) has mentioned some barriers to behavioural change that may need to be overcome which include; denial - the attitude that it can never happen to me, irrational beliefs - such as only the poor and uneducated, the non believers become HIV positive, the inability to control the sexual urge - a big area of blame rather than an acknowledgment of responsibility, peer pressure - which can exist at any age, cultural practices - such as wife inheritance, female genital mutilation, taboos around the area of sex, lack of communication between partners

³⁷ Study done during a caregiver's course at the Council of Churches in Zambia Makeni Centre, 20 June 2004.

and spouses, lack of support from sensible and trustworthy parents, relatives or friends. A behavioural change requires both realism and optimism. People are able to change. Magesa (2003: 200) has correctly observed that in many parts of Africa the link between sexual behaviour and HIV is now well established in the minds of the majority. However, a change in sexual behaviour does not follow suit. The Church can serve people in the healing ministry not only by praying for people but by educating them and teaching them how to heal themselves by avoiding risky behaviour.

Stigma and discrimination based on HIV status is a trend that has been associated with HIV since the early days of the pandemic. As early as 1988, Herek and Glunt in: *An epidemic of stigma: Public reactions to AIDS* argued that people living with HIV and their support networks were experiencing a particular and more intense type of discrimination and prejudice than that of people with other medical conditions. In their research into this subject the Panos Institute of London (Lachman, 1999: 53) terms this discrimination the “third epidemic”, the first epidemic being the transmission of HIV in homosexual men and intravenous drug users and the second epidemic being the heterosexual transmission of HIV. Webb (1997: 10) frequently argues that stigma and discrimination against children and youth infected with and affected by HIV/AIDS is a characteristic of the HIV pandemic in Zambia as well as in many countries, particularly in the developing world. Brown (2004: 75) asserts the same in her analysis of the Malawian experience.

There is a good deal of anecdotal information from service providers, and the occasional high profile case of stigma and discrimination (such as that of Nkosi Johnson the South African youth, who was refused admission to a school on the basis of his HIV status) which makes news headlines. However, for the most part, the stigma and discrimination faced by many goes unreported. An example of this is the story given below which the researcher heard from a woman in Lusaka:

*I have been a member of **chigwirizano ca amai** (women’s guild) for a long time now. As soon as it became known that I am HIV positive, no one in the fellowship will have anything to do with me. My best friend does not even want to see me anymore. The Pastor has never been to visit me as well. A nurse who knows I am HIV positive refused to let her child play with my child.*

Additionally, there is little understanding of how stigma and discrimination actually affects people, how it affects their lives, and how it affects their access to basic rights such as health care.

St. Camillus Mission Hospital in their study entitled *Living positively with AIDS* (2003: 3) advises that there is need to fully understand the nature and extent of this discrimination, its impact and effect on the rights of people living with HIV, and what has been done to counteract this phenomenon. Only when that is done shall faith communities be in a position to identify where things have gone wrong, and what still needs to be done in order to address and reduce stigma and discrimination against those affected by HIV. Muchiri (2002: 9) has said in his public ministry Jesus Christ had a place in his heart for everybody. Jesus did not fail to touch even the leper. He spoke to the woman with a haemorrhage when people were pushing all around him. He took time to go to the house of the rich outcast, Zacchaeus. Circles of Hope follow Jesus' example by opening the doors of love and compassion to all members of the Church who are HIV positive.

3.2.1 Defining stigma and discrimination

The standard point of departure for defining stigma is Erving Goffman's (1963: 74-80) classic study on stigma related to mental illness, physical deformities and what were perceived to be socially deviant behaviours. Goffman describes stigma as "an attribute that is deeply discrediting" and results in the reduction of a person or group "from a whole and usual person to a tainted, discounted one." He goes on to note that by regarding "others" negatively, an individual or group confirms their own "normalcy" and legitimizes their devaluation of the "other".

Expanding on Goffman's work, Link and Phelan (2001: 363) describe stigma as a dynamic process occurring within the context of power. This process has four distinct steps. The first three steps seek to divide the 'tainted' from the 'usual' people by distinguishing and labelling differences; associating negative attributes with those differences; and separating 'us' from 'them'. Building on Link et al's conceptualization, Gilmore and Sommerville (1994: 23) describe these three steps in the process as allowing the others ('them') to be perceived as non-persons. This allows the 'us' to distance themselves from the negative attributes of the others', to justify treating the 'others' in negative ways that would be unacceptable if they were one of 'us,' and to prevent 'us' from being treated in the same negative manner. These

steps culminate in the fourth and final step in Link and Phelan's process - status loss and discrimination towards the stigmatized.

Parker and Aggleton (2002: 40-51) similarly suggest that stigma can become firmly entrenched in a community by producing and reproducing relations of power and control. Dominant groups legitimize and perpetuate inequalities. Those based on gender, age, sexual orientation, class, race or ethnicity use stigma. By doing so, dominant groups effectively limit the ability of stigmatized groups and individuals to resist because of their entrenched marginal status. Furthermore, the stigmatized often accept the norms and values that label them as having negative differences (Goffman, 1963: 100). As a result stigmatized individuals or groups may accept that they 'deserve' to be treated poorly and unequally, making resistance to stigma and resulting discrimination even more difficult. Research by Alonzo and Reynolds (1995: 98) shows that this internal stigma is manifested in many ways including self-hatred, self-isolation and shame.

Meanwhile, Burris (1999: 1231) has defined stigma not as a status, but as a social relation between a stigmatised person and a 'normal' person based on a shared belief that some part of the stigmatised person's identity is 'spoiled'. Stigma can also be seen as the imposition of a special, discrediting and unwanted mark on a person or a specific category of persons in such a way that in their interactions with others they are looked at as fundamentally and 'shamefully different' by themselves and others³⁸. The mark of difference is imposed on people who have or are believed to have a distinctive status or a 'deviance'.

Brown, Trujillo and Macintyre (2001: 8) defines prejudice or stigma more in terms of social attitudes and resultant behaviour: "the holding of derogatory social attitudes or cognitive beliefs, the expression of negative affect, or display of hostile or discriminatory behaviour towards members of a group on account of their membership of that group". Thus the ultimate effect of stigma, as noted by Goffman (1963: 89), is the reduction of the life chances of the stigmatized through discriminatory actions. Therefore for the purpose of this study, the researcher does not conceptualize discrimination as separate from stigma but as the result of the process of stigma. He defines discrimination as the negative acts that result from stigma and that serve to devalue and reduce the life chances of the stigmatized.

³⁸Nabagala at www.hdnet.org/popups/stigmasef12.pdf [October, 20, 2003]

3.2.2 Manifestations of stigma

Herek and others (1998: 36-47), show that the mark of stigma is usually non-material. In certain instances, however, the differentiation intention and process have gone as far as translating into material things (e.g. mutilations to the human body, tattoos, brands etc). In these cases stigmatised persons are not only looked at as different, they appear unmistakably different and their difference shows. For example, during the Nazi regime in Germany, all Jews were required to wear a yellow star on the outside of their clothes as a way of ensuring that they stood out as being ‘shamefully different’. Sometimes confinement in specially designated areas is also used as a material way to visualise the difference and to draw a boundary that separates the stigmatised person from other human beings. An example of this may be the quarantining of lepers. Stigma may remain at the level of subjective perception. However research has shown that in most cases stigma manifests itself in various ways when society behaves and acts in a certain way towards those stigmatised (known as enacted or objective stigma).

Manifestations of stigma include:

- Communications: words³⁹, images, popular discourse;
- Social relations (including within institutions and within families and communities);
- Laws and policies;
- Self-inflicted stigma, the experience of those at risk of stigma; and
- Prejudice, avoidance, ostracism, hostility, violence, etc.

Discrimination is one of the key manifestations of stigma.

³⁹Words are very important forms of communication. HIV sensitive words are been encouraged to be used as one means of fighting stigma. Therefore, words like some of the ones that Janet Brown has used in her dissertation are not encouraged. These include words such as HIV/AIDS sufferers or HIV/AIDS patients. It is preferred to use terms such as People Living with HIV or AIDS, or people affected by HIV or AIDS. Other inappropriate words include phrases such as hopelessness, helplessness, home bound patients, horrors of AIDS and people in the AIDS community. Meanwhile in some of the Zambian local languages people use equally discriminatory terms such ‘*kanayaka*’ (the light has been lit), ‘*yamene transport*’ (once you are positive you have a straight way transport to death), *makiizi yakumochari* (keys to the mortuary), *Kaliyondeyonde* (skeleton), *kalaye noko* (say goodbye to your mother), etc. The avoidance of all such words is encouraged, in preference for more life affirming, respectful and positive words.

3.2.3 Why stigma?

Richter (2001: 11) argues that fear, ignorance and an inability to accept any deviance from the 'norm' constitute the main reasons for prejudice or stigma against people living with HIV. She puts forward four origins of stigma against people living with HIV: moral attitudes and systems of belief, sex and morality. Thus HIV is seen as a punishment for immoral behaviour that one should dissociate oneself from. Brown (2004: 74) agrees with this assertion and says:

There are many reasons for this blatant denial of the problem, not the least of which has to do with the fact that AIDS is a sexually transmitted disease. Therefore, in order to bring it to the surface for discussion is not culturally appropriate in most African cultures, particularly in groups containing both men and women. Although sex obviously is happening, if one were to judge from the discussions being held by Africans, it simply does not exist. The vast majority of Africans consider sex a very private, and off limits topic for casual conversation.

An example of lack of willingness to talk about issues of sex can be illustrated by an actual incident this writer encountered. In 1998, when the researcher worked as a congregational minister, he decided to have a series on what was dubbed *family enrichment*. When he touched on sex, the immediate reaction of some of the elders of the church was very negative with a few threats that he would be reported to the Synod leadership so that he would be disciplined for preaching on these things. Below is an excerpt from that sermon of 1998:

"Be fruitful and multiply!" "Reproduce!" was one of the first things God commanded the creatures of His glorious creation. Then again, after the great deluge, God reminded Noah and all that survived with him that they had an important job to do - reproduce!

Bring out every kind of living creature that is with you - the birds, the animals, and all the creatures that move along the ground- so that can multiply on earth- and be fruitful and increase in number upon it. Then God blessed Noah and his sons saying to them, be fruitful and increase in number and fill the earth. (Genesis 8: 17; 9: 1 NIV).

Throughout history, God put His stamp of approval on human sexuality and reproduction. To Abraham and later to Jacob (Israel) He basically said, "I am God and I want you to reproduce!"

I am God Almighty: be fruitful and multiply; a nation and a company of nations shall come from you, and kings shall come out of you loins (Genesis 35:11; see also Genesis 12:1, 2, 7).

God has a point to make, He is above what today in our Church is considered politically correct in many matters, even using the human sexual act to illustrate what He wants to say if need be. The prophet Hosea, for example, was commanded by God to go and marry a prostitute and have children by her. God certainly knew this would raise the eyebrows of some of the self-righteous, letter-of-the-law religious leaders in Israel, but having His prophet move in with a local prostitute provided God with an excellent opportunity to use the predictable reaction of the community to illustrate His own displeasure over their far worse acts of spiritual fornication and unfaithfulness to Him. When the Lord began to speak through Hosea, the Lord said to him, 'Go, take to yourself an adulteress wife and have children of unfaithfulness... so he married Gomer daughter of Diblam and she conceived and bore him a son (Hosea 1: 2,3). Many passages of the Bible are unabashedly erotic, including the Song of Solomon, and various descriptions of the relationship between God and His 'unfaithful' Church. Even the promised world of spiritual bliss to come for His saved children begins with rapturous ecstasies as God transforms our present bodies into Heavenly bodies. Then begins the marriage feast of the Lamb (Jesus) for all who believe in Him, His 'Bride', who then enjoy ardent pleasures forever more at the right hand of God. (See Revelations 19; Psalm 16:11.) The Scriptures are rich in sexual stories, allusions and sexual terms, demonstrating that God is far from being a prude when it comes to sex, and that He speaks plainly. As a result, some sections of the Bible, such as the Song of Solomon, were virtually banned by fourth century celibates who feared they were just too hot.

Some people in our Church almost want to have the Bible banned as too sexual and sexist for us as Africans. They say these are not things to talk about in public. The truth is that although the Bible is a sexy Book, it also contains much thorny commentary on the hypocrisy of humanity, which may be the real source of some of our problems when we are dealing with HIV/AIDS.

Some of the factors which have continued to fuel stigma include:

- a) Ignorance and a lack of knowledge have led to fear and irrational behaviour;
- b) Self interest: this includes a desire to create a chasm between healthy and 'un-healthy' people so as to reduce the possibility of personal vulnerability to HIV; and

- c) Media images of defencelessness, and a dichotomy between those who are innocent (for example, children infected through vertical transmission from mother to child) and those guilty (for example, those infected through sexual intercourse) (Richter, 2001: 14-18).

Children and youth infected with and affected by HIV are even more vulnerable than adults are as they face the possibility of stigma relating to their own status as well as stigma flowing from their parent or caregiver's status. This stigma often continues even after the death of their caregiver, when they are rejected or treated with scorn by the extended family and the community. It forms part of the wider denial of the HIV pandemic. Children and youth infected with and affected by HIV too often form a constant reminder of the death of a parent or sibling: something that the community does not want to face and confront.

3.2.4 Link between stigma and discrimination

Discrimination entails a person acting on a pre-existing sentiment or stigma, which results in a person being treated unfairly. Stigma and discrimination therefore form a continuum of harmful thoughts and behaviour that is based on prejudice. When the discrimination is unfair and not justifiable then the action may be unlawful and in some cases, the stigmatised person could use legal remedies to resolve the matter.

Discrimination follows when a distinction is made that result in a person being treated unfairly and unjustly based on their belonging, or being perceived to belong, to a particular group. Once a person's prejudiced thoughts lead them to doing something, or to omitting to do something that either harms or denies services or entitlements to another person, the act that harms is a discriminatory act. For example, a person may fear a child or youth infected or affected by HIV and may perceive them as blameworthy or inferior, and for this reason may be extremely indifferent to their needs. These thoughts and perceptions constitute stigma. If this same individual then decides to exclude a stigmatised child from the local Sunday school, it is at this point that they have discriminated against the child.

Ross and Clay (2003: 16) show us that Jesus freely talked and kept company with people from all lifestyles, while his disciples were much more concerned about protocol and appearances. The Church in the past has been guilty of the same anxieties, concerned for the ethic of respectability over the ethic of love. However the calling of the Church is not to be reserved for the respectable but rather to be a space to which people come to find forgiveness for their sins and healing for their wounds. In the context of this work this means taking HIV

into the language of the Church. Then the worship and witness of the Church will speak megatons of acceptance and affirmation rather than being judged and excluded.

3.2.5 The impact of stigma and discrimination

Richter (2001: 12-13) quotes from an article written by Mann (2001) where he states that discrimination has a powerful and insidious impact on the dignity and self-respect of the person being discriminated. Mann (2001) saw dignity as flowing from two sources: an internal one (the way an individual sees her/himself) and an external one (the way other people see that particular individual). Mann (2001: 32) argued that when a person's dignity is repetitively compromised by external sources the person's internal source of dignity would also be under-mined. This in turn affects that person's self-image, self-confidence and well-being and thus ultimately reduces a person's capacity to deal with their HIV status. He argued that HIV discrimination might be just as damaging as HIV itself. Mann (2001: 48) furthermore argues that violations of dignity have such significant, pervasive, and long-lasting effects that injuries to individual and collective identity may represent a thus far unrecognised pathogenic force of destructive capacity towards well-being at least equal to the capacity of viruses or bacteria. Strode and Barrett-Grant, of Save the Children (2001: 22) observe the following as effects of stigma and discrimination amongst affected people:

- a) It causes great emotional pain, feelings of powerlessness and impacts on their perception of self and self-worth;
- b) It creates secrecy around HIV and AIDS, and fear of disclosure of HIV status;
- c) It acts as an impediment to accessing services, which are rightfully theirs, such as health care and education, which further impacts on the physical and mental well-being;
- d) In case of children, it limits the right of children and youth infected with and affected by HIV/AIDS to parental care;
- e) Again in case of children, it impacts on the right of children and youth infected with and affected by HIV/AIDS to appropriate alternative care and support, in the absence of parental care;
- f) It has a detrimental effect on the physical well-being of children and youth, due to the lack of appropriate care; and
- g) It increases circumstances of poverty and vulnerability to exploitation amongst children and youth infected with and affected by HIV/AIDS.

In November 2001, a group of African church leaders met in Nairobi to draw up an ecumenical plan of action for responding to the HIV pandemic. Their conclusion was this. 'For the churches', they said, 'the most powerful contribution we can make to combating HIV transmission is the eradication of stigma and discrimination. This is a key that will, we believe, open the door for all those who dream of a viable and achievable way of living with HIV and preventing the spread of the virus'⁴⁰.

For Church leaders, this may offer a way forward. Of course home- based care and youth education are so important as well. Adequate resources are essential, and it is vital that the individuals responsible for them have high enough institutional status to make them happen. Combating stigma, on the other hand, involves highly personal commitment and the courage to take a public stand. Patterson (2003: 11) says that ending stigma demands visionary, strong, sensitive, truthful and well-informed leadership. It demands that the Church shatters the conspiracy of silence and admits to the presence of HIV in its midst; and that churches go out of their way to nurture and encourage those who are HIV positive because they are the most valuable potential resource they can have in the struggle against HIV. It demands a re-evaluation of the morality that the Church is teaching, and the way it is preached to the young. It demands analysis of the ways in which the Church in all cultures has taken sides in the battle between life and death and a willingness to discern new lessons about how it can choose life. It is in choosing life that Christian hope is born. Life, hope and truth: these, and not stigmatisation and exclusion, are the foundational values of the healing community that the Church is called to be. Patterson (2003: 16) further suggests ways for combating stigma and indicates the following seven ways as helpful at local congregation level:

- People should stop seeing AIDS as an 'us' and 'them' issue: AIDS is in the Church
- Need for basing education on people's real experience, not on wishful thinking
- Encouraging theological and ethical reflection on HIV/AIDS
- Welcoming people living with HIV/AIDS as a valuable resource
- Building welcoming, non-stigmatising communities
- Breaking the conspiracy of silence

⁴⁰For full text see online on <http://www.wcc-coe.org/wcc/what/mission/ehaia-docuemnts-e.html#statements> [accessed January, 6th, 2005]

- Now talk to them freely about this disease....⁴¹.

As Ross and Clay (2003: 17) says that de-stigmatising those who are HIV-positive will not only make a world of a difference to their own experience but will also create an environment in which the challenges posed by the epidemic can be realistically faced by others. There is little incentive to go for an HIV test if a positive result will mean immediate stigmatisation and exclusion. No wonder some people prefer not to know their HIV status in these circumstances. Yes, voluntary testing and an increase in the number of people who know their HIV status is a key plank in the strategy to resist the spread of the virus. If the Church can play its role in creating an environment of acceptance and solidarity for those who discover that they are HIV-positive, then voluntary testing will increase and communities will be strengthened in their battle against the disease.

The following real life story of a colleague⁴² at the CCZ office goes a long way to illustrate the need to be open about one's status and how one can be helped to live life to the full. The Church should lift its voice against stigmatisation and discrimination to break the silence on a controversial topic, and break down barriers between people. In creating a missional theology, which promotes the praxis of the creation of Circles of Hope at a congregational level, this information on stigma and discrimination forms the basis for putting up a concerted fight for what Janet Brown (2004: 229) calls the need to demonstrate Christ's love and compassion to the affected community of people:

"It was not easy to face the fact that sooner or later I'll die because I'm infected with a disease that has no cure. However, one day I had to gain courage and went for the test and tested HIV positive."

These are the words of Mrs. Joy Lubinga, a 50-year-old widow who is currently living positively with the HIV virus and is openly sharing her experiences with the aim of helping to break the silence and the stigma on HIV.

Joy, who is administrative assistant in the HIV/AIDS Department at the Council of Churches in Zambia (CCZ), has amazed many people by the way she openly speaks about her status.

⁴¹Rev Prof. Maake Masango, quoted in WCC document.

⁴²Her permission was sought and the publication of her story published in the CCZ newsletter and the story is here reprinted. Story written by Juliet Ilunga Communications Officer of CCZ and is found on www.pansaka.com/partners/ccz [accessed August,2004]

This is because, though so many messages have been put across about positive living, many people are still not ready to face the reality and go for testing.

Many people still believe that knowing their HIV status would be like a death sentence because they would face the reality that they could die anytime.

In Zambia, despite some people having all the clear symptoms of HIV, they would not dare go for testing. They would rather die without being told.

To most people, the mention of HIV brings shame upon one's family, and so no one wants to be associated with that shame.

However, this has not been the case with Joy. She believes God gave her the courage to face the facts and go through a new experience.

"I started thinking of going for an HIV test in 1993 when I began to have frequent headaches and some body aches that made me lose so much weight. I had also lost appetite," Joy said in an interview.

Her husband, Mr. Lubinga, who was a Director at CUSA-Zambia, one of the liquidated companies, died in 1998 after a long illness. According to Joy, her husband was diagnosed with Tuberculosis (TB) and suffered until his death.

"I realised that my husband died so early because he gave up so quickly. Immediately he was told that he had TB, he lost hope for living and he only took the TB drugs for a short period," Joy said.

She recalls vividly how she came back from work and was told by her children how her husband had just been in bed that day. "This was just after my husband was told he had TB. He had not yet been down, but when I got into the bedroom, he was lying in bed and when I asked him what the problem was, he just turned his face away from me and faced the other side."

From that moment, Joy realised that her husband had given up and lost all hope for living.

She explained that her husband's health then deteriorated and that he was in and out of the hospital in Lusaka. "I nursed him both at home and in the hospital."

According to Joy, one day when her husband was in the hospital, the doctor called her and asked her if she knew what was wrong with her husband. "I said 'no,' and then the doctor told me that my husband had AIDS. He said because of the type of meningitis he had, he would either die or run mad soon."

She said this was disturbing news and she did not know what to do. Surprisingly, Joy never thought so much about whether this meant she was also infected with HIV, but she rather began to think of how she was going to take care of her five children and adopted niece.

This to Joy was not an easy day, as the message was like a bitter pill to swallow. She, however, told her oldest daughter, who is now 27 years old. "When I told my daughter, she hugged me and we cried," Joy said.

She says she thanks God for the strength to nurse her husband until he died on 5th September 1998.

In 2003, her health began to deteriorate and she had lost so much weight, she had no appetite and had frequent headaches. It was because of this that she gained courage and went to the New Start Centre, a Voluntary Counselling and Testing Centre in Lusaka, and had the test done.

Asked what her experience was, Joy said, "It's not easy to explain how I felt when I was told I was HIV positive. Quite alright I suspected that I could be positive because of my late husband's situation and my deteriorating health, but it was like the thought that I would die any moment from then became so real."

Joy told her daughter that the thought of leaving her children as orphans was like a nightmare to her.

She, however, went to the hospital where she had her CD4 counted, and the result was 314. The doctor told her that she was still okay and advised her to observe her diet and advised her accordingly.

"Unfortunately, I continued losing weight and developed a rash all over my body. When I went back to the hospital, my CD4 count had gone down to 119 and the doctor advised me to start taking the Anti-retroviral drugs (ARVs) that were going at about US\$50 per month."

She said that the drugs were too expensive for her, a reason she approached the Council of Churches in Zambia General Secretary, Reverend Japhet Ndhlovu, to help her access the government scheme for ARVs.

"Reverend Ndhlovu willingly assisted me to get that scheme, and to date, I'm still getting the drugs," Joy said.

Her health has since improved, and she has put on weight and is quite healthy. She says she usually sees the doctor whenever she has some ailment and is treated like any other person.

Asked how the disclosure of her status has affected her relationships with others, Joy says, "I've had no problems with my work-mates, they've been supportive and encouraging. I think they understand these issues well."

Her children have also been supportive and always want to ensure that things are all right with her. "My children want to see me happy all the time."

The worst experience, according to Joy, was at church, where she could hear gossip, and some people did not want her to take up certain positions in the Church because she was HIV positive.

"However, other church members were very supportive and prayed for me. My family members have also been supportive. Not one of my family members complained when I publicly disclosed my status."

Joy explained that she had to publicly disclose her status because she really wanted to play a role in breaking the silence on HIV/AIDS, especially in the Church.

"Once we break the silence in the Church, then we will fight stigma. Many people are not willing to disclose their status because HIV/AIDS is associated with immorality and so people, especially those in the Church, would not want to be considered as immoral," she said.

Joy, who believes she contracted the virus from her husband, says she does not want to blame her late husband because that would mean harbouring hurt in her heart, which is sin.

This, she says, would also have a negative impact on her health because as long as she is hurting, she will not be happy.

She urges other people to go for voluntary counselling and testing (VCT) as a way of breaking the silence. Once people know their status, they will make plans for their lives and for the lives of their children.

This, she says, will help people live longer and healthier, as they would know what is required of them. She says knowing her status has helped her live a healthier life because she knows what she should eat as well as what not to eat.

"I'm also working hard to ensure that I secure a better future for my children. My first-born is working, the second born is married and teaching, and the third born is studying business administration. The fourth born is doing grade 11 while the last born is in grade six," she said.

Joy says being HIV positive does not really change a person's life. "People must understand that HIV/AIDS is like any other disease and that one can even live longer than a person who is not HIV/AIDS positive."

"I want to appeal to the Church to embrace people living with the virus so that more people can be encouraged to come out and disclose their status."

Joy is HIV positive, but she is hopeful that she will live long and see her children grow and become independent; her ever-smiling face evidences this.

The story of Joy is a shining example of people living positively with HIV and how her work has helped break down Church stigma by disclosing her HIV status, educating others on HIV facts, and persuading others to seek counselling and testing and setting up Circles of Hope support groups. The story of this woman and others underscores the notion that only people living with HIV often are the best authorities on stigma but they may also be in the best position to help dispel it even as they help in coming up with an HIV sensitive theology.

When leaders do this, the stories spread like wildfire and HIV may literally take on a new meaning in people's minds. In Uganda when an Anglican priest Gideon Byamugisha risked scandal and discrimination by coming out and living openly with HIV, the Church of Uganda made him a Canon (Mande, 2003: 2-10). Byamugisha says that in HIV is not the condition itself that hurts most because many other conditions lead to serious suffering and death, but

the stigma and the possibility of rejection and discrimination, misunderstanding and the loss of trust that HIV positive people have to deal with (Ross and Clay, 2003: 15).

It is important to reach out in recognition of common humanity - all were created in the image of God and thus all deserve respect, love and acceptance. Leaders should also watch their own language in writing and talking, as language is a potent tool for stigma. The language of 'us' and 'them' should be banned from all Church documents that talk about HIV. The truth is that when Churches stigmatise and exclude people living with HIV they are discriminating against their own body, and the whole Church loses credibility. HIV positive pastors and others have the potential to be the most powerful resource-people in combating stigma and discrimination. Church leaders could take positive steps to encourage people to come out and live openly with the virus, rather than stigmatising them, excluding them, or denying their existence.

The Pan African Christian AIDS Network (PACANET)⁴³ has said that people living with HIV are crucial partners in the fight against HIV and, as such, the Church should face the fact that stigma and discrimination are sin. Following the biblical mandate to show love, grace, compassion, care, hope, practical support, forgiveness and advocacy, the Church needs to be empowered with accurate and up-to-date facts to reduce myths and break stigma. Once leadership has been provided in this critical area as seen above people would stop seeing HIV as an 'us' and 'them' issue since HIV is in the Church. Encouraging theological and ethical reflection on HIV would take place when the people themselves set the agenda for such a reflection. In a greater way the creation of Circles of Hope is hinged on breaking silence, stigma and discrimination⁴⁴.

Religious leaders have a unique role to play in addressing stigma and discrimination within communities. Leaders can influence a community's response. Leadership is there to give hope for those who suffer and this could be translated into action to support those infected and affected by HIV infection. Leadership can also use language that is compassionate loving and caring regarding HIV. It is also about creating structures and policies that are more accommodating to people positively living with HIV.

⁴³In a statement released at a Pre-ICASA symposium that brought about 260 participants from 35 countries in Nairobi, 18th – 20th September, 2003

⁴⁴At the time of writing this work there are twenty-nine support groups here known as Circles of Hope under the Council of Churches in Zambia membership?. There are however three thousand nine hundred local congregations in Zambia, thereby confirming the author's view that there is no effective strategy in place to address HIV and AIDS in a holistic way.

Let us then turn to look at people living with HIV as a valuable resource in building welcoming, non-stigmatising communities and in breaking the conspiracy of silence.

3.3 The challenge of involving people living with HIV

This is an obvious area of challenge for Church leadership in Zambia. When stigma has been fought of the benefits of peace will be shown and people will experience justice. The success of the Circles of Hope praxis hinges on the involvement of people living positively with HIV. The determination of people living with HIV has been an indispensable part of building an effective response to the epidemic and a counterattack to the stigma and discrimination often faced by HIV positive individuals. Personalising the pandemic is a strong weapon against ignorance and fear. The involvement and activism of HIV positive people has challenged societies to deal more openly with issues that might otherwise be taboo, especially where sex is concerned (UNAIDS 2003: 37). As has been shown in Chapter 3 when an appropriate theology that would help Churches respond effectively to this disease is developed, it is the people living with HIV who are more crucial. The Executive Committee of the WCC (1986) drew the attention of the Churches to the following concern:

to confess that Churches as institutions have been slow to speak and to act- that many Christians have been quick to judge and condemn many people who have fallen prey to the disease and that through their silence many churches share responsibility for the fear that has swept our world more quickly than the virus itself.

The World Council of Churches meeting (Nairobi, 2001) for planning an ecumenical response to HIV in Africa, referred to above ,came up with the following three commitments on theology and ethics:

- We will condemn discrimination and stigmatisation – as a sin and contrary to the will of God;
- We will urge members to recognise and act on the urgent need to transform ourselves if we are to play a transforming role in the response to HIV/AIDS.
- We will launch a global effort to stimulate theological and ethical reflection, dialogue and exchange on issues related to HIV/AIDS which will include:
 - Sin and sinner, stigma and stigmatised
 - sexuality

- gender
- love, dignity and compassion
- confession and repentance

The contention of this dissertation is that churches in Zambia will be seen to be more practical on issues of HIV only once they begin to fully embrace PLWHA. Leadership has a role in fighting stigma. This embrace would be actualised only through the creation of support groups herein called Circles of Hope, as mentioned in Chapter 2. Theological institutions and churches then need to have in place an effective strategy that addresses the issue of HIV in a holistic way on a congregational level where it effectively reaches and influences members by creating these Circles of Hope. A curriculum⁴⁵ as proposed by the WCC or by MAP International (2004) can be used and adapted to other local realities within Zambia. A missional theology, which promotes the praxis of the creation of Circles of Hope at a congregational level, is one holistic approach to combat the HIV pandemic as can be seen from the objectives of these support groups.

The creation of Circles of Hope would surely be a positive contribution to this initiative. Currently through the efforts of the author and staff colleagues at the Makeni HIV/AIDS Resource and Training centre at the time of writing this work a mere twenty-nine congregations out of an initial number of close to three thousand nine hundred CCZ related churches have so far started such support groups at local congregation level. The objectives⁴⁶ of such groups are:

- Help enrich lives through positive Christian living by providing spiritual, emotional as well as physical support.
- To inform and educate church members on HIV issues but also to help PLWHA on new information regarding available drugs or helpful food supplements
- To advocate for ARV therapy as well as for treatment of opportunistic infections

⁴⁵A full sample for the HIV curriculum for theological institutions in Africa can be found at <<http://www.wcc-coe.org>>. Theological colleges and congregation can use this material to prepare pastors to form part of the HIV mitigation efforts by local congregations. The curriculum however falls short of mentioning support groups as a key factor in fighting HIV at local congregation level.

⁴⁶The following ideas have been adapted from the Northmead Assemblies of God presentation given to the Church Leadership of CCZ Lusaka based Churches on 16 April 2004 held at St Paul's United Church of Zambia. One- hundred-and-eighty Church leaders attended the meeting.

- To improve and enhance the lives of PLWHA through diet, health, physical fitness, nutritional supplements, minerals and vitamins but also touching on moral values
- Networking within the local congregation as well with other networks
- Voluntary Counselling and Testing
- Home based care and
- Skills empowerment such as training of counsellors, care-givers and training of trainers.

3.4 The challenge of empowering women

The vulnerability of women is dealt with when they are empowered. The Zambia Demographic Health Survey (ZHDS, 2002: 29) provides information on the status of women in Zambia, and on physical and sexual violence against women. Overall the report says more than one in ten women aged 15-49 have no education (12 percent) and women are generally less educated than are men. Four in ten women in Zambia are illiterate. Most women work seasonally (53 percent). Agriculture is the predominant sector of the economy, employing 54 percent of women. Forty-two percent of all working women in Zambia are either paid in kind or not paid at all.

Women working in the non-agricultural sector are more likely to earn cash than are women working in agriculture. Among currently married women who earn cash for their work, 41 percent report that they alone make decisions about how their earnings will be used and 32 percent report that they decide jointly with their husband. It is interesting to note the responses that women gave during the ZDHS (2002: 10) concerning their beliefs on wife beating. A large majority of women (85 percent) believe that a husband is justified in beating his wife for at least one reason. Almost eight in ten women believe that a husband is justified in beating his wife if she goes out with another man. A slightly smaller proportion agree that if a woman neglects her children (61 percent), or argues with her husband (52 percent), then he is justified in beating her. The 2001-2002 ZDHS (2002: 31) found that more than half of women reported having experienced beatings or physical mistreatment since the age of 15, and almost one in four women (24 percent) experienced physical violence in the 12 months preceding the survey. Among physically abused women currently in unions, almost eight in ten report their current husband/partner as a perpetrator of the violence, while among never-married women who experienced physical abuse, the mother or father is the most commonly

reported perpetrator (35 percent). Overall, 15 percent of women report having experienced sexual violence by a man and 8 percent reported such experience in the 12 months before the survey was done. Among every married woman who ever experienced sexual violence, the current husband/partner is reportedly the most common perpetrator of such violence (37 percent). More than four in ten never-married women report their current boyfriend as the perpetrator of sexual violence.

Gitome (2003: 198-199) says that women are ten times more at risk of being infected with HIV than men. As the receptive partner in a sexual relationship, a woman has a relatively larger surface area of her genitals being exposed through which the virus can penetrate. She goes on to say that faithfulness among women in monogamous marriage does not necessarily protect them against infection. Some of their husbands continue to keep other sexual partners and this increases their risk of becoming infected. Byamugisha (2002: 16) warns that not all legal sex may necessarily be safe because of unfaithful spouses.

Bernice (2004, online <http://www.ucc.org/justice/witness/wfj112904.pdf>), in her article entitled: *The Female face of HIV/AIDS*, has said that AIDS has a woman's face. She says half of those infected with HIV worldwide are now women and girls. This is confirmed by a recent 2004 UNAIDS report. Over the past decade there has been an increasing feminization of the HIV pandemic, so much so that the 2004 focus of World AIDS Day, December 1, was women and girls. It is now estimated that 20 million women and girls are HIV positive worldwide.

According to Hellen (2002: 93) women and girls are particularly vulnerable. They are biologically, culturally, economically and socially vulnerable. This vulnerability is due to inadequate knowledge, insufficient access to HIV prevention services, inability to negotiate safer sex, a lack of female-controlled HIV prevention methods and the reality of sexual violence in their lives, in some cases by their intimate partners. Moreover in many places women face a hostile judicial system and a lack of access to reproductive services.

Girls are being infected at a frightening rate as is also shown by the statistics from Zambia in Chapter 1 of this work. UNAIDS/WHO (2004) *Report on the global HIV/AIDS epidemic* reports that the rate of HIV infection among young people worldwide is growing rapidly - they are 67% of the newly infected; and in the developing world, young women make up

almost 2/3 of those newly infected. In Zambia, marriage at a young age can also make for increased vulnerability to infection.

This is the reason why Phiri (2004: 136) says African women theologians have declared:

If we do not deal with gender and HIV, the world will not make a difference in combating the virus. As women of faith, the members of the Circle of Concerned African Women Theologians have covenanted to continue in solidarity seeking ways to transform our faith communities to talk about HIV/AIDS and empower women to stop their own death.

It should be no surprise that HIV infection is on the rise among women and girls considering the explosion of sex trafficking of women in the world during the past decade. Bernice (2004 online <http://www.ucc.org/justice/witness/wfj112904.pdf>) says it is estimated that at least two million women and girls are trafficked each year. Many of these are young girls sold by their families to brothels in Asia, but they also include women in the U.S., Mexico, Africa and Europe.

Many of the HIV infected women are married. Bernice (2000) quotes a recent study in South Africa, for instance, which found that 10.5% of married couples in that nation were HIV infected. It found that married women actually are at somewhat greater risk of infection because they did not practice safe sex and did not know their husbands were infected⁴⁷. There is no reason not to assume that this is true in Zambia as well.

Women in war zones are particularly vulnerable to HIV infection as rape is increasingly being used as a tactic against women who have been captured. However, women in other places also are susceptible to infection by rape. Moreover many women find it difficult to negotiate safer sex with their partners who have recently returned from war, prison or other highly susceptible places.

Many women do not know their HIV status until they become violently ill. That is why it is critically important for everyone to be tested for HIV infection. There is a need to empower women to play a leading role in fighting the pandemic and particularly so as women pastors. There is also a need for a leadership in Zambia which has to make HIV funds work for

⁴⁷ This is well illustrated in a Zulu movie with subtitles in English released in South Africa (January 2004). In *Yesterday*, the main role is played by Leleti Khumalo whose husband is working on a South African mine. She was found to be HIV positive and could not believe it. The husband who was later confronted by the wife could not accept what she told him and even went ahead and physically molested her for suggesting that he too needed to be tested for HIV.

women. Church leaders should advocate that these funds target women. Leadership has to ensure that women learn about HIV prevention and how to negotiate for their own sexual safety. Leadership has to ensure that women get equal access to treatment and promote literacy for girls. The Church should promote zero tolerance of violence against women.

The Church leadership should get busy on working at ending it by naming it, owning it, educating about it, advocating for those living with it. Only if it is named (Wink, 1984: 56) and claimed can it be brought to an end.

Phiri (2004) analyses theologically the response of teenage girls to an essay writing competition that was sponsored by the Kwazulu Natal Regional Christian Council. In her analysis she says: “Becoming aware of the wrongness of something is the beginning of becoming an agent of change. The girls and women all over the world are hoping for a relationship with a man that does not include violence against women and children. They want to see the end of sexual violence that denies them the capability to abstain from sex until marriage if they so choose. They want the power to make positive decisions about their bodies even after marriage in order to protect their lives. Despite the current problems of HIV in South Africa they see new life which is possible in this world. Nature and women’s bodies are no longer viewed negatively. They are part of the new community of all the redeemed.”

In Phiri’s (2004) analyses that the issues that the girls raised as agents of change are justice issues, even if in some cases they are contrary to the teaching of the church. The justice that the girls were seeking is based on the character of God. Jesus implemented the justice of God by siding with the oppressed of the society and by making it possible for the oppressed to begin to experience the new life on earth. Thus, justice for all humanity is not only important but it is necessary for the realisation of the presence of God on earth.

On the other hand, the Global Consultation on Ecumenical Responses to the Challenges of HIV in Africa, (2001), states concerning gender and HIV:

1. We will challenge the traditional gender roles and power relations within our churches and church institutions which have contributed to the dis-empowerment of women, and consequently to the spread of HIV/AIDS.
2. We will combat sexual violence, abuse and rape in homes, communities, schools and conflict/war situations.

3. We will address gender roles and relations in families that contribute to the vulnerability of women and girls to HIV infection.
4. We will support organisations that help young women to negotiate safer sexual relationships.

Long gone is the time when many were in denial of the disaster. Today it is becoming common knowledge in Zambia that denying the reality does not save human lives. Women and children are the most infected and affected. Numerous grandmothers, widows and orphans are abandoned to themselves in the community. Young girls are sexually abused and exploited, condemned to domestic slavery and constrained to become sex workers. Their basic human rights are therefore violated. This situation exists because of the lower and fragile status of women and young girls in the African society linked to the gender issue. The impact of the social ideology of the representation of women and young girls has contributed to their vulnerability to the HIV pandemic, considering how much the social ideology affects the attitudes of people in their daily lives, especially in the field of sexuality.

Empowering women is essential for a holistic strategy. Their exclusion would only result in a partial attention to the entire challenge of the pandemic. This strengthens the reason for dealing with shortcomings of current prevention strategies.

3.4.1 Shortcomings of current prevention strategies

Current HIV prevention strategies according to Amalemba, Wilfred, Dortzbach and others (1996: 19-31); Cecil (1992: 15-18) and Chukwu (2002: 20-30) commonly promote monogamy, fidelity and condom use in connection with morality and religion (such as the **ABC strategy** which stands for Abstinence, Be Faithful and Use Condoms). This has had its own shortcomings as shown by the Network of Religious Leaders Living with or personally affected by HIV and AIDS (ANALERA+).

Aprodev (2000 online <http://www.aprodev.net/files/gender/HIV-AIDS.pdf>) and Hubley (1995: 20-31) have indicated that these strategies have failed to address the underlying concepts of masculinity and high-risk or even violent practices of sexuality and they have proven to be insufficient and even harmful. Furthermore, Phiri (2004: 138); Kaleeba (2000) and Katongole (2001) have said that due to systemic gender inequality and women's powerlessness women have been unable to enforce these strategies vis-à-vis their male partners. Often they have added to the existing burden on women's lives, as safe sex

negotiation has become the exclusive responsibility of women. These prevention strategies have victimised and further marginalised infected women. An effective strategy will take the gender questions seriously.

3.4.2 The need for a new and inclusive understanding of the HIV crisis

HIV is not just a health issue (Stiebert, 2001: 174 -185; Kiiti, 1994: 67) but also a development, gender, social and economic issue and should be regarded inclusively. Njoroge and Dube (2001: 41) have suggested that it is therefore necessary to approach the HIV crisis with a gender analysis and to look for gender-sensitive responses to the crisis. Kiiti (1996: 17) says this requires comprehensive and contextualised programmes and a new language which avoids stigmatisation and marginalisation.

At a Gender Conference in Norway⁴⁸ participants formed a proposal to contextualise the ABC strategy and to extend it into an ABCDE. Instead of addressing and blaming individuals (women) for HIV infection, which in fact the frequently used ABC strategy is doing, the responsibility for change should be given back to the local community. It is necessary to work and promote dialogue within the local context taking into account existing power relations. Men must be held responsible for their sexual behaviour and local authorities, churches or educational and social institutions must be challenged when they maintain and defend discriminatory and harmful norms and practices.

A B C D E

- A. Advocacy for (gender) equality
- B. Attention to Body and Sexuality
- C. Work with the Community and in Context
- D. Dialogue for development
- E. Empowerment for sharing of power

⁴⁸The conference brought agencies in Europe that work with the World Council of Churches together. GOOD organized a Conference on gender and HIV/AIDS in Oslo, Norway, 11-13 September 2000. The conference focused on the relationship between sexuality, power, culture and gender in order to get a better understanding of the HIV crisis. The aim was to identify innovative approaches and to develop gender-sensitive tools and strategies for empowerment programmes.

A comprehensive and inclusive approach that is based on advocacy of gender equality and that encourages women and men in the local communities to promote social change is needed.

Messer (2004: 95-111) shows that some of the messages given to mitigate the spread of HIV have sadly added to the stigma and that the 'ABC' is one such message⁴⁹. Within the African Network of Religious Leaders Living with or personally affected by HIV and AIDS (ANERELA+), a new model has been developed, called SAVE (Safer practices, Available medications, Voluntary counselling and testing, and Empowerment through education).

Messer (2004: 98) says that HIV prevention will never be effective without a care component and the SAVE model combines both prevention and care components as well as providing messages to counter stigmatization. HIV is a virus not a moral issue. As such the response should be based on public health measures tempered by human rights principles.

S refers to safer practices covering all the different modes of HIV transmission. Examples are safe blood for blood transfusion, barrier methods for penetrative sexual intercourse, sterile needles and syringes for injecting, safer methods for scarification and the adoption of universal medical precautions.

A refers to available medications. Antiretroviral (ARV) therapy is by no means the only medical intervention needed by people living with HIV or AIDS (PLWHA). Long before it may be necessary, or desirable, for a person to commence antiretroviral therapy, medical needs concerning opportunistic infections and pathology tests arise. Treating opportunistic infections results in a better quality of life, better health and longer term survival. Of vital importance to every person is good nutrition and an adequate supply of clean water and this is doubly so for PLWHA.

V refers to voluntary counselling and testing, one intervention which may mitigate HIV-related stigma and increase the effectiveness of HIV prevention efforts. A person who knows

⁴⁹The way in which ABC has been presented and understood by most people is; firstly abstain, if you can't abstain then be faithful, and if you can not be faithful then use a condom. This in no way takes any cognizance of a person's HIV status. If you or your partner or prospective partner is living with HIV, and you have not been tested but have unprotected sexual intercourse, this puts the other person at risk of HIV infection. It is also true that while abstinence may be appropriate at some stages of life, faithfulness is always appropriate. In addition to this the use of a condom automatically falls into the category of being used by people who can not be faithful and do not want to abstain. This fuels stigma and keeps people from safer sexual practices.

his or her HIV status is in a better position to protect him or herself from infection or from infecting another, depending on the person's status. In addition someone who is HIV positive can be provided with information and support to live positively. People who are ignorant of their HIV status or who are not cared for can be sources of new HIV infections.

E refers to empowerment through education. It is not possible to make an informed decision without having all the facts at one's disposal. Misinformation and mis-action are two of the greatest factors driving HIV related stigma and discrimination. Correct information needs to be disseminated to all within churches to ensure that people respond to others through knowledge and from a perspective of Christ centred love. This will assist people to live positively – whatever their HIV status – and break down barriers which HIV inevitably has caused between people and within communities. Education also includes information on good nutrition, stress management and the need for physical exercise.

The Post Newspaper of Wednesday 21st July (2004:5) reports that a United Nations report had warned that any action against HIV that does not confront gender inequality is doomed to failure. The joint United Nations programme on HIV/AIDS (UNAIDS), the United Nations Development Fund for Women (UNIFEM) and the United Nations Populations Fund (UNFPA) stated in a report released at the International AIDS conference in Bangkok (15 June, 2004) that there would be no progress in fighting the disease in the absence of strategies that have special focus on women. The joint report of UNAIDS/UNFPA/UNIFEM, (2004) *Women and HIV/AIDS: Confronting the Crisis*, reveals that 48 percent of all adults living with HIV are women - up from 35 percent in 1985. The report notes that the situation is even more alarming in sub-Saharan Africa where women make up 57 percent of those living with HIV. It further states that young African women aged between 15 and 24 are three times more likely to be infected than are their male counterparts

3.4.3 Empowering for sharing of power

Gender inequalities are the underlying cause of high HIV infection rates in girls and women and these inequalities further speed up the spread of the virus. It is important to develop ways in which men and women can be empowered to change gender relations so that they can protect themselves, their children and their communities as a whole. Women's sexual rights should be promoted. As Ross (2002: 54) suggests there is a need to build a community of

women and men in breaking through the barriers of rejection in dealing with HIV/AIDS and women.

Dube (2001: 45) argues that the debates are more often than not, naïve for they ignore the structures at work that makes abstaining, being faithful and condomising, *NOT as easy as ABC!* She says that she would insist that as long as human relationships are based on inequality fighting HIV is more than just abstaining, being faithful and condomising.

Biblical literature according to Carroll (2003: 890), Hawthorne (1993: 596) and Kalmin (1992: 296) presents many examples of multiple partners among married biblical characters who loved God. Jacob had both Rachel and Leah and was given their servants. These two sisters were their father's bargain in exploiting the labour of Jacob (*Gen. 29-30*). King David coveted and married Bathsheba, the wife of Uriah. David virtually used his power to have her brought over; he had sex with her, killed her husband and eventually married her (*2 Sam 11*). Bathsheba's views are hardly given except when she sent a message to David to tell him that she was pregnant. Though she was later called the mother of the famous king Solomon Bathsheba, she was a victim of male violence. David used his power over a powerless woman. He raped her. In his old age, David is furnished with Abishag, a young Shunammite girl, who is brought to revitalise the king. Although the king fails to 'know' her she had been sought to come and lie in the bosom of old age (*2 Samuel 1:1-4*). King Solomon had countless wives and concubines (*1 Kings 11*). The biblical text also gives many other cases of sexual abuse. Lot who was attacked by men is said to have offered his two virgin daughters to the city mob to protect his male visitors (*Gen. 19:4-10*). Dinah was raped by Schechem (*Gen. 34*) while Tamar was raped within the house by her half-brother, Amnon (*2 Sam 13*). There are many examples of women who, because of patriarchal structures that denied them access to property, had to seduce men to get material and social security. There is Tamar, the widow who had to dress like a prostitute to trick Judah (*Gen. 38*), her father-in-law in order to get a son. There is Ruth who lay at the feet/private parts of Boaz, leading him to make a decision to marry her, thus securing her own future and that of Naomi (*Ruth 3-4*). Furthermore, Kenneth Ross (2002: 53) indicates that Jesus lived his life in a world where there was great distance and separation between men and women. Men are dominant figures and women were regarded as inferior. In that context of looking down upon women, Jesus shows a positive way forward. Ross (2002: 53) says:

He (*Jesus*) spent time with women, he showed the understanding of the issues, which concerned them, and unsurprisingly, women found Jesus approachable. Several of the great passages of the Gospels are concerned with women breaking through the taboos of the time to engage directly with Jesus. The community of men and women is set upon an entirely new basis.

Gender inequalities therefore should be broken down. The Church should work towards building communities where respect and dignity of both women and men will be a new level of relating to one another. What is required in the fight against HIV is a partnership of men and women. This is the reason why patriarchal sins should be understood and removed.

3.4.4 Patriarchal sins in the fight against HIV

Much like the biblical world, the churches and African societies are still very much patriarchal (Carroll, 2003: 893). The Zambian society, as is many societies in southern Africa, still marginalises women from access to property and decision-making. According to Baab (1962: 931), many women still need to dress like Tamar and to work as sex workers for life to go on. Davids (1997: 701) says many who are married or in relationships fear to insist on safe sex lest their providing husbands/partners desert them and leave them without food or shelter. Further, male violence has even escalated in the HIV era so much so that many girls, women and elderly women are raped both in the home and out of it. In such a situation the formula of 'be faithful' does not work for many married and unmarried women. Dennis (2003: 12) supports the view that the formula of abstain is defeated by underlying social ways of distributing power unequally.

Indeed, the churches in Zambia, more often than not, are the guardians of patriarchal power and other unequal relationships. HIV studies however, show that a major factor in the spread of HIV is the powerlessness of women. Their incapacity to make decisions about their lives is due to lack of material ownership and decision making powers (UNAIDS, 2000?: 45-54). It is said strategically that as long as men and women are defined as unequal the control of HIV will prove to be a challenge. Tibatemwa (1999: 11) agrees that as long as families, churches and denominations continue to promote the inequality of men and women a significant part of solving the problem in curbing the spread of HIV is not possible. This factor calls the church and its leadership to repent from baptising the patriarchal relationship and to struggle with propounding a theology that affirms both men and women as made in God's image and equal before God (*Gen. 1:27*). Jesus has long since set a precedence for this when he disregarded patriarchal power and called into being a church that recognises the equality of man and

women (Mark 5: 24-43; *Matthew* 15: 21-28 *Luke* 7: 36-50; 10: 38-42 & 18: 1-8; John 4; 8: 1-12; 12: 1-8; 19-20; *Acts* 2: 14-21). As *Facing AIDS the challenge, the Churches' response* (1997: 16) correctly puts it: wherever gender discrimination leaves women under-educated, under-skilled and unable to gain title to property or other vital resources it also makes them more vulnerable to HIV infection.

It is important while mentioning the sin of patriarchal attitudes not to be blind to the fact that the involvement of men in HIV prevention, care and support is very crucial in this fight. Gustav (2002 on <http://www.idp-europe.org/indonesia/compendium/en/index.php>) indicates that leadership needs to develop strategies to address this issue as a matter of priority. It is not going to go away all by itself since it is engrained in the culture of the people.

3.5 The challenge of involving men in HIV prevention⁵⁰

Gennrich (2004: 13) says it is becoming increasingly apparent that men play a major role in spreading the virus, and therefore they need to be mobilised as a vital part in the struggle to contain the pandemic.

Men are key determinants in the propagation of HIV infection. Jackson (2002: 88-89) contends that the global HIV pandemic is driven by men. She says men have more opportunity to contract and transmit HIV, men usually determine the circumstances of intercourse and men often refuse to protect themselves and their partners. Only when programmes that directly address men's sexual behaviour are designed can there be significance in reducing the rate at which the pandemic is spreading in Zambia. As it has been established above, the main mode of transmission of HIV is through intercourse. Hence, there is a need to positively influence men as the chief and powerful decision-makers in the family especially in the patriarchal Zambian society. Men have a key role to play in preventing HIV spread because they typically take the initiative in sexual relations and control the use (or non use) of preventive measures including condoms. Men usually make decisions as to with whom, where and how to have sex. Gennrich (2004: 14) says one of the most pernicious myths currently in circulation is that sex with a virgin cures a man of HIV.

⁵⁰Because of realizing the role of men in this fight against HIV the researcher of this study took an active role in initiating a men's network under the Council of Churches in Zambia known as 'Christian Men Making a Difference' (CMMD). The network was launched on 4th October 2002 in Lusaka under theme 'Men Make a Difference Say No to Violence against Women and Children'. See *Annual Report* for the Christian Council of Zambia for 2001 – 2002.

This could not be further from the truth. Toccalli (1990: 92) warns that sex with a virgin will not cure anyone. What it does is pass on the virus to innocent children or young women.

In *AIDS In Africa* Jackson (2002: 92) talks about a series of workshops which were held in Botswana, Malawi, Namibia, South Africa, Swaziland, Zambia and Zimbabwe around issues of men, sex and HIV and the following were the major outcomes to help men change their risks behaviour:

Promote open discussion about sex and sex education among young people; boys need role models of responsible sexual behaviour from their relatives, teachers and others and they need opportunities to learn about sex and sexuality. Ignorance is not bliss, but a high risk strategy, particularly in cultures and societies where male risk taking and sexual dominance are the norm that boys will grow up to copy. Provide safe environment for boys and men to talk seriously about sexual issues. Work to change social definitions of masculinity at all levels.

Men tend to have more sexual partners than women and men often do not use condoms consistently. Why do men behave that way? Mostly because society tells them that is how they should behave. Boys grow up expecting to have a lot of sex. Many men and women think that it is 'natural' for men to have more partners or that a man's sexual drive is so strong that it cannot be controlled. So boys grow up believing they have a 'right' to have sex whenever they want it and some girls grow up believing it is their duty to satisfy men and women who want to protect themselves often feel they can not raise the subject with their partner⁵¹.

In *HIV/AIDS: Grasping its gender dimension*, Aprodev (2000) <http://www.aprodev.net/files/gender/HIV-AIDS.pdf> states that such attitudes were reinforced by traditional polygamy, where a man could have more than one wife. When all partners respected traditional polygamy and were faithful this gave men authority over their wives but limited the likelihood of transmission of any disease. The tradition today that condones polygamy is often interpreted as men's right to have sex with as many women as they wish. They do this without regard to obligations of fidelity or family responsibility. All women are viewed as sex objects for men. Furthermore men may not be afraid of their marriage breaking up, partly because in many cases wives are economically dependent on them and if the

⁵¹The views expressed in this paragraph and subsequent ones on men and sex were shared in group work sessions by men during the launch of the men's network in Lusaka as indicated above.

marriage does break up and *lobola* was paid the children of the marriage belong to the husband's family and not the wife's.

Fylkesnes and others (1997: 112) have observed that men have considerable power in sex and they are seldom criticised for having several sexual partners. They are usually expected to take the lead in sexual matters and they often expect to have their sexual demands met. Men's abuse of this power is a primary factor behind the HIV pandemic.

Jackson (2002: 89-90) suggests that the ideal needs to be generated that a real man cares enough about his wife to be faithful to her or if this is not achieved or he already has HIV, that he is sufficiently responsible and caring towards any partner, including his wife or wives, to use a condom. Implicit in this ideal of caring for others is that he also cares for himself, and will take responsibility for keeping himself HIV free too. Endorsing men's important role as fathers may further encourage responsible sexual behaviour.

Recognising the role that men play in the spread of HIV is not the same as simply blaming men. Males are as trapped in social expectations of gender roles and behaviour as females are, even if those stereotypes often benefit males far more than females. Gennrich (2004: 30) suggests that it is thus important that men are encouraged to identify and prioritise their own issues in HIV prevention, care and support and advocate for these issues. It will be critical as such to build men's capacities to be responsive to HIV prevention including policy development and advocacy, and the encouragement of voluntary counselling and testing among men.

Due to Zambian men's position in society, they have a great role to play in the control of HIV. Leadership in all spheres of life needs to face this issue and develop strategies to deal with it effectively and faithfully. The place where this should start is the local congregation.

3.6 The challenge of local congregation mobilisation

Baranowski (1988: 44) agrees that community action has proved to be one of the strongest weapons in the battle against HIV. Schools, churches, mosques, sports, the workplace and other forums that bring people together are effective tools in the armoury of HIV prevention measures. The leaders of these groups are respected and influential within the community and they provide opportunities for addressing risky behaviour and for expanding medical services

and counselling. They can also reach out to the broader community, as each schoolchild or employee carries home with them the prevention message they learn.

Strong community participation has been a major factor in Senegal's success in maintaining a low rate of prevalence in the general population (UNAIDS, 2003: 34). Peer education has been an effective tool in this mobilisation of Senegalese communities. The key to build community-level responses is inspiring local ownership of the initiative. Communities should be able to be proud of accomplishing something they themselves had a part to play in.

For the Church these local communities are local congregations whose mobilisation is critical because as Hendriks (2004: 212) says members of this community are involved in vocationally based critical and constructive interpretation of their present reality and in this case of the HIV virus. In congregations the struggle brings about answers to make life meaningful. The congregation is the local manifestation of the universal Church. As such, it acts as the institution where Christian identity and values are passed on to future groups of people (Hendriks, 2004: 213).

When talking about local congregation mobilisation, one need to listen to what McCoy (1993, in his MTh dissertation) has stated about the local Church concept and community. He says one of the abiding tensions in thinking about the local church in mission has been between what Winter called "modality" and "sodality" groups (Winter, 1974: 122), or what in a different context has been dubbed the "community" church and "fenced" church (BCC, 1981: 32-41). He says that, a fairly sharp distinction has been drawn between church communities which are open, flexible and welcoming, with porous boundaries (if they have boundaries at all), and those which are closed, inflexible, welcoming only to those who are willing to meet rigorous membership standards, and thus have clear boundaries. McCoy (1993) says that Winter (1974) seemed to suggest that the sodality - the clearly defined, committed, purpose-driven community - was the best kind of structure to engage seriously in mission. By contrast, a 1981 British Council of Churches policy document advocated "open" communities as the best model for effective mission and ministry among young people (BCC, 1981: 32-41).

Such dualisms are typical of modernist thinking, and they need to be transcended if we going to develop genuinely appropriate missional communities. He says the team which produced *Missional Church* has largely succeeded in doing just that (Guder, 2000: 213).

First, in building on the foundations established earlier in the book, the missional community is defined as the pilgrim people of God who are on a journey towards the fullness of the reign of God (Guder, 1998: 204). Then the categories of *centred* and *bounded* sets are introduced from sociological analysis as an alternative to the traditional distinction between ‘fringe’ and ‘core’ membership.

The congregation as a whole is a centred set – a community of those who are invited on a journey towards the values and commitments identified with the reign of God. The centred set “represents the church as a people on the way toward the fullness of God’s reign in Jesus Christ”, which is “open to all who may want to be on this journey” (Guder, 2000: 206). The bounded set is a sub-set of the congregation, a covenant community, and “those who have chosen to take on the commitment, practices, and disciplines that make them a distinct, missionary community” (Guder, 1998: 208). Here the “modality” and “sodality” models, the “open” and “closed” churches, are no longer in opposition to one another but are symbiotically joined. The centred set is where people are made welcome, where they can explore the cost of discipleship and experience a sense of belonging as they journey further on the shared pilgrimage. The bounded set is that covenant community within the congregation, which knows itself to be a sign, foretaste and instrument of God’s reign. Both sets are headed in the same direction: towards the reign of God. The role of the leadership is to cultivate and form the congregation, calling them into the covenant community of the bounded set, and directing their attention outward towards their context (Guder, 2000: 212). Therefore the particular community, empowered by God’s Spirit, not only lives out the gospel internally but opens up the gospel externally by the way it lives, so that others may see and respond.

It is indeed a challenge for leadership among Zambian Churches to mobilise local congregations for commitment to work for the realisation of the reign of God. Strong community participation is indeed the secret behind many success stories in the fight against HIV and all its related challenges.

3.7 The challenge of condoms

The ZHDS (2002: 195) survey reports that there is considerable resistance in Zambia to teaching youth about condom use, with more than one-third of respondents not approving. The proportion of women who believe children 12-14 years old should not be taught to use

condoms is slightly higher (39 percent) than that of men (32 percent). There is no association between openness to teaching pre-adolescents about condom use and respondents' level of education. Meanwhile, *Africa Alive!* reports that the Youth AIDS Prevention Initiative is one of the organizations which is working hard to promote prevention messages through entertainment and catching the attention of many young people who are the most affected by this pandemic including information about condoms.

Women and men were asked whether they think it is acceptable for condoms to be discussed in the media. Over 80 percent of both women and men think it is acceptable for condoms to be discussed in the media. Men are slightly more likely than women to consider such discussion in the media acceptable. Older women are less likely to consider condom discussion acceptable, although this is not true of older men.

The survey reports that by province, such discussion is considered least acceptable by women in Northern Province and men in Central Province, while both women and men in Western Province are the most likely to consider it acceptable.

Condom discussion in the media is more acceptable to respondents with a higher education. In the same ZDHS survey, men were asked whether they agree or disagree with certain statements regarding condoms. 52 percent of men feel that condoms decrease a man's sexual pleasure, 41 percent are of the view that condoms are inconvenient to use, and 6 percent think a condom can be reused. The data further shows that 77 percent of men feel that condoms are effective in preventing HIV and other diseases. 36 percent believe that a woman has no right to tell a man to use a condom, and 84 percent feel that condoms are effective in preventing pregnancy.

There are no major variations in most of men's attitudes towards condoms between rural and urban areas, except that men in rural areas are almost twice as likely to think that a woman has no right to tell a man to use a condom as those in urban areas. The proportion of male respondents holding this view decreases with increasing level of education.

The Church's traditional⁵² message is one of abstinence before marriage and monogamy after it. In practice this is often a fiction and most people know it. Thus, the chastity and abstinence

⁵²Professor Nkandu Luo of the University of Zambia in an article published in the *Post Newspaper of Zambia* of 28 April 2002 accused the Church of hypocrisy over the use of condoms. Prof.Luo said the Church should not totally condemn the use of condoms, as there are people even within the Church who cannot abstain. 'You

scenario becomes a kind of parallel reality: intended for public consumption, backed by social and religious sanctions, and designed to conceal the real facts.

This is bad news for public health planning which depends on addressing what is really going on, not what people wish was true. It is also bad news for the Church, which cannot be successful in combating transmission of HIV until it engages with the moral contradictions implicit in this reality gap. When cultural norms contradict religious teaching, particularly in the case of something as near to home as sexual behaviour, then culture generally wins. It is naïve to imagine that churches will reconstruct their ethical teaching with the sole object of enabling people to avoid sexual infection. In this situation, what is the distinctive contribution the Church can make? First, its message should be based on correct scientific data supported by a public health message.

Nevertheless, the Church's message is not necessarily the same as the public health message. Ross (2002: 36) says it is acknowledged that an absolute ban on condom use is not a sound moral position to take. In the case of discordant couples the life of the HIV negative partner might be preserved by the use of condoms. Equally, the youth who are already sexually active can reduce the likelihood of catching the virus by the use of condoms. There is need for leadership in the Church which would be unequivocal in allowing the use of condoms where this can give some protection to those who otherwise as Ross says (2002: 37), would be at the mercy of the virus.

Being one of a group or community means conforming to the gender expectations implicit in your own culture. For young people this may mean being sweet and innocent if you are a girl or macho and assertive if you are a boy. Moral lectures are almost irrelevant: it is virtually impossible for individuals, especially young people, to stand up against the social mores of their peers.

cannot tell someone who has tasted sex to abstain", she said. She said people in the Church were also contracting sexually transmitted diseases and were dying from AIDS, which confirmed that they were having unprotected sex. She said people in the Church should not pretend that they are more holy but should be realistic about the situation. "The issue about the condom is that we are not packaging the message properly to include telling people the consequences. We can't tell everybody to abstain, it's not possible, maybe after a century", Prof. Luo continued: "The Church in its teachings should emphasise that the condom was not a solution to AIDS, she said. She further stated that HIV was a war and if nothing was done, it would be knocking on peoples head's instead of the doors.

Muchiri (2002: 40) and Smedes (1993: 80) suggest that behavioural change starts with an acknowledgement of what really happens, and it takes place at the level (and in the company) of one's peers and one's own community. This represents a real minefield for church leaders, who fear that 'accepting the reality of people's lives' will mean watering down traditional teaching, and undermining their advocacy of faithful sexual relationships.

Patterson (1996: 10) indicates that loving, truthful, non-exploitative relationships are at the heart of the gospel. What church leaders could do is to ask others working in the field of HIV prevention to support them in focusing on what is already at the heart of the gospel message, which is the importance, for human growth and happiness, of relationships that embody the values of life, hope and truth.

A Catholic priest Hippler (2005 online www.h-o-p-e.net/06downloads/Aids-%20Condom%20-%20Oikonomia%20-%20englisch.doc) suggests that the Orthodox Church, principle of *oikonomia* may offer the church a better understanding in dealing with the issue of church and condoms. He describes *oikonomia* as a consequence of God's unconditional love for every human being. The principle of *oikonomia* accepts that there are rules and regulations, but those can be set aside for a specific reason or a specific group of people for the sake of their wellbeing. This does not mean the end of a rule, but an exception by accepting and highlighting the rule, determined and reasoned by the unconditional and never-ending love of God and Christ, symbolised and carried forward by the church. *Oikonomia* is the constant realisation of the mystery of God's love, revealed by Jesus Christ. He further says in the spirit of Vatican II which called on the Catholic Church to read the signs of the time, at a time of HIV, the sign may be not to enforce greater burdens and moral prescriptions on people, but to give them more unconditional love. He suggests that the Church is not to fight the disease with moral arguments but should embrace the syndrome and the people infected and affected with love - a love that does not stop with the provision of care for the sick and dying, but one that abandons judgment and is open to the realities of human interactions in such a time as this. Maybe the answer lies in accepting, cherishing and highlighting a principle of *oikonomia*. According to the argument presented in this work a holistic model of dealing with HIV will require that even in this critical matter truth may lead to genuine freedom which makes actions out of justice and this will create an environment of *shalom* among God's people.

In return, churches might agree to stop picking and choosing which bits of the public health message they want to deliver, stop condemning the use of condoms when these will save lives, and stop undermining prevention efforts by those who promote them. This leads us to ask the question: what kind of leadership is required in this time of HIV?

3.8 The challenge of leadership

In opening the 15th International AIDS Conference in Bangkok (*The Post*, Friday 16th July, 2004: 6), the then United Nations Secretary General⁵³, Kofi Annan, had called on leaders all over the world to demonstrate that speaking about HIV was a point of pride and not a source of shame. He said leadership meant showing the way by example by breaking the wall of silence that continues to surround the pandemic. Leadership comes from all levels of society, from those who hold positions of power to those in the general communities. Leadership would mean breaking with traditional practices that increase the risk of contracting HIV. Leadership means respecting and upholding the human rights of all who are vulnerable to HIV. Leadership means daring to do things differently, because of understanding that HIV is a different kind of disease. It stands alone in human experience and it requires people to stand united against it.

D'Souza (1999: 18) defines leadership as influencing and directing individuals and groups' behaviour to enable them to pursue the goals of an organisation, while Manning (1988: 20) defines it as "the achievement of a specific purpose through others". If leadership is about getting results through others there is need then to embrace all the 'others' who can make a difference. In some cases, some individuals may count. Most often, though, co-operation and collaboration with many individuals and organisations is essential. For a far and enduring success there would be need to create what Manning (1988: 21) calls "a community of champions".

Leadership is required in order to turn back the global AIDS epidemic. Hendriks (2004: 197) agrees that leadership is crucial for implementing change. Leadership after the example of Nehemiah is to understand that God called you on behalf of his people to do what in many ways seem to be humanly impossible. Leadership is necessary to help the Church to rediscover its identity and mission in this time of HIV (2004: 197). In the words of Bernard

⁵³ From January, 2007 a South Korean Kim Ban Moon took over as United Nations Secretary General

Montgomery as quoted by Maxwell (2000: 1) leadership is the capacity and will to rally men and women to a common purpose and the character which inspires confidence.

Kofi Annan has further indicated that leadership at all levels is important in this fight. He says the best of the global AIDS response to date has shown the absolute necessity of both *leadership and of teamwork*. Above all, Annan says, it calls on all sectors of society to show *leadership in galvanising* the response to HIV - among towns and villages, young people and those not so young, companies and community organisations, countries and continents. He further says only when all these forces join in a common effort then will the fight against the epidemic bring about decrease in risk, vulnerability and impact⁵⁴.

3.9 The challenge of church leadership in relation to HIV

As Roxburgh (2005: 45) suggests, leadership needs to be sensitive to God's will for if they were God's directions and purpose will emerge out of sincere interactions for mobilising God's people for change. He goes on to say that the role of leaders is to cultivate environments that release the missional imagination of the people of God. Since God's concern is for the entire world, leadership for change in a time of HIV and AIDS is surely on God's agenda. Bosch (1991: 392) says that to participate in missions is to participate in a movement of God's love toward people, since God is a fountain of sending love. The leadership, which is sensitive in this way, will develop and empower all God's people for full participation in Church ministry (Hendriks, 2004: 14). This leadership should empower the congregation to grow towards spiritual maturity.

Similar to the expression made by Roxburgh (2005: 143), HIV has caused the Zambian churches to be in the midst of transition in which the culture is moving through discontinuous change as also shown above by Castells. HIV has revealed to the Zambian society that leadership capacities that were developed through the missionary era just over a century ago do not have sufficient capacity to be relevant in leading the churches towards reformation around the *mission Dei* in a time of HIV.

Roxburgh and Regele (2000: 151) say that that leaders and organisations often fail because they loose connection with the actual changes at work within their organisation's culture. They loose their internal power of mission that shaped their initial formation and therefore

⁵⁴ In the Foreword to the 'Global Strategy Framework on HIV/AIDS', UNAIDS, 2001

they loose connection with the very groups in the external environment for which they came into being. On the other hand, Handy (2004: 198) shows that the work of God takes place through the creative strategy of leadership. Strategic planning with steps for implementation translates wisdom into work. An action plan informed by mission does the work of God as it moves towards an appropriate response. The will of God is discovered through the consummation of leadership. As Handy (2004) advises, it is important to note that the will of God is not the same as the wisdom of God. The will of God is the result of leadership that discerns the vision of God and implements that vision through a strategy that includes planning and directing the process. Roxburgh (2005: 159) says that the work of centring Christian community within God's story is the enormous task that *leaders* desire to shape in order to form such communities as a sign, witness, and a foretaste of God's reign.

In as far as the combating HIV is concerned - the subject of focus - Piot of UNAIDS (2003: 1) has put it ably when he said: "above all, effective action against HIV has required *sustained and effective leadership* at every level - from village to global". Leadership commitment is the basis for:

- systematic and accountable planning;
- tackling stigma;
- addressing the needs of those most vulnerable to infection and those made vulnerable by the impact of AIDS;
- supporting communities in their efforts to devise effective solutions to the spread and impact of AIDS; and
- Strengthening the infrastructure needed in the health, planning and development sectors.

In their book, *Church leadership: Following the Example of Jesus Christ*, Richards and Hoeldtke (1988: 72-74) say the power of leadership is not to claim to know the will of God more than anyone else, but growing towards maturity in Christ's will, glorifying God by letting Christ's attitude increase and thereby becoming better witnesses. This agree with what Roxburgh (2005: 145) has said that leadership takes seriously the biblical understanding of the people of God as the place where God's spirit is most specifically at work. It is in and through God's people that God's future emerges. As Frances (2002: 7) says, leadership is about having the vision, based on promise, which leads to an appropriate response through

doing God's work with all people of goodwill. When leaders claim to know the will of God as a private revelation they are close to misusing power and abusing the people, as we have already warned about fundamentalist tendencies in Chapter 3. This leadership is about what Roxburgh (2005: 146) calls **cultivation** and is about learning to be cultivators of environments out of which God's people might innovate and imagine where God is at work. Bright (1999: 54) argues that any use of power to abuse the people is therefore contrary to the purpose of God, because God's desire and purpose is directed toward the ultimate good of his people. Effective use of leadership power involves discipline that corrects disorder and direction that overcomes disorganisation and confusion. Leadership under the reign of God seeks to lead with the values of truth, freedom, justice and peace as seen in Chapter 3.

Strong leadership, then, at all levels of society beginning from the church is essential for an effective response to the epidemic. Leadership by governments in combating HIV is essential and their efforts should be complemented by the full and active participation of civil society, the business community and the private sector. Leadership involves personal commitment and concrete actions. UNAIDS (2003: 7) says:

Heads of State and Government are not the only political leaders who can make a difference in fighting HIV/AIDS. Cabinet-level ministers and African parliaments have crucial leadership roles in drawing up effective, strategies, policies and programmes. Parliamentarians can also hold governments accountable for implementation of national AIDS plans. Dedicated politicians also act as conduits for communicating prevention messages to the areas they represent- both rural and urban- as well as relaying particular local needs and demands to policy-making bodies.

Since governments are not the only ones that should provide leadership, over much of the globe, Green (2003: 287) affirms that faith-based organisations have considerable moral and political responsibility and influence. In some countries, they have advocated for better statutory reproductive health or testing services or more humane treatment of people living with HIV. Patterson (2003: 7) tells us of how in South Africa, churches have been active in the campaign for medication to prevent mother to child transmission of HIV, and two successive Anglican archbishops have risked censure by the stand they have taken on HIV. Effective responses to HIV depend on strong leadership.

By contrast, negative reactions from influential religious authorities can torpedo national policy and turn public health planning into a battleground. Patterson (2003: 10) noted that in Latin America and in parts of Africa, certain churches have gone out of their way to

undermine public strategies, disassociating themselves from national campaigns because they advocated condoms or promoted sex education in schools. They have disseminated false information in order to prove their point, withheld vital information about prevention, and used language in manipulative and inaccurate ways. *AIDS is caused by adultery*, states a particular Council of Churches document on HIV and Youth, '*using condoms results in disabled babies*' thunders an archbishop (quoted by Gennrich, 2004: 19). The credibility of the whole Church is compromised when its leaders are allowed to get away with lies and manipulative propaganda. McGuire (1989) in the article entitled: *AIDS: community based response* encourages that Church leaders require training, they require commitment, they need great honesty, they need support from their peers, and they will need to be in touch with the experience of grassroot groups in their own churches. This strengthens our contention that a missional theology, which promotes the praxis of the creation of Circles of Hope at a congregational level, is a basic presupposition for a holistic approach to combat the HIV pandemic. This missional theology when it touches leadership should be in truth, cultivating freedom, ensuring justice and peace among all God's people.

Recently, Zambian church leaders have organised consultations designed to revisit their record on HIV and see how they can address the issue more effectively. Anglicans, Catholics, Lutherans, Presbyterians, Methodists, the Salvation Army, people of different faiths and the various ecumenical bodies have all issued statements acknowledging past failure and committing themselves to change HIV infection⁵⁵.

The question is: What next? Churches are complex organisations and archbishops and bishops are pastors to all their people. Patterson (2003: 12) indicates that the church particularly in poor countries has many problems and few leaders are in a position to drop everything else and focus on HIV. They hesitate to say so publicly, but privately many admit that they do not know what to do, they do not know where to start and they are afraid that if they say anything it may be wrong.

⁵⁵An example of these statements is well documented on online on <http://www.wcc-coe.org/wcc/what/mission/ehaia-docuements-e.html#statements> [accessed 6 January ,2005] These include the 'Global Consultation on the Ecumenical Response to the Challenge of HIV/AIDS in Africa' held in Nairobi – Kenya, jointly organised by AACC and WCC 25-28 November 2001, 'The Mkono-Kampala Declaration- 'AACC Church leaders Consultation on the approach to the HIV/AIDS crisis' Uganda 15–17 January 2001, Southern Africa Regional Consultation, Lutheran World Federation- Pan African Lutheran Church Leadership consultation in response to HIV/AIDS pandemic, Nairobi- Kenya, 2 – 6 May 2002, Anglican Communion across Africa, Johannesburg- South Africa- August 2001, Dakar Declaration organised by the AACC women Desk, 23 – 25 April 2001, African Religious Leaders Assembly on Children and HIV/AIDS, Nairobi – Kenya 9-12 June 2002; Cameroon – AACC Covenant etc.

3.10 Types of leadership skills required

The researcher has noted the challenges that face church leadership in Zambia. It is the argument of this work that a locally born theology which promotes the creation of Circles of Hope will be the praxis which will enable an environment of truth, freedom, justice and peace to exist. As seen, the challenges or impediments to that include the challenges of fighting silence, stigma and discrimination, empowerment of women for reducing vulnerability, involvement of men in prevention, care and support, involvement of people living with HIV, local congregation mobilisation and the un avoidable question of condoms. What leadership skills, then, are required to form a strategy effectively that will bring about transformative change in this area? One should be mindful of Roxburgh's (2005: 145) timely warning that cultivating leadership does not mean that God's people are simply waiting to suddenly discover the answers to all the problems facing *them*. When describing leadership as cultivating environments, leaders protest that this is a naïve and unworkable perspective. While looking at these skills, one must be mindful that leadership should not be removed from the people of God. HIV challenges might require what Roxburgh (2005: 148) has called situational roles as the case was for various biblical leadership images.

3.10.1 Leadership patterns in Africa

Smit and Cronje (2002: 16, 27, 296-297, 350) indicate that the upbringing and socialisation of individuals in African society have always emphasised interpersonal, informational and decision-making roles. Interpersonal roles are subsumed in the notion of *ubuntu in Zulu* and *umunthu* in Chichewa or brotherhood in English. Thus, *ubuntu* is a literal translation for collective personhood and collective morality. Therefore, a leader (*mtsogoleri* in Chichewa) guided by the *ubuntu* philosophy is expected to inform and communicate with his or her own group and to be their mouthpiece in external communication. Decision-making is the hallmark of leadership, which involves analysis of the situation at hand in consultation with others and guiding the process until a course of action is selected.

According to a study that was done in South Africa by AMROP in Smit and Cronje (2002: 295) it was discovered that leadership is one of the many lines of enquiry into a new management model for South Africa. Of particular importance is a 1996 study on the question of black leadership. The survey is a first step in understanding what has come to be

known as *Afro-centric style of leadership*. The result of this survey can be summarised as follows:

Creating a vision: looking backwards and forwards – African leaders have strong strategic emphasis. Their focus is not so much on short-term hurdles but on long-term goals. They are fairly traditional leaders who prefer tried and trusted practices. Their hesitancy to experiment may blind them to opportunities that offer a competitive edge. They believe that specialist knowledge is an important resource, so they prepare themselves thoroughly, consulting relevant sources of information.

This may slow down the decision-making process; taking up time that could be better spent in as far as the corporate world is concerned. Greater efficiency needs to be developed.

They agree with Louw (2002, at www.phys.uu.nl/unitwin/ubuntu_page.html) who argues that in line with the philosophy of *ubuntu*, many African leaders maintain a balance between the dignity of position and establishing harmonious interpersonal relationships. He further says that compared with leaders from the individualistic cultures they may seem fairly restrained and hesitant to use their power or persuasion to change others' approaches. This does not mean, however, that they are not in touch with their colleagues, but their relationships have a different basis. HIV helps us to have a sense of community and respect for others, which is necessary in helping to create a less adversarial relationship between those leading and the followers. Greater emotional investment in the relationship with their followers could lead to more inspirational leadership.

For many African Church leaders the importance of team work cannot be underestimated. D'Souza (1999: 72) says that leaders can not do the job alone. They may lead, but they need others to follow. To function effectively as a team, group members must also be aware of the factors that contribute to or hinder a team's functioning. Team members should have the opportunity to agree on the particular factors they need to work on their own team. Some of the dynamics in team work may include issues such as being clear about the group goals and objectives, setting roles and responsibilities, group procedures and interpersonal relationships. HIV requires teamwork at all levels especially at a congregation where it affects many people. A hierarchical, top-down *modus operandi* has been characteristic of many western styles of leadership in many organisations and sometimes even in the Church.

This is supported by Edmund (2003: 27) who also emphasise that communication is a powerful value in African culture and working for the common good is valued above

aggressive competitiveness and individual excellence. This emphasis on teamwork is reflected in African leaders' approach: a spirit of co-operation, grassroots support for decisions and encouragement of a free flow of information is its hallmarks. Furthermore, Edmund (2003: 28) says that a more Afro-centric approach to leadership brings greater sensitivity to bear on interpersonal relationships, without forfeiting the right to rely on the individual leader's judgement in the final analysis. This perspective is very necessary in considering and understanding leadership patterns in an African style which are helpful for the type of leadership required in a time of HIV. The Afro-centric type of leadership is very appropriate and close to the biblical style of leadership, which is servant-like and is guided by what is considered to be for the good of all God's people. The sensitivity to others cannot be anything more than the love of God as encouraged in 1 *Corinthians* 13. That is from the positive angle. The researcher simply needs to mention here that there are bad leadership practices which are not helpful in our quest to combat the pandemic of HIV. Reno (1998: 217-220) has given an exposé of the phenomenon of Africa's warlords in his book, *Warlords Politics and African States* and Perry (1975: 65-70) has helped to understand how the chieftainship system has operated in many African states in relation to the abuse of power and patronage.

Leadership in Christian terminology is about the Cross. There is a parallel here with an Afro-centric leadership style. In this time of HIV such leadership style is highly recommended as it will surely bring about the desired change in order for the congregations to put in place effective strategies for combating HIV at congregational level where it affects the members most.

As Roxburgh and Regele (2000: 16) suggests, this is new turf. No one alive today has been here before. This is a new place, calling for pioneers. People are on the way from a world in which they were trained to lead and have a great deal of comfort in leading, to a world they do not as yet recognise. Given the responses to change, how do leaders lead in this new time and place?

3.10.2 Transformational leadership

One can safely borrow Roxburgh and Regele's (2000: 17) words that God is calling his people to become missionary people to their own culture. They have been cast into this place of transition. The reality is that leaders of congregations and denominations without choice or

preparation have been pushed into this new, in-between place. Addressing the HIV pandemic requires transforming many aspects of the local culture. Transformational leaders are similar to charismatic leaders, but are distinguished by their special ability to bring about innovation and change. Transformational leaders emerge to take an organisation through major strategic change. They have the ability to make the necessary successful changes in the organisation's vision and mission, in its goals, strategies, structures, culture, reward systems etc. Transformational leadership is most appropriate in dynamic situations such as the subject matter of this work – Christian leaders who will motivate a missional theology, which promotes the praxis of the creation of Circles of Hope at congregational level, in the context of HIV.

The challenge of change in societies is forcing organisations and Churches to review their values, and to develop new strategies and new ways of doing things. In using an illustration of a small Reformed Church congregation of Mariental, Hendriks (2004: 110) indicates that the people who gathered for a visioning camp meeting summarised the spirit of their camp in these words, 'you can not do today's work with yesterday's tool and still expect to be in business tomorrow'. For this reason a number of noted authors, including Kotter and Moss Kantor of Harvard, Laurie and Peters, collectively view leaders as 'change agents' (as quoted by Smit and Cronje, 2002: 297). It is about a leadership that breaks through old habits of thinking and acting in order to forge new solutions to old problems. Transformational leaders are needed in all organisations and churches in order to align their organisations with the ever-changing environment. Environmental change is not going to slow down, and that is why leaders who can manage change are of critical importance in today's world.

Roxburgh and Regele (2000: 18) say some leaders are simply confused by all the change. They either do not understand it or feel it is too much for them to address. These are the leaders who hang on to old patterns in the hope they will work for them at least a little bit longer. Other leaders are stimulated by the new and the next while others are so mystified by all the change with its attendant stresses and conflicts that now they are just standing on the sidelines watching from the outside.

To support the view that leaders are change agents, Smit and Cronje (2002: 293-297) point out these six key leadership skills as the ones that describe the actions of transformational leaders which are so related to steps for doing practical theology as seen in Chapter 1:

- i. Leaders are people who tune into their organisation's environment and sense needs, opportunities, and dangers. They are people with intellectual curiosity who ask questions about possibilities and establish a sense of urgency. They, as Christians, know that they have been called to be followers or disciples of Jesus Christ and thus they want to participate in the mission praxis of God.
- ii. Leaders think in a kaleidoscopic way. They look at a pattern, challenge the pattern by shaking the kaleidoscope, and study the new pattern to find new possibilities. In other words, leaders challenge assumptions and conventional thinking to find new solutions to old problems. They do a wider contextual analysis for a specific time and place.
- iii. Leaders form and communicate inspiring visions. Leaders inspire people with their ideals and offer a better way for every one if they change and adapt to these ideals. They give meaning to followers by providing them a dream and a goal. (After they have done their local analysis and draw upon the interpretation of scripture to be a sign of God's Kingdom on earth, they come up with a vision and mission to lead them).
- iv. Leaders build a coalition to support their change. Leaders cannot bring about change themselves. They need other members to back them. There is needed to form a support coalition (they are part of God's body an apostolic faith community which is willing to do something for God's glory).
- v. Leaders turn dreams (changed visions) into reality by nurturing and supporting their coalitions. Leaders let their followers take the vision and move ahead with it. Great leaders build other leaders. Leaders give their followers ownership of the task: they set rules, they provide their followers with the resources needed (financial, human, physical and information) and they reward them for their performance (there is a transformative action of participation which leads to a clear strategy and implementation of the vision).
- vi. Leaders drive the change process by pushing. Change is neither simple nor singular but a complex process with identifiable stages. The way in which congregations or groups respond to change depends where they are in their own growth and maturation cycle (Roxburgh and Ragele, 2000: 31). (there is implementation and evaluation of progress).

D'Souza (1999: 12) comments when discussing leadership that there is need to be reminded that Christian leadership essentially involves *service*. When considering Church and/or Church related institutions the concept of service is appropriately grasped. Yet when mentioning corporations and businesses, the word *service* sounds out of place. There can never be a better time to emphasise the theology of service such as during this time of HIV as we shall see below. Part of the confusion may come from not understanding the true concept of leadership. For many, the word leadership connotes power, authority, honour, prestige, or

personal advantage. That is not Christian leadership. D'Souza's (1999: 13) definition of Christian leadership is worth noting at this point:

My description of Christian leadership is that it seeks to be of service, rather than to dominate; encourages and inspires; respects rather than exploits others' personalities; reflects, prays, and acts on Jesus Christ's words, "whoever wishes to be first among you, shall be your servant, even as the son of man came not to be served, but to serve, and to give his life as a ransom for many" (Matthew 20:27).

Jesus' teaching as well as his earthly life epitomised this approach to leadership as defined by D'Souza. Jesus showed his disciples how to lead by his own example of selfless service. The same is demanded of those who would carry out his mission on earth today. Mott (2005: 25) says:

I have in mind the use of the word leadership which our Lord doubtless had in mind when he said, 'He who would be the greater among you shall be the Servant of all'. Leadership is the sense of rendering the maximum of service, leadership in the sense of the largest unselfishness. Leadership in the sense of unswerving and unceasing absorption in the greatest work of the world, the building of the Kingdom of our Lord Jesus Christ.

The leader then sees the bigger picture, and understands the purpose of the life and work of the group or organisation. To lead (i.e. go before) implies that the leader has foresight and a sense of direction. In every structure there is need to set individual efforts in the context of the over-all purpose. Someone needs to provide this goal orientation.

D'Souza quotes Greenleaf from his book *Servant Leadership* (2002: 14) and says:

A mark of leaders, an attribute that puts them in a position shows the way for others; is that they are better than most at pointing the direction. As long as one is leading, one always has a goal. It may be a goal arrived at by a group consensus, or the leader, acting on inspiration, may simply have said, 'let's go this way'. Nevertheless, the leader always knows what it is and articulates it for any who are unsure. By clearly stating and restating the goal, the leader gives certainty and purpose to others who may have difficulty in achieving it for themselves.

Leadership focuses on purpose. For Christian leaders, their purpose means pursuing the same goal that Jesus pursued helping people become all that they can become under God. Jesus said: "I have come that you might have life- life in all its fullness (John 10"10). Effective Christian leaders, like their Master as Hesselbein (1999: 37) says, seek to enable others to experience that life in its fullness. Leaders' lifestyles and their methods relating to people

show themselves in many ways yet focus on helping others to grow to their maximum, “to the measure of the stature of the fullness of Jesus Christ” (*Ephesians* 4:13).

Even a casual view of Jesus’ life shows his concern for people. Human beings are the most important resource leaders have. Without people, material and financial resources are worthless. Kotter (1999: 13) says: “Leadership is service, in the sense that it seeks to meet the needs of another or of the group by performing needed functions”. UNAIDS (2003a) in an article entitled: *Together we can: leadership in a world of AIDS*, has said that sometimes strong directive power is effective leadership, such as when a group has lost its sense of direction or purpose; with another group or at another time when the group is functioning well in its relationships and has its directions clear, non-directive styles of leadership are needed. Sometimes the group needs to be encouraged and supported. At other times, it may need to be reoriented. Leadership serves the needs of the group.

Christian leaders involved in HIV work will have to keep the purpose and mission of the Church in the forefront of all activities through functions such as goal setting, planning, organising, programming, motivating, co-ordinating and evaluating. They also need to establish a climate conducive to the full development of human resources. That places the burden upon Christian leaders at the top of an institution to assume the responsibility for developing people.

While developing others, leaders also need to develop a healthy self-image. This journey is never complete. There are no limits to personal growth. People partly discover themselves through introspection and reflection and mostly through experience. Quiet contemplation in struggling to discern God’s will for the present situation has great value, but action provides the real test and the best learning.

3.10.3 Servant leadership

Anderson (1997: 198), in quoting Greenleaf (2003), indicates that in servant leadership the leader is not subservient to the desires and goals of the organisation, but is the servant of the mission or goal of the organisation. It is the vision of the specific mission or goal that marks the effective leader. ‘Foresight’ is the lead that the leader has. Greenleaf (2003: 21) endorse the view that the leader is the servant of the mission of the people of God. This mission must be perceived as the ‘vision’ that informs the goals and strategy of the people. The vision does

not come through predicting what will pass in the future by reading past performance and extending present goals, but through reading signs of the future in the present.

Effective leadership means reading these signs of God's promise in the context of present events and translating these signs into goals; this is "preparing the way of the Lord" (Mott, 2005: 80).

Greenleaf (2003: 13) further shows that the servant leader is a steward of the resources needed to attain the vision. In addition, the power to carry out this stewardship is a delegated power. What the author of the book of Hebrews said of one who serves as priest is also true of the leader: "And one does not presume to take this honour, but takes it only when called by God, just as Aaron was" (*Hebrews* 5: 4). As a good steward, the servant leader is faithful and accountable to the Lord who cherishes and loves the people. One of the most compelling metaphors in the bible is that of the steward. Jesus used the concept to develop the theme of faithfulness and accountability in some of his parables (Luke 12: 42- 48). Paul wrote that an overseer "as God's steward, must be blameless, must not be arrogant or quick-tempered or addicted to wine or violent or greedy for gain" (1 Timothy 3: 2-3). Gunderson (1997: 16) says that discipline and direction are the twin components of effective leadership. Power in the service of vision serves as a discipline against disorder as well as a direction for the disorganised. Townsend (2001: 11) agrees that it is only the theology of service which will help overcome stigma and discrimination, which will work towards the empowerment of women and involve people living with the virus in the fight and create a community of the people of God where truth, freedom, justice and peace will be the underpinning values.

Moses exercised servant leadership when he responded to God's call and brought the vision of liberation from bondage and entrance into a 'Promised Land' to his people in Egypt. The story of their forty years of wandering in the wilderness before they actually entered into the land under Joshua's leadership is a case study in servant leadership using power to discipline and give direction. Confronted with disorder that threatened the very existence of the people, Moses exercised discipline after first becoming their advocate⁵⁶.

When the people turned away from God to worship the golden calf, Moses made intervention on their behalf directly to God (*Exodus* 32: 11-14). Having earned the right to be their leader by risking his own standing with God on their behalf, Moses confronted their disorder and

⁵⁶ The story is well told in the book of Exodus 30 – 32.

brought them under discipline. When Moses saw that the people were running wild (for Aaron had let them run wild, to the derision of their enemies), then Moses stood in the gate of the camp, and said, ‘Who is on the Lord’s side? Come to me!

With the power to discipline came the power to lead through directing the people back toward the Promised Land in fulfilment of the vision. Though in the end he himself was not allowed to enter due to his own disobedience, he nonetheless led the people to the very threshold of the land before turning the leadership over to Joshua.

Power in the service of vision ushers in a strategy that unites the wisdom of God with the work of God in order that the purpose of God finally may be accomplished.

The wisdom of God provides the common sense of leadership. God’s wisdom is not mysterious. Rather, it enables the leader to censor outrageous idealism and sense the wisdom of working with God on behalf of the people. A clearly defined mission that the people of God seize as their own task leads to singleness of purpose. Effective servant leadership means directing and co-ordinating the energies and resources and the people of God, this is being a ‘faithful steward’ of God’s vision.

Anderson (1997: 202) puts more succinctly the qualities that a servant leader who can be trusted with power would have when he says:

The servant leader will be able to articulate more clearly than anyone else the vision of the people of God as a contemporary interpretation of its mission. The servant leader will be more closely aligned with the promise that leads to the will of God than anyone else, and will factor that promise into the planning process. The servant leader will lead others who are responsible for implementing the planning process into full disclosure of the promise, vision and goals that he/she holds to be essential to the planning process. The servant leader will exercise power by empowering others to see the vision, work the plan and reap the benefits and blessings of doing God’s will. The servant leader, more than anyone else will be an advocate for those who stumble and fall through their own failure or who are wounded by others through the process.

3.10.4 The challenge of change

Castells (2000: 1) suggests that the turn of the millennium is thought to be a time of change. However, in line with our focus in this work HIV has brought change which sometimes is not easy to grapple with. Roxburgh and Regele, (2000: 32) suggests that change is manageable when it occurs developmentally or incrementally within established frameworks. Significant

change creates a crisis within systems and their leaders when it becomes disconnected from the assumed roles and expectations of the system.

There is a need however for a leadership that can cope with the challenge of change itself. HIV is moving congregations to change the way they relate to other fellow human beings. Change is a complicated process; at the heart of which lie people and their natural resistance to change. Kotter (1999: 15) agrees that the change process poses challenges to any organisation and their leaders. As seen in Chapter 1, the pandemic of HIV has brought about significant change in the way people do business and go about their lives. The Kenya Episcopal Conference (2002) *Trainers' Manual* affirms that HIV has permeated through every aspect of life affecting all human beings from all walks of life. Roxburgh and Regele (2000: 48-50) warns that when the pace of change in the environment outstrips the pace of change inside the Church organisation, the organisation will run into problems. If Church organisations do not align their visions with the environment or adapt their missions, goals, strategies, structures, and organisational cultures to change, they will fail. In addition, if leaders do not sense the need for change and do not look beyond the boundaries of their 'comfort zones', they will lead their organisations to failure.

Dealing with change is one of the most difficult challenges facing leadership. Magretta and others (1999: 99) say that understanding when and how to change is a vital function of leadership in today's fast changing world. What further complicates the aspect of dealing with change is that because change is unexpected, and most of it new, leaders do not necessarily have any guidelines on how to deal with the situation. Precisely because religious leaders have not had any guidelines on how to deal with the situation brought about by the HIV pandemic, there have taken place many seminars, workshops, conferences, consultations and all manner of meetings. All these in an effort to try and help each other on how to effectively respond to the scourge which has brought about so many deaths of especially many promising young people. The statements from such forums are a clear indication of the desire to want to effectively respond to the challenge of change but to also emphasise that the change process is difficult. The birth of ZINGO (Chapter 2) in Zambia also goes to show how the Zambian Churches have tried to respond to the challenge of change brought about by HIV though as indicated above, this response has not effectively reached the congregation level where it is needed most except in a few isolated cases.

There will be need in time of change to improve on skills that are sometimes called ‘change leadership skills’. These skills are adapted from D’Souza, (1999: 398–408).

‘Change leadership skills’ include (this once again fits in very well with the practical theology methodology which is the basis of this study, as indicated in Chapter 1).

Diagnostic skills – This means the ability to analyse existing situations, and the effectiveness of current resources and services. These skills form the basis of sound planning for change and development. It is not easy to maintain a balance between confidence in what is now being done and a healthy dissatisfaction that seeks something better⁵⁷. Analytical skills need tools of research and often require group problem-solving methods. There is greater need in this new HIV scenario for the ministry to work with smaller groups within local churches who can use their own analysis of the situation - and what can be done about it to make a difference. The methodology that is pursued reminds one that *the members of the faith community are involved in a vocationally based, critical and constructive interpretation of their present reality.*

Planning Skills - Planning skills involve setting new goals, innovation and creativity, developing alternatives, and the use of choices. Leaders must determine the resistance, the degree or readiness to change, and the resources available for overcoming resistance. *This is a critical correlational hermeneutic.*

Motivating Skills - Motivation involves both stimulating and supporting. Leaders must constantly keep new possibilities, goals and values in sight. At the same time they must constantly stimulate people to achieve them or they become complacent with the accustomed ways of doing things. This results in a mediocrity of services. Excessive negative criticism undermines morale. People need a sense of accomplishment and approval. *They should want to be a sign of God’s Kingdom on earth while moving forward with an eschatological faith based reality view.*

Implementation Skills - Executing plans depends on the ability to secure needed new resources as well as skilful timing, assigning responsibilities and necessary re-training. Carrying out plans often requires periods of experimentation and open-mindedness toward

⁵⁷Churches and Christian organisations are better known for not easily responding to new changes as they usually consider the way they have been doing ministry for the many past years as the ‘gospel truth’ and responding differently would be like departing from the ‘truth once entrusted to the saints’.

revising, altering, and discarding parts of original plans. Change leaders also need to build up the morale of people as they practise and become acquainted with the change, understand the effects of stress on the beliefs, values and action of the affected people and decide on the action before pausing to assess the process and progress. *While obediently participating in transformative action at different levels that theology leads to a strategy and implementation.*

Evaluation Skills - Evaluation, closely related to diagnostic skills, forms the basis for the stabilisation of the new process. Change leaders also need to develop appreciation for the work done and to mobilise general support for changes already made. This ensures continuity and consistence. *That theology goes beyond strategy and implementation to include evaluation of progress. Practical theology has a praxis methodology.*

3.11 Conclusion

This chapter has dealt with the first hypothesis, namely that the problem before us is that the Churches in Zambia do not have an effective strategy in place that addresses the issue of HIV in a holistic way on a congregational level where it effectively can reach and influence members. A committed leadership is needed to advance this cause. Committed leadership need to facilitate an effective strategy that will influence the desired change towards a holistic approach. It should be a praxis oriented process that will lead towards a theology of community which produces truth, peace, freedom and justice.

There are many challenges that face Church leadership in Zambia. For the purpose of this study however, the researcher has dealt with some of those which are pertinent to the Zambian context. In this case, he has shown how Church leadership is critical in removing silence, stigma and discrimination, gender bias – the sin of patriarchy, the need to influence the total involvement of men in preventive measures as well as community mobilisation. Religious leadership in Zambia cannot continue to ignore and stigmatise the usage of condoms when it stands for life in fullness. These challenges pose as hindrances for the fullness of life amongst God's people.

Leadership is one of the most important functions for activating the process of mobilising for change. It is defined as influencing and directing individuals and group behaviour to enable them to pursue the goals of an organisation. The researcher has examined four theoretical models, based respectively on the characteristics of leaders, the behaviour of leaders and situations in which leaders and followers function. As this discussion on the foundations of

leadership has shown, there is no doubt that it is a complex concept. A variety of models have been researched and developed and a Christian leader who wants to contribute to the reign of God, will seek the servant leadership model especially in this time of HIV. There is much that can be learnt from the charismatic, Afro-centric and transformational leadership styles, which is appropriate in this time of HIV.

The researcher has shown that the Church needs leaders who are sensitive to the purpose of God amongst his people. There is a need for leaders who have a responsibility to God and to his people – the apostolic faith community. God’s plan in building His Kingdom requires fully developed leaders ready to assume challenges in the area of HIV.

Since Churches in Zambia do not have an effective strategy in place that address the issue of HIV in a holistic way at a congregational level where it effectively reaches and influences members, the researcher has shown that it is a committed leadership which will facilitate that effective strategy and influence the desired change of a holistic approach. This leadership should empower the congregation to grow towards spiritual maturity. This leadership should build congregations to become an oasis of healing.

This will lead to a point when there is proper leadership, infection rates will be reduced, the pandemic will be controlled and communities will experience total healing. This healing will be through care and support that HIV positive people will find through the Circles of Hope support groups. As the above mentioned challenges have already been considered, the next chapter pre-supposes that once there is good leadership, it will help to create an agenda for a theology of HIV. Chapter 4 will thus look at the theological basis for creating the concept of Circles of Hope.

CHAPTER FOUR

THEOLOGICAL BASIS FOR THE CIRCLES OF HOPE SUPPORT GROUPS

4.1 Introduction

De Gruchy (2006: 2) says that HIV and AIDS is for African theology what Auschwitz and Hiroshima were for North Atlantic theology. In Chapter 1, the researcher argued that the Church in Zambia is challenged by the pandemic of HIV. God the creator is concerned about the current situation because it has touched his image in the creation. By its very nature and mission, the Church, the apostolic faith community, cannot ignore the call to fight the stigma, prejudice and oppression associated with the pandemic. This chapter will then look at the scope of developing a relevant theology for HIV. The chapter suggests that the involvement of people living positively with the virus is critical in order to have a theology which is devoid of traits of fundamentalism. For this kind of encounter, a Trinitarian and biblically based theology is needed that promotes truth, freedom, justice, peace and community as it relates to overcoming HIV stigma. Such a praxis based theology will emerge when the laity and HIV positive people are participating in theological reflection. Doing this kind of theology is direly needed in a time of HIV.

4.2 A relevant theology in a time of HIV

From the information in Chapter 2 and the challenges sketched out in Chapter 3 the researcher has shown how this body of Christ, the Churches in Zambia, have thus far responded to HIV. Some of the challenges are addressing stigmatisation, involvement of HIV positive people, empowering women, involving men and developing leadership that will deal with these issues. Hypothesis 1 has already been proved to be correct. It is very clear that the Zambian Churches do not have an effective strategy in place that addresses the issue of HIV in a holistic way at a congregational level where it can effectively reach and influence members. In order to have an effective strategy, this chapter then contends that, according to Hypothesis 2, a missional theology which promotes the praxis of the creation of Circles of Hope at a congregational level is a basic presupposition for a holistic approach to combat HIV. The essence of theology as Hendriks (2004: 24) puts it is to know God, to discern his

will and guidance for the way the Church should live and witness even in this time of HIV. Theology is faith seeking understanding, even for such a time as this. God is a trinity and missional and, as such, mission is an extension or amplification of God's very being. Human beings were created in the image of God (*Genesis* 1: 26-28) and the Church must be his body. Christ is the abiding head of this body and at the same time the one who, by the presence of the Spirit, gives life to it (*WCC Study* no 181, 1998: 13). The faith community, then, cannot really understand God in a personal way without participating in his missional praxis. What then is missional theology?

4.3 Redefining mission theology in the context of HIV

Bosch (1991: 389) has observed that during the past century or so there has been a subtle but nevertheless decisive shift toward understanding mission as God's mission. During preceding centuries "mission" was understood in a variety of ways. Sometimes it was interpreted primarily in soteriological terms: as saving individuals from eternal damnation. In other cases it was understood in cultural terms as introducing people from the east and the south to the blessings and privileges of the Christian West. On the other hand, it was perceived in ecclesiastical categories as the expansion of the Church or of a specific denomination. Sometimes it was defined "salvation" - historically: as the process by which the world (evolutionary or by means of cataclysmic event) - would be transformed into the kingdom of God. In all these instances, and in various (frequent conflicting) ways, the intrinsic interrelationships between Christology, soteriology, and the doctrine of the trinity so important for the early theologians, was gradually displaced by one of several versions of the doctrine of grace. "Mission" therefore is an activity of God-self. It is not primarily an activity of the Church but an attribute of God. God is a missionary God. Guder (1998: 4) calls the change in the understanding of "mission" to have moved to a theocentric reconceptualisation of Christian mission. This is the hermeneutic of this study. Guder (1998:4) goes on to say that:

'we have come to see that mission is not merely an activity of the Church. Rather mission is the result of God's initiative, rooted in God's purposes to restore and heal creation. 'Mission' means 'sending' and it is the central biblical theme describing the purpose of God's action in human history.'

Circles of Hope support groups can be viewed as an instrument of God to restore the brokenness of humanity brought about by HIV and bring healing. These faith groups are a concrete form of the Church as a witness of God's good news in Jesus Christ in the context of

despair brought about by HIV. The biblical message is more inclusive and more transforming and therefore has no room for stigmatisation due to HIV infection. Guder (1998: 5) says that God's mission embraces all of creation, God so loved the world is the emphasis of the John 3:16. At this juncture it is befitting to note the full text in summary of how Guder (1998: 11-12) concludes the meaning of the term *missional* as it encapsulates the basic hermeneutic of this study. It emphasises the essential nature and vocation of the church and as such a missional ecclesiology is biblical, historical, contextual eschatological and has to be practiced.

McDonagh (1994: 19) has written that theology or theological reflection is always done in time and the narrative character of theology underlines this fact. For that reason, theologies as a human enterprise are developed in the rhythms of time and not out of or before and beyond time. There is no theology outside the relationship with God as only those whose lives are drawn into the orbit of God's praxis can truly understand (Newbigin, 1987: 60 as cited in Hendriks, 2004: 31), human existence and cosmos. Hendriks (2004: 27) says that in the wilderness the manna was a meal for one day. In much the same way, theology has a contextual nature. Maluleke (2001: 136) argues that a theology of AIDS must penetrate the thick and complex veil of things private and public in human cultures. It is in these realms that AIDS thrives. He furthermore contends that this kind of theology cannot be built upon the foundations of ignorance about HIV any more than it can be built on theological illiteracy. In every situation, faith seeks to comprehend what the living God requires of his people. The apparently reasonable theological reflection hinges on the kaleidoscopic nature of time, which remains a mystery to all, just as it was to Augustine, John Calvin, John Mbiti, Kwame Bediako, and many other theologians.

Biblical words for 'time' are many, and are not in themselves a sound basis for reflection. These must be gathered from the contexts in which the words are used. Hebrew has a couple of words for time: *moed* and *iddam* both mean an appointed time and season (Armstrong, 1982: 988). On the other hand, the Greek has many words for 'time'. For the purpose of this study, the researcher shall only look at *chronos* and *kairos* respectively.

Chronos means the computing of time and a list or table of events showing their sequence in time (Deist, 1987: 44). A period of time, a long time, a longer time, considerable time, the whole time, all the time, at every time, for a time, for a while, in time, the time for the fulfilment of the promise, the time when the star appeared (Arndt and Gingrich, 1952: 896).

The word *chronos* sometimes refers in the New Testament, as in secular Greek, simply to the passing of time (Luke 20:9: Acts 14:28). *Kairos* means the appointed time or the time of the establishment of God's Kingdom on earth (Deist, 1987: 136) or according to Mills (http://www.jubileecentre.org/online_documents/brieftheologyoftimepart2.htm) a fixed time or season.

4.4 About time

The two words are helpful in distinguishing time as both objective and subjective respectively. Time is measurable like clock time, and on the other hand time is identified as subjectively which is significant for a person or the community. *Kairos* is in that sense stored time. In both Jewish and Christian vocabulary *kairos* indicates time as an event of divine movement for human response, like the prophets and Jesus' announcement of the reign of God (Mathew 3: 1-4). This *kairos* was the time of God's special presence and summons. However, as Douglas (1996: 1119) says in the New Testament *kairos* often occurs in similar contexts, though it does not in itself mean a decisive moment. Referring to a group of South African theologians who wrote the *Kairos Document* - a theological comment on the Apartheid state, Maluleke (2001: 130) observed that the writers explained *kairos* in terms of 'crisis', 'moment of truth', 'moment of grace' and 'opportunity' and a 'dangerous time'. All these definitions of *kairos* fit the challenges posed by the HIV pandemic. The HIV pandemic does seriously present us with a critical and dangerous time, a moment of truth as well as a moment of grace and opportunity.

When liberation theology was first officially sanctioned, Bosch (1991: 444) quotes from Gutiérrez in words so appropriate to define what *kairos* means, that although the text did not refer to a context of HIV, it aptly applies to it too:

Latin America is obviously under the sign of transformation. It appears to be a time of zeal for full emancipation of liberation from every form of servitude, of personal maturity and collective integration. We cannot fail to see in this gigantic effort toward a rapid transformation and development an obvious sign of the Spirit who leads the history of humankind and of the peoples toward their vocation. We can not but discover in this force, daily more insistent and impatient for transformation, vestiges of the image of God in human nature as a powerful incentive.

These two 'terms', *chronos* and *kairos*, are distinguished but not separated. The time-laden character of theology involves both times. Therefore, change in theology, as in every human event, is linked to the ticking clock, even in biological form. The significance of that change

is related to human subjects and their capacity to read the signs of the times. This is the reason why Hendriks (2004: 30) says theology is about discernment. He puts it in this way:

The solution to faith communities' questions about how to participate in God's missional praxis is a critical, constructive dialogue or correlation between their interpretations of the realities of the global and local context and the faith resources at their disposal. On one hand the discernment process is rational and on the other, it is a mystery.

Therefore, theological reflections on HIV take place in a chronological time-span, since the first diagnosis of AIDS in 1981 and the subsequent development of the global pandemic demands more attention. One can therefore safely agree with Louw (1999: 97) that the task of practical theology is hermeneutical and that this process involves the interpretation of the meaning of the interaction between God and humanity, the edification of the faith community and becoming engaged in praxis through communities of faith in order to transform the world or to impart meaning in life. The researcher does this reflection, therefore, so that the Zambian faith community which has been hit hard by HIV may find an alternative transformative paradigm and praxis for the way forward. This alternative is according to Maluleke (2001: 137) a theology that will build individual as well as community character. This demands some serious theological reflection.

4.5 In need of serious theological reflection

Once again, as indicated above in the words of Maluleke (2001: 129): "The HIV/AIDS pandemic constitutes a new *kairos* for the Church in (Southern) Africa". The lack of serious theological reflections in a time of HIV is certainly a tragedy that has bothered the Church in the last two decades. However, why pick out HIV as a subject of theological significance? Why not cholera or tuberculosis or indeed malaria which are all big killer diseases? There was a *kairos* time when liberation theology addressed political independence from colonial masters or black theology in a *kairos* time of oppression or anti-apartheid theology in a time of racial discrimination in South Africa. Nicolson (1995: 7) argues that when it comes to the question of the challenge of HIV, theologians have been slow and silent and...churches have been quiet too. While short journalistic articles on AIDS in Africa - often superficial if not misguided - abound in magazines and newspapers, very few in depth theological treatises and books on this issue exist. Nicolson (1995: 8) painted this picture:

It is very important that a theology of AIDS should be developed which arises out of our own context. There has not yet been nearly enough theological attention given to AIDS in South Africa. There have

been three articles in the *Journal of Theology for Southern Africa* (Louw, 1990, Saayman, 1992, Wittenberg, 1994) one in *Missionalia* (Saayman & Kriel, 1991); one in *Theological Evangelical* (Saayman, 1991) and one in *Koers* (Miller, 1990)... only one book about a theology of AIDS has been published in South Africa (Saayman and Kriel, 1991).

The Zambian situation, of course, is much worse because, as revealed by the researcher, the visits to the umbrella Christian bodies indicated an absence of published written material even on the very existence of HIV programmes.

From the time immemorial the prophets of Israel, Jesus himself, and great religious thinkers and theologians from Augustine to Barth have sought to respond to the crises of their times as a particular call from God. It is perhaps only a recent fashion to name the crisis and bracket theology with it, as a "Theology for a Nuclear Age". The tradition of addressing fresh human crises theologically or in a reflective religious way is much longer and stronger. Bouma (1992: 148-149) reflects:

Theology is produced as people of faith reflect on the ways they have experienced God in their lives. Theology, all theology, presupposes faith. All theology also presupposes that the person doing theological reflection has had experiences in this life with God.

It is important at this stage to underline that such a theology will be a relevant theology.

4.6 Relevant HIV theology

Weatherford and Carole (1999: 37) suggest that as a global crisis, HIV compels the Church to re-examine its theology and redefine its doctrines. The community of faith should therefore follow Jesus in seeking to proclaim and promote the reign of God in the world for the healing and transformation of the world, by acting in imitation of Jesus' sharing, heart and mind. Sandford (1992: 721) says:

Jesus can be our example. He is not some celestial superstar, but one who has lived where we live. We can therefore look to him as one model of the Christian life. The biblical standards for human behaviour, which seems to us to be so hard to attain are seen in him to be within human possibility. Of course there must be full dependence upon the grace of God.

This is part of discerning the will of God for this time of HIV. The reading and re-reading of that mind and its thoughtful application to the needy and excluded of a particular time form a part of the permanent theological task called Practical Theology. It is a task that must be approached thoughtfully using the resources of God-given minds after the fashion of

Augustine, Calvin, Barth and all the other great Christian thinkers. Indeed using scripture and tradition (Holcomb, 2006: 2-4). It can never treat the mind in separation from the heart and action but it must be true to its gifts and limitations. Viladesau and Massa (1991: 243), in referring to Thomas a Kempis, say that over the millennia, Christian, Jewish and indeed pagan minds have contributed powerfully to elucidating how Christians might act individually and socially in imitation of Christ. The more systematic attempts to do this have appeared in different if related theologies, which were distinguished as Christian ethics (White, 1994: 121) or as the Roman Catholics like to call it, moral theology (Curran 1999: 32). This is similar to what Louw (1998: 21-123) has called *A pastoral hermeneutics of care and encounter*. It has never been an entirely satisfactory distinction, particularly when it hardened into sharp division. It was a distinction unknown to Augustine and other very early thinkers. Here the focus is on a systematic outline of Christian living according to the mind of Christ without losing touch with the biblical narratives and tradition. Such a theology will involve the laity.

4.7 Involve laity in doing theology

Theology is also a community activity for both experts and laypersons; it grows out of life together of people of faith. It grows as people share together their lives and the interpretation of events that surround them in the light of faith. Louw (1999: 94) confirms this when he states:

The contextual approach describes and analyses the real situation in order to design action strategies, which in turn could change the social milieu or radically transform the political situation.

From the seventeenth century, particularly the nineteenth and early twentieth centuries, in more intellectually or theologically oriented parts of the Christian Church, systematic theologies became popular in a quest for a new kind of intellectual certainty: orthodoxy. This is well explained and described by Peter Berger (1969) in *Sacred Canopy*. Orthodoxy has led to a denigration of the people's theology and a loss of the awareness of the social process involved in the origins and production of all kinds of meaning, including thinking about God. As a result, the Church has looked increasingly to expert theologians to formulate and express theology. This had led to an increasing gap between the academic theologies of the seminaries and the theologies found among those in the pews. This implies that theology can not be an abstract academic discipline apart from a faith community's life and struggle to discern God's ongoing praxis (Hendriks, 2004: 31). Most pastors are blissfully unaware of

either, living in a theological world of their own creation. The theology of experts is precisely that: a theology of experts. Here the concern is to do theology which is about transformative action. According to Hendriks (2004: 33):

Theology tries to discern present and past realities hermeneutically in order to discern God's will, so as to participate, vocationally, in his ongoing praxis towards an anticipated future eschatological reality. The active, reflective spiral leads to a new formulation of the truth and values that may be expressed systematically in new theological creeds but above all in the life and witness of the Church. As such, aspects of the eschatological future are now realised, creating joy and hope.

Interest in people's theology or theology of the pew is likely to enjoy resurgence at this time as more and more Zambian Christians have been educated to a degree where they have legitimate confidence in the value of their own ideas and critical reflection of interpreting the scriptures. Many smaller faith communities are also getting more interested in doing Bible studies where they reflect on issues that affect them in society. The Circles of Hope support groups have provided space for HIV positive Christians to do bible study from the context of being HIV infected. Hendriks (2004: 28) states: "...it is important to develop an inductive methodology (*of doing theology*) - a methodology 'from the bottom up'".

The theological 'giants' of yesteryear were giants in comparison with a less well educated laity. Today theological expertise is much more widely spread throughout the Christian community. The result is likely to be a fresh look at many aspects of Christian faith, life and worship, as people from widely differing backgrounds reflect on the meaning of God in their lives. The fresh insights coming from women theologians and others are only some examples of the creative theological processes at work. Phiri (2004: 136) says:

African women theologians are saying that if we do not deal with gender and HIV, the world will not make a difference in combating the virus. As women of faith, the members of the Circle of Concerned African Women Theologians have covenanted to continue in solidarity seeking ways to transform our faith communities to talk about HIV/AIDS and empower women to stop their own death. The mission of the Circle is to research, write and publish theological literature by African women that is based on our experiences of African issues with a special focus on religion and culture.

From the experience of these women of the Circles, the churches should struggle to discern God's will for their present situation (Hendriks, 2004: 24). Theology is and always has been the living product of communities of faith wrestling with the meaning of their faith in the face of the ambiguities of life. HIV is an ambiguity of life seeking deeper theological reflection.

As Martey (1993: 36) says, analysis of the African context must begin with African reality - reality which is to be located in time and space. In this process the faith journeys of other people and communities, both those who have gone before and those journeys that are contemporary are extremely helpful. Tukunboh (1978: 1) talks about the five cycles of the Church's growth as we shall see below. As witnesses to the faith we are following the examples of the struggles and tentative solutions of others before us who have believed and trusted in the God of Jesus Christ, the Son of Mary. According to Bouma (1992: 150-152) it is true that theology as produced by or rather within the Church has always emerged from a crucible and heated interactions of various views. These views have played against each other, resulting at times in compromise or in new formulations or in the inclusion of a variety of interpretations. This vitality of the process is sometimes overlooked in the study of systematic theology, much of which seems to be written in such a way as to suggest that it is beyond controversy, above heated argument, and that no genuine difference of opinion is possible.

Adams (1981: 193-205) argues that contemporary theology is characterized by four basic methodologies: systematic theology with its concern for the dogmatic task; philosophical theology with an emphasis upon the apologetic task; political theology with its stress upon the ethical task; and contextual theology with its focus upon the hermeneutical task. Each of these methodologies is operationalised by a number of models. For concern in this section of the study, the researcher is dealing with what Adams terms as the 'third-eye' theology model of CS Song (contextual theology). Tukunboh (1978: 1-4) goes on to state:

Speaking generally, the church usually undergoes five cycles of growth in theological formulation: 1) the evangelistic or *kerygmatic* stage wherein after the Word has been proclaimed and conversions made, the first fruits are gathered in for worship and constituted as cultic community. 2) Next, these converts are taken through the various catechetical schools for teaching and indoctrination. 3) As the teaching is done, efforts are made to put the literature in local languages (i.e., paraphrase). Commonly, this takes poetic form to aid memorization and dissemination. 4) With growth comes a myriad of problems both from within and without. At this stage, apologists arise to write a defence of the faith and steadily contend it. 5) The final stage deals with putting together the beliefs and teaching of the church in systematic form. This credo stage may take various patterns including dogmatic theology, systematic theology, historical theology, etc.

Sometimes theology is born out of confrontation, consultation and resolution. Tukunboh (1978: 4) concludes by saying that the churches in Africa, find themselves still struggling to

stand at the third base (i.e., the poetic stage), and simultaneously are stretching to reach both the fourth and the fifth base. This study argues that it is possible when the local faith communities are engaged in constructing local theologies to reach the fourth and fifth stage. This concurs well with the argument that this work is practical theology in nature and, as seen in Chapter 1, at an ecclesiastical level: the study is within the faith community. The body of Christ, a missional Church that acts in worship, witness, help, service, fellowship and planning. At the level of secular society, the Church also has an important role to play. It faces the public and should influence it in a positive way (Hendriks, 2004: 33).

In the process of producing living theology of HIV that is authentically related to people's lives, therefore, there are no experts. There are those who have more awareness of the theologies of other communities. There are others who are more knowledgeable about the Bible and the contexts that have shaped the expressions of faith. Robinson (1996: 60) says that a missionary encounter with our culture needs a 'declericalized' theology. In other words, we need a properly developed lay theology. Developments in scholarly studies of the Bible took the Bible out of the hands of the layperson. The Bible has now become the professional property not of the priesthood and the congregation but of the scholars. The missionary encounter with the culture of the day, says Newbigin (1987: 4), requires the energetic fostering of a declericalized, lay theology. He then refers to the project started by Willem Visser't Hooft, Hendrik Kraemer and Suzanne de Dietrich at the Ecumenical Institute at Bossey where lay people from all over the world and from all walks of life have caught a glimpse of a lay theology.

Opportunities should be created for lay people to be prepared and equipped to think out the relationship of their faith to their daily work. This is where the real missionary encounter takes place. It is in such dynamics of pondering that value of theology may be found. The community of faith is the place where theology emerges, as the people of faith share in the community their experiences of God, humanity and creation. Their reflections on those experiences produce living theology. According to Stuart (1998: 151) the focus of this method is in praxis: Mission is understood here as the ongoing praxis of the church. Missiological method should be a reflection on praxis which provides direction for praxis. So how does this assist in the quest for an HIV-relevant theology? Two basic principles emerge. First, it is those who live the life whose reflections are the primary, not the only, but the primary basis for the emergence of a theology relevant to that life. If you seek a theology of

black Christians under the system of Apartheid in South Africa, listen to the black Christians who lived under that system. If you want a theology of every day life, live and encounter people and their daily experiences within their context. If one wants a theology of family and marriage one has to ask those who are involved in the issues of family and marriage.

More to the point, if the Church seeks a theology of HIV, it needs to listen to those who are living with HIV, those who provide care, as well as their friends and families. Indeed those who are closest to the virus are the ones to develop a praxis theology of HIV. This means that those suffering from HIV cannot be driven away from the Church, if they are the resources required to do the task of theological reflection. As observed by the UNAIDS Windhoek meeting of 2003, the role needs to be explored at the level of theological education, so that clergy and lay leaders go into local congregations with some understanding of the dynamics of accompanying stigmatised and suffering people, of praying with them and their families, of standing and waiting alongside them and of loving them into hope. This is a unique contribution of the Circles of Hope support groups. Furthermore, addressing the stigmatisation of people living with HIV is the church's best possible strategy for changing attitudes and removing fear. The experience of living with HIV raises profound questions about the meaning of suffering and the nature of God and in sharing these insights, the spirituality of the whole worshipping community may be enriched. People living with HIV have commented that the liturgies and rituals of the church have been a great source of strength, particularly when they are combined with the support of the worshipping community. This was well put in: *Panama Declaration of the International Community of Women Living with HIV/AIDS* (2006 at <http://www.icw.org/>) when they said, 'nothing for us without us'. This is where members of this community of people of God, created in the image of God, are involved in a vocationally based critical and constructive interpretation of their present reality of living positively with the HIV-virus. If they are excluded, the richness of God's love and grace is denied not only to them, but also to the rest of the apostolic faith community, which as a result of their loss will be unrepresentative, fragmented, less whole and diminished (Byamugisha, 2002: 23-25). Steinitz (1997: 30) says there is no shame in being HIV-positive, there is however shame in deliberately exposing another person to contracting HIV. What follows then is an attempt to sketch what may be involved in an appropriate de-stigmatising theological reflection in Zambia in a time of HIV. One of the options is that it will be derived from the biblical and theological model for Circles of Hope but needs to watch out for fundamentalist views.

4.8 Watching out for fundamentalist views in setting an agenda for a HIV relevant theology

Fundamentalism has undoubtedly become an evocative symbol for the eighties. The term according to Caplan (1985: 18) is said to date from 1920 when the editor of a prominent Baptist paper, alarmed at what he saw as the 'havoc' wrought by rationalism and worldliness in American Protestantism, coined the expression and defined fundamentalist as those ready to do battle royal for the fundamentals of Protestantism (Marsden, 2006: 159). Marsden talks of Niebur who latter called it an aggressive conservative movement in the protestant churches of the USA. Nowadays Caplan (1985: 18) says the term is not so narrowly construed. It may denote, among other things; the rise of the new religious rights in the USA and the spread of schismatic protestant organisations both in the west and the developing world.

A model for the specific body of orthodox belief of Christian fundamentalists was proposed by Barr (1977). In his influential study, *Fundamentalism*, Barr (1977: 1-4) identifies four basic fundamentalist characteristics paraphrased as inerrancy of scripture, individual salvation, personal witness to belief, abstracted from social context and invalidity of hermeneutic exegesis of scripture. Barr's study of Christian fundamentalism has served as a model for the study of fundamentalist orthodoxies outside of Christian tradition and is widely acknowledged in contemporary studies. Gifford (1988: 1-10) sees most of the traits of Christian fundamentalism in Africa as mainly expressed through a Pentecostal ideology and argues that the continent needs something structural and something immediate.

Antoun (2001: 3) has defined fundamentalism as a trans-national religious phenomenon that has entered many domains of culture and social organisation with startling consequences for individual, the intimate social group and even the nation state. Antoun (2001: 2) goes on to say that fundamentalism is much broader phenomenon as an orientation to the modern world, both cognitive and emotional, that focuses on protests and change and on certain consuming themes: the quest for purity, the search for authenticity, totalism and activism. There are several manifestations of fundamentalism and Antoun (2001: 2) he mentions four of them, namely **totalism**, a religious orientation that views religion as relevant to all important domains of culture and society including politics, the family, the marketplace, education and law; **scripturalism**, which is the justification and reference of all important beliefs and acts

to a sacred scripture held to be inerrant, selective **modernisation**⁵⁸ which is the process of selective and controlled acceptance of technological and social organisational innovations introduced by the modern world; and finally, **traditioning** which is the process of making scriptural accounts, events and images relevant to present day to day activities.

Brouwer, Gifford and Rose (1996: 14) states that fundamentalism also reveals itself when certain Americans believe, unlike the citizens of other advanced industrialised countries that once tried to imbue colonies with their special cultures that other peoples of the globe can and ought to be **made over to their image**. Fundamentalist Christian Americanism pushes this globalisation and simplification of culture more intensely on the religious plane because its believers have more than something to sell. They have a particular biblical truth to share and billions of unsaved souls to rescue. The Pentecostal theological framework tends to support this new fundamentalism driven by Americanism. Their identity is known as they define their enemies: it is anti-Islamic, anti-communist, anti-Catholic and anti-feminist.

This study is not about the subject of fundamentalism and therefore it will suffice for the purpose to indicate the following argument in developing an HIV theology which is sensitive to local realities.

As seen briefly above, in this time and age no longer is a single system of theology the answer. A rich diversity of theologies, not always resolvable into a single coherent system, is emerging as the experience of the one God is refracted through the diversity of human experiences and cultures⁵⁹. In Hendriks's (2004: 310) words, it is about doing theology ecumenically:

Faith communities link with and are influenced by past and present faith communities, which lead to diversity and unity. The diversity is *because* there are and have been many local faith communities all over the world. They find their unity in their communion with God. Therefore, *theologising* should take

⁵⁸In the second volume of Manuel Castell's trilogy: *The information Age: Economy, Society, and Culture* he deals with the social, political and cultural dynamics associated with the technological transformation of human societies and with the globalisation of the economy, but in that same book he also talks of the horror that made New York's twin towers into Ground Zero, murdering 3,000 people and shattering the lives of countless others, as having surged from the depth of the world's untreated contradictions. The magnitude of the event, arguably ushering in a new public consciousness, obscures an understanding of it. He describes the characterisation of the goals and values of al-Qaeda in its own discourse as this self definition of what attracts its followers and provides meaning for them giving rise to another level of fundamentalism.

⁵⁹A single system of theology would be possible only if we lived in a single culture, spoke a single language, lived in the same society and had essentially the same social background. We do not!

place with a realisation of this unity and of being one family sharing a common vocation and destiny. This is the ecumenical *dimension of doing theology*.

Robinson (2004) says: “We need the witness of the whole ecumenical family if we are to be authentic witnesses of Christ to our own culture”

(<http://academic.sun.ac.za/buvton/Vennote/Robinson.htm>). The portraits of Jesus painted in different cultures make it vividly clear how much our vision of Jesus is shaped by our culture. Newbigin (1989: 70) then concludes: “The fact that Jesus is much more than, much greater than our culture-bound vision of him can only come home to us through the witness of those who see him with other eyes”.

This fact is very disconcerting to those who seek single and simple answers to complex issues, and who insist that the Church take only one universal position. These are some times said to hold a fundamentalist view. Fundamentalism, even in dealing with HIV, can make it extremely difficult for church organisations to get along with one another peacefully in practice. Du Toit (2003) indicates that this problem manifests itself in various ways, e.g.:

Fundamentalism often makes constructive dialogue about theology amongst Christians impossible – people argue according to different premises, they do not hear or understand one another, and they are only interested in discourse as long as it offers them the opportunity to convince other parties of their own point of view.

Fundamentalism threatens the integrity of Christianity and individual leaders when people who seemingly adhere to the same basic religion, demonstrate division and are intolerant of one another.

Fundamentalism at its most extreme is a threat to peace in Zambia⁶⁰ (as it is elsewhere in the world), particularly when religious groups become fanatic about their beliefs and are prepared to progress to public protest and resistance; Fundamentalism was (and still is) the cause of most of the (religious) wars in the history of humankind – when fanaticism progresses to violent struggle to defend and protect the truth (http://academic.sun.ac.za/buvton/vennote/Ben_du_Toit_artikel_fundamentalism.htm).

⁶⁰It is worth noting that what could have been a force to reckon with on the religious front in the fight against HIV in Zambia has recently suffered because of fundamentalist tendencies. The three umbrella Church mother bodies mentioned in this text allowed the creation of an arm called the Expanded Church Response (ECR). The purpose was to galvanise a strong network of all Christian denominations including those that were not affiliated to the traditional mother bodies in their fight against. Unfortunately one arm of the Christian family kept insisting that they would not work with people of other faiths namely Muslims, Hindus and Bahais. This situation began to polarise and demonise people instead of focusing on fighting the common enemy - HIV. They did not begin to protest or become fanatic, but efforts of cooperation began to diminish. The leadership of the CCZ, EFZ and ZEC decided therefore to withdraw their mandate, as of January, 2005, from the Expanded Church Response Network and transferred their support instead to an all embracing front of the Zambia Interfaith Networking Group on HIV and AIDS (ZINGO).

One can identify various characteristics of fundamentalism which, combined, can be a deadly threat to the church in its quest to have an appropriate theology for a time of HIV. Katongole (2001: 144) argues that the introduction of theology in HIV discussions often simply polarises the discussion into two theological camps with ‘liberals’ on one side and ‘conservatives’ on the other. While liberals tend to look at the advantages of the condom in halting the spread of HIV (and often cite the recent scientific and WHO statistics in support of their position), conservatives seem to be stuck with moralistic statements about the will of God regarding the ends of sexual union. Thus it would be ideal to be reminded about the following indications of sliding into a fundamentalist view which is dangerous to the Church:

- a) Your perception of a matter becomes the only truth. Another interpretation or perspective is not possible. It is completely clear to you, no difference of opinion is possible. You can listen to others with great patience, but your opinion is final. No teaching ability is shown.
- b) God gets co-opted to justify your point of view. This truth is seen to be of a divine origin – inspired by a dream, confirmed by an experience or a phenomenon in nature, supported by similar sounding words from the Bible (e.g. a specific verse). Because divine justification is claimed, no critical reflection of or opposition to this truth is tolerated.
- c) This truth comes with a moral appeal.
- d) Others must be convinced of or converted to this point of view. Your truth must be recognized by others, and everything possible must be done to attain this, not only for the sake of the truth itself, but also because it is a divine calling.
- e) This truth must be defended at all costs. When this truth is threatened, the attacks must be repelled (violently if necessary). There is even a point at which defence metamorphosis into attack.
- f) Conspiracy theories is a natural element of this stance. Observations are made, a network of signs are seen, and these are interpreted as a bulwark of menace. The foundation of this threat is suspicion of any point of view which differs from your own.
- g) This threat and moral appeal is interpreted specifically within the spiritual sphere – the devil or evil spirits are behind everything (Ben du Toit, 2003).

However, the differences among people are real. In *Missional Church* (<http://academic.sun.ac.za/buyton/vennote/Mike%20McCoy.htm>), McCoy (2001) suggests that missional communities do not seek the homogeneous oneness hoped for by modernity, nor do they celebrate the fragmented diversity of postmodernism. Guder (1998: 179) says

they welcome and nurture the incredible richness and particularity of perspectives, backgrounds, and gifts but always within the embrace of God's reconciling unity.

These real differences include differences in the ways in which people experience and relate to and understand God in a time of HIV, in the ways in which people make sense of their actions in morality and ethics and in the ways in which the one true God is worshiped. The unity of the Christian Church is and always has been God in Christ. What then are the biblical and theological models for the basis of creating the concept of Circles of Hope which are devoid of traits of fundamentalism?

4.9 A biblical and theological model for Circles of Hope⁶¹

A theological framework that facilitates discussion on the nature of God and his relationship with PLWHA needs to accommodate searching questions and changing realities. The model proposed here reflects the love of the triune God for his people since the moment of creation and God's continuing involvement in the well being of the created world through an eternally existing covenantal relationship. Barth's (1958) thinking on creation and covenant is complemented by the work of Moltmann (1974) whose view of the 'crucified God' who died outside the gate on Golgotha for those who are outside has a special resonance for those living with HIV who are treated as outsiders.

Clifford (2004: 7) says if covenantal relationships between God and his people and by extension between those people themselves are to be restored and maintained, the various forms of injustice that underlie the spread of HIV have to be addressed. Foremost among them is stigma, which all too often leads to a dangerous silence as well as rejection.

⁶¹ Scripture or the Bible in this dissertation is used without doing deeper exegesis. The researcher is aware that the Bible has both history and metaphor and written in various contexts for particular audiences. The interpretation of biblical texts continues in our own day to be a matter of lively interest and significant debate. In recent years the discussions involved have taken on some new dimensions. Granted the fundamental importance of the Bible for Christian faith, for the life of the church and for theological reflections, the researcher has opted not to do serious exegesis of the texts used in this work. The problem of the interpretation of the Bible is hardly a modern phenomenon, even if at times that is what some would have us believe. The Bible itself bears witness that its interpretation can be a difficult matter. Alongside texts that are perfectly clear, it contains passages of some obscurity. In the meantime, the methodological spectrum of exegetical work has broadened in a way which could not have been envisioned many years ago. New methods and new approaches have appeared, from structuralism to materialistic, psychoanalytic and liberation exegesis. On the other hand, there are also new attempts to recover patristic exegesis and to include renewed forms of a spiritual interpretation of Scripture. In this work, therefore, the researcher has opted to choose texts that have relevance with the subject at hand without going into detailed exegesis just as members of the Circles of Hope would read the Bible as they meet to encourage each other.

Before looking at the specifics of the Circles of Hope, there is need to establish a biblical and theological basis for this concept and practice. One passage that is particularly helpful in understanding the nature of Circles of Hope support groups is Hebrews 10:22-25 (NASB). On the basis of Christ's finished work, the Hebrews author writes:

Let us draw near with a sincere heart in full assurance of faith, having our hearts sprinkled clean from an evil conscience and our bodies washed with pure water. Let us hold fast the confession of our hope without wavering, for He who promised is faithful. And let us consider how to stimulate one another to love and good deeds, not forsaking our own assembling together, as is the habit of some, but encouraging one another, and all the more, as you see the day drawing near.

The three exhortations in this passage are to:

- a) draw near to God
- b) hold fast to confession of hope
- c) stimulate one another to love and good deed.

The first exhortation encompasses worship and prayer and the enjoyment of being in God's presence, the second encompasses the grounding in the Word of God and in the faith, while the third addresses application and action, especially ministry to others.

The Circles of Hope activities are centered on God's Word (which is one of the core pillars), but the various dynamics of the groups give more flexibility to the local group in every given local faith community. While a typical Circle of Hope group will incorporate all three exhortations, there may be times during the year when the activity of the group is centered on only one aspect – prayer, outreach, service or worship.

The Hebrews passage exhorts readers first to “draw near to God”. This is an amazing thought, that God desires that they may have a warm, loving relationship with Him, not simply a judicial relationship of being found ‘not guilty’. While the idea of a relationship encompasses more than prayer, it certainly includes prayer, and a prayerful attitude and spirit.

The passage in Hebrews 10 talks about "holding fast to the confession of hope..." Christianity involves not only a relationship with God through Jesus Christ, but also an entirely different outlook on life which is grounded in the hope of God's promises.

The word Hope in the context of HIV does not lack irony. But that is what the suggested support groups are about - they have had to offer hope to HIV positive people who often feel pretty hopeless about themselves, about the world, and about the possibility of living a positive and meaningful life. The words of Paul's letter to the Romans (5:1-5) put this better by saying:

We have peace with God through our Lord Jesus Christ, through whom we have gained access by faith into this grace in which we now stand. And we rejoice in the hope of the glory of God. ...And hope does not disappoint us, because God has poured out his love into our hearts by the Holy Spirit, whom he has given us.

The Apostle Paul wrote to the Christians in the big city Rome about his hope. The story of his relationship with Christ is a good model for Circles of Hope. He had to admit that what he was doing did not make much sense to a lot of people, but he had to do it.

Peace, living by grace, joy, suffering – but living with a vision, facing disappointments, love, the reality of support by the Holy Spirit - that is what Circles of Hope are about.

If the love of God was simply a theory in the hearts of believers, it would not be the love of God. A Circle of Hope inevitably expresses that love. They have a mission to live that love and to see to it that their love creates, fuels, and is motivated by God's love to spread truth, freedom, justice and peace for all. This removes the silence, shame and stigma associated with HIV infection.

This is an aspect of “mission,” in the sense that people who create such support groups are being obedient to the command “go ye therefore” and they are reaching out in action with the Love of God to others who would ordinarily live without hope for the fullness of life considering the devastation caused by the HIV virus. The apostle Paul further writes (NASB):

For who makes you different from anyone else? What do you have that you did not receive? And if you did receive it, why do you boast as though you did not? Already you have all you want! Already you have become rich! You have become kings—and that without us! How I wish that you really had become kings so that we might be kings with you! For it seems to me that God has put us apostles on display at the end of the procession, like men condemned to die in the arena. We have been made a spectacle to the whole universe, to angels as well as to men. We are fools for Christ, but you are so wise in Christ! (1 Corinthians 4:7-10)

It is a “mission” for in so reaching out to one another, the attitude, the *missio Dei* of God in Christ Jesus becomes incarnated in the fellowship of PLWHA (Phil.2:5-11).

As a result, Circle of Hope is also a place where people can be introduced to the possibility of real community in Christ and as indicated above it is a community which is inclusive. Refugees from fractured relationships and families need a circle of hope. In writing to the Christians at Thessalonica Paul further says (NASB):

We are not trying to please men but God, who tests our hearts. You know we never used flattery, nor did we put on a mask to cover up greed—God is our witness. We were not looking for praise from men, not from you or anyone else. [W]e were gentle among you, like a mother caring for her little children. We loved you so much that we were delighted to share with you not only the gospel of God but our lives as well, because you had become so dear to us. (1 Thessalonians. 2:4-8)

Circle of Hope is a gentle place for people facing real despair. So much of the church has been a platform for a diatribe to convince people they are sinful, flawed and in need of a Savior. Many popular sermons remind a skinny teen of every flaw. The Circles are offering a transformation of this image. Again, even though the world regards this as foolish, Paul insists that transformation in Christ leads to a reality that is a true destination, a source of hope:

You have taken off your old self with its practices and have put on the new self, which is being renewed in knowledge in the image of its Creator. Here there is no Greek or Jew, circumcised or uncircumcised, barbarian, Scythian, slave or free, but Christ is all, and is in all. (Colossians 3:9-11)

HIV positive people need a circle of hope to end up as a survivor living in the real world and facing up to their new selves in Christ.

Members of the Circles of Hope meet for fellowship and encouragement, centred on the truth and promises of His Word which gives hope.

The other angle of the passage from Hebrews 10 has to do with ministry - ‘stir up one another to love and good deeds.’ This function of Circles of Hope groups is to serve as people resources for ministry. It should happen individually. It may also happen collectively as a group.

This kind of biblical rationale explained above should serve as sufficient ground to motivate local congregational leaders to start support groups for people who are HIV positive.

Furthermore, the Trinitarian basis also offers a number of intriguing theological supportive arguments.

4.10 Trinitarian theology and Circles of Hope

Clifford (2004: 35-40) reminds us that the doctrine of the Trinity is the starting point for Church based Systematic Theology in the monumental work by the 20th century theologian, Karl Barth (1958: Volume III/1). The volumes that are particularly relevant in considering theological framework for discussing Circles of Hope relate to the theme of creation and covenant. This theology reveals something of the nature of God and God's relationship with humankind and provides a model for the relationships between human beings. This will be dealt with in a little more detail.

Barth (1958: 54) often makes the point that God did not need to create heaven and earth. But having done so, God does not grudge the existence of the reality distinct from Himself. He does not grudge the reality, the nature and freedom given to creation.

Furthermore, the first two chapters of Genesis tell of the world's creation in seven 'days' emphasising its goodness: 'God saw everything that he had made, and indeed, it was very good' (Genesis 1:31). Because these events fall outside the historical knowledge, it is tempting to disregard them, or rank them alongside creation myths from other cultures. But for Barth (1958: 51), mythology is not an option: 'The biblical creation narratives... stand in strict connection with the history of Israel, and so with the story of God's action in the covenant with man'.

In other words, creation is the beginning of the eternal relationship ('covenant') between God and humanity. Old Testament scholars have recognised successive covenants – binding agreements – between God and his people, beginning with the covenant with Noah (Genesis 9.21: God promises never again to destroy all living things because of human sinfulness), and continuing through the covenants with Abraham, Moses and David, each covenant entailing obligations on both sides.

Barth (1958: 101), however, places this understanding between God and his created people and the relationship that is implied by it, right back at the time of the creation with the institution of the Sabbath 'God blessed the seventh day and hallowed it, because on it God rested from all the work that he had done in creation' (Genesis 2:3). Creation and covenant

are thus intrinsically related, a relationship that Barth expresses as creation being ‘the external basis of covenant’ and covenant ‘the internal basis of creation’.

The seventh day is both an end and a beginning. It marks the end of the story of creation, whose goal, says Barth, is ‘Sabbath freedom, Sabbath rest and Sabbath joy’. This is not restricted to God alone, but is shared with humankind: ‘*Humanity* is created to participate in this rest before any human activity (1958: 98). This sharing by God of the climax of creation with human beings is the first revelation of his covenant of grace, and thus there is also a beginning – it is the starting point for all of human history that is now to follow. This means that human story, and all individual personal stories, derives their meaning from God’s covenanted relationship with his creation and his people. Personal stories, whether in health or in sickness and suffering, are somehow caught up into the fuller narrative of God’s covenantal relationship with humanity.

From the outset, God is involved in the well-being of the world he has created, and this sharing is ‘good’. But there is a further important strand to Barth’s argument. In terms of human history, the covenantal relationships with the Hebrew people set out in the Old Testament, for all their magnificent promises, would still have been only half the story. Historically, we have to wait until the New Testament to see the fulfilment of God’s new covenant with his people in the person of Jesus Christ, as prophesied in Jeremiah 31:34: ‘They shall all know me, from the least of them to the greatest... for I will forgive their iniquity and remember their sin no more’. But the reality of the doctrine of the Trinity is that all three Persons – Father, Son and Holy Spirit – were present at Creation: ‘The decisive anchorage of the recognition that creation and covenant belong to each other is the recognition that God the Creator is the triune God, Father, Son and Holy Spirit’ (Barth, 1958: 48).

At the very beginning, then, God not only creates humankind and establishes a special covenant relationship with them; he identifies with them through his Son.

In the New Testament, the relationship between the Father and the Son (and consequently the relationship between human beings and God) finds its most profound expression in the Gospel of John. Jesus tells his disciples: ‘I am in the Father and the Father is in me’ (John 14:11), and continues: ‘I am in my Father, and you in me, and I in you’ (John 14:20). Barth extends this ‘indwelling’ relationship back to creation: ‘What God does as the Creator can in

the Christian sense only be seen and understood as a reflection, as a shadowing forth of [the] inner divine relationship between God the Father and the Son (Barth, 1958: 52).

This indwelling relationship is developed by Paul, who in turn applies it to the Church in terms of Christians' relationship to Christ and to one another. Paul's memorable image of the church as Christ's body, with each member having a different role that is vital to the well-being of the whole, ends with a statement of what this entails for the relationship between the members themselves: 'If one member suffers, all suffer together with it; if one member is honoured, all rejoice together with it' (1 Corinthians 12:26). Barth (1958: 60) makes an important point in this context: 'While the authors of the New Testament presuppose the being of Christ in the Christian, with no fear of injuring the supremacy of the divine initiative they do in fact look more in the opposite direction, namely, to the being of the Christian in Christ.

To be able to assert that 'Christ is in me' is a wonderful thing for Christians living with HIV. Their experience of being rejected by the church – the body of Christ – may make them feel unable to say with any conviction, 'I am in Christ', even though that remains true.

Old Testament history reveals a cycle of covenant-breaking as people turn away from God, and covenant renewal, as God in his goodness and mercy never gives up on them and calls them back to him. In a sense, this cycle comes to an end with the New Testament. There, Christ once and for all fulfils God's covenant with humankind and, in Barth's words, makes 'common cause' with Christians, giving and joining himself with them (1958: 60):

Christ attests to the world the reconciliation to God effected in Him, the covenant of God with man fulfilled in Him, as He associates with Christians, making common cause and conjoining himself with them. He does not merely do this ideally or partially, but really and totally. He does not merely comfort, encourage, admonish or protect them remotely or from afar. But as He calls them to Himself in the divine power of His Spirit, He refreshes them by offering and giving Himself to them and making them His own.

Therefore, in Barth's writings, creation and covenant – God's eternal relationship with humankind – are inextricably linked. Creation has prepared the covenant and becomes the unique sign of it. Barth brings together the Old Testament teaching on creation and covenant, and the New Testament revelation of Jesus Christ and the Church's doctrine of the Trinity. This broad theological canvas is a particularly helpful framework for the discussion of HIV. It places contemporary human relationships with God in an eternally existing pattern that is

rooted in creation itself. Humankind is not brought into relationship with the Trinity at a given point in time – that relationship is shown to have been there for all time. This timelessness may help us to see beyond the perceived chaos arising out of HIV. It reveals God's eternal involvement in and commitment to his world and his people, whatever befalls them. In turn, it offers a model for human relationships: Circles of Hope are about promoting human relationships in the context of affliction by HIV.

God is 'light', 'love' and 'life' (Cf. 1 John 1:4; 4:8; 5:20), as the communion of the three divine persons, Father, Son and Spirit. Any effort to relate Christian faith to a contemporary worldview even in a HIV context, would be very limited if it left out the central doctrine of the Trinity. As Giacomo (1989: 61) observes, in the vision of faith, creation is being drawn into the divine love-life, as God acts in the incarnation of the Word and through the outpouring of the Spirit. Rusch (1986: 34) says that as the Trinity gathers creation into itself, the universe comes home; and all the struggling emergence of time finds its absolute future. This is what the Circles of Hope are expected to offer to those who participate in their dynamic fellowship.

Feinberg, (2001: 81) echoes that what should have been a celebration of God as the absolute Being-in-Love at the heart of the universe, what might have been a sense of the divine community enfolding all conscious creation into its own love-life, appeared as an exercise in supercelestial mathematics in which one could not be properly multiplied, or divided, by three.

In recent years, because of a new relevance, trinitarian theology has been undergoing a considerable renewal. Here, the researcher shall attempt no overall statement, but merely emphasise some of the perspectives found increasingly relevant to the current discussion of the theological rationale thereof for the creation of Circles of Hope support groups.

First of all, what kind of reality is Christian faith trying to realise when dealing with HIV and the experience of God? How does such experience and meaning affect all experiences of reality?

Giacomo (1989: 40) indicates that most radically, the analogical, all-connecting imagination of the Christian faith is envisaging the ultimate ground of humans' existence as intrinsically relational. Rusch (1986: 27) speaks of the divine persons as 'subsisting relationships'. The divine three can only be understood in relation to one another, as 'for' and 'in' the other. The

absolute one-ness of God is concretely realised in a limitlessly self-communicating relationality. Meanwhile, Burrell (1986: 25) underscores this by saying that God is God by being a communion of mutual self-giving. The Be-ing of God is a life of communion. And the life of God is one of unrestricted, all-embracing love. Circles of Hope are an attempt to embody this love which embraces **all** regardless of their HIV status.

Torrance (1988: 60) says the originating Love that God is (Father) expresses its fullness in the Word, and rejoices in its infinite excess in the Spirit. In that self-utterance and self-gift, all God is, all that the universe is or will be, is contained. The universe, emerging in the long ages of time, is ever being called and held in existence by the gift of God. In another work entitled *Trinitarian Perspectives: toward Doctrinal Agreement*, Torrance (1994: 57) says the eternal now of the Trinity is the matrix of time, not its contradiction. That relational vitality, which Gunton (1991: 160) calls the 'divine processions' of the Word and the Spirit, is creating the universe in its dynamic image. What is procession 'within' the divine mystery is imaged in the created process of the universe. On the other hand, Charnock (1996: 123) says that the universe finds its ultimate coherence in as much as the Trinity draws it to participate in its own field of relationships, to be alight in the Word, enlivened in the Spirit, and surrendering in thankfulness to the originating love of the Father. From its experience of this relational field of divine presence, Christian faith comes to confess the Trinity as the transcendent presence immanent in all existence. All instances of being, becoming and life have their beginning, form and goal in the 'Love-Life' of God, 'so that God might be all in all' (1 Cor 15:28). The evocative language of Cunningham (1998: 13) returns such intense theological expressions to the world of mystical imagination: 'The Godhead is the enfolding and unfolding of everything that is. The Godhead is in all things in such a way that all things are in God'.

The Word was in the beginning the primordial self-expression of Love. God is self-differentiated in this other, and Love becomes self-communication. The universe has been uttered into existence to be a world of endlessly differentiated 'words', *logoi*, meanings. Anthony (2003: 337) has quoted Aquinas who said: 'created things cannot attain to the perfect image of God in a single form'. It was fitting 'that there be a multiplicity and variety in created things so that God's image be found in them perfectly in accord with their mode of being'.

But there is the third divine person. Father and Son become Trinity through the Spirit. Cunningham (1998: 30) says the Love that has differentiated itself, and been self-expressed in the other, becomes, in the eternal now, a communal activity 'in the unity of the Holy Spirit'. The Circles of Hope emphasise love instead of stigmatisation. Volf (1998: 207) says as Christians, human beings cannot live apart from fellowship with other Christians. Circles of Hope are about fellowship with others. Salvation has an indispensable ecclesial structure, and in this sense relations between Trinitarian and ecclesial persons do correspond. The relational dynamics of the Circles of Hope as theological, the participation in the ecstasy of the Spirit, for the breath of God's moves the differentiated, distinct, and independent realities of creation into self-transcending communion can thus be understood from this angle. In this perspective, the cosmos lives and breathes the mystery of the 'primordial, expressive and unitive' Being-in-Love at the heart of its existence (Gunton, 1991: 167). If the original and ultimate reality is inherently relational, if ultimate unity is self-giving communion, trinitarian faith is a healthy disturbance for all closed little worlds of isolated independence as it also deals with the image of God in all people (Grenz, 2001: 91).

Defensive alienation (stigma) from the other, resistance to peace and reconciliation, any hardened disharmony with the rest of creation sets humans outside the stream of life.

Gunton (2003: 32) says in an obvious sense that the ecological imagination is more hospitable to a trinitarian conception of ultimate reality than the former dominant mechanistic worldview. A mechanistically-modelled science had little patience with any theology, let alone any theology needlessly complicated with trinitarian references to processions, relationships, and the unity of the divine nature and the plurality of the divine persons. But Huffman and Eric (2002: 19) indicate that current views of the processive and relational character of cosmos might be expected to find some of the tradition of trinitarian theology quite intriguing. The contemporary paradigms of science and the theological paradigm of God seem to be converging. Feinberg (2001: 10) says that for two thousand years, theology has regarded the ultimate as a realm of processive, interpersonal, relational life, for God is concretely in only a manifold of relationships. As a more holistic science realises this tradition of theological thought and faith, points of dialogue can emerge, in the one exploration of the real.

Traditional trinitarian theology, following what Cunningham (1998: 91) says, passes from the consideration of the processions and relationships of the divine persons *ad intra* (i.e., in the

eternal 'within' of God) to their presence and relationships *ad extra*, in the universe of creation. The self-communication of the Trinity *ad extra* is treated under the heading of the biblical category of 'mission' or 'sending' – the way, for instance, God 'sends' the Son and Spirit into the world. In giving a brief indication of this point, the researcher takes some liberty with the traditional terminology, but only in the hope of suggesting a better comprehension of its meaning in the present context of the discussion on the missional basis of Circles of Hope.

The following points can be made. For example, Anthony (2003: 360) asks, how can a divine person be 'sent'? The problem here is to imply neither inequality in the co-equal Trinity, nor some primitive form of spatial movement – as though God were not everywhere in the first place. In his answer to this question, Anthony (2003: 361) makes these two points:

- The divine person is sent in as much as the eternal procession of the Son/Spirit is prolonged into time and history. The life, the consciousness of God thus takes in the world of time and its emerging world.
- Because the mission is an extension into time of the eternal procession, it means that the divine persons begin to exist in the world in a new way: 'Thus, the Son is said to have been sent by the Father into the world, even though he was already in the world, because he began to be in the world in a visible way by taking flesh'.

The divine mission is understood to be the self-immersion of the Trinity in the created universe. The risk, fragility and movement of a temporal world enter into the one Trinitarian consciousness. Hoekema (1986: 56) says the world is an aspect of God's own experience. From this point of view, the missions of Word and Spirit are the Trinity's dynamic openness to the world and to history. The Mystery communicates itself to the created other in order to enfold creation into its communal life.

But there is a second point: Rusch (1986: 76) allows for two dimensions of these missions, the 'invisible' and the 'visible'. The failure to transpose this traditional distinction in an adequate manner has locked Christianity into a narrowness that is ill-prepared for the cosmic scope of its present challenge.

So, firstly, a word on the other aspect of missions: Kärkkäinen (2004: 30) suggests that we begin with the recognition that God is present to everything and everyone in an absolutely fundamental manner, as the sheer Be-ing, the source of all being. As the giver of existence, God is present in the innermost depths of all reality – even in the reality of much suffering

brought about by HIV. Bloesch (1995: 51) indicates that yet there comes a wave of freedom, of self-communicating love. God is not content, as it were, simply to be the nameless universal mystery at the heart of reality. Bray (1993: 12) says that beyond self giving to one another, the Trinity wishes to give itself to all, so that all can enter a new realm of a new selfhood and communion. Bloesch (1995: 67) calls this the area of grace. Circles of Hope are a means of experiencing grace by HIV positive people. By receiving this new gift, God's people are not only God's creatures but become God's intimates. The Circle creates that intimacy by all open hearted and genuine participants. Kärkkäinen (2004: 37) says that the Trinity acts in creation with the fullness of self-communication, to be present to creation in the nakedness and special connectedness of love.

Bray (1993: 17) reminds that the divine gift brings about that transformation of human consciousness which tradition names 'sanctifying grace'. There occurs a special experiential immediacy with the divine. Das and Frank (2002: 14) calls the human self as 'conformed to God'. Through love it is made like the Spirit of love, and through new understanding it shares in the wisdom of the Word. (Bloesch 1995: 70) says: 'because by such knowing and loving, created consciousness makes contact with God in its activity; in this special manner God is said not only to be in such a consciousness, but to dwell in it as in his temple. Erickson (1998: 111) also speaks of the Father as given and indwelling through grace, but not as 'sent'. The first divine person is present precisely as the source of all divine life and giving, the Father who is 'above all and through all and in all' (Eph 4:6). Circles of Hope are an attempt towards positive life and giving. Volf (1998: 195) says that the relations between many in the Church must reflect the mutual love of the divine person and this therefore underscores the Trinitarian theological basis for the importance of the Circles of Hope concept. Although any consideration of the relationship between the Trinity and the Church or in this case the Circles of Hope presupposes a complete doctrine of the Trinity, a comprehensive Trinitarian reflection of this sort is not possible within the framework of this work.

Suffice for the purpose of this work to say a horizon of loving presence precedes any particular context of time or space. In this way, the Word and Spirit are 'invisibly' sent to indwell human consciousness. Giacomo (1989: 3) says that however unnamed, unexpressed, in its unknown depths, human consciousness is awakened into a new level of being. It begins to participate in the very consciousness of God as self-communicating love. The capacities

for dialogue are now extended to loving communication with the divine: ‘for the Word is not any kind of word, but the Word breathing love. Wherever there is evidence of a consciousness, lovingly alive, in reconciling wisdom and self-transcending love, it is the dwelling of God. Circles of Hope are an embodiment of that love of God as participants experience de-stigmatisation from the silence and shame associated to HIV infection.

Das and Frank (2002: 17) echo that it is true that this metaphor of ‘sending’ or mission might too easily give the impression of the divine persons arriving in the world from the outer space of the divine realm. On the other hand, the concern of this study is that “mission” affects the lived sense of human selfhood. Christian theology speaks of the divine indwelling. It is at once God dwelling in humans, and their dwelling in God. To search into who they are is to find themselves in the presence of God, the Self in all their selves. The three classic biblical expressions of such intimacy with the divine mystery are familiar. They are:

- temples of the Holy Spirit, the divine creativity hidden in all creation;
- members of the Body of Christ in whom all things cohere;
- they share in the divine life as sons and daughters of the Creator as the final all-welcoming mystery of the future.

Such an indwelling means that God is known with an ‘inside’ knowledge. It is familiarity with the reality of God born out of participation in the Love-Life that God is: ‘Beloved, let us love one another, because love is from God; everyone who loves is born of God and knows God... For God is love... No one has ever seen God; if we love one another, God lives in us and his love is perfected in us’ (1 John 4:7-12). To experience God in such a way is to find oneself as a ‘connected self’, a self-to-be-realised in relationship to the other. This ‘other’ today admits of a global, ecological, and cosmic extension. Hence the adoration of such a God orientates the believer into a world of relationship and communion. It implies an agenda for the transformation of human relations, their communities and their global co-existence. This work contends that the removal of stigma through Circles of Hope will thus create that co-existence and there will be freedom, justice and peace for all. This is an expression of a community which lives in fellowship with one another.

In a world of both needless complexity as well as astonishing connectedness, Christian faith can find a new health and a new wholeness in contemplating the universe in the light of its fundamental mystery.

4.11 Community

Community is the basis of moving from a theology of punishment and vengeance to a theology of compassion. Clifford (2004: 15) says that covenantal relationships do not tolerate any form of rejection at any level; it allows no stigmatisation. Stigmatising someone goes beyond refusing to see God's image in that person. Those who perpetuate stigmatisation create inequality in human relationships and are therefore breaking community. Inequality was memorably condemned in Jesus parabolic saying when he said: 'why do you see the speck in your neighbour's eye, but do not notice the log in your eye?' (Luke 6:41). The HIV pandemic is about more than sickness – it is the impetus for the scandalous rejection and stigmatisation of many thousands of people and permeates every area of life for those affected. Clifford (2004: 20) calls on all people of faith to have before them the vision of a loving God who knows from within not only physical suffering, but all embracing torment. It is the face of this God that should be seen in so many HIV positive people as efforts are made to create an all embracing community.

The Christian community must make room for all God's people to seek God, to praise God, to reflect on their experiences in the light of faith and to discover their theological and moral bases as part of the theology, worship and morality of the whole community (Steinitz, 1997: 63). Categorical exclusions also reflect a lack of trust in God and a lack of appreciation for the unconditional nature of God's love. Jesus was consistently engaged in breaking down the categorical exclusions imposed against such people as women, Samaritans, lepers and the demon possessed. That process has also been an ongoing feature of the community of faith wherever it has found itself. The community of faith is often found struggling with the issues of increasing inclusion and with breaking down the walls of partition that separate people from each other as they come to a renewed vision of God's acceptance of all people (Robert, 1999: 33). The second principle in the development of HIV relevant theology is that all scriptural morality and ethic is reflective. Christian moral theology starts with the beam in the eye of the beholder, not the mote in the eye of the other (Mande, 2003: 30). This is true at both personal and communal levels. People of faith are called to examine themselves in the light of their experience of God and not to sit in judgement on others. Too much ethical material is produced by those to whom the issues are not a personal or community reality, but who have made up their minds beforehand on the basis of legalistic prescriptive rules.

The extent and depth of the pandemic as charted by UNAIDS as seen in Chapter 1 suggests that there is a major world crisis. Indeed the numbers as indicated in Chapter 1 have meanings that no mere digits could convey. As Fylkesnes and others (1997: 339) have also put it the meanings emerge in the stories of individuals, families and whole societies devastated by the fears (Alcamo, 2003), the sufferings (Dixon, 1994) and the deaths (World Bank, 2000) experienced throughout the world over the last two decades and more. To appreciate the real challenge to theology in a time of HIV, it is necessary to listen to these stories, their tellers, persons living with HIV themselves, the HIV affected, their families, partners, lovers, carers as indicated above⁶². Here is one story told by a woman from Lusaka:

“What wears me down is that my role in society has changed. It is no longer easy to meet friends especially in the same way as before. I am aware that they are thinking about me being infected. I often make the situation worse myself. I feel that I can live with my leprosy or HIV if you like, by withdrawing. It is not HIV itself that I am suffering from, its people that make me suffer”.

More illuminating still for theologians would be engagement with the struggle in the praxis of caring for and suffering with. On the basis of such stories and praxis, of co-suffering or compassion, fresh analysis may be possible and new understanding emerges.

A world crisis and its harrowing and heroic stories of human suffering require Christian response and reflection, some fresh theological consideration. The HIV crisis has some distinctive characteristics beyond its global range and savage suddenness, as it brings together in such devastating mix the great human powers of sex and death. How this mixture affects theology should be of interest to those involved in doing theology for life. Liberation theologies of Latin America (Gutiérrez, 1973; Boff, 1987), black and womanist kinds (Markham, 2003; Welch, 1985; Watson, 2003; Oduyoye, 2003) are only the most recent examples of how serious social challenges with their new questions on human meanings and morals have compelled serious and fruitful rereading of these scriptures and traditions. Petrella (2004: 62) says:

The first step for liberation theology is pre-theological and involves faith commitment. The theologians must share in the same way in the liberation process, be committed to the oppressed. It is impossible to become a liberation theologian without physical contacts with the actual subjects of the theology,

⁶²Some of these stories formed the basis of theological reflection for the author who has heard many in various interactions. Several of these stories are told in this study.

whether that contact takes place through sporadic visits to oppressed communities, the alternation of periods of theoretical work with periods of pastoral work in a poor church or actually living and working full time with the poor. Theology therefore is a second act emerging from this contact: before we do theology we have to do liberation. First comes liberative practise, only afterwards does theology emerge.

There is thus an ongoing process of drawing upon an interpretation of the normative sources of scripture, experience and tradition. While talking about womanist theology, Townsend (2001: 404) indicates that womanist theology challenges the theological presuppositions and assumptions of feminist theology as well. Womanist theology is not only subjective. Womanist theology attempts to articulate a theoretical critique of cultural hegemony through a call for the re-imagining of the roles of men and women in religious practices and also secular society. Within a theo-ethical framework, it is inductive and based on praxis as well.

It is not, therefore, an understatement to claim at this stage that the HIV pandemic has had far-reaching implications for the practice of theology and the understanding of the Christian faith. Louw (2000: 128) gives an example of the implications:

As a theological problem AIDS offers the Church two possibilities: either the point of departure should be the causal explanatory model, in which case God automatically is the callous despot who treats people like hostages; this God has a computer: everything is programmed according to laws. The second possibility is the hermeneutical interpretive model, which identifies God with suffering. In this perception, God has a heart: All man's actions and thoughts are taken to the crucified heart of a suffering God. Such an image of God does not induce Christianity to ask who, what is the cause of AIDS, but how, and what is the quality of our compassion.

The experience of liberation theologies should, however, alert any serious theologian that the impact of the pandemic on Christian thinking and practice should preclude reducing the discussion to marginal if genuinely important details like the use of condoms or exchange of needles in programmes on prevention. The questions for theology raised by HIV may not be confined within the conventional limits of ethical theology. The central problem in the ethical debate as Louw (1994: 128) suggests is the debate around whether HIV is a punishment from God. The UNAIDS Windhoek meeting of 2003 noted that at the heart of the stigmatising attitudes to HIV that can be found within churches, lie widely differing understandings of God. Sometimes Christians have presented a model of a vindictive God who inflicts HIV as a punishment for human sin. By contrast, this work contends that God is a God of compassion who delights in creation. HIV is a virus (albeit extremely dangerous to human beings) but not

a divine punishment for sin. The embodied human being is the temple of the Lord. The abuse of bodies is therefore an offence, both against God and against God's creation, as well as being a sinful exercise of power.

The ethical theological questions go beyond the tabloid writers' concerns with condoms and needles (the tabloid mentality is not always restricted to journalists). The theological re-reading undertaken here examines central issues of Christian belief and living, before it takes up some of the significant details in their proper Christian context. Mande (2003: 16) argues that:

it is time for reforming the Church's attitudes towards sex, sexuality and sexual health. A religion unpurged by the discipline of theology and hard thinking will not possess any real permanent value.

One thus needs to see what values of communities operate under the reign of God and how these are a serious component of an HIV sensitive theology which promotes de-stigmatisation of those infected by the virus.

4.12 Truth and Circles of Hope

Community and truth help the move from a theology of punishment to a theology of compassion. Circles of Hope are a concept which promotes community and truth.

Cochrane (1999: 1) in quoting Victor Turner, suggests that human beings all share an identical cognitive structure, the diversity of our thought patterns being simply the result of different histories, different linguistic and cultural contexts. In that case we have no *a priori* grounds by which to privilege a particular stream of history or a specific cultural framework above another. The Oxford dictionary talks about the truth as being fact, reality, certainty, genuineness, legitimacy, exactness and accuracy. All these may not necessarily be objective as they may easily be a result of different histories and different cultural contexts. In this section the researcher shall limit the definition of truth by agreeing with the views expressed by Henry Frank (2003: 3-4) who says truth is about comprehension of reality. It is the coincidence of the idea with the fact. Truth is the realisation of the Universe. Truth is the demonstration of unity. That which is truth to humanity must be truth to God. The universe is one.

Suffice to say, the pursuit of Pilate's question “what is truth⁶³?” in its current hermeneutical complexities is a task for another time and place. Truth is central to the Jewish and Christian traditions, as central as is God. It is God. More accurately and profoundly God is truth (*John* 14: 6). The ultimate reality revealing itself is basic truth for humanity, at once summoning and enabling human beings to recognise the truth and to live by it. Doriani (2001: 12-15) in his book *Putting the truth to work*, says only by listening to the God-given call to truth, by seeking and at least partially attaining the truth and striving to do it or live by it can human beings live with one another. The dialectic of person and society demands minimal truthfulness for its minimal successful resolution. Such minimal achievement is an expression of the reign of God and indeed of the presence of God.

Communal and personal crises like war and the pandemic HIV threaten truth. At least without continuous commitment to truth the crisis will be misunderstood and the response mistaken. Dixon (1994: 11) argues that the temptation to conceal the truth of the extent of the pandemic is one aspect of how the threat may aggravate the crisis. Fears of contagion by family, friends and carers based on untruth can readily undermine social and personal responses. Dixon (1994: 12) again says only the truth in the gospel phrase will set people free to deal effectively with the crisis. In *Intensifying HIV prevention*, UNAIDS (2005: 4) says there is a divinely begotten hunger for truth, which may hope through research to find medical means of prevention and cure. Maluleke (2001: 130) observes that the AIDS crisis catapults us into a moment of truth because it brings us face to face with the failure, sinfulness, frailty and interdependence of human beings. It reveals the truth about the limits of human knowledge, the inability of science and technology to save us.

Fylkesnes, Musonda, Luo and others (1993: 7) have in their joint work discussing *HIV among women in Zambia* all agreed that complex problems of confidentiality and information can arise for people living with HIV, for their partners and carers, medical and social. Furthermore, Robert (1999: 99) wonders how the truth is respected in the context of personal rights to privacy and dignity and of social need may not be easily discerned. This strengthens the arguments that the other values of the reign of God of freedom, justice and peace/solidarity will play a role here as they will in handling most moral dilemmas arising

⁶³The researcher is very much aware that in countless classrooms around the Western world, young people are taught tolerance, openness to alternative perspectives, to value themselves and their own views and to accept and revel in diversity. He believes that school curriculum should have a component which takes the search for truth seriously. Unless there is truth to be sought, the distinction between truth and untruth becomes meaningless.

from this pandemic. Beyond that it is important to recognise that values of the reign of God do not come cheaply. Truth like grace will often be costly. It is the responsibility of the community of disciples, of witnesses to the reign of God, to ensure with Jesus Christ that the cost is shared and the heavier burden of it borne by those in the best position to pay. Sims and Moss (1991: 123) have suggested that here we may refer to the truth of highly industrialised nations being able to financially help nations with weaker economies to respond effectively to the challenges brought about by HIV. Recent efforts by the Global Fund⁶⁴ and the George Bush funds called the Presidents Emergency Plan for AIDS Relief (PEPFAR)⁶⁵ for Africa and the Caribbean should be upheld.

Truth is the will of God and in order to realise the Circles of Hope as a sign of God's Kingdom on earth this theological underpinning of truth must be the under-girding principle throughout, as discussed in Chapter 6.

4.13 Freedom of association and HIV

Circles of Hope is a concept which promotes communities with freedom of association in the context of HIV infection.

The Roman Catholic theologian Gascoigne (2004: 128-129) indicates that the freedom of God in creation and covenant forms the basis of human freedom of choice as well as of the progressive liberation of person and society which the reign of God seeks, enables and achieves if only partially in history. Horton (2006: 201) says the messianic programme announced by Jesus in Luke 4 is the basis of the liberation of the reign of God which is already set. This is well said by Gutiérrez (1991: 13) that with prisoners to go free, the blind to see, the lame to walk and the poor to receive the good news of the reign of God, the basic

⁶⁴The Global Fund was created to finance a dramatic turn-around in the fight against HIV, tuberculosis and malaria. These diseases kill over 6 million people each year, and the numbers are growing. To date, the Global Fund has committed **US\$ 3 billion in 128 countries** to support aggressive interventions against all three. Zambia is one of the beneficiaries of the funds through the National AIDS council. By funding the work of new and existing programmes, they can save millions of lives, stop the spread of disease and halt the devastation to families, communities and economies around the world. Source <<http://www.theglobalfund.org/en/>> [March, 18, 2005].

⁶⁵President Bush's Emergency Plan for AIDS Relief aims to achieve the goals of treating at least two million people with anti-retroviral therapy, preventing seven million new infections, and caring for 10 million persons infected with and affected by HIV, including orphans and vulnerable children. The Emergency Plan focuses its efforts in 15 countries in Africa and the Caribbean. These countries which are home to nearly 50 percent of HIV infections worldwide are Botswana, Côte d'Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Vietnam and Zambia, http://www.usaid.gov/our_work/global_health/aids/pepfar.html> [March, 18, 2005].

enslavement of the human condition, personal and social, sacred and profane in sin and oppression are to be overcome. This is what Stacey Johnson (1999: 215) has called the freedom of the children of God which is at once gift and task. It is, as Horton (2006: 202) indicates, seen as the maturing of person and society so that each person and each society is gradually enabled to harness itself and its resources in creative self-expression and other-service as such it indicates the human shape of the liberation of the reign of God.

In the face of the pandemic the search for freedom from further infection through effective and humane preventive measures is an essential response to the call of the reign of God. Development of therapeutic measures connects the call of the reign of God to truth and its call to free people from the slavery of disease (Freedman and Combs, 1996: 22). And freedom may well clash here or certainly appear to clash. UNAIDS, in: *Voluntary Counselling and testing* (2000), shows that programmes of mandatory testing for so-called risk groups or of quarantine for people with HIV, are usually unfair restrictions of people already restricted socially or physically. Here, the crossover between freedom and justice emerges in human rights or liberties. Webb (1997: 49) supported by Brand and Heyns (2005: 107) affirm what other HIV human rights activists have been preaching, namely, that, every person has the right to privacy, dignity, autonomy and bodily integrity. In other words, every person has the right to be treated with respect and it is an individual who makes their own decisions about their body. In quite a different manner, freedom and maturity emerge for the sexually active as forming the basis for the integration of sexuality into personal maturity in relating to other sexual beings. The interrelation of the primary values of the reign of God with one another and their influence in shaping the secondary values must be continually kept in mind. Freedom is also the will of God and this theological truth should equally undergird HIV theological framework. The United Nations High Commissioner for Human Rights website indicates that where individuals and communities are able to realise their rights - to education, free association, information and, most importantly, non-discrimination, the personal and societal impact of HIV is reduced. Where an open and supportive environment exists for those infected with HIV where they are protected from discrimination, treated with dignity and provided with access to treatment, care and support, and where HIV is de-stigmatised, individuals are more likely to seek testing in order to know their status. When that happens, infection rates will go down and communities will be transformed. This can effectively take place in the context of community. As Bosch (1991: 472) states, it is the community that is the primary bearer of mission. In looking at the presence of God in the

power of the community, as seen in Chapter 1, there is a struggle to **discern alternatives to positive living in the context of HIV infection** for the present time. Here one finds a faith community in prayer, listening and discerning. The faith community then becomes a sign of the reign of God. The right to dignity, community and acceptance are a reflection of what was received from God and this is the faith community's identity in Jesus Christ. It is about who people are in Christ: they are created, redeemed and sanctified even when the body is withering away from a life threatening virus. This new identity becomes the basis of justice since Circles of Hope as a community promotes justice.

4.14 Justice and Circles of Hope

Circles of Hope promote justice which is part of the nature and being of God. For many biblical scholars, justice is the central description of God in the scriptures, particularly in the Hebrew Scriptures (Bieringer and Elsbernd, 2002: 41-50). Justice in the Hebrew Scriptures and covenant with the God of love in the Christian scriptures is of the same concept. Bieringer and Elsbernd (2002: 43) say both Jewish and Christian faiths see justice first and foremost as a quality of God. Belief in a just God has important consequences for the way the Jewish and the Christian faiths see God and the human person. In both scriptures the justice of God is the shape which the love of God, or better, the love that is God, takes in a covenantal, saving relationship with the errant Israel and sinful humanity. God is a unified, integrated being whose personality is a harmonious whole. On the one hand, God's justice seems so severe, requiring the death of those who sin. This is a fierce, harsh God. On the other hand, God is merciful, gracious, forgiving, longsuffering. Are these two sets of traits not in conflict with one another? Is there internal tension in God's nature? Erickson (1995: 297) answers this dilemma in a better way:

If we begin with the assumption that God is an integrated being and the divine attributes are harmonious, we will define the attributes in the light of one another. Thus, justice is loving justice and love is just love. The idea that they conflict may have resulted from defining these attributes in isolation from one another. While the conception of love apart from justice for example, may be derived from outside sources, it is not a biblical teaching. What we are saying is that love is not fully understood unless we see it as including justice. Actually, love and justice have worked together in God's dealing with humanity. To fulfil his just administration of law, God's love was so great that he gave his son for the world. Love and justice are not two separate attributes competing with one another. God is both righteous and loving.

Divine justice characterises God's commitment to and responsibility for the world and for humanity through his eternal covenant with both the old side shown in creation, with Abraham and Moses, and the new side shown in Jesus Christ. Walton (1994: 15) calls it the eternal expression of God's will and the instrument that obligates God to act on behalf of his people. That commitment and responsibility require and enable human commitment and responsibility to and for one another. Weatherford and Carole (1999: 10) shows us that the great prophets of justice in eighth-century Israel denounced as unacceptable to God assemblies of worshippers who neglected the widow, the orphan and the stranger, the judges who refused justice to the poor (cf. *Amos*). Trent (1991: 3548) says for Jeremiah, faith in God is primarily expressed in justice. In more contemporary language recognition of, respect for and response to the human others is the test of authentic recognition of the ultimate other (Mario, 1999: 45-46). Justice demands that fairness and equality are the focuses in both Old and New Testament versions of the reign of God on the deprived and excluded. The blessed, who hunger and thirst after justice, as disciples of Jesus will be judged, rendered justice himself or herself on how far they fed and cared for these least ones. To feed and care for them is to care for Jesus, the incarnate ultimate other (*Mathew 5, 25: 31-46*).

Bosch (1991: 72) looks at justice as God's saving activity on behalf of his people and that human justice is the effort people make to respond to God's goodness by carrying out his will. Weatherford and Carole (2002: 12) indicates that in a more analytic mode justice is distinguished as personal and social, as regulating fairness in relations between individual persons and in structural relations within society.

Many of the problems revealed by the HIV pandemic are problems of justice, personal and social (Kelly 2006a: 2). Some of these may be adequately expressed in terms of human rights and pursued in that fashion. Cahill (2005: 159) looks at justice as it relates to HIV as a concern for social relationships that help spread HIV and fail to alleviate AIDS, relationships of power and vulnerability that are in violation of equity, the common good and the preferential option for the poor. However, not all delicate justice problems may be translated into human rights language without considerable loss of moral impact. Issues of testing (what is now popularly known as VCT = Voluntary Counselling and Testing), for example, may be treated usefully in terms of rights but there are cases such as mandatory testing of candidates for admission to theological seminaries, or before a couple gets married where larger concerns like witness may also need consideration. Here the interconnection between values

of the reign of God emerges as freedom and justice overlap in rights, and truth and peace overlap in witness. These values are part of God's attributes and thus are indeed the will of God - values to be seriously considered in a theology for HIV. The next value is the value of peace within the Circles of Hope.

4.15 Peace and Circles of Hope

Circles of Hope are about peace. Peace in the lives of those affected and the community. Peace is a much-neglected theme in theology and particularly in ethical theology, where it barely figures as a side issue in the just war discussion. Yet it is a central theme in the biblical tradition of the reign of God and increasingly central to the survival of the human race. Circles of Hope are to promote peace among people in the context of HIV. Bosch (1991: 118) underscores this fact by saying that peace-making is an intrinsic aspect of the church's missionary agenda. The presence and power of God to be realised and manifested in genuine peace between and within individuals, between and within societies, constitutes the most profound challenge facing the disciples of Jesus Christ today. Swartley (2006: 32) affirms the wide range of meaning of *shalom* such as well being, greetings, inter-group relations, and observes several levels of meaning in reference to the political sphere. *Shalom* may denote an offer of peace prior to war or a peace that is forced on people by war. Rasmussen and Birch (1978: 135) indicate that in the biblical tradition, peace, *shalom* in Hebrew, far exceeds the minimalist absence of war or maintenance of law and order. Flourishing in communion might be a much better description of the peace anticipated under the reign of God and offered by Jesus to his disciples and through them to the world. It incorporates both ideas of flourishing in unity or solidarity with implications of truth, freedom and justice. It also involves the more specifically Christian themes of healing, reconciliation and forgiveness. *Shalom* is better concretised by Swartley (2006: 33) who quotes rabbinic texts and says:

Shalom primarily signifies a value, an ethical category - it denotes the overcoming of strife, quarrel and social tension, the prevention of enmity and war. It is still to be sure, depicted as a blessing, a manifestation of divine grace, but in great many sayings it appears to be normative context. The majority of passages on the subject of peace are concerned with family or communal life, that is with internal peace among the people and only a minority are concerned with external relations between Israel and other people, between nations and states.

The HIV pandemic should stimulate a much-needed development in understanding and promoting the value of peace under the reign of God as peace is indeed the will of God. The

dimensions of communal life, healing, reconciling and forgiving have obvious relevance for both the personal and social challenges of HIV. Their understanding and application here will provide insight into other peace needs and possibilities. When there is genuine peace among people of a faith community it would be fertile ground for creating a community where as Newbigin (1989) says there will be ‘the congregation as hermeneutic of the gospel’. In the book: *The Gospel in a Pluralist Society* (1989: 80-141), most of these characteristics reappear (i.e. of truth, freedom, justice and peace), only in a different sequence. In a congregation that takes its character not from the character of its members but from the living Christ, it becomes the place where men and women and children find that the gospel gives them the framework of understanding, the ‘lenses’ through which they learn to see. The congregation as hermeneutic of the gospel will experience peace and that peace will result in:

- A community of praise including reverence and thanksgiving;
- A community of truth;
- A community of loving concern;
- A community forming a royal priesthood;
- A community of mutual responsibility;
- A community of hope.

The world Council of Churches 6th Assembly in 1983 in Vancouver (Gill, 1983: 30) was responding to a situation of crisis as outlined in the assembly statement on peace and justice and they said:

Humanity is now living in the dark shadows of an arms race more intense and of systems of injustice more widespread than the world has ever known. Never before has the human race been as close as it is now to total self-destruction. It could as well be a time of crisis brought about by the pandemic of HIV and AIDS. Never before had we so many lived in the grip of deprivation and oppression.

It goes on to state what the Christian response to this situation should be:

The churches today are called to confess anew their faith and to repent for the times when Christians have remained silent in the face of injustice or threats to peace. The biblical vision of peace with justice for all is not one of several options for the followers of Christ but is an imperative for our times (1983: 30).

Furthermore, the report repeats what it considers to be the nature of the Christian response at this time:

The [single, though twofold] foundation of this emphasis should be confessing Christ as the life of the world and Christian resistance to the powers of death in racism, sexism, caste oppression, economic exploitation, militarism, violations of human rights, *HIV and AIDS* and the misuse of science and technology (1983: 30).

In taking this position, Vancouver clearly shifted from the position of understanding Christian involvement in world affairs largely as a concern of Christian ethics - to translate the values of the kingdom into achievable social goals (the middle axioms of the responsible society). Instead, it placed the emphasis on confessing the faith, which calls for a new understanding of the missionary task of the church. To realize this intention, the assembly envisaged a “conciliar process of mutual commitment” that would bring the churches together to take a common stand on the urgent issues concerning the survival of humankind. It envisioned such a council taking the churches to a new stage in the covenant relationship into which they had entered at the inaugural assembly at Amsterdam (1948).

Vancouver intended the elements of justice, peace and the integrity of creation to be viewed as three aspects of one reality: as a single vision towards which the Church works and as three entry points into a common struggle in these areas. The addition of the term “integrity of creation” to help clarify “the biblical vision of peace with justice” was particularly useful. Besides alluding to the damage being done to the environment and the threat posed to the survival of life, the term also gave a new prominence to the doctrine of creation and the opportunity to re-affirm Trinitarian faith, beginning with God as Creator and therefore also Liberator and Sustainer. These words are so true even today in the context of HIV in Zambia.

4.16 Conclusion

The argument that has been spelt out is that it is important to have an appropriate theological framework before engaging in the missional praxis of the creation of Circles of Hope. Since a missional theology which promotes the creation of Circles of Hope at congregational level is the basic presupposition for a holistic approach to combat the HIV pandemic in Zambia, this chapter has attempted to show how that agenda could be shaped. Circles of Hope have been defined. It is about the reign of God and the significance of building community. This theology builds a community whose people are driven by virtues of truth, peace, justice,

freedom and which encourages spiritual formation and is basically an expression of identity. On this basis silence, shame and stigma have no room. It is a theology about the nature of God and his relationship with human kind. It is a biblical and Trinitarian theology. This has implications for a missional church. This study is an attempt to generate a relevant theological praxis for the HIV pandemic.

The stories on HIV are always situational and prompt the faith community towards a theological reflection. As such it is a way of caring and refocusing the infected and affected to focus on God. Having faith in the reign of God opens up fresh possibilities of redemption and liberation for all the sufferings and the threats posed to the whole human community by this pandemic. The challenge of the HIV pandemic demands a vigilant leadership at all levels if lives have to be saved.

The researcher has shown that it is neither legalism, nor fundamentalism nor moralistic theologies, not even a modernistic type of ethics which knows all about right and wrong, which is going to be a sound theological basis. This requires an identity that surfaces in spirituality and that flows from God's identity, God's graceful presence in and through the Holy Spirit in the faith community. As Hendriks (2004: 35) rightly puts it this identity happens through the basic disciplines of the faith community which includes worship, service, communion, preaching, teaching, witness, pastoral care, justice and ecumenism. This results in people that make the values of the reign of God visible. This visibility is seen in the practice of community, truth, peace, freedom and justice. As such, they will truly be an eschatological community that will create hope and joy and energise people with a new vision of an identity of those created, redeemed and sanctified even when the body has been attached by a life threatening virus.

A missional theology is sensitive to the local context of the people. As such if one wants to have an effective strategy in place that addresses the challenge of HIV in Zambia, one shall need to understand how the people think, what their customs and traditions are. The next chapter therefore focuses on Circles of Hope as a basis of the healing community in the context of HIV infection. This healing is very important as it has to enable the Church to have a vision and mission for being a sign of the reign of God on earth. Healing within the Zambian cosmology will obviously have an effect on how the subject of healing is understood.

CHAPTER FIVE

CIRCLES OF HOPE AS A WELL SPRING OF HEALING

5.1 Introduction

Van Laar (2006: 231) says that in Western society, medicine is practised in the hospital, religion in the Church. He goes on to say that in Africa matters are different. Healing is an integral part of Church life. This chapter will then look at the meaning of health and the role of traditional medicine in the context of HIV in Zambia. In view of the subject of this work, the chapter will go on to look at anti-retroviral therapy and the role of Circles of Hope as a means of healing for HIV positive people. The church as healing community and the biblical foundations for such alternative healing will also be explored.

The researcher has shown that in setting an agenda for a theology of HIV, missional theology is what is needed. HIV is one of the missional challenges facing the Churches in Zambia today. As seen in Chapter 1, to reflect contextually and appropriately is to participate in the *missio Dei*.

In this chapter, the researcher shall deal with the second hypothesis, namely:

That a missional theology which promotes the praxis of the creation of Circles of Hope at a congregational level is a basic presupposition for a holistic approach to combat the HIV pandemic.

A missional theology, as seen in Chapter 4, is sensitive to the local context of the people. If one wants to have an effective strategy in place that addresses the challenge of HIV in Zambia we shall need to understand how the people think, their customs and traditions. The researcher shall not do this in a general way but in a rather specific manner. The Zambian cosmological view on health and healing should be used towards building a holistic approach to combat the pandemic. The researcher shall also evaluate this presupposition by drawing upon the interpretation of the normative sources of scripture and tradition. A holistic model must start with the people and where they are. The researcher shall also look at the praxis of the creation of Circles of Hope as a base for healing within local congregations. The sociological position of the researcher is that of a Zambian (African), born and bred within

the country. Part of the work of this chapter will be, as indicated in Chapter 1, from the perspective of a participant observer, and descriptive in style. The way African people think about illness and healing is partly the lived experience of the researcher whose father is an herbalist. For many Zambians, there is a continued struggle between the traditional ways of life and the influence of Western urbanisation. It would be unrealistic to either assume that there is total break with the past or that the Zambians are completely Western and urbanised. There is an unresolved tension between the two realities and they continue to interface in the discussions on the Zambian (African) view of issues such as healing.

5.2 Zambian traditional view of healing

It is very important to state at the outset that according to the traditional African view healing is a thoroughly religious phenomenon. Green (1995: 16) explained “according to the African religious cosmology (it is) the failure to communicate with the ancestors, ‘the living dead’ (which) brings about illness or suffering”. Homsy and King (1996: 5) agrees with that. According to Mbiti (1969: 44) it is also possible for a person to be overcome by the power of evil spirits, by misfortune, or by the machinations of one’s fellow beings. The role of bacteria, viruses, infections, is decidedly secondary. The primary cause of disease is found in the religious realm and it is there also where the means to heal has to be found. A second very important dimension to the African view on healing, which is linked very closely to the first, is that a person can only be healthy if she or he belongs to a healthy community. Because the concept of community plays such an important role in this study, it is necessary to define it briefly. In general the African community is still based on the extended family system and the village community. The majority of African people are still rural. Many (perhaps most) urban Zambians keep their rural link alive. In times of crisis (such as illness), for example, they turn to their village or extended family for support. Those Zambians who became permanently urbanised have created various alternatives to the extended family village or community such as the African Indigenous Churches. Church organisations such as women’s associations, burial societies, labour unions and political parties are alternative forums of community. In urban as well as rural areas these communities are vibrantly alive.

It is of great importance in this section to be reminded of the words of Bediako (1995: 104-106) who says that there is need to draw on aspects of the primal imagination as a unified organic view of knowledge of truth and avoid dichotomies in epistemology which, since the European Enlightenment, have drained the vital power out of Christian theology. He further

reminds us that modern theology in the West seems to have pursued a course of development which divorces the Christian Gospel and the issues it raises from religion and the main springs of human quests and questions. Consequently, this kind of theology has lost touch with, and is incapable of answering, crucial issues which lie at the heart of human existence issues which are essentially religious questions of human identity, community, ecological equality and justice. The primal imagination may help us to restore the ancient unity of theology and spirituality. He agrees with Newbiggin (1989: 106) who says that it calls for a more radical conversion than has often been thought, a conversion not only of the will but of the mind, a transformation by the renewing of the mind so as not to be conformed to this world, not to see things as our culture sees them, but – with new lenses - to see things in a radically different way.

What is needed in fighting HIV is to avoid those dichotomies and, in view of human quests and questions, to be able to look at the gospel imperatives for such a time as this. How then do the Zambians understand traditional medicine?

5.3 Traditional medicine in Zambia

The majority of people in Zambia have access to traditional health care only. Traditional healers are well known in their communities for their expertise in treating many sexually transmitted infections (STIs) (Green, 1994: 14-15). The World Health Organisation (WHO) has advocated the inclusion of traditional healers in National AIDS programmes since the early 1990s (WHO, 1990). Zambia has recently incorporated the traditional healers' association representation on the National AIDS Council Special Committee for Research.

African traditional medicine encompasses, as indicated above, a diverse range of practices, including herbalism and spiritualism, and traditional healers represent a range of individuals who call themselves diviners, priests, faith healers or bone-setters, among others. The term 'traditional healer' used here, though an oversimplification of a complex range of practices, refers to either herbalists, spiritualists or to those (the great majority of healers) involved in both realms.

African traditional healers reflect the great variety of cultures and belief systems on the continent, and possess equally varied experiences, training and educational backgrounds. This diversity is further enhanced by their adaptation to the dramatic social changes that have affected much of the continent (or African traditional healers in Zambia) since colonisation,

such as urbanisation, globalisation, population migration and displacement, and civil conflicts (Good, 1998: 21). Whenever African healers' knowledge, attitudes, beliefs and practices about sexually transmitted infections (STIs) and HIV have been explored, findings have reflected the stage of the pandemic, the amount of information these healers have been exposed to, and their pre-existing belief systems about health and disease in general, and STIs and HIV in particular.

Many reports have noted the genuine interest and enthusiasm of traditional healers to collaborate with their biomedical counterparts. Social research has shown that, in many African countries, healers could name and describe numerous types of STIs (which do not always correspond to the biomedical definition). However, few of them consider HIV an 'African' disease (Green, 1992a: 121-130, Green and Dgedge, 1993: 262). Many traditional beliefs about the prevention of STIs or HIV include limiting the number of sexual partners, wearing protective charms or tattoos, having 'strong blood', using condoms to reduce the risk of 'pollution' or undergoing a 'traditional vaccination' consisting of introducing herbs into skin incisions (Green, 1992b: 261-281, Nzima et al., 1996: 7-8). In numerous cases, condoms have become acceptable to traditional healers. Although many African healers consider semen an important element for nourishing a growing foetus and maintaining the mother's health and beauty, their concern for family and cultural survival can override this belief and allow them to promote condom use (Green, 1995: 14-15).

As Good (1998: 54) has suggested, there is undoubtedly the need for more research in the uses, effects, benefits and challenges of traditional medicine. Multiplicity of variables needs to be assessed. It is only with systematic documentation of the already existing best practices that it can be hoped to answer crucial questions regarding the effectiveness, advantages and limitations of traditional medicine, and determine how this can further incorporate traditional medicine into the HIV response.

In most African societies, therefore, healing combines herbal medication, psychotherapy, psychology and religion. The healing ceremonies, generally conducted by a priest-healer, a diviner doctor or medicine-person, usually involve confession, atonement, forgiveness and reconciliation. Meanwhile disease is at the heart of a belief-system encompassing ancestors, witches and sorcerers on the one hand, and feelings of hatred and jealousy emanating from the human heart on the other. Disease unravels itself in the web of bruised relationships among the living themselves or between the living and the ancestors. Tlthagale (2004: 53)

says the phobia of evil spirits lurking around intensifies the experience of the disease. In a society where human presence is strongly valued and accredited, distrust also flourishes when incomprehensible situations set in or unfortunate events take place like catching the HIV-Virus. This peculiar understanding of disease is deeply etched in the African consciousness.

Tlhagale (2004: 53-54) affirms that medicine, like disease itself, is understood as having inexplicable power. Evil spirits are exorcized by symbolically hitting the person who is suffering. They are also driven out of the body by drinking water mixed with salt or ash in order to vomit. Medicine is inserted under the skin (*kutemela*) in order to protect the victim from evil. Protective amulets are worn on the body (*chithumwa*) in order to brazen out the power of evil spirits. Medicine for strength is made out of parts of the human body, hair of what is considered a fierce wild animal such as a lion or wild beast, the skin of a snake etc. The disease and cure, while they play themselves out in the human body, both belong to the same spiritual realm. There is a fine line between the symbolic meaning and the physical effect of the medicine used: what might start as a symbolic gesture ends up by being taken literally.

5.4 New possibilities⁶⁶ – the miracle of anti-retroviral drugs⁶⁷

In view of the particular discussion of HIV in this study, it is important to look at healing from the medical angle as well, before looking at what the implications are for the missional theology, which encourages the praxis of Circles of Hope as places of healing. This is not an in-depth study on what ARVs are able to do, but a mere mention to indicate that, in discussing healing in the context of HIV in Africa, one can not fail to notice that they do exist and that some of the members of the apostolic faith community are experiencing new life with the miracle of ARVs.

AVERT⁶⁸, an international AIDS charity, says that the main type of treatment for HIV available today is called HIV antiretroviral drug treatment. It is not a cure, but it can stop

⁶⁶Most of the work in this section is adapted from *Special Focus Area: Anti-Retroviral (ARV) Treatment in Developing Countries: Questions of Economics, Equity and Ethics*. [Online]

<http://www.worldbank.org/aids-econ/arv/conf-aids-4/box4-5.htm> [accessed 2005 April 6]

⁶⁷ARVs have assumed a new name in Zambia as many people are referring to them as having a ‘Lazarus’ effect due to the miracle that some people whose viral load was very low suddenly rise to their feet and begin to go about with life. Lazarus in the bible was brought back to life after having died for four days (*John 11*)

⁶⁸<http://www.avert.org/starttrt.htm> [accessed 2005, April 7]

people from becoming ill for many years. The treatment consists of drugs that have to be taken every day for the rest of someone's life.

HIV is a virus and when it is in a cell in the body, it produces new copies of itself. With these new copies, HIV can go and infect other previously healthy cells. So HIV can quickly spread through the billions of cells in the body, if it is not stopped from reproducing or producing new copies of itself. Antiretroviral treatment (ART) for HIV infection consists of drugs which work by slowing down the reproduction of HIV in the body.

The drugs are often referred to as: anti-retrovirals, ARVs, anti-HIV drugs or as HIV antiviral drugs. Persons taking them need to take at least two or, preferably, three drugs at the same time. The reason for this is that if one takes only one drug, it will be just a short time before the drug will stop working. This is referred to as becoming resistant to the drug. If one takes several drugs together, and if the drugs are from more than one group, then it generally takes longer for one to become resistant.

The decision about which drugs to take, and indeed which drugs should be made available in a particular country or area, depends on a number of different factors. These include the availability and price of drugs, the numbers of pills to be taken, the side-effects of the drugs, the laboratory monitoring requirements and whether there are co-blister packs or fixed dose combinations available.

The World Health Organisation (WHO)⁶⁹ recommends that if HIV antiretroviral (ARV) drug treatment is to be made available to a large number of people in a resource poor, or developing country, then it is advisable that the provision of treatment is standardised.

In scaling up anti-retroviral therapy, WHO (2002) recommends a particular combination of drugs. This is chosen and should be provided for everyone to take when they start treatment anti-retroviral therapy. This is sometimes called the first line regimen. For those people who need to change later from this first choice of drugs, there should have been a second choice of drugs selected which is known as the second line regimen. WHO recommends that if someone needs to change from the second line regimen, he/she should then be referred to a specialist physician for individualised care. Mombe (2005: 63) suggests that before initiating anti-retroviral therapy, it is useful to determine how ill the patient is. Among the tests that

⁶⁹World Health Organization (WHO) *Fact sheet* 1 December, 2003
<http://www.euro.who.int/document/mediacentre/fs0603> [2005 March, 29]

help to establish the patient's state of health are: a complete blood count, blood chemistry profile, including viral load test and CD4 cell count, tests for hepatitis B and C; and tests for infections such as syphilis and tuberculosis. Women should take a pregnancy test. These tests are also used for monitoring during therapy.

There is a need in any combination to have drugs from more than one group. In general the drugs from the protease inhibitor group are the least suitable for a number of reasons including cost, the number of pills which need to be taken, and the particular side effects that occur with the protease drugs. So WHO recommends that generally a first line regime should consist of two drugs from the nucleoside group and one from the non-nucleoside group.

In this way they can also help prevent the body becoming vulnerable to other infections, because the immune system has a chance to get stronger again. ARVs do not however kill viruses. These drugs block steps in the process through which viruses reproduce. This means that although people on ARV treatment can feel a whole lot better and perhaps even completely well, most of the time they may get serious infections and have other health problems. ARVs do not prevent the virus from being passed on from an infected person to someone else.

The World Health Organisation has recommended that anyone whose CD4 count is below 200 should take ARVs. By then their immune system is already very weak and they are open to more serious infections which may kill them shortly. Even when a person's immune system is already almost completely destroyed, it is possible for them to regain a measure of fairly good health, and extend their life for a good few years, if they embark on a regimen of ARVs. This is shown in true life story of one Nontsikelo Zwedala as reported by Treatment Action Campaign of South Africa⁷⁰.

My name is Nontsikelo Zwedala. I am from Cofimvaba in the former Transkei. It is a poor rural area and there are no jobs. I have been in Cape Town for four years. I am 31, with one child. I was diagnosed with HIV in 1998. The doctor said people must take me to the hospital to get a death certificate because I was almost dead from AIDS. I was angry with the doctor because he did not clarify to me what HIV/AIDS was all about the first time. When I came back from the hospital the family I was living with chased me out - they were relatives. I went home

⁷⁰Story of Nontsikelo Zwedala <http://www.tac.org.za/treatment/?Life+with+ARVs> [2005 April, 4]

to the Eastern Cape. Then my boyfriend called me back to Cape Town and we lived in his house in Nyanga for two years.

Then he died in 2000 because of AIDS. After that the doctors told me I was very weak. My weight was 42kg, down from 76kg, my CD count was 14 and my viral load was 3,000,000. So they suggested that I go into trials for anti-retroviral drugs. I started in April 2001 with the Lung Institute in Observatory. Last time I was tested my CD count was 200 and my viral load was undetectable. My weight is now 65kgs. Before I went on the drugs I was ill and could not take care of my son. I was very thin, my skin was bad, and I had lost my hair. I had fungal infections on my hands and feet. I had had malaria and TB twice. I was afraid I was going to die. When I began the anti-retrovirals, I was afraid there would be bad side effects.

So I was afraid both ways - afraid to die and afraid to take the drugs. Today my weight is back up to 65kg and I feel healthy and strong. When I began the drugs I had some side effects, but after two months they disappeared and I began to feel better. Every day I have to take three pills in the morning and three at night, at eight o'clock. At first it was not easy to stick to that, but now I never, ever forget or miss my drugs. If I had not taken, anti-retrovirals I would not be here and there would be no one to take care of my son. He understands everything about my situation and my drugs and he reminds me to take them. I feel bad and angry because I know there are many people with HIV who do not get access to anti-retrovirals. I believe the government should provide treatment for everybody. Thabo Mbeki should know that HIV causes AIDS and it is killing people out there. He should know that it can be treated so to allow people to live a long life with HIV. If he cannot afford to buy the treatment from the pharmaceutical companies he must talk to them to lower their prices. There are options like generic producing and parallel importing. He can reduce military spending because there is no war in South Africa but people are dying of AIDS. I joined the Treatment Action Campaign in 1999. I have education about HIV/AIDS, treatments, positive living and the politics of our situation. I am part of project Ulwazi, which means knowledge. We go to clinics, trade unions and schools to talk about HIV/AIDS. I talk about treatment and I disclose my status to people. I live here in Kosovo squatter camp in Phillipi. All my neighbours know I have HIV and am on anti-retrovirals. My neighbours support me a lot - there are very good people around here. At first some were scared I would infect them. Later they began to understand that AIDS can't be caught by helping and caring for people. I live in this one-room shack with my sister, my cousin, my friend and my son, Pikolomzi. Every morning we go to

fetch water - we have to walk nearly 2km using a supermarket trolley to hold our water containers. Our shack is small. In the winter, it is unhealthy here - you can see the holes in the roof where a lot of rain comes through...

5.5 The church as a healing community

The Church cannot ignore such realities as the story of Nontsikelo and the wider context which influence people's thinking on health and healing. Many would need to be helped so that they get access to anti-retroviral (ARVs) and stop Africa's many deaths which could be avoided. Mombe (2005: 53) says antiviral drugs are substances that inhibit the development and spread of viruses by interfering with the viral life cycle. Some anti-retroviral drugs have been specifically designed to fight HIV infection. They are also called anti-HIV drugs, HIV anti-retroviral drugs or merely anti-retrovirals. Anti-retroviral therapy (ART) helps the HIV-infected person to maintain a functional immune system and combat the opportunistic infections that accompany HIV infection. The goal of anti-retroviral drug therapy is to stop the progression of HIV infection by slowing down the reproduction and spread of the virus in the body. Thus ART usually helps to improve the patient's quality of life, and reduces the death rate due to HIV.

Healing and the Church go hand in hand. That is why right from the very beginning in their establishment of Christianity in Africa, Western Christian missionaries were faithful to Jesus Christ's commission to preach the 'good news' teach and heal the sick. The Church has to be a sign of the reign of God on earth (The All Africa Conference of Churches *7th Assembly Report*, 1997: 33). The commission to heal was fulfilled through the establishment of medical hospitals and clinics. The success of Christianity in Zambia, just as in many parts of Africa, was in part due to the preaching of a healer-Saviour who redeemed humankind not only from physical sickness but also sin and other dehumanising conditions. There were missionaries who adopted a holistic approach in their encounter with the people of Africa, but in general missionaries preached a spiritual salvation based on their own experience and Africans were accepted into the Church upon their receiving baptism and making an oral confession of faith in Jesus Christ.

This practice was bound to lead to a fragmented acceptance of the Christian faith and consequently a life characterised by ambiguities and contradictions. For many, Christianity

was only adopted outwardly but it did not inspire their spirituality. It is no wonder that Mbiti (1969), Mugambi (2002: 91), Bolaji Idowu (1973: 106), Okot P'Bitek (1971), and other critical observers have highlighted this apparent ambiguity – that many Christians, while upholding their piety as bequeathed to them in the missionary enterprise, still maintain their traditional beliefs and practices during important or critical stages of life. These include for example, birth, initiation, marriage, death, and when faced with mysterious and incurable sickness such as in these days of HIV, suffering and other anxieties of daily living. The healing and evangelical missions directed to the Africans did not have a holistic impact but was seen as directed to different parts of the same person, the body and soul, whereas in Africa this dualistic view point of the person is not existent. As Mugambi and Nasimiyu–Wasike, (2003: 56) puts it; to the African people in traditional life the world was a religious reality to the extent that no aspect of existence could be considered without reference to the comprehensive balance of relationships. It is in this sense that religion has been said to permeate all spheres of traditional African life.

Generally, the African worldview, which influences a traditional understanding and approach to illness and health, has not been taken seriously and has often been totally ignored. Hastings (1979: 67) and Idowu (1965) have both observed that missionaries condemned the African attitude and approach to sickness and healing. Idowu (1965: 107) further argues that African medicine was seen as devilish and witchcraft which is a basic fear in African traditional society was dismissed. Most mainline⁷¹. Churches today still deny the reality of witchcraft, magic and divination a denial that has alienated the Church from a crucial area of pastoral care. Tlhagale (2004: 49) cautions that both the process of inculturation, the deepening of faith and the ever-increasing influence of western education, have an effect of subverting the belief in magic, witchcraft and divination. He says it is important not to underestimate the depth of the belief in the African worldview. While this worldview is in the process of conversion, of opening itself up to the influences of other cultural forces, it nonetheless continues to have a firm grip on the minds of many Zambians. Many Christian believers have an undecided attitude to the process of magic, witchcraft and divination.

⁷¹Mainline Churches here refer to old major Christian denominations like – Lutherans, Reformed, Roman Catholic, Methodist, Moravians, Presbyterian to mention just a few.

Thus the healing ministry of the Church is an integral part of its witness to the gospel, and should address itself not only to the physical aspects of sickness but to the spiritual and social as well. Njuguna (2003: 75) and Nicholson (1995: 15) say HIV is leading the Churches onto a path of conversion.

Wanyoike (1973: 10-24) supported by Wangusa and others (2003: 31-67) indicate that the Church in its role as 'shepherd' of God's flock should address herself to this situation by alleviating suffering and enabling the realisation of God's reign. The Church must administer healing that will resolve harmony in the lives of individuals, community and the environment. In *Luke* 4: 16, Jesus declared his mission as to "preach the good news to the poor...proclaim release to the captives, recovering the sight of the blind and to set at liberty those who are oppressed..." The pastoral work of the Church is thus to be seen in terms of healing, guiding, sustaining and reconciling the people of God.

The Church needs to take hold of the message that humans were created to be people in community – not isolated individuals pursuing their own futures. Traditional concepts of health and sickness support the view that disharmony in relationships with God, neighbours and significant relatives' leads to separation, brokenness and sin. This lack of wellbeing occurs in all cultures and calls for the gifts that the Church has to offer (Robert, 1999: 24).

Holistic medicine is clearly a concept and practice whose time has come. A primary commitment of Christians involved in whole person health care, however, is to return health care to the domain of the Church. People should not be treated medically separately from a holistic approach. In practical terms, whole person care treats each person's illness as multidimensional, focusing particularly on the emotional and spiritual factors that have contributed to getting sick. It recognises the close connection between a person's sense of wellbeing, or lack of it, and physical health. Feelings of alienation from God and from significant others, of anger, of guilt, and of frustration eventually find expression in bodily and emotional illness if they are not attended to. Whole person health care takes particular interest in the range of psychosomatic illnesses in which soul and body appear to be divided and working against the total health of a person (Robert, 1999: 28). As Loe and Alkire (1994: 10) puts it, every form of illness causes suffering. Most cause both physical and psychological suffering. All of them create spiritual suffering, since they reveal, sometimes with a certain cruelty, the fragility of human nature.

Loe and Alkire (1994: 26) go on to argue that “when Christ heals those who are physically ill and restores them to health, his purpose for them is something far greater. It is to free them to health once and for all from corruption and death by raising their bodies”. These have, by the power of God, become incorruptible and immortal, and bestow upon them in this new body as in their souls, true life for all eternity.

Therefore we do not loose heart. Though outwardly we are wasting away, yet inwardly we are being renewed day by day. For our light and momentary troubles are achieving for us an eternal glory that far outweighs them all. So we fix our eyes not on what is seen, but on what is unseen. For what is seen is temporary, but what is unseen is eternal. Now we know that if the earthly tent we live in is destroyed, we have a building from God, an eternal house in heaven, not built by human hands (*2 Corinthians* 4:16–5: 1).

Henceforth the miracles that Christ performs seem to be visible signs of this coming restoration, where bodies will be healed for once and for all of every illness, and there then will be an experience of a perfect and permanent health. The troubles to be borne in this earthly existence are of little consequences compared to the life that is “hidden with Christ in God” (*Colossians* 3: 3).

5.6 Biblical foundations for healing

Holcomb (2006: 65) states that the New Testament pictures the healing acts of Jesus and of the early Church as signs of the reign of God that is at hand. The accounts include critical details of who is healed, when they are healed, and how they respond. The unclean lowly woman, the despised and outcast leper, the isolated paralytic, the blind beggar - these experience the dramatic embrace of God’s love. Once they have been thus loved and accepted their experience threatens all those powers, traditions, and people that have ignored, rejected, and suppressed them. Healing is part of creating a new order in society. It announces salvation. It demonstrates justice. It points to shalom: God’s intended wholeness for all creation.

After Peter’s Pentecost sermon to more than three thousand people, a forty-year old lame man lying at the gate to the temple was healed. Peter proclaimed that the resurrection power of Jesus, which was active to restore all things, had healed the cripple, and that this Jesus was to be worshiped as Lord over all. The threatened authorities arrested Peter and John. They

understood that this healing was more than a good deed, but rather a challenge to their power, a call for a new allegiance, and an assault on the prevailing system.

The intensity of Jesus' response to sickness is illustrated in the story of healing of a man with a crippled hand (*Mark 3: 1-6*). The healing is necessary on the Sabbath, since in Hebrew thought not to heal the man would leave him nearer to death - as Kinoti (1994: 64) says, "sickness is proximity to death". That is, the struggle against sickness is a struggle to save those afflicted from the power of death and the threat it poses. Since sickness opposes the creator God's saving power it must be righted and the creation restored. Jesus is the Redeemer in whom the mercy of God is present. What is new in his ministry is that the beneficiaries of God's mercy are not the religious authorities and legal scholars but those considered outsiders: the poor, the disabled, the sick, and the bereaved. Jesus made himself accessible to those who needed him, ignoring conventional limitations and thus according proper recognition to those who were cast out of society for whatever reason. Consistently he met people at their particular points of need and addressed those needs. Jesus is presented as a combatant, constantly opposing with his power those forces that kept people in subjugation. Holcomb (2006: 90) says whatever held people in subjection must be confronted and its power to do so destroyed, thus the sick were healed, the disabled returned to full activity, and the oppressed freed.

When Jesus welcomed the sick and disabled with open arms he presented a potent model to his followers. The manner in which Churches and their members respond to the challenge of HIV is an indication of the degree of seriousness with which they follow the example of Jesus. A response of love and compassion - an open-arms response - is demanded of God's people. It is a mandate expressly given by Jesus, as for example, in the parable of the judgement (*Mathew 25: 31-46*). Such a response is a further sign of God's gracious love, not only in the face of HIV but also to the entire community. It announces for all to see and hear that the reign of God is being realised and that it is taking shape in the world. If HIV in fact means falling into death's realm of power, loving acceptance of people living with the virus announces that God's saving power takes the field against death's destructive power. Compassion is indeed a first call upon God's people in the crisis created by the HIV pandemic (Moloney, 2005: 15).

By contrast, much of the healing today has been co-opted by the system of some Churches. It is easy to make an uneasy truce with the prevailing system rather than to be witness to a new

order based on God's justice. Too often human are locked in narrow, parochial, self-serving definitions of health care that are clearly unbiblical and reinforce a compartmentalisation of life that denies the wholeness of the gospel's message. When health is restricted to the individual, when people are imprisoned by the glittering promise of technological mastery, when there is a failure to connect health care and social justice, and when there is denial that healing has an intrinsic relationship in regard to a taking care of the earth, there is then a clear indication that there is a resistance to the biblical definition of health, healing and wholeness.

From the outset of the bible, it is clear that all creation is one, proclaimed as good, and intimately dependent on its creator. God's intention for creation is expressed in the Old Testament vision of *shalom*. Mwaura (2006: 185) says that shalom entails peace, justice, wholeness, fulfilment, harmony, and peace characterising the earth and all its inhabitants. This is the root of the Bible's understanding of health: it provides a basis for the Old Testament understanding of salvation. This shalom is never individual but corporate, known in community. It is never just between people, but always incorporates a right relationship to all creation. Its purpose is not human mastery and dominion, but the praise and glory of God.

Jesus Christ comes as the prince of this shalom, or peace and his body is to be the sign that creation itself has been redeemed. God reigns. Shalom will be restored. The reign of God will come on earth. Hoffman and Grenz (1999: 43) affirm that shalom provides the basis for the foundation for all the Church's ministry of healing - healing of the person, healing of the community, healing of the earth, for the glory of God.

This role of the Church as a healing community is rooted in the belief that it is a global and ecumenical reality. While communities may have different visions and ways of working together to accomplish their mission, ultimately they all exist for the healing of the nations. Mwaura (2006: 185) confirms this by saying that the mission of the Church in Africa is to bring shalom to all people and institutions.

5.7 The healing ministry of the church continues in the time of HIV

As in the time of Jesus, the healing ministry of the church today must be grounded firmly within the context of the lives of the people. No form of human need, no area of suffering fell beyond the purview of Jesus who through ministries of healing and the forgiveness of sin established the more just and merciful reign of God at those points where God's creation was most in anguish.

As already indicated in Chapter 1, the larger social and political realities confronting the Church in Zambia today are a temptation to focus on the HIV crisis in relative isolation from the multiple problems which are its firm foundation. The significance of the HIV crisis, can not be diminished but rather put it in a proper perspective by being aware that the main factor which is new and different in the HIV pandemic is the virus itself. Beyond the virus most of what the Zambian people are experiencing represents old problems that have been poorly patched and bandaged, or ignored entirely.

Gennrich (2004: 54-55) indicates that it comprises people concerned about those who already are HIV challenged or who have been diagnosed with HIV, the Church must be aware of the many contexts within which these individuals are fighting for their lives and well-being. Ideally care for PLWHA includes a broad range of health care and social services designed to enhance the quality of life, maximize individual choice, and minimize hospital and institution-based care.

The UNICEF (2003) report on *Africa's Orphaned Generation* rightly observes that in reality, the health and human service systems as well as many families are already overwhelmed or are ill-prepared to deal with the crisis. Ideally, home-based care services should be rendered with compassion in a manner that allows PLWHA and their loved ones to act as partners with their caregivers. Armstrong (2000: 32) and Bor (1998: 77) both note that those who have cared for persons with HIV know that HIV disease, especially in its later stages, presents complex challenges. The host of opportunistic infections that characterize HIV may attack virtually any part of the body. HIV disease stubbornly refuses to be limited to any single organ or treatment strategy.

The World YWCA (1991) has correctly observed that care needs vary also among different populations. Bernice (2004 online <http://www.ucc.org/justice/witness/wfj112904.pdf>) says HIV disease in women is manifested quite differently than in men; and the *Training Manual for Care for Children Infected and those Affected by HIV and AIDS* (2003) observes that HIV disease in children is manifested quite differently than in adults. Neurological complications of HIV disease may pose unique challenges. Ruzindaza (2001: 16) says individuals with HIV disease also have unique social and psychological needs as a result of the dire nature of the illness and the stigma that accompanies diagnosis. As has been mentioned above, the pandemic of HIV infection is widening most rapidly among poor people in Africa.

It is doubtful if Jesus would have found himself at home in this untidy landscape which is bordered on all sides by rather strict norms regarding what is right and what is wrong, what is proper behavior and what is sinful behavior, and who the people are who are welcomed or shunned at the doors of churches and temples.

In the New Testament we are presented with the flesh and blood Jesus who finds himself embroiled in controversy over his healing ministries and the teachings of the temple. The touch of Jesus is the healing touch of the Most Holy One. He is born into a world in which disease and suffering are rampant. Very early he realizes that the temple's mandates regarding holiness will stand in the way of his works of healing. Jesus will have to decide whether to observe the laws of Torah and the temple or to be obedient to God.

In thinking about the healing ministry of the church Dube (2002: 123) says it is appropriate to think that the Jesus who in doing God's work would redefine the meaning of holiness. It is this Jesus whom the church must learn to understand and follow in HIV ministries. The purity code contained in the Torah was based on the theological conviction that because YAHWEH was holy, Yahweh's chosen people were to be holy too.

Purity codes established external boundaries delineating the holy from the unholy: the clean from the 'unclean'. The most pure, holy and clean were priests and Levites: those associated with the service of the temple. At the other end of the spectrum was the leper. Stigmatized as the one in whom impurity ruled, the leper was the one most to be feared: the one to be announced by the words, 'unclean, unclean'.

Twelftree (1991: 187) indicates that Jesus came into such a world and touched the leper. Into such a world, Jesus came and brought an image of holiness defined not by its distance from what was considered unclean, but by its proximity to it. Into a world so divided and separated within itself came Jesus, who, with the touch of a hand, restored human community.

Jesus entered into a world so fascinated with the notion of affliction's sinful cause, yet he began giving attention to illness and affliction as opportunities within which one could experience God's compassion and love. Into a world which so clearly judged some as sinners and made outcasts of others, came this man Jesus who, in forgiving sin and in cleansing the leper, gave a preview of God's more just and merciful kingdom.

Jesus redefined the meaning and activities of holiness. In Jesus holiness included entry into the lives of others: holiness became an act of engagement, not a state of separation. In Jesus holiness took on the suffering of others; holiness associated with what was meek, lowly, despised. In Jesus holiness's healing touch was the touch of inclusion and participation; the touch that said 'you belong'.

The healing miracles of the New Testament present us with a Jesus who broke down barriers, who took risks which still challenge us today. Jesus risked his life unconditionally for the neighbor, without fear of reputation, for the sake of the Kingdom, risked his life, lost it, and returned to reveal the promise of the scriptures for eternal life. Jesus' challenge is present in this *Kairos* moment. Jesus is found in the face of every person who is HIV positive. As the Church works closely with PLWHA they come to a deeper understanding of what love is really all about. Janet Brown (2004: 112) has called for the resurgence of the ministry of love in the Church of Jesus Christ as we deal with HIV and AIDS. Meanwhile Gitome (2003: 200-204) calls on individual theologians to get involved in reconstruction theology and calls on the Church to be Christ-like in the ministry of care to people living with HIV.

HIV has taught humanity things about love that transcends all the debates of all the churches of all the centuries about sexuality. The HIV pandemic has given the Church an opportunity to learn about the character of the love that sustains and upholds in sickness and in health. In learning to care for one another and to love one another in the best and the worst of times, HIV has brought to the community of believers an actual knowledge of love that is larger than anything ever experienced, understood, asked for, or can ever be forgotten the loss, the Church is captured by a love such as this.

The Church in the deepest and most profound sense of the word is not about the institution, structure or denomination. As the WCC Faith and Order (1998) study indicated that it was the *koinonia*, the ageless human response to Jesus invitation. The Church is a community - the communal witnessing to the present love of God in the lives of people. The community is attempting to serve Christ in a world that every day sees the human family taunted, torn and tortured in one way or another. The Church is a communal gathering of those who remember, and follow, and serve the Christ who in the majestic words of Handel's Messiah was 'a man of sorrow', 'rejected and despised'.

The radical, defiant Jesus violated the purity codes. He was rejected, forced out into the countryside for his association and physical contact with the leper. He was scorned by the temple because he took it upon himself to forgive the sins of the people. This Jesus of the healing miracles is the Jesus many people lost touch with early in the AIDS epidemic.

Gitome (2003: 200) reminds us that early in the 1980s and 1990s, the pretender Christ rose up: those who felt it incumbent upon themselves to preach God's wrath, to speak God's words of judgment and condemnation, to proclaim that HIV is God's punishment for sin.

That was surely contrary to the Jesus of the healing miracles, present always with those who were sick and suffering. The Jesus who always located himself and God's unconditional and unmeasured love precisely at the point where God's creation was most in anguish. It is perhaps true to say that if the historical Jesus were physically present today he would present himself wearing the visible signs of Kaposi's sarcoma: so complete, so total, so inescapable would his identification be with all who are living with HIV.

Not only has HIV robbed people of their family members, loved ones and friends, HIV has robbed the churches of their collective memory of the compassionate Jesus, the Messiah of the marginalized, the prophet most at home among the people pushed to the periphery.

The Church needs to care about its healing ministry in the midst of the HIV pandemic. The church need to make a Covenant to Care, a concept which is so simple and yet so deeply grounded in the Old and the New Testaments:

The passion of the researcher for the Church's healing ministry is to see churches develop a Covenant to Care by creating Circles of Hope developed partly in response to a question raised by a 36-year old young woman at Kamwala Reformed Church congregation in 2000. Mai Soko⁷² was a policewoman, she was living with HIV, Kaposi's sarcoma was visible on her arms and face, she was a single mother. Halfway through a house visitation she took up the courage to ask: "Would I be buried with a Church service when I die even when you know that I am dying of AIDS, would I be welcome in the Church ever again?" A 36-year old young woman cut the matter to the quick, and asked the most profound theological question to a minister doing house visitation.

Mai Soko died that same year later in Lusaka where the researcher had come to know her before she died and thus there was time to prepare her funeral service. She chose all the hymns that were sung and the verses that were read. A never forgotten memorial service was conducted at the Kamwala congregation of the Reformed Church in Zambia. When Amai Soko died the researcher decided that

⁷²Mai Soko is an assumed name given to the real character of the person being described in this part.

she and all others like her deserved an answer to the question she had raised. The researcher knew that one way of answering her question would be for churches to issue Covenant to Care statements letting it be known in their communities that if you have HIV or if you are the loved one of a person who has HIV, you are welcome here.

It has been the hope of this researcher that churches in Zambia would seriously take up the challenge that is so well put by the United Methodist Church's resolution on 'Aids and the healing ministry of the church' (1992), namely:

As members of the Church we covenant together to assure ministries and other services to persons with AIDS. We ask for God's guidance that we might respond in ways which bear witness always to Jesus' own compassionate ministry of healing and reconciliation; and that to this end we might love and care for one another with the same unmeasured and unconditional love that Jesus embodied.

The healing ministry to which the churches continue to be called in this third decade of the HIV pandemic is a ministry of truth and revelation. The pretender Christs focused on God's wrath forgetting perhaps that Jesus looked at those who suffered and saw therein the face of God's creation. Gitome (2003: 201) reminds us that if the Church aspires to be the faithful disciples of the crucified and risen Christ and the love he exemplified, then it is its task and holy duty to proclaim that:

- the face that HIV wears is always the face of a person created and loved by God;
- the face that HIV wears is always the face of a person who is someone's mother or father, husband or wife, son or daughter, brother or sister, loved one or best friend;
- the face that HIV wears is always the face of a person who is the most important person in someone else's life.

In a web based article entitled 'Building a healing Church', the following are some points of consideration as suggested by Carnahan (2003 <http://gbgm-umc.org/health/hivfocus/focus019.cfm>). He calls them covenant points:

- Making a covenant to be a place of spiritual nurture and uplift
- Making a covenant (a promise) to affirm the sacred worth of persons with HIV
- Making a covenant to be harbingers of hope. We all need hope in our lives: things to look forward to. We all need to celebrate life in whatever form it is given to us today. The covenant is to be a place of joy and celebration.

- Making a covenant to be a companion to one who is ill and alone, no matter how? How long the hours are in a hospital. Making a covenant to visit, to not be afraid.
- Making a covenant to provide care when loved ones need a break. Lend a hand. It's one of the gestures of Christ's healing touch.
- Making a covenant to take time to be there. You are the presence of Christ in the midst of suffering, doubt and fear. No greater commission was ever given to the followers of Christ than to be the presence of Christ in the lives of others.
- Making a covenant to work with other churches and community groups to address the larger context of HIV.
- Making a covenant to see that HIV prevention becomes a reality.
- Making a covenant to take care of yourselves. Remembering that? Jesus withdrew from the disciples to pray, to be alone with God, to care for his spiritual needs. Perhaps there were times when Jesus wept over the burdens he carried. It is okay to cry. Perhaps there were times when he felt uncertain, unsure, not up to the task of establishing God's reign on earth. God understands our unbelief, our lack of confidence. As in the life of Jesus, God moves people from prayer to action. God is with his people always in their covenant- making and their covenant keeping.

The researcher argues that here is need for faithful leadership that can help to bring about nonjudgmental attitudes and make churches places of openness where persons whose lives have been touched by HIV can name their pain and can reach out for compassion and consolation. Ruzindaza (2001: 90) says that leadership will create awareness of what persons with HIV have to offer the congregation. It will also show that the congregation is not fully representative of the body of Christ as long as any person with HIV is excluded, barred or kept out.

Twelftree (1991: 188) implores that Church members should be the visible followers of the Christ Jesus. Jesus redefined the meaning of holiness who with the touch of the hand established the merciful and just reign of God. This was among those whom temple and society believed to be 'unclean' and those judged to be sinners; those who were cast out by others who deemed themselves to be holy.

A healing Church should break down barriers, take risks for the sake of a new heaven and a new earth (*Revelations 21*), it should make a covenant to follow him: the Son of God, the Christ of the journey, the Jesus who knew what it was like to be lonely, rejected and despised.

But what are these Circles of Hope that are being proposed to act as a base for theological reflection which would help to de-stigmatise HIV infection and promote healing in Zambia?

5.8 Attempts to define Circles of Hope

In this section, the researcher deals with the deductive and dialogical methodology within a hermeneutic approach. Chapter 1 and 2 did a wider and local contextual analysis. Chapter 4 sketched the necessary themes for the theological and biblical engagement of the paradigm of Circles of Hope. In drawing upon an interpretation of the normative sources of scripture and tradition, this section will focus on the definition of the term under use, and look at how such support groups are started and how they operate.

The term ‘Circles of Hope’ refer to support groups of people living with HIV and has been coined by the Northmead Assemblies of God congregation of Paseli Road in Lusaka under the leadership of Bishop Joshua Banda. Currently, amongst the more than 14,000 local congregations for the Church in Zambia across denominational barriers, only 44 known congregations have started implementing the idea of ‘Circles of Hope’. It all started in 2003 at Northmead Pentecostal Assemblies of God in Lusaka and the Trinity congregation of the United Church of Zambia based in Church Road, also in Lusaka. This work has seen expansion through a formalized creation of Circles of Hope as an arm of the Council of Churches in Zambia – HIV work at Makeni Centre. The researcher has been instrumental in initiating that work.

According to <http://www.geocities.com/athens/4177/circlehist.html>, for nearly all early civilizations, the circle represented ultimate cosmic order. Early people believed that the universe was held together by a binding force, or thread. This was represented by the *ouroboros*, a snake swallowing its own tail. In this way, the circle became the symbol of perfection, representing the unity of self; the heart of humanity; the seed; the womb. It is in this regard that the researcher sees Circles of Hope as representing the heart of humanity in this time of HIV. A circle is also a symbol of unity and wholeness.

The circle evokes sitting around the village fire or under a tree. However it manifests itself, the circle is all about being a place for community to grow, about being face-to-face with a basic need for freedom, love, and justice and it is about being knit together in a network of people that overcome stigma, silence, shame and share resources. Plus, it is all about being something that can roll somewhere further towards other congregations and faith

communities. Apart from just adopting it as a name for HIV support groups, the Northmead Assembly Of God Church did not elaborate on the meaning of the term of Circle of Hope from which the inspiration of the CCZ led groups are being created. This work attempts to do that.

The name Circles of Hope as such has a lot of significance. It speaks of a ‘circle’ and ‘hope’. A circle has no end or beginning. It wants to communicate that these support groups depend on the everlasting love of God manifested through people of faith on earth through their works of care, love and compassion. A circle has a way of keeping those inside safe and protected from harm coming from outside. The support group gives HIV positive members of the body of Christ fellowship which protects them from self stigma, silence and shame associated to HIV.

According to *The Encyclopaedia of the Lutheran Church*, Vol. II, (Augsburg, 1965: 660), the Missouri Synod has attempted to give a very succinct definition of the word fellowship which thoroughly agrees with the researcher`s understanding of the term as it would apply to the Circles of Hope concept. The Synod said that the term “fellowship” has a twofold meaning. On the one hand, it can refer to the unity which persons *have* with Jesus Christ by faith in Him. The word also suggests that people in whom the Holy Spirit has worked faith in Christ, will desire to *express* this unity with other people who confess the Christian faith.

On the other hand, the Greek word *koinonia* (translated “communion” or fellowship in most English versions) helps to see that fellowship is always fellowship *in* something. Fellowship cannot simply be equated with friendship or a feeling of togetherness. Christians are partners who share in the Gospel (1 Cor. 9:23), in faith (Philemon 6), in sufferings (Phil. 3:10) and comfort (2 Cor.1:7), in trouble and endurance (Rev. 1:9), in the Holy Spirit (2 Cor. 13:13; Phil. 2:1), and in eternal glory (1 Peter 5:1).

McLaren (1998: 70) reminds that understanding the meaning of fellowship, however, involves more than a definition of the word *koinonia*. The Epistle to the Ephesians makes it clear that the unity of people with the triune God and the consequent unity they have with all those who believe in Him is the overarching theme of the entire Christian message. God revealed to His holy apostles and prophets: “how the Gentiles are fellow heirs, members of the same body, and partakers of the promise in Christ Jesus through the Gospel” (Eph. 3:6).

Through the word of life the Gospel, God unites people together in fellowship with each other. This fellowship is first of all fellowship with God the Father and with His Son Jesus Christ. Therefore, Easum and Bandy (1997: 30) says that fellowship has both a vertical and a horizontal aspect: fellowship with Christ and fellowship with other believers. A study of 1 John would help the reader see that when fellowship among Christians is threatened, a return to the Gospel restores and strengthens fellowship; for without faith in the Gospel, whose content is Christ, no fellowship exists.

This work focuses on the vertical aspect of fellowship, namely that people become members of the church by being united with Jesus Christ. Fellowship is a divine creation. The work emphasises the outline given in Ephesians 1. Before the foundation of the world, God, the Father of our Lord Jesus Christ, planned our redemption and chose us to be His sons and daughters. In the fullness of time, He sent His Son Jesus Christ to do what was necessary to establish peace between Himself and the human race, which was separated from Him by sin. Through Christ all people, whether Jew or Gentile, have access to God's forgiveness. Through Baptism, they enter into his covenant by being united to Christ (Titus 3:48). They receive the Holy Spirit, who enables them to call God "Father." God's Spirit is "the guarantee of our inheritance until we acquire possession of it" (Eph. 1:14). The Holy Spirit works through the Gospel and the sacraments to preserve His children in union with their Saviour. McLaren (1998: 72) says that apart from union with Jesus Christ, through faith there is no church, and thus no true fellowship with others. The researcher wishes to differ with that assertion in as far as the fight against HIV stigma is concerned and wishes to submit that this fellowship must be **all** embracing in the search of creating a community where peace, love and dignity for all will thrive. Circles of Hope are a fellowship of those who have identified common suffering of rejection and exclusion because of their HIV status. The horizontal aspect of the Circles of Hope fellowship is with all those in every place who are HIV positive. Volf (1998: 211-212) summarises this very well when he says that the catholicity of Christians cannot be limited ecclesially. A catholic person involves internalisation not only of that person's Christian siblings and friends, but also of the person's **entire "environment"**- of the creator as well as of every creature. Every person is a catholic person insofar as that person reflects in himself or herself in a unique way the entire, complex reality in which the person lives. The HIV context is but one of those environmental issues which require a catholic approach in the sense of giving it its better place first and foremost within the body of Christ and then to influence the entire community beyond any artificial barriers.

This lesson points to the responsibility of Christians to *manifest* the unity which has already been given to them through the power of the Holy Spirit. As branches united to a vine bear fruit, so also do those who are united with Christ spontaneously show love toward others (John 15:12-17). Love stands at the top of the fruits of God's Holy Spirit because one who loves as Christ loved us, seeks to build up his fellow believers. When love controls the conduct of Christians, their chief concern is to help each other remain faithful to Jesus Christ and thus remain members of His church. Genuine love "rejoices with those who rejoice, weeps with those who weep", strengthens the weak, encourages the strong and admonishes those who are in error. In a sense, love builds up. In their relationship to each other, believers will heed the words of the apostle: "Therefore be imitators of God, as beloved children, and walk in love, as Christ loved us and gave Himself up for us, a fragrant offering and sacrifice to God" (Eph. 5:1-2).

The emphasis of this section is summarized in the words of the apostle Paul, "[Be] eager to maintain the unity of the Spirit *in the bond of peace*" (Eph. 4:3). God wills that His church express the peace it *already has* by striving to be at peace with others in the church and in their surrounding 'environment.'

God is the protection of life for those living positively with the virus. Those inside the circle support each other; they are intrinsically connected to each other because of a common bond of their faith in God and their HIV status.

In as far as hope is concerned the Reformed Ecumenical Council observed rightly at their meeting in Utrecht (2005) that hope has at its essence the conviction that life does not end with death, but that death is merely the doorway to a new life. While this message needs to be proclaimed, it should not be done at the expense of a positive meaningful life here on earth. An HIV theology of Hope will be built if the church clearly states that HIV is its problem so that those infected can be provided an opportunity to embrace the Circles of Hope concept so that they do not have to carry this burden on their own anymore.

True hope will be built where those who are suffering from HIV are surrounded with love, care and compassion of fellow believers and where those who are dying are assured that the relatives of the deceased will also be cared for after the death of their relative.

The church owes the world hope - for both this and the ultimate new world. Because the church knows that it is a commissioned witness of the coming new order, it has to erect signs

of the reign of God already. Because she knows that the gates of hell cannot prevail against her, she can risk the impossible. Because she heard God saying: 'Behold! I am making all things new!' (Rev. 21:5), she can already begin something new. Nothing may remain unaffected. The suggestion that things might stay as they are, is the very antithesis of the gospel. It is nothing less than a denial of Christ's resurrection and of the inauguration of the new age. Hope is built not only through words but even more so through praxis. Hope cannot be built in a climate tainted with stigmatisation and discrimination. Clifford (2004: 28) says that in order to meet the challenge of offering healing and renewal to those it serves, the church must first acknowledge healing itself. This is about presenting a theology of love and hope instead of a theology of vengeance. It also involves repentance for having increased the stigmatisation of and discrimination against people living with HIV. Furthermore, if the Church is to be effective in halting HIV related stigma, further healing needs to be done. The Church must transcend and heal internal divisions and cooperate with secular organisations and representatives of other religions including those whose beliefs it may have previously declared itself to be implacably opposed. In other words, what is needed to bring hope is an inclusive and healing theology. The UNAIDS Windhoek meeting (2003) observed that the stigmatisation of people living with HIV calls the church to ask itself what it means in this time to be the inclusive community that Jesus proclaimed.

The UNAIDS Windhoek meeting further observed that as a community of disciples of Jesus Christ, the church should be a sanctuary, a safe place, a refuge, a shelter for the stigmatised and excluded. The Church is called to work towards both the prevention of stigma and the care of the stigmatised. And yet churches have habitually excluded and stigmatised those who are 'different', those who did not conform and those who sinned or were thought to have sinned. This challenges the understanding of the church's identity and calls for deeper reflection on the issue of inclusion and exclusion within the faith communities. Jesus ministry was inclusive to the point of scandalising religious authorities and respectable people of the time. In a time when people living with HIV are being stigmatised and discriminated against within churches, this suggests the need for renewed theological reflection on the nature and identity of the church itself.

Someone who knows that God will one day wipe away all tears, cannot with resignation accept the tears of those who suffer and are oppressed now. Bosch (1991) in *Witness to the World* indicates that:

...If we believe that one day all disease will vanish, we cannot but begin to anticipate here and now the victory over disease in individuals and communities. We believe in God not because we despair of the present and future; rather we believe in the present and future of both *humanity* and the world because we believe in God. Precisely because Christians hope for the eternal and ultimate things, they also hope for the temporary and the provisional.

5.9 Circles of Hope for healing

This study contends that Circles of Hope support groups are a base for experiencing healing in the local congregation. All this is done as part of discerning an appropriate alternative response during this time of HIV. Here the researcher has been working with the second hypothesis namely that:

A missional theology which promotes the praxis of the creation of circles of hope at a congregational level is a basic presupposition for holistic approach to combat the HIV pandemic.

This is a critical correlational hermeneutic. It is bringing healing in concrete terms within the Church amongst people affected by the virus. This healing is brought about because of the holistic approach to combating HIV infection.

The Circles of Hope will be one concrete way in which local congregations can break the silence as well as provide a platform for Christian PLWHA. These groups would help in developing positive mental attitudes, and the prevention of re-infection. Christian PLWHAs are helped to deal with the present, past and the future and also how to deal with their remaining lifetime. Circles of Hope will increase the rate of voluntary counselling and testing and congregations will be strengthened in their battle against the disease (Robert, 1999: 17). These Circles will be inclusive rather than exclusive.

5.9.1 Creating Circles of Hope

Robinson (1996) and Ronald (1995) have both suggested that priority should be given to new and innovative ways of addressing the underlying causes of the spread of HIV at the community level in order to bring about behavioural change. In the *Renewing Our Voice* project of 2004, it was emphasised that an approach is needed that is specifically target group orientated and tailor-made for different groups within the congregation. Furthermore, it is clear in *Protocol for the Identification of Discrimination against People living with HIV*

(2000) that an analysis in the planning stage of work on HIV needs to be looked at from an integrated and contextualised perspective that takes into consideration issues like gender inequality, violence, sexuality and stigma.

Leaders, therefore, should support small-scale initiatives, as well as promote stronger input from all stakeholders on the agenda regarding HIV. Existing methodologies such as peer group education for women and men, body literacy projects, capacity building of local congregations and empowerment of women's organisations can bring about behavioural change. In particular, the empowerment and participation of HIV-positive people in prevention and care programmes will give HIV a human face and challenge stigma and marginalisation of those infected by the virus.

5.9.2 Promoting dialogue – the basis of Circles of Hope

Ndhlovu (1998: 2; 2000: 61-70), Muchiri (2000: 76) and Mario (1999: 10-32) have all agreed that the silence surrounding sexuality has killed and will continue to kill people. This is particularly relevant for many faith-based communities who are often very reluctant, or who even adamantly refuse, to talk openly about sexuality. Church leaders in particular will need to address the concepts of gender, sexuality, power (including violence against women) and culture in relation to HIV in all their dialogue and co-operation with their members. A prerequisite for a meaningful dialogue is the admission of vulnerabilities in these areas. Gennrich (2004: 17) calls upon local congregations to cooperate fully on prevention strategies and care programmes. Meanwhile Singhal and Rogers (2003: 30) have suggested that Churches are well advised to take up the invitation of dialogue with HIV positive people, and should recognise and benefit from the gift of spirituality being offered to them.

Lindqvist (2005: 56) contends that emotional/spiritual support for persons infected with HIV and their loved ones and care partners is a vital aspect of living with HIV. Baranowski (1988: 10) goes on to say that the need for support groups in every local congregation community and almost every church are significant. Sometimes getting started seems a daunting task. The researcher will attempt in this section of the study, to point out a few salient directions that may assist with starting a local congregation Circle of Hope support group. Most of the foregoing information is therefore a result of the trial and error methods that the researcher has been involved with through the Council of Churches' Makeni HIV/AIDS Resource and Training Centre.

There are close to a 150 HIV positive people that the CCZ is working with in about twenty support groups. Van der Walt (2004: 16) commented:

The silence of churches, synagogues, and mosques across the nation - the refusal to listen with love - serves to push aside people with HIV/AIDS. The church, and that means all people, must stop pushing away their own brothers and sisters with AIDS; they must stop trying to put them out of their lives and out of their families. The church is supposed to bring people together, not to leave them out in the cold. The church is to be a place of healing.

5.9.3 The importance of Circles of Hope support groups

According to Loverde (2005), the triune God means one God within whom there is a community of three persons. Human beings are created in the image and likeness of God and covenant people share explicitly in the very life of the triune God. The trinity is thus a model for support groups. This is about unity from the unity of the Father, Son and the Holy Spirit. The Church is the presence of Christ in the world. Christ who reveals the Father and who remains with believers through the Holy Spirit.

Support groups help meet the needs of persons living with HIV, their loved ones and caregivers. Caregivers include a variety of people - the loved ones of persons living with AIDS (PLWHAs), friends, health care professionals, and facilitators of support groups. According to the Global Network of People Living with HIV/AIDS manual for people living with HIV, *Positive development: setting up self-help groups and advocating for Change* (1999: 117) such support groups:

- provide people with HIV a relaxed and informal place to share their experiences and build new friendships; help caregivers to renew their faith and confidence in the face of devastating losses;
- give couples (at least one of whom is HIV positive) an opportunity to discuss relational, legal, health, and other issues that concern them;
- provide specific groups of people -such as women, persons over 50, teenagers, church men's groups, a choir- - a support group of their peers to discuss their experience of HIV in their lives.

Support groups are especially important to persons who are HIV positive. So many emotions confront people after they have tested positive. They can become frightened, bewildered, and worried. As they face changing social supports and financial situations. When others reject them and treat them inappropriately, they can become depressed, angry, and feel isolated.

In the Circle of Hope groups, PLWHAs meet others who have had similar experiences. They learn they are not alone and that they can build a new life:

I could share with these people my deepest secrets and still be loved. I would give up an arm or leg to have a new Circle of Hope group. I have tried to start one but it never panned out.... When I first became sick it was the group that gave me the strength to keep going. In the group we talked about life and we also got a guest to come in and teach us nutrition, legal aspects, alternative medicine and many other programs.... It saved my life so I know how important it can be for others. When I heard the facilitator share her story of how she discovered that she was HIV positive I identified with her and it gave me strength to realise that I was not alone. (From a member of the Garden Township Circle of Hope group, February, 2005)

Shelp and Sunderland (1987: 136) show that HIV support groups often become a major source of love and acceptance. Usually people gain acceptance, support, nurture, and intimacy from their birth families, close friendship groups, and/or religious groups, such as churches and synagogues. However, too often these groups reject individuals when their HIV positive status becomes known; especially if the person contracted HIV intravenously, from drug use or same gender sex. On the contrary, the Zambian experience of Circles of Hope has been that for any person to become a member of the support group they have to have tested HIV positive and so there is no rejection whatsoever. It does not matter how one contracted the virus. Stories of drug users and gay people, however, have not come to the fore yet in the experience of the groups that the CCZ is spearheading.

Loved ones of PLWHAs can also benefit from special support groups to deal with their issues, including their feelings about care giving, fear of contagion and infection, grief, changed social conditions, health concerns, and obsessional thoughts.

Voluntary caregivers, if not family members may face the same issues of anticipatory loss and grief, isolation, helplessness, and hopelessness as do the people actually living with HIV. Premilla (2004: 17), and Kidd and Clay (2003: 45), indicate that support groups can help caregivers meet the challenges of social isolation and lack of a support system and reduce stress, enhance coping skills, and avoid burnout. Groups enable caregivers to discuss concerns with others sharing the same experiences and emotions and to work out complex feelings of worthlessness, frustration, or alienation.

HIV negative persons are another category that would benefit from the existence of support. Groups. Those who have lost friends, neighbours, and loved ones to HIV can suffer from what Dixon (1994: 59) refers to as survivor syndrome. Symptoms of this state are intrusive images of disaster, psychic numbing, struggles to find meaning, and guilt. This is what Louw (1994: 180-183) describes as symptoms of shock, numbness, disbelief, anger and feelings of hostility and even feelings of guilt. Persons feeling this way are liable to participate in self-destructive behaviours, such as overt and covert suicide attempts. They may start to have unsafe sex. A goal of survivors' groups, therefore, is to keep their members HIV negative.

5.9.4 Types of support groups

From the Circles of Hope praxis, the following have been key aspects that form the basic content of the application of the strategy that is in the process of developing. The angle is more from one of participant observation from the field which flowed from the application of the ideas of Stone (1996) as found in his book *Theological Context for Pastoral Care Giving*. On participant observation, Musante (2001: 1) says that it is a method in which a researcher takes part in the daily activities, rituals, interactions and events of a group of people as one of the means of learning the explicit and tacit aspects of their routines and their culture.

Four general types of support groups can be experimented with. Support groups to be effective are small groups that gather for support for dealing with a **shared** concern or experience making them different from home to home-based care groups where **patients** are **recipients of care** when they are not able to care for themselves. Support groups:

- a. follow a suggested, often ritualistic, format; have established written guidelines; but use rotating facilitators. Common examples would be 12-step groups, including HIV positive 12-step groups, some types of church groups meeting for prayer, action, and/or study.
- b. use rotating facilitators or no designated facilitators. They follow either a loose regular format or are free form. Common examples would be consciousness raising groups; some types of church groups meeting for prayer, action, and/or study, such as covenant groups; social groups.
- c. are facilitated by trained volunteers. These groups usually have some kind of verbal or written agreement about the format of the meetings and the ground rules for the group. Common examples here would a variety of HIV-related support groups sponsored by HIV support and other organisations bereavement groups, church small groups, parents' groups, social action groups.

- d. are facilitated by trained professionals. The format and guidelines of these groups vary with the professional's style of leadership and the purpose of the group. Common examples would be HIV/AIDS support groups run by therapists, social workers, clergy; group psychotherapy, general groups and groups focusing on a certain issue such as physical abuse or recovery from addiction; support groups for trained volunteers facilitating support groups.

Stone (1996: 135) comments that, when established with the appropriate guidelines, support groups provide a non-judgmental environment where people with similar experiences vent their feelings, work on their day-to-day problems, explore issues that concern them, including spiritual issues and widen their base of friends.

This study focuses mostly on how congregations can sponsor the third type of support group, those facilitated by trained volunteers, with some emphasis on groups led by clergy. A support group for HIV-positive people is the example that is used.

The groups described in this work are about HIV positive people helping each other. Sometimes PLWHAs need to be in therapy support groups but most often other types of groups are more appropriate. Additionally, care must be taken not to convey the message that just because a person is HIV positive she or he needs psychotherapy. This is often a western mentality. This approach can be especially problematic when dealing with Africans whose worldview on disease is different. Many people in Zambia are not psychotherapy-oriented and get their support and guidance from their own peer groups and/or religious leaders, traditional leaders, village headmen and medicine people, if not from some elders in the family networks. Psychotherapy continues to be viewed as very a western method of dealing with illness and crisis.

5.9.5 Getting started

Mugambi (2002: 95) reminds us that Christianity came with the teaching that the Church is to be understood as a new family whose head and centre is Jesus Christ. This new family is not based on kinship, clans or ethnic identity. Neither is it based on racial origins or social status. Primarily, it is founded upon faith in Jesus Christ, and its cohesions are maintained with the Church whose individual members are expected to live according to the new relationships as proclaimed by the gospel. Meanwhile, Mugambi (2002: 96) says in the pre-Christian days when conflicts arose they were inevitably settled in an informal manner through the good

services of the village elders or headman. Parties were encouraged to air their views and open up. Solutions were suggested and the best option adopted for resolving the conflict.

In fact, Nyirongo (1997: 83) adds that in the past parties resolved conflicts out of high respect for the elders and the need for mutual harmony among all the village inhabitants. Nowadays, much of this tradition has disappeared but the Church has taken that role for many Zambian people. Village mediation as a tool helped parties to resolve their disputes in an amicable manner. It was useful because disputants could meet and discuss how best the conflict or disagreement between them could be resolved without the need to resort to violence. In the process it helped clear misunderstandings and build community cohesion and harmony. The possibility of people sitting together under a tree settling disagreement, discussing challenges and creating cohesion and harmony within the village community is what we would refer to as a typography for the proposal of this work, namely that of Circles of Hope which can be used to deal with issues around HIV.

There are as many ways churches can start and maintain HIV-related Circles of Hope support groups. First, a church should assess if there is a need for such a group as well as the type of need that exists. At this point they need to pay attention to who has suggested a support group - the group to be served and/or the group offering the service? They must be sure those to whom the service is offered also feel the need for a support group.

Sometimes churches that want to start an HIV support group have their own agenda, such as gaining new church members, bringing the gospel of Jesus Christ to the participants in a catechesis way, or helping group members to leave their sinful lifestyle. In their book, *AIDS and the Church: the Second Decade*, (1987: 136-137), Shelp and Sunderland emphasize that:

AIDS ministries are primarily ministries of support, nurture and consolation. They are not primarily evangelistic ministries in the sense of pressure to convert to a particular faith or morality. To view evangelism as the primary or sole objective of ministry to people with AIDS is to misunderstand ministry and probably will be counterproductive with the targeted audience. ..."Saving" people, it should be remembered, is God's business. Thus, the purpose of all ministries, including AIDS ministry, is to represent God's love for all humanity, without condition, and to embody and express that love in all human relationships.

Another step is to find out if the service is offered elsewhere. If support groups exist and no more are needed at the time, ask those groups if they have facilities such as referrals, low cost space, pastoral counseling, and safe religious space for PLWHA's.

Shelp and Sunderland (1987: 138) suggests that if it is determined that people need one or more support groups appropriate persons should be secured to be facilitators. If these volunteers are inexperienced in leading HIV support groups, then the congregation may hold a training event or send them to a training event. A local HIV support organization, a social worker, pastoral counselor, or psychotherapist experienced with working with people with HIV; and/or instructional training booklet like those produced by the WCC, all can assist the training.

Stone (1996: 164) recommends that it is always important to involve potential group members in the planning for the training of the facilitators and for the purpose of the group. ‘Ownership’ of the group by its members is a vital issue. Group members should share in the leadership at every stage of planning.

Groups can be open-ended or time-limited. They should have a specific focus, such as a group for HIV positive people, a group for caregivers, or a group for women who are HIV positive and/or at risk of becoming HIV positive. Discussions can centre on a variety of topics, including medical information, treatment options, common experiences, or physical, emotional, and/or spiritual support. Members can also spend time praying for each other.

They should set an agenda, a regular meeting time, and a convenient location and advertise these as appropriate. Announcements can be made on Sunday in the church and personal contacts can be established to let people know of the group.

5.9.6 The role of facilitators

A support group, whether formed from a spiritual, pastoral or psycho/social perspective, must be facilitated by experienced, compassionate and competent persons. Good facilitators are, in the words of pastoral counselor Clinebell (1984: 98), “group-centered leaders”, and “midwives”. He wrote that their job is to help the group achieve an emotional climate and a level of communication, which will facilitate the growth of all group members. Facilitators model an attitude of support, caring, concern, and respect for all.

Creating an atmosphere of respect and dignity and maintaining it is of utmost importance, especially for groups of HIV positive people. In other contexts, PLWHAs often experience rejection and oppression because of their positive status, as other people have just assumed it

is a result of sexual immorality Individuals need a safe place where they can be themselves as they hear their own stories through other people's experiences.

Facilitators set basic boundaries, making it clear that the group norm is tolerance of each individual's uniqueness. They demonstrate respectful and caring behavior by listening carefully to what each group member says and addressing each one with respect and dignity. They model asking questions and expressing disagreements in a supportive, non-threatening way (Clinebell, 1984: 99).

The facilitators and group should develop group guidelines. For instance, an important ground rule is that no physical violence or threats of physical violence will be tolerated. The group may want to be a non-smoking group.

Make a group agreement that members who are not already married to another group member must not enter into sexual relations during the time period the group meets. Speaking of support groups whose purpose is healing and/or recovery, feminist psychotherapist Charlotte (1992: 293) says of healthy support groups:

sexual or emotional exploitation is not accepted as part of the norm. People do not emotionally, sexually, or in any other way exploit each other. The group is not used as a place to find sexual or dating partners. (Remember groups often become one's psychological family and it is incestuous to have sex with one's brothers and sisters.) If two members become involved, one should leave.

This boundary is not intended to be sex-negative. This boundary is intended to maximize healing and prevent abuse that happens in heterosexual relationships. Davis and Bass (1990: 30) have written extensively of the sexual abuse of women by men in Alcoholics Anonymous. Sexual exploitation is not limited to heterosexual men or men in general. Abuse can be initiated by either gender.

Boundaries will vary from group to group according to its context and needs either in rural or urban Zambia. Another very important concern is confidentiality. All must be done to ensure the group understands that 'what is said in the room stays in the room'.

Co-facilitators can be a better leadership model than a single facilitator. For example, where the group is a mixed-sex group a male and female team can be very effective. If at least one of the facilitators is HIV positive the group may experience this as especially affirming and

encouraging. A key requirement, of course, is that the co-facilitators get along and work well together.

It should be mentioned here that each group has its own life. As each group is unique, support groups tend to move through certain stages. The facilitator should know these stages and phases and be ready to guide the group.

5.9.7 Early stages in a group

People newly-diagnosed with HIV deny that they need a support group. Sometimes this reaction covers some type of fear about joining a group. Perhaps the person has never been in a support group setting before or has had a negative experience with a small group. The person may also realize deep down that attending a group will bring home the reality of his or her diagnosis. Change itself - just meeting new people - can be scary.

Most people experience coming into a support group as a threatening situation. Some may show a great deal of superficiality and politeness, especially in their first few meetings of a support group. Others may reveal fears and anxieties, such as hesitancy, aloofness, or silence.

From a bout, the second or third group meeting confrontations and oppositions can begin. For example, if a number have told stories of being rejected by others because of their HIV positive diagnosis, those who have not experienced rejection may share their experience. The facilitator must make it clear that expressions of differences, disagreements, and a broad range of feelings, including anger, are acceptable.

Confronting differences can be especially difficult for persons with AIDS Dementia⁷³, for they may think a question or challenge is an assault, an attempt to do harm. For this reason the confrontation of people with AIDS Dementia must be done carefully and in an atmosphere of unconditional acceptance. The facilitator and group must make a special effort to create a warm, caring, safe environment for them.

5.9.8 Later stages of a group

Stone (1996: 100) reminds one that trust evolves and deep friendships are formed if the group is truly supportive. Then the hard work begins. Individuals freely express their anger and

⁷³AIDS Dementia – A variety of neurological disorders are common in the later stage of AIDS. Collectively caused HIV- associated dementia, this develops when HIV or another microbial organism infects the brain. HIV itself creates proteins that kill brain cells, leading to the deterioration of the brain.

resentment, their fears and anxieties concerning illness and death, and also their affirmations and celebrations of life.

A support group for HIV positive persons probably will be ongoing, rather than time-limited. New group members will come into it and a clear process for new group members entering should be established. More senior group members may leave as a result of increased illness or death.

The congregation and pastor(s) can help support these groups by informing them of the availability of services, such as individual pastoral care, congregations that welcome persons with HIV and their loved ones, weekly prayer items, and sanctuary space for healing services⁷⁴, memorial services, and funerals.

Deal with group transitions openly - both 'arrivals' and 'departures'. Welcome new members and invite everyone to introduce themselves. Discuss sicknesses and deaths of members. If the group is engaging in a 'conspiracy of silence' about the sickness or death of a group member, a facilitator might remark that he/she misses the deceased member very much or make a similar comment to signal that it is acceptable to talk about sickness, death, and grief.

Facilitators should encourage members (if they seem willing and ready) to visit any fellow member who has been hospitalized or is having home based care. That members visit each other will reassure those still attending the group that they will not be forgotten when they are unable to come. Visitors should also be allowed into the group so that they are to process their feelings about their experiences able.

The tone and content of meetings will vary. In some meetings members will focus on issues of death and dying (Louw, 1994: 116). At others the atmosphere will be light. Facilitators have to be intuitive and sensitive to the group's needs. They have to avoid 'pressing' too hard while at the same time knowing when to give the group a little push.

Although HIV support groups must experience a great deal of mourning, celebrations should also be a part of group life. There is need to plan special events and get-togethers, particularly during the holidays. A special meal to welcome a member returning after an illness should be prepared.

⁷⁴Healing services within the Reformed Church in Zambia tradition may need to be incorporated in very sensitively developed liturgies. At the moment there are no healing spaces in the liturgies of the RCZ, the church denomination to which the researcher belongs.

The Church is indeed living with HIV. Some members in the body are HIV positive. Life calls for celebrations. Local congregations need to find new ways to be supportive of one another, not only when confronting HIV, but in all dimensions of common life. As the members of the Church learn to be more supportive, loving, and caring of each other, they will grow in the ways God has called them to grow.

5.10 Conclusion

The researcher has dealt with the second hypothesis in this chapter, namely that a missional theology, which promotes the praxis of the creation of Circles of Hope at a congregational level, is a basic presupposition for a holistic approach to combat the HIV pandemic. God as a Trinitarian community is a basic theological model for the creation of Circles of Hope.

In order to understand how people in Zambia think about illness and health, their customs and traditions have had to be examined in the light of the Zambian cosmological view on health and healing. There is a question of mixed identity when it concerns traditional and modern medicine. Certain aspects of the African cosmological view (such as the suspicion that even HIV could be due to bad personal relations) if held on to, are surely the factors that contribute to the further spread of the HIV virus. Certain aspects such as the concept of the village model are helpful to curb the further spread of the virus and help to bring healing in to the lives of those already affected. Africa is thus caught up in crossfire. Clinging on to some traditional worldviews cannot be realistic in the context of HIV. It is a view of the holistic nature of human beings that will be helpful in this time of AIDS. The researcher has also examined the medical facts around health and healing with ARVs which give new hope of and new possibilities for HIV positive people to live productive lives. Another angle he has examined is how this affects the holistic approach to combat the HIV pandemic. He has also evaluated this presupposition by drawing upon the interpretation of the normative sources of scripture and tradition. A holistic model must start with a missional theology which promotes the creation of Circles of Hope support groups. The researcher has shown that the healing of people suffering from HIV can be brought about concretely through the provision of ARV therapy but holistically through such support groups. The different types of support groups, their dynamics, the role of a facilitator and how a local congregation can get started with such support groups were discussed. These groups are to exist to support the respect and dignity of all afflicted and affected persons.

The researcher contends in this study that measures are required to develop strong theological reflection and education in church structures which would result in the establishment of Circles of Hope in all local congregations. These Circles of Hope would act as source for the promotion of behavioural change, support action for safer sexual behaviour and combat stigmatisation and discrimination against people with known HIV infection. In this way there will thus be an experience of holistic healing which takes on board both the African and biblical view of health and healing into account.

The concept of Circles of Hope differs greatly with home based care concepts. Home based care groups according to the World Health Organisation in their 2002b report entitled *Home based long term care* are an important element in the quality of care given by mainly families but may be supported by other trained volunteers and other community care givers. Janet Brown (2004) has sufficiently dealt with this concept in her dissertation submitted to the University of Stellenbosch. Circles of Hope are support groups created in local churches whose membership is confined only to those members of the body of Christ who are HIV positive and their care givers and family members.

In the next chapter the researcher will discuss a strategy to mobilize the church in Zambia.

CHAPTER SIX

A STRATEGY TO MOBILIZE THE CHURCH IN ZAMBIA

6.1 Introduction

De Gruchy (2006: 3) says that the HIV pandemic raises some important missiological issues, for the need to pool resources and find collective strategies in the common struggle against the pandemic creates an entirely new context in which to think about ecumenical and interfaith partnerships. The researcher agrees with him. Particularly in the Zambian context, there is need to revisit what it means to be a missional Church with a theology of hope and love and which is able to help people discern God's will. The concluding chapter of this work will deal with such issues and emphasise the paradigm of creating circles of hope as means of concretising pastoral care and challenging the Church to be a healing community that promotes access to information, scales up sustainability while networking for partnership for the common goal of going beyond the involvement of the local Church.

6.2 Revisiting the plot of the study

The previous chapters of this study have been submitted in order to lay the foundation for the current. The entire work comes into proper focus when formulating a holistic ministerial strategy for the Zambian churches to combat HIV. This is offered as the praxis of Circles of Hope support groups at local congregation level. The researcher has examined the facts, proved that it is clear that HIV is rampant in the Zambian society and is causing major social and economic disruption. This very fact makes it God's agenda because HIV has touched the image of God the Creator in humanity. As shown in Chapter 1, it is clear that doing theology in the context of HIV is done with a Trinitarian hermeneutic. It is not the Church **but God** that is the key to unlocking our identity. It is moving away from the institutional Church to a **missional church** where the focus is not the Church but the world (for God so loved the world *John* 3:16). In the light of the discussion of the problem, the researcher has shown that **Churches** in Zambia do not have an effective strategy in place that addresses the issue of HIV in a holistic way at a congregational level where it effectively reaches and influences members. There are a few cases where this is beginning to happen, but so far it is only about twenty-eight local congregations out of three thousand nine hundred that are related to the Council of Churches in Zambia that have begun to address HIV with the praxis of Circles of

Hope. This is adequate proof that hypothesis one is true. God is concerned about the work of his body, the apostolic faith community. There is a need to scale up the intervention. There is need to mobilise for a deliberate effort to break the fear, silence, shame and stigma associated with HIV. This leads to the second hypothesis.

The researcher has also stated that a **missional theology** which promotes the **praxis** of the creation of Circles of Hope at a congregational level is a basic presupposition for a holistic approach to combat the HIV pandemic. Circles of Hope are in this study proposed as part of an alternative response to the HIV stigma crisis. The seven theological colleges from which currently the three thousand nine hundred local congregations get their ministers trained do not have a missional theology component which tackles the proposal of creation of Circles of Hope in their HIV curriculum. Only in one case (Justo Mwale Theological College) has a mere mention of the concept received partial attention. Even there, however, there has been no deliberate effort taken to develop a theological paradigm that would be built in the curriculum to advocate for the creation of Circles of Hope. In fact, some of the seminaries namely Sikalongo Bible Institute, Chembo Bible College, Lutheran Evangelical Church College, and Salvation Army Bible College do not even as yet have an HIV curriculum in place. HIV is mentioned just in passing in those colleges. They say they have no lecturers trained to tackle work of that magnitude. As shown above, only 40 out of more than 14,000 local congregations have responded to HIV stigma by creating Circles of Hope support groups. That statistic is enough to show that there is no effective holistic strategy which effectively impacts the local congregations amongst the *Zambian Churches*.

In the **contextual analysis** undertaken in the previous chapters the researcher has shown that HIV have brought about new challenges both to the ministry and work of the Church in Zambia. These challenges have an impact on the nature, identity and mission of the Church in Zambia. God the Creator, Redeemer, Sanctifier is concerned about this problem because it has affected the integrity of his creation. God works through his body, the faith community. This is indeed an aspect of the *mission Dei*. Therefore, the creation of HIV support groups as missiological praxis in local congregations is one such appropriate vehicle to mobilise the local church for greater involvement. These support groups will be the praxis point for a local theology which will promote community which produces truth, justice, peace and freedom. Furthermore, as part of this analysis, there has been an attempt to discern what God is doing in the fight against the life threatening HIV through the instrument of the ecumenical Church.

Members of the Zambian Churches through their national umbrella bodies are involved in a vocationally based, critical and constructive interpretation of their present day HIV reality. Their efforts, nevertheless, have not been implemented effectively at congregational level where their application is greatly needed.

In drawing upon the contextual and local analysis, it was furthermore attempted to **critically and constructively interpret some of the critical theological reflections** prompted by encounters with HIV affected and infected people. This has included some thoughts on Christian community, truth, freedom, justice and peace. A missional theology is sensitive to the local context of the people, to the normative values of God's word, and to a realisation of the reign of God.

In expanding on that missional theology, this study has further built on the second hypothesis, namely, that a missional theology which promotes **the praxis** of the creation of Circles of Hope at a congregational level is a basic presupposition for a holistic approach to combat the HIV pandemic. An effective **strategy** that addresses the challenge of HIV in Zambia needs to understand how the people think, their customs and traditions. Healing in this work has been suggested as a conscious spiritual activity of people who are suffering from HIV and who are participating in Circles of Hope. The way such support groups can be created has been examined and with practical suggestions offered. This has been done to construct the argument that Circles of Hope support groups in local congregations can be **a sign of the reign of God** on earth while advancing with an eschatological faith based reality in view. The praxis of Circles of Hope support groups and the utilisation of a holistic theology for human dignity can not have a transformative impact on a congregation level if the challenges are not analysed and questions of leadership are not examined. That is why the role of leadership has been critically considered. Leadership is critical in discerning God's will for the present situation. Leadership is the vehicle by which values of truth, freedom, peace and justice can be experienced by the community of God's people.

The argument is about innovative leadership. A committed leadership is needed as is one well versed in missional theology. That leadership will facilitate the effective strategy and influence the desired change brought about by a holistic approach. The type of leadership required is one with the ability to discern God's will in mobilising for change. A leadership which is sensitive in this way will develop and empower the laity for full participation in Church ministry. This leadership should empower the congregation to grow towards spiritual

maturity. Spiritual maturity will eliminate silence, shame and stigma associated with HIV, further allowing for the full expression of the *shalom* of God.

All this is adequate proof that the second hypothesis is true. A holistic approach and a faithful and effective way of fighting the pandemic can never be obtained without a solid and contextual theology.

6.3 Suggested strategy, process and priorities

Strategic planning is a tool used for one purpose only: to help an organization do a better job - to focus its energies, to ensure that members of the organisation are working towards the same goals, to assess and adjust the organisation's direction in response to a changing environment. In short, Bryson (2005 online <http://www.supportcenter.org/sf/genie.html>) indicates that strategic planning is a disciplined effort to produce fundamental decisions and actions that shape and guide what an organization is, what it does, and why it does it, with a focus on the future.

This chapter is strategic in nature, because it involves preparing the best way to respond to the circumstances of the global and local contexts of HIV explained in this study. Whether or not these are known in advance churches often must respond to dynamic and even hostile environments. Being strategic, then, means being clear about what needs to be done in Zambia to do God's will in creating a safer welcoming church for all those affected and afflicted by HIV. It is about being aware of the church's resources, and incorporating both into being consciously responsive to a dynamic environment.

The process is about planning for a future where people are able to competently manage HIV and where stigma, silence and discrimination, with all their attendant factors of fear, shame and guilt, will have been fought. It is about developing a holistic theological model for the Circles of Hope praxis. This model takes cognisance of the African view of health and healing, as it is a contextual theology whose agenda is set by the people themselves. Contextuality, is always listening to the stories of PLWHAs. It attends to values under the reign of God and moral virtues, and considers the presence and power of God in truth, freedom, justice and peace. The values of the reign of God and sexuality are another important component for that holistic theology. Other tenets include creating a care and compassion movement, dealing with death and dying issues, having consistent counselling, promoting prevention and pastoral care. The approach to reach that goal, is a committed and

motivated leadership which works for transformation and the spiritual maturity of mobilised local congregations.

The process is disciplined in that it calls for a certain order and pattern to keep it focused and productive. It raises a sequence of questions that helps all those planning to make a new level of impact to examine experiences, test assumptions, gather and incorporate information about the present, and anticipate the environment in which the church will be working in the future. The process of having to discover God's will and for the Church to be a sign of God's kingdom on earth is about fundamental decisions and actions by the Church, because choices must be made in order to answer the sequence of questions raised by the pandemic. The plan is ultimately no more, and no less, than a set of decisions about what to do, why to do it, and how to do it. Because it is impossible to do everything that needs to be done in respect of the challenges raised by HIV, this strategy implies that some ministry decisions and actions in regard to HIV are more important than others - and that much of the strategy depends on making the hard - and right - decisions about what is most important to achieving transformative action to the glory of God. A mere twenty-eight out of three thousand and eight hundred congregations require the making of a multiplicity of hard decisions to create more support groups to bring about concrete healing in the body of Christ.

Dealing with HIV can be complex, challenging, and even messy, but it is always defined by the basic idea of bringing hope to the lives of many people both inside and outside the Church.

Current knowledge about HIV and about future conditions if the need for behavioural change is not entrenched in people's lives is sufficiently reliable. The creation of Circles of Hope is a reliable new level alternative response which has to be tackled together with other current available strategies and strengthens the need for cooperation with other key players in the field.

This strategy is made with strong assumptions that the church must be receptive to a dynamic, changing environment because as seen above the church cannot continue its old practices - HIV has changed not only people's lives but also the way that theology is done. The strategy then, stresses the importance of Church leadership in making decisions that will ensure the Church's ability to successfully respond to changes in this context.

The Church in Zambia needs constant appraisal as it asks itself: “Are we doing the right thing”? Perhaps more precisely, it means making that assessment using three key requirements: a definite purpose in mind, an understanding of the context, particularly of the forces that affect or impede the fulfilment of that purpose; and creativity in developing effective responses to those forces.

Chapter 6 then looks at responses to the HIV pandemic, where priorities have, and should have been. The researcher argues that a theological, holistic model and strategy that effectively addresses the HIV crisis should involve a continuum of policy and practice spanning prevention and impact mitigation. Care is an important component of all of these. A Church which does not offer pastoral care for the sick and dying will lose its relevance in the world. Thus far, prevention responses have been inadequate and generally ineffective. In Zambia, the spread of HIV continues, requiring planning for increased care needs and other aspects of impact mitigation. There are few signs that this is beginning to happen. However there is a beginning in the area of local faith communities in the creation of special support groups called Circles of Hope. More needs to be done and, as such, the priority need is to address afresh the theological content for the formation for ministry. The need for networking and partnership is emphasised as a new frontier for the ministry of the Church as well as the need to collaborate with the ‘world’ or business organisations, in particular. The researcher briefly looks at partnership with non-governmental organisations (NGOs) in this fight. He also underpins the ministerial challenges that this pandemic has posed to the Zambian Churches.

Greyling (2001: 15) contends that if the Church wishes to be true to its calling it will have to be a space in which those infected and affected by HIV will feel safe to share their pain. Pastors and all layers of Church leadership will have to be sensitised to the need to understand the importance of their support for the creation of Circles of Hope.

6.4 A holistic theological model

This strategy would consider seriously the continuous development of a holistic theological model. As the WCC (2002: 21-23) has stated that the HIV pandemic raises difficult theological issues in various areas such as creation, human nature, the nature of sin and death, the Christian hope for eternal life and the role of the Church as body of Christ. Furthermore, the reality of HIV raises other issues, such as human sexuality, vulnerability and mortality,

which stir and challenge people in a deeply personal way. As Heather (1997: 11) points out, Churches struggle with these theological and human issues and they differ, sometimes sharply, in their response to some of the challenges posed by HIV. It is important that the Churches learn to face the issues *together* rather than separately and that they work towards a common understanding of the fundamental questions - theological, anthropological and ecclesiological – which are involved. The challenge for the formation of Circles of Hope is best approached from a congregational perspective. Greyling (2001: 19) suggests that the strategy for the way forward should include inspiring congregations to initiate such HIV based action groups which will activate prevention, support and care programmes within the congregation.

The Church's response to the challenge of HIV comes from its deepest theological convictions about the nature of creation, the unshakeable fidelity of God's love, the nature of the body of **Christ's identity** and the reality of **Christian hope**. This, as Mugambi (1995: 24) has suggested forms part of the theology of reconstruction which will lead African people to regain their integrity.

Meanwhile, Gitome (2003: 201) shows us that the creation in all its dimensions is held within the sphere of God's all-encompassing love, a love characterised by a relationship, expressed in the vision of the trinity as a model of intimate interaction, of mutual respect and of sharing without domination. This inclusive love, characteristic of the trinity, guides the understanding of the Christian claim that men and women are made in the 'image of God' (*Genesis 1: 27*). *So God created man in his own image, in the image of God he created him male and female he created them.* Since all humanity is created in God's image, all human beings including all those positively living with HIV are beloved by God and all are held within the scope of God's concern and faithful care.

Since HIV touches the intricate subject of sex, in the fullness of creation there is the potential for goodness of the human body and of human sexuality. The meaning of human sexuality needs to be fully comprehended (Foster, 1985: 92-93). As with other aspects of creation, sexuality also can be misused when people do not recognise their personal responsibility, but it has to be affirmed strongly as one of God's good gifts, finding expression in many dimensions of human existence. The Churches have recognised marriage as the primary place for the expression of sexuality in its various dimensions.

Romans 8: 38-39 indicates a promise that nothing can separate believers from the love of God in Christ: no disasters, no illness or disease, nothing done by humanity not even death itself, can break God's solidarity with his people and all creation. Creation, nonetheless, *groans as in the pains of childbirth*, (*Romans 8: 22*) *we know that the whole creation has been groaning as in the pains of childbirth right up to the present time*, can be seen from much suffering, injustice and waste in the world. Some of these can be understood as the consequence of humanity's own making, of the exercise of the freedom given by God to his creatures.

6.4.1 It is about hope

The Christian **faith is a faith of hope**. These support groups which are unfolding are about creating hope in concrete terms. In hope, questions and doubts within the larger frame of God's love and final purpose for the entire creation is made clear. It is hope about '*abundant life* (John 10:10) where justice reigns, where each is free to explore all the gifts God has given them. This Christian hope is hope in Christ gone into glory – the basis of hope. Christians thus share in the sufferings of Christ who is Emmanuel, 'God with us' that they may also be glorified with him. *And in their weakness they are sustained by the Spirit, who lives in them, interceding when they do not know how to pray and granting life to mortal bodies* (*Romans 8 :11, 26; Ephesians 3: 16*).

Christians are strengthened by this hope as they wrestle with profound questions about suffering. They affirm that suffering does not come from God. They affirm that God is with them even in the midst of sickness and suffering, working for healing and salvation in the *valley of the shadow of death* (Psalm 23:4). Through the suffering of Christ on the cross the entire creation has been redeemed. Christian hope is rooted in the experience of God's saving acts in Jesus Christ, in Christ's life death and resurrection from the dead.

In considering Christ as the suffering servant (*Isaiah 42:1-9; 49: 1-7; 50: 4-11; 52: 13-53: 12*), Christians are called upon to share the sufferings of persons living with HIV, opening themselves in this encounter to their own vulnerability and mortality.

6.4.2 It is about love

The Church as the body of Christ is to be the place where God's **healing love** is experienced and demonstrated. Circles of Hope are about experiencing healing in fellowship with others that are afflicted. As the body of Christ the Church is bound to enter into the suffering of

others, to stand with them against all rejection and despair. Because it is the body of Christ, he who died for all and who enters into solidarity with those affected by HIV thus making their hope in God's promise come alive and visible to the world.

Many Christians and Churches have shown Christ's love to those infected and affected by HIV but unfortunately some have also helped to stigmatise and discriminate against such persons, thus adding to their suffering. The response of Christians and Churches to those affected and infected by HIV should be one of love and solidarity, expressed both in care and support for those touched directly by the disease and in efforts to prevent its spread. Greyling (2001: 22) suggests that the greatest barriers to achieving HIV prevention are fear, denial and ignorance.

WCC (2003: 30) has indicated that in responding to the challenge of HIV, Christians are motivated by urgent imperatives, passionately felt. They are to show Christ's love for the neighbour, to save lives, to work for reconciliation and to see that justice is done. Making ethical decisions however requires a process of discernment, which includes gathering the latest information, wrestling with deeply sensitive issues and weighing differing, sometimes conflicting views and interests. This process needs to be under girded by bible study, prayer and theological reflection which are the hallmarks of the Circles of Hope.

Christians make decisions following principles which derive from their understanding of the biblical witness and their faith convictions. That is when they become involved in a critical and constructive interpretation of their present reality. The justification for encouraging the formation of the Circles of Hope in local congregations is also based on the following points:

- Because all human beings are created and beloved by God, Christians are called to treat every person as of infinite value; **this is about living in truth with God and with their neighbours.**
- Because Christ died to reconcile all to God, Christians are called to work for true reconciliation – which includes justice - among those alienated due to the HIV virus; **justice brings about the *shalom* of God.**
- Because they are 'members of one another', being built up by the Spirit into one body; Christians are called to a responsible life of **justice within a community.**

Such principles should be applied to a range of questions such as:

- How do Churches respond to their members living with HIV?

- How can Churches promote responsible behaviour without being judgmental and moralistic?
- What public health measures to reduce HIV transmission should Churches advocate?
- How can resources for care and research be fairly shared?

This would mean that in each case the following should be done: explore all available options; weigh the benefits (and difficulties) of each and ask, ‘which of the possible courses of action best expresses Christ’s love for all those involved?’

Such a process of discernment is difficult: the options may not be fully clear; none of the options may be wholly satisfactory; the implications of some biblical or theological principles for specific problems today may not be clear. It is all the more important, then, that Christians and Churches reflect and work on these issues **together**. The challenge of HIV demands nothing less than an **ecumenical response**. Only an ecumenical response will guarantee a theological holistic model which promotes the praxis of the creation of Circles of Hope. Kobia (2003: 151) has urged that the African Church itself will have to change language, policy, and behaviour as well as mobilise its own resources to reverse the epidemiological trend and give hope to those infected and affected by HIV.

6.4.3 It is about discerning God’s will

Churches are expected to give both spiritual direction and moral guidance, and to play a responsible role in the discussion of these issues in the wider society, as well as in discussions of biomedical ethics. In doing so, they struggle to discern God’s will in this time of HIV. In witnessing to their own faith convictions, they enrich the wider debate and make common cause, where possible, with persons of goodwill who appeal to more general sets of ethical principles such as respect for life and persons, beneficence and justice.

Gennrich (2004: 37) suggests that the Churches do have crucial contributions to make to this wider debate. In accordance with their commitment to truth, for example, they can emphasise that the process of ethical discernment leaves no room for judgements based on superficial generalisations or stereotypes, on fear, or on incomplete or false information. The Churches can do much to promote, both in their own lives and in the wider society, a climate of sensitive, factual and open exploration of the ethical issues posed by the pandemic. Kobia (2003: 156) suggests that the approach would be to identify and analyse the forces that sustain, protect, enhance and enrich life, compared to the forces that seek to destroy life.

Themes of hope beyond void, spiritual and ethical exposition on the meaning of life beyond death, using ordinary languages of the people, would enrich the discourse on alternative ways of living with HIV.

In accordance with their emphasis upon personal and communal responsibility, the Churches can promote conditions – personal, cultural and socio-economic - which support persons in making choices. This requires a degree of personal freedom on the part of these people which is not always available. A good example would be that of women in Zambia who, even in marriage, may not have the power to say ‘no’ or to insist on the practice of such effective preventive measure such as abstinence, mutual fidelity and condom use. If the Church talks freely of such hindrances it will help bring about a change in that situation. Byamugisha (2000: 10) warns that not all lawful and acceptable sexual unions in homes and communities are safe unions. Conversely, let us also accept that not all unlawful/unacceptable sexual unions are safe. Surely we would be accepting that not all unlawful/unacceptable sexual unions were unsafe? Perhaps it is unlikely that not all unlawful/unacceptable sexual unions are safe.

A holistic theological model, therefore, will continue to be open to questions and challenges that the pandemic has brought about.

6.5 Pastoral care and counselling within the church as a healing community

This strategy will seriously consider Circles of Hope as an alternative base for exercising the pastoral care and counselling of those affected and afflicted by HIV. By their very nature, as communities of faith in Christ, Circles of Hope are called to be healing communities. This call becomes the more insistent as the HIV pandemic continues to grow. Within the Churches the Circles of Hope are increasingly confronted with persons affected by HIV within their community who are seeking support and solidarity. Van Dyk (2000: 19) says that in care and counselling, the very credibility of the Church is at stake. According to the HIV Educational Global Information System⁷⁵, a comprehensive HIV strategy links prevention, treatment, care and support for people living with the virus. The interaction of HIV with other infectious diseases is an increasing public health concern.

⁷⁵ <http://www.aegis.com> [accessed October, 5th, 2006.]

According to Ecumenical Advocacy Alliance⁷⁶, the pandemic continues to be measured in alarming statistics around the globe. Churches and people of faith everywhere must take up their pastoral and prophetic role to overcome stigma and discrimination, to care for body and spirit, and to advocate for universal treatment and effective forms of prevention.

Gilks (1998: 67) in: *Sexual health and health care: care and support for people with HIV/AIDS in resource poor settings*, shows that many within the Church have found that the witness of persons living with HIV has enhanced their own lives. They have reminded the Church that it is possible to affirm life even when faced with severe, incurable illness and serious physical limitations, that sickness and death are not the standard by which life is measured and that it is the quality of life - whatever its length - that is most important. Such a witness invites the Churches to respond with love and faithful caring. Greyling (2001: 24) underscores this by saying that the Church has a wealth of professional counselling services to offer via its professional services. Through counselling courses lay counsellors can be trained to work in collaboration with local HIV action groups and, in the case of this work, with Circles of Hope support groups.

Churches can make an effective healing witness through Circles of hope support groups towards those infected and affected by HIV, despite the extent and complexity of the problems. The experience of love, acceptance and support within a support group where God's love is made manifest can be a powerful healing force. Healing is fostered when Churches relate to daily life and where people feel safe to share their stories and testimonies. Churches help persons enter the healing presence of God through sensitive worship. The Churches exercise a vital ministry by encouraging discussion and analysis of information, by helping to identify problems and by supporting participation towards constructive change in the community.

Many trained and gifted members of the community, as well as some pastors, are already providing valuable care. This, however, needs to be enhanced in the face of the many new infections. The Circles of Hope include counselling as a process for the empowerment of persons affected by HIV. They may help them deal with their situation and prevent or reduce HIV transmission.

⁷⁶ www.e-alliance.ch [accessed October, 10th, 2007]

6.6 The local church and its involvement

Here the strategy will require that the local church should critically consider to open its doors to all unconditionally and in doing so emulate Christ who opened the door to all, irrespective of who they were or what they had done. This has been alluded to in Chapter 3 as one of the challenges facing leadership in Zambia. Salvation is given to all by grace, through faith, not because of deeds or behaviour (*Ephesians 2: 6-8*). By accepting everybody Christ gave all access to his forgiveness and to a new life. Today through the local church, this new life is received through the Word and the sacraments. The church becomes guilty of the gravest form of discrimination that exists when it excludes some people from these sources of life.

The spread of HIV is dependent on cultural, social and economic realities. The Church should question seriously its own role in developments facilitating the spread of the disease, and challenge its own members and society at large to take steps to remove prevailing discriminatory attitudes and actions. Gitome (2003: 202) advises that Church leaders ought to be agents who influence change of attitude and behaviour, so as to facilitate a decline in the spread of HIV. Church leaders should be in the forefront to build a movement of care and compassion through local congregations.

6.7 Circles of Hope to break fear and guilt

This strategy is suggested to ensure that fear and guilt associated to HIV is broken. The world-wide pandemic of HIV has given birth to a world-wide epidemic of fear which needs to be analysed and to which a concrete response should be made. There is not only the fear of the disease as such, but also of the social stigma of uncleanness. HIV brings with it the fear of dying, non-existence, physical pain, rejection, isolation and shame. Persons with HIV struggle with the issue of damnation or salvation on the spiritual level. Greyling (2001: 19) suggests that fear can be broken by allowing members in the local congregation to face reality by having an encounter with children who are HIV infected or people in the terminal stages of HIV. This he says will help to put a 'face' to HIV for by interacting with HIV positive people who share their hopes, disappointments, fears and dreams they would experience first hand the impact of the disease.

Afraid to be shamed, persecuted or to share the social stigma of the people living with HIV, family and friends often struggle in deep loneliness with the fear of losing their loved ones. WCC (2003: 31) gives examples of instances in some Christian congregations when HIV

infected persons were not welcome or if they died are not given a Christian funeral. Other congregational members used to fear that they would contract the disease from contact or by sharing Holy Communion with them. Furthermore, they fear the harmful consequences if the church is branded as endorsing 'immorality'. Further, there is a reason to fear that abuse of confidentiality of medical information might lead to the persecution of HIV positive persons in society.

The result of this fear is a web of lies alienating people with HIV from other people and the truth. Fear erodes, and may even lead to the destruction of the identity of the individual, the fullness of the church and the inclusiveness of the Holy Communion. Social fear results in discrimination, personal fear results in isolation. An ultimate consequence may be depression or even suicide.

Because HIV is often wrongly associated with sexual promiscuity and drug abuse, society may impute guilt to those infected or affected by the virus. Thus those who are infected may carry a heavy burden of guilt. Because HIV is an infectious disease, responsibility for having infected others also leads to feelings of guilt. This is exemplified by a mother giving birth to an infected child, or by infection spread by intravenous drug abuse or sexual relations. On another level, an interpretation of the illness as divine punishment or curse is manifested as guilt. A HIV infected person experiences guilt for not having protected him or herself. Guilt may also result from the burdening rather than the support of one's family and society.

The first word which the Church must address to those who are locked in fear is the Gospel assurance: *Fear not because God is with you (Luke 1: 28, 30)*. Secondly, the Church must affirm that in Jesus the link between disease and punishment has been irrevocably broken. *Jesus answered, it was not that this man who sinned, or his parents, but that the works of God may be made manifest in him. We must work the works of him who sent me. (John 9: 3-4)*. God is a God of love who does not afflict his beloved children as a curse or punishment. Therefore HIV cannot be considered a curse or a punishment from God. Thirdly, God takes away the shame, *reconciling the world to himself not counting the trespasses against him and entrusting to us the message of reconciliation (2 Cor. 5: 19)*

Circles of Hope therefore are a good base from which to break fear and guilt as they would be established in every local congregation on the basis of compassion, love and care and would expose members of the congregation directly to the 'face' of HIV.

6.8 Access to information

The strategy will require full access to information on the need for a theology of truth, as mentioned above in Chapter 4. Just as the prevention of HIV is dependent on everybody's access to adequate knowledge of the disease, in the same manner the formation of Circles of Hope is dependent on access to information. Today this information mainly reaches the educated, while excluding groups who are in special need of knowledge as they are highly exposed to the pandemic.

This information should be interpreted in the Christian context and the local, social and cultural realities. Enlightened Church leaders should specifically address its members and those groups who have lesser access to information. Gitome (2003: 204) reminds us that the Church is endowed with a big responsibility of information dissemination as well as education for their congregants.

The Body of Christ as a reconciling community must respond affirmatively to the manifold human brokenness. The church must respond to the crisis of HIV while obediently participating on different levels such as:

- Prayer and pastoral care for those affected by the pandemic, and for those responding to it in a caring way.
- Fellowship, inclusive of all people even those segments of society most directly affected, e.g. prostitutes, homosexuals and intravenous drug abusers.
- Practical assistance to meet the needs of those who are sick, their families and friends as well as their care givers.
- Encouraging volunteers and training them for counselling and support.
- Education. This includes information to relieve the fear which comes from ignorance and misconception, education to avoid behaviour which may lead to HIV infection, and a deeper understanding of biblical and theological foundations for an appropriate response to the HIV crisis. This must also include an opportunity to wrestle with fear and guilt, sin and disease, reconciliation and the nature of the church.
- Providing facilities for hospitality and engaging in a dialogue with groups most directly affected.
- Advocacy of the rights of people threatened with discrimination or repression.

The dimensions of fear and guilt in the worldwide pandemic of HIV challenge us to become in the words of Paul *ambassadors of Christ, God making his appeal through us* (2 Cor. 5: 20). God's grace as revealed in the life and ministry of Jesus Christ is incarnate and non-judgmental, caring for all those to who HIV has brought suffering.

6.9 Attending to issues of death and dying through Circles of Hope

Kobia (2003: 151) reminds us that the strategy is about making affirmation of values, soul and spirit of African heritage in the face of death. At the centre of Christian confession is the death and resurrection of Jesus Christ. Death as the way to life is the message in baptismal theology, in the call to conversion, in Christian ethics. Lewis (1994a: 4) says that dying and death are inseparable from life. It is a bodily as well as a social experience, which has to be faced by every human being. As Christians we affirm that 'dying to ourselves', we shall live with Christ. Circles of Hope can play a critical role in helping those members of the Church whose struggle with HIV may finally lead them along the path of dying.

The Christian community, through the ages has faced death, not only with mourning and fear, but also with hope and expectation. Death has been defeated. *God is not the God of the dead, but the living, for to God all are alive* (Luke 20: 38). The Church has always stood at the side of the dying to convey hope. The Church commended the dead to God, buried them, and gave comfort to the bereaved ones. In other times and in countries of war, epidemics and hunger, this ministry was a major expression of the Church's life and faith. In other times and countries, dying and death were almost made invisible in the daily life of the Christian community. The HIV pandemic has again brought the Church back to the reality of dying and death in the midst of human community.

Lewis (1994b: 7) says the reality of death can no longer be put outside the family life as if it did not exist, as is done in some parts of the world. Death should be visible and recognisable in the midst of community. The whole community dies with the dying, people say in Africa. This does not change because the person dies from AIDS. Mugambi (2002: 124) says death marks the end of the procreation cycle and at the same time it anticipates the renewal of life through the next cycle. Thus death anticipates birth. Viewed in this way, death need not be negatively regarded, since it is inevitable as an integral part of the natural order.

HIV challenges the church not only to develop a more profound understanding of death and dying, but also to develop relationships with people who are dying, and with those who have

been and will be bereaved. People must not be left alone at this time of great stress and grief. If the Church is to show God's presence at the end of life, they must participate in the concrete tasks of care that are associated with this illness. Circles of Hope provide such an opportunity for the Church's concrete involvement. The Church is called to demonstrate the presence of God in Christ with people who are suffering and dying. The Church must be in their midst to witness to this.

Because of prejudice and failure to understand, a sense of shame and guilt is often attached to dying with AIDS. This is true both for the one who dies and also for those who mourn. The community of believers is called to witness God's grace by giving unconditional acceptance and support when others condemn. In some churches there are still remnants of discriminatory traditions in burial practices and rites. Persons under Church discipline, or otherwise not fully accepted by society, have not always been buried the same ways as others. Churches are asked to make sure that all such discrimination is eliminated. In death there is no inequality, no punishment of the deceased, the family or friends.

Lewis (1994b: 20) suggests that dying people need to accept both the realities of their death and themselves as whole people. Christians believe that confession, forgiveness and reconciliation with God are essential elements in this acceptance. Many who die from AIDS do not share this understanding. Still the Church is called to minister and witness to them. All persons created in the image of God should suffer and die with dignity.

The Church celebrates life. At the time of dying it celebrates the final stage of mortal life and the birth into life eternal. The heart of the gospel is that Christ is rising. There is a need to talk of Christ's death and resurrection. He was young, despised and rejected. Many persons with HIV therefore can identify with him.

Lewis (1994a: 7) affirms that the ministry to the dying and to the bereaved is not the responsibility of ordained pastors alone. It should be shared among all church members. Special training needs to be given to enable people to share in this ministry. The community involvement varies greatly between urban and rural areas, as well as between cultures. Where people share this ministry of hope and healing, community is built, people are drawn closer to the crucified and risen Lord. This is one clear area in which Circles of Hope can touch the lives of those infected people in the Church.

6.10 Creating a caring community

This strategy is to crystallise the care community of the body of Christ - the Church. Circles of Hope are a true embodiment of care within a local Church context. To be true to itself the compassionate faith community must seek to offer effective care to the suffering while encouraging and enabling them to care for themselves as far as possible. Given the limitations of their freedom, justice also demands such caring. Only in this way can they be integrated into the healing solidarity and peace of the reign of God. Care, like compassion and all other aspects of ministry, must constantly look for guidance to these primary values of the reign of God (Shelp and Sunderland, 1987: 97).

Jesus shared food and fellowship with all, including those who were isolated from the good life or the accepted community. He restored people, gave them a feeling of value and themselves. This is the focus of Circles of Hope. The proclaiming of gospel must result in the breaking down of fences, dispelling of fear, and freeing of people from hopelessness:

- A caring community is one that acknowledges its role in the brokenness of God's creation, and only in this understanding they participate in the process of healing brokenness.
- A caring community is the one that is informed and educated about HIV. The community will provide information about HIV and its prevention. People need to hear the stories of those affected by the AIDS crisis to better understand the impact of the disease.
- A caring community needs to provide compassion to the whole person, to provide practical, social and spiritual support for those affected by the HIV crisis.
- A caring community empowers people to take responsibility for their own lives and relationships.
- A caring community is one that promotes the just distribution of health care resources for people throughout the world and within countries. In particular, in this HIV crisis, health care resources need to be justly shared between the northern and southern hemispheres.
- A caring community provides nourishment and renewal to its members who are giving care to those affected by HIV and who are struggling daily with the HIV crisis.
- A caring community works in partnership in this crisis with religious and community groups and government agencies.

- A caring community needs to dialogue and explore together what it means to celebrate humanity, including sexuality and to struggle with the problem of the meaning of life, of sin, of human solidarity, of suffering and death.

Care must be the driving factor for Circles of Hope wherever they will operate. This care as seen in Chapter five should not be reduced simply to medical care, essential as that is. At the medical level, the call to truth in researching further understanding of the origins, transmission and overcoming of the virus(es) has obvious resonance for the reign of God. A further call is to ensure that medical understanding is effectively disseminated particularly where myths about origin and transmission are widespread. Janet Brown (2004: 78-82) has alluded to some of the myths that exist, namely: not everyone infected gets HIV, HIV was invented by the CIA in the US Army biological warfare lab in Maryland (USA) to kill black people, nothing happens by chance, HIV is the result of witchcraft, HIV comes from the grey monkeys or green monkeys, or some type of monkey from Africa, there is a miracle cure, organic food and or vitamins will shield or cure you, promoting the use of condoms is really a plot by white people to cut down the black birth rate, African condoms are no good, condom use perpetuates promiscuity, having sex with a virgin can cure HIV, and dry sex prevents HIV. Sometimes these myths are simply due to ignorance. Sometimes they are promoted out of prejudice/prejudgement about so-called 'deviants' such as gay men or drug-users while information about heterosexual transmission is ignored or distorted. However in Zambia as it is a mainly heterosexual activity that has been identified as the primary the mode of transmission.

Medical treatment, whether via ARV therapy or even a much more effective treatment than is at present available, could not hope on its own to heal the psychological and social destruction wrought by HIV. Counselling care remains critical to psychological healing. Social healing involves more radical measures from overcoming prejudice to cultural change to economic reform. Programmes of care in these different areas, which for Christians form part of the coming of the reign of God, will be effective only over time (as is the case with all the programmes mentioned in Chapter 2). The reign of God is coming, but in history only over time. This is illustrated by two case studies as shown above in chapter three and chapter five.

Caring effectively for commercial sex workers already infected with HIV or exposed to infection takes time. Commercial sex work is not cured instantly and by a simple decision of

the will. Willingness to be helped will usually be very hard to elicit or to encourage. Free condom distribution could be an important first step in saving life and enabling for recovery in the short term

Due to the impoverished circumstances in which so many commercial sex workers operate alongside the Zambian borders it may be necessary, among other measures, to provide free condoms, without endorsing in any way commercial sex or prostitution. A Christian care of commercial sex workers, which seeks to protect the infected from infecting others, and the non-infected from being infected by others, could regard the provision of free condoms as a morally acceptable interim measure. This measure in the interim is being used to save life and so offers some hope of tackling and eventually overcoming the commercial sex syndrome. This will be more practical than preaching against these people in sermons where paradoxically they may not even be present when the sermon is being delivered.

To care for people with HIV in these situations and as part of that care to prevent them spreading it further, every dimension of the problem has to be analysed and tackled. All this demands time for individual and groups. In that time care for life may require interim measures akin to the provision of clean needles for drug addicts. With all the risks of misunderstanding both in regard to the 'safety' of so-called safe sex and to the apparent endorsement of promiscuity, it may be socially necessary and morally legitimate to accept the use of condoms as indicated above. It must be made clear however, that this is in no way regarded as good in itself. It is tolerated as an interim measure to protect life and allow time for the personal and social conversion which the coming of the reign of God calls for and enables in these situations.

6.11 Scaling-up and sustainability

The strategy involves scaling up of this praxis. There are examples of remarkable HIV interventions run by committed and concerned people. These include prevention, care and dealing with impact through theatre groups, orphans care and income-generating projects (like some of those interventions mentioned in Chapter 2 carried out by the three church umbrella organisations and their subsidiaries). However these have neither stopped the pandemic nor alleviated much of the misery associated with it precisely because they are small-scale and localised.

If Circles of Hope have to make a lasting impression, prevention has to be done at this level – after all it is individual behaviours patterns that must be changed in a community context. A multitude of Circles of Hope programmes across the country is needed. These will make a difference. This is where local church congregations play a significant role in the Zambian setting. As indicated in Chapter 2, Zambia currently has more than 14,000 Christian congregations through out the country (while CCZ related Churches have 3,900). If small scale programmes that are localised in the capital city of Lusaka managed to reach to all those points of presence with greater impact, a great deal would be achieved in terms of scaling up interventions as well as building a movement of care and compassion., Care and impact responses desperately need to be scaled up because the numbers of affected and infected are so great. Education for orphans might be provided via home based care through a particular church in one area, these responses, however important in themselves, must be expanded. As rightly observed by the World Health Organisation (2004) in a document entitled *Scaling up antiretroviral therapy in resource limited settings*, the difficulty is to achieve large-scale responses and remain sensitive to geographical and cultural variations especially when resources are limited.

The pandemic raises important questions about sustainability. People understand sustainability to mean that when the core funding - be it government or donor - runs out, the local Church/community or administration will be able to continue the project using its own resources. This may be a laudable target for many projects. It makes sense that communities should be asked to cover the recurrent cost of providing clean water, should build classroom blocks and should manage these themselves. Micro credit projects, mainly under the Zambia Social Investment Fund (ZAMSIF projects), take pride in being self-sustaining. However, HIV changes things and this is especially true for projects designed to assist people impacted by the disease (Barnett and Whiteside, 2002: 325).

Sustainability is achievable with Circles of Hope. It does not require donor funding to start a care group at local congregational level. The human resources of people living with HIV and AIDS are there within each congregation. ‘Sustainability’, like ‘coping’ (see below) is often another way of asking people to do more with less and this is doable with circles of praxis. A concrete example of this is a project designed to help orphans that is constant and results in the community becoming better off - or at least no worse off. In an HIV affected area, the

numbers of orphans will rise and the community resources – human, physical and financial – will be contracting as adults fall ill and die.

Sustainability is not a blanket criterion that can be used to judge the viability of projects in HIV affected areas. There are two main reasons for this. Firstly, and alluded to the above, is that the pandemic means that resources are being lost in communities and in the nation at the same time as demand rises. The second is the time–frame for support. The most extreme example is where young children are orphaned. They will need care and support at least until they are 16 years old, and possibly longer. Donors (or partners as is the new term describing this relationship) need to look at long term assistance – something most cannot do because they have neither the time–frame nor the budget to make this sort of commitment. Meanwhile Circles of Hope support groups would rely heavily on the commitment of local leadership and local people with a central role being played by PLWHAs.

6.12 Education

The strategy calls for continuous education in the praxis. The community of disciples is, after all, engaged in education while preaching and teaching the good news of the reign of God for that education to be effective the community must practise what it preaches. Mugambi and Nasimiya–Wasike, (2003: 91) reminds us about the need for confession of faith to have an influence on the life and living of African people. The disciple’s ministry of education should emulate the model of Jesus’ ministry. Education or communication for conversion is based above all on witness. In this light the ministries of companionship, of care, and of truthful and sensitive pastoral care can be seen to be at the heart of the Church’s education programme. Meanwhile, Long and Cornelius (1994: 120) say that education is also a two-way process. The would-be educators must themselves be educated. The teachers must listen and learn. With such a new phenomenon as HIV and its continuing developments, only a learning Church can be an effective teaching Church. A couple of implications of this rather obvious point may be usefully spelled out.

Learning can and must take place at many different levels in the Church and deal with many different aspects of the pandemic and respond to it. This learning process includes persons who are living with HIV. It must be recognized that *their* partners, companions and carers also have much to contribute. Through their experience they may have unique access to understanding some of the moral needs and possibilities arising out of the pandemic. The

interaction between this immediate experience and associated understanding and the moral tradition of the Church may already be yielding results. This takes time and no theological or theoretical analysis may be adequate compared with practical experience and understanding. Mutual education amongst all people involved in this matter of creating the praxis of Circles of Hope must, as a matter of necessity, continue. There are, anyway, more serious issues pending than the couple of examples cited earlier might indicate.

The need to break the silence around human sexuality and HIV is long overdue and the best place to do so is with those who have the task of preaching the good news. Truth about the reign of God demands no less, and the values of justice and freedom exclude discrimination against people living with HIV just as much as against other social 'lepers'. The value of peace with its implications of unity, reconciliation and forgiveness confirms this need to integrate all people into a genuinely Christian and inclusive community.

6.13 The ministerial challenge: communication

This is the challenge as it has related to the new level of ministry to enhance the creation of Circles of Hope in every local congregation in the Zambian community. It affects the Church and its pastoral work in communicating this initiative. Changes and failures in the Churches have played a major part in the creation of societies such as we have in Zambia where there is little certainty about the rights and wrongs of adultery, fornication and even homosexuality. Zambia is still in denial as to the existence of homosexuality. This has led to the National HIV strategic plan (2002: 32) to make this observation:

although there needs to be a systematic review to identify policies that act as barriers for effective prevention of HIV/AIDS, one known example is the prohibition of condoms distribution for use by prisoners. In light of reportedly high levels of HIV prevalence and homosexual activity among prisoners, the non-availability of condoms will most certainly increase the spread of HIV/AIDS in the prison.

It is this sort of morally uncertain society which creates the conditions where HIV can spread. What then can the churches do to meet the challenge? How can they be more effective in their responses? The Church in Zambia unlike in other western parts of the world still has a great deal of moral authority. Many people believe in God and submit to the teaching of those who speak in the name of God. Religious organisations in Zambia like churches are often the primary providers of health and social services and can influence people's attitudes and

access to services through their approach to HIV (Yamamore, Dageforde and Brunner, 2003: 84). Religious organisations can provide spiritual, material and emotional support to communities infected and affected by HIV. Through the proposed Circles of Hope churches can help people to deepen their own spiritual relationships with God, which can improve their ability to deal with a range of difficulties. More generally, churches offer a place for a holistic theological praxis on the nature of morality, and on the need for compassion and social justice. They offer a place in which people can discuss the relationship between religious and medical explanations for disease, and share information.

Church-related anti-stigma work supported through Circles of Hope can raise the level of debate about human rights, poverty and HIV in broader society. To a greater or lesser extent, religious organisations play a role in setting and maintaining moral boundaries even in largely secular societies. The Church in Zambia has not yet lost its political and moral power they continue to exert social power outside of the church (Cochrane and West, 1993: 34). Zambia is characterised by a high degree of religiosity and a strong Christian presence (no wonder former president Chiluba declared the country as a Christian nation⁷⁷). In Zambia religious (especially Christian) organisations help define what is right and what is wrong, how to think about the purpose of life and how to think about death and suffering.

All too often when people say, ‘the Church should speak out’, what they mean is that Church leaders should make speeches and issue press statements. The problem is that it takes two to ‘speak out’ in these days of the mass media. It needs the speaker and it needs the reporter or editor related to press, radio or television. Can anything come from a declaration? Certainly - if it results in political will reflected by adequate funding for HIV control. New directions for the future are already clear if there is a willingness to abandon failed policies. According to the bulletin of the World Health Organisation (2006: 698-776) what must now happen is the integration of prevention and care, which amounts to the combination of sound public health practice and the promotion of ARV therapy. These need to find home within the concept of Circles of Hope. The Church in Zambia should enter into serious dialogue with African traditional practices so that its virtues may help in holistic healing. It is obvious that there is a

⁷⁷It is not the intention of the researcher to enter into a debate as to whether President Chiluba was justified in declaring Zambia as a Christian nation. It is however clear that the declaration lacked proper theological underpinning as to the ramifications of such a declaration. It is now clear that the statement has been used for political expediency and in some cases to appease the Church to support the powers that be.

common ground in which the Zambian heritage meets and interacts creatively with the Christian tradition.

Slowing the AIDS pandemic requires nothing less. The researcher has alluded in Chapter two to the first Church statement on HIV by the three umbrella Church organisations in Zambia when very little was known about HIV. The problem is that it never ‘made’ the news as required by newsmakers. How many times has the Church suffered a similar fate?

The plain fact is that impressive public statements on great issues are ten-a-penny in this present information swamped age. They make a talking point and are forgotten within a week. If the Churches’ message is no more than statements then it is fated to be soon forgotten. The message of the Church, therefore, has to be something that is understood, held and lived-out by its members at local congregational level. This means that the teaching of the churches has to be, first of all, a teaching within the churches. A poll commissioned by the CCZ Youth Desk (2003) revealed that a few young Christians felt that their churches were not giving any helpful teaching and guidance on sexual morality. Part of the trouble is that some congregations often reflect a wide age-band and it is difficult for preachers to handle sensitive areas of teaching in such meetings. The formal sermon, however, is only one of the ways by which teaching is done in the churches. There is a need for a more creative use of groups, literature, tapes and dialogue.

In recent years many congregations have seen remarkable changes. From being collections of people who turned up in the church building on Sundays and then rapidly dispersed, they have become genuine fellowships with a sense of belonging together and supporting each other. All of this is a great gain but, as with all changes, there can be less desirable side effects. This rediscovery of fellowship in the churches has gone hand-in-hand with a growing lack of awareness of the needs and issues of the outside world. This tends to reflect itself in what is taught in sermons and in catechism classes.

Congregations are increasingly concentrating on concerns that are internal to themselves such as discovery and use of individual gifts, the way a congregation should order itself, the nature of worship⁷⁸, how women should dress when attending church etc. Some of these issues are

⁷⁸The Reformed Church in Zambia experienced a major split in 2001 precisely on the issue of ‘mode of worship’ and today there exists in Zambia another charismatic Church called the Bible Gospel Church in Africa (BIGOCA) led by a former Synod Moderator. Fifteen ministers with their followers went along with the new Church.

not petty matters. There are, however, far more fundamental issues in the scripture to which a Church's internal orderings are, to put it gently, somewhat secondary. Too little is being taught about the nature of God, the creative purposes and about the way people should live, and the awesome blend of holiness and readiness to forgive human frailties. Too little is being taught about human sexuality and the call to care for one another in a time of HIV.

In *Unfinished Business: Returning the Ministry to the people of God*, Ogden (2003: 212) says too little is being worked out in many congregations about how Christians, individually and corporately, make their presence felt in their surrounding communities and in the world at large, especially in the context of HIV. Christians need to be learning what their faith and morality amounts to and how to relate it to the critical, questioning and often careless society in which they are placed.

Cook (1995: 18-20) suggests that the Churches are not meant to be fielding a relatively small number of media experts to speak on their behalf. They are meant to be sending out hundreds of thousands of ordinary believers who can commend their way of living and answer the questions that it raises. Cook is supported by Nelson (1993: 169) who says such people must spend most of their time not in cloisters, studies, earnest conferences or joyous conventions but in the rough and tumble everyday life.

Furthermore, Nelson (1993: 170) indicates that until the Church significantly improves in that area it will not draw in many new disciples or may not even make much of a difference to the moral standards of society. What is urgently needed is the human evidence that the Christian message is related to facts as well as opinions.

The Churches' spokespeople have a further difficulty when it comes to speaking out on the HIV question because it reveals a deep dilemma within the Christian community. This is the dilemma between being upholders of high principles on the one hand and showing love and understanding for those who come short of them on the other. Christians are conscious that they themselves are sinners wanting to help other sinners. True Christianity has no place for 'holier than thou' attitudes.

6.14 Biblical teaching on sexuality

In Zambia, as observed by the Catholic Bishops in their pastoral letter of November 2002, (see Komakoma, 2003), a similar observation is made by the National HIV/AIDS Strategic

Plan of 2002, in which HIV is mainly connected with 'sexual promiscuity'. There may be other factors such as socio-cultural beliefs which subordinate women in society and difficult socio-economic conditions which compel women to exchange sex for money or gifts. There may be other cultural practices also, such as dry sex and the traditional practice of widower cleansing explain please which facilitate the transmission of HIV, but above all it has to do with 'risky sex' behaviour with or without a condom. It would seem that the Bible in principle denounces all sexual immorality. Here lies the conundrum however, for people who are loved by God carry out such practices and the bible calls on believers to be concerned for all people. Christians are called to '*love their neighbour as themselves*' and they cannot pick and choose what neighbours to love and what neighbours to despise.

Fierce denunciation of sexual immorality could deeply hurt individual people and alienate them from ever discovering the reality and love of God. Heterosexual intercourse within marriage is God's will for human beings and nothing else is. It may not be popular to hold such a biblical principle in an age that has been schooled by television influence with advertising into feeling that everybody has a 'right' to almost anything they want. In trying to be relevant, contemporary, the Church has sometimes sacrificed its message and put its own identity at stake.

The Church, therefore, when confronted with the moral challenge of HIV, has huge and real problems within its own ranks that make public life difficult. It is, however, of crucial importance that they get their priorities right. They must be compassionate and even take the risk of being 'accused', as was Jesus, of being 'friends of sinners'. They must never be accused, however, of being friends of sin. One of the ways to make a positive contribution in the current crisis is to uphold biblical sexual morality. The Church must stand against the tide and teach that sex is for heterosexual marriage only. The Bishop of Norwich in the UK (Reid, 1995: 75) made all this clear in an unequivocal address when he said:

Both homosexual practices and heterosexual promiscuity are clearly, according to the scriptures of the Old and New Testaments, condemned as sin. Why? Because they offend against what Jews and Christians understood as normal human relationships: and it is upon normal relationships that all societies depend for their very stability... historically it is interesting that the breakdown of ancient civilisations often coincided with a breakdown in sexual morality. Sexual immorality is never a private

matter; it cuts at the roots of civilised society. The Christian teaching is simple and clear cut. Normal human relationships mean celibacy before marriage and fidelity within marriage⁷⁹.

The Zambian Catholic Bishops (Komakoma, 2003: 9) have once again echoed the same message: the Biblical teaching of chastity or purity is still the best way of eradicating HIV completely. No one dies of 'abstinence' or 'purity'. Abstinence does not kill and does not cost money. Risk behaviour, with or without condoms, certainly kills sooner or later. In the Church we call for healthy and responsible behaviour for all.

The HIV crisis indeed needs to be the stimulus for a moral awakening. The crisis represents a watershed for contemporary society, fear may well induce some to modify their sexual behaviour but what is needed is a radical renewal of society. It is here that we come to the crux of the challenge of HIV to the Churches. If the whole case for chastity rests upon the fear of contracting HIV then it will collapse when a cure is found. The Church has to do more to replace adverts of 'safe sex' with 'safer chastity'. The Church has to teach what Reid (1995: 30) has called 'good sex'.

At the moment the general public is being bombarded with images and teaching about sex that are incompatible with Christian teaching and which are positively conducive to the spread of HIV, to say nothing of other equally tragic side effects such as marriage breakdown, single-parent families, abortions and guilt. What is desperately needed is a vision of 'good sex' – something that enhances life. It has not been the purpose of this work to give an exposition of what the churches should be teaching. Gavin Reid (1995: 81-84) says good sex has the following marks among its qualities:

- First it is pure. This means that sex has to be recognised as part of the loving will of God. Sex is God's idea in the first place. It cannot be 'dirty'. Sexuality is all part of the creation that was pronounced by its creator to be 'good'. To take part in 'good sex' rules out of the possibility of guilt.

⁷⁹The researcher is very aware of the on-going debate that the Anglican Church has opened up which is a divisive subject. This is on homosexuality. This could significantly alter the church's stand on sexual morality and the denomination's place in the worldwide Anglican Communion. This came after the ordination of Gene Robinson, an openly gay priest, as bishop of New Hampshire. Furthermore the researcher is also aware that the South African Parliament has just passed a law allowing gay marriages. South Africa is the first African country to legalise same sex marriages. Homosexuality is a very divisive subject among the Zambian Churches and much as the researcher of this study does not agree with that position of promoting and legalizing homosexuality, the focus of this work is on how best the Church in Zambia can fight stigma as it relates to HIV and not to discuss homosexuality. Without developing further detailed discourse the researcher disagrees with such practices as they do not help in combating HIV.

- Secondly, it is profound. We cannot think of it as an ‘it’ or account for it in terms of individual acts. It is a holy secret between two people deliberately designed to be physiologically and emotionally compatible with each other. It creates a bond that has psychological permanence to it and which requires a matching physical loyalty. The act is only part of the whole. It is the icing on the more substantial cake of a lifelong relationship. Individual sexual acts are oasis moments on a long journey, which expects its full share of desert stretches.
- Thirdly, it is pleasurable. It was clearly meant to be by God and it ought so to be for men and women in marriage.
- Fourthly, it is procreative. While the mind is meant to be used so that bringing children into the world stems from responsible decisions, and while sex was clearly designed for partnership before parenthood, good sex is meant to be related to the conception of children. It is more about giving pleasure than taking it. It is about mutual unselfishness. The condition it creates between two people makes them fit to be parents and creates the bond that will give their children the security they need during the long road to maturity. Contraception is part of responsible parenthood.
- Fifthly, good sex is partial. It is clearly understood as forming only a part of life, but it has a quality that invades the whole. It creates the emotional and sexual security that allows a couple to be open to all that life holds for them as individuals as well as in their relationship. Life is not meant to be perennial honeymoon. ‘Bad sex’ can be obsessive. It can lead people to wanting more and more experiences and possibly involving a multiplicity of partners. It is ‘thing centred’ rather than ‘relationship centred’.

Smedes (1993: 3) in his book: *Sex for Christians* says good sex sets people free to be total people who approach circumstances and other people with security and joy of knowing that they are loved and cherished. The community as a whole is enhanced if its members enjoy this sort of sexual fulfilment.

If the churches are to develop and promote a teaching about good sex, then as Frymer-Kensky (1992: 1145) indicates they will also have to promote an equally positive teaching about chastity. Failure to do so will only add to the hurts that many single people feel. A positive teaching about chastity will have to distinguish between chosen singleness and unchosen singleness. Teaching, however, is only part of the Church’s response to the circumstances brought about by the challenge of HIV infection. While there is such a need for the advocacy of good sex, there is a need for changes in life style.

Commending and living out good sex morality, however, is not the primary task of the Churches. The primary task is the worship of God backed by witness and the sharing of the

good news to be. Churches are not societies for moral and social improvement but this challenge of HIV infection calls on people of good will to network and work in partnerships with all like-minded people, for the battle is great. Churches are communities committed to the sharing of the gospel and the gospel in its fullness will include working with other people to save lives.

6.15 Networking and partnership⁸⁰

The researcher proposes that the strategy is about networking and strategic partnerships. To date, and with a few notable exceptions, public health authorities, church and non-profit organisations have taken the leadership role in the work on the HIV pandemic. However, these two sectors need support to make their efforts more effective. A new partnership is needed that deploys business resources and skills in the wider battle against the disease. The organisational and communications skills of business complement the medical resources and skills of the other sectors. By working together in partnership the three sectors can produce a much greater impact than if they work in isolation. The words of Nelson Mandela summed up the global situation and the need for partnership approach in facing the challenge as follows:

The severity of the economic impact of the disease is directly related to the fact that most infected persons are in the peak productive and reproductive age groups. AIDS kills those who on whom societies relies to grow the crops, work in the mines and factories, run the schools and hospitals and govern nations and countries, thus increasing the number of dependent persons. It creates new pockets of poverty when parents and breadwinners die and children leave school earlier to support the remaining children. With cruel irony, even our achievements in improving communications networks and transportation systems, and building regional economic blocs, influence the attitudes and behaviour patterns of people in ways that sometimes accelerate the spread of the disease. These are well known facts. If we recall them now it is to underline the scale and the multifaceted nature of the problem. The health sector cannot meet this challenge on its own. Nor can government. All sectors and all spheres of society have to be involved as equal partners. We have to join hands to develop programmes and share information and research that will halt the spread of this disease and help develop support networks for those who are affected⁸¹.

No one sector can conquer this disease on its own. Without networking and partnerships HIV will continue to grow rapidly, in the developing world in particular. The success of future

⁸⁰This section on the seven principles of partnership is adapted from “What is Partnership?”, 1994 by Ros Tennyson et al., published by the Prince of Wales Business Leaders Forum

⁸¹Speech delivered by the then South African President Nelson Mandela to the World Economic Forum, Davos, 3 February 1997.

campaigns against the spread of HIV will depend on the total impact of preventive measures in an effective and businesslike manner. Dennis (2003: 13) says that it is clear that the challenge to address this terrible pandemic does not rest with the state and non-governmental organisations alone. The Church after all is the light of the world and the salt of the earth, and is therefore duty-bound to join battle against this disease. In this way, the global pandemic will be contained and in future hopefully eradicated.

It must be stated right from the outset that there is no single answer to the many questions involved in setting up a particular working partnership on HIV. Circumstances will vary depending on the dynamics of those involved in the partnership and their specific context. The blending of resources and sharing of risks can benefit each of the partners, as well as the whole human society.

6.16 Partnering with others

The Church in Zambia needs to strongly partner with non-governmental organisations (NGOs) in scaling up its work in the area of HIV and AIDS. Of particular interest to the contention of this work of creating Circles of Hope, will be those NGOs that deal with support groups of PLWHA such as Network of Zambian People Living with HIV (NZP+).

People who are HIV-positive can also network with AIDS MAP Global HIV/AIDS Information⁸².

According to their website cited in Chapter two, NZP+ says the biggest challenge encountered in their project is the resistance from the Church. They say that Church leaders do not see it fit for PLWHA to have children and yet their stance on the use of condoms is negatively affecting PLWHA. To overcome this, the researcher proposes a partnership with the unfolding concept of the Circles of Hope with NZP+.

NZP+ is a National Organization of People with HIV. NZP+ fully believes that People with HIV have a positive role to play in AIDS prevention and impact mitigation efforts. NZP+ also recognizes that opportunities and services to access and retain self-development should not be limited on the basis of a seropositive status. Much can be learnt by the Church engaging with such groups.

⁸²<http://www.aidsmap.com> [accessed January, 12th, 2007]

Partnership with NGOs and groups like NZP+ has potential to bring about strengths in their overview of local and national trends. Its senior officials are often linked to the international agencies such as World Bank and UNAID which can provide a view of global trends. Such information is vital for risk analysis. Along with private healthcare providers, the public sector provides care for the infected and sets the legal framework in such areas as blood screening and the treatment in the workplace of those with HIV. It may run its own country wide HIV prevention programmes which may be available to companies, and may also have some capacity for large-scale HIV monitoring and evaluation.

In terms of cash resources and full-time employees, NGOs are smaller than their public and private sector counterparts. However they are public interest organisations with considerable social and political influence, if not power. They have the credibility that comes from working closely with those most affected by the epidemic. NGOs often best understand the conditions and social attitudes that lead to the spread of the disease, and in many parts of the world, have led the campaign to draw public attention to HIV issues in the community and the workplace. They also play a part in providing services and care to people living with HIV or at risk of acquiring the disease.

NGOs are often at the leading edge of HIV issues. These can be controversial and, as such, they are subject to criticism and suspicion from both government and (in some cases even) from business. The three sectors (Civil Society, Business and Government) have very different needs and interests and bring different skills and resources to the table. Conditions vary widely from country to country, and there can be no hard and fast rules on how partnerships should be initiated, structured and operated. Companies may take the lead, but so might government or civil society through various NGOs or even through the church. Hendriks (2004: 221) deduces the need for networking appropriately, when he states that in combating HIV, one needs co-operation from a number of disciplines that should be presented to local communities. Building networks and partnerships, he says, are crucial elements of the process and are part of the public dimensions of the Church's work and witness. The Church in Zambia has no choice in the fight against HIV but to build strategic networks and alliances with NGOs with similar attitudes towards the creation of support groups for people living with HIV.

6.17 Conclusion

In concluding this study then, the HIV pandemic is the worst medical and social tragedy to have befallen humankind. Lost to many people is the fact that it does not affect all regions of the globe equally. Figures show that over 70% of PLWHA are in sub-Saharan Africa the majority of who are young and energetic. With an overall HIV prevalence rate of 16% and a life expectancy of 34 years, HIV has severely impacted the lives of Zambians across the country. Stigma remains one of the most significant challenges in Zambia across the prevention-to-care continuum. The wider environment of these effects and statistics has provided for us a broader contextual situation. The Church in Zambia can not afford to hide its head in the sand anymore. The impact of HIV is being felt at all levels of society. This has posed a threat to economic progress and human development by attacking the most economically productive age group and reversing gains in life expectancy and child survival. The increasing burden on health budgets has stretched national and community resources to the limit, leaving no room for complacency or pretence about the magnitude of the problem. Since some members of the Church are positively infected, we can say with certainty that the Church; the body of Christ has HIV. HIV is a national disaster. It can not be managed without mobilising all the sectors of the country. The Church in Zambia needs to make HIV prevention a matter of compelling priority. This Church is an instrument for the missional praxis of the triune God.

The first hypothesis in this study set out to deliberate on the premise that Churches in Zambia do not have an effective strategy in place that addresses the issue of HIV infection in a holistic way on a congregational level where it effectively reaches and influences members. This lack of strategy is confirmed by the fact that only 28 out of more than 3,800 congregations having established support groups of people living with HIV infection. It has been shown that most of the interventions in Zambia are at national level through workshops and the issuance of statements some of which have been examined. Subsequently, it has been shown that measures are required to develop strong theological reflections and education which would result in the establishment of Circles of Hope in all local congregations. These Circles of Hope would act as fountains for promoting behavioural change, support action for safer sexual behaviour, combat stigmatisation and discrimination against people with known HIV infection, and promote healing.

There must be appropriate theological reflections that touch on the work of the reign of God. Areas to be covered under such reflections would include moral virtues, truth, freedom, justice, peace, sexuality, ministry and morality, companionship, care, and education. This reflection is an attempt to suggest a constructive interpretation of the present realities brought about by a time of HIV.

God's will for the present situation can only be discerned through critical and sensitive leadership in order to bring about genuine healing. The role of the local Church and networking are essential commodities to realise a vision of a Zambia that is HIV free. The creation of Circles of Hope support groups is a new frontier that promotes missional theology which is holistic in combating HIV at a congregational level where it is greatly needed. This then will be a new ministerial strategy so far not attempted by the Zambian Churches. None of this can materialise and be sustained if there is not a process of continued facilitation, training and vision setting. Religious leaders who are already tasked with many other duties may not be able execute these additional challenges. The Makeni HIV/AIDS resource and training centre is thus a one stop centre that can serve the Churches in Zambia in this initiative and demonstrate how it can be scaled up to give hope to the many HIV positive people.

The Church in Zambia could offer valuable input by mobilising its social capital at the level of all the above strategies. The Church has engaged the people at a profound level. In any given week, Christians from all walks of life interact in congregations and undertake various activities within the communities. In most of rural Zambia the Church is about the only social institution that people, Christian and non Christian alike, relate to. Fifty percent of all rural based health facilities in Zambia are provided by Church institutions. The Church in Zambia thus occupies a strategic social site and offers a broad network that links ordinary people in so many social and economic activities. Therefore galvanising efforts would release enough energy towards eradicating stigma and discrimination associated with HIV through circles of hope. This will help to build a Zambia which is HIV competent.

One HIV positive woman in Zambia said:

God has not called us to judge, but to guide, support, love, care and bring hope to people living with HIV. Please do not judge me. Get close to me. Know me. Support me, for how do you expect me to grow if you do not give me a chance? May the Circles of Hope support and bring hope to the many Zambians afflicted and affected by HIV and AIDS.

6.18 Final recommendations

In the final part of this study, the researcher wishes to state that HIV is different in many respects to the bulk of other diseases faced by humankind. Successful interventions in the past that have reduced the stigmatisation of disease and increased awareness and understanding - such as education, social support mechanisms, developments in medical science and strong epidemiological models - are often absent, ineffective or simply undeveloped in the case of HIV. HIV stigma is also reinforced by significant social, cultural, religious, legal and economic factors, demanding a multi-dimensional, comprehensive and sustained solution, rather than one that relies, for example, on education or awareness alone. As is the case with effective prevention, which demands a combination of actions, effective stigma reduction demands a set of interventions which simultaneously address both infected and affected people.

Churches in Zambia need to have in place as a matter of necessity and urgency an effective strategy that addresses the issue of HIV stigma in a holistic way at a congregational level where it effectively reaches and influences members. It is not just about statements and policy documents.

A missional theology which promotes the praxis of the creation of 'Circles of Hope' at a congregational level should be encouraged in theological colleges and local congregations in Zambia as one means for a holistic approach to combat HIV infection and its related stigma.

It is recommended that an inter-organisational co-operation as well as a multi-disciplined approach (local government, local communities, non-governmental organisations, research institutions, churches and even other faith communities) be enhanced in dealing with HIV in Zambia.

It is also recommended that supportive and healing communities are developed as a means of fighting the silence, shame and stigma associated with HIV.

There is also need to explore further how theology and policy, education and awareness, political and Church mobilisation can help in reducing stigma.

In the meantime, HIV stigma continues to dominate the epidemic, and will not be mitigated by half-hearted solutions: it is too complex. This study has illustrated how a lack of focused

and aggressive action against HIV stigma over the years has led to its continuing ascendancy. HIV stigma represents a failure by governments, specialised agencies, NGOs and civil society and much more the faith based communities that has allowed biomedical solutions and ideologies to prevail, such as antiretroviral (ARV) drug scale-up; vaccine development; and lengthy debates on morality and sexuality.

It seems that little has been invested in understanding some of the fundamental social and structural problems underpinning stigma - despite knowledge of the negative affect stigma has on the uptake of HIV prevention, treatment, testing and care services.

It is thus essential to recommend the creation of Circles of Hope in tackling stigma. But, the limited nation wide reach of the Circles of Hope initiative, and stigma's ever-changing nature (similar to virus itself), mean that high quality anti-stigma theologically influenced programmes, tailored to context, need to be rapidly be scaled up and continually adapted. They must be driven by an equivalent level of theological education, funding, passion and commitment as that which has resulted in the successes of ARV roll-out.

This study recognises that the absence of support groups of people living with HIV will enable new forms of stigma to emerge and as such new solutions will be required.

This study has provided a snapshot of the current state of HIV in Zambia and mentioned the challenge of stigma, and it is hereby concluded that the continuing presence of stigma represents a catastrophic failure in HIV policy-making and programme design. Medical science alone is limited in its effect on HIV stigma; but HIV stigma can block the achievements of medical advances by simply preventing affected people from engaging with testing or treatment services. HIV stigma forms a major barrier to advances in repairing the personal, social religious and cultural damage caused by the HIV epidemic.

In light of all this, the researcher would like to further recommend that all Faith based HIV policies and programmes should include a specific component that addresses the impact of HIV stigma and promote the creation of support groups as an entry point for its reduction.

Adequate funding must be available to scale up concrete and comprehensive stigma reduction interventions, and to monitor and evaluate the impact of HIV stigma and the effectiveness of stigma reduction strategies and programmes such as the Circles of Hope in Zambia.

It is vital that the approach to fighting stigma and discrimination should not become too technical, losing sight of the personal impact of loss of self respect and feelings of isolation felt by people living with HIV.

HIV positive people must be empowered in the context of addressing stigma so that all activities and programmes are people centred and not statistics focused.

Strong theological and Church responses against stigma and discrimination are absolutely crucial, and there must be awareness of new processes and initiatives that could exacerbate stigma within local Churches and communities, particularly in relation to gender.

In addition, issues around funding can lead to aid being given to groups headed by men, who then bring in other men as experts and consultants. Women at the forefront of community responses to stigma, and other care and support needs of affected people, are consequently denied proper resources.

Leadership is a key element in the struggle against stigma. Leaders at all levels, have a clear responsibility to create a more open society that is free from stigma, silence or denial about HIV and AIDS.

Health is a human right. The theological education to reduce HIV related stigma should be tackled alongside with advocacy for health systems that are strengthened at the local level so that everyone has access to basic health care, no matter what their position. Adopting this approach with those affected by HIV must be central in this fight.

Finally, the issues raised in this dissertation present major challenges for theological education, preaching, liturgy and Eucharistic practice and the peaceful co-existence of people within various Zambian communities. It is therefore recommended that Churches and faith based communities in Zambia think critically beyond pastoral care **for the dying** and move into empowerment **for positive living**. The creation of support groups of people that are living positively with the virus within the faith communities is an affirmative way of breaking the silence, shame and stigma that has for a long time been associated with the Church. Care needs to be taken into consideration so that such support groups do not become another level of stigma for excluding HIV positive members of the body of Christ. This is proposed as ministerial strategy for combating HIV in Zambia.

APPENDIX 1

Questionnaire used by the researcher during field visits to Church umbrella organisations and other Faith Based Organisations in Zambia

1. Give me a brief historical background of your organisation?
2. How is the structure organised?
3. What responses has your organisation made to the problem of HIV and to many deaths caused by AIDS in our country?
4. Do you have any HIV policy statements issued by your organisation?
5. Do you have any programmes that support people living with HIV? What are they called and what do they do?
6. Give me any further information of what your organisation is currently doing about the challenge of HIV?

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