

# HIV/AIDS AND THE CHRISTIAN FAITH



A MANUAL FOR LEADERS



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## ACKNOWLEDGEMENT

With an HIV prevalence of 13.3% among the 15-49 years age group, Zambia has a moderately severe HIV/AIDS epidemic with around 1 million people living with HIV/AIDS (PLHIV) and over 600,000 orphans and vulnerable children (OVC). Most of the underlying drivers of the HIV/AIDS epidemic in Zambia are issues of social justice, such as gender inequalities, poverty, stigma and discrimination, marginalization and other injustices. The Christian Church in Zambia has been in the frontlines of the HIV/AIDS response, providing leadership and guidance to counter and right some of these injustices. The Church has provided compassionate care and counsel, and has been a source of hope and strength for Zambians living with HIV and those who are affected by HIV/AIDS.

The Church in Zambia is very diverse, comprising of many denominations and belief systems. While the Church has been a staunch ally in the national HIV response, the Church response to HIV/AIDS has been largely left to each denomination to define and implement. In the denominations where information about HIV/AIDS is readily available to Church leaders and the leaders are HIV-competent, the Church response has been of tremendous help to PLHIV and those affected by HIV/AIDS, and to the country as whole. However, in the situations and/or denominations where Church leaders lack correct information about HIV/AIDS and where misconceptions and myths about HIV/AIDS are prevalent, the Church often inadvertently becomes a vehicle for social injustice and other HIV-related harm, a situation that urgently requires to be addressed and corrected.

This manual was developed by an interdenominational group of men and women of God in Zambia, as a first combined effort by the Christian Church in Zambia to begin to systematically address HIV/AIDS in our country by ensuring that the leaders of the Church tomorrow, graduate from Theological and Bible schools, HIV/AIDS competent. These men and women of God gave of themselves and of their time, and worked tirelessly over many months to develop this Guide so that the Church in Zambia can increasingly respond to HIV/AIDS faithfully and competently, and provide PLHIV and those affected by HIV with compassionate, respectful, and non-judgemental care. They include Principals, Heads of Departments and Lecturers from the following Theological Institutions:

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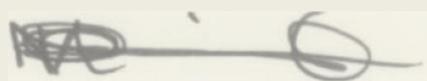
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Our special thanks go to Rev. Ezron Musonda for generously spearheading the efforts for putting the pieces together and finalizing the Manual.

While this manual was developed for training pre-service Church leaders, we hope that in-service Church leaders will also find it a useful tool and guide for addressing the issue of HIV/AIDS in their congregations and churches. We also hope that the manual will find wider use and application among the Christian Churches and denominations that did not participate in its development, to guide their HIV/AIDS responses.

Finally, the development of this manual has been supported by the President's Emergency Plan for AIDS Relief (PEPFAR) and was made possible by the support of the American people through the United States Agency for International Development (USAID) under the terms of the Support to the HIV/AIDS Response in Zambia (SHARe II) Project, implemented by John Snow, Inc. (JSI). The SHARe II project provided both technical guidance and funding support towards the development and production of the Guide. We wish to thank USAID and PEPFAR, for making the development and production of this Guide possible. Our special thanks also go to the SHARe II team for their excellent technical guidance, and editorial input and support.



**Dr Mukachilima Chikuba – McLeod  
Chief of Party – JSI/SHARe II**

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## ACRONYMS

<b>ABC</b>	Abstain, Be Faithful, Use Condoms
<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>ART</b>	Antiretroviral Therapy
<b>ARS</b>	Acute Retroviral Syndrome
<b>ARVs</b>	Antiretrovirals
<b>BCC</b>	Behaviour Change Communication
<b>CBOs</b>	Community-Based Organisations
<b>CCZ</b>	Council of Churches in Zambia
<b>CSW</b>	Commercial Sex Worker
<b>EFZ</b>	Evangelical Fellowship of Zambia
<b>FBOs</b>	Faith-Based Organisations
<b>HBC</b>	Home Based Care
<b>HIV</b>	Human Immuno-deficiency Virus
<b>HPV</b>	Human Papilloma Virus
<b>HSV</b>	Herpes Simplex Virus
<b>HTC</b>	HIV Testing and Counselling
<b>MC</b>	Male circumcision
<b>MCDMCH</b>	Ministry of Community Development Mother and Child Health
<b>MCP</b>	Multiple Concurrent Partnerships
<b>M&amp;E</b>	Monitoring and Evaluation
<b>MSM</b>	Men who have sex with men
<b>MTCT</b>	Mother to Child Transmission
<b>NAC</b>	National HIV/AIDS/TB/STI Council
<b>NAP-WGHA</b>	National Action Plan on Women, Girls, and HIV/AIDS
<b>NASF</b>	National HIV/AIDS Strategic Framework
<b>OIs</b>	Opportunistic Infections
<b>OVC</b>	Orphans and Vulnerable Children
<b>PCP</b>	Pneumocystis Carinii Pneumonia
<b>PEPFAR</b>	The President's Emergency Plan for AIDS Relief
<b>PLA</b>	Participatory Learning and Action
<b>PLHIV</b>	People Living With HIV/AIDS
<b>PMTCT</b>	Prevention of Mother to Child Transmission
<b>PRA</b>	Participatory Rural Appraisal
<b>RBC</b>	Red Blood Cells
<b>RNA</b>	Ribonucleic Acid
<b>SDA</b>	Seventh Day Adventist
<b>SHARe II</b>	Support to HIV/AIDS Response in Zambia, II
<b>STD</b>	Sexually Transmitted Disease
<b>STI</b>	Sexually Transmitted Infection

<b>TATC</b>	Trans Africa Theological College of Central Africa
<b>TB</b>	Tuberculosis
<b>TCCA</b>	Theological College of Central Africa
<b>TOT</b>	Training of Trainers
<b>UNGASS</b>	United Nations General Assembly
<b>UNZA</b>	University of Zambia
<b>USAID</b>	United States Agency for International Development
<b>VCT</b>	Voluntary Counselling and Testing
<b>VSU</b>	Victim Support Unit
<b>WHO</b>	World Health Organization
<b>ZCC</b>	Zambia Counselling Council
<b>ZDHS</b>	Zambia Demographic and Health Survey
<b>ZSBS</b>	Zambia Sexual Behaviour Survey

## GLOSSARY OF TERMS

TERM	DEFINITION
Advocacy	Speaking or writing in favour of something; public recommendation regarding an issue
Care	To be concerned and to feel an interest about something, through actions and words, and/or to look after or provide for their needs
Catharsis	An emotional purification or relief or renewal brought about by sharing one's deepest fears or the release of pent-up feelings or repressed emotions after talking about a problem in therapy
Compassion	Feeling for another's sorrows or hardship that leads to a strong desire to help or alleviate the suffering
HIV Concordant Couple	Same HIV status (both are either HIV positive or HIV negative)
Condemnation	Expression of strong disapproval or renunciation
HIV Discordant Couple	A couple that does not have the same HIV status (one person is positive and the other person is negative)
Drivers of HIV/AIDS	The key contributors to the spread of HIV/AIDS
Drug	Substance, other than food, used as a medicine or as an ingredient in medicine, obtained from moulds, plants, animals, minerals or prepared synthetically
Empathy	The quality of entering or process of entering fully into another's feelings or motives
Epidemic	A widespread occurrence of an infectious disease within a community or defined location at a particular time
Gender	The differences between men and women that are socially and culturally defined
Homily	Sermon - a moral talk that warns, encourages urges or advises
Intravenous drug	A drug administered through the blood veins
Liturgy	An appointed form for the rites and ceremonies of public worship
Misconception	A mistaken idea or notion
Migrant labour	People who move from one place to another place in search of employment
Myth	A traditional belief, opinion or theory phenomenon which is not based on fact or reality
Regimen	The regulated and systematic plan of activities and regulation of remedies to effect cure
Sympathy	The process of sharing of another's sorrow or troubled feelings

## DESIGN OF THE INSTRUCTOR'S MANUAL

The manual is divided into seven units as shown in the table below

No.	Unit	Unit Description
<b>Unit One</b>	<b>HIV/AIDS: Basic Science</b>	This unit seeks to impart scientific facts about HIV/AIDS and its implication and application in the Zambia context
<b>Unit Two</b>	<b>Biblical, Theological and African Perspectives on HIV/AIDS</b>	Unit two seeks to aid the reflection on HIV/AIDS issues from the biblical, theological and contextual perspectives to effectively address the threat of HIV/AIDS
<b>Unit Three</b>	<b>The Church's Engagement with the HIV/AIDS Epidemic</b>	The purpose of unit three is to equip leaders for the Church to frame their HIV/AIDS responses within the Church's heritage, using its own internal resources
<b>Unit Four</b>	<b>Pastoral Care and Counselling</b>	This unit focuses on the Church's practical response through pastoral care and counselling undergirded by the information and reflection brought out in Units one, two and three
<b>Unit Five</b>	<b>Liturgy</b>	The focus of this unit is to anchor the knowledge of the previous units by helping leaders to sharpen their skills for designing worship services which incorporate HIV/AIDS-relevant messages in Church's rites and sermons/homilies
<b>Unit Six</b>	<b>HIV/AIDS Program Development and Sustainability</b>	Seeks to help the facilitator/instructor to equip students with skills to lead and manage sustainable HIV/AIDS programmes
<b>Unit Seven</b>	<b>Special Topics Related to HIV/AIDS</b>	Unit seven brings together special topics that may help provide key information to shaping of the future response to HIV/AIDS

Each unit has the following features:

- **Unit Title**
- **Unit purpose**
- **Note to the facilitator/instructor**
- **Unit objectives**
- **Key methods of Instruction**
- **Suggested Teaching Aids**
- **Topics**
- **Required Reading List**

For further information on certain topics, appendices are provided after the conclusion of the manual.

## INTRODUCTION TO THE MANUAL

This facilitator/instructor’s manual is specially designed for use in Christian theological schools in Zambia. It has been written and prepared for the purpose of instruction in key HIV/AIDS areas identified by a team of theological educators drawn from a cross-section of denominations with support from the USAID-funded SHARe II project. For the purposes of this manual, when stating the position of the Church or making recommendations, the terms “Christian Church” and the “Church” are used to collectively refer to the denominations that participated in the development and finalization of the manual; these are listed above in the “Acknowledgements” section. The terms are not meant to include all Christian Churches and denominations in Zambia.

HIV/AIDS has affected every congregation in Zambia and affected all members, clergy and laity alike. This realisation calls for an HIV/AIDS competent Church that is able to respond to the epidemic with biblical conviction, empathetic spirit, theological depth and contextually situated information. By bringing together a group of schools of theology, we aim to equip and enable Christian leaders graduating from these institutions to provide life-giving and consoling HIV/AIDS information, messages, and care to the flock entrusted to them.

The role of theological schools in addressing the threat of HIV/AIDS cannot be over-emphasised, as the leadership of the Church is shaped by these institutions. The Church in Zambia remains one of the most important institutions in the community and is strategically positioned to address the challenges presented by the HIV/AIDS epidemic. The Church wields authority and is best situated to advocate, educate and disseminate information to people in our society, and also to provide care and counsel.

The content of this manual has been agreed upon by leaders and representatives of theological schools who felt that this information would enable graduates to impart the necessary knowledge, attitudes and skills to their Churches that will mitigate the impact of the HIV/AIDS epidemic in their congregations and their surrounding communities. This manual is fluid and adaptable, schools are free to use the information included in a manner that fits their needs. Each theological school will determine the level at which the material will be offered and will have the leeway to prioritise issues contained herein in accord with their situation and doctrine.

The basic teaching methodologies within this manual include: lecture; power point presentations; learning tasks; general discussion; group work and role play. Group discussions and role play will be followed by plenary sessions before input by the facilitator. Facilitators shall determine which teaching methodology best helps disseminate the information in order to achieve the desired objectives and purpose of each unit. Although tasks are included within each unit, facilitators can be flexible—the tasks are merely examples of the many activities a facilitator can come up with in each given unit.

The facilitator/instructor must note that the information in the manual is basic and intended to provide foundational knowledge to be expanded upon through further reading, research and discussion groups. Facilitators are therefore encouraged to use the variety of recommended resources that are provided in the manual and any other resources they may find useful to deliver the content.

It is our hope and expectation that this manual will be reviewed regularly and updated to make it relevant to the users and to the HIV/AIDS situation in Zambia. Users of this manual are therefore kindly requested and encouraged to comment constructively on its content, structure and flow to ensure that subsequent editions are not only improved, but are increasingly relevant.



PSALM

PRAISE ye the LORD. O give thanks unto the LORD; for he is good; for his mercy endureth for ever. Who can utter the mighty acts of the LORD? who can shew forth all his praise? Blessed are they that keep judgment, and he that doeth righteousness at all times. Remember me, O LORD, with thy favour that thou bearest unto thy people: O visit me with thy salvation; That I may see the good of thy chosen, that I may rejoice in the gladness of thy nation, that I may glory with thine inheritance. We have sinned with our fa-

## UNIT ONE: HIV/AIDS – BASIC SCIENCE AND CONCEPTS

### UNIT PURPOSE

This unit is designed to provide the learner with knowledge and skills related to the basic science on HIV/AIDS in Zambia. It is aimed at enabling the student to competently discuss matters related to the HIV virus including the drivers of the HIV epidemic in Zambia; natural disease progression; the importance of prevention, treatment, care and support; as well as adherence to HIV care and treatment.

The unit also prepares the student to confidently deliberate on issues related to populations affected by HIV/AIDS and how inequalities and inequities impact gender and sexual dynamics in relation to HIV/AIDS.

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#### NOTE TO THE FACILITATOR/INSTRUCTOR:

**Give ample time and attention to facilitate discussions of the topics under this unit to build an understanding of what HIV/AIDS is, its main implications and the means available for the prevention, treatment and care of PLHIV**

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### UNIT OBJECTIVES

At the end of the unit, students should be able to:

- Understand the basic facts about HIV and AIDS
- Identify and discuss myths and misconceptions surrounding HIV/AIDS in Zambia
- Discuss the main and the underlying drivers of HIV/AIDS in Zambia
- Analyse the relationship between men who have sex with men and HIV/AIDS
- Describe the relationship between sexually transmitted infections (STIs) and increased transmission of HIV
- Discuss the prevention, treatment and care of HIV/AIDS and the importance of adherence to care and treatment
- Describe the impact of the HIV/AIDS epidemic on Zambian society

### KEY INSTRUCTION METHODS

- Lecture
- Power point presentation
- Learning task(s)
- Group work

### SUGGESTED TEACHING AIDS

- Flip Charts/Chalk Board/White Board
- Markers/Chalk
- Hand-outs/Charts/Graphs
- Overhead Projector

## TOPIC 1.1 – BASIC FACTS ABOUT HIV/AIDS AND HIV/AIDS TRENDS

### 1.1.1 DEFINITIONS

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#### **TASK(S):**

**Question for general or group discussion: What do participants understand by HIV/AIDS?**

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#### **WHAT IS HIV?**

HIV is a type of minute (very tiny) microorganism/virus that destroys the immune cells of the body. Our blood is made up of two components: liquid and solid. The liquid part of the blood is called plasma. The solid part is made up of cells. There are essentially three types of cells in the blood: Red blood cells (RBC) which take oxygen from the air we breathe to the rest of the body; platelets which help the blood clot (they help to stop bleeding); and white blood cells (WBC) which identify, attack, and destroy infection and cancer.

The white blood cells, are the ‘soldiers’ in our bodies—they are the body’s natural defence force; they are mobilized to fight off infections, cancers and other diseases. HIV attacks a special type of white blood cells called the CD4 cells. HIV binds to a receptor on the outside of the CD4 cell (like a lock and key), which allows HIV to fuse with the CD4 cell and inject its genetic code into the CD4 cell.

Once HIV has injected its genetic code in to the CD4 cell, it uses the machinery of the CD4 cell as a factory to reproduce and make millions more of the HIV virus, which ends up destroying the CD4 cell. When the CD4 cell bursts open when it is destroyed, it releases the new HIV viruses into the blood stream, and these go on to infect other CD4 cells, in a continuous attack, reproduction, destruction, and release of even more HIV viruses.

HIV thus destroys the CD4 cells, a major part the ‘soldiers’ of the body leaving the body defenceless and vulnerable to attack by other infections and cancers. At the beginning of HIV infection, as HIV destroys the CD4 cells, the body manufactures new CD4 cells to replace the ones that are destroyed by HIV so that the immune system continues to function well. Often, the body can manage to subdue HIV for even a number of years.

However, with time, HIV destroys the CD4 cells (the immune system) to such an extent that the body loses the ability to fight off diseases and the patient starts to develop infections (called opportunistic infections) and/or cancers. In hospitals, doctors use CD4 cell counts as a measure of how well the immune system is functioning in patients with HIV.

In an adult patient, if the immune system is not functioning well, based on CD4 count level and other considerations (e.g. presence of opportunistic infections and/or cancers) the patient is started on HIV treatment or anti-retroviral therapy (ART).

Sometimes HIV treatment is started even when the immune system is still functioning well in order to ensure the best health outcomes. For example in Zambia, the most recent treatment guidelines recommend starting ART pregnant women and young children, soon after HIV diagnosis, and the treatment is continued for life.

## WHAT IS AIDS?

AIDS is a state of lowered immune response to infections and cancers, and is characterized by reduced CD4 count, high viral load (large numbers of circulating HIV virus in the blood) and presence of opportunistic infections. Opportunistic infections (OIs) are infections that take advantage of the lowered immunity to invade the body e.g. Tuberculosis (TB), Herpes Zoster (shingles), Cryptococcal (fungal) meningitis, and Kaposi's Sarcoma (cancer).

### 1.1.2 THE HISTORY OF HIV

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#### TASK(S):

Ask learners to discuss their suppositions and/or assumptions on the history of HIV in Zambia and globally

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The virus that causes AIDS, HIV, was discovered in 1981 by French and American researchers after a long period of searching to find the cause of immune suppression in homosexual men who presented mainly with *pneumocystis carinii* pneumonia (PCP), a rare type of pneumonia and aggressive *Kaposi's Sarcoma* in California. According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), since the beginning of the HIV epidemic, about 74 million people are estimated to have been infected worldwide and over 39 million people have since died of HIV; 35 million are currently living with the HIV, with two thirds (24.7 million) living in sub-Saharan Africa (UNAIDS 2013).

### 1.1.3 HIV/AIDS IN ZAMBIA

The first case of HIV in Zambia was diagnosed in 1984. According to the Zambia Demographic and Health Survey (ZDHS) 2013/14, the HIV prevalence rate in the age group 15–49 is 13.3% (Central Statistical Office, et al. 2015). HIV prevalence in Zambia also varies by province, with Copperbelt (18.2%) being the highest and Muchinga (6.4%) the lowest; and by residence with urban prevalence at 18.2% vs. 9.1% in rural areas. The Zambia UNGASS 2010 report estimated that in 2009 there were 82,000 HIV infections with an average of approximately 226 adult infections per day and 25 mother to child transmissions (MTCT) per day (UNGASS 2010). After 30 years of the HIV epidemic in Zambia, as of 2013, there were approximately 1.1 million PLHIV in Zambia, and approximately 130,000 were children (UNAIDS 2013).

### 1.1.4 WHO ARE THE ZAMBIANS LIVING WITH HIV?

HIV testing and counselling (HTC) has been relatively successful among women (78.3% of women aged 15-49 have ever tested and 46.2% in the last 12 months), but rates among men in the same age-group are lower (59.5% and 37.1% respectively) (Central Statistical Office, et al. 2015). This means that some of us do not know whether we have HIV infection or not. Fortunately this situation is changing as more Zambians, both individuals and couples, are going for HTC in order know their HIV status. HTC is very important because it is the first step one needs to take in order to make the right decisions about HIV treatment and care, and also about HIV prevention.

Back to the question of who the PLHIV in Zambia are: HIV infection does not discriminate; as long as there is exposure to HIV any person can get infected with HIV—black or white, rich

or poor, young or old. Many of us in Zambia are living with HIV (1.1 million), and all of us have family, friends, and neighbours living with HIV, your MP, your Minister, your Chief, your doctor, your teacher, your pastor, your sister, your brother, your mother, your father, your cousin, your uncle, your aunt, your friend or your neighbour could be living with HIV. Anyone who has not had an HIV test could also be living with HIV.

The important thing to note is that people living with HIV or affected by HIV are part of our community; they are part of us. Like other members of our community with any other illness such as asthma, diabetes, or hypertension, they deserve to be treated justly and with respect, and sometimes, they need our care and support.

It is also important to note that Zambians living with HIV should no longer be afraid of dying from AIDS because HIV is no longer the death sentence it once was. This is because HIV treatment with anti-retrovirals (ARVs) brings with it the hope to live a healthy and long life, if one starts treatment on time and adheres to treatment.

### 1.1.5 COMMON MYTHS AND MISCONCEPTIONS ASSOCIATED WITH HIV/AIDS

HIV/AIDS, like other illness that are largely sexually transmissible, is still very highly stigmatized in Zambia. HIV is a lifelong infection with no cure, and before the advent of antiretroviral therapy (ART), was the major cause of illness and one of the leading causes of death in the country. At the beginning of the epidemic, information about HIV/AIDS was not readily available, which led to some level of misinformation. As such, a lot of myths and misconceptions developed around HIV/AIDS, including the ones highlighted below, which must be dispelled or corrected in order for the country to achieve control of the epidemic:

- **HIV IS CAUSED BY WITCHCRAFT:** HIV is not caused by witchcraft. HIV is caused by a retrovirus which lives in the body of infected persons and is transmitted through bodily fluids such as blood, semen, pre-seminal fluid, breast milk, rectal fluids and vaginal fluids. It is always important to bring people who are very sick to the hospital so that they can be started on HIV treatment as soon as possible, and not wait too long so that they too ill to be saved.
- **PEOPLE WITH TUBERCULOSIS (TB) ALWAYS HAVE AIDS:** People with Tuberculosis (TB) do not always have HIV. According to the WHO Global TB report for 2013, an estimated 87 million people develop active TB disease every year (compare with only 35 million PLHIV in 2013). Because HIV weakens the immune system, PLHIV are 30 times more likely to develop active TB disease.
- **PEOPLE WHO ARE NOT THIN DO NOT HAVE HIV:** HIV does not discriminate—everyone is susceptible to HIV regardless of size, ethnicity, religion, income level, etc. If an individual engages in behaviours that may lead to HIV infection (see Table 1), then he/she is putting him/herself at risk of contracting the virus.
- **CONDOMS ARE NOT SAFE:** Scientific evidence indicates that when used consistently and correctly, latex condoms significantly reduce the risk of contracting sexually transmitted diseases, such as HIV. Studies have found that 98-100% of those who use latex condoms correctly and consistently remain uninfected.
- **SEX WITH A VIRGIN CURES HIV/AIDS:** There is no evidence to support this belief. In fact, having sex with a young girl (whether a virgin or not) is criminal offense in Zambia and not only that, it puts the girl at high risk of contracting HIV from you.

- **YOU GET HIV BY HAVING SEX WITH A WOMAN WHO HAS HAD AN ABORTION:** There is no evidence to support this belief. You can get HIV by having unprotected sexual intercourse with an HIV-infected woman, whether that woman has had an abortion or not. If a woman is not HIV-infected you will not get HIV from her even if she has had an abortion.
- **MOSQUITOES TRANSMIT HIV:** Insects such as mosquitoes that bite people cannot transmit HIV. HIV cannot survive outside of the human body. After biting an HIV-infected person, the blood collected by a mosquito is digested killing the HIV virus, and rendering the mosquito incapable of transmitting the virus.

### 1.1.6 MODES OF HIV TRANSMISSION

#### TASK(S):

**For general or group discussion: Discuss the ways in which HIV is transmitted**

Certain body fluids from an HIV-infected person can transmit HIV - these body fluids are:

- **Blood; Semen; Pre-seminal fluid; Rectal fluids; Vaginal fluids; and Breast milk**

For transmission to possibly occur, these body fluids must come into contact with

- **A mucous membrane or damaged tissue, or**
- **Be directly injected into your bloodstream (e.g. by a needle or a razor blade)**

Mucous membranes are the soft, moist areas just inside the openings to your body. They can be found inside the rectum, the vagina or the opening of the penis, and the mouth. The main modes of HIV transmission are shown in Table 1 below:

**Table 1: The main modes of HIV transmission**

#	Mode	Explanation
1.	<b>Sexual HIV Transmission</b>	HIV is transmitted mainly through unprotected, penetrative vaginal or anal sexual intercourse with a sexual partner who has HIV. About 80% of new HIV infections in Zambia are transmitted sexually
2.	<b>Mother to Child Transmission</b>	HIV can be passed from an HIV-infected mother to her child during pregnancy, birth, or breastfeeding. Without prevention (PMTCT), the risk of mother to child HIV transmission can be as high as 35%
3.	<b>Contaminated Blood, Blood Products, Organs, and Tissues</b>	Receiving blood transfusions, blood products, or organ/tissue transplants that are contaminated with HIV. This risk is extremely small because of the stringent measures applied in the storage of donor blood and blood products in hospitals. Less than 0.1% of new HIV infections result from using blood and blood products in Zambia
4.	<b>Contaminated Needles and/or Sharp Objects</b>	Being stuck with an HIV-contaminated needle or other sharp object. This is a significant risk for injection drug users who share needles. There is also a risk for health care workers through accidental work-related exposure, and also a risk for sharing contaminated household items such as razor blades

HIV does not survive long outside the human body (such as on surfaces), and it cannot reproduce outside the human body. It is not spread by:

- Air or water
- Insects, including mosquitoes or ticks

- Tears or sweat
- Casual contact like shaking hands or sharing cups and dishes
- Closed-mouth or “social” kissing
- Toilet seats

### 1.1.7 STAGES OF HIV PROGRESSION

HIV infection has a well-documented progression. If you are infected with HIV and don't get treatment, HIV will eventually overwhelm your immune system, and you will eventually develop AIDS. People may progress through these stages at different rates, depending on a variety of factors.

**ACUTE INFECTION STAGE:** Within 2-4 weeks after HIV infection, many, but not all, people develop flu-like symptoms, often described as “the worst flu ever.” Symptoms can include fever, swollen glands, sore throat, rash, muscle and joint aches and pains, fatigue, and headache. This is called “acute retroviral syndrome” (ARS) or “primary HIV infection,” and it's the body's natural response to the HIV infection.

During this early period of infection, large amounts of virus are being produced in your body. The virus uses CD4 cells to reproduce and destroys them in the process. Because of this, your CD4 count can fall rapidly.

Eventually your immune response begins to bring the level of virus in your body back down to a level called a viral set point, which is a relatively stable level of virus in your body. At this point, your CD4 count begins to increase, but it may not return to pre-infection levels. It is important to be aware that you are at particularly high risk of transmitting HIV to your sexual partner(s) during this stage because the levels of HIV in your blood stream are very high. It is therefore very important to practice safe sex to reduce your risk of transmitting HIV.

**CLINICAL LATENCY STAGE:** After the acute stage of HIV infection, the disease moves into a stage called the “clinical latency” stage. “Latency”, which literally means dormant or hidden, is the period where a virus is living or developing in a person without producing symptoms. During the clinical latency stage, people who are infected

#### The HIV Window Period

There's a period of time after a person is infected with HIV during which they won't test positive for HIV, using an antibody test. This is called the “HIV Window Period.” When a person becomes infected, HIV multiplies in the blood and the body develops antibodies against the virus. HIV has most commonly been diagnosed in adolescents and adults using tests that detect antibodies. However, newer tests can detect both antibodies to HIV and certain proteins of the virus itself.

The window period can be from 9 days to 3 months, depending on the person's body and on the HIV-test that's used. It is extremely rare for an HIV-infected person not to develop antibodies by 3 months after exposure. A person who tests negative for HIV antibodies 3 months after an exposure does not require further testing unless he or she has had repeated exposures to HIV.

During the Window Period, you can test HIV negative even if you are HIV infected. Most importantly, you can still catch HIV from someone who is in the window period. In fact, there is evidence that a person in the window period is more likely to pass the virus on because they have a very large amount of virus circulating in their body during this time.

with HIV experience no HIV-related symptoms, or only mild ones. This stage is sometimes called “asymptomatic HIV infection” or “chronic HIV infection.”

During the clinical latency stage, the HIV virus continues to reproduce at very low levels, although it is still active. If you take ART, you may live with clinical latency for several decades because treatment helps keep the virus in check. For people who are not on ART, the clinical latency stage lasts an average of 10 years, but some people may progress through this stage faster. It is important to remember that people in this symptom-free stage are still able to transmit HIV to others, even if they are on ART, although ART greatly reduces the risk of transmission.

If you have HIV and you are not on ART, then eventually your HIV viral load will begin to rise and your CD4 count will begin to decline. As this happens, you may begin to have symptoms of HIV as the virus levels increase in your body.

**AIDS STAGE:** This is the stage of HIV infection that occurs when your immune system is badly damaged and you become vulnerable to infections and infection-related cancers called opportunistic infections (OIs). In someone with a healthy immune system, the CD4 counts are between 500 and 1,600. When the number of your CD4 cells falls below 200, you are considered to have progressed to AIDS.

You are also considered to have progressed to AIDS if you develop one or more specific opportunistic illnesses, regardless of your CD4 count. Without treatment, adults who progress to AIDS typically survive about three years. In children the period of survival without treatment after developing AIDS is much less.

Once you develop a dangerous opportunistic illness, life-expectancy without treatment falls to about one year. However, if you are taking ART and maintain a low viral load, then you may enjoy a near normal life span. You will most likely never progress to AIDS.

**FACTORS AFFECTING HIV DISEASE PROGRESSION:** PLHIV may progress through these stages at different rates, depending on a variety of factors, including their genetic makeup, how healthy they were before they were infected, how soon after infection they are diagnosed and linked to HIV care and treatment, whether they see their healthcare provider regularly and take their HIV medications as directed, and different health-related choices they make, such as decisions to eat a healthful diet, exercise, and not smoke or drink, or take other drugs and substances that might affect their response to treatment. In addition, some people find it beneficial to maintain a balanced mental and spiritual state.

ART, or HIV treatment with ARVs, when used consistently, prevents the HIV virus from multiplying and from destroying your immune system. This helps keep your body strong and healthy by helping you fight off life-threatening infections and preventing HIV from progressing to AIDS. In addition, taking ART, by driving the level of HIV virus circulating in your body has HIV prevention benefits; it can help you prevent the spread of HIV to others. Studies have shown that the efficacy of HIV treatment as prevention is 96%—in other words, HIV positive people taking ARVs as recommended by doctors, were more than 20 times less likely to infect their partners than untreated people (Cohen 2012).

## TOPIC 1.2 – THE DRIVERS OF THE HIV/AIDS EPIDEMIC IN ZAMBIA

### 1.2.1 THE SIX MAIN HIV DRIVERS AND THE SIX UNDERLYING DRIVERS

#### TASK(S):

Ask learners to identify and discuss the main drivers of the HIV epidemic

Table 2 shows the identified drivers of the HIV/AIDS epidemic in Zambia as of 2009.

Table 2: The drivers of the HIV/AIDS epidemic in Zambia

Key Drivers		Underlying Drivers	
1.	Multiple concurrent partnerships (overlapping sexual relations with two or more partners)	1.	Gender inequalities including gender-based violence (GBV)
2.	Low and inconsistent condom use	2.	High levels of poverty
3.	Low levels of male circumcision	3.	Harmful cultural and traditional practices
4.	Mobility and migrant labour	4.	High levels of abuse of alcohol/other substances
5.	Vulnerability and marginalized groups	5.	High levels of stigma and discrimination
6.	Mother to child vertical transmission	6.	Low levels of education

#### Driver 1

**MULTIPLE AND CONCURRENT SEXUAL PARTNERS (MCP):** According to the National AIDS Council (NAC 2009), evidence shows that the bulk of the new infections are coming from casual and multiple concurrent sexual relationships. In many Zambian cultures MCPs, particularly for men were and are to some degree still considered acceptable behaviour. Thus, HIV infections occurring as a result of MCPs often occur in the context of social norms or what is generally viewed as acceptable behaviour by a given group.

#### Driver 2

**LOW AND INCONSISTENT CONDOM USE:** Although condoms are very effective in preventing HIV infection, their use remains very low in Zambia, largely because condom use is socio-culturally bound. According to the 2013/14 ZDHS, condom use is still very low with both regular and non-regular partners. Unprotected sex and MCPs are key behavioural determinants of HIV risk: 15.7% of men 15-49 had sex with two or more partners in the last 12 months, and only 29% used a condom during the last sexual intercourse. In comparison, while women have similar rates of protected sex (29.7%), 1.7% of women reported multiple concurrent partners (Central Statistical Office, et al. 2015).

#### Driver 3

**LOW RATES OF MALE CIRCUMCISION:** Rates of voluntary medical male circumcision (VMMC) for Zambian men 15 – 49 are low at 21.6% nationally, despite the fact that male circumcision (MC) significantly reduces the risk of HIV infection for HIV negative men, if

combined with other HIV prevention measures (Central Statistical Office, et al. 2015). Studies have shown that MC can reduce HIV infections by up to 60%, when used with other HIV prevention interventions (Bailey 2007).

#### Driver 4

**MOBILITY AND MIGRANT LABOUR:** The extent of the problem in Zambia has not been fully established, but the mining and agriculture industries for example, employ many young highly mobile migrant workers. Mobility and labour migration destabilize stable family relationships, and facilitate MCPs and the use of sex workers.

#### Driver 5

**VULNERABILITY AND MARGINALIZED GROUPS:** Groups that are disenfranchised and/or discriminated against such as commercial sex workers, prisoners, and men who have sex with men (MSM) have a higher HIV risk. However in Zambia, not much research has been done among some of these groups to define the extent of the problem and design appropriate interventions to address the HIV/AIDS epidemic in these groups

#### Driver 6

**VERTICAL: MOTHER TO CHILD TRANSMISSION OF HIV:** HIV transmission from mother to child during pregnancy, labour and delivery, or breastfeeding is known as mother to child transmission (MTCT), and is the most common mode of HIV infection in children. When HIV is diagnosed before or during pregnancy, mother to child HIV transmission can be reduced to less than 1% if appropriate medical treatment is given and breastfeeding is avoided. Where breastfeeding cannot be avoided there are treatment and feeding options available from healthcare providers that can still help to reduce the risk. HIV Infections of children under 14 years constitute about 10% of all HIV infections in Zambia (UNAIDS 2013).

### 1.2.2 THE UNDERLYING DRIVERS OF THE HIV/AIDS EPIDEMIC IN ZAMBIA

**POVERTY:** As a developing country, Zambia's ultimate goal is to become a developed nation, with improved socio-economic status for all her people. An estimated 60% of Zambia's 13.8 million people live below the poverty line, a fact that confirms the need to address economic vulnerability as a core strategy to addressing HIV/AIDS in Zambia. There is a bidirectional link between poverty and HIV infection. Poverty increases the risk and vulnerability of poor people to HIV as they may put themselves at risk of HIV infection in order to survive today e.g. a widow who may choose to have unprotected sex in order to obtain money to put food on the table to feed her children, today. HIV infection on the other hand may deepen poverty as poor people sell off their few assets in order to raise money to pay for healthcare costs for sick family members. Additionally as parents sicken and die, HIV not only destroys families it also impoverishes surviving family members.

**GENDER INEQUALITIES AND INEQUITIES:** Gender inequalities can contribute to HIV transmission when the suppressed or marginalized gender (which in most cases is a woman) has to succumb to the 'supreme' gender in most activities affecting them, including sex. Even in marriage, a woman may be subject to unhealthy ways of relating sexually, including rape. The physical power inequalities between female and male predisposes woman to sexual abuses such as rape and other forms of assault. In situations where gender inequality

between men and women is prevalent, often women are given fewer education and development opportunities resulting in them being financially and economically (especially those who may not even have the security that a spouse may at times provide), forcing them to engage in 'dangerous' activities for survival including commercial sex work, making them very vulnerable to HIV.

In championing the cause for gender equity and equality, the Church is not calling for complete revamping of the positive gender roles and responsibilities that have defined the way Zambian communities have done things for centuries. Rather, the church encourages that in the context of the current environment, careful consideration is given to the different implications of social, economic and political laws, policies, programs and actions on men and women, and boys and girls and is encouraging pushing for equity where inequity exists. For example, given that children are a legitimate source of household labour in many Zambian homes, does the girl-child in these households receive the same opportunity to remain in school and study as the boy-child? And if not, what should the Church do to ensure that girl-children get equal schooling opportunities?

A gender-equal church would help women and girls realize their rights and determine their life outcomes. It would also help to create an environment that would allow them to participate in decision-making at the household and community levels, potentiating the growth of the Church, and society as a whole.

**HARMFUL CULTURAL AND TRADITIONAL PRACTICES:** The role of culture and tradition in the epidemiology of any disease among human beings cannot be over-emphasised. Certain cultural practices such as wife inheritance/sexual cleansing, tolerance of MCPs, cross-generational sex, and some practices accompanying initiation ceremonies have contributed to the high rates of HIV infections in Sub-Saharan Africa and Zambia (for more such practices, see *appendix 4*).

**HIGH LEVELS OF ALCOHOL MISUSE AND DRUG ABUSE:** Drunkenness and alcohol abuse lead to risky sexual behaviour bringing an increased risk of HIV. People who take excess alcohol or other mind-altering drugs often make rash and foolish decisions especially in the area of sex. Many people under the influence of drugs or alcohol, or both, have sexual encounters that they do not even remember!

**HIGH LEVELS OF HIV-RELATED STIGMA AND DISCRIMINATION:** HIV-related stigma is a process where people living with or associated with HIV are discredited, devalued or treated differently because of HIV. When stigma is acted upon, the result is discrimination. Discrimination is therefore related to stigma, and it is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status or HIV association.

HIV-related stigma and discrimination severely hamper efforts to address HIV/AIDS in Zambia. Fear of discrimination often prevents people from seeking HIV counselling and testing; it prevents them from seeking timely HIV treatment; it prevents them from freely taking their ARVs; and it prevents them from disclosing an HIV-positive status and receiving the support they need from family, friends and the community.

Fear of stigma and discrimination has undermined the ability of individuals, families and communities to protect themselves from HIV and to provide support to people living with HIV and/or those affected by HIV, by perpetuating the wall of silence and shame that

surrounds HIV infection. Therefore, the church must work together with others to end stigma and discrimination and build a more HIV compassionate church including encouraging openness about HIV and supporting people who wish to speak out, treating PLHIV with respect and dignity and providing them with a supportive environment; and supporting couple HTC family-centered HTC so that families can become units of support for PLHIV and those affected by HIV/AIDS.

### 1.2.3 POSSIBLE INTERVENTIONS TO ADDRESS THE DRIVERS OF THE HIV EPIDEMIC IN ZAMBIA

#### TASK(S):

Discuss possible interventions that address the drivers of HIV/AIDS in Zambia

In order to achieve effective control of the HIV/AIDS epidemic, Zambia has to put in place effective measures and intervention to address the drivers of the epidemic. Scientific evidence shows that an **effective HIV prevention** response must **combine biomedical** (e.g. ARVs, condoms, voluntary medical male circumcision - VMMC), **behavioural** (interventions aiming to change behaviour to reduce vulnerability to and risk HIV such as partner reduction and delay of sexual debut), and **structural** (e.g. supportive policies and laws) interventions, to address the drivers at the individual, couple, community and national levels. All these aspects are part of the national response to HIV/AIDS.

For example, in the national HIV/AIDS response, approaches at the individual and couple levels, include delay of sexual debut (among youths), promote mutual monogamy, partner reduction and secondary abstinence, increase condom use and uptake of VMMC. Approaches at community and national level must decrease alcohol use/abuse, gender-based violence, transactional sex, and other harmful practices (e.g. dry sex, sexual cleansing, and some risky initiation processes). Table 3 below outlines some possible interventions (not exhaustive by any means!) that have been implemented through the national HIV/AIDS response to address the identified drivers of HIV in Zambia.

Table 3: Possible interventions for the drivers of HIV/AIDS in Zambia

No.	Driver	Possible Interventions
1.	Multiple and Concurrent Sexual Partnerships (MCPs)	<ul style="list-style-type: none"> <li>• Provide factual and current information on MCPs and their HIV transmission risk; and</li> <li>• Provide a supportive social and cultural environment for breaking sexual networks and for mutual faithfulness</li> </ul>
2.	Low and inconsistent condom use	<ul style="list-style-type: none"> <li>• Provide factual and current information on the effectiveness of condoms in preventing HIV transmission and other STIs; and</li> <li>• Facilitate access and availability, and promote and support use, where appropriate.</li> </ul>
3.	Low rates of male circumcision	<ul style="list-style-type: none"> <li>• Provide factual and current information on the effectiveness of male circumcision in preventing HIV transmission and its other benefits;</li> <li>• Support cultural remodelling in traditional settings to make voluntary medical male circumcision for HIV prevention a norm; and</li> <li>• Facilitate access and availability, and promote and support use</li> </ul>

4.	Mobility and labour migration	<ul style="list-style-type: none"> <li>• Provide information about the HIV risk associated with high mobility and labour migration to target populations; and</li> <li>• Provide innovative HIV prevention services where high mobility and labour migration are prevalent, and promote and support utilization</li> </ul>
5.	Mother to child transmission (MTCT)	<ul style="list-style-type: none"> <li>• Provide factual and current information about MTCT; and</li> <li>• Provide PMTCT services, facilitate access and availability, and promote and support use</li> </ul>
6.	Vulnerable and marginalized groups	<ul style="list-style-type: none"> <li>• Provide factual and current information about the HIV risk associated with vulnerability and marginalization; and</li> <li>• Provide HIV prevention, treatment, and mitigation services as appropriate, and promote and support use</li> </ul>
7.	High poverty levels	<ul style="list-style-type: none"> <li>• Provide information about the HIV risk and poverty link; and</li> <li>• Provide economic strengthening support to increase individual and household economic resiliency to HIV through both micro and macro level policies and services</li> </ul>
8.	Gender inequities and inequalities, and GBV	<ul style="list-style-type: none"> <li>• Provide information about the link between HIV risk and vulnerability, and gender inequities and inequalities, and GBV;</li> <li>• Facilitate and support programs and services aimed at increasing gender equity and equality; and</li> <li>• Provide GBV services, and promote and support uptake</li> </ul>
9.	Harmful cultural and traditional practices	<ul style="list-style-type: none"> <li>• Provide current information about HIV risk and vulnerability associated with harmful cultural and traditional practices; and</li> <li>• Respectfully engage cultural standard-bearers and support cultural remodelling to reduce HIV risk and vulnerability associated with harmful cultural and traditional practices</li> </ul>
10.	High levels of alcohol misuse and substance abuse	<ul style="list-style-type: none"> <li>• Provide information about the link between HIV risk and vulnerability and alcohol misuse and substance abuse; and</li> <li>• Facilitate and support programs and services to reduce alcohol misuse and substance abuse, and promote and support uptake</li> </ul>
11.	High levels of HIV-related stigma and discrimination	<ul style="list-style-type: none"> <li>• Provide information about the link between HIV risk and vulnerability and HIV-related stigma and discrimination; and</li> <li>• Facilitate and support rights-based laws, policies, programs and services to reduce HIV-related stigma and discrimination, and promote and support uptake</li> </ul>
12.	Low levels of education	<ul style="list-style-type: none"> <li>• Provide information about the link between HIV risk and vulnerability and low educational attainment levels; and</li> <li>• Facilitate and support both childhood and adult literacy programs and services, and promote and support uptake</li> </ul>

## TOPIC 1.3 – HUMAN SEXUALITY AND HIV/AIDS

### 1.3.1 DEFINITIONS

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#### **TASK(S):**

Invite learners to discuss the concepts under this topic: sex, sex roles; gender, gender roles; sexuality

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**SEX:** Refers to the biological and physiological characteristics that define men and women.

**SEX ROLES:** Sex roles are biological functions specific to males only and females only, for example, females breastfeed, conceive, give birth, menstruate while males ejaculate, produce sperms, make females pregnant.

**GENDER:** Gender is a social construct specifying the socially and culturally prescribed roles, behaviours, activities, and attributes that a given society considers appropriate for men and women. According to Gerda Lerner, gender is the "costume, a mask, a straitjacket in which men and women dance their unequal dance" (Lerner 1986).

**GENDER ROLES:** Gender roles are culture based, and are a construct involving a set of social and behavioural norms that, within a specific culture, are widely considered to be socially appropriate for individuals of a specific sex.

The perception of gender roles includes attitudes, actions, and personality traits associated with a particular gender within that culture. Gender roles are predominantly considered within a family context as well as within society in general, and may collectively be referred to as gender stereotypes.

Gender roles are usually interchangeable because they are not biological e.g. both men and women are capable of collecting fire wood, cooking a meal, changing a punctured car tyre and roofing a house, but society decides which of these activities are suitable for men and which are suitable for women.

Finally, while most cultures distinguish only two genders, some recognize more e.g. transgendered individuals.

**HUMAN SEXUALITY:** Human sexuality is the capacity to have erotic experiences and responses. Sexuality may be experienced and expressed in a variety of ways, including through thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships, which may manifest in a number of ways including biological, physical, emotional and/or spiritual aspects.

The biological and physical aspects of sexuality largely concern the reproductive mechanisms and functions, and the basic biological sexual drive that exists in most people—they include sexual intercourse and sexual contact in all its forms.

The emotional aspects of sexuality include the bond that exists between individuals, and is expressed through profound feelings or physical manifestations of emotions of love, trust

and caring. The spiritual aspects of sexuality concern an individual's spiritual connection with others.

Sexuality impacts and is impacted by cultural, political, legal and philosophical aspects of life, as well as issues of morality, ethics, theology and/or religion.

### 1.3.2 THEOLOGICAL PERSPECTIVES ON HUMAN SEXUALITY

Human sexuality is divinely inaugurated; it is part of God's perfect gift and design from the beginning and willed as a fundamental aspect of human existence. In God's disclosure of Himself and ourselves, the naked gift of life and sexuality has been clothed with the language of covenant and marriage. In this regard, marriage has been the Christian interpretation of human sexuality.

In the perspective of God, human sexuality is seen as a human couple, "God created man in his own image, in the image of God he created him, male and female he created them" (Gen. 1:27). In the perspective of God, sexual and personal fulfilment belongs together in a companionship of man and woman that is total and life-long. Human Sexuality is part of our covenant-of-life with God:

- It admits us to the sacramental covenant of marriage when we make our vows to the one we love. When a man and woman enter into a state of mind that is marriage, they begin to know, serve and love one another in a way which brings them into the state of mind that exists between God and us all.
- It brings a couple to a threshold, for a life time, of the life and self-giving of God. In one another, they meet their maker, in their love of one another; they give and receive his love, in their service, reassurance and service, they share the service, reassurance and healing that is the grace of God.

### 1.3.3 SEXUAL ORIENTATION

Sexual orientation is an enduring personal quality that inclines people to feel romantic and/or sexual attraction to persons of the opposite sex, the same sex, or both sexes. These attractions are generally subsumed under heterosexuality, homosexuality, and bisexuality, while asexuality (the lack of sexual attraction to others) is sometimes identified as the fourth category.

- **HETEROSEXUAL:** Male to female sexual attraction/relationships
- **HOMOSEXUAL:** Male to male (gay) or female to female (lesbian) sexual attraction/relationships
- **BISEXUAL:** Heterosexual and homosexual at the same time
- **ASEXUAL:** No sexual attraction to others

### 1.3.4 COMMON SEXUAL PRACTICES

Sexual practice or sexual activity is the manner in which human being experience and express their sexuality. Most human sexual activity has sociological, cognitive, emotional, behavioural and biological aspects, which may include personal bonding, sharing emotions,

sexual intercourse and other forms of sexual behaviour. Because of this, sexual activity can have both helpful and damaging consequences. Although there are many sexual practices only two are defined below:

- **PENETRATIVE:** Vaginal sex, Anal sex (can involve a man and a woman or a man and a man) and Oral sex;
- **NON-PENETRATIVE:** Kissing, caressing, fondling, holding hands, masturbating, etc.

### 1.3.5 SAFE AND UNSAFE SEX

In public health terms, “unsafe sex” has been defined as sex between two or more people, without taking measures to prevent infection.

- **UNSAFE SEX:** Or unprotected sex is sexual activity engaged in without precautions or measures to prevent infection.
- **SAFE SEX:** Safe sex, from the national HIV/AIDS response viewpoint, sexual activity engaged in by people who have taken precautions to protect themselves against STIs such as HIV/AIDS (e.g. by using condoms). It is also referred to as safer sex or protected sex.

### 1.3.6 MEN WHO HAVE SEX WITH MEN (MSM) AND THE RISK OF HIV TRANSMISSION

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#### **TASK(S):**

**Ask learners to analyse the relationship between men who have sex with men and the risk of HIV infection**

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Men who have sex with men (MSM) are male persons who engage in sexual activity with other males. In the United States of America (USA) gay, bisexual and other MSM are more severely affected by HIV than any other group. Globally, UNAIDS estimates that at least 6% and as high as 20% of men had had sex at least once with a man (UNAIDS 2005).

Because sodomy is illegal in Zambia, it is difficult to get accurate data on the prevalence of MSM sexual behaviours. However, it is largely accepted that MSM risks of HIV infection occur within the more widespread HIV epidemic among heterosexuals. Anal sex (penis inserted into the anus of a man or woman) is the highest-risk sexual behaviour for HIV transmission because of the high risk for tears and abrasions in the anal lining (mucosa).

The national HIV/AIDS response program recommends a minimum package of services, including HTC, distribution of condoms and other safe sex measures and access to ART to protect MSM from HIV. The national HIV/AIDS response emphasizes as equally important policy efforts to reduce stigma/discrimination and increase health service uptake.

### 1.3.7 EARLY SEXUAL DEBUT

Girls and boys who indulge in sexual activities at an early age are at higher risk of contracting HIV because they are most likely to sustain cuts and bruises during sexual intercourse due to the fact that their bodies are not yet fully developed for the purpose of

sexual activity and they may also not be mature enough or have acquired the skills to negotiate for safer sex.

### 1.3.8 THE RELATIONSHIP BETWEEN GENDER AND THE INCREASED RISK OF HIV INFECTION

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**TASK(s):**

**Ask the learners what they perceive to be the link between gender and HIV vulnerability**

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From a gender perspective, in the Zambian setting women are vulnerable to HIV than men. With the prevalence of HIV at 15.1% for women and 11.3% for men, it is clear there is disproportionate impact of HIV on women (Central Statistical Office, et al. 2015). Gender inequities and unequal power relations between men and women, harmful cultural and gender norms, inadequate legal and policy protections and enforcement for women, inadequate access to economic resources and a higher HIV care burden for women are factors that increase the vulnerability of women and girls and contribute to the negative impact of the HIV epidemic on them.

For example, in many Zambian cultures, it is taboo for a woman to refuse sexual intercourse with her husband if he wants to have sexual intercourse, even if doing so would put the woman at risk of contracting an STI or HIV. In some cases, men who are HIV-positive may not be willing to use any form of protection with their spouses further increasing the risk. Women who are economically disadvantaged may exchange sexual favours, including unprotected sex, for financial support/payment, increasing their risk of acquiring HIV or transmitting HIV. Biologically, women as the receptive partner in sexual intercourse are more susceptible to STI's and HIV, as they may remain in contact with infected semen much longer than a man may remain in contact with infected vaginal fluids.

Finally, when a family member is very sick from HIV/AIDS, women are often the caregivers. In situations where adequate infection control measures are not available, there is some risk of HIV infection if the caregiver has cuts and comes into contact with contaminated bodily fluids in the course of their duties. These and other factors work together to put Zambian women at high risk of and make them very vulnerable to HIV infection and other STIs.

## TOPIC 1.4– SEXUALLY TRANSMITTED INFECTIONS (STIs) AND HIV/AIDS

### 1.4.1 COMMON SEXUALLY TRANSMITTED INFECTIONS IN ZAMBIA

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**TASK(s):**

**Question for general/group discussion: What are STIs? Mention some STIs that you know. What do you think is the relationship between these STIs and HIV/AIDS?**

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Sexually transmitted infections are caused by more than 30 different bacteria, viruses and parasites and are spread predominantly by sexual contact, including vaginal, anal and oral sex. The most common sexually transmitted infections are chlamydia, syphilis, gonorrhoea,

hepatitis B virus (HBV), HIV, human papilloma virus (HPV), herpes simplex virus type 1 (HSV-1) and herpes simplex virus type 2 (HSV-2). A person can have an STI without having obvious symptoms of disease. Therefore, the term “sexually transmitted infection” is a broader term than sexually transmitted diseases (STDs) and the preferred term.)

### 1.4.2 SIGNS AND SYMPTOMS OF COMMON STIS

The common symptoms of STIs include vaginal discharge in women, urethral discharge in men, genital ulcers and abdominal pain. Eight of the more than 30 pathogens known to be transmitted through sexual contact have been linked to the greatest incidence of illness. Of these eight infections, four are currently curable: syphilis, gonorrhoea, chlamydia and trichomoniasis. The other four are viral infections and are incurable but can be mitigated or modulated through treatment: hepatitis B, herpes, HIV and HPV.

### 1.4.3 THE RELATIONSHIP BETWEEN STIS AND HIV/AIDS

STIs can have serious consequences beyond the immediate impact of the infection itself. Some STIs can increase the risk of HIV acquisition three-fold or more. STIs make it easier for HIV to pass from one person to another. This is partly because of the open sores (ulcers) and irritations that these infections cause in the male and female genitals (WHO 2013).

In Zambia, an individual with an STI should be encouraged to test for HIV. An HIV infected person who also has an STI is more likely to pass HIV to others. An HIV negative person with an STI is more likely to get infected with HIV. Ulcerative STIs (e.g. syphilis, gonorrhoea, herpes simplex) significantly increase the risk of HIV infection.

Human Papilloma Virus (HPV) causes cancer of the cervix. As cervical cancer advances, it leads to ulceration of the cervix, making the woman more vulnerable to HIV infection. Hepatitis B increases risk of developing liver failure, liver cancer or cirrhosis, a condition that causes permanent scarring of the liver. Pregnant women infected with HPV can pass the virus to their babies during childbirth.

## TOPIC 1.5 – HIV PREVENTION, HIV CARE AND HIV TREATMENT

### 1.5.1 HIV PREVENTION

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#### **TASK(S):**

**Questions for learners: What does HIV prevention constitute and why is it important?**

**What is the role of pastoral caregivers in HIV prevention?**

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HIV prevention is action or a set of actions taken by individuals, couples, communities and nations to slow down or even stop the spread of HIV infection from one person to another.

#### **Why is HIV Prevention Important for Zambia?**

Successful HIV prevention in Zambia would save the lives of many Zambians and prevent many HIV-related illnesses. HIV prevention is important for the following reasons:

- Zambia has what is considered to be a moderately severe HIV/AIDS epidemic. According to the 2013/14 ZDHS, Zambia's HIV prevalence for adults aged 15 – 49 years was estimated to be 13.3%. That means that approximately 13 out of every 100 adults aged 15 - 49 years in Zambia are living with HIV (Central Statistical Office, et al. 2015).
- Providing HIV care and treatment is a priority in order to save the lives of Zambians who are living with HIV. The Government of Zambia provides anti-retroviral drugs (ARVs) for HIV treatment **free** in health facilities across the country in both rural and urban areas.
- Although HIV treatment with ARVs is available, ARVs are currently very expensive. HIV prevention is therefore important for Zambia because we need to keep our burden of HIV low, so that we can continue to afford to provide good quality HIV care and treatment for Zambians living with HIV. If the number of people who are living with HIV continues to increase, the HIV treatment cost will also continue to increase, stretching the country's ability to pay for quality HIV care and treatment services.
- Without successful HIV prevention, Zambia's HIV disease burden will continue to grow quickly, exacting an ever-increasing physical, psychological, social and economic toll on individuals, families, communities and the nation as a whole. Successful HIV prevention today will translate into a healthier nation with better health services, better education, better schools, better roads and increased economic development for Zambia.

### Combination HIV Prevention

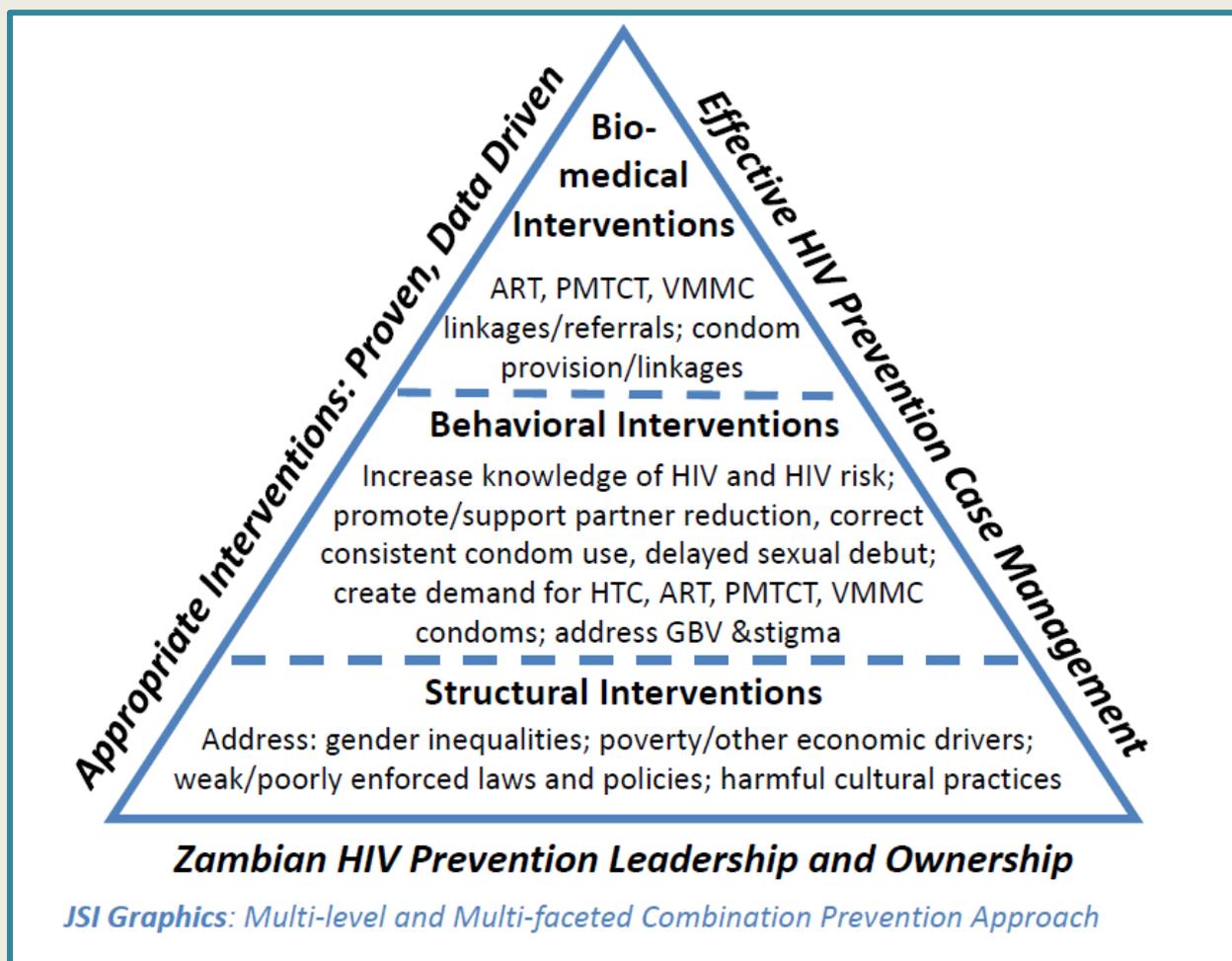
From the national HIV/AIDS response perspective, successful prevention programs require a combination of evidence-based, mutually reinforcing biomedical, behavioral and structural interventions backed by a strong leadership, robust health systems and adequate and accessible services. Some of these interventions are highlighted in Figure 1.

At the individual level, some of the actions recommended through the national HIV/AIDS response for Zambians to take today and in the future to stop the spread of HIV include:

- Knowing your HIV status
- Reducing the number of sexual partners: reducing the number of sexual partners to one mutually faithful partner significantly reduces risk of HIV infection.
- Whether one is HIV positive or HIV negative, using condoms correctly and consistently with every sexual partner.

HIV prevention options for young people include:

- Delaying sexual debut (delaying the age at which one starts having sex).
- Abstaining from sex (abstaining from sex provides 100% protection from sexual HIV transmission).
- Ensuring you and your fiancé are tested for HIV before you get married so that you can make appropriate HIV prevention or HIV care and treatment decisions.



**Figure 1: Combination HIV Prevention Approach**

Specific action should also be taken by women who are HIV-positive:

- HIV positive women, like women who are not HIV positive, should get family planning advice from healthcare providers
- Pregnant women with HIV can access ARVs for free at antenatal clinics – taking ARVs will reduce the chance of a woman passing HIV to her baby.
- For HIV Positive mothers with babies, advice on breastfeeding and other options to reduce the possibility of MTCT is available from healthcare providers.

### **The Role of the Church in HIV Prevention**

There are many ethical issues raised by the HIV/AIDS epidemic and the Church has to confront these issues and provide guidance. Above all, the experience of love, acceptance and support within a community where God's love is made manifest can be a powerful healing force (World Council of Churches 1996). In a country like Zambia where the underlying drivers of HIV/AIDS are issues of social justice, no institution is as well placed as the Church to provide non-judgemental counsel, guidance, advocacy and support to help prevent the spread of HIV. Through their witness to the gospel of reconciliation, the value of each person, and the importance of responsible life in community, the churches have a distinctive and crucial role to play in preventing the spread of HIV.

## 1.5.2 HIV CARE AND TREATMENT

### TASK(S):

**Questions for learners: What does HIV care and treatment constitute and why is it important? What is the role of pastoral caregivers in HIV care and treatment?**

HIV Treatment is a combination of several anti-HIV medicines, or ARVs, taken by a person living with HIV to control or reduce the amount of HIV in the body and by doing so, help the individual to feel better. When an individual tests positive for HIV, they may not begin taking ARVs immediately. The decision to start ARVs is taken by the individual and their doctors, and takes into consideration the current CD4 cell count and current health status.

With regard to ART, it is important to take note of the following:

- ARVs have to be taken every day for the rest of a person's life.
- ARVs do not cure HIV; they only control the amount of HIV in the body
- ARVs are available free in healthcare facilities in Zambia.

When an individual takes their ARVs according to the instructions from the doctors, the treatment can work very well. The amount of HIV in the body can become well controlled, which greatly benefits the individual. In order to properly control the amount of HIV in the body, ARVs must be taken as instructed by healthcare providers.

ARVs for children, even small babies, are also available for free in Zambia. ARVs work very well for children when taken according to the instructions of the healthcare providers. ARVs allow HIV-infected children to live healthier and longer lives, enabling them to go to school, play and work like other children.

### FAITH AND HIV TREATMENT WITH ARVs

The church has sometimes struggled with the issue of taking ARVs and healing through faith. The two are not mutually exclusive. Many Christian faiths offer spiritual healing as part of support for PLHIV on ARVs. This is based on our belief that prayer is an avenue for seeking God's intervention in all situations, because nothing is impossible for God.

Some religious leaders have encouraged or even directed their congregants to stop taking ARVs and other life-saving medicines, telling them that their HIV disease has been cured through faith healing. The important thing to understand is that God's healing can be at the physical or spiritual level.

We Christians believe that prayer brings peace of mind (Phil. 4:6-7). Peace of mind is very important in any physical healing process, including for people taking ARVs. We must remember that ARVs are God's gift to man to help us deal with the HIV/AIDS epidemic.

For most believers taking ARVs, the ARVs work with prayer to bring spiritual and physical healing, so that the individual lives a healthy life in spite of HIV infection.

In the instances where complete healing of HIV infection is believed to have taken place, it is important to confirm through an HIV test that physical cure of HIV infection has taken place before stopping taking ARVs, in order to avoid adverse health outcomes.

*Adapted from the Churches Health Association of Zambia Faith& ARVs Pamphlet*

When we support people in our communities to take their ARVs freely and without fear of unjust treatment from others, we have healthier communities and fewer people dying unnecessarily from HIV infection.

### **The Importance of HIV Counselling and Testing and Early Entry into Care**

In Zambia, many of us do not know whether we are infected with HIV because we have never gone for HIV testing and counselling (HTC). HTC is a very necessary and important first step to HIV care and treatment, including accessing ARVs. Many of people go for HTC only when they are already very sick. ARVs then must be started almost immediately to try and save their lives. When ARVs are started late when someone is already very sick, they sometimes do not work very well because HIV has already done too much damage to the body. Early entry into care is thus critically important.

In order for HIV treatment to work well, you have to start ARVs at the right time. Healthcare providers will tell you the right time to start ARVs, but you have to go for HTC so that your HIV status is determined first. If you are found to be HIV-positive, more tests can be done to determine if you need to start ARVs. Going for HIV testing and knowing your HIV status will help you make the correct decisions regarding HIV prevention. If you are HIV positive, going for HIV counselling and testing will help your healthcare providers to make the right decisions about your HIV care and treatment, including when to start your ARVs.

### **The Importance of Adherence to HIV Care and Treatment**

Adherence to HIV treatment means taking the ARVs exactly as instructed by the healthcare providers (nurses, doctors, pharmacists and counsellors). This involves taking all of the medication at the right time and exactly as the instructions state.

If you do not take ARVs as instructed, they will not be able to control the HIV infection in your body as well as they should. The amount of the virus in the body will likely increase and you will become sick. Because adherence to ARVs is so important to how well you respond to treatment:

- Do not share ARVs with or borrow ARVs from anyone: - make sure everyone in the home has enough ARVs for their own use;
- Stay in care – do not stop going to the clinic or hospital for your reviews even if you feel well so that the healthcare providers can continue monitoring you;
- Do not miss appointments – this will help your healthcare providers to make timely adjustments to your care and treatment, including ART, if need be.

Other measures that can help HIV care and treatment and ARVs to work well include: good nutrition; reducing (or even stopping) alcohol intake; getting plenty of rest; getting enough exercise; and taking care of your spiritual health through reading the Bible, prayer, worship and fellowship.

### **HIV Treatment is Important for HIV Prevention!**

People living with HIV who are aware of their HIV status are living longer and healthier lives because of HIV care and treatment, including ARVs. When HIV treatment is successful, it provides several benefits including the following:

- **THE INDIVIDUAL FEELS WELL:** With successful HIV treatment the individual on ARVs is healthier and feels better and can live a normal life free from frequent HIV-related illnesses and free from the threat of early death.
- **HIV PREVENTION:** Successful HIV treatment provides an enormous opportunity for HIV prevention because it reduces the amount of virus circulating in the body, reducing the risk of transmitting HIV to a sexual partner. Early HIV treatment has been shown by studies to reduce the risk of HIV transmission to an uninfected partner by at least 96% (Cohen 2012).

### The Role of the Church in HIV Care and Treatment

The Church in Zambia has played a major role to play in ensuring that compassionate, non-judgmental and competent care and support is provided to PLHIV and those affected by HIV/AIDS, be they Christians or non-Christians.



By providing a climate of love, acceptance and support for PLHIV and those affected by HIV/AIDS and by ensuring that they are treated with respect and dignity, the church can continue to play an increasingly bigger role in providing valuable pastoral care and ensuring that the church becomes a healing community and a place of refuge for our brothers and sisters living with HIV.

## TOPIC 1.6: THE IMPACT OF HIV/AIDS

### 1.6.1 THE IMPACT OF HIV/AIDS ON CHILDREN, WOMEN, FAMILIES AND COMMUNITIES

The impact of HIV/AIDS on children occurs at many levels. At the family level, HIV/AIDS in any member of the family often redirects resources to HIV care and treatment, and as family resources diminish, children may face reduced availability of food and poor nutrition and may be taken out of school. The family may no longer be able to provide for other essentials such as health care and clothing. Children may be forced to take on adult household roles when their parents are sick and this often interferes with schooling, which may in turn affect their future prospects. At the individual level, children living with HIV, like adults, now can have access to lifesaving ARVs and live long healthy lives. However HIV takes a very heavy emotional, physical and psychological toll on children as they try to live and grow with HIV. This requires that they are provided with quality HIV care, treatment and support. Children orphaned and made vulnerable by HIV/AIDS face compounded challenges above and beyond those faced by other children including in terms housing, nutrition, education, parenting and health care. HIV/AIDS accounts for most of the estimated 1.3 million OVC in Zambia. Urban children (about 27%) are more likely to be orphaned than rural children (about 16%). In all, 67% of children are being brought up in poverty (UNGASS 2010).

In Zambia women are disproportionately impacted by HIV/AIDS: the prevalence of HIV/AIDS in women 15-49 is 15.1% compared to 11.3% in men; women are at greater risk of HIV infection during unprotected heterosexual sex than men due to biological differences; women bear most of the HIV care burden when family members are ill; due to economic and social dependence on men, the power of women to refuse sex and/or negotiate for safer sex is limited; and finally, when family resources are limited, girls are most likely to be taken out of school than boys, further deepening their vulnerability to HIV due to lack of education and the opportunities education provides.

At the family and community level, the illness and death of adults and children from HIV/AIDS is always a tragedy that is made worse by the lack of comprehensive social security and pension schemes for most people. Aged parents and extended kin rely on their children and other younger relatives for financial and material support. Therefore, loss of young productive adults exacerbates poverty levels in the family by negatively affecting traditional forms of social security for old people. HIV/AIDS in families and communities tends to exhaust the limited resources available, tipping families and communities into poverty. Additionally, most families depend on family labour to earn income; HIV/AIDS depletes available family labour further deepening poverty and its related ills.

### 1.6.2 THE IMPACT OF HIV/AIDS ON DEVELOPMENT AND THE NATIONAL ECONOMY

HIV/AIDS not only impacts every sector of Zambian society, including education, health, business and technical, agriculture, security, governance, Church and church-planting.

**EDUCATION:** The illness and deaths of teachers affect the quality of education provided; school enrolment may be negatively impacted when resources are redirected to HIV care and treatment; children may be forced to leave school to care for sick or ailing parents; children may be forced to leave school to work and provide needed income for the family where there is no stable income and adults are sick.

**HEALTH:** Death of health personnel; high cost of HIV care and treatment overstressing the health budget; high HIV disease burden overstrains health systems in terms of staffing, bed space, lab and pharmacy logistics etc.

**BUSINESS AND TECHNICAL SECTOR:** High attrition of qualified and skilled workers; high HIV-related absenteeism negatively affecting productivity and profitability; health costs and funeral costs; less spending power when customers prioritize health care over the goods and services offered by the private sector, and thus reduced profits and economic growth.

**AGRICULTURE:** Food production and food security are adversely affected when farmers get sick and die; household labour for agriculture is reduced when members of the household are sick or die; resources for agricultural inputs are redirected to HIV care and treatment, reducing yields and incomes and sometimes tipping households into poverty.

**SECURITY:** Effect on military personnel leading to loss of valuable experience and skills; weakened national military and thus increasing instability in the nation.

**GOVERNANCE:** Loss of human capital, inability of government to efficiently supply services and resources; loss of tax base; spiral increases in providing health care, education, welfare and other services.

**DECREASE IN LIFE EXPECTANCY:** Change in demographic features; rise of generations of orphaned children; unprecedented loss of life and unprecedented grief.

### 1.6.3 IMPACT OF HIV/AIDS ON PEOPLE LIVING WITH HIV/AIDS

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#### TASK (S):

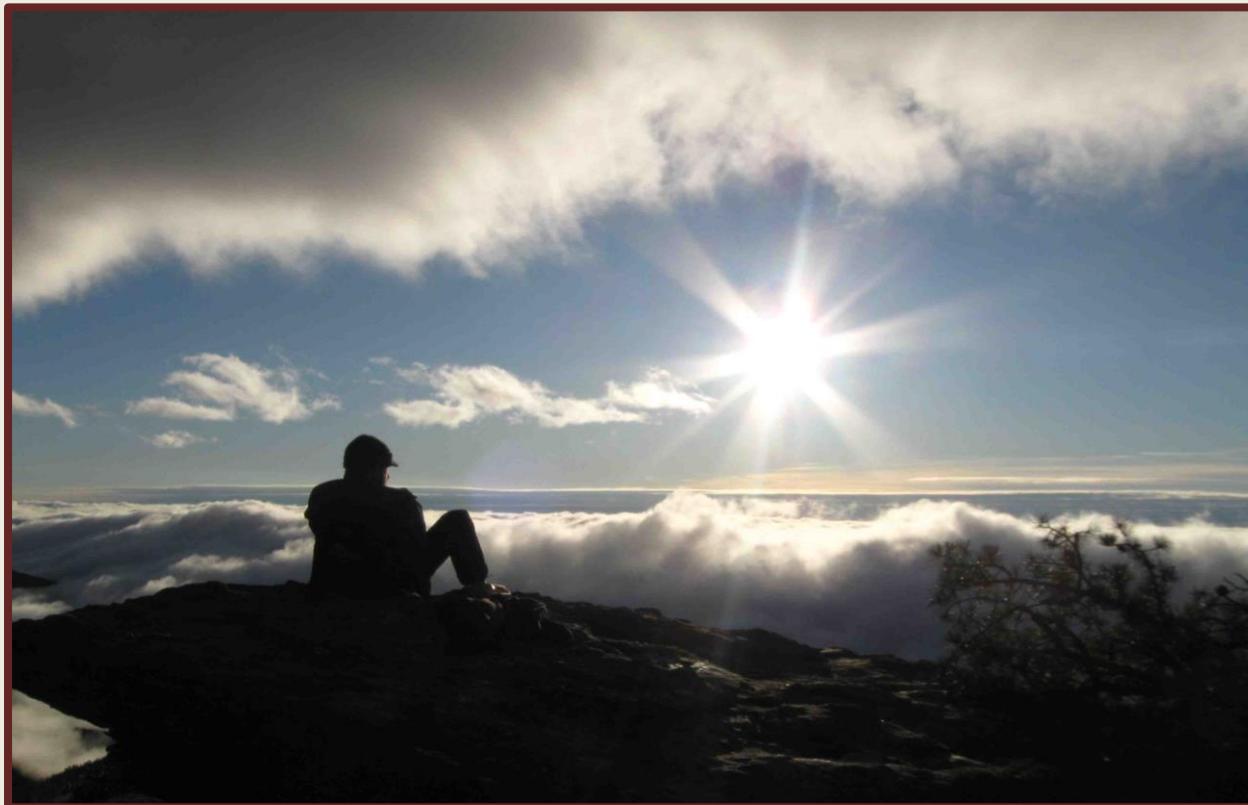
- Discuss your experience in relation to the impact of HIV/AIDS on the whole of society – individuals, families, communities.
  - Discuss: A religious leader gives a sermon that says HIV is a punishment from God. Is that stigmatising and/or discriminating against congregants living with HIV?
- 

HIV-related stigma is a process where people living with or associated with HIV are discredited, devalued or treated differently because of HIV. When stigma is acted upon, the result is discrimination. Discrimination is therefore related to stigma, and it is the unfair and unjust treatment of an individual based on their real or perceived HIV status or HIV association. HIV-related stigma and discrimination severely hamper efforts to address the HIV/AIDS epidemic in Zambia.

- Fear of discrimination often prevents PLHIV from seeking HIV counselling and testing; it prevents them from seeking HIV treatment; it prevents them from freely taking their ARVs; and it prevents them from disclosing HIV-positive status to enable them to access support and services.
- Fear of stigma and discrimination has undermined the ability of individuals, families and communities to protect themselves from HIV and to provide support to PLHIV

and/or those affected by HIV, by perpetuating the wall of silence and shame that surrounds HIV infection.

- Fear of stigma and discrimination robs individuals and communities of the opportunity to take appropriate HIV prevention measures; to get timely HIV care and treatment; and to receive the support from family, friends and the community.



Therefore, we must work together to end stigma and discrimination, and the Church must play a leadership role in this effort, including ending stigma and discrimination which takes place within the Church.

## RECOMMENDED READING

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## UNIT TWO: BIBLICAL, THEOLOGICAL AND AFRICAN PERSPECTIVES ON HIV/AIDS

### UNIT PURPOSE

This unit focuses on the biblical, theological and African perspectives on HIV/AIDS. By so doing, it will help the facilitator and learners to reflect effectively on HIV/AIDS in relation to human life and sexuality issues.

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### NOTE TO THE FACILITATOR/INSTRUCTOR:

Divide the learners into groups for discussion and encourage each group member to participate through comments, feedback, contributions and questions before presenting their findings to the larger group

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### UNIT OBJECTIVES

At the end of the unit, learners should be able to:

- Identify and discuss biblical, theological and African perspectives on HIV/AIDS;
- Appreciate the value of upholding biblical principles;
- Apply these perspectives by demonstrating compassionate and positive attitudes towards life and PLHIV.

### KEY METHODS OF INSTRUCTION

- Lecture
- Learning task/ group work/paper presentation

### SUGGESTED TEACHING AIDS

- Flip Charts/Chalk Board/White Board
- Markers/Chalk
- Hand-outs/Charts/Graphs
- Overhead Projector

## TOPIC 2.1 - HUMAN LIFE IN THE CONTEXT OF THE HIV/AIDS EPIDEMIC

### 2.1.1 CREATED IN THE “*IMAGO DEI*”

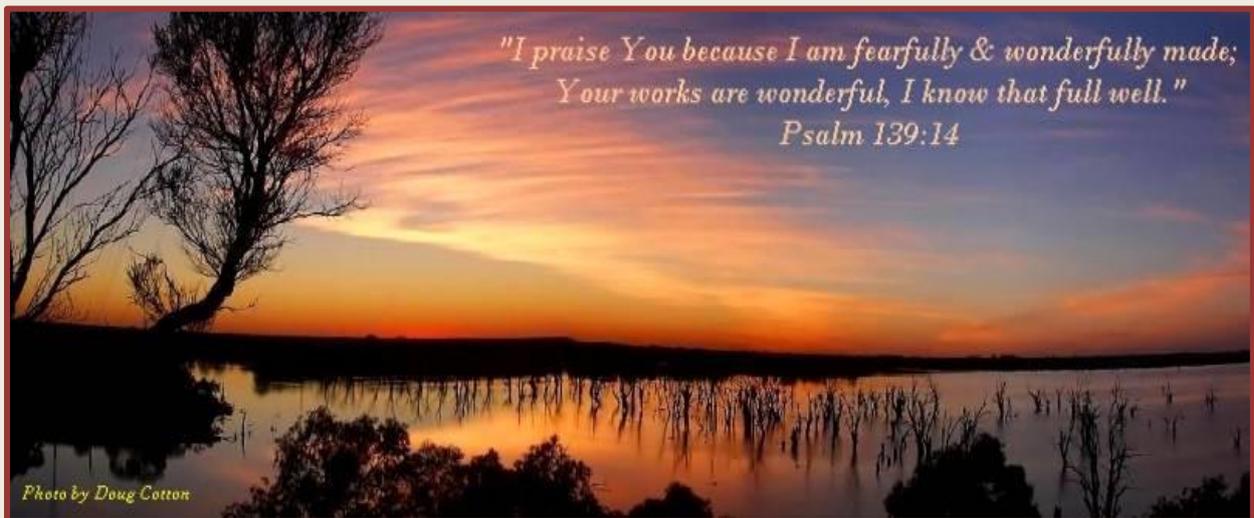
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#### TASK(S):

- What is meant by being created in the image of God?
  - What is your understanding of ‘human life’?
- 

*Imago Dei* means ‘Image of God’. God created human beings in His image. This creation is a special act of God after bringing to life other living things: animals, trees, etc. Even if

someone has HIV, Asthma, TB, Diabetes, or any other disease, they are created in God's image, and as such must be treated with dignity and love (Gen. 1:26-27; 2:7).



### 2.1.2 SANCTITY OF LIFE

God is a God of life. Everything he created, especially human beings (be they living with HIV or not), is precious and worth preserving (Ps. 8; 139:13-16; Exod. 21:22-25). Safeguarding life from its conception to its natural end is important and praiseworthy.

The reason why the sanctity of life applies to humanity is the fact that God created us in His image and set us apart for all other forms of life. Although that image has indeed been marred by sin, His image is still present in humanity. We are like God, and that likeness means that human life is always to be treated with dignity and respect.

The sanctity of life means that humanity is more sacred than the rest of creation and should motivate us to combat all forms of evil and injustice that are perpetuated against human life. Violence, abuse, oppression, discrimination and many other evils are all violations of the sanctity of life.

**HIV/AIDS Application:** Given the sanctity of human life, every human being is precious to God be they living with HIV or not, and their life is worth preserving.

### 2.1.3 THE DIGNITY OF HUMANS

Humans have dignity by virtue of being created in the image of God. "The fact that God created man and woman in His image invests them with inestimable worth, dignity and significance" (Kostenberger and David 2004).

**HIV/AIDS Application:** Given the inherent dignity human beings possess by virtue of being created in the image of God, this dignity therefore, does not depend on the way the world perceives this person (including with regard to their HIV status), but the fact that he/she is God's creation, created in His image.

## TOPIC 2.2 - HUMAN SEXUALITY

### 2.2.1 DEFINITIONS OF HUMAN SEXUALITY AND ABSTINENCE

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#### TASK(S):

- Invite the learners to discuss what is meant by 'Human Sexuality' from a biblical perspective, and then present their findings to the class
  - Ask: what is meant by abstinence? What is the value of practicing abstinence? What is the relationship between abstinence and faithfulness?
- 

#### Human Sexuality from a Biblical Perspective

Human beings, fashioned by God in His own image, are created male and female (Gen. 1:27). Thus from a biblical perspective, human sexuality speaks to the maleness and femaleness of human beings. It includes the overall sexual behaviours and attributes of humans both males and females. Sexuality is part of human life which encompasses personal and social meanings as well as sexual behaviour and the biology of human beings.

However, though it is an essential attribute of human nature, sexuality is not intended to be the defining characteristic of our humanness. Paul, the apostle, urged followers of Christ to understand that *"there is neither male nor female, for you are all one in Christ Jesus"* (Gal. 3:28). The apostle's words are intended to place human sexuality in a redemptive context i.e. of secondary importance to an individual's relationship to God. Jesus clearly taught that love rather than sex is the primary bond in all Christian relationships. Jesus said the two greatest commandments are to love God and to love one's neighbour (Mark 12:28-30).

**HIV/AIDS Application:** In Zambia, approximately 80% of all HIV transmissions are transmitted through heterosexual sex, therefore, HIV/AIDS in Zambia is largely an issue of human sexuality. However, discussing issues of human sexuality has culturally been taboo in most Zambian cultures, and therefore the Church, which exists in a cultural context, has also largely remained silent on the issue. In dealing with HIV/AIDS, the Church therefore has to confront the issue of human sexuality squarely and provide guidance to the body of Christ regarding how Christian teaching about human sexuality can help to prevent new HIV infections and can help PLHIV to live with dignity.

#### Abstinence

The central concept in capturing the Christian perspective about sexuality is 'chastity'. It is around this concept that abstinence from pre-marital sex is taught. It is within the same vein that healthy relationships between boys and girls are promoted. Sexual abstinence prior to marriage and sexual faithfulness in marriage are biblical expectations (1 Thes. 4:1-8), and it is evident that the practice of abstinence constitutes the best preparation for the observance of the faithfulness. From a scientific standpoint, Dailard (2003) defines abstinence as the avoidance of sexual activity of any kind especially penis-to-vagina contact. Biblically, the word that is synonymous with abstinence is chastity and it might be defined differently by different churches. For example, Focus on the Family, a global Christian ministry dedicated to helping families thrive, defines chastity as conforming your body and your sexual self to God's vision of human sexuality as laid out in Scripture and articulated by

church tradition—for married people, fidelity and for unmarried people, abstinence (2015). The Church of Christ of Latter Day Saints defines chastity as sexual purity; those who are chaste are morally clean in their thoughts, words and actions; and further, chastity means not having any sexual relations before marriage and fidelity to husband or wife during marriage (2015), from the forgoing, the value of abstinence is in its spiritual and personal moral discipline and one of the ways to overcome the many entrapments of the world related to human sexuality including HIV/AIDS (Ojo 2005).

**HIV/AIDS Application:** From a Public Health perspective, abstinence is the only fail-safe way to avoid sexual transmission of HIV infection, and in this regard, both science and Christian teaching agree that abstinence is a critically important aspect of HIV prevention.

## 2.2.2 BIBLICAL DEFINITION OF MARRIAGE

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### TASK(S):

- **Ask: what can couples in marriage do in order to enhance exclusiveness, faithfulness and permanence in their marriages? Discuss and present your conclusions to the class.**
  - **Compare marriage from the Biblical, Theological and African perspectives and see the areas in which marriage from an African perspective can be practiced in such a way that it brings glory to God.**
  - **Ask, what are the implications of the African perspective on marriage and the HIV/AIDS epidemic?**
  - **Ask, how can we help couples to uphold the teachings of the Bible regarding the one-flesh union and faithfulness to one another?**
- 

Marriage is a one-flesh union between one man and one woman on a permanent basis to the exclusion of others. It is a God-ordained institution that models exclusiveness, faithfulness and permanence. God’s purposes for marriage include companionship, procreation, picturing of the relationship between Christ and the Church, as a means for the preservation of the human race and the expression of the sexual impulse (Gen. 1:26-28). Sexual relationships should be confined within the marriage setup.

## 2.2.3 BIBLICAL PERSPECTIVE OF MARRIAGE

Marriage is shown to be rooted in God’s creative act of making humanity in His own image as male and female (Gen 2:18-24). This implies a monogamous, heterosexual relationship. A man and woman who marry become one flesh. The Gospels add a warning regarding this oneness “*so they are no longer two, but one. Therefore what God has joined together, let not man separate*” (Matt. 19:6).

## 2.2.4 THEOLOGICAL PERSPECTIVE OF MARRIAGE

There is a critical relationship between the picture of Christ as the groom and the Church as the bride that married people need to consider seriously in their relationship. The husband should consider his role in the same manner that Christ took his. He loved the Church and gave himself for it. Because of his love for the bride, the husband will not harm the wife,

who is the object of his love. Instead he will make every effort to ensure that she is well cared for, that is, cherished, washed, nourished and be ready to be presented to God as a glorious being (See Eph. 5:21-33).



**HIV/AIDS Application:** With this teaching and guidance from Holy Scripture, we can see that it is not right for a man or a woman to put their spouse in the way of harm, including through behaviour that put them at risk of infections such as STIs and HIV. Most HIV/AIDS programs promote and emphasize mutual monogamy.

### 2.2.5 AFRICAN PERSPECTIVE OF MARRIAGE

Marriage and the birth of children are central to our African way of life. Marriage is sometimes entered into through the mutual agreement of two families and the issue of love does not necessarily arise; it is something that the couple is expected to grow into. So, marriage in an African perspective is often not an individualistic consideration of the man and the woman but a family decision. If the woman fails to bear children, the bride's family is expected to provide other arrangements for children for the husband.

**HIV/AIDS Application:** Given this perspective and the lack of individual decision-making power women and young couples have, the risk of exposure to HIV infection for the woman is as great as the risk of emotional and other harm. Additionally, because marriage is a 'family' issue, the family often gets involved in other decisions relating to the couple, in both helpful and unhelpful ways. For the former, a good example is how the family rallies round and ensures that orphans who have lost a parent or both parents to HIV/AIDS are cared for, through the extended family network. An example of the latter is where an HIV positive mother is unable to make the decision not to breastfeed and protect her baby from HIV exposure, because decisions about child-rearing rest with other members of the family (aunts, mother-in-law, mother), rather her and her husband.

## 2.2.6 FAITHFULNESS IN MARRIAGE

People entering marriage are expected to be faithful to their marriage vows. We see that in the understanding of marriage: biblically, theologically and traditionally, the aspect of faithfulness cannot be overemphasized. Even when there are compromises in the African perspective of marriage, i.e. where childlessness provokes decisions that seem contrary to faithfulness, e.g. a brother fathering children for his brother (*Levirate* marriage) or another woman being brought into the relationship (polygamy), still whoever is involved in this relationship is expected to be faithful.



The Bible teaches us that, "*Therefore a man leaves his father and his mother and cleaves to his wife, and they become one flesh*" (Gen. 2:24), indicating that marriage is sanctioned by God and is a covenant relationship. Cleaving involves unswerving loyalty and fidelity to one's marital partner. The Bible further gives guidance regarding faithfulness in marriage (1 Cor. 7:1-7). God's blessing rests on sexual intimacy only when it occurs within the bounds of marriage. All sexual relationships outside of marriage are condemned by Holy Scripture, and are therefore never appropriate.

**HIV/AIDS Application:** We see that both science and the Christian faith agree that faithfulness is an essential ingredient to controlling the HIV/AIDS epidemic in Zambia. As such there is a big role for the church to play to take the Biblical teaching and message of mutual faithfulness in marriage, both to the believers and unbelievers, as part of the Church's push to prevent HIV and bring unbelievers over to Christ.

## 2.2.7 PREVENTION OF SEXUAL HIV TRANSMISSION AND CONDOM USE: THE NATIONAL HIV/AIDS RESPONSE AND THE CHRISTIAN HIV/AIDS RESPONSE

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### TASK(S):

- Ask: What is 'safe sex' and is the condom method the only way that guarantees safe sex and absolute protection from HIV?
  - In a marriage, how would you advise a spouse whose partner has been unfaithful and would like a solution to his/her predicament concerning the desire to prevent HIV infection?
  - What are the other uses of the condoms? Would these be legitimate uses and if so, why? If not, why?
  - If one person in a married couple acquired HIV, would you encourage him or her to continue having sexual relations with his or her spouse without protection?
  - At what point would you advise a spouse whose husband or wife is said to have acquired HIV to use a condom?
- 

### The National HIV/AIDS Response: Prevention of Sexual HIV Transmission and Condom Use

In Zambia approximately 80% of HIV transmissions are as a result of heterosexual sex. The condom is not the only effective method of HIV prevention for heterosexual transmission of HIV. Abstinence offers 100% protection for prevention of heterosexual transmission of HIV. Mutual fidelity or faithfulness also offers very high protection from heterosexual transmission of HIV. Scientific literature indicates that the condom is one of the most effective HIV prevention methods available, offering up to 98% protection when used correctly and consistently for every sexual act. However, in Zambia, condom use remains very low at only 29% overall; the reasons for this are many and complex and include individual preference, cultural and religious barriers and health system barriers that reduce access and availability.

Low condom use has been identified as a driver of the HIV/AIDS epidemic in Zambia (refer to topic 1.2, page 8). For a moderately severe HIV/AIDS epidemic like the one Zambia is facing, scientific evidence shows that several options of HIV prevention interventions are required, in order to give people a range of choices to prevent HIV and to achieve effective HIV epidemic control (refer to topic 1.2, pages 11 and 12).

Condoms therefore are available through the national HIV response programs and are considered as an important and very effective HIV prevention option, offered together with a range of other HIV prevention options, in a combination HIV prevention package.

### The Church HIV/AIDS Response in Zambia: Prevention of Sexual HIV Transmission and Condom Use

The promotion and use of the condom for HIV prevention has raised many ethical questions and has been a point of debate for many Christians and for the Church. Part of this debate and dilemma arises from the fact the condom is a very effective contraceptive, and has been

used to prevent pregnancy. Additionally, at the heart of the debate about condoms is issue of sexual morality and what the Bible teaches about sex.

For the Christian Church in Zambia, Christian teaching about abstinence from sex for those who are not married and mutual fidelity within sexual relationships for those who are married remains the bedrock and foundation for the prevention of HIV. Above and beyond any other, this is the cornerstone of the Christian Church's HIV prevention response for preventing heterosexual transmission of HIV.

There is no doubt that the reality and magnitude of HIV/AIDS that is facing the world and Zambia in particular today, is a very harsh one; we have seen many lives lost and many people suffer ill health due to HIV/AIDS. Despite a robust national HIV response, with over 600,000 people on ART, we continue to see many of our people die from HIV/AIDS.

The Church's primary aim will be to help change behaviour (including addressing the issue of immorality, one of the root causes of HIV/AIDS) and social conditions (including addressing the social injustices such as poverty, marginalization, and discrimination that might increase HIV vulnerability) in order to help Christians adhere to the Biblical teaching of abstinence and faithfulness, and thus ultimately reduce the vulnerability and risk of individuals to HIV infection, and the likelihood of transmitting HIV to others.

In some Christian denominations, within the marriage setting, after careful consideration on the grounds of pastoral responsibility to save lives, and without making judgements or claims that condom use is or should be the only HIV prevention option, Christian leaders recommend condom use. For example, in an HIV-discordant married couple where one partner is HIV positive and the other is HIV negative, some Christian leaders would recommend condom use because condoms can help to reduce the risk of HIV transmission to the HIV negative partner.

Similarly, in a marriage setting, where the two partners in the marriage are both HIV positive, some Christian leaders would advise the couple to use condoms, in order to prevent HIV re-infection and development of HIV resistance.

However, in both HIV discordancy and in the case where both partners are HIV positive, despite recommendation of condom use to prevent HIV, the Biblical teaching of mutual fidelity within the marriage still applies.

The Christian Church in Zambia recognizes that the Church's response to HIV/AIDS fits into a broader national HIV/AIDS response. Government, civil society, cooperating partners and donors are all players in the national HIV/AIDS response, and will continue to play their roles. The Church will play its primary role of encouraging and supporting abstinence from sex for those who are not married and mutual fidelity within sexual relationships for those who are married, and thus contribute to national HIV prevention efforts.

## TOPIC 2.3 - EVIL, SUFFERING AND DISEASE

### 2.3.1 BIBLICAL, THEOLOGICAL AND AFRICAN PERSPECTIVES ON EVIL, SUFFERING AND DISEASE

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#### TASK(s):

- Ask the class what is meant by evil, suffering and disease from the Biblical, Theological and African perspectives?
  - Ask: why is there suffering if God is perfectly loving and perfectly powerful?
  - Ask: What does the Bible teach about human suffering and disease?
- 

#### Evil

Evil is related to the rebellion of Satan when he wanted to make himself like God (Isa. 14:13-14). In writing about evil, O'Donovan wrote the following: Through his pride and his carefully planned decision to rebel against God, Satan introduced evil into the universe. Rebellion against God cuts a person off from the life and holiness of God. God is the source of all of life and all goodness and holiness. The absence of life is death and the absence of good is evil. Evil is a term that designates what is not in harmony with the divine order. In the Bible evil is clearly depicted under two distinct aspects: moral and physical.

Moral evil pertains to the breaking of God's law and going against one's conscience; **moral evil is wilful sin such as murder, fornication and stealing**. Physical evil concerns the adverse effects of the physical world upon the life of human beings; **physical evil is natural harm such as famine, illness, death** and natural disasters.

The reconciliation of the existence of evil with the goodness and holiness of a God who is infinite in his wisdom and power is one of the challenges of *theism* – belief in one God, the creator and ruler of the universe. The presence of evil in the world brings into question either of God's perfect goodness and perfect power (O'Donovan (1992).

The Holy Scriptures indicate that evil has been permitted by God in order that His justice might be manifested in its punishment and his grace in its forgiveness. The universe we live in is perfectly designed as a place to choose between good and evil. However, such choices would not be possible in a physically-perfect universe in which natural evil did not exist. Pain, suffering and death are integral parts of the material world due to Adam's sin, but Christianity offers hope through the suffering of Jesus Christ. Evil in this world is not a disproof of God, but a constant reminder of our need for the perfect God of the Bible (2 Cor. 1:8-9).

**HIV/AIDS Application:** The Bible gives clear guidance and a clear distinction: Although the pain, suffering and death brought about by HIV infection can be classified as physical evil, people living with HIV/AIDS are clearly not evil. Holy Scriptures tell us that physical evil, such as the suffering and death caused by HIV/AIDS, is but a constant reminder of our need for God who is all Goodness and Perfect. In our suffering today, including suffering through HIV/AIDS, we share in the suffering of Christ (Col. 1:24) so that in heaven we may share in His glory (1 Pet. 4:19).

## Suffering

Sin is directly or indirectly responsible for all that we see wrong in the world, including natural disasters. After the fall of man into sin, God pronounced a curse on humankind for his rebellion against Him (Gen. 3:16-19). This implies that every time we rebel or go against God's law of love, pain and suffering ensues. These painful and evil changes in the world were not a part of God's original creation. They are a result of man's choices.

- In Luke 13:2-4 Jesus commented on a situation where eighteen people had been killed by the falling tower of Siloam when he suggested that the event did not occur because the people were worse sinners than those around them. Here Jesus did indicate that all men deserve such suffering and more because of their sins (Luke. 13:3,5). In saying this Jesus did imply that human suffering does indeed result from specific sins. But he also clarifies that those who suffer the consequences of sin are not necessarily worse sinners than others.
- However, the Bible states that there may be other reasons for human suffering. In the Gospel of John (John 9:2-3) before Jesus healed the blind man, his disciples asked him, *"Rabbi, who sinned, this man or his parents, that he was born blind? Neither this man nor his parents sinned,"* said Jesus, *"but this happened so that the works of God might be displayed in him"*. Refer too to 1 Pet. 4:1 and Job 1 and 2).

**HIV/AIDS Application:** All in all only God knows the full answer in every situation. Christians therefore should renounce every sin in their lives and then trust God for His grace and help to deal with the situation, including HIV infection (Heb. 4:16). The important thing for Christians living with HIV to remember is that God is in full control. God will open the road and show the way, but man must himself walk through it. God will provide the circumstances and means for healing (such as ARVs), but man himself must use them – that is man's responsibility.

## Disease

Disease is the opposite of health. Health, according to the World Health Organisation (WHO), is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO 1946). Disease is also referred to as sickness and can lead to death. There are some sicknesses that come as a direct result of some particular sins; others are due to environmental exposure; some are due to particular life styles; and others still from spiritual impoverishment, and mental or emotional causes.

**HIV/AIDS Application:** While some people may become infected by HIV because of their own individual behaviour which puts them at risk of HIV, not all PLHIV become infected through their own individual behaviour or choice (for example, babies born with HIV have no choice in the matter and a faithful spouse infected by their unfaithful spouse is not at fault). Therefore the Church, rather than denouncing everyone living with HIV as sinful, must be a place of love, care, compassion, acceptance and solace for PLHIV.

The moralization of HIV infection by some religious leaders has alienated some of the faithful living with HIV/AIDS and denied them the opportunity to obtain the care and support they need from their fellow Christians. Additionally, it has also driven away some

unbelievers who might have wanted to come and learn, and become part of the Body of Christ. The role of the Church is not to condemn, but to provide PLHIV and those affected by HIV with compassionate, respectful, and non-judgemental care and support.

This is not to say that the Church must shy away from rebuking those who clearly continue to err, just because they have HIV. The Church must continue to spread the message of repentance to erring brothers and sisters and win souls to Christ, to prevent them from perishing in eternal damnation (Luke 13:2-5).

### 2.3.2 AFRICAN PERSPECTIVES ON EVIL, SUFFERING AND DISEASE<sup>1</sup>

From the African traditional perspective, all good or ill is experienced by men and women because of power-force or 'life-force'. Life-force is vital for health, wealth, worldly power and success. To have the life-force is to be healthy and strong, to lose it is to grow weak and die. This life-force exists in greater concentration in famous men (e.g. chiefs), strong charms, revered fetishes, powerful gods.

Humans (both living and departed), animals and plants have life only as they have this life force. Families, lineages and tribes have corporate vital force and their happiness and prosperity depend on conserving and strengthening it. Through the use of magical spells or curses a person's fortune can be enhanced or reversed and his health can be manipulated. Through the use of powerful life-forces a person may achieve great success.

#### Magic

This refers to a ritual performance or activity that is thought to lead to the influencing of human or natural events by an external or impersonal mystical force beyond the ordinary human sphere. This life-force is found in powerful concentrations in certain body parts and plants (Gehman 1989). There are several elements included in magic:

- Belief in mystical powers;
- The use of means to tap these powers through ceremonies, rites, spells, use of charms and medicines;
- There is a specialist who may inherit his powers from the ancestors or may purchase them for personal gain, or he may learn the secrets through apprenticeships with another specialist.

The significance of divination is as a result of the African worldview that sees spiritual causations to everything that takes place. There is an ultimate explanation for road accidents, sickness and death. Consequently, it is important to seek guidance from a specialist to ascertain the cause of the misfortune, determine what steps should be taken to chart the future or seek ways to avoid danger. In these circumstances, divination becomes important within the African Traditional worldview.

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<sup>1</sup> For the purposes of this manual, African perspective implies the African Traditional perspective

The Christian response to evil, suffering and disease as perceived from the above African perspective is trust in God who has power and is stronger than magic, witchcraft, sorcery and divination. Darkness (other powers) cannot overshadow light (the power of God).

**HIV/AIDS Application:** Christians need not be afraid of that which can only kill the body but rather of that which can kill the soul as well (Luke 12:4-5). Relate to topic 1.5 on HIV prevention, HIV care and HIV treatment. The comfort to all Christians living with HIV and to all Christians is that God is faithful and he will protect his own.

## TOPIC 2.4 – HEALING

### 2.4.1 DEFINITION OF HEALING

Healing is the state of being whole, sound or well or the state of returning to health or the state of being cured. Lasting health requires healing of the mind and spirit as well as healing of the body.

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#### TASK(S):

- In your groups as you deal with the meaning of healing, discuss some of the misconceptions about healing, medicines and then present your work in class.
  - What activities should one diagnosed with HIV involve himself or herself in if he or she has to live positively?
- 

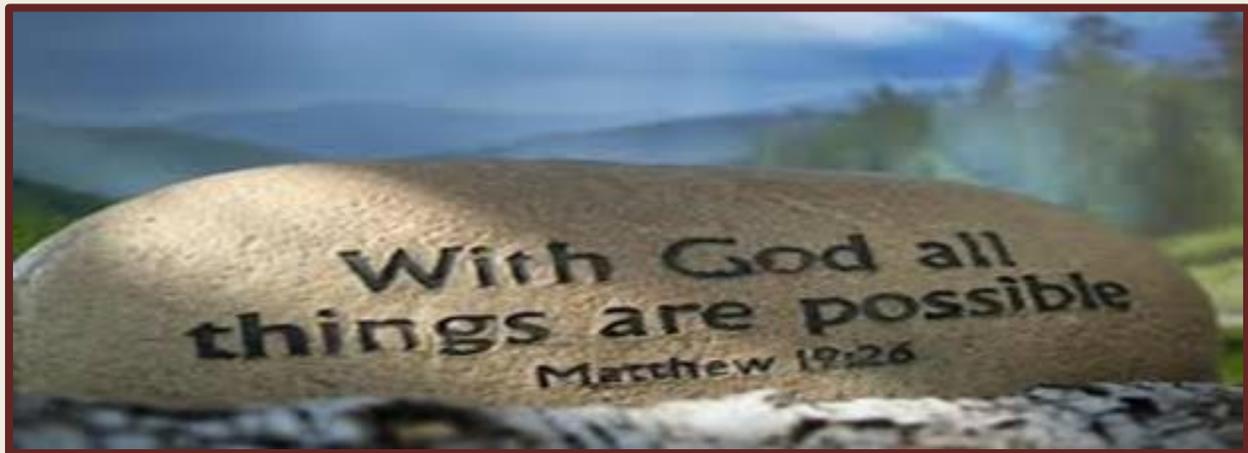
In understanding healing we first must understand that we are created in God's image. "So God created mankind in his own image, in the image of God he created them; male and female he created them (Gen. 1:27) meaning that God created man in perfect health, sinless and not subject to death. With the fall of mankind because of Adam and Eve's disobedience, that aspect of our likeness to God ended. Sin entered the world and along with it, sickness, disease and death. Today, man still bears his likeness to God, but that likeness is distorted by sin. Man was created with a material part, the body, and an immaterial part, the soul. The Psalmist praises God, "I praise you because I am fearfully and wonderfully made; your works are wonderful, I know that full well" (Ps. 139:14) because God created man to be perfect, but for the sin of Adam and Eve. Because man can suffer sickness and disease, man needs healing and this healing may be healing of the soul and/or healing of the body.

### 2.4.2 HEALING AND SUPERNATURAL HEALING AND HIV/AIDS

Regardless of the reasons for the sickness, God is merciful and in most situations He grants healing from the sickness in response to **prayer and the use of safe medicines**. However in some situations, God grants healing without the use of medicine and this is supernatural healing. In the power of the Holy Spirit, Jesus was a healer. He brought and offered freedom from sin, evil, suffering, illness, sickness, brokenness, hatred and disunity (Luke 4:16, Matt. 11:2-6). Jesus' healing was complete healing, healing both the body and the soul of disease and infirmity. Through resurrection and ascension, Christ has overcome all evil powers, even death. Therefore, even today, God the Holy Spirit fills the Church with the transforming authority of the resurrected Lord who heals and liberates from evil, and strengthens the

church for its healing and reconciling mission and enables people to cope with continuing suffering and illness in the light of Christ's redemption.

**HIV/AIDS Application:** Given the discussion above, with regard to HIV/AIDS, in most cases God grants healing through prayer. Taking ARVs enables PLHIV to live normal healthy lives. It is therefore important to encourage PLHIV in the church to pray for healing and to take their ARVs as the two are not mutually exclusive, but work together through the grace of God to provide both healing of the body (controlling the HIV virus) and healing of the soul (peace of mind). We Christians also believe that in some cases God grants complete healing even for HIV infection, because nothing is impossible for God.



Because of Christ's perfect sacrifice, no power, not HIV infection or any other disease or evil, has final damaging influence on those who put their confidence in God's love manifested in Christ (Rom. 8: 31-39). Holy Scriptures assure us that in God's Kingdom, our healing will be complete "*He will wipe every tear from their eyes. Death will be no more: mourning and crying and pain will be no more*" (Rev. 21:4).

### 2.4.3 MEDICINES: CONVENTIONAL AND TRADITIONAL

**USE OF CONVENTIONAL MEDICINES:** There are some Christians who think that it shows a lack of faith to seek healing from sickness by using prescription drugs. The idea cannot be supported from the Bible as evidenced by the following texts: 2 Kings 20:1-11 (in this text, we see application of medicine, *poultice of figs* to heal King Hezekiah's boil); Jeremiah 8:22 (in this reading, anointing balm and physician are mentioned for healing); and Luke 10:29-37 (the good Samaritan cleans the wound, puts healing oil, wine and bandages the wound). It is therefore appropriate for Christians to seek conventional medicines.

**CONSULTING TRADITIONAL HEALERS:** Many traditional healers in Zambia use plant and other materials to make medicines that are very helpful in many disease conditions. The difference between conventional medicines and traditional medicines is that the efficacy of conventional medicines has been tested using scientific methods, while that of most traditional medicines has not been scientifically tested.

However, a Christian should be very careful before going to a traditional healer for medicine to cure his sickness because some traditional healers are also diviners. Some of the traditional healers are involved with the power of evil spirits through traditional religions and may administer medicines that may have been sourced or procured by means of

divination which the bible speaks against in Deuteronomy 18:10-12; 32:15-21; 1 Corinthians



8:4; and 1 Corinthians 10:20. Even when traditional healers may not be involved with the power of evil, one has to be very careful when taking the medicines provided because the healer may administer medicines without proper doses, thereby putting the patient's life at risk. Always let the conventional healthcare providers know what other medicines you are taking, including traditional medicines, so that they can factor those in in your treatment plan.

**HIV/AIDS Application:** Given the foregoing, it is quite clear that all healing comes from God and it would be unethical for any Christian pastor/leader to discourage people from seeking conventional medicine, including discouraging PLHIV from taking their ARVs. All the ingredients used to make ARVs are part of God's creation and the physicians and other caregivers who provide care to PLHIV were put in this position by God to fulfil His purpose. Appropriate care and ARVs work together with prayer to bring healing to God's people.

A caution for PLHIV who seek traditional medicines for managing their HIV infection is that they should not stop their ARVs. They should also inform their doctors and caregivers that they are taking traditional medicines so that they can be monitored for adverse reactions as a result of overdosing and unwanted drug interactions.

#### 2.4.4 POSITIVE LIVING: MENTAL, PHYSICAL, SOCIAL AND SPIRITUAL HEALTH

Positive health, dignity and prevention (PHDP) helps people living with HIV lead a complete and healthy life and reduce the risk of transmission of the virus to others. PHDP is

characterized by its systematic delivery of a range of combination, behavioural, and sociocultural services within local communities. Advances in HIV treatment have dramatically improved the life expectancy and quality of life of PLHIV. Expanded access to HIV testing and ART has helped to transform HIV into a chronic disease. These advances magnify the urgent need to decrease HIV transmission, including for sero-discordant couples, in which one partner is infected with HIV and the other is not, and the need to appropriately meet the health needs of a growing number of PLHIV and provide quality care, treatment and support not only for HIV, but also other conditions.

The Church has been a leader in providing a supportive care for PLHIV in Zambia. In order to improve on this track-record and build a more HIV-compassionate environment within the Church's response to HIV/AIDS, the issue of HIV-related stigma and discrimination must be dealt with. This will enable PLHIV to access the information, services and support that the Church is so well placed to provide, without fear. Some of these include:

- Emotional and mental care that includes being involved in support groups, supportive confidant friends, counselling, encouragement, focusing on purposeful living, seeking spiritual outlets and meditation upon what is positive in life;
- Social care and support that includes family support and Christian fellowship;
- Physical care and support include proper shelter, safety, maintaining good health, getting enough rest, appropriate exercise and activeness, avoiding exposure to infectious diseases, regular physical examinations, early diagnosis and treatment of opportunistic infections and other diseases;
- Strict adherence to prescribed HIV treatment and care, and access to quality clinic and hospital care and medicines; and
- Access to healthy food, and eating a healthy and balanced diet with safe clean water.

Beyond this, what is expected of a Christian living with HIV and what should Christians living with HIV expect of their Creator? There is no question that living with HIV is challenging. However, Christians living with HIV, like any other Christians, must remember an important aspect of their lives: God's purpose for their lives and God's infinity mercy and love.

With regard to God's infinity mercy and love, the Bible says *"But now, this is what the Lord says— he who created you, Jacob, he who formed you, Israel: Do not fear, for I have redeemed you; I have summoned you by name; you are mine"* (Is. 43:7). God's favour and good-will to his people speak abundant comfort to all believers whether the believer is living with HIV or not. All who are redeemed with the blood of his Son, he has set apart for himself. Those that have God for them need not fear who or what can be against them. True believers are precious in God's sight; his delight is in them, above all other people. Though they face challenges such as HIV infection, yet, while they have God with them, they need fear no evil; they shall be borne up, and brought out. The faithful are therefore encouraged and dissuaded from anxious fears (Matthew Henry 1706).

With regard to God's purpose in our lives, the Bible says *"Everyone who is called by My name, And whom I have created for My glory, Whom I have formed, even whom I have made"* (Isa. 43:7). According to the Bible therefore, our purpose, the reason we are here, is for God's glory. In other words, our purpose is to praise God, worship Him, to proclaim His greatness, and to accomplish His will. This is what glorifies Him. Therefore, in this we find that God has given us a reason for our existence, a meaning for our existence whether we are Christians living with HIV or not. We were created by Him, according to His desire, and

our lives are to be lived for Him so that we might accomplish what He has for us to do. When we trust the one who has made us, who works all things after the counsel of His will (Eph. 1:11), then we are able to live a life of purpose. How the particulars of that purpose are expressed is up to us and the circumstances that are available to us.

## TOPIC 2.5 - DEATH AND RESURRECTION

### 2.5.1 UNDERSTANDING DEATH

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#### TASK(S):

- Ask: what do you understand about death and resurrection?
  - In what ways can an HIV infected person be helped in order to have hope for the future, faith to trust in the Lord Jesus Christ and to obtain salvation that is found in Christ Jesus?
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Death means different things to different people – it is understood in so many ways. The definition given here is a Christian one: For Christians, Death is the cessation of life in its familiar bodily state. So this does not mark the end of existence, but is simply a transition to a different mode of existence – it is not extinction, but rather a transformation.

- Physical death is the separation of the soul from the body;
- Spiritual death is the separation of the person from God – this can happen to anybody who does not believe in Christ. He/she may be physically living, but is spiritually dead; and
- Eternal death is the finalizing of the state of separation from God.

For Christians therefore death is only the beginning of life eternal in heaven. Holy Scriptures tell us that *“Precious in the sight of the Lord is the death of his faithful servants”* (Psalm 116:15) and *“For the Lord himself will come down from heaven, with a loud command, with the voice of the archangel and with the trumpet call of God, and the dead in Christ will rise first”* (1 Thes. 4:16).

For the faithful therefore, our death is a moment of victory *“When the perishable has been clothed with the imperishable, and the mortal with immortality, then the saying that is written will come true: “Death has been swallowed up in victory. Where, O death, is your victory? Where, O death, is your sting?”* (1 Cor. 15:52-55). These and many other passages in Holy Scriptures assure that when believers die, they have won, they are victorious! They will rise again when Christ comes to judge the living and the dead and they will be clothed with new bodies and live eternally! This is a central Christian belief.

**HIV/AIDS Application:** With the medicines that are available today, Christians living with HIV can live long and healthy lives like other people with any other diseases. They no longer need fear premature death, if they start treatment on time and adhere to their treatment. When a believer living with HIV dies, they are conquerors; they have won! HIV infection no longer matters because they will be clothed with new bodies, and death has no power over them as they shall rise with all the other believers at Christ’s second coming.

## 2.5.2 UNDERSTANDING THE RESURRECTION

The resurrection is the awakening of those who have died either to everlasting life or to everlasting contempt (Dan. 12:2; John 5:25, 28-29). It is also the opening up of the graves by God in order to raise the dead, and putting His Spirit into them so that they live (Ezk. 37:12-14). We Christians believe, through Christ's resurrection we are conquerors and that nothing can separate us from the love of God in Christ: *"No, in all these things we are more than conquerors through him who loved us. For I am convinced that neither death nor life, neither angels nor demons, neither the present nor the future, nor any powers, neither height nor depth, nor anything else in all creation, will be able to separate us from the love of God that is in Christ Jesus our Lord"* (Rom. 8:37-39).

Our duty as Christians is to remain faithful to Christ's teaching and to God's purpose for our lives, and also to teach non-believers and bring them to Christ, so that they too may have eternal life in Christ.

**HIV/AIDS Application:** The hope of all Christians, including Christians living with HIV/AIDS, is to be resurrected when Christ comes and to have eternal life with God. When believers are resurrected with Christ, HIV infection will no longer be of consequence because they will be clothed with new bodies that will know no disease or death.

## TOPIC 2.6 – FAITH, HOPE AND SALVATION

### 2.6.1 FAITH FROM THE BIBLICAL, THEOLOGICAL AND AFRICAN PERSPECTIVES

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#### TASK(S):

- Ask the students to explain what they understand by faith, hope and salvation from biblical, theological and African perspectives;
  - How does this understanding impact on issues of HIV/AIDS?
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#### Faith from the Biblical and Theological Perspectives

Faith is the assurance of eternal life for all those who believe in Christ Jesus, the Son of Man as told to humanity by the evangelist John in the following words: *"...for God so loved the world that he gave His only Son..."* (John 3:16).

**HIV/AIDS Application:** Faith is a formidable healing force and this force is available for Christians and others living with HIV to tap into. In the Gospels Jesus says *"...Truly I tell you, if you have faith as small as a mustard seed, you can say to this mountain, 'Move from here to there,' and it will move. Nothing will be impossible for you"* (Matt. 17:20). Even today, faith is working in the lives of Christians to bring comfort, healing and peace of Mind through the Holy Spirit.

Evidence from over 1,200 studies and 400 reviews has shown an association between faith and a number of positive health benefits, including protection from illness, coping with illness and faster recovery from it. For PLHIV, faith can accrue a number of positive health benefits, including good response to treatment with ARVs, better mental and emotional ability to cope with HIV infection, and resilience to developing HIV-related illnesses. Through

faith, HIV becomes an avenue for God's love and healing power to be demonstrated in the lives of the faithful.

### Faith from an African Perspective

The object of faith for Africans is not usually in God but in their own supreme deities, and this is a very deeply rooted perspective. We frequently see this from the behaviour whenever Africans find themselves in trouble. It is not always to God that they run to but to traditional healers. At the very first sign of any trouble, they go back to what sustained them before Christianity, so that although they are Christians, their allegiance is divided and in most cases biased towards 'their own supreme'.

## 2.6.2 HOPE FROM THE BIBLICAL, THEOLOGICAL AND AFRICAN PERSPECTIVES

### Hope from the Biblical and Theological Perspectives

The resurrection is the basis for the believer's hope in the face of death (1 Cor. 15:53-59). St Paul addresses the Thessalonians about death and Christian hope when he says: *"Brothers and sisters, we do not want you to be uninformed about those who sleep in death, so that you do not grieve like the rest of mankind, who have no hope. For we believe that Jesus died and rose again, and so we believe that God will bring with Jesus those who have fallen asleep in him..."* (1 Thes. 4:13-18).

**HIV/AIDS Application:** The hope of all Christians, including Christians living with HIV/AIDS, is to be resurrected when Christ comes and to have eternal life with God.

### Hope from the African Perspective

Africans' hope in the afterlife is rooted in the fact that they would go on to join their ancestors and loved ones who have gone before them. This then, presupposes that the one who leads a good life in this life, is expected to be joined to the ancestral spirits and continue living well and be beneficial to the clan and those who live otherwise become wondering spirits tormenting people.

## 2.6.3 SALVATION AND ETERNAL LIFE FROM THE BIBLICAL, THEOLOGICAL AND AFRICAN PERSPECTIVES

### Salvation and Eternal Life from the Biblical and Theological Perspective

Death is considered natural in the Old Testament (Ps. 90) and also as a curse, a result of sin (Gen. 3:19). Despite the grey outlook on death in the latter which, was more prominent, Abraham was promised peace with his fore fathers (Gen. 15:15), Isaac too went to his grave peacefully at a ripe age (Gen. 35:29). The promises of these two patriarchs over a 'good' death and the promise of meeting their forefathers somehow paint a whole different picture on death: that of hope beyond the grave and a good long life for all those who walk with faith in God.

From the New Testament we see that man's salvation was bought through the Perfect sacrifice of Jesus' crucifixion on the Cross of Calvary. With regard to salvation, the Bible tells us that: *"Peter replied, repent and be baptized, every one of you, in the name of Jesus Christ*

*for the forgiveness of your sins. And you will receive the gift of the Holy Spirit. The promise is for you and your children and for all who are far off—for all whom the Lord our God will call”* (Acts 2:38-39). Salvation therefore is God’s way of providing deliverance for man from sin and spiritual death through repentance and faith in Jesus Christ.

In looking at eternal life, the resurrection of Christ is the cornerstone of Christian faith. Because Christ was resurrected, we can have faith that we too who are believers will be resurrected to Eternal life. The Bible tells us that not only is there life after death, but eternal life *“By his power God raised the Lord from the dead, and he will raise us also”* (1 Cor. 6:14). Jesus Christ, God in the flesh, came to the earth to give us this gift of eternal life, by the grace of God.

**Application to HIV/AIDS:** Salvation is available to all through the grace of God. God, who is Love, and loves all His children, does not discriminate on the basis of HIV status; salvation is open to all. Similarly, God’s gift of eternal life, given through God’s grace, is available to all true believers, irrespective of HIV status.

### Salvation and eternal life from the African Perspective

The African peoples are humanistic in their approach to religion. They do not seek God for His own sake, but rather they venerate the ancestors, appease the spirits in order that they may receive favour in return. This attitude has been described as utilitarianism. Sin boils down to only social ills with adequate punishment received here and now. This wrong conception of sin results in the wrong conception of salvation. If an anti-social act is all there is to sin, salvation from sin would be in the same terms. Thus, it is plain in the oral tradition that to be saved is to be accepted (Adeyemo 1979).

One is accepted to the community of the living by being good to one’s neighbours, and secondly accepted among the community of the dead ancestors by remembering them through libations, prayers and offerings. An aspect of this acceptance is the struggle for power or ‘vital force’. It is believed that one who excels his equals has been specially favoured by the ancestors and such honour is indicative of salvation.

Occasionally, deliverance is sought from the power of the evil spirits and the enemies. Sacrifices involving blood may be rendered to ward off ill fortunes. Charms and armlets are worn by some people or hung at lintel of their houses with the belief of deliverance from opposing evil forces

Thus, salvation in the traditional thought African peoples implies acceptance in the community of the living and the living-dead, deliverance from the power of the evil spirits, and possession of life force (sometimes ‘life force’ can mean ‘vital force’) (Magesa 1997).

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## UNIT THREE: THE CHURCH'S ENGAGEMENT WITH THE HIV/AIDS EPIDEMIC

### UNIT PURPOSE

This unit helps the facilitator/instructor to focus on the Church response to HIV/AIDS. It aims to sensitise the Church leaders towards a positive change in attitude in relation to HIV/AIDS and to equip them to frame an effective and compassionate response within its own heritage and using its own internal resources.

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### NOTE TO THE FACILITATOR/INSTRUCTOR:

The Church engagement in the fight against the HIV/AIDS epidemic is cardinal. The facilitator needs to help the students to explore areas which will help the Church engage itself through first and foremost being a 'listening' Church which practices the love it preaches so that those infected and affected may find a 'home' in the Church and an embrace through its ministers.

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### UNIT OBJECTIVES

At the end of the Unit, students should be enabled to:

- Demonstrate acquisition of knowledge related to various Church-based HIV/AIDS issues;
- Understand and develop various strategies the Church might employ in creating positive conditions to promote and sustain a caring, compassionate and empathetic attitude towards those living with and affected by HIV/AIDS;
- Understand various approaches to developing Church ministries to respond to the complex challenges associated with HIV/AIDS;
- Promote ecumenical and inter-disciplinary networking relevant to Church and community-based responses to HIV/AIDS;

### KEY METHODS OF INSTRUCTION

- Lecture
- Role Play
- Learning tasks/Group work/Plenary

### SUGGESTED TEACHING AIDS

- Flip Charts
- Markers/Chalk
- Hand-outs/Charts/Graphs
- Overhead Projector
- Chalk Board/White Board

## TOPIC 3.1 - THE CHURCH HERITAGE: INITIAL RESPONSE TOWARDS HIV/AIDS

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### TASK(S):

- Organize a Role Play: Show how the Church first responded to HIV/AIDS. (pastor ignoring the issue, putting fear into people and pronouncing judgment)
  - Discuss and ask: Is this where the Church is today? After discussing this question, a role play depicting the change of attitude by the Church should be performed.
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### 3.1.1 THE CHURCH'S INITIAL RESPONSE TO HIV/AIDS

The Church in Zambia has been at the frontlines of the HIV/AIDS response and has offered valuable services to PLHIV and those affected by HIV/AIDS. The Church has provided compassionate care and counsel, and has been a source of hope and strength for Zambians living with HIV and those who are affected by HIV/AIDS. While it provided care and support, the Church's initial response to HIV/AIDS was also often coloured by fear, prejudice, stigma, discrimination and judgment. HIV/AIDS was seen as punishment from God for sin, and the Church was in some cases full of condemnation of PLHIV through insensitive sermons/homilies.

As we have discussed previously, our Saviour Jesus Christ debunked this view that disease or illness is punishment from God for sin. The Bible tells us that *"As he went along, he saw a man blind from birth. His disciples asked him, Rabbi, who sinned, this man or his parents, that he was born blind? Neither this man nor his parents sinned,"* said Jesus, *"but this happened so that the works of God might be displayed in him"* (John 9:1-3). Therefore Christ says that the ills that sometimes befall man are not always to be looked on as special punishments of sin; sometimes they are for the glory of God, and to manifest his works.

### 3.1.2 THE CHURCH IS NOW AT THE FRONTLINE IN THE FIGHT AGAINST HIV/AIDS

While the Church continues to be a staunch ally in the national HIV/AIDS response, the Church response has been largely left to each denomination to define and implement. In the denominations where information about HIV/AIDS is readily available to church leaders, and the leaders are HIV-competent, the Church response continues to be of tremendous help to PLHIV and those affected by HIV/AIDS, and to the country as whole. As the Church keeps pace with new developments in the field of HIV/AIDS and remains well informed and understands the epidemic better, a more HIV competent, compassionate and empathetic, Church has emerged.

However, in the situations and/or denominations where church leaders lack correct information about HIV/AIDS and where misconceptions and myths about HIV/AIDS are prevalent, the Church, even today, is often a vehicle for social injustice and other HIV-related harm, a situation that urgently requires to be addressed and corrected.

With the advances in HIV treatment and care, the epidemic has entered a new phase where PLHIV are living healthy and long lives. The Church is therefore mindful that even with free ARVs, the other related costs of HIV/AIDS as a chronic illness (e.g. transport, laboratory tests

and nutritional requirements) are increasingly proving to be difficult to afford for many people, particular the poor.



HIV/AIDS and access to affordable care and treatment has therefore increasingly become an issue of social justice and an area of advocacy for the Church. Given the high cost, in both human terms (suffering and death) and resource terms (affordability of treatment and care), the imperative for effective HIV prevention could not be greater; the Church therefore needs to become more competent and proactive in addressing the drivers of the epidemic.

## TOPIC 3.2 - USE OF BIBLICAL TEXTS IN RESPONSE TO HIV/AIDS

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### **TASK(S):**

**Ask a question for general or group discussion: Why is the use of biblical texts important in the Church's response to HIV/AIDS?**

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In the Church, help, hope and encouragement in every situation is guided by the word of God as presented in the Bible. In the wake of HIV/AIDS, we still fall back on the Bible as a guiding tool on how best the people infected and affected by HIV/AIDS can be given hope and meaning in life. From the Biblical texts we can learn how to deal with the challenges posed to us by the epidemic: hopelessness, fear, despair, and stigmatization/discrimination.

### **3.2.1 THE SANCTITY OF HUMAN LIFE AND HUMAN DIGNITY**

- All human life has value – all are created in the image of God (Gen. 1:26-27)
- This image of God still remains in people regardless of their HIV status

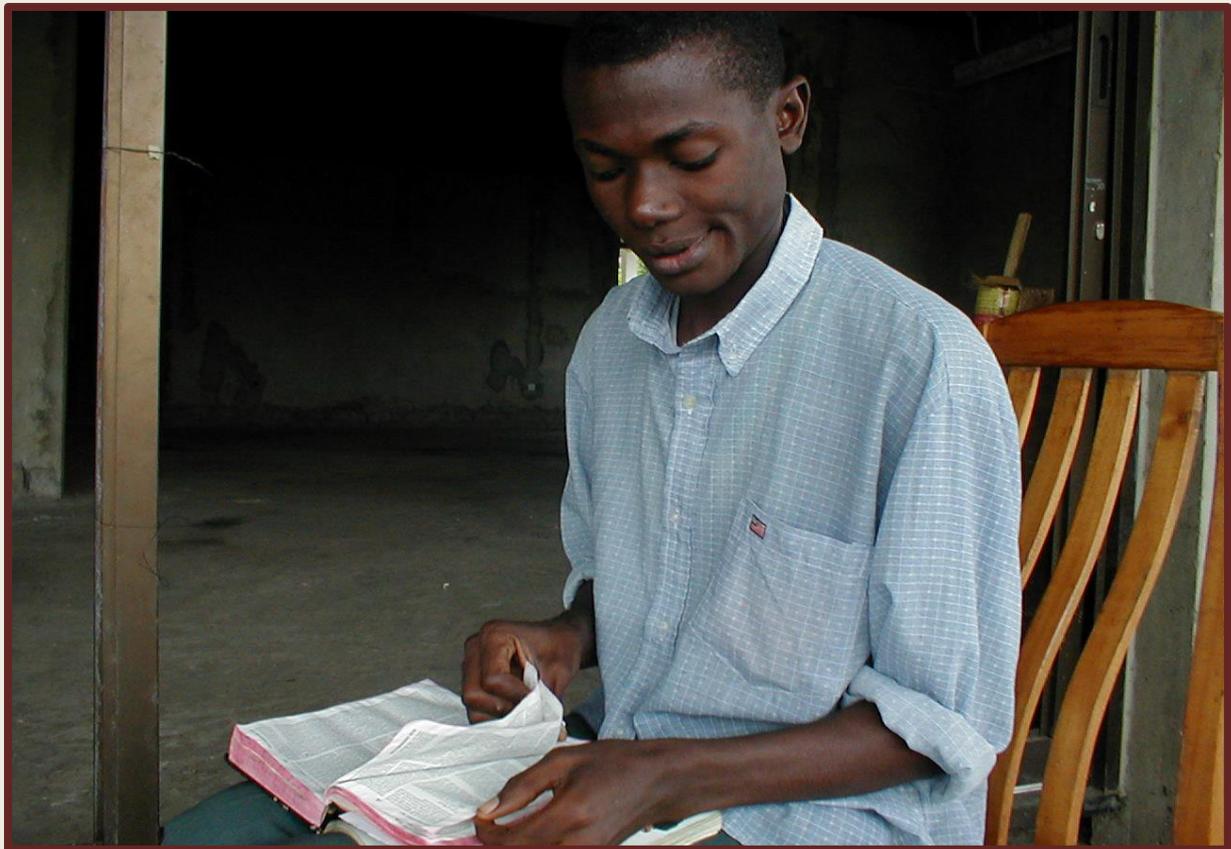
Given the sanctity of human life, every human being is precious to God be they living with HIV or not, and their life is worth preserving. Given the inherent dignity human beings possess by virtue of being created in the image of God, this dignity therefore, does not

depend on the way the world perceives this person (including with regard to their HIV status), but the fact that he/she is God's creation, created in His image.

### 3.2.2 PERSPECTIVES ON SUFFERING, SICKNESS

Death and Suffering entered the world because of sin (Rom. 5:12-21). Sickness and Suffering may be used by God to display His power and glory (John 9:3). Sickness and Suffering may be used by God for discipline in the believer's life (James 5:13-16). Sickness and Suffering may be used by God to bring out repentance in man (Num. 21:4-9). Sickness and Suffering may come into the believer's life for reasons known only to God (Job chapters 1 and 2)

People living with HIV/AIDS are clearly not evil. The Bible tells us that the suffering and death caused by HIV/AIDS, is but a constant reminder of our need for God who is all goodness and Perfect. In our suffering today, including suffering through HIV/AIDS, we share in the suffering of Christ (Col. 1:24) so that in heaven we may share in His glory (1 Pet. 4:19).



### 3.2.3 PERSPECTIVES ON HEALING

The believer's privilege is to seek the will of God in matters of physical healing – whether by natural (immune system), medical (antibiotics, antiretroviral, herbal) or supernatural means (miracles).

- The believer may ask the Lord for physical restoration, according to scripture (James 5:14-16) and if the healing is for the glory of God, His power will be displayed (John 11:4).

- Healing does not always take place, and we should and cannot expect then, that in every case healing is to be granted upon request, as is forgiveness of sins (Erickson 1983). The apostle Paul learnt this lesson (2 Cor. 12:1-10), and we must learn it as well. It is not always God's plan to heal. That fact will not trouble us, if we but remember that we are not intended to live forever in this earthly body (Heb. 9:27).
- Relate to topic 1.5 on HIV prevention, HIV care and HIV treatment.

All in all only God knows the full answer in every situation. Christians therefore should renounce every sin in their lives and then trust God for His grace and help to deal with the situation, including HIV infection (Heb. 4:16).

For Christians living with HIV, it is important and helpful to remember that God is in full control and that they must allow his will to be done in their lives. Sometimes God will open the road and show the way, but man must himself walk through it; God will provide the circumstances and means for healing (such as ARVs), but man himself must use them – that is man's responsibility.

### **3.2.4 APPROPRIATE RESPONSE TO HIV/AIDS: COMPASSION NOT CONDEMNATION**

It is the duty of Christians to desire and aim to be Christ-like. We are to bear one another's burdens. If we are Christians, we are obliged to show mutual forbearance and compassion towards each other. It therefore matters not what a brother or sister is suffering from – be it HIV/AIDS, diabetes, hypertension, asthma – as the body of Christ we must show love and compassion to one another, just as we ourselves were shown love and compassion by God our Father, through Christ's perfect sacrifice for us on the cross.

- God is compassionate (Ps. 103:4, 13-14; Matt. 5:48; John 3:16).
- Jesus has compassion for the sick, no matter the origin of their sickness (Matt 9:35-36). Because we are the followers of Christ, we need to have the same compassion.
- Paul commanded us to be compassionate (Gal. 6:2, 10).
- Compassion is an expression of the fruit of the Spirit which is love (Gal. 5:22).

We are also to show love and compassion to non-believers, whether they are living with HIV or not, just as our Saviour did.

### **3.2.5 FOSTERING A SENSE OF BELONGING FOR PLHIV AND THOSE AFFECTED BY HIV/AIDS**

In Topic One, we looked at who Zambians living with HIV are so that we could get a clear picture of who PLHIV are. We saw that:

- In Zambia many of us have never gone for HTC to know our HIV status. This means that some of us do not know whether we have HIV infection or not. Anyone who has not had an HIV test could be living with HIV;
- HIV infection does not discriminate; as long as there is exposure to HIV any person can get infected with HIV – black or white, rich or poor, young or old; and
- Many of us in Zambia are living with HIV (approximately 1.1 million), and all of us have family, friends, and neighbours living with HIV – your doctor, your teacher, your

pastor, your sister, your brother, your mother, your father, your cousin, your uncle, your aunt, your friend or your neighbour could be living with HIV.

We concluded that the important thing to note is that people living with HIV or affected by HIV are part of our community; they are part of us. Like other members of our community with any other illness such as asthma, diabetes, or hypertension, they deserve to be treated justly and with respect, and sometimes, they need our care and support.

Christians living with HIV are part of the body of Christ, and the Church needs to embrace them with open arms, and treat them with the respect and dignity they deserve. Additionally, the Church's duty is to reach out to non-believers and win souls for Christ, and therefore the church has a larger mandate to embrace all PLHIV, whether they are believers or not, and offer acceptance, solace and healing, just as our Lord Jesus welcomed and healed all who came to him, without discriminating on any basis. Through Christ, God's purpose of mercy and reconciliation embraced all mankind, and not an elect few (2 Cor. 5:19; Matt. 25:35-40).

The great end in all our actions as Christians must be that God may be glorified. Nothing demonstrates this more than when Christians show love, compassion, and kindness to one another and to non-believers (Rom. 15:7; Matt. 25). Christian teaching therefore demands that the Church fosters a sense of belonging for PLHIV and for others who suffer from other different afflictions, and remains true to the two greatest commandments that Christ himself gave us: *“Love the Lord your God with all your heart and with all your soul and with all your mind and with all your strength. The second is this: Love your neighbour as yourself. There is no commandment greater than these”* (Mark 12: 30-31).

### TOPIC 3.3 - THE ROLE OF THE CHURCH IN AWAKENING THE PEOPLE'S CONSCIENCE: CARE, COMPASSION AND EMPATHY

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#### **TASK(s):**

Allow adequate time for learners to discuss their understanding of the terms: conscience, care, compassion and empathy.

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#### 3.3.1 DEFINITION OF CONSCIENCE, CARE, COMPASSION, EMPATHY AND COMPETENCE

##### Conscience

The Oxford English Dictionary defines Conscience as “a person's moral sense of right and wrong, viewed as acting as a guide to one's behaviour” (2015).

From a theological understanding conscience can be defined as “our normal powers of reasoning as applied to practical matters and in particular to moral decisions” (Campbell, 1987). Conscience is the inner law which summons us to love doing what is good and to avoid evil. It is a law written by God on our hearts, the most sacred core and sanctuary of a person (Jer. 31:31-34; Ezek. 11:14-21; Matt. 15:8; Rom. 2:15).

## Care

The Oxford English Dictionary defines Care as “the provision of what is necessary for the health, welfare, maintenance and protection of someone or something”; “serious attention or consideration applied to doing something correctly or to avoid damage or risk”; “feel concern or interest; attach importance to something”; or “look after and provide for the needs of” (2015).

To care is to show and be concerned about the wellbeing of another. A caring person will look out for the other who may be requiring help. It can be someone incapacitated and/or at times one with a psychological or other problem that they cannot deal with. The Church’s pastors and pastoral care-givers perform this ministry on behalf of Christ. “The Ministry of pastoral care is based theologically on the Christian affirmation that God created human kind for relationships with God and other creatures. Our human caring is based on God’s care; we care for each other because God cares for us.” (Patton 2005).

## Compassion

The Oxford English Dictionary defines Compassion as “sympathetic concern for the sufferings or misfortunes of others” (2015).

Compassion is one of the emotions, or attitudes with an emotional component, that are altruistic or other-regarding. Compassion presupposes sympathy, is close to both pity and mercy, and leads to acts of beneficence (Campbell 1987).

## Empathy

The Oxford English Dictionary defines Empathy as “the ability to understand and share the feelings of another” (2015).

Empathy is the human capacity to comprehend directly the state of mind and feeling of another person. Empathy involves, in effect, putting oneself in the place of the other, understanding and sharing the other’s emotional experience, and seeing the world as he/she sees it. The line between empathy and sympathy cannot be drawn rigidly, but in general terms empathy involves a sharing in quality rather than in quantity, in kind rather than in degree. It is this which makes it possible to enter into the emotional situation even of persons incapacitated by the strength of their feelings without oneself being overwhelmed by those feelings (Childress and Macquarrie 1986).

## Competence

The Oxford English Dictionary defines Competence as “the ability to do something successfully or efficiently” (2015).

Competence can also be defined as the combination of training, skills, experience and knowledge that a person has, and their ability to apply them to perform a task properly and successfully. Care, empathy, compassion and conscientiousness, defined above, grounded in Biblical teaching should be part of the core competencies of the Church and Christians, i.e. those attributes that differentiate the Church and the faithful from secular organizations and non-believers.



**HIV/AIDS Application:** The Church is being called to deal with the HIV/AIDS epidemic conscientiously; with PLHIV and those affected by HIV/AIDS with empathy, compassion and care; and do so with the required levels of HIV competence. This requires that the Church take deliberate measures to put in place or provide the policies and structures and training that will enable it to achieve this.

### 3.3.2 WHAT THE CHURCH CAN DO TO BRING AWARENESS TO ITS CONGREGATIONS

How can the Church become more conscientious, empathetic, compassionate, caring and competent with regard to HIV/AIDS? There are many ways that the Church can achieve this and these include the following:

- Providing correct and appropriate information about HIV/AIDS through sermons/homilies, and through other Church activities;
- Alleviating silence, stigma and discrimination by addressing the issue of HIV/AIDS in congregations, and providing guidance to the Body of Christ about the damage stigma and discrimination cause, and further, providing guidance on just and respectful relations with PLHIV and those affected by HIV/AIDS ;
- Equipping the Church to adequately handle issues of sex education (parents, children and youth) and sexuality and continually redirect towards Christian teaching and appropriate Christian behaviour;
- Exploring the ethos of love, care, compassion and empathy in the context of HIV/AIDS, and providing the training, support and structures to ensure that these ethos are made operational in the Church;
- Serving and caring for PLHIV and those affected by HIV/AIDS with respect, empathy and compassion, and according them the dignity they deserve;
- Providing advocacy and leadership on the issues of HIV/AIDS prevention, care, treatment and support, and also the HIV-related social justice issues;

- Adopting an inclusive (gender, age, class, ethnicity), but appropriate approach to addressing HIV/AIDS in the Church and the communities the Church serves.

### 3.3.3 AN UPRIGHT AND TRUTHFUL CONSCIENCE MUST FOLLOW CERTAIN NORMS

Having examined the drivers of the HIV/AIDS epidemic and the sections on evil, suffering and death, we clearly see that sometimes HIV infection results from sinful behaviours and sometimes it is not a result of sinful behaviour. The Bible quite clearly tells us that illnesses are most often not punishment from God for sins committed, but rather are sometimes an avenue for God's love to be demonstrated (John 9:1-3). The Bible also quite clearly shows how much God loves all mankind; he sent his only begotten son to die for us so that, if we choose, we can be saved by Grace (John 3:16).

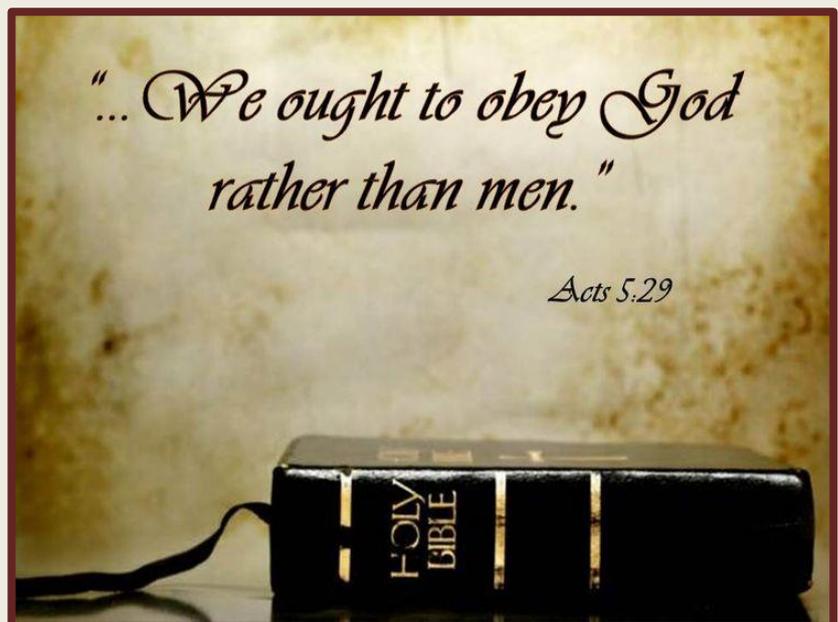
Our relationship with God is like the loving relationship between parent and child; God knows each one of us and cares for each one of us deeply – *“are not five sparrows sold for two pennies? Yet not one of them is forgotten by God. Indeed, the very hairs of your head are all numbered. Don't be afraid; you are worth more than many sparrows”* (Luke 12:6-7). We therefore see that:

- HIV/AIDS is often not a punishment from God for sins committed, and therefore we should never look down upon or discriminate against PLHIV, and consider them to be all sinners; and
- God's love and Grace is available for all who choose to be saved from sin, whether they have HIV infection or not.

A person who obeys his/her conscience (based on Christian moral principles) avoids sin at all costs and lives an upright life, will eventually receive what is good (Rom. 8:28; Prov. 34:14; 37:27). All those who do what is good and follow God's commands will be blessed (Ps.112:1-10). If we avoid sin, live an upright life and follow God's Commands, we will receive what is good and/or be blessed whether we have HIV infection or not, because God's grace is not dependent on HIV status.

Therefore the golden rule *“whatever you wish that men would do to you, do so to them”* (Matt. 7:12), must be evident in people's dealings with others; it must be evident in our dealings with PLHIV and those affected by HIV/AIDS.

Charity always proceeds by way of love and respect for one's neighbour and by listening to one's conscience, under the guidance of the Holy Spirit (1 Cor. 10:23-29). As Christians, we are called to remain true to the two greatest commandments that Christ himself gave us to love God and love our neighbours as ourselves (Mark 12: 30-31).



## TOPIC 3.4 - PROMOTE ECUMENICAL AND MULTI-DISCIPLINARY NETWORKING RELEVANT TO CHURCH AND COMMUNITY-BASED RESPONSES TO HIV/AIDS

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### TASK(S):

- As a Church-based organization giving Church-based responses to HIV/AIDS, why is networking outside the Church realm necessary?
  - Mention some of the multi-disciplinary organizations with which the Church can network.
  - Mention and discuss some of the HIV/AIDS programmes that the Church can do in collaboration with other stakeholders.
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### 3.4.1 WHY SHOULD WE NETWORK?

HIV/AIDS knows no boundaries: Christians and non-Christian alike are infected and affected. This means all the efforts towards reduction and/or elimination of HIV/AIDS, should come from both the secular and religious world.

Apart from 'spiritual nourishment', PLHIV need other services for them to live positive, healthy and fulfilling lives. While the Church can provide some of these services, it cannot always provide all, and PLHIV must look beyond the Church to access the services. In Zambia, there are many institutions (including the government) and organisations, with qualified professionals that provide HIV-related services that the Church may not be able to. It is therefore important for the church to network and make helpful linkages in order to:

- Ensure the Christians living with HIV/AIDS in their congregations and outside, receive the full continuum of care for their HIV infection, including spiritual care, and ensure that this care is coordinated, to provide the best support to the individual and ensure the best spiritual and health outcomes.
- Ensure that the Church stands ready to provide spiritual and other care (where feasible) to non-Christians, as part of its duty to expand Christ's healing ministry and bring solace and healing to all without discrimination, and also in order to win souls to Christ, as part of Christian evangelism.

### 3.4.2 INSTITUTIONS AND ORGANIZATIONS INVOLVED IN HIV/AIDS

Because HIV/AIDS is not only a health issue, but a social, economic and political issue, Zambia's response to HIV/AIDS is also a multi-sectoral response, calling on different institutions, organizations and players to provide a multi-component package of services, implemented by a multi-disciplinary teams and partners, which includes the following:

- HIV treatment and care facilities and professionals, both government and non-governmental, providing clinical care for HIV infection;
- HIV testing and counselling organizations/centres and psychosocial counsellors, providing HIV testing and support;

- Government institutions like the Ministry of Health, Ministry of Community Development Mother and Child Health (MCDMCH) and National HIV/AIDS/TB/STI Council (NAC) that provide guidance for and coordination of the national HIV response, and also provide most of the services;
- Legal and law enforcement like the Victim Support Unit (VSU) of the Zambia Police Service and Legal AID, that provide legal and other protective services to PLHIV and those affected by HIV/AIDS
- The Church and other religious entities and organizations, which provide spiritual care and support, and also sometimes provide other HIV-related services including home-based care, HIV testing and counselling, and HIV care and treatment.
- Advocacy and support groups that champion the cause of PLHIV and those affected by HIV/AIDS, including groups like the Treatment and Advocacy Literacy Campaign (TALC), THE Network of Zambians Living with HIV/AIDS (NZP+), and the Coalition of African Parliamentarians Against HIV/AIDS (CAPAH) – Zambia chapter.
- Local and International NGOs providing HIV prevention, treatment, care and support services such as the USAID-funded SHARe II project implemented by JSI, which provided support for the development of this manual and carries out other HIV prevention work.
- Donor agencies and other funding organizations that provide funding and technical support for HIV/AIDS programs including HIV treatment

### **3.4.3 WHAT PROGRAMMES SHOULD THE CHURCH PROVIDE AND HOW DO WE COLLABORATE WITH OTHER STAKEHOLDERS?**

The major limiting factors to the type and mix of programs the Church can support are competence, resources and capacity. Each Church group can determine what it is best positioned to provide, based on its competences, resources and capacities from this menu of HIV-related services:

- HIV Prevention Services: Including biomedical, behavioural and structural interventions (refer to topic 1.5, page 18 for the mix of HIV prevention services);
- HIV Care and Treatment: HIV clinical care, provision of ARVs and treatment of opportunistic infections
- HIV Support Services: Some HIV support services are intended to benefit PLHIV (e.g. support groups specific for PLHIV), while others are intended to benefit both PLHIV and those affected by HIV/AIDS (e.g. spiritual support and OVC support)

Whatever mix of services a particular Church group chooses to provide, it is important to understand that these services constitute a continuum of care and therefore complement each other. It is therefore important to create linkages that would allow the beneficiaries to access other related services with ease. For example, HIV testing and counselling services should provide linkages and referral to HIV prevention, care, treatment and support services.

## RECOMMENDED READING

Campbell, A. ed. (1987). *A Dictionary of Pastoral Care*. New York: Crossroad Publishing Company.

Muchiri, J. (2002). *HIV/AIDS Breaking the Silence: A Guide for Pastoral Caregivers*. Nairobi, Kenya: Paulines Publications Africa.

Patton, J. (2005). *Pastoral Care: An Essential Guide*. Nashville: Abingdon Press, 2005.

Slattery, H. (2002). *HIV/AIDS A Call to Action: Responding as Christians*. Nairobi, Kenya: Paulines Publications Africa.

## UNIT FOUR: PASTORAL CARE AND COUNSELLING

### UNIT PURPOSE

Pastoral care and counselling is a key aspect of the Church's response to the HIV/AIDS epidemic. In this unit, therefore the facilitator/instructor will focus on providing the learners with knowledge, attitudes and skills to enable them carry out their the pastoral responsibilities regarding pastoral care and counselling for persons infected with or affected by HIV/AIDS.

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### NOTE TO THE FACILITATOR/INSTRUCTOR:

Pastoral care and counselling should be holistic, i.e. it should touch every aspect of a human being: the physical, mental, emotional, social and spiritual. Pastoral Care is a continuation of Jesus' ministry of the sick and those afflicted with various ills, and so calls for empathy, compassion, sensitivity and humility. All the topics of this unit should help to bring about a care and counselling that will aid the infected and affected to move on with their lives despite the challenges of their situation.

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### UNIT OBJECTIVES

At the end of this unit learners should be able to:

- Understand the key concepts in pastoral care;
- Understand the role of pastoral care and counselling for people infected and affected by HIV/AIDS;
- Equip students with care and support skills for people infected and affected by HIV/AIDS;
- Equip students with counselling skills for people infected and affected by HIV/AIDS;
- Use counselling to impart hope and encourage positive living to people living with HIV/AIDS (and those who have tested negative to maintain their negative status);
- Equip students with knowledge to help support adherence to HIV treatment and care.

### KEY METHODS OF INSTRUCTION

- Lecture
- Role Play/Acting out
- Learning tasks/Group work/Plenary

### SUGGESTED TEACHING AIDS

- Flip Charts/Chalk Board/White Board
- Markers/Chalk
- Hand-outs/Charts/Graphs
- Overhead Projector

## TOPIC 4.1 - PASTORAL CARE/COUNSELLING

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### **TASK(s):**

Ask learners to discuss what counselling is within the scope of pastoral care and its relevance in light of the HIV/AIDS epidemic

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### 4.1.1 PASTORAL CARE

Pastoral Care describes ministry, whether provided by ordained or lay people that is concerned with the well-being of communities and individuals. Traditionally, the phrase is rooted within the Jewish/Christian Tradition, deriving from the image of the shepherd and the way he cares for the flock (Carr 1997). It is a continuation of Jesus' ministry as evidenced by Jesus' words of command to Peter: "...feed my lambs...tend my sheep...feed my sheep" (John 21:15-17). Jesus was already commissioning his disciples for the ministry which he was about to leave to them: that of caring for his flock not only in their joys but especially in their sorrows. It is based on this, that all pastors, priests and representative Christians are called to care for the flock entrusted to them in their congregations without partiality for one's differences, including HIV status.



The Ministry of pastoral care is based theologically on the Christian affirmation that God created human kind for relationships with Him and other creatures. Our human caring is based on God's care; we care for each other because God cares for us (Patton 2005). We care for each other, irrespective of HIV status.

- Pastoral care is the action of a community of faith that celebrates God's care by also hearing and remembering those who are in some way cut off from the faith

community (there are many reasons and circumstances that can lead to people being cut off, including their HIV positive status) as described by the image of the lost sheep in Luke 15 (Patton 2005).

- Pastoral care is a generic term used for all forms of pastoral caring roles performed by Christians. It seeks to fulfil the four pastoral functions of guiding, healing, sustaining/nurturing and reconciliation.
- Counselling is one of the many roles performed under pastoral care, other roles are: psychotherapy, spiritual direction, chaplaincy, care of the sick, etc. Counselling is an important component of pastoral care and is a viable tool in helping combat the HIV epidemic and alleviating the pain and suffering that PLHIV go through.
- Counselling, well understood within the scope of pastoral care, by pastors/priests/representative Christians, can be applied to the congregational context in a bid to support congregants in their various problems including those associated with the HIV/AIDS epidemic.

#### 4.1.2 COUNSELLING

Counselling is a relationship between two or more people, in which one person (technically called the 'counsellor') seeks to provide information, encourage, help and support another person, or persons (technically called the 'client' or 'counselee') to deal more effectively with the problems of life. Counselling is interdisciplinary which draws its practices from a wide range of disciplines including psychology, sociology and spiritual. Two key aspects of counselling are described below:

- Counselling is a changing and purposeful relationship between two (or more) people in which methods vary according to the client's needs. Both the counsellor and the client share together in this relationship which aims to help the client to understand his (or her) situation and decide what should be done.
- Counselling is a series of direct contacts with a person (or a group of people), with the aim of offering him (or her) assistance in changing attitudes or behaviour (Taylor 1983).

People seek counselling for various reasons so the role of a counsellor is to listen carefully, and respond sensitively, so that the client is enabled to express emotional and other dimensions to the presenting problem and is encouraged to accept potentiality for understanding self and autonomy in making decisions. The expertise of counselling lies in facilitating the process rather than providing direct answers or information (Campbell 1987).

Counselling can also be looked at as either 'secular' which is non-religious, drawing its perspectives from the way the world perceives issues or 'pastoral' which applies faith perspectives in its efforts to give therapeutic healing—drawing from Christian values as presented or commanded in scripture. It is on this basis that we have Pastoral counselling—the counselling done by the pastor/priest/representative Christian.

In HIV care, counselling is an important first step for people who wish to have an HIV test to know their HIV status. Counselling continues to play an important role in the lives of PLHIV and those affected by HIV, as they cope with HIV or the effects of HIV in their lives.

### 4.1.3 PASTORAL COUNSELLING

Pastoral counselling is a type of counselling that applies faith perspectives in therapeutic healing. Pastoral counselling draws its strength from Christian values as presented or commanded in scriptures. A few aspects are presented below:

- Persons and relationships are understood to be within the context of the Christian faith.
- Pastoral counselling requires knowledge, presence and guidance.
- Pastoral (Christian) counselling is distinct from secular counselling, because it rises to another dimension: "it looks deeper than the immediate circumstances of a person's life and reminds that person that he or she is a child of God created in and for a relationship with God," and so should be submissive to the will of God (Patton 2005).

Although Christian counsellors often use skills from the field of secular psychology and counselling, they recognize that the Bible is their final authority. Christian values then, in Pastoral counselling are cardinal. Despite their differences, secular and Christian Counselling share the same desire to help people overcome their problems and finding meaning and joy in their lives again. In both, individuals ultimately become healthy and well-adjusted people both mentally and emotionally; this is their major similarity.

### 4.1.4 CRISIS COUNSELLING

A crisis is an interruption of the ordinary. A crisis presents an intolerable difficulty that exceeds the person's current resources and coping mechanisms (James and Gilliliand 2001).

It is that moment when things can either get better or even worse. Families in this day and age will at some point or another be plunged into complicated issues that are critical in nature that nobody can predict, leading to inadequate mental or emotional unpreparedness, because there is no warning.

These crises may be medical as receiving doctor's report relating to cancer or HIV status. For example, loss of a loved one, a road traffic accident, attempted suicide or actual suicide, a robbery, a major illness or positive HIV test, are all crises. While a crisis cannot be prepared for and is unanticipated, there is need to have some preparations in place that can help in managing these critical moments in caring for those facing these crises through appropriate responses (Mottram 2007). A few aspects of crisis counselling are described below:

- Quick crisis intervention is required to help one who has suffered a crisis to quickly return to his/her emotional or physical functioning, thereby avoiding harm of self and others.
- When dealing with a crisis situation, a Counsellor needs first and foremost to calm the situation, bring sanity to the one affected before 'real' counselling can take place. This makes crisis counselling unique from other forms and types of counselling such as educational, supportive, preventive, confrontational and spiritual.
- Ensures the individual is stable and has a short-term plan which includes mastery of self and the emergency or disaster situation and helps connect the individual to formal and informal resources and support or helps the individual pursue potential natural supports/resources.

### 4.1.5 COUNSELLING ETHICS

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#### TASK(S):

- **Ask the question: What do you understand by the word 'ethics' in counselling?**
  - **Discuss: What is the role of the professional code of conduct?**
  - **Mention and discuss some counselling skills that you know. Facilitator/instructor can suggest elaboration of some of these skills by acting out.**
- 

Counselling (secular and pastoral) like every profession is guided by an ethical code of conduct within whose boundaries the counsellors operate. In Zambia, the Zambia Counselling Council (ZCC) has a professional code of conduct by which all counsellors operating in Zambia should abide. It is recommended that every counsellor operating in Zambia should be affiliated to ZCC (offices are at the University of Zambia, Lusaka Campus).

#### DEFINITION OF ETHICS

- The word 'ethics' comes from the Greek word, *ethos*, which means custom, and is defined as: "a set of moral principles of what is right and wrong; what human beings should freely do or refrain from doing." Donald Attwater (1997) continues to explain ethics as "a science which investigates the laws of right conduct."
- From the biblical perspective ethics are viewed in relation to the teaching of Christ on moral values and norms. The pastoral counsellor/caregiver therefore has on top of the ZCC ethical code of conduct to consider the Christian ethical values, as found in the Sermon on the Mount (Matt. 5-7); the Decalogue (Exod. 20:1-17); and writings of the Apostles.
- Some of the ethical issues in the ZCC are: confidentiality, rights of clients, client autonomy and safety of client (read the ZCC code of ethics for more details).

### 4.1.6 COUNSELLING SKILLS

A counsellor needs skills to be able to conduct a successful counselling session. Below are but a few definitions of what a skill is:

- The Longman Dictionary of Psychology and Psychiatry (1984) defines skill as "an acquired higher-order activity required to perform complex acts smoothly and precisely". It is an ability that can be obtained and that which requires training and practice
- Webster's New Collegiate Dictionary defines skill as "a learned power of doing something competently" (quoted in Egan, 1975). Egan explains that skills are physical, intellectual, and social competencies that are necessary for effective living in the areas of learning, self-management, involvement with others, and participation in groups, communities and organisations (1975).

### 4.1.7 THE BASIC COUNSELLING SKILLS

Effective counselling is rooted in two basic skills; attending and active listening skills.

**ATTENDING SKILLS:** These are relationship building skills: welcoming, establishing rapport (friendliness, courtesy) and appropriate use of body language. Good 'Attending' pays attention to someone's feelings and expresses awareness and interest in what client is communicating verbally and non-verbally.

**LISTENING SKILLS:** These skills involve listening to the words that are being said verbally or non-verbally; clearly or vaguely. They refer to the ability of counsellors to be able to capture and understand the messages the clients communicate as they tell their stories. This calls on the client to be present psychologically, socially and emotionally.

Active and effective listening should be purposeful, i.e. the purpose of listening is to understand the client better: his/her message, problem, feelings, deficiencies and strengths. The skill of listening is not just biased towards the client, but the counsellor has to also listen to himself/herself: own understanding of feelings towards the client and aspects of the presenting story. An effective counsellor should be neutral, appreciative and sensitive to the needs and aspirations of the client while at the same time recognising and addressing those feelings in a more constructive way.

#### 4.1.8 OTHER COUNSELLING SKILLS

##### Paraphrasing

Paraphrasing is defined as putting words said or written by someone else, into your own words so that the meaning is the same or interchangeable with that of the original speaker or writer. It is similar to rephrasing, to put it another way. In counselling, it is to say a statement of a client differently but without changing the meaning, for example:

**Client says:** *If I took my medication regularly, I would be feeling better by now.*

**Counsellor paraphrases:** *In other words you are saying you have not been taking your medication sometimes, and that is why your health is not improving.*

##### THE PURPOSES OF PARAPHRASING

- To convey that the counsellor understands the message of the client
- Help the client by simplifying, focusing and crystallizing what they said
- May encourage the client to elaborate
- Provide a check on the accuracy of the counsellor's perceptions

##### Summarising

In a summarization, the counsellor combines two or more of the client's thoughts, feelings or behaviours into a general theme. Summarization is usually used as a skill during choice points of a counselling interview in which the counsellor wants to draw connections between two or more topics.

Otherwise, when the client appears to be jumping from one topic to another without any particular focus or direction, a summarization can help the client to decide which topic is most important. Summarization is also used as a way to close a session. Summarising therefore covers a longer period of the client's discussion than paraphrasing.

### THE PURPOSES OF SUMMARISING ARE TO:

- **Start a session:** You may wish to structure the beginning of a session by recalling the high points of a previous session;
- **Consolidate the message of the client highlighting the main points:** It may help crystallize in a more coherent and integrated manner what the person has been talking about, and thus helps the person put facts and feelings together;
- **Review progress:** It frequently serves as a necessary perception check for you because it pulls together materials discussed over an extended period of time and allows the client the opportunity to clarify any misconceptions you have in your thinking about him or her;
- **Serve as a transition:** Plans for taking the next step in counselling require mutual assessment and agreement on what has been learned so far; and
- **End a session:** A client seems to have expressed everything of importance to her or him on a particular topic, and summarizing provides closure so you can move on.

### Challenging

Challenging is an invitation to examine internal behaviour that seems to be self-defeating and harmful. Although challenging and confronting are not associated with counselling *per se*, there are times when they are appropriate and even necessary, such as when clients fail to own the problem, fail to come up with a way forward, avoid reality of the problem, or when they are hesitant and unwilling to co-operate with the counsellor's efforts. Without question, challenging in counselling can be challenging not only for the one counselled, but also for the counsellor.

Because challenging is about bringing into focus discrepancies in the client's feelings, thinking and behaviour that they are tending to overlook or ignore, it is best done sensitively and respectfully. Uncomfortable as challenging is, in the final analysis you are trying to help the client—if you share or fail to effectively deal with the client's blind spots and distortions, you may end enabling them to avoid issues, and fail to help them.

### Probing

Probing means asking the client for additional information—this is useful when dealing with clients who do not demonstrate willingness to explore their problems or behaviours freely. Probes and prompts are used to encourage such clients to open up.

Effective probing is non-judgemental, and flows from what was previously said. Good probing questions ask for elaboration, classification, and repetition, thus helping the client to fill in missing pieces. They can take many forms:

- **STATEMENTS:** *'It is not clear to me which of these two options you would choose';*
- **REQUESTS:** *'Tell me what you mean when you say that there is a crowd at home';*
- **QUESTIONS:** *'Now that you have decided to take early retirement, do you have any plans?' 'What do you really want to do?'*

Probes can be minimal e.g.: *uh-huh, hmmm, yes, I see, ah, oh, etc.* (in agreement or urge one to talk more). They can also be non-verbal e.g.:

**Client:** *'I do not know if I can tell you this, I have not told anyone.'*

**Counsellor response:** *Maintains good eye contact and leans forward a bit (a posture that persuades client to say more).*

## Clarifying

This is an attempt to focus and understand the basic nature of the client's verbal content. It addresses the question: *What is really the problem? What is the client trying to say?* The purpose of this skill is to help the client discriminate specific issues from assumed issues of any given problem which may be precipitated by internal (e.g. anxiety) and external factors.

## Questioning

Questioning in counselling is inevitable. There are 'closed-ended' and 'open-ended' questions. Closed-ended questions are questions which invite 'yes' or 'no' answers or very brief answers, e.g. *What is your name?* Answer: *Mary*. To know more about Mary, you will have to ask many more questions which may seem interrogative.

Open-ended questions are those questions that clients cannot easily answer with "Yes," "No," or one or two-word responses, e.g. *Can you tell me about yourself?* Answer: *I am Mary, married with three children; I live in Woodlands, etc.* They are an invitation to talk, to explore. Always use appropriate questions and ask one question at a time.

### 4.1.9 THE COUNSELLING PROCESS

A counselling process is a way in which counselling is conducted. It has three stages each with an ultimate goal (Egan 1975).

**CURRENT SCENARIO:** This is an information gathering stage whose goal is to identify the problem in order to set the stage to helping the patient deal with the problem.

**PREFERRED SCENARIO:** The problem having been identified, exploration of options follows. The counsellor helps by informing the counselee so that they may pick an option that will be helpful according to the presenting problem to enable them live their lives to the full.

**STRATEGY/ACTION PLAN:** The option has been picked by the client (counselee). At this stage, modalities or plans of how this will be executed will be mentioned by the client. Remember, modern day counselling favours non-directive method of counselling which does not give advice but instead respects the clients' autonomy to come up with a solution to their own problem—by allowing this process, the counsellor helps the clients to grow.

In addition, the following five steps are present in every counselling process, and the important tasks of counselling that need to be performed:

1. **Relationship Building:** Relationship building is the establishment of a therapeutic relationship between the counsellor and the client, and the development of rapport between the two. To enhance the right kind of relationship, counsellors must be there for their client. They need to be healers of the mind and emotions, and they need to make their client feel secure. Counsellors must be non-judgemental and flexible. They must be facilitators of change. Whenever possible, the counsellor should provide a model for the client as the client goes about effecting the desired change in his/her life.

2. **Assessment:** The second important stage in the counselling process is assessment, which is the process by which the counsellor determines the client's psychological status. To learn more about his or her client, the counsellor must use techniques such as observation, interviewing, obtaining life history data, performing standard assessments and making clinical judgments (Waehler and Lennox 1994). It is important to understand that assessment continues throughout the treatment period.
3. **Goal Setting:** The third stage of counselling is goal setting. Goal setting is highly important to the counselling process because it is at the foundation of the counselling process – if cognitive and behavioural changes do not occur in the client over the course of the counselling sessions, then those sessions will have been a failure. The counsellor should help the client set the right kind of goals; to do that, the counsellor must be able to quickly and accurately assess the client's problem(s) and then assist him or her in finding the right solution(s). The goals should be specific, measurable, realistic, achievable, time-specific, psychologically and emotionally healthful, and arranged in their order of importance, and once the goals have been agreed and established, the client must accept responsibility and assume ownership for them (Hawkins 1987).
4. **Intervention:** The fourth stage of the counselling process is intervention, which is the step where the counsellor assists the client reach the aforementioned and pre-set goals. The counsellor should set an atmosphere of trust for the client, one where the client can both feel trusted and also trust him or herself and the counsellor in making the correct decisions. Once the client has begun to meet or attempt to meet the established goals, the counsellor and client need to frequently evaluate the client's progress and make changes, when necessary, to get back on track (Kotler and Brown 1992).
5. **Termination:** The final stage in the counselling process, which is a time for "reviewing and dissolving the counselling relationship. The counsellor must know when the counselling process is complete. She/he needs to realize when the goals of the sessions have been accomplished, or in some cases, when all that can be done has been done.

## TOPIC 4.2 – COUNSELLING PLHIV AND THOSE AFFECTED BY HIV

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### TASK(S):

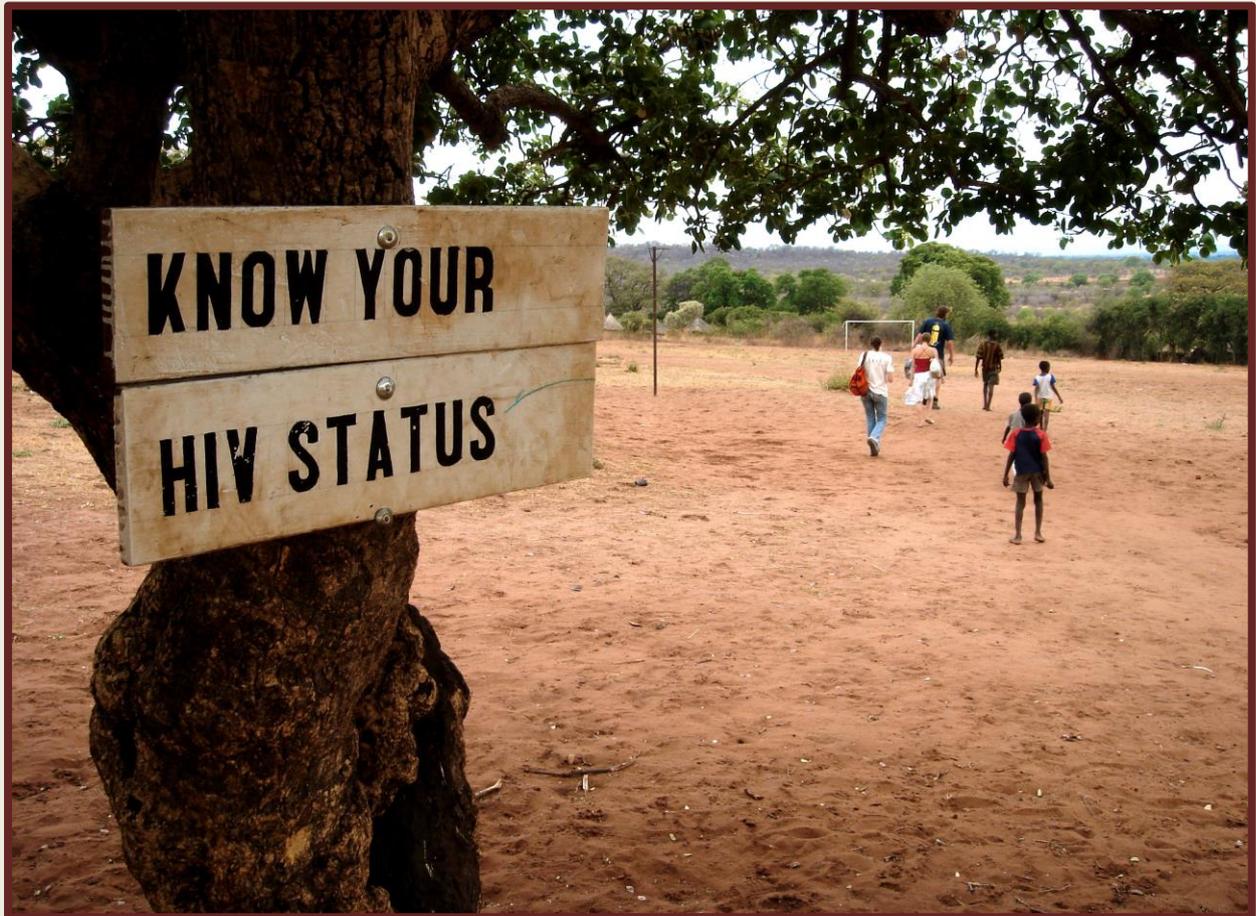
Ask learners to discuss the question: **What is the importance of Counselling in the context of HIV/AIDS.**

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Because HIV/AIDS is a serious chronic (long term) condition, that has physical, mental, emotional and psychosocial effects, counselling for HIV infection is very important. For this kind of counselling (or indeed any other form of counselling) to be effective and yield the desired results, it has to follow a particular format.

### 4.2.2 HIV TESTING

HIV testing is important. It is the only sure way to detect the presence of HIV antibodies in a person for “you cannot tell by looks alone”. Unit One emphasises this aspect. HIV testing should be voluntary. There are two types of counselling needed for HIV testing: Pre-test and Post-test counselling.



### **Pre-test Counselling**

This is counselling done before one tests for HIV. This counselling session prepares the person who is about to be tested, providing him/her with knowledge on HIV/AIDS including on aspects like the HIV window period, the psychological implications of receiving results, particularly if they are positive, and disclosure if they choose to disclose.

### **Post –test Counselling**

This is done after the test, to prepare client to receive the results whether positive or negative. It seeks to help a client to deal with their emotions in either result. The counsellor briefly reviews the pre-test knowledge on HIV/AIDS with the client. If the client understands what HIV is and the healthcare and support available for PLHIV and the affected, he/she is more likely to be receptive and cooperative in the efforts of the caregivers.

### **HIV Test Results**

In Zambia, HIV test results, whether positive or negative, shall be given only in person when post-test counselling has been provided. Informing clients of their test result by telephone or other media is not recommended, but where unavoidable, should be undertaken with caution according to the guidelines on HIV/AIDS Counselling in Zambia (MOH 2006). Individuals who test HIV negative should receive support and guidance to remain negative and linked to services such as VMMC for HIV negative men. Individuals who test HIV positive should be referred to early HIV care, treatment and support.

## Positive Living

For a person who is HIV positive, this refers to the steps in life that one can take to move on with life and make the best out of the challenges and opportunities presented by HIV infection. Being HIV positive is no longer a 'death sentence' for although there is no known cure, ART assists PLHIV to live long and healthy lives.

### 4.2.3 HIV DISCLOSURE

Disclosure of HIV sero-status is one of the most difficult decisions a person living with HIV has to make. In Zambia, disclosure of HIV infection is not mandatory; in most cases the decision to disclose or not disclose is entirely up to the person living with HIV. PLHIV have real fears about how others, including those very close to them, will treat them if they know they are living with HIV. In settings where stigma and discrimination are prevalent disclosure of HIV positive sero-status becomes very difficult" (Waehler and Lennox 1994). However, in Zambia and a number of other countries, wilfully infecting a sexual partner with HIV is a punishable criminal offence.

PLHIV should not be pressured to disclose HIV sero-status; rather they should be assisted to disclose HIV status, and only when they are ready to do so. Disclosure is important for the following reasons:

- **Love and Support:** Disclosure helps to provide a supportive environment for the individual living with HIV so that they do not have to deal with their HIV infection alone and in isolation. If the individual is on ART, those to whom they have disclosed can provide adherence support as they take their ARVs, and encourage them to live positively. Apart from being a source of love and support, if the family is aware of the status of their relative, they will put in every effort to ensure everything needed for the infected member of the family is provided such as appropriate nutrition; making sure the patient receives treatment for any opportunistic infections and accord the infected rest from strenuous duties.
- **HIV Prevention:** Disclosure protects the uninfected members of the family, enabling them to take precautions as advised by medical personnel on how best to avoid exposure to HIV as they live with and offer their caring services to their loved one living with HIV. Disclosure to current and former sexual partners allows them to make decisions about HIV testing so that they too can know their status and take appropriate HIV preventive actions, or get linked to care and support in a timely manner if HIV positive.

The client should be made aware of the advantages and disadvantages of disclosure so that they are prepared for any eventualities, such as being stigmatised and discriminated against. On the positive aspect, however, they may be embraced and empathised with making the burden of their HIV infection lighter.

Isolation and secrecy in dealing with a positive HIV result is detrimental to the client's physical, biological and psychological health. The client should be made to understand that his/her caregivers, who may include family members, will provide efficient care only if they are aware that he/she is infected (Zambia Counselling Council 2007).

#### 4.2.4 LEGAL AND ETHICAL ISSUES

The ethical issues outlined in the Counsellors' Professional Code of Conduct written by the ZCC and other writers in the field of Psychology and Counselling, have to be adhered to. Counsellors who fail to conduct themselves appropriately and within their jurisdiction may be subject to reprimand and corrective action by the ZCC and other entities, and may also face legal action by the client.

#### 4.2.5 CARE FOR THE CAREGIVER

Who cares for the caregiver? Although this is an important question, it is rarely paid attention to. Caregivers, including counsellors, need care and counselling too, to be able to release the stress of the demanding work that they do. They usually work with people who are very sick, irritable and hard to please. Relaxing with other caregivers now and again discussing some of the stresses/challenges being encountered and listening from others can help bring the stress levels down. Those caregivers and counsellors who have to deal with the stages of care where catharsis is a significant part of the process will need this general support interaction, and in addition, counselling from counsellors.

Caregivers can also receive practical support from volunteers who go into the home regularly to allow the caregiver to shop, go to school, go to church, or just get a complete break. Pastors, elders and Church members can offer encouragement, prayer and counselling (Garland and Blyth 2005).

### TOPIC 4.3 - PRE-MARITAL COUNSELLING

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#### **TASK(S):**

**Ask learners to discuss what premarital counselling is and why it is necessary**

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Pre-marital counselling is a type of counselling done before marriage and aims at sensitizing the youth and adults not yet in marriage of the expectations, fruits and challenges of marriage and especially emphasizing the sacredness of the sexual act which is reserved only for those who in the eyes of God declare their intentions to live their marriage state according to God's design (Heb. 13:4).

Premarital counselling in the context of HIV/AIDS is critically important because it sets the groundwork for HIV prevention through mutual fidelity and faithfulness, which is the cornerstone of the Church's message about HIV prevention. Premarital counselling in Zambia, due to the high HIV prevalence, must bring up the issue of HIV/AIDS and HIV testing and counselling. It is important for the couple to know their HIV status so that they can make appropriate decisions about HIV care and treatment if one or both are positive, and HIV prevention if one or both are negative.

In the case of HIV discordancy, the HIV positive partner has to go on ART in order to protect the HIV negative one. In addition, some Christian Churches would recommend using

condoms once the two are married, in order to further protect the HIV negative partner. The topics below should all be highlighted during pre-marital counselling.

### 4.3.1 SANCTITY OF SEX

God created the bodies of both man and woman, including their sexuality with great care. It was God's plan for ensuring that the human race would continue to multiply on earth (Gen. 1:28). However God wanted sexual relationships to be more than a means of bringing new life into His creation but something to be seen as a blessing through which a man and woman experience sexual pleasure and joy within marriage. When a man and woman get married they give their bodies to each other as a gift and this is God's plan regarding sex (Prov. 5:18-19; Song of Sol. 7: 1 Cor. 7:1-5; Ps. 139:14). Sex is not for those outside marriage.

### 4.3.2 FIDELITY AND INFIDELITY

**FIDELITY:** Fidelity is the quality or state of being faithful, loyal or devoted to uphold one's marriage vows. It is the adherence of a man and woman to the teaching of the Bible that sex shall be practiced only within the marriage relationship and with one's wife or husband.

**INFIDELITY:** Infidelity refers to marital unfaithfulness, disloyalty to a marriage partner. Both husband and wife must not be insensitive to the ultimate dangers and harms that infidelity will bring into their relationship and family. (Prov. 5:18-19; 1 Cor. 7:1-5).

Multiple and concurrent partnerships (MCPs), which from the Christian perspective are in the form of fornication or adultery, are a major driver of HIV in Zambia. The Christian teaching and practice of fidelity within marriage is an important aspect of HIV prevention for married Christians, and dovetails with the edicts of the national HIV response to stick to one mutually faithful sexual partner.

### 4.3.3 OPEN COUPLE COMMUNICATION ON SEX

Sexuality pervades many aspects of life and is also a subject that is greatly misunderstood. In this sexuality-charged society it is important that those intending to marry have opportunity to talk about sex and issues related to it openly so that they will build and have values that are appropriate and consistent with the teaching of the Holy Scriptures. Misinformation is the basis of many sexual problems and so the acquisition and sharing of accurate information openly will prevent difficulties. This information can be in four areas:

- The Biblical teaching about sex
- Basic facts about male and female anatomy and physiology
- Information about techniques of intercourse
- Teaching on healthy sexual attitudes

With appropriate grounding of couples on the issues of sex and sexuality, and the importance of communication on these issues, the Church begins to build couples and families who are equipped to deal with some of the challenges of living in today's world, including the challenges that the HIV epidemic presents. A couple that communicates on

sexual matters can make decisions together to prevent HIV. A couple that communicates on sexual matters can provide mutual support for HIV care and treatment, including on decisions related to family planning and reproductive health.

#### 4.3.4 ABSTINENCE

Abstinence is the discipline or practice of restraining oneself from something which one desires or wants. With regard to sex it is refraining from sexual relations.

Primary abstinence is refraining from sexual relations for someone who has never had intercourse: that person is a virgin. Secondary abstinence is refraining from sexual relationship for someone who has had previous sexual relations and maybe permanent or temporal. If one desires to pursue sexual purity before marriage or re-marriage in case of widows or widowers, then a commitment to abstinence shall be a worthy goal.

From the HIV prevention perspective, abstinence is the only failsafe way to prevent sexual transmission of HIV. Individuals who are HIV negative cannot be infected with HIV through sexual intercourse if they abstain from sex, and individuals who are HIV positive cannot pass on HIV to others sexually, if they abstain.

Sexual abstinence outside marriage and faithfulness within marriage, are the cornerstones of HIV prevention for Christians. The Bible does not sanction sex outside marriage; it is a sin.

### TOPIC 4.4 - MARITAL COUNSELLING AND HIV/AIDS

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#### TASK(S):

- Ask learners to explain why they think it is important to invest much time in helping families through their different stages of the adjustment of married life.
  - Ask the learners to discuss some likely issues that couples may bring to the counselling session.
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#### 4.4.1 COMMUNICATION IN MARRIAGE

The greatest cause of sexual problems in marriages can be attributed to misinformation, misconception and taboos. Sex education and communication on this subject by couples is usually left to be drawn from all kinds of unreliable sources, because discussion of matters related to sex is often culturally taboo.

Knowledge about sex and other relational issues within marriages must be gathered from authentic sources such as the Church marriage animators/Counsellors whose values are drawn from the Bible and the *alangizis* (traditional culture initiators) who are encouraged to pick out the positive aspects that don't 'clash' with Christian values. Couples must then communicate with each other so that they will appreciate their sexual and gender roles and make adjustments that will lead them to find satisfaction in their relationship.

A Christian couple that has healthy sexual communication within their marriage stands a greater chance of meeting each other's sexual needs and successfully working on the areas

where they have problems, than a couple that does not communicate about sexual matters. Poor communication on sex and other sexual matters is the cause of many sexual problems that later lead to infidelity and/or MCPs, putting the couple at risk of HIV infection.



#### 4.4.2 SEXUAL SATISFACTION AND DISSATISFACTION

The clearest description of sexual satisfaction perhaps is what we find from the Song of Solomon. In vivid poetic language the book describes the pleasures of physical sex between married lovers. The descriptions are explicit but not offensive (Song of Sol. 7:1-10). The same is true of Proverbs (Prov. 5:18-19) from where we read: *“May you rejoice in the wife of your youth, may her breasts satisfy you always, may you be captivated by her love.”*

However, sex within marriage may at times not be consistently exciting or pleasurable and there are numerous reasons that might cause this to occur and lead the couple to seek help through counselling. Reasons are many and may include illness, stress and consistent absence of a spouse, which leads to lack of intimacy.

Whatever the cause, the Church needs to stand ready to provide guidance and counselling to couples facing sexual dissatisfaction in order to help the couple stay faithful to one another, as infidelity (including MCPs) will put them at risk of HIV infection if negative, or put others at risk of HIV infection, if positive.

#### 4.4.3 ADULTERY

Whenever the Bible speaks approvingly about sex, it refers to the fact that sexual relations shall be practiced by two people a man and woman who are in marriage. Thus, adultery

speaks or concerns sexual intercourse by a married person with someone other than their mate. This is also known as extra marital sex. The Bible forbids adultery and strongly condemns it because it inflicts and causes emotional injury to those involved.

Not only does adultery risk introducing HIV into the household, it's a major threat to the family (Matt. 5:27-28; 1 Cor. 6:9-11; Prov. 6:23-29; 32-35). The danger of activities like adultery is that in a married couple, even if only one party of the couple introduces the risk to HIV, both parties are at risk because "your sexual partner's HIV risk actually becomes your HIV risk, even if you yourself are faithful.

#### **4.4.4 SEXUAL ABUSE**

Sexual abuse may be explained as forced involvement in sexual acts, or sexual mistreatment. It may also include exhibitionism, forced intercourse, or other behavior which the victim resists, or the fondling of sexual organs of a minor or other person who is naïve or powerless to resist. To this we could also add rape (Including marital rape), all forms of sexual exploitation such as forcing powerless victims into prostitution or production of pornography (Collins 1988).

Apart from other broader implications and effects, sexual abuse which involves physical penetration and/or physical trauma (particularly where there are cuts and bleeding) carries a risk of HIV infection. The presence of STIs or lesions in the attacker or victim increases risk of HIV transmission. Children are at higher risk of HIV infection because sexual abuse of children often causes significant trauma (cuts, bruising, etc.) and often multiple episodes of abuse have taken place before the abuse is discovered.

#### **4.4.5 DISCORDANCE**

HIV discordant couples are those where one partner is HIV-infected and the other is not, where couple is defined as two persons in an ongoing sexual relationship and each of these persons is referred to as a partner in the relationship. Discordance is therefore the presence of HIV in only one partner in a couple. Discordance is discovered after a couple has gone through HIV testing. Pre and post HIV test couple counselling is required to discuss this possibility, and lay ground for handling this development. In Zambia, HIV discordance occurs in about 12% of couples who go for couple HIV testing and counselling.

HIV discordancy raises many complex issues in couples intending to marry or in married couples. In a study done in Uganda misconceptions about discordance were widespread among clients and counsellors. Common explanations included: the concept of a hidden infection not detectable by HIV tests, belief in immunity, the thought that gentle sex protected HIV-negative partners, and belief in protection by God. Some of these explanations for discordance reinforced denial of HIV risk for the negative partner within discordant couples and potentially increased their risk of later acquiring HIV infection and testing positive (Bunnell RE et al, AIDS Care 2005).

In any discordant couple, negotiation of sexual relations is the most formidable challenge. In Zambia, HIV testing and counselling guidelines provide protocols that the counsellors can use to discuss discordancy with affected couples which clearly explain discordance,

emphasize that there is high risk of HIV infection in the negative partner in discordance, and provide guidance on and linkages to risk reduction strategies and services such as ART for the HIV positive partner and condom use (for the Church, this applies for those denominations that recommend condom use for discordant couples within the marriage setting). In the final analysis, it is the couple that has to make the decisions that make sense for their situation, based on correct scientific information.

Often when information is insufficient and/or incorrect, that is when couples find themselves in difficulties over HIV discordance, and split up. When counselling is grounded in the Bible and sufficient information is provided, couples are often able to move past the presence of HIV infection in their union and take measures to protect the HIV negative individual and collectively make decisions that will ensure they emerge from the HIV situation stronger and more united.

#### 4.4.6 MARRIAGE IN A HIGH HIV-PREVALENCE ENVIRONMENT

HIV/AIDS is an undeniable reality. Couples should be counseled about HIV/AIDS and should acknowledge that HIV is truly present among us and appreciate the life-giving message of faithfulness to their spouses and respect for the sexual act without any abuse of it. Sexual dissatisfaction in marriage can lead one partner to seek sexual encounters elsewhere which will be adultery thereby exposing couple to HIV. Sexual abuse, especially forced intercourse can bring about cuts and bruises in the genitalia giving the virus an entry point for infection.

Communication in all aspects of marriage is important for a couple to lead a happy HIV free marital relationship. It is also important for the Counsellors in marital counselling to sensitive couples on the many negative cultural practices that may expose them to contracting HIV, e.g. beauty tattoos, using breast milk to squeeze into the genitals of baby girls and boys to supposedly “sweeten” them, dry sex, etc. (see appendix 4 – Traditional and cultural practices which drive HIV infections in Zambia).

### TOPIC 4.5 - FAMILY COUNSELLING AND HIV/AIDS

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#### **TASK(S):**

**Discuss with the learners possible difficulties that often arise after marriage, including HIV-related difficulties, and how these difficulties may be overcome and keep the marriage and family alive and glowing.**

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#### 4.5.1 DISCLOSURE OF HIV STATUS TO CHILDREN AND FAMILY MEMBERS

A difficult situation that any parent will face is when, if, and how to tell their children and family regarding their own HIV status or that of their child or any other family member. Children and other family members possess varying abilities to cope with crises such as HIV infection depending on their age and circumstances.

It is therefore best that one is frank with this process of disclosure as even young children will do well with more information than the opposite. Sensitivity should be exercised as to

what this news will bring in the life of the children and family hence the need for counselling. When in doubt, seek professional help; there are child counsellors who can help in the disclosure process.

#### **4.5.2 COUNSELLING AND THERAPY FOR TRAUMATIZED CHILDREN**

It is important that the necessary information, support and guidance be provided for vulnerable and traumatized children such as children who have been raped. However it should be recognized that children have different abilities, and comprehend issues affecting their welfare and health differently. These children should be counseled and encouraged to test for HIV through their parent or guardian.

Particular attention should be paid when dealing with adolescents as this stage of life is already a very highly emotionally charged time, which the added dimension of sexual abuse or other trauma complicates. In provision of counselling to children and adolescents the autonomy and well-being of the children shall be taken into consideration. This requires careful balancing of the needs of the child with those of the adults in their lives.

#### **4.5.3 DENIAL AND ACCEPTANCE**

HIV denial is common and sometimes is part of the normal process as one goes through acceptance of their initial diagnosis. Denial should not persist or it will potentially interfere with the individual's ability to get the much needed treatment and support as well as the wellness that accompanies their overall health.

Denial will also prevent an individual from taking the necessary precautions to prevent the spread of infection to others. Meanwhile acceptance will bring about positive outcomes as an individual will access the much needed treatment and ultimately take precautions to prevent the spread of the infection. It should be known that the longer one waits to accept and positively deal with HIV diagnosis the more the danger they create for themselves and their loved ones, and others.

Acceptance allows one to seek HIV care, treatment and support so that their HIV infection is treatment and controlled, and they live a healthy life with all the support systems from family Church and community in place. Acceptance also allows one to take measure to prevent transmission of HIV to others.

#### **4.5.4 HEALING AND LIVING WITH HIV**

HIV has been with us for some time now and no cure has yet been found. Many years ago when one was diagnosed with HIV it meant you were close to death. However, people are now living long and healthy lives with HIV.

Even though no cure has been found yet, PLHIV are able to stay healthy and cope with the infection. Counselling should help a person to accept their HIV status and to adopt a healthy life style that includes regular medical check-ups. Today HIV can be managed and a person can live a long healthy life with HIV.

## TOPIC 4.6 - COUNSELLING THE STIGMATISED AND DISCRIMINATED

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### TASK(S):

- Ask learners to discuss areas where they feel that those infected with HIV are stigmatized and discriminated.
  - Ask how learners can help come up with HIV, Care and Support ministries to help those infected, stigmatized and discriminated.
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### 4.6.1 DEFINITION OF STIGMA AND DISCRIMINATION

Stigma is defined as a set of negative and often unfair beliefs that a society or group of people have about something. Sociologists have taken this a bit further - in a seminal study on stigma in 1963, stigma was defined as “an attribute that is seen as deeply discrediting to a person or group” (Aidsmap 2005). Those attributes could be illness, physical deformity, aberrant behavior or social group (based upon religion or ethnicity, etc.). Stigma lets people or groups see differences of "others" in a negative light while confirming their own sense of normalcy and decency. Subsequent researchers have viewed this more as a social process that creates or perpetuates social inequities and which is used to legitimize discrimination.

### 4.6.2 HIV RELATED STIGMA AND DISCRIMINATION

HIV-related stigma is a process whereby people living with or associated with HIV are discredited, devalued, or treated differently because of their HIV status. When stigma is acted upon, the result is discrimination. Discrimination is therefore related to stigma, and it is the unfair and unjust treatment of an individual based on his/her real or perceived HIV status or HIV association. Leaders who have counselled people living with HIV will know and understand that HIV infection is one of the most isolating illnesses, and this largely because HIV-related stigma and discrimination are still very prevalent.



As previously discussed, HIV-related stigma and discrimination severely hamper efforts to address the HIV/AIDS epidemic in Zambia. Fear of discrimination often prevents us from seeking HIV counselling and testing; it prevents us from seeking HIV treatment; it prevents

us from freely taking our ARVs and it prevents us from disclosing an HIV-positive status. Fear of stigma and discrimination has also undermined the ability of individuals, families and communities to protect themselves from HIV and to provide support to PLHIV and/or those affected by HIV, by perpetuating the wall of silence and shame that surrounds HIV infection.

### 4.6.3 FORMING SUPPORT GROUPS FOR PLHIV

The formation of support groups has important benefits for PLHIV as individuals and communities. Experience will indicate that these kinds of involvement, especially if it comes after a period of feeling hopeless and depressed, builds up a person's motivation to live and live positively. Involvement gives HIV-positive people support and can empower them in ways that increases the value of their self-worthiness and continued contribution to their families and community. Furthermore, Churches through partnering and being open to PLHIV can minister to their spiritual needs. Assisting PLHIV can take many forms, including visitations, financial assistance, training family members in caregiving etc.

### 4.6.4 LOVE, CARE AND EMBRACING OF PLHIV AND THOSE AFFECTED BY HIV/AIDS (PRACTICAL PASTORAL CARE)

Those infected/affected with HIV deal with a variety of issues such as social isolation, rejection by friends and family, prolonged periods of illness, fear of what tomorrow will bring, the sometimes negative reactions of the religious community, reproductive decisions, guilt and grieving. As givers of pastoral care, we need to recognize these issues and help people as they work their way through them. We also need to educate our community about HIV/AIDS so that it may respond supportively.

## TOPIC 4.7 - BEHAVIOR CHANGE COMMUNICATION AND SUPPORT

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### TASK(S):

- Ask learners to describe what behavior is and its impact on the HIV/AIDS epidemic.
  - To curb the HIV/AIDS epidemic, there is need for change of behavior from negative to positive (highlighting examples and where possible acting out for more elaboration).
  - Ask learners to discuss what some of the challenges for behavior change would be.
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### 4.7.1 BEHAVIOR CHANGE

Behavior change refers to the adoption of new, healthier life styles that replace risky habits and attitudes. Behavior change is a cornerstone of HIV prevention. It refers to a process of individuals adopting and maintaining positive health behaviors and discarding harmful ones. Behavior change is an important component of health education. It addresses the issue of why people continue to be infected and affected by HIV/AIDS/STIs, even when they have necessary knowledge.

## 4.7.2 WHAT SHAPES BEHAVIOR?

The **nature** versus **nurture** debate is one of the oldest philosophical issues within psychology. Nature refers to all of the genes and hereditary factors that influence who we are – from our physical appearance to our personality characteristics. Nurture refers to all the environmental variables that impact and influence who we are, including our early childhood experiences, how we were raised, our social relationships and our culture.

In most cases, the interaction of hereditary and environmental shapes behavior. Some of these factors are discussed below:

### Hereditary or Genetic Factors

Heredity is the transmission of genetic characters from parents to offspring. Hereditary or genetic factors are those behavioral traits and attributes that are mainly inherited and passed on from one generation to another. For example a person with a facial tic or a mole that is similar to one that a parent or grandparent has, is considered to have inherited the genetic information that led to the particular behavioral or physical characteristic.

### Social Factors

The social factors that shape behavior are usually learned or copied from parents, peers, teachers, neighbors and other individuals (celebrities, movie stars, sports men etc.); these people have potential to influence behavior in a significant way.



### Religious Factors

There are many factors that lie in this realm such as heaven, hell, witchcraft, etc. that will compel people to adopt certain life styles consistent with their beliefs or persuasions, some of which are harmful. Harmful religious practices in relation to HIV/AIDS include encouraging PLHIV to abandon HIV treatment or ART on religious grounds, and thus putting their lives at risk.

### Cultural Factors

Cultural norms have a powerful influence on individual behavior, and can compel one to adopt helpful and/or harmful behaviors in order to conform to the dictates of their cultural environment. Harmful cultural practices in relation to HIV/AIDS include spouse inheritance, sexual cleansing, dry sex and sex with infants/virgins in the belief it will cure of HIV.

## 4.7.3 BEHAVIOR CHANGE COMMUNICATION (BCC)

Behavior change communication promotes positive health behavior for prevention of HIV infection among different target audiences in the society. Behavior change among individuals and communities is achieved through a combination of communication approaches and strategies/interventions.

Behavior change interventions and communications therefore refer to an interactive process using behavior change interventions and communication approaches to develop, promote and sustain positive behaviors in individuals and communities. BCC service delivery focuses on the use of a variety of targeted messages and campaigns.

Mediums for BCC include drama, poetry, story-telling and songs in addition to traditional print and audio mass media (newspapers, billboards, radio and TV). Behavior change interventions and communications have many inter-related roles for HIV prevention which include:

**CREATING AWARENESS:** Increasing knowledge and changing attitudes and practices among various target audiences. The changes that take place at different levels of the behaviour change continuum help to create demand for the utilization of HIV prevention, care, treatment and support services.

**STIMULATING COMMUNITY DIALOGUE AND PARTICIPATION:** in this situation, behaviour change efforts aim at strengthening community structures to be able to guide community discussions on the negative and positive social norms, values and risk factors to HIV transmission. The discussions encourage positive social norms and values and help identify risk reduction and avoidance strategies to address HIV infection.

**PROMOTING COLLABORATION AMONG STAKEHOLDERS:** Behaviour change interventions and communication efforts strengthen coordination and collaboration mechanisms among key strategic partners for wider participation, provision of services and support of HIV prevention initiatives.

**PROMOTING ADVOCACY FOR SUPPORT OF PREVENTION INTERVENTIONS:** Behaviour change interventions and communication efforts aim at lobbying and creating a conducive and supportive environment to facilitate change of behaviour by targeting policy makers and social leaders at national and district levels to support HIV prevention initiatives. Leaders hold the key to programme success and their support and commitment are essential to the achievement of prevention goals.

The effectiveness of BCC will depend on a variety of factors including the ones highlighted below:

- Communicating accurate and relevant information about how to prevent HIV infection and delay the onset of AIDS in a manner that is easily understood by and emotionally comfortable for the intended audience.
- Stimulating the communities' initiation of response activities including community participation in education and advocacy.
- Building the capacity of communities to provide environments conducive to HIV prevention, treatment and related care.
- Motivating individuals' desires to adopt behaviours that protect themselves and others from HIV infection and related illnesses.
- Enabling individuals with the skills for performing HIV-protective behaviours both in sexual relations and in the provision of care for PLHIV.
- Creating an institutional culture that relies on evidence-based planning for the HIV and AIDS response.

#### 4.7.4 COUNSELLING FOR BEHAVIOR CHANGE

The broader counselling stages and steps have been discussed above. The following is a helpful approach in counselling intended to achieve behavior change through behavior change communication. Ensure that:

- The counselee gives attention to the message being communicated and understands the message.
- Steps are taken leading to change in attitude that will ultimately impact on the behavior of the counselee.
- Social support systems are in place to help the counselee overcome social influences that may lead to failure to maintain healthy behavior. Thus the counselee should be primed or prepared to positively deal with negative social influences.
- The counselee has an opportunity to increase their self-confidence as they learn new behavior patterns.
- There is support for the behavior change by getting feedback and appropriate support and encouragement.

#### 4.7.5 BEHAVIOR CHANGE CHALLENGES

In any change process, there are often challenges that might impede progress. If these challenges are anticipated and planned for, the change process moves more smoothly and faster. The following are some of the challenges that may be encountered during behavior change processes:

- Counselees may find it easier to do what they have always done than make the adjustments toward change. For example many see abstaining from sexual intercourse (Christians included) as uncomfortable or unattainable, and may opt to totally disregard this HIV prevention option.
- Young people in today's highly sexualized society which is inundated with a glut of sexual content from various media may see the Christian teaching of abstinence, which is the most effective method for prevention of sexual transmission of HIV, as antiquated and as a deprivation.
- Environment, such as living in an area full of bars or night clubs, may make it difficult for one to abstain from drinking or other negative social vices. Environment does shape behavior, and behaviors like alcohol misuse increase risk of HIV infection and vulnerability to HIV.
- Many people often desire rewards for behavior change - meaning there must be an incentive that will accompany behavior change. Emphasizing the health benefits and HIV prevention that result from behavior change is important.
- Change is often resisted and when it is advocated by others it is sometimes seen as an imposition by another person and seen as impinging one's independence and freedom to own choices. Providing the correct information and providing a supportive environment to make the helpful changes will assist in this situation.

## 4.7.6 HOW TO CHANGE BEHAVIOR

The information, motivation and behavioral (IMB) skills model is based on many other behavior change concepts, though it is generalizable across different conditions and provides a simple guide for behavior change:

- **Information:** This includes basic information about HIV, including how it is transmitted, disease progression, disease outcomes and management of HIV.
- **Motivation:** This looks at the personal attitude of the individual towards management of their situation or condition, how they perceive support from others in managing this situation/condition, and the perception of how those who are HIV-uninfected manage their lives, as well as how those with HIV manage their health.
- **Behavior skills:** These are the tools and strategies that help HIV negative individuals to remain HIV free and also that help PLHIV to manage their condition successfully.

In this model, information and motivation are a prerequisite to obtaining behavioral skills and ultimately behavior change (WHO 2003).

## TOPIC 4.8 - REFERRAL

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### TASK(S):

**Start the session by finding out what participants understand about 'Referral' and the challenge this may have on confidentiality in counselling.**

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### 4.8.1 WHAT IS REFERRAL?

It is simply the transfer or recommendation of a counselee or one seeking help from a counsellor to other helping professionals.

### 4.8.2 WHY REFERRAL?

The basic premise of all pastoral counselling is that the client receives the best care available. Hence, it is crucial to refer clients to other helping professionals when their care needs exceed a counsellor's ability or when personal factors are likely to interfere with a productive working relationship.

A counsellor should not attempt to do what someone else can do better... besides, a client's failure to make progress with a counsellor is another reason to consider a referral. This point is about a



counsellor realising and acknowledging his/her own limitations in terms of competence – he/she should not encroach in another’s expertise. If the relationship is too close, or too strained, the counsellor should recuse himself/herself from helping. Instead, he/she should prepare the counslee for referral. Dual relationships (if relationship becomes intimate) should be avoided - they can distort reality and confuse roles.

### 4.8.3 HIV/AIDS REFERRAL

In HIV/AIDS counselling, referrals are required not just for the reasons highlighted above, but those that will enable a client to get further help for his/her problem. For example, once tested positive, a client will be referred to the doctor for further tests that will determine the kind of health care needed and support groups available for networking.



For HIV positive patients, issues of CD4 count, viral loads and type of ARVs to be administered will be determined by the doctor, hence the need for referral. The counsellor should dispel the clients fear that confidentiality is not respected because ‘others’ are co-opted in their case along the way by explaining ‘shared confidentiality’ which simply means that all helping professionals are bound by the same ethical conduct (which outlines the professional conduct of all counsellors) and will not betray their clients’ confidence and trust.

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## UNIT FIVE: LITURGY

### UNIT PURPOSE

The worship and liturgy of the Church is the place where believers express their faith in God through worship. This unit aims to help the facilitator to equip students with skills for framing an effective and compassionate response to HIV/AIDS through the Church's worship rites, practices and delivery of homilies.

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#### **NOTE TO THE FACILITATOR/INSTRUCTOR:**

Being aware that a good number of today's congregants are either infected or affected by HIV/AIDS, necessitates the clergy to design and develop HIV/AIDS sensitive worship services. The facilitator should in this case, equip learners with skills, attitudes and knowledge to enable them to come up with appropriate liturgy. The practical aspect expected of the learners in this unit makes it vital to have many tasks.

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### UNIT OBJECTIVES

At the end of the unit, students should be enabled to:

- Define Liturgy in its historical perspective;
- Design and conduct HIV/AIDS sensitive worship services (i.e. in content of prayers, preaching and Rites conducted in worship);
- Explore and develop rituals designed to promote healing and coping among HIV/AIDS infected and affected persons;
- Outline the implications of liturgy to HIV/AIDS.

### KEY METHODS OF INSTRUCTION

- Lecture
- Learning tasks/Group work/Plenary
- Role play (on HIV/AIDS sensitive homilies)

### SUGGESTED TEACHING AIDS

- Flip Charts/Chalk Board/White Board
- Markers/Chalk
- Hand-outs/Charts/Graphs
- Overhead Projector

## TOPIC 5.1 - UNDERSTANDING LITURGY

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### **TASK(s):**

Engage students in a discussion that will enable them to come up with the definition of Liturgy as well as identifying some basic rituals, symbols and signs relevant to their congregational liturgical celebrations/ceremonies

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### 5.1.1 DEFINITION OF LITURGY

The word 'liturgy' has its origins in the Greek word *leitourgeios* to describe "public service", in the sense of serving God in public and communal worship (O'Collins and Farrugia 2000). Liturgy involves signs, symbols and sacred actions which form our public prayer and worship that spring from the language and events of God's own self-revelation to us. It is the "apex or source and summit" of Christian worship. Simply put, Liturgy is the order of things in a worship service. If a Church sings a hymn, takes an offering, offers a prayer and hears a sermon or homily, it has a liturgy (Campbell, 1987).



### 5.1.2 PURPOSES OF LITURGY

Jesus said "For where two or three gather in my name, there am I with them" (Matt. 18:20). Liturgy is the structured and shared worship that Christians engage in when they are together. Liturgy serves many purposes including these three highlighted below:

- To adore, worship and serve God in fellowship with others, and not as an individualistic activity.

- In liturgy our relationship with God by his grace every Lord's Day enables us to not only hear about the Gospel, but we actually practice it and embrace it for ourselves all over again.
- Properly ordered worship (liturgy), offered to God from the heart, is one of the most important means God has given us to celebrate life together (Maxwell-Stewart 1996).

### 5.1.3 ORIGINS AND DEVELOPMENT OF LITURGY

The Bible does not give us a precise liturgy. It stems from the reality that humanity has always sought a relationship with the divine, both within the individual heart and as a family seeking to live and grow together under a rule of spiritual wisdom.

Even before Christianity, mankind has always been a community of praise and service whose religion (in the divine/supreme) has been marked by rituals and signs; sacred places, language and gestures; times and seasons rooted in the cycles of nature; sacrificial offerings of thanksgiving, sorrow and intercession; public prayer and canticle; priests, prophets and spiritual leaders.

Moreover, the religion of Israel, a chosen people was centred on the Temple in Jerusalem. Their lives evolved around the temple where the great festivals were held to enact and renew the covenant between God and his chosen people. Everything about the temple liturgies celebrated and reinforced this identity as a holy nation set apart by their stringent laws of ritual purity, and lifted the minds and hearts of the participants collectively towards God the Father and Creator.

Above all, this rich religious life of priestly chant, endless sacrifices, processions, incense, and the turning circle of feast days through the year, was designed to embody the hope of the coming of the Messiah, spoken of in the unique Hebrew tradition of divine prophecy. The Christ would gather a universal people, bring in a perfect worship, joining the people's praise with the eternal worship of the angelic choirs, and finally liberate humanity from the power of sin by engendering inner purity of mind and heart, instead of mere conformity to ritual law. He would bring about lasting peace and communion between heaven and earth.

When Jesus was on earth, he went to all the key feast days in the temple and publicly claimed to be, in person, the fulfillment and real meaning of the liturgies which were being celebrated (Luke 4:15-19). Jesus Christ is the very heart of our familial relationship with God. He both brings about heavenly communion in us, and is Himself the focus and goal of our belonging to God. He is both the author and the object of all true adoration and praise, all grace and blessing, all growing in divine life and of all celebration and thanksgiving. Jesus is not only the fulfillment of the religion of Israel as God the Word Incarnate; He is the source and summit of the whole of the liturgy of creation. In Him every created thing and every interlocking law and relationship in the cosmos finds its true purpose, meaning and beauty. In Him too all the religious instincts of humanity find their completion and correction.

Christian tradition holds that, the Church's worship should begin with a call to worship, should contain hymns, prayers, offerings, the reading and preaching of God's Word, and should conclude with a benediction. Certain actions in this worship are reserved for

ministers and there is considerable freedom in the arrangement of others (e.g. both choir and congregation sang in the worship service of the temple; both ministers and people prayed in the worship service of the Church in Corinth). The particular order of events itself conveys meaning in worship. Order is everything in life. In Lev. 1:3-9 there is scrupulous attention to the order of events in sacrificial worship (Maxwell-Stewart 1996).

#### 5.1.4 IMPLICATIONS OF LITURGY FOR CHRISTIAN MINISTRY IN THE CONTEXT OF HIV/AIDS

The concept of liturgy refers to the whole fabric of the Church's public prayer. Liturgy, therefore, encompasses all of life and for that reason the threat of HIV/AIDS being part of life is admitted into the liturgical life of the Church. It is the living out as well as the acting out of our relationship with Christ to the Father and of our mutual relationships and vocations to one another in His Holy Spirit.

Liturgy is our participation already in this earthly and temporal existence through sacramental signs. The source of power and effectiveness in the sacraments is the Holy Spirit of God who unites heaven and earth in one communion of love. Therefore, when the Church is at worship, its prayers, songs and sermons must reflect that communion of love by being HIV/AIDS sensitive and HIV competent.

This HIV sensitivity and competence requires that every church leader (Minister/Pastors, Sunday school teachers, youth, women, Bible study and worship leaders), mainstream HIV/AIDS within their given context, audience and Christian background so as to build a church that knows and successfully carries out its mission of healing, compassion, hope and justice, saving lives from death, despair and hopelessness, and healing a hurting and suffering people. This requires that these church leaders are provided with tools and training to be able to effectively mainstream HIV/AIDS into the liturgy.

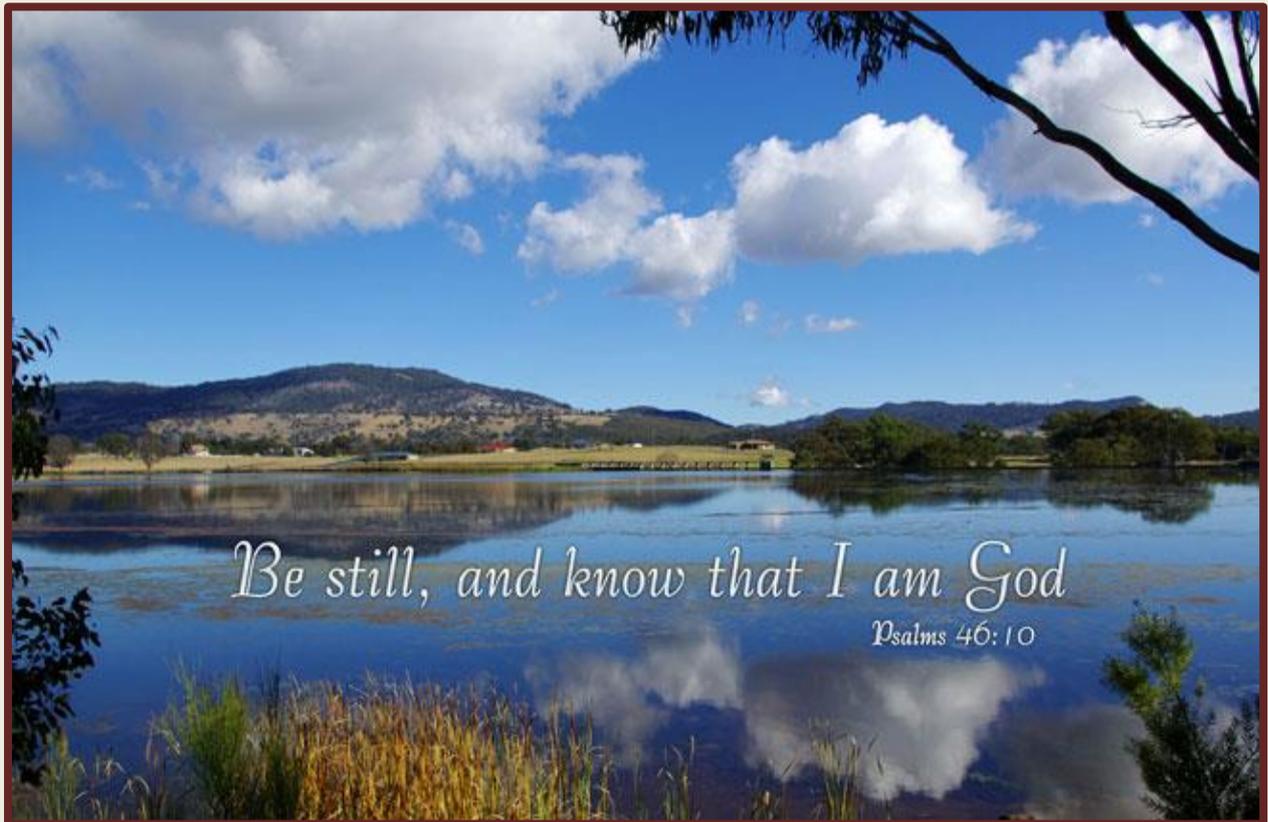
## TOPIC 5.2 - PRAYER AND WORSHIP

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### TASK(s):

- **Mention and discuss the components of 'worship'.**
  - **Discuss and evaluate the importance of Liturgy in the developing of Church rituals designed to promote healing and coping among HIV/AIDS infected and affected persons.**
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Worship includes silence, contemplation, words, songs, dances and practices that are used to communicate with God in fellowship in solitude and corporately. Liturgy can help Christians to feel themselves part of a community linked across the world and through the centuries in worshipping God and gaining a renewed sense of themselves and their place in God's world. Liturgy puts God at the center, and PLHIV and those affected by HIV/AIDS can tap into God's transformative and healing power through Liturgy, to obtain the healing and the peace of mind that only a relationship with God can provide.



### 5.2.1 ESTABLISHING SPECIAL WORSHIP DAYS FOR HIV/AIDS

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#### **TASK(s):**

- Ask the learners to share and discuss what the practice in their congregation is for special worship days for HIV/AIDS - how are the services conducted?
  - What challenges have you encountered in observing special worship days and how can you make them more meaningful for HIV/AIDS interventions?
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Establishing special worship days for HIV/AIDS will be accomplished by each Church designating special worship days that focus on HIV/AIDS. Other internationally recognized days also offer opportunity for integrating HIV/AIDS into Liturgy e.g. annual commemorations like World AIDS Day on 1st December, and Voluntary Counselling and Testing (VCT) day on 30<sup>th</sup> June.

Liturgy is important in the lives of Christians. It expresses the rhythms of all human life – rest and renewal, death and birth, sadness and joy; it can be celebrated simply or elaborately, in speech or song, using traditional words or contemporary ones; it can take place in a church or in a different meeting place, and it uses every part of us – our ears to hear, our voices to read and speak and sing, our bodies to stand, sit and kneel and move.

In carrying out all these aspects of the Liturgy and appropriately mainstreaming HIV/AIDS, the Church can truly become a beacon of hope and place of healing for PLHIV and those affected by HIV/AIDS.

## 5.2.2. INCORPORATING HIV/AIDS IN PRAYERS AND IN THE PRAYER BOOK

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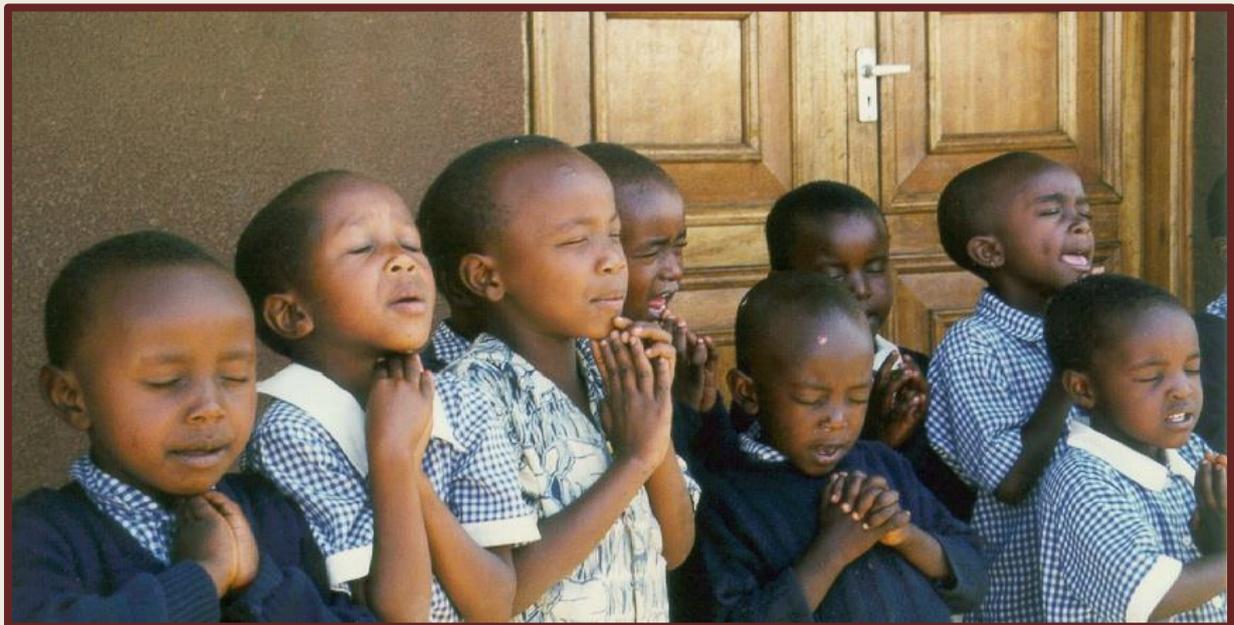
### TASK(S):

- Ask learners to bring a service book from different denominations
  - Let them evaluate and identify gaps in relation to HIV/AIDS sensitivity
  - Ask them to recommend amendments to the service that would make them HIV/AIDS sensitive.
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Incorporating HIV/AIDS in prayers and in the prayer book acknowledges that when God's people come together, all are included. HIV/AIDS sensitive prayers in Church prayer books indicate that the Church is intentional about its commitment to the fight against HIV/AIDS.

Jesus gave believers authority over all demons and every disease (Matt. 10:1), but we can't be in authority unless we are under authority of our heavenly Father. This implies that we take time to hear Him and then obey Him and give commands for healing, in HIV/AIDS or any other ailment, according to His will.

Prayer is the vehicle for communicating with God and through which God can reveal His will to us. Jesus prayed; he was thus able to heal by exercising His authority because He knew whom to command and what to command. Jesus rose early every morning to listen to His Father (Mark 1:35), and He prayed into the night on many occasions (Luke 22:39). He did nothing and said nothing except what the Father told Him (John 5:19; 8:28).



Therefore in the Church's response to HIV/AIDS, prayer should be central so that we may receive God's guidance and His help. Prayer offers the Church a very good opportunity for HIV/AIDS mainstreaming so that the body of Christ and others, may receive the healing and comfort only He can provide. Jesus tells us that "Come to me, all you who are weary and burdened, and I will give you rest. Take my yoke upon you and learn from me, for I am gentle and humble in heart, and you will find rest for your souls. For my yoke is easy and my burden is light" (Matt. 11: 28-30).

Jesus Christ calls the weary and heavy-laden to come to him. This is the gospel call: Whoever will, let him come. All who come will receive rest as Christ's gift, and obtain peace and comfort in their hearts. This promise is true whether one is HIV-infected or HIV-uninfected. His commandments are holy, just, and good. So powerful are the assistances he gives us, so suitable the encouragements, and so strong the consolations to be found in Him, if we take his yoke and submit to his authority (Matthew Henry 1706).

### 5.2.3 DEVELOPING HIV/AIDS RELATED PRAYERS, SONGS/HYMNS AND SERMONS

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#### **TASK(s):**

- Invite learners to write an HIV/AIDS related sermon using an appropriate biblical text.
  - Ask learners to compose HIV/AIDS sensitive prayers and songs for presentation to the class.
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There is need to incorporate HIV/AIDS in annual preaching calendars and special occasions and commemoration days. During these services, special offerings for these worship days can target support and care for HIV/AIDS affected and infected persons.

Creative writing of new biblically, theologically and contextually relevant liturgies, sermons and songs for HIV/AIDS, should focus on promoting love and giving hope. It should be emphasized here that the pulpit is not to be used to intimidate or to condemn, but rather to sensitize, encourage and educate.

Only when Christian leaders and the Church truly mainstream HIV/AIDS into the Liturgy and nurture and tend to Christ's flock with compassion and love, and with appropriate Christian action, will the Church's response to HIV/AIDS and the Church be the beacon of hope it should be to PLHIV and those affected by HIV Christian and non-Christian alike.

### 5.2.4 EXPLORING AND DEVELOPING RITUALS DESIGNED TO PROMOTE HEALING AND COPING AMONG PLHIV AND HIV-AFFECTED PERSONS

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#### **TASK(s):**

Invite learners to discuss what rituals can be designed to promote healing and coping among HIV/AIDS infected and affected persons as opposed to stigmatising against them because of their condition.

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#### **Scriptural Reflections on Important and Related Themes**

The Bible has scriptural texts that when reflected upon, can help change the mind-sets of people regarding those thought of as marginalised in society. This can help bring about sensitivity in most people thereby enabling them to behave kindly and lovingly towards those with various afflictions both physical and psychological.

No matter how big the handicap of a person, they will react well and even respond to treatment when embraced. The love shown can manifest itself in the one with pain to the point of numbing it. In the Holy Scriptures, Jesus taught us that the Spirit of God is the Spirit

of love. He that does not love the image of God in his people has no saving knowledge of God. For it is God's nature to be kind and loving, and to give happiness (1 John 4:8).

### **Devotion on the Theme of Stigma – Jesus and the Infectious**

Jesus' attitude towards the leper was that of willingness to heal and reaching out to touch this person despite the infectious disease, which nobody wanted to associate themselves with in those days (Matt. 8:3; Luke 5:12-13; Mark 4:40-41).

Jesus' attitude to the woman with prolonged bleeding – he was aware and he wanted to meet her needs. He didn't condemn her for touching him but instead wished her 'peace' (Luke 8:43-48). Jesus provides the Christian Church the perfect example of how to embrace all human beings irrespective of their state or status.

### **Devotion on the Theme of Stigma – Jesus and Societal Stigmatisation**

Jesus' attitude towards the Samaritan woman – he desired to build a bridge between himself and the woman of another ethnic grouping, which was despised thereby giving an example and displaying his famous 'convivial' practice. He did not withhold to give to this woman what was good; salvation (John 4:1-27). Jesus' attitude to Zaccheus—Jesus offered Zaccheus communion before conversion, which is a natural reaction of one who meets Christ in sincerity. Jesus sought Zaccheus who was sinful and saved him (Luke 19: 1-10).

Again, here our Lord teaches about the need to reach out to those who are marginalized in society, not only because it is the right thing to do, but also because we are all equal in value before God our creator.

## **RECOMMENDED READING**

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## UNIT SIX: HIV/AIDS PROGRAMME DEVELOPMENT AND SUSTAINABILITY

### UNIT PURPOSE

This unit is intended for the facilitator to help equip the learner with the skills to initiate, lead and sustain Church related HIV/AIDS programs. It is designed to enable the facilitator guide the learners through the generic process of empowering learners with the ability to lead HIV/AIDS mainstreaming in a church and its surrounding communities. Through this unit the learner will be equipped with the skill of leading a change process for the purpose of facilitating for the successful implementation of HIV/AIDS related programs in church.

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### NOTE TO THE FACILITATOR/INSTRUCTOR:

**Programme development and its sustainability is cardinal to the success of Church HIV response programs. The facilitator therefore, needs to help the learners using various instructional methods to come up with practical means of ensuring that HIV/AIDS programs are sufficiently equipped with adequate resources and appropriately skilled manpower who are able to help sustain the HIV/AIDS programme in its entirety.**

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### UNIT OBJECTIVES

At the end of this unit, the facilitator/instructor should have helped the learner to:

- Identify, demonstrate and model leadership, managerial and community resource development skills useful in successful HIV/AIDS programming.
- Identify, demonstrate and model program planning, development, implementation and evaluation skills.
- Critically examine, analyze and discuss biblical and cultural perspectives related to program management and optimizing community participation within the context of HIV/AIDS.

### KEY METHODS OF INSTRUCTION

- Role play
- Discussion groups
- Lectures
- Group exercises

### SUGGESTED TEACHING AIDS

- Flip Charts/Chalk Board/White Board
- Markers/Chalk
- Hand-outs
- Charts/Graphs
- Overhead Projector

## TOPIC 6.1 - MAINSTREAMING HIV/AIDS

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### TASK(S):

- Ask the learners to discuss the meaning of mainstreaming and the importance of mainstreaming HIV/AIDS into the core functions of the church including worship, ministry, evangelism and missions, fellowship and education
  - Ask learners to discuss the importance of working together as a group
- 

### 6.1.1 MAINSTREAMING HIV/AIDS ACTIVITIES IN CHURCH PROGRAMS

In the Church, HIV/AIDS mainstreaming means not only embedding HIV/AIDS activities into core church functions but also ensuring that they are given the required attention and resources. This can be done in several ways including the following;

- **WORSHIP:** Mainstreaming HIV/AIDS into the worship and other forms of Liturgy is a powerful way of ensuring that Christians and others benefit from God's healing power, which is manifested in different ways.
- **MINISTRY:** Such as home-based care (HBC) especially for very ill PLHIV and care for orphans and vulnerable children. The Bible says *"What good is it, my brothers and sisters, if someone claims to have faith but has no deeds? Can such faith save them? Suppose a brother or a sister is without clothes and daily food. If one of you says to them, 'Go in peace; keep warm and well fed,' but does nothing about their physical needs, what good is it? In the same way, faith by itself, if it is not accompanied by action, is dead"* (James 2:14-17). By faith anything we do if it is done in obedience to God is good. Faith is the root, good works are the fruits; and thus when we provide care for PLHIV and those affected by HIV/AIDS, including OVCs, and we do so for the Glory of God, we contextualize HBC and other care services in the Church and mainstream HIV/AIDS into Ministry.
- **EVANGELISM AND MISSIONS:** Sharing the Good News of our Lord and Saviour Jesus Christ. The idea that should be appreciated under evangelism and missions in relation to HIV/AIDS programming is that as the need for salvation is preached and the masses are made aware of the punishment that awaits those that are not saved, it is important for the evangelising team to be aware of the sensitivities that surround PLHIV. Statements that are viewed as judgemental may result in profound repulsion as opposed to fulfilling the goal of bringing the lost to Christ.
- **EDUCATION:** Teaching church members about the main drivers of the HIV/AIDS epidemic in Zambia. A key resource in this area is the HIV/AIDS messaging tool kit for Zambian leaders developed by SHARe II. Reference to Unit 1 of this manual will also be helpful.
- **FELLOWSHIP:** Expressing encouragement and hope for those infected and affected by HIV/AIDS.
- **BEHAVIOUR CHANGE COMMUNICATION (BCC):** Mainstreaming HIV/AIDS activities during meetings, camps (for the youth, women and men church groups) and

lectures. With this approach, people do not have to think about the cost, as one is giving a lecture, they can be encouraged to provide examples about HIV.

- **CAPACITY BUILDING:** for effective mainstreaming the church partnering with other stakeholders can facilitate trainer-of-trainer programmes in mainstreaming, psychosocial counselling, peer education, adherence counselling and palliative/care giving etc.

In as much as mainstreaming of anti-HIV activities may be desired in the church, this can only happen if the previously HIV/AIDS non-competent environment is changed to one that allows for appreciation of HIV/AIDS as a problem that has not spared the Church. Such change however, is contingent upon changing the prevailing culture in the Church. This is on no account an easy task and among the factors that would make such a process possible is having some basic leadership skills.

## TOPIC 6.2: LEADERSHIP AND COMMON LEADERSHIP STYLES

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### TASK(S):

Ask learners to:

- Define leadership and explain the leadership styles that they know
  - Discuss models of effective leadership and core leadership characteristics and qualities
  - Ask the learners to form groups and discuss the various leadership styles. What type of leadership will respond well to the HIV/AIDS epidemic?
  - Ask the learners to identify and outline the different levels of leadership. What is meant by the three-one principle?
- 

### 6.2.1 DEFINITION OF LEADERSHIP

Leadership is the action of leading a group of people or an organization, or the ability to do this. It involves investing oneself in guiding a group toward worthy ideals and accomplishments (Preston 1934). It is the process of influencing and guiding people in a stimulating and inspiring way.

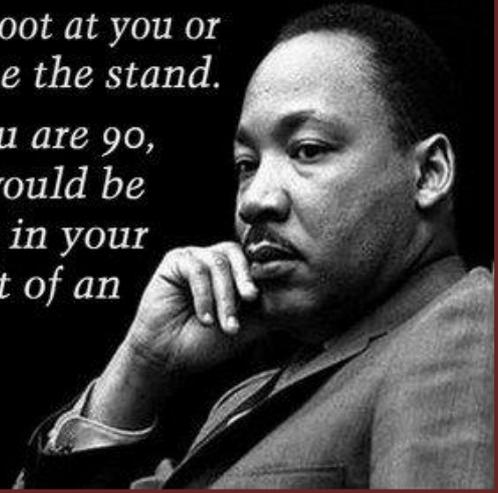
Leadership also involves mobilizing others to want to get extraordinary things done in organizations. To this concept Kouzes and Posner (2007) add that a leader transforms values into actions, visions into realities, obstacles into innovations, separateness into solidarity and risks into rewards.

Some people use leadership and management synonymously, however, there exists a distinction between these two terms. While leadership is the ability to shape the attitudes and behaviour of others, management on the other hand is the function that coordinates the efforts of people to accomplish goals and objectives using available resources efficiently and effectively.

Perhaps, what is more confusing is the use of terms like managerial leadership. This, in prosaic terms is defined as the process of directing and influencing the work of team members. This type of leadership is concerned with guiding and directing others.

*“You may be 38 years old, as I happen to be. And one day, some great opportunity stands before you and calls you to stand up for some great principle, some great issue, some great cause. And you refuse to do it because you are afraid... You refuse to do it because you want to live longer.... You’re afraid that you will lose your job, or you are afraid that you will be criticized or that you will lose your popularity, or you’re afraid that somebody will stab you, or shoot at you or bomb your house; so you refuse to take the stand. Well, you may go on and live until you are 90, but you’re just as dead at 38 as you would be at 90. And the cessation of breathing in your life is but the belated announcement of an earlier death of the spirit.”*

*- Martin Luther King Jr.*



Managers who happen to lead institutions act to help a given group attain its objectives with the maximum application of its capabilities. They do not stand behind the group to push it in a certain direction, they place themselves in front of it to facilitate progress and inspire the group to accomplish organizational goals.

### 6.2.2 THE NATURE OF LEADERSHIP

In the past people believed that leaders were born but not made. This belief was seen in the system of hereditary rulers and thought to be a universal trait among human communities over the world. Today this type of leader is still found in some parts of the world. Among these are kings, chiefs, dukes and barons.

Conversely, there exists another school of thought which stipulates that leaders are made and not born. Proponents for this line of thinking believe that leadership is no longer a nature of inheritance; because leaders are not born but made and leadership itself can raise a person’s performance to a higher standard, and can help build a man’s personality beyond its normal limitation.

That is to say if all people are given the same chance, some will emerge as leaders while others will be followers. They assume the position of leadership and take charge and control

of situations. In modern day, this can easily be likened to the way leaders ascend to power in democratic nations like Zambia.

### 6.2.3 LEADERSHIP STYLES

There is no best style of leadership. How a leader behaves depends in most cases on the circumstances. However, there are at least four (4) common styles that leaders take in leading others:

#### Autocratic

This leader is popularly known as “tough guy”. He dictates orders and determines all policy without involving group members in decision-making. This style is effective when the situation the leader is dealing with is of urgent nature and also when subordinates require strong leadership. It is dangerous to assume that everybody needs democracy because other people need authoritarian leadership. And if you do not do that you can be seen as a weak leader. This leader also looks for problems and examples of poor performance; does not believe that members should contribute to decision-making; blames; is impatient with questions and requests; and is non-supportive (Gaudrault 2008).

#### Democratic

This is sometimes referred to as persuasive or shared leadership. This leadership style emphasizes participation by everybody. It is a consultative leadership style, and decision making is by consensus or majority.

#### Laissez-faire

This is an open style of leadership. The ultimate responsibility is with the followers or subordinates. The style however, is effective when dealing with expert professionals, and intellectuals. It is also practical when juniors are mature and ready for self-responsibility, and know what they want.

#### Participatory

This leader believes that members want to do a good job and that leaders should help to solve problems. He or she believes that members, and members’ ideas, need to be recognized and that leaders should be oriented towards people’s needs. He or she is helpful, consultative and supportive.

### 6.2.4 MODELS OF LEADERSHIP FROM THE BIBLICAL PERSPECTIVE

#### The Jesus Model (Mark10:43-44)

In the Bible, the role of leadership is referred to as that of a servant. Jesus taught two principles of leadership. The first of these is the sovereignty of spiritual leadership. The second pertains to the suffering of spiritual leadership.

Regarding the first, God assigns places of spiritual ministry and leadership. Regarding the second principle, serving and suffering are paired in the teaching and life of our Lord Jesus.

The spirit of servant-hood entails the leadership qualities of dependence, approval, modesty, empathy, optimism and anointing.

### Paul's Model of Leadership

*"Now the overseer is to be above reproach, faithful to his wife, temperate, self-controlled, respectable, hospitable, able to teach, not given to drunkenness, not violent but gentle, not quarrelsome, not a lover of money. He must manage his own family well and see that his children obey him, and he must do so in a manner worthy of full respect. (If anyone does not know how to manage his own family, how can he take care of God's church?). He must not be a recent convert, or he may become conceited and fall under the same judgment as the devil. He must also have a good reputation with outsiders, so that he will not fall into disgrace and into the devil's trap" (1 Tim. 3:2-7).* According to the Apostle Paul, the following leadership qualifications are required of spiritual leaders:

**SOCIALLY:** Must be above reproach;

**MORALLY:** Must be blamelessness regarding sexual faithfulness – faithful to one's marriage partner, temperate, sober;

**MENTALLY:** Must be prudent and having sound judgment and having a disciplined mind, beyond that- able to teach;

**PERSONALLY:** Must be gentle, hospitable and not greedy for money;

**DOMESTICALLY:** Able to manage own family well; and

**PERSONAL MATURITY:** Magnanimous in spirit and also visionary.

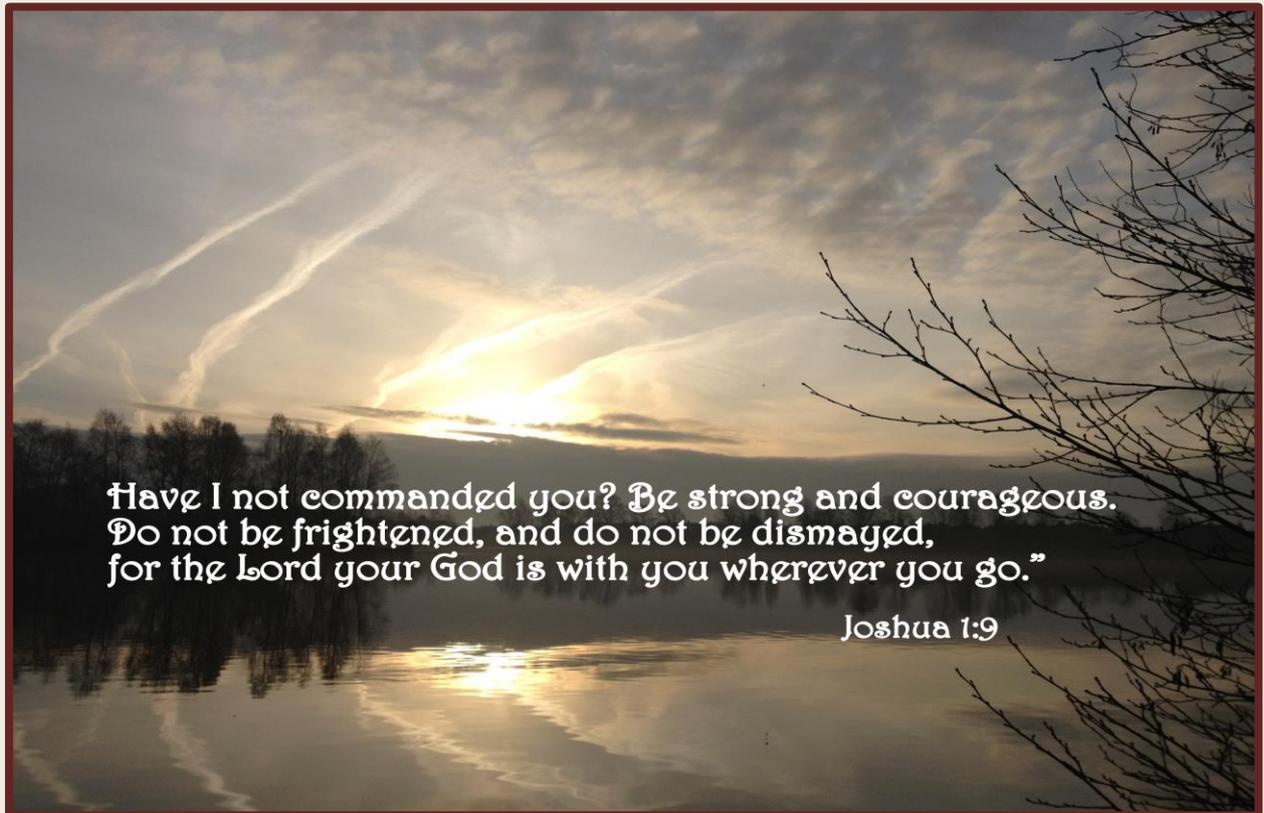
### Peter's Model of Leadership

The Christian leaders' motivation must be one of willingness; he must not be greedy for money, he must not be dictatorial; he must be a worthy example for the people; and he must also be humble. The Bible provides this guidance: *"Be shepherds of God's flock that is under your care, watching over them—not because you must, but because you are willing, as God wants you to be; not pursuing dishonest gain, but eager to serve; not lording it over those entrusted to you, but being examples to the flock. And when the Chief Shepherd appears, you will receive the crown of glory that will never fade away" (1 Pet. 5:2-4).*

### Nehemiah's Model of Leadership (Neh. 13:31)

Nehemiah was a man of prayer. He also showed courage in the face of danger. A leader must also have a genuine concern for the welfare of others. A leader must also have keen insight and be able to make clear decisions.

A leader must also have some good administrative skills. A leader must also raise the morale of his colleagues, have faith and build the faith of others. A leader must put the Word of God ahead of all his activities. A leader must be able to organize both projects and people.



### 6.2.5 LEADING CHANGE

Change can be planned or emergent. The former is initiated by top management and labelled as Top-Down change. In keeping with Kurt Lewin's (1947) model for overcoming resistance in change, planned change follows the sequence of "unfreezing-changing-refreezing". The latter, is on the other hand referred to as the Bottom-Up change and in an organisation it is largely initiated by ordinary employees. In a community environment, this type of change would be initiated by ordinary community members; it is more participative and allows for the members to define the change. However, whether the change is planned or emergent does not automatically spell success.

For change to be successful, a range of leadership behaviours both at the organizational and individual level should happen. Although leaders should not try to dictate exactly how change should happen at both these levels, they should provide encouragement, support, suggestions and the necessary resources. Being a widely researched topic, several scholars have provided frameworks for implementing planned change. Among them is a professor at Harvard Business School and world-renowned change expert named Kotter (1996) who elaborately illustrates an eight-step change process. The eight-stage model of planned organizational change (implemented in the stipulated order) is explained below:

1. **ESTABLISHING A SENSE OF URGENCY:** This is crucial in gaining the needed cooperation from all players in the change process. If urgency is low and complacency is high, transformations usually encounter numerous difficulties.
2. **CREATING A GUIDING COALITION:** It is often dangerous to think that a leader can implement major organizational change single-handedly, without consulting and/or involving others. The task of persuading people to support major change is never easy,

and it is too big a job for a single leader to accomplish alone. Successful change in any organization requires collective effort by the identified stakeholders. Therefore, the leaders must build a team of “change supporters” both inside and outside the organization. These should come not only from the top leadership, but also from among middle and lower levels of management. This team must share the commitment to the need and possibilities for organizational transformation, and guide the change process

3. **DEVELOPING A COMPELLING VISION AND STRATEGY:** Leaders are responsible for formulating and articulating a compelling vision that will guide the change effort and for developing the strategies for achieving that vision. A “picture” of a highly desirable future motivates people to change. A good vision serves three important purposes: clarifying the general direction for change; motivating people to take action in the right direction and helping aligning and coordinating the actions of many different people in a fast/efficient way.
4. **COMMUNICATING THE CHANGE VISION WIDELY:** The real transforming power of vision is unleashed when most of an organization’s constituents share a common understanding of its goals and direction. The key elements in effective communication of vision are; simplicity, passion, metaphor, multiple forums, repetition, leadership by example, explanation of seeming inconsistencies, listening and being listened to.
5. **EMPOWERING THE CONSTITUENTS FOR BROAD-BASED ACTION ON THE VISION:** Upon appointing people to spearhead the required change, continually empower them by removing obstacles that they may encounter when executing the vision; this will help the change move forward. At this stage it is also important to recognize and reward people for making change happen. On the other hand, identify people who are resisting the change, and help them see what's needed. Take action to quickly remove barriers.
6. **GENERATING SHORT-TERM WINS:** it is important not to just focus on one long-term goal. The aim in this step is to ensure that each smaller target is achievable and from inception it should carry with minimal room for failure. The change team may have to work very hard to come up with these targets, but each "win" that you produce can further motivate the entire staff.
7. **CONSOLIDATING GAINS AND PRODUCING MORE CHANGE:** Kotter asserts that many change projects fail because victory is declared too soon. Real change runs deep and takes time. Quick wins are only part of what needs to be done to achieve long-term change.
8. **ANCHORING NEW APPROACHES IN THE ORGANIZATIONAL CULTURE:** To make any change stick, it should become part of the core of the organization. The organisation’s corporate culture often determines what gets done, so the values behind your vision must show in day-to-day work. It is also important that the organisation’s leaders continue to support the change. This includes existing staff and new leaders who are brought in. if you lose the support of these people, you might end up back where you started.

### 6.2.6 IMPLEMENTING CHANGE FROM A BELIEVER’S STAND POINT

Christian leadership requires that the leader seeks God’s guidance and help in all situations so that he/she can remain grounded in working for the Glory of God. The following are important to keep in mind and/or practice:

**PRAYER:** It is important to pray for any matter requiring change in order to obtain assistance to discern God’s will in the given situation, and in order to ask for and receive God’s help.

**SUBMISSION TO THE WORD OF GOD:** The intended change must be in line with the teaching of the word of God as provided in the Bible.

**KEY LEADERS:** These are people in the church who need to be on board. Sometimes people will work to block change simply because they were not a part of the original guiding coalition. There are two simple principles to follow when building an effective change team. The first one being, it is wise to err on the side of involving more people rather than fewer. If there is a question as to whether or not a certain person's support will be needed, this should be included. The second one is to ensure that people from all levels of the organization are involved in planning the change process. This also means involving the people who will most be affected by the proposed change. More than anyone else, they will make the change process succeed or fail.

**EXPERTISE:** Expertise or competence is necessary in order to achieve the desired change. Represented in the team should be all the various points of view and skill sets relevant to the situation - In terms of discipline, experience, age, nationality, gender, etc.

**CREDIBILITY:** Team members must possess good reputations and be trusted and taken seriously across the organization.

**LEADERSHIP:** The team must include enough proven leaders to be able to drive the change process. Of course, management skills are also needed on the team.

**INTEGRITY:** Personal problems that can be ignored during easy times can cause serious trouble in harder, faster-moving times. People with large egos who do not realize their own weaknesses and limitations or appreciate the strengths of others, and also people who create mistrust by playing people against each other should not be considered to lead change processes.

**TRUST:** Trust is very important in any change process - when people trust each other, creating a common goal and strategy becomes possible.

The Church must increasingly and competently use its position to promote a deeper understanding of the HIV/AIDS epidemic, reduce its impact and reverse its spread. Church leaders involved in HIV/AIDS leadership must be assisted and supported to:

- Become knowledgeable about HIV/AIDS, understand the underlying factors fuelling epidemic, and develop an increased ability to freely speak and think about HIV/AIDS as a phenomenon and as a human experience. This requires that the Church invests in building knowledge levels and skill to provide HIV/AIDS leadership;
- Develop into leaders who will take their own HIV/AIDS leadership performance and that of the Church to the level required to meet the complex challenges of HIV/AIDS, focusing on achieving the intended results both in HIV prevention and in creating a supportive environment for HIV care, treatment and support;
- Find in themselves and others new sources of hope, commitment and strength for sustained action, to lead the Church's HIV response compassionately and competently. This requires that they enhance their existing leadership qualities, acquire new skills and qualities to bring to bear on HIV/AIDS programming;
- Generate successful HIV/AIDS initiatives that will make an ongoing difference in the Church response to HIV/AIDS and the lives of PLHIV, and find new ways to change

attitudes and assumptions that perpetuate stigma, denial and silence, and that also increase HIV vulnerability; and

- Engage in developing and forming effective partnerships, results-oriented coalitions and communities of practice with others inside and outside the Church involved in the HIV/AIDS response.

## TOPIC 6.3 – REQUIRED SKILLS FOR LEADING HIV/AIDS PROGRAMS

### 6.3.1 COMMUNICATION SKILLS

Communication skills, such as ability to read, write, speak and listen, are essential in any undertaking. Effective communication is a critical component of successful HIV/AIDS programming and leadership and follows a logical process.

Figure 2 illustrates the process of communication. This process consists of six elements, namely, the **sender** (the source of the message - the sender is the one who encodes the message); the **message** (encoded to suit the channel and the receiver); the **medium** (the medium is the immediate form which a message takes - for example, a message may be communicated in the form of a letter, in the form of an email, or face to face in the form of a speech or as a video clip on TV); the **channel** (the means through which the message is transmitted e.g. radio, newspaper, TV, person-to-person), the **receiver** (the individual who receives and decodes the message) and the **feedback** (the reaction of the receiver to the message) as shown in the diagram.

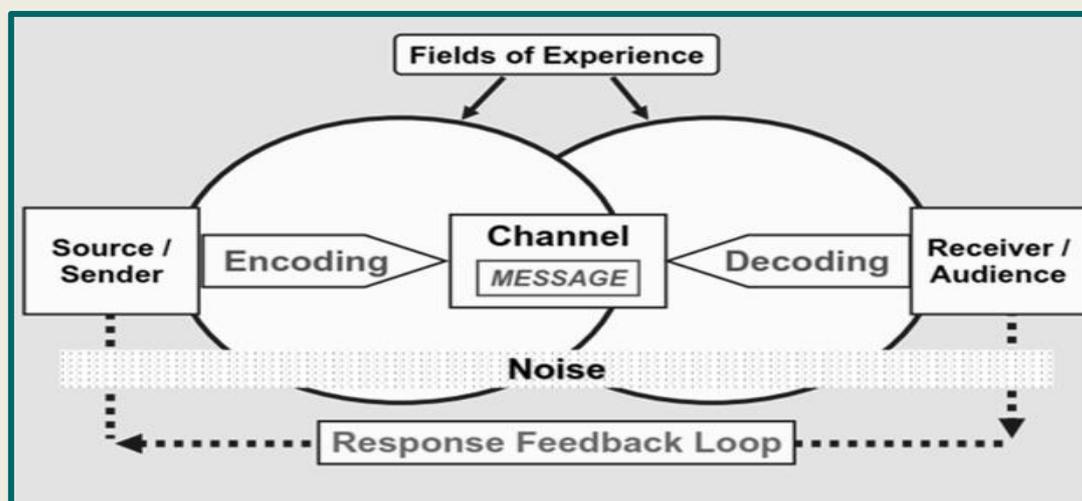


Figure 2: The process of communication; Source: Advanced Business Solutions

In order to achieve effective communication, it is important to make sure that each element in the process is appropriate. It is important to match the message to the medium and channel and to the receiver in order to get the desired change or response. Some of the barriers to effective communication include the following:

**SENDER:** With regard to the sender, the barriers could be the choice of the medium of communication or the choice of words, or the knowledge of the sender or personality and also lack of adequate preparation. The sender must choose a language that is understood

throughout the system. If the message they send is not the same as the one received, effective communication did not happen.

**MEDIUM:** With regard to the medium, the use of inappropriate channels of communication can also be a barrier to communication. For example, if you use TV as your channel of communication when only 1% of the population that is intended to receive the message has access to TV, your communication will not be effective.

**MESSAGE:** The message has to be appropriate for both the channel and the receiver. For example if the message is intended for a rural community where only 10% can read/speak English and the message is conveyed in English, communication will be ineffective. In written messages simple things like placement of a comma can mean the difference between life and death as in this famous example: “**Hang him not, let him live**” and “**Hang him, not let him live**”. The first saves the individual from hanging while the second condemns him to hang.

**RECEIVER:** If the message is not matched to the receiver communication will be ineffective. The receiver must get the same message that the sender sent. This involves interpretation or decoding. If the message itself is unclear or full of jargon, the receiver will not interpret it correctly or will simply ignore it.

**FEEDBACK:** Feedback ensures that communication did occur. Without feedback, neither the sender nor the receiver has any measure of how effective they were as communicators because they cannot be sure communication even occurred.

In HIV/AIDS programming it is very important that communication is effective in order to change behaviour and reduce vulnerability and risk to HIV and also in order to increase uptake of HIV-related services by PLHIV and those affected by HIV.

Correct and consistent messaging is a cornerstone of HIV/AIDS programming. Therefore Church leaders and program implementers involved in HIV/AIDS work must not only be good communicators, they must also be HIV competent.

The goals of effective HIV/AIDS communication in the Church are to promote a deeper understanding of the socio-cultural and economic factors fuelling the spread of the HIV/AIDS epidemic and the impact of HIV/AIDS on human development in order for the church to mount an effective, compassionate and competent response that addresses all these facets; and to promote effective strategies to reverse the spread of the epidemic that address individual, societal and institutional factors, including gender inequality and stigma and discrimination.

### 6.3.2 COMMUNITY MOBILIZATION SKILLS

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#### TASK(S):

- **Ask the participants to discuss concept of community mobilization**
- **Discuss how you would go about doing Participatory Learning and Action (PLA)**
- **Outline the main pillars of PLA, its methods and the key steps in its use**

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Community mobilisation is an attempt to bring both human and non-human resources together to undertake developmental activities in order to achieve sustainable

development. It is a process through which action is stimulated by a community itself, or by others, that is planned, carried out and evaluated by a community's individuals, groups and organisations on a participatory and sustainable basis to improve the standards of living in a community. It is a process of decision-making that involves the participation of community members as equal members of their own society. Members of the community participate in making decisions that affect their lives.

There are many ways and tools that are used when people participate in community activities. The tools that used are grouped together under the name PLA (Chambers 1997). PLA, formerly known as Participatory Rural Appraisal (PRA), can be defined as a family of approaches and methods designed to enable rural people to actively participate in projects and activities aimed at enhancing their way of life. It empowers them to:

- Share their knowledge
- Analyse their situations
- Plan their actions
- Implement their ideas
- Evaluate their progress

PLA completely discards top-down approaches. Such non-participatory methods are based on the premise that development practitioners understand communities' problems better than they do themselves. It also suggests that outsiders know how to solve those problems just because they have money and new technology. Some development workers involved in community work think they have the right to lecture, set rules, impose technology and push projects on communities from the outside!

PLA is all about helping communities to solve their own problems, therefore it demands that outside "experts" and project managers change their attitude and behaviours. This involves a reversal of learning, whereby development practitioners learn from local people by watching and listening to them rather than the other way around. This means that practitioners change their role from educators and "knowers" to learners, facilitators and catalysts of action. Their job is to empower villagers to express, analyse, share and extend their knowledge. PLA facilitators need:

- Respect for communities
- Openness
- Patience
- Listening skills
- An awareness of gender issues
- A commitment to including those who are normally marginalized.

Effective community mobilization for HIV/AIDS will result in an increase in the number of Church-supported community HIV/AIDS initiatives, including HIV prevention, home based care, change in harmful traditional practices, reduction of stigma and discrimination, support for orphans and voluntary counselling and testing. If the Church undertakes all these good works in faith and for the glory of God, surely we will begin to reverse the HIV/AIDS epidemic in Zambia!

This requires that women, men, girls, boys, PLHIV and those affected by HIV/AIDS are increasingly involved in decision making processes affecting their lives and that decision making processes increasingly reflect the concerns of communities through a process of active communication.

Often, the Church will find that there are already other players in the HIV/AIDS arena in the communities they serve. This requires active networking to ensure messaging congruency and consistency, and also to ensure that all players are consulting and involving the affected communities, and using community conversations as their approach to stimulate and scale up social change related to HIV.

### 6.3.3 MANAGING GROUP DYNAMICS

This is a skill that involves assisting the group to work more closely together, to cooperate and support each other; to build trust, and to minimize conflict. The chairperson should take note of the main points raised in the discussion in order to help understand the relationships between members. Working together in groups brings about mutual support, solidarity, increased impact and bringing together the talents of many people. Most importantly, the group can work well if they appreciate the different personality types that make up the group, develop effective listening skills and good communication, and build trust and work cooperatively (Gaudrault 2008).

## TOPIC 6.4 - HIV/AIDS PROGRAMME MANAGEMENT

**IMPORTANT NOTE:** This manual does not attempt to comprehensively cover the very broad topic of HIV/AIDS program management, but rather to introduce some of the key steps and concepts to give learners a basic understanding of the topic. The learner who wishes to know more about HIV/AIDS program management will be directed to resources that may be helpful at the end of this unit.

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### TASK(S):

Ask the students to discuss:

- **The importance of management in HIV/AIDS; the functions of management; and the importance of planning**
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### 6.4.1 FUNCTIONS OF MANAGEMENT

If the Church is successful in mainstreaming HIV/AIDS into all aspects of the church Liturgy and Ministry, it is going to need trained and skilled leaders and managers in order to ensure HIV/AIDS programs are implemented effectively and competently.

Management is the function that coordinates the efforts of people to accomplish goals and objectives using available resources efficiently and effectively. Good management ensures that a given institution is run in an efficient manner, implying that using as few resources as possible while maximizing production. In order to allow for an adequate understanding of management, its functions have to be explored. The following are the basic functions in most management process:

## Programme Planning

Planning is a very important part of management. The three common elements in planning are: To meet necessary standards or achieve the objectives; to economize on resources; and to be ready in time or know the time limit. Planning may be short term or long term. While short term planning may be specific to a particular constituent and meant to achieve an identified objective, long term planning is inclined towards the fulfilment of a vision. The latter is often referred to as strategic planning. An agreed plan is also the only way to coordinate people's actions. There are several kinds of planning:

**PROJECT PLANNING:** planning a well-defined project like construction and building a health facility, planning an HIV/AIDS awareness campaign.

**RESOURCE PLANNING:** planning of how to supply the necessary resources, starting from the actual needs.

**BUDGETING:** The available resources or the action programme for a certain period, usually a year, are expressed in monetary terms.

**HEALTH PLANNING:** especially in the area of HIV/AIDS. This is usually done by starting from an inventory of the problem and affected population, that is, from the needs.

**LONG TERM OR STRATEGIC PLANNING:** Strategic planning is an organizational management activity that is used to set priorities, focus energy and resources, strengthen operations, ensure that employees and other stakeholders are working toward common goals, establish agreement around intended outcomes/results, and assess and adjust the organization's direction in response to a changing environment. It is a disciplined effort that produces

Who are we as the Church HIV/AIDS Program?	• Requires the Church HIV/AIDS Program to identify the essential qualities that define it, including its fundamental commitments - vision, mission, core values and mandates
Where are we in terms of implementation of the Church HIV/AIDS response?	• Demands that the Church HIV/AIDS Program to critically analyzes itself and its internal and external environments, and clearly outlines the HIV/AIDS challenges it currently faces, as a springboard for defining the Church HIV/AIDS response roadmap
Where do we want to go in terms of the Church HIV/AIDS response?	• Requires that the Church HIV/AIDS Program clearly defines the goals, objectives and strategic issues toward which or on which it should work over the next five years of their HIV/AIDS response plan
How can we get there?	• Calls for the Church HIV/AIDS Program to articulate the strategies and actions needed to reach identified HIV/AIDS response goals and milestones, and/or to resolve the identified strategic issues
How will we know we have arrived?	• Requires the Church HIV/AIDS Program to define a simplified framework for assessing progress in the implementation of its HIV/AIDS response strategic plan and in achieving set goals and milestones

Figure 3: Strategic questions for Church HIV/AIDS Program strategic planning (JSI Graphics)

fundamental decisions and actions that shape and guide what an organization is, who it serves, what it does, and why it does it, with a focus on the future. Effective strategic planning articulates not only where an organization is going and the actions needed to make progress, but also how it will know if it is successful (Balanced Score Card Institute 2015).

There are many different frameworks and methodologies for strategic planning and management. While there are no absolute rules regarding the right framework, most follow a similar pattern and have common attributes. Many frameworks cycle through some variation on some very basic phases:

- Analysis or assessment, where an understanding of the current internal and external environments is developed,
- Strategy formulation, where high level strategy is developed and a basic organization level strategic plan is documented
- Strategy execution, where the high level plan is translated into more operational planning and action items,
- Evaluation or sustainment / management phase, where ongoing refinement and evaluation of performance, culture, communications, data reporting and other strategic management issues occur.

Whether long term or short term planning, three elements are seen in planning and they are: The period of time for carrying out the plan must be defined; the objectives or standards to meet in program implementation must be defined; and the resources required to achieve the pre-determined goals estimated. Additionally, each strategic planning process must answer five basic questions that will guide the strategic planning process as shown in *Figure 3* above.

## Organising

Organising is the function of management which follows planning, and involves the putting together or mobilizing of resources that are necessary to accomplish organizational or institutional plans. These resources include money, machines, materials, manpower, services, facilities and equipment.

Organizing, like planning, is a process that must be properly designed and executed. A key result of the organizing process is the organizational structure, which refers to the type of framework a program uses to distinguish power and authority, roles and responsibilities, and the manner in which information flows through the program and/or organization. Having a suitable organizational structure allows a program to implement proper operating procedures and decision-making processes that will help it in accomplishing its goals.

Organizing requires the manager to determine how he or she will distribute resources and organize employees according to a designated plan aimed at achieving program goal. The manager will need to identify different roles and responsibilities, assign work, and coordinate the right amount and mix of people to carry out the plan. Each person must be aware of his or her responsibilities to avoid frustration, confusion and loss of efficiency. In addition to providing structure for work processes and roles and responsibilities, organizing also determines how decisions will be made, how information is distributed and how the program will respond to problems.

## Staffing/Coordination

It is the function of manning the organization structure and keeping it manned, to ensure that qualified manpower are identified and employed in order to fulfil particular organizational functions. The main purpose of staffing is to put right man/woman on right job. Staffing involves: Manpower planning; recruitment, selection and placement; training and development; remuneration; performance appraisal; and promotions and transfers, as appropriate and applicable. Often for the Church, staffing also involves enlisting volunteers from within the body of Christ to assist in HIV/AIDS program implementation.

## Directing/ Supervising

This function involves directing and supervising personnel to do the work that is expected of them to fulfil organizational objectives and goals. Direction is that personnel aspect of management which deals directly with influencing, guiding, supervising, motivating sub-ordinate for the achievement of organizational goals. It includes motivation, modelling, mentoring and also coordination of functions. It also involves communication and human relations. Some of these are described below:

1. **SUPERVISION:** Implies overseeing the work of subordinates by their superiors. It is the act of watching & directing work & workers.
2. **MOTIVATION:** Means inspiring, stimulating or encouraging the sub-ordinates with zeal to work. Positive, negative, monetary, non-monetary incentives may be used for this purpose.
3. **LEADERSHIP:** A process by which manager guides and influences the work of subordinates in desired direction.
4. **COMMUNICATIONS:** The process of passing information, experience, opinion etc. from one person to another. It is a bridge of understanding.

## Controlling/Evaluating

This function is intended to ensure that plans are going on as intended and also to correct deviations from the intended course of action. It implies measurement of accomplishment against the standards and correction of deviation if any, to ensure achievement of organizational goals. The purpose of controlling is to ensure that everything occurs in conformity with the standards. An efficient system of control helps to predict deviations before they actually occur. Therefore controlling has following steps: Establishment of standard performance; measurement of actual performance; comparison of actual performance with the standards and finding out deviation if any; and corrective action.

## 6.4.2 PROGRAMME MANAGEMENT

Programme management is the process of managing and coordinating related projects, often with the intention of improving an organisation's performance or outcomes. Programme management requires a holistic view of business strategy, synergy and management of various teams, and good communication. The programme management process involves the following focus areas:

**PLANNING:** converting strategic objectives to programme goals

**RISK MANAGEMENT:** Dealing with deviations from the desired output needs to be managed by strong risk management activities. All risks need to be identified, analysed and mitigated to increase the probability of success for the programme.

**STAKEHOLDER MANAGEMENT:** Large programmes usually have many stakeholders who can potentially impact the programme in a positive or negative way. Stakeholder needs and expectations need to be managed to ensure a successful programme. Support from various stakeholders can be guaranteed only if they are involved in the decision-making process.

**PERFORMANCE MANAGEMENT:** Program success depends on its close alignment with meeting the program objectives. Alignment can be ensured by programme governance models and effectively meeting the performances of the programme in relation to its objectives. Variances need to be managed by effectively implementing strategies to reduce the negative deviations.

**ORGANIZATION MANAGEMENT:** Various stakeholders have to be managed to ensure coordinated and smooth implementation. Change agents have to be enabled and oriented to align all stakeholders towards the programme vision.

**COMMUNICATION AND MANAGEMENT AND GOVERNANCE:** Communication plays a critical role to effectively manage interfaces between stakeholders, processes and organizations. Governance structures help in enabling the communication and foster decision-making. It ensures that any decision taken is in the interest of larger programme objectives.

### 6.4.3 ACCOUNTABILITY AND TRANSPARENCY IN PROGRAMME MANAGEMENT

#### Accountability

Since civic or non-profit organizations operate under public laws, they also need standards of accountability and transparency. These laws are designed to ensure that the interests of their members and the general public are properly served and that these institutions do not violate the public's trust.

Having financial problems has always been the most likely place that non-profit or civic organizations get into trouble with the law. Today it is also a place that public and donors look to measure an organization's trustworthiness. Prudent financial accountability ensures fiscal controls are in place.

The current trend for funders and donors (exacerbated by the media) is to examine carefully overhead expenses [the ratio of spending on programs (services) versus spending on administration (management) and fundraising].

There are wide discrepancies in how this information is reported; some agencies even reporting no fundraising costs (though it is rare that a non-profit can successfully operate with no fundraising costs). Being accountable means ensuring these figures are reported accurately. When overhead percentages are low or high it doesn't necessarily mean that anything is wrong (a number of legitimate factors account for these variances) but it does mean that it should be reviewed closely.

All not for profit organisations provide some type of community benefit; that is why you get the advantage of being a non-profit entity. Accountability includes ensuring that you are effectively providing this benefit service.

Organizations need to evaluate their services impartially and perform a needs assessment of their client/constituency population, making changes if needed. This often happens as part of a strategic planning process and is a critical part in being an accountable organization.

## Transparency

Transparency involves how much you tell the public about your organization and how honestly and quickly you reveal this information. This involves, making public the organization's financial records.

### 6.4.4 GENDER, AGE, ETHNICITY, CLASS, RACE AND MANAGEMENT

Effective HIV/AIDS program management must take into the beneficiary mix that the Church programs are intended to reach, and make appropriate accommodations. Some of these considerations and accommodations are described below:

**CHILDREN AND HIV:** In HIV programming it is a big mistake to think children are small adults; children have specific needs that must be met by programs. For example HIV Prevention directed to children, must be pitched at a level they understand, i.e. age-appropriate; children on ART need special HIV treatment formulations and this requires that those dealing with children in church program be aware of some of the issues surrounding HIV treatment in children; and some children who are living with HIV have fears, are depressed, need protection and all have other basic needs – they therefore need people training in counselling children to handle some of these issues, and the Church thus must invest in training or acquiring the services of child counsellors.

**YOUTH AND HIV:** In Zambia, youths, particular girls, are at very high risk of HIV for a number of reasons including the acceptance of trans-generational sex where older men who have higher HIV prevalence have sexual relations with younger girls. As a country, we need to acknowledge the reality that the majority of youth become sexually active at very young ages (in Zambia 49% of girls are married by the time they reach 18 years) and need to strengthen measures to protect the youth from HIV.



There is therefore need for Youth Pastors. There is also need for youth to know the impact that peer pressure has upon their conduct. They need to be loved and included. Youth also need mentoring. Youth also need information and protection. They need to know that abstinence is important. Youth need recreation and fulfilled lives. Youth also need balanced parenting and understanding. Parents also need information and training to be parents of youth. Orphans and other

vulnerable children need care support and protection. All these aspects should be included in Church HIV/AIDS programs that deal with children.

**WOMEN AND HIV:** As discussed earlier gender power relations often make it difficult for a woman to refuse to have unprotected sex in marriage even when it is clear that having unprotected sex would put her at high HIV risk and would be detrimental to her well-being. Women are most often the caregivers when someone in the family has HIV, and therefore need to protect themselves by taking precautionary measures when caring for those living with HIV. Widows and other women made vulnerable by HIV/AIDS need protection so that their property is not taken away from them and so that they are not subjected to traditional practices that increase HIV vulnerability. Church HIV/AIDS program must address some of these vulnerabilities including playing an advocacy and support role in some of the HIV-related social justice issues that affect women.

**MEN AND HIV:** In many traditional Zambian cultures, having multiple sexual partners by men was not frowned upon, and was in some cultures actively encouraged. In the era of HIV/AIDS these and other harmful cultural norms put men at high risk of HIV. Men in Zambia have far less contact with the healthcare system than women, and therefore are much harder to reach with HIV prevention, care, treatment and support programs. Some HIV prevention options rest largely in the hands of men, biologically (e.g. voluntary medical male circumcision) and socially (e.g. gender power relations that put decisions about condoms use in men's hands), and it is thus important that HIV/AIDS programs reach men. Christian men need to be role models in HIV prevention, care, treatment, and support. This requires that they need greater level of responsible behaviour. They should lead by example in the family. Men need to provide checks and balances; avoid abusing younger girls and children. Men should also be in the lead in curbing multiple concurrent partnerships. Church HIV/AIDS program would be a great avenue for reaching more men in Zambia.

#### 6.4.5 BIBLICAL AND CULTURAL PERSPECTIVES ON MANAGEMENT

**THE BIBLICAL PERSPECTIVES** pertain to the advice of Jethro to Moses, his son-in law regarding the administrative functions of division of labour, delegation of authority, assignment of responsibilities, staffing, empowerment of subordinates (Exod. 18: 17-26; see also division of labour in Num. 18:1-7) and also God's arrangement of the tribes of Israel in their wilderness travel.

**CULTURAL PERSPECTIVES** pertain to a strict hierarchy of tiers from the lower organs to the upper echelons of the organization/institution. There is an aspect of consensus, negotiation, as well as give-and-take in decision-making. The system tends to be slow because of the time it takes for everyone to have an in-put in decision-making.

#### 6.4.6 HIV/AIDS AND GENDER CHALLENGES IN HIV PROGRAM MANAGEMENT

The National HIV/AIDS response faces a number of challenges including issues of governance, poverty, gender, economic, socio-cultural, legal, sexual violence and physiological factors that are different for men and women in addressing the HIV/AIDS epidemic. Gender and HIV/AIDS have been mainstreamed in most areas. However, the rate of implementation of these policies is slow. Most of the structures mandated to mainstream gender are inadequately resourced and have limited analytical skills and techniques in

gender and thus remain weak and unable to implement gender policies and planning adequately. The gender dimension and links to human rights remain challenges in most interventions in the framework. Inequalities and power imbalances between women/girls and men/boys heightens the vulnerability of females to HIV infection. Certain cultural and traditional practices have been identified as some of the factors contributing to the rate of HIV/AIDS transmission by contributing to the subordination of women, these include:

- Low economic and political status of women
- Poverty
- Limited decision-making powers
- Limited power to negotiate safe sex
- Prostitution and unprotected sex
- Early marriages
- Multiple concurrent sexual partners
- Peer pressure
- Alcohol consumption

The Church through its Christian teaching is very well positioned to champion the cause of gender equity in order to prevent HIV and increase access to and uptake of HIV care, treatment and support services for both genders. Formal Church HIV/AIDS programs would allow the Church to implement a better-organized and well-coordinated HIV/AIDS response that addresses these challenges.

## TOPIC 6.5: HIV/AIDS SUPPORT GROUPS AND HOME BASED CARE

**IMPORTANT NOTE:** It is not expected that all Churches will implement these aspects of the HIV/AIDS response, and therefore each theological institution should work out modalities on how best to implement this aspect of the curriculum, depending on the scope of the Church HIV/AIDS Program and the HIV/AIDS capacities and competencies.

### 6.5.1 ESTABLISHING SUPPORT GROUPS FOR PLHIV

It is important for the facilitator to help the learners build an understanding that HIV/AIDS has hit almost every family; if you are not infected then you are affected. Support and care for people living with HIV is every one's responsibility.

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#### **TASK(s):**

**In plenary, ask the learners to share their experiences about occasions when they provided support to a relative or friend living with HIV. In keeping with ethical guidelines, names of such relations should be withheld both within class and afterwards whenever reference is made to the subject.**

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**Note:** the facilitator will at this point explain to the learners what it means to care and support PLHIV. Examples from what the learners may have mentioned can be used to enhance understanding.



Care and support means meeting the overall needs of People living with HIV/AIDS and their families. These needs include; health needs, emotional needs, spiritual needs, nutritional needs, social needs and physical needs. The benefits of care and support groups for People living with HIV/AIDS include; reducing isolation and discrimination towards PLHIV while encouraging acceptance around HIV like it is with other chronic diseases; helping everyone understand how HIV can and cannot be passed on; strengthening HIV prevention messages by encouraging everyone not to avoid contact with PLHIV; helping people infected with HIV to live a positive life: allowing the PLHIV and care-givers to be productive members of society for as long as they are able; reducing the impact of HIV/AIDS on companies, families

and society as a whole as PLHIV feel supported in their time of need; improving the quality of life for PLHIV and their care-givers.

Unless the Church provides a compassionate and supportive environment that is free from stigma and discrimination and has a minimum level of HIV competence, it will be very difficult for PLHIV to open up about their HIV infection, join the Church-based PLHIV support group and obtain the support that the Body of Christ can provide. PLHIV support groups work best when they are led and managed by PLHIV themselves with input from technical and other experts as needed. PLHIV support groups often start small and grow with time, as more and more people see the benefits.

Where feasible, linkage or affiliation with the Network of Zambian People Living with HIV/AIDS (NZP+) is encouraged, in order to access additional support and resources.

### 6.5.2 TRAINING INDIVIDUALS AND FAMILIES TO PROVIDE HOME-BASED CARE

Without good pastoral care, desperation and despair may overcome the person living with HIV or affected by HIV/AIDS. Home-based care is not only a way of giving comfort to the sick or dying. It is also a vitally important part of keeping the person with HIV healthy and active, as long as possible. People living with AIDS, like everyone else, need to feel accepted and loved. Complete care takes much time, but there are some simple things anyone can do to make the sick person feel cared for. Caregivers can be trained in the following areas:

- Skills in communication to enable them to give hope, love, support and comfort by providing spiritual care
- Ensuring a hygienic environment is maintained in the home that will contribute to protect the person living with HIV and others from germs.
- Protection of uninfected members of the family from infection through use of home-based care kits, including gloves, bleach and some basic medicines.
- Providing simple facilities for washing hands with soap and water after helping the person with his or her personal and hygiene needs.
- Covering of wounds with waterproof dressing.
- Food and nutrition and maintaining a balanced diet and a healthy exercise regime
- How to deal with mouth sores, diarrhoea, bed sores, pain and coughs and Tuberculosis

## TOPIC 6.6 - HIV/AIDS PROJECT MANAGEMENT

**IMPORTANT NOTE:** This manual does not attempt to comprehensively cover the very broad topic of HIV/AIDS project management, but rather to introduce some of the key steps and concepts to give learners a basic understanding of the topic. The learner who wishes to know more about HIV/AIDS project management will be directed to resources that may be helpful at the end of this unit.

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**TASK(S):**

Ask learners to explain and discuss what is meant by project management and its importance in relation to HIV/AIDS projects

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### 6.6.1 DEFINING THE PROJECT

A project is an individual or collaborative enterprise that is carefully planned to achieve a particular aim (Oxford English Dictionary). **Error! Bookmark not defined.** A project is a temporary endeavour undertaken to create a unique product, service, or result. A project is temporary in that it has a defined beginning and end time, and therefore defined scope and resources. The end is reached when the project's objectives have been achieved or when the project is terminated because its objectives will not or cannot be met, or when the need for the project no longer exists. Temporary does not necessarily mean the duration of the project is short. It refers to the project's engagement and its longevity.

Temporary does not typically apply to the product, service, or result created by the project; most projects are undertaken to create a lasting outcome. For example, a project to prevent HIV leaves a lasting impact in HIV infections averted, while a project to treat HIV leaves a lasting impact in lives saved. Projects can also have social, economic and environmental impacts that far outlive the projects themselves (PMBOK Guide 5<sup>th</sup> Edition).

Project management, then, is the application of knowledge, skills and techniques to execute projects effectively and efficiently. The process of directing and controlling a project from start to finish may be further divided into 5 basic phases (PMBOK Guide 5th Edition):

#### 1. PROJECT CONCEPTION AND INITIATION

An idea for a project will be carefully examined to determine whether or not it benefits the organization. During this phase, a decision making team will identify if the project can realistically be completed.

In HIV/AIDS project management, during this phase a problem is defined and an intervention conceived to address the problem. For example: **Problem** - No HIV testing facilities nearby in order for people to learn their HIV status and make appropriate HIV prevention, care, treatment and support decisions. **Intervention** - The Church HIV/AIDS Program decides to support a Church HIV testing and counselling (HTC) centre in order to bring HTC services closer to the people and benefit Christians living in the community and also non-Christians living in the community

#### 2. PROJECT DEFINITION AND PLANNING

A project plan, project charter and/or project scope may be put in writing, outlining the work to be performed. During this phase, a team should prioritize the project, calculate a budget and schedule and determine what resources are needed.

During this phase an implementation plan is developed. In the **Church HTC Centre** example above, the implementation plan defines the scope of work including the location of the HTC centre, the size of the population to be served, the HIV testing targets to be achieved and the intended outputs and outcomes; the resources required to implement the project including the project budget, the required human resources, and the required materials and

equipment; and the monitoring and evaluation processes and procedures for tracking progress of implementation

### 3. PROJECT LAUNCH OR EXECUTION

Resources' tasks are distributed and teams are informed of responsibilities. This is a good time to bring up important project related information. This is the project start-up phase when implementation begins. In the **Church HTC Centre** example, this would be the phase when the HTC centre staff is hired, procurement of test kits and other consumables is done, and the HTC centre is opened and begins to provide HTC services to the intended beneficiaries, and linking them to other HIV services as appropriate.

### 4. PROJECT PERFORMANCE AND CONTROL

Project managers will compare project status and progress to the actual plan, as resources perform the scheduled work. During this phase, project managers may need to adjust schedules or do what is necessary to keep the project on track. This refers to monitoring and evaluating project performance and making adjustments as necessary. In the **Church HTC Centre** example, the project manager and his/her team would undertake monitoring and evaluation activities to ensure the project inputs (e.g. test kits, staff and other resources) are achieving the intended outputs (e.g. number of people tested) and outcomes (e.g. number of people linked to other HIV services such as VMMC, PMTCT, ART, OVC support and PLHIV support groups)

### 5. PROJECT CLOSEOUT

After project tasks are completed and the client has approved the outcome, an evaluation is necessary to highlight project success and/or learn from project history.

This refers to the phase when the project ends and is closed out. In the **Church HTC Centre** example, the HTC centre is either closed or the operations of the centre are handed over to another partner or project.

Projects and project management processes vary from industry to industry; however, these are the traditional elements of a project. The goal is typically to offer a product, change a process, or to solve a problem in order to benefit the organization or a specific population.

## 6.6.2 PLANNING THE PROJECT

The key to a successful project is in the planning. Creating a project plan is the first thing you should do when undertaking any kind of project. Often project planning is ignored in favour of getting on with the work. However, many people fail to realise the value of a project plan in saving time, money and many problems. Haughey (2015) provides a simple guide to project planning as below:

**STEP 1 – DEFINE THE PROJECT GOALS AND OBJECTIVES:** A project is successful when the needs of the stakeholders have been met. A stakeholder is anybody directly or indirectly impacted by the project. As a first step, it is important to identify the stakeholders in your project. It is not always easy to identify the stakeholders of a project, particularly those impacted indirectly. Examples of stakeholders are: The project sponsor; the customer who receives the deliverables; the users of the project outputs; the project manager and project team.

Once you understand who the stakeholders are, the next step is to find out their needs and prioritise them. From the prioritised list, create a set of goals and objectives that can be easily measured. A technique for doing this is to review them against the SMART (Specific, Measurable, Achievable, Realistic and Time-specific) principle. This way it will be easy to know when a goal or objective has been achieved. Once the project objectives have been determined, define the project deliverables.

**STEP 2 – DEFINE PROJECT DELIVERABLES:** Using the goals you have defined in step 1, create a list of things the project needs to deliver in order to meet those objectives. Specify when and how each item must be delivered and provide an estimated delivery date. More accurate delivery dates will be established during the scheduling phase.



**STEP 3 – CREATE A PROJECT SCHEDULE:** Create a list of tasks that need to be carried out for each deliverable identified in step 2. For each task identify the following:

- The amount of effort (hours or days) required to complete the task
- The human resource who will carry out the task and the other resources required

Once you have established the amount of effort for each task, you can work out the effort required for each deliverable, and an accurate delivery date. Update your deliverables section with the more accurate delivery dates. A common problem discovered at this point, is when a project has an imposed delivery deadline from the sponsor that is not realistic based on your estimates. If you discover this is the case, you must contact the sponsor immediately. The options you have in this situation are:

- Renegotiate the deadline (project delay).
- Employ additional resources (increased cost).
- Reduce the scope of the project (less delivered).

**STEP 4 – DEVELOP SUPPORTING PLANS (HUMAN RESOURCE, MONITORING AND EVALUATION, ETC.):** This section deals with plans you should create as part of the planning process. These can be included directly in the plan.

- **Human Resource Plan:** Identify by name, the individuals and organisations with a leading role in the project. For each, describe their roles and responsibilities on the project. Next, describe the number and type of people needed to carry out the project. For each resource detail start dates, estimated duration and the method you will use for obtaining them.
- **Communications Plan:** Create a document showing who needs to be kept informed about the project and how they will receive the information. The most common mechanism is a weekly or monthly progress report, describing how the project is performing, milestones achieved and work planned for the next period.
- **Risk Management Plan:** Risk management is an important part of project management. Although often overlooked, it is important to identify as many risks to your project as possible, and be prepared if something bad happens. Here are some examples of common project risks:
  - Time and cost estimates too optimistic.
  - Unexpected budget cuts.
  - Stakeholders changing requirements after the project has started.
- **Monitoring and Evaluation Plan:** Development of the Monitoring and Evaluation Plan is an essential step to manage the process of assessing and reporting progress towards achieving project outputs and outcomes, and to identify what evaluation questions will be addressed through evaluation. The M&E Plans assures that comparable data will be collected on a regular and timely basis, to inform project implementation, decision-making and future programming.

### 6.6.3 THE IMPORTANCE OF OBJECTIVES

Objectives provide guidelines for effective planning and effective project implementation. Objectives must be SMART. A SMART objective is:

**SPECIFIC:** Objectives should provide the “who” and “what” of program activities. It is advisable to use only one action verb since objectives with more than one verb imply that more than one activity or behaviour is being measured. Avoid verbs that may have vague meanings to describe intended outcomes (e.g. “understand” or “know”) since it may prove difficult to measure them. Instead, use verbs that document action (e.g., at the end of the session, the students will “list” three modes of HIV transmission...).

**MEASURABLE:** The focus is on “how much” change is expected. Objectives should quantify the amount of change expected. It is impossible to determine whether objectives have been met unless they can be measured. The objective provides a reference point from which a change in the target population can clearly be measured.

**ACHIEVABLE:** Objectives should be attainable within a given time frame and with the available program resources.

**REALISTIC:** Objectives are most useful when they accurately address the scope of the problem and programmatic steps that can be implemented within a specific time frame, to achieve the project goal. Objectives that do not directly relate to the program goal will not help toward achieving the goal.

**TIME-SPECIFIC:** Objectives should provide a time frame indicating when the objective will be measured or a time by which the objective will be met. Including a time frame in the objectives helps in planning and evaluating the program.

## 6.6.4 PROJECT MONITORING AND EVALUATION

Monitoring and evaluation (M&E) helps those involved with community development projects to assess if progress is being achieved in line with expectations. Monitoring is the ongoing collection and analysis of data that informs project managers if progress toward established goals is being achieved. Evaluation is a comprehensive appraisal that looks at the long-term impacts of a project and exposes what worked, what did not and what should be done differently in future projects. Figure 4 below outlines a broad step-by-step process for M&E (Comm Dev, Business for Social Responsibility n.d.).

- 1. LOGIC MODEL AND INDICATORS:** After finalising a Logic Model for planning and management purposes, associated indicators should be created in consultation with stakeholders to monitor achievement at every step of the project, from inputs and activities to outputs and outcomes.
- 2. VALIDATE INDICATORS WITH STAKEHOLDERS:** Indicator development provides an opportunity for beneficiary or community participation. By providing input on the indicators, beneficiaries are not only made aware of, but more importantly provide input to, project design and objective setting. This process of vetting indicators helps build ownership and transparency.
- 3. CONDUCT BASELINE ASSESSMENT:** An assessment of current conditions is necessary in order to create a baseline against which to measure progress over time. For example, one can only effectively gauge an increase in HIV testing and counselling over time if there is information on initial levels of HIV testing and counselling at the beginning of the project.
- 4. SET TARGETS AND SCALE:** After finalizing the list of indicators that will be measured to monitor progress, targets should be set for each indicator. Targets are the goals that you are aiming to achieve by a certain point in time.
- 5. MONITOR INPUTS, OUTPUTS AND OUTCOMES:** A project's specific data collection cycle will depend on the timeline for its targets, though periodic data collection in line with an organisation's quarterly reporting efforts is a good way to integrate community development into business processes. Data collection should ideally be participatory. By involving the community in monitoring, stakeholders can keep abreast of progress and make suggestions for course corrections, while the project partners can benefit from increased support and buy-in as a result of such transparency.
- 6. CONSULT STAKEHOLDERS ON MONITORING RESULTS:** By reporting performance data gathered through monitoring, a project can meet community expectations for

transparency and continue the dialogue about project design, management and performance. Information that is developed from monitoring should be disclosed in a “culturally appropriate” form that is accessible to all external stakeholders.

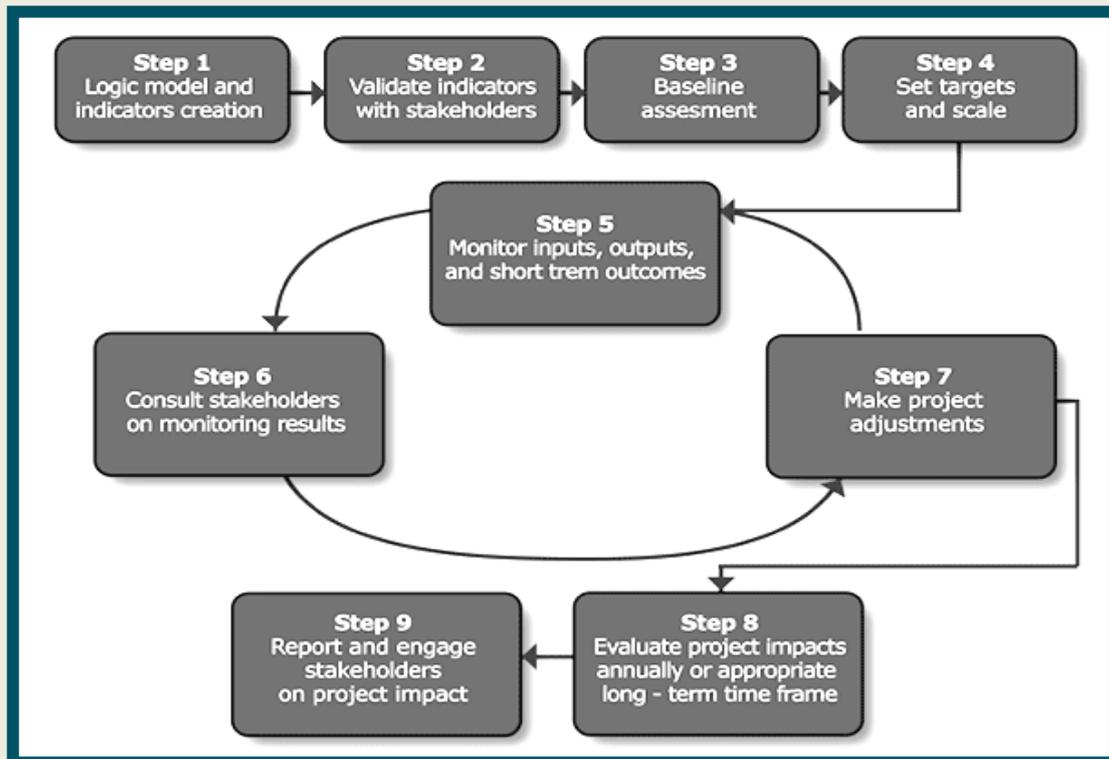


Figure 4: Monitoring and evaluation process; Source: CommDev (2015)

7. **MAKE PROJECT ADJUSTMENTS:** Engaging stakeholders through data collection and reporting will help project managers gain information on how projects should be adjusted to better ensure that goals are consistently being met. Once this information is brought to light, adjustments to the project should be made to improve performance. This is an iterative cycle that should be repeated throughout a project’s life.
8. **EVALUATE PROJECT IMPACTS:** Project impact evaluation occurs after a project has been completed. It is an analysis that helps to explain why the project did or did not produce particular results. Unlike monitoring, it is not used for on-going management, but focuses on final outcomes. Evaluation can not only help clarify whether costs for a project were justified but also inform decisions on the design and management of future projects and serve as an accountability mechanism.
9. **REPORT AND ENGAGE STAKEHOLDERS:** A final step in M&E is to share information on project impacts with shareholders, communities and the public at large through multiple channels. Reporting should not be seen as an end in itself, but rather as an invitation to dialogue with external stakeholders. The project can use M&E to inform the public of project progress and lessons learned, as well as to invite feedback on future programming.

### 6.6.5 MAINSTREAMING GENDER- SPECIFIC PROJECT COMPONENTS

As previously discussed, in espousing gender equity and gender mainstreaming, the Church is not advocating that we completely revamp the positive gender roles and responsibilities,

defined by Christ Himself and God-given, that have defined the Christian approach to gender issues. Rather, we must, in the context of the current HIV environment, give careful consideration to the different implications of church policies, programs and actions on men and women and boys and girls. Church gender considerations must optimize the contributions of Christian men and women and Christian boys and girls to developing and maintaining a just and equitable society that does not increase the risk or vulnerability of any of its members to HIV/AIDS. The following list will help to build gender equity into project design and implementation.

**Table 4: Project Design and Preparation Checklist - Gender Mainstreaming**

Item	
1	Which population groups are served by the project (women only, men only, men and women, other groups)?
2	What information is already available about each population group and women in particular?
3	Has there been consultation with people whose lives will be affected by the project, and what attention has been given to women in this process?
4	Has information on women's and men's work in the household and community been collected? Is it adequate for the purposes of the project?
5	Has there been consultation with people whose lives will be affected by the project, and what attention has been given to women in this process?
6	Are women involved at all levels in the planning and implementation of the project?

## TOPIC 6.7 - RESOURCE MOBILIZATION AND HIV/AIDS CAMPAIGN

### TASK(S):

- Ask the learners to identify the resources that would be useful in an HIV/AIDS campaign
- Divide the class in two groups and ask the learners discuss the reasons for mobilizing local resources before presenting to the plenary session. What are the advantages of working to mobilize resources with and from the community, besides just raising money?
- Ask the learners to identify and discuss the contributors or sources of these community resources and report their findings to the class.
- Ask learners to discuss the importance of mobilizing local resources for HIV/AIDS campaigns and to identify ways to mobilize local resources
- Ask learners to explain and discuss what they understand about networking and its benefits

### 6.7.1 IDENTIFICATION OF LOCAL RESOURCES AND COMMUNITY MAPPING

#### IN HIV PROGRAM MANAGEMENT FUNDRAISING IS IMPORTANT FOR:

- Program survival, expansion and development
- Reducing dependency on external donors
- Building a constituency of support
- Creating a viable and sustainable organization

### **IDENTIFYING POTENTIAL SOURCES OF RESOURCES**

- Foreign donors
- Local resource mobilization: local foundations and trusts; community foundations
- Service clubs and associations
- Local companies and small businesses
- Individuals (major donors, direct mail)
- Special events
- Local income generation projects

Individuals and institutions donate or give to church and community driven programs for various reasons including the following:

#### **INDIVIDUALS GIVE BECAUSE:**

- They are asked
- They care or are concerned about those in need
- Of personal experience
- They feel involved and want to make a difference
- They will personally benefit or want to be recognized

#### **ORGANIZATIONS GIVE BECAUSE:**

- They feel they are fulfilling their corporate-social responsibility
- They have done their research and feel, there is a good fit between their reason for existence and that which you stand for
- They understand the community's financial, geographic and topical limitations
- They understand the current policies and priorities of a given community grouping
- They have seen that you have demonstrated prior success and proper financial management (accountability)
- This enables them to demonstrate that they are a good corporate citizen

#### **SOME RESOURCES THAT ARE LOCALLY AVAILABLE INCLUDE:**

- Materials – for example, office supplies
- Services and facilities – office space, photocopying machines, printing services, telephone communication
- Human resources – volunteers, experts, free consultants, free legal support.
- Equipment – vehicles, bicycles, tables, etc.
- Money – cash

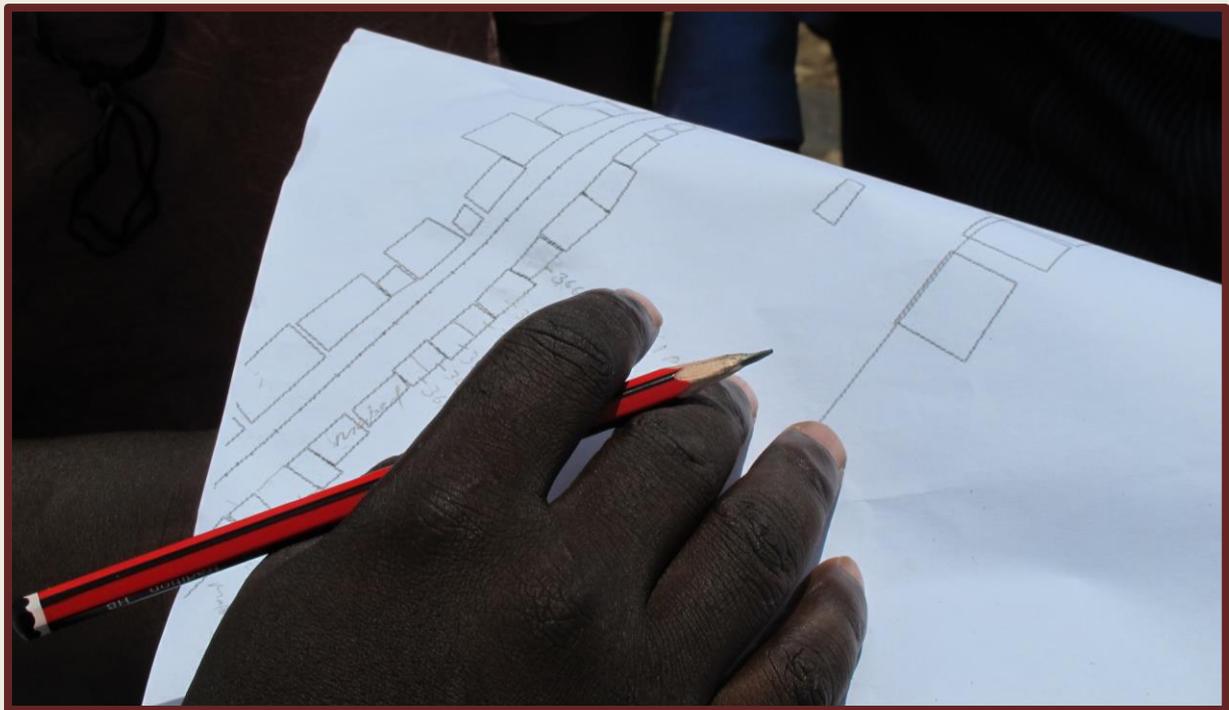
### **6.7.2 THE METHODS OF RESOURCE MOBILISATION**

- Lobbying and advocating for assistance: human resources , funds and other resources
- Ensuring that your organisation is visible – by seeing to it that the community is aware of what the organization does

### 6.7.3 COMMUNITY MAPPING

This is the process of identifying and taking inventory of the range of financial and nonfinancial resources of the community, this includes the NGOs, groups and associations resident in the identified community and local institutions (including local government agencies). Non-financial resources include skills, talents (such as handicrafts), and capacities. Each community has a unique set of asserts upon which to build its future. According to the World Bank (2007) mapping plays a role in availing an overview of the locality, its key problems, features and issues. Equally importantly mapping opens up conversations between the local residents and the outsiders. As community members transfer their perceptions onto the map, a common language is created between outsiders and local residents, interesting points emerge, and this is a good opportunity to ask questions. It is often a valuable exercise to let different groups do a map each, since they will put different emphases on issues and this can lead to important insights into local politics or divisions of opinion. There are a variety of maps including the following:

**RESOURCE MAP:** this is a map showing land types, ownership and usage. It helps to visualize the general layout of the village, cultivated and uncultivated areas, cropping patterns, grazing land, forest, soil types, erosion, users of the resources, etc.



**SOCIAL MAP:** this is a map also showing the basic layout of the village, but concentrating on infrastructure and social features. It helps to identify the stratification of communities in terms of resources, as well as their access and distribution. On these maps, symbols can be used to represent different classes of wealth, household assets e.g. land livestock, health problems, the distribution of landless families, female-headed households, different social groups or tribes, how many people there are in each household, educational status, etc.

**HISTORICAL MAP:** a map used to stimulate discussion on why and how a problem arose and to help a community gain insight into the “root” of a problem. This can be a map of the area as it was 10 or 20 or 50 years ago, drawn by older members of the community. This can complement a map of the area at present and is very useful for comparisons and questions.

Why has this changed? What caused this? When did this happen? To follow up, a projected map of the future, in 10 years' time can be drawn as an answer to the question, "What will happen if nothing is done to solve this problem?"

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**TASK(S):**

Break the class into groups of three or four. Then ask learners to carry out a mapping process of the community in which the college is situated. Hypothetically, the purpose of this process is to provide insight for an eminent project that is aimed at providing support to the PLHIV and orphans and vulnerable children (OVC). This exercise should take about 30 minutes. At the end of this exercise, each of the groups will present their findings.

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### 6.7.4 DONOR MANAGEMENT

This requires an understanding of external resources and implications for donor support and understanding the funder's requirements. Donors often have their ways of overseeing the projects they fund and may require specific monitoring and evaluation, and reporting formats, finance and admin rules and procedures, and levels of quality in program implementation. If the HIV/AIDS program accesses and uses donor funding that has these requirements, it must comply.

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**TASK(S):**

Ask the learners to each write in 300 words about how they would manage donor support. They should reference at least three literature sources. Submission of the scripts will be done after one week.

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### 6.7.5 NETWORKING, FORMING PARTNERSHIPS AND COLLABORATION

**DEFINITION OF NETWORKING:** Networking is a process by which two or more organizations and/or individuals collaborate to achieve common goals.

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**TASK(S):**

In an interactive plenary session, ask the learners the following:

- Why is networking important?
  - In an urban community setting, how can you effectively foster networking?
  - In a rural community how can you effectively foster networking?
- 

Some of the points that should come out of this exercise are listed below; with your guidance direct the discussion in a manner that will ensure that most of the bullets below are mentioned:

- Promoting exchange of information, ideas, insight, experience, skills and lessons learnt
- Technical assistance: accessing technical assistance from individuals and/or organizations with expertise in areas or sectors of interest to the organization/institution

- Resource mobilization: identifying and securing financial/material resources to expand the institution's work
- Coordination: coordinating efforts and approaches to enhance quality and ensure efficient and effective service delivery
- Increased Coverage: achieving effective wider coverage of area of operation.
- Referrals: Creating effective referral systems for the benefits of target groups (OVC, PLHIV)
- Solidarity: Providing institutional members with a sense of solidarity with others, and mutual psychosocial support
- Advocacy: Joining with others to engage influential "power-holders" in addressing structural or root causes of problems

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## UNIT SEVEN: SPECIAL TOPICS RELATED TO HIV/AIDS

### UNIT PURPOSE

This unit addresses critical and emerging issues related to HIV/AIDS including ethical and policy issues. It covers topics of particular interest that may not have been covered in other units or may have only been 'over-viewed'. It provides an opportunity for the facilitator/instructor to enable learners to engage in in-depth exploration of such issues, which may equip them with knowledge that will support them in formulating effective, theologically sound responses to the complex challenges imposed by HIV/AIDS.

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#### **NOTE TO THE FACILITATOR/INSTRUCTOR:**

The facilitator should guide and encourage learners to follow parliamentary debates and enactments on HIV/AIDS to see government involvement in this epidemic. If possible the Ministry of Health Official should be invited to class to discuss government policies on HIV/AIDS.

The facilitator/instructor should do a research on especially first topic's subheadings and encourage learners to do so in advance before the lesson – the subheadings can be categorised and dealt with in bits.

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### UNIT OBJECTIVES

At the end of this unit, the facilitator should have enabled students to:

- Engage with and discuss special issues associated with institutional care, rehabilitation and sustainable development within the context of HIV/AIDS;
- Analyze and discuss special issues related to cultural beliefs and practices impacting HIV/AIDS-related prevention and transmission;
- Analyze and discuss special issues associated with economic, social and political realities associated with HIV/AIDS;
- Analyze and assess special issues associated with ethical and legal issues related to HIV/AIDS.

### KEY METHODS OF INSTRUCTION

- Lectures
- Role plays, case studies
- Storytelling Visits to local institutions with supervised practice.

### SUGGESTED TEACHING AIDS

- Flip Charts/Chalk Board/White Board
- Creative reading materials
- Reflection papers
- Markers/Chalk
- Hand-outs/Charts/Graphs
- Overhead Projector

## TOPIC 7.1 - INSTITUTIONAL CARE; REHABILITATION; DEVELOPMENT AND SUSTAINABILITY

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### TASK(S):

- Gauge learners' understanding of what Institutional Care; Rehabilitation; Development and Sustainability is all about
  - Divide the group into discussion groups to discuss the relevance of Institutional Care; Rehabilitation; Development and Sustainability
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### 7.1.1 DEFINITIONS OF INSTITUTIONAL CARE, REHABILITATION AND DEVELOPMENT AND SUSTAINABILITY

#### Institutional care

This is a type of care given to HIV/AIDS patients in institutions outside the home under the care of professional/trained caregivers. Institutions such as: hospices, hospitals and other health centres provide such care.

#### Treatment/Rehabilitation

Involves treatment provided aimed at improving the quality of life of a person living with HIV through ART and treatment of all opportunistic infections associated with HIV infection. Rehabilitation can also involve treatment given to restore physical functioning e.g. in case of a stroke.

#### Development and Sustainability

This aspect is about empowering institutions that offer health care by availing knowledge, skills, and attitudes that can help develop and support sustainable institutional care and/or programs. In this way the Church's efforts for self-sustainability, as opposed to always looking up to outside donors for help will be enhanced.

### 7.1.2 SPECIAL TOPIC: THE ROLE OF THE CHURCH IN THE HIV/AIDS RESPONSE

The following are areas in which the Church can involve itself in ensuring church HIV/AIDS programs aimed at care and rehabilitation are supported and sustained for the benefit of PLHIV and those affected by HIV/AIDS. Practically, the learners with the help of the facilitator are to engage in serious in-depth discussion on how they, in their own religious congregations can help bring about a positive impact accordingly. It must be noted here that congregations can prioritise and deal with areas which most affect them and their congregants with regards to the HIV/AIDS epidemic. Without question the scope of church HIV/AIDS Programs will be determined by each individual church. However, there are tenets and requirements that each church grouping should adhere to and these include responding with love, compassion, competence and without judgement. Below, is a descriptive example of how a Church response can move towards HIV competence taken from Dr Sue Parry's Beacons of Hope book (Parry 2007), which might be helpful to others:

## TOWARDS AN HIV COMPETENT CHURCH

**AN HIV COMPETENT CHURCH** is a church that has first developed an inner competence through internalization of the risks, impacts and consequences of HIV and has accepted the responsibility and imperative to respond appropriately and compassionately. In order to progress to outer competence, there is need for leadership, knowledge and resources. Outer competence involves building theological and institutional capacity in a socially relevant, inclusive, sustainable and collaborative way that reduces the spread of HIV, improves the lives of PLHIV and those affected by HIV, mitigates the impact of HIV and ultimately restores health, hope and dignity.

### **THE PROCESS TOWARDS HIV COMPETENCE**

#### **INNER COMPETENCE**

1. Acknowledge the scope and risk of HIV attitude change:
2. Personalize/internalize the risk in an honest open way
3. Recognize the impact and consider long term consequences
4. Assess the risk factors that increase vulnerability
5. Confront stigma, discrimination and denial associated with HIV
6. Accept the imperative to respond appropriately and with compassion.

#### **THE BRIDGE BETWEEN INNER AND OUTER COMPETENCE**

- Leadership
- Knowledge
- Resources

#### **OUTER COMPETENCE**

1. Develop theological competence on HIV
2. Develop technical competence through building institutional capacity to plan, implement, monitor and evaluate and coordinate HIV programmes effectively
3. Ensure social relevance, inclusivity and seek to build social cohesion
4. Network: seek allies and collaborate for increased scale and sustainability
5. Advocate and reclaim the prophetic role of the church
6. Restore dignity and hope, with compassion, to all who are HIV infected and affected

*Source: Dr Sue Parry, HIV Competent Church, April 2007, EHAIA documentation*

The Church's tailored response might include some of the following areas:

- Managing/running hospices
- Supporting child headed homes for orphans
- Supporting feeding Centres for orphans, elderly and the poor
- Supporting home-based care for the HIV/AIDS and terminally ill patients
- Advocacy on economic, social and political issues in relation to HIV/AIDS
- Advocacy and support for national and church budget allocation to HIV/AIDS programs

- Mitigating the impact of HIV/AIDS on the family structure
- Highlighting and mitigating the impact of family stressors in relation to HIV/AIDS
- Highlighting and mitigating the impact of HIV/AIDS on the labour force and economic growth
- Addressing issues of mortality rates and life expectancy in the wake of HIV/AIDS
- Addressing HIV vulnerability and risk related to wars, conflict, human displacement and migrant labour
- Addressing gender inequality, violence and exploitation, women's rights and commercial sex
- Providing advocacy and support for rebuilding public health systems

## TOPIC 7.2 - ETHICAL AND LEGAL ISSUES

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### TASK(S):

- Ask the learners why it is difficult for people to go for HIV/AIDS testing
  - Discuss the importance of confidentiality in HIV/AIDS testing and counselling
  - Break learners into discussion groups to discuss HIV/AIDS in relation to euthanasia, suicide and abortion
  - Ask the learners to discuss society's views on gender rights especially that of inheritance, childlessness and early/child marriages
  - Based on the above discussion, ask learners to divide themselves to portray two families: one that has allowed their child to finish school before marriage and the other that has withdrawn their child from school and allowed early marriage. The role-play should depict the advantages of getting into marriage at an appropriate time and the consequences of early marriage respectively.
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### 7.2.1 SPECIAL TOPIC: HIV/AIDS TESTING AND CONFIDENTIALITY

#### HIV/AIDS testing

HIV testing is an important component in combating the epidemic. Nobody can tell one's status by looks alone (refer to units one and four). Most people don't test for fear of knowing that they are infected and thereby going to die (a preconceived notion that doesn't hold any water anymore because ART provides effective treatment for HIV). Such persons need to be sensitised with the correct information.

#### Confidentiality

There are other people who do not test because they do not trust the counsellors and other service providers for fear of breach of confidentiality. Such people are concerned that their status will be disclosed to other people who should not be having access to this information. These people should be assured of the confidentiality of the counsellor that he/she is committed to through the Counselling Ethical Conduct and the 'shared' confidentiality between all counsellors and other helping professionals.

Violation of this confidence without the knowledge of the client can lead the counsellor into great trouble with the authorities (ZCC) and the client has a right to sue such a counsellor.

## 7.2.2 SPECIAL TOPIC: HIV/AIDS IN RELATION TO EUTHANASIA, ABORTION AND SUICIDE

### Euthanasia

Euthanasia is defined as “mercy killing for the purpose of putting an end to extreme suffering, or saving abnormal babies, the mentally ill or the incurably sick from the prolongation, perhaps for many years, of a miserable life, which could impose too heavy a burden on their families and society”.

Although the Church has not taken a collective position on euthanasia, her teaching is that nothing and no one can in any way permit the killing of an innocent human being whether terminally or aged. Neither is anyone permitted to ask for this act of killing nor can he/she consent to it. No authority can legitimately recommend or permit such an action. Euthanasia is a violation of divine law and an offence against the dignity of the human person, a crime against life and an attack on humanity.

HIV/AIDS and other incurable diseases do not change the teaching of the Church on Euthanasia. No one has the right to ‘help’ end the life of a person living with HIV for that is only a prerogative of God, the life giver. The Church has observed that “the cries of gravely ill people who sometimes ask for death are not to be understood as implying a true desire for Euthanasia. It is almost always a case of an anguished plea for help and love, what the sick person needs besides medical care, is love, the human and supernatural warmth with which the sick person can and ought to be surrounded by all those close to him or her”.

### Abortion

Abortion is defined as the interruption of a pregnancy before the foetus is viable. It can be spontaneous or criminal (Campbell 1987). According to the Penal Code Cap 87 of the Laws of Zambia, procuring a miscarriage or abortion by whatever means is an offence which leaves the perpetrator liable to imprisonment of fourteen (14) years. The Law however does provide for the following exceptions where abortion is allowed if the continuance of the pregnancy would involve:

- i. Risk to the life of the pregnant woman; or
- ii. Risk of injury to the physical or mental health of the pregnant woman; or
- iii. Risk of injury to the physical or mental health of any existing children of the pregnant woman; would be greater than if the pregnancy were terminated; or that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

Whatever the reasons, the Church does not condone the taking of a life not even in the case of HIV infection. Pastors of souls have the responsibility to help women who find themselves at ‘crossroads’ of whether to keep the pregnancy to full term or have the option to abort medically or otherwise because the life of a human being has to be protected or safeguarded from its conception to its natural end and nobody has the right to deliberately

end it. This, then, means that even though a woman is HIV positive, it is not a basis for allowing an abortion.

## Suicide

Suicide is a deliberate act of self-injury and to some degree intended at the time of commission to result in death (Campbell 1987). There are many reasons why people commit suicide one of which is to save themselves from something they consider worse than death.

In many chronic illnesses, particularly highly stigmatized illnesses, apart from the physical effects there is often accompanying psychological and emotional trauma. HIV is no different; PLHIV may worry about living with HIV. Particular mention here is made of adolescents who are living with HIV who can have significant psychological effects from HIV that are accentuated by going through normal growth changes that involve significant hormonal fluctuations. The Church has to therefore be on the lookout for PLHIV who are struggling with their HIV status and provide information, support and counselling and in some cases referral for specialist mental health care. Well informed people whose consciences are formed, will often not reach the point of committing suicide for they will be aware of the help available and that with a positive mind and attitude following the counsellors' and health personnel's instructions they can live worthwhile lives in their families and in society.

### 7.2.3 SPECIAL TOPIC: HIV/AIDS-RELATED STIGMA AND DISCRIMINATION

HIV-related stigma and discrimination are harmful to successful HIV prevention, treatment, care and support in many ways including:

#### 1. CAUSING UNNECESSARY SUFFERING AND DEATH

By preventing people who need HIV treatment from going to seek care and from taking their ARVs without fear of being seen, judged and/or treated unjustly, stigma and discrimination cause unnecessary suffering and death.

#### 2. FUELLING THE SPREAD OF HIV

By making it difficult for people to tell others about their HIV infection, stigma and discrimination contribute to the continuing spread of HIV in Zambia – reluctance to go for HIV testing and reluctance to discuss or practice safe sex even when one is aware they are HIV positive, means that people are more likely to infect others.

### 7.2.4 SPECIAL TOPIC: WIDOW/WIDOWER, CHILDLESS AND ORPHANS IN TERMS OF INHERITANCE

#### Widow/Widower

The vulnerability of this category usually pertains to the issue of property grabbing. While the widow is more vulnerable, recent times have shown that men (widowers) too, have become 'silent' victims especially if they are the ones unemployed at the time their spouses die and where even if they were working, their income was much lower than their wives. Property grabbing is not right – it impoverishes the widow/widower and/or the orphans,

condemning them to a life of poverty and heightened HIV risk or poor health outcomes from ART and other care.

### Childlessness and Widowhood

The general understanding of people regarding marriage in Zambian culture has always been that it should be productive, i.e. every marriage should produce children. Producing children is tied to marriage. Although this is a misconception (because children are a gift from God), it has been taken as a norm. Being childless therefore has no place in a society like ours and couples who find themselves thus, suffer a lot of discrimination. A childless surviving spouse especially a female suffers a lot of ridicule from the family of the man and even society. She has no grounds for claiming anything of her late husband's even when the law provides for her. It may not even be her fault that she is childless (but her husband's problem) and at times it is nature because as mentioned earlier on, children are a gift from God and not a 'must' or 'prerogative' in every marriage.

### Orphans

The HIV epidemic has seen a rise in the number of orphans in the country. With fewer and fewer family members remaining, the issue of looking after orphans is becoming a big challenge: those who remain have families that they can barely look after, so added responsibility of orphans is something most people cannot just contend with. In some cases, surviving members take advantage of the situation by agreeing to look after the orphans and taking in trust the finances left by parents of these orphans but only to use the funds to their own benefit. It is inconceivable to think of a society that dehumanises and would want nothing to do with those who are childless and yet despises orphans so much – this is inconsistent thinking and definitely incompatible. The so called culture which supposedly loves children doesn't really know what it loves or hates. Orphans, particularly girl orphans are also at risk of sexual abuse and or early marriage, and thus high HIV vulnerability.



## Inheritance

The issue of gender rights in terms of inheritance for those who are childless, widows/widowers and orphans remain challenging for families, society and the government. While the Church (James 1:27) and even the Zambian law (Intestate Succession Act No 5 of 1989) are very clear about these issues, people tend to turn a blind eye letting their 'misunderstood' traditional/cultural norms and their greed dictate to them. The Zambian Law has the *Intestate Succession Act* (No.5 of the laws of Zambia 1989), for those who die without leaving a written Will. It is clear in the distribution of inheritance – it is the right of every person to be given what is due to them regardless of their status. The law takes into account various situations as may be experienced in the country. The country also has the *Testate Estates Act* for those who die leaving a written Will. There are heavy penalties for those who violate the Act.

HIV/AIDS has however ushered in its own complications. There is usually finger pointing as to who was responsible for the HIV infection in a home and if especially it is the woman who infected the husband and he dies, she risks being struck out (rarely men) even in a written will. This leaves the *Intestate Succession Act* and at times even the *Testate Estates Act* at the 'mercy' of the family of the deceased which should not be the case. The teaching of the Church on such issues is based on the Gospel of Matthew 7:12, the evangelist gives a golden rule: "do to others whatever you would have them do to you..." This Gospel passage is about love of God and love of neighbour (Matt. 22:34-40). If we have love for God, we will have love for our neighbours and will rejoice in their good. If this is so, then gender rights either to male and female will be respected. The Church will not let the widows/widowers, the childless and the orphans cry out to God for vengeance (Exod. 22:20-22).

### 7.2.5 SPECIAL TOPIC: HIV/AIDS-RELATED CHURCH-BASED POLICY ISSUES

Even though the Churches may not have written down policies on HIV/AIDS, they are all in agreement of the need to pay particular attention to the epidemic which has hit Zambia and the rest of the world. It is precisely this concern, that led to the development this manual and curriculum for implementation in all the theological schools where pastors are trained to work in the vineyard of the Lord with the sensitivity on the challenges of this vineyard which has become '*infested with the HIV/AIDS weed*'. Unit three expresses the differences in Church's approaches to HIV/AIDS, then, and now: from stigma, "the wages of sin is death..." (Rom. 6:23) to an embracing stance which comes with the understanding of how HIV is transmitted either through own actions or the actions of others. The Church must competently and compassionately deal with HIV/AIDS so that Christians living with HIV and those affected by HIV can "have life to the full" (John 10:10).

### 7.2.6 SPECIAL TOPIC: MORALITY, ETHICS, SEXUALITY AND THE CHURCH

#### Morality

Morality is about abundant, meaningful and constructive life lived in God's presence and according to God's will. The moral life demands sacrifice and suffering. Morality is necessary for a number of reasons, some of these being:

- It provides an orientation to life for individuals. It is a map to find our way in life.

- It is the fabric of society, providing the structure and glue that keeps society healthy and functional
- It helps us to make difficult decisions now in order that life will improve in the future. In short, morality is essential to all of life.

## Ethics

Ethics considers what it means to be good or right. It is a critical reflection on moral norms, values and behaviour of individuals and societies in order to assess their validity. It is the study of moral experience; the systematic and communal reflection on and an analysis of moral experience. Ethics is a deliberate reflection on moral judgments, actions and lifestyles. Morality and ethics are important in that both are central to personal, family, social and environmental wellbeing. Ethics asks why things are the way they are; how life ought to be lived and how what is, can be transformed into what ought to be.

## Sexuality

Sexuality affects all aspects of one's life. It emerges as part of an interactive development process between biological and sociocultural factors. A person's gender is a social construct. There exists what is considered a complementary difference between men and women. This means that men are physically and spiritually created to fulfil their role of males, husbands, fathers and so forth; and that women are physically and spiritually created to fulfil the role of females, wives, and mothers (Gen. 1:26-27; 2:21-25; Eph. 5:22-32; Col. 3:18-24). Both sexes are created in the image of God and they both possess equal dignity. Sex was not only created by God's making of humans "male and female"; it was ordained as the means for propagating the race (Gen. 1:28).

The union of a man and a woman in marriage is a way of demonstrating God's generosity by fulfilling the command to populate the earth. The limits for the use of sex, however, were within marriage. From the Biblical perspective and also the Christian perspective, adultery is forbidden (Exod. 20:14), also being referred to as a "great sin" (Gen. 20:9) and a "great wickedness and sin against God" (Gen. 39:9). Incest is forbidden (Lev. 18:6-18); sex during a woman's menstrual period is forbidden (Lev 18:19); homosexuality is forbidden (Lev. 18:23); bestiality is forbidden (Lev. 18:23) and also, fornication is forbidden (Lev. 19:29; Isa. 23:17; Ezek. 16:15, 26, 29).

While there are restrictions on sex, it is also celebrated within the beauty of marriage. The Song of Solomon reveals the beauty of courting (1:2-3:5), cleaving (3:6-5:1), and marriage (5:2-8:14). The marital relationship is between one man and one woman. It is a relationship that in courting should not involve premarital sex. The wedding ceremony should take place (Song of Sol. 3:6 – 5:1) notwithstanding the method used.

Jesus upholds the Old Testament definition of marriage (Matt. 19:1-6); condemns fornication (Matt. 5:32; 15:19; Mark. 7:21); condemns adultery. Improper sexual relationships result from a depraved heart (Rom. 1:24; 2 Cor. 12:21; Gal. 5; 19-23; Eph. 5:3; 1 Thes. 4:7). Sexual immorality also received apostolic and ecclesiastical condemnation (1 Cor. 5:1-6, 9). Believers are not to associate with the sexually immoral. Thus, sexual immorality has received divine judgment.

## 7.2.7 SPECIAL TOPIC: EARLY/CHILD MARRIAGES (CF. MARRIAGE ACT)

Child brides are a common feature in Zambia especially in rural areas. Despite the government slapping a ‘ban’ on early/child marriages, people have decided to go their own way not even being wary of how the long arm of the law would deal with them. The rationale behind child/early marriages is that a young girl who reaches puberty and is not in school does well to marry and start raising a family. But even those in school are withdrawn in preference for marriage for economic as well as cultural reasons. The Marriage Act, Chapter 50 of the Laws of Zambia Section 33 Sub-section 1 states that: “*a marriage between persons either of whom is under the age of sixteen years shall be void*”. The gender activists will call a marriage of minors, an abuse since they are not yet grown up to take on adult responsibilities (Anti-Gender-Based Violence Act no 1 of 2011).

Early child marriages should be discouraged – it robs children of their childhood as well the education they need to be well-enlightened, independent and responsible adults. From the health perspective, girls and boys who indulge in sexual activities at an early age are more at risk of contracting HIV because they are most likely to sustain cuts and bruises during sexual intercourse due to the fact that their bodies are not yet fully developed for the purpose of sexual activity. When it comes to childbirth a young girl has a hard time going through the trauma of labour and risks her life and that of the baby.

One of Zambia’s major goals in the response to HIV and AIDS is to delay the age at which young people first have sex and discourage premarital sexual activity because it reduces their potential exposure to HIV.

## TOPIC 7.3 – POLITICAL, ECONOMIC, SOCIAL ISSUES IN RELATION TO HIV/AIDS

**IMPORTANT NOTE:** This topic is intended to introduce the learner to the HIV/AIDS landscape in Zambia, and some of the key players they may collaborate with and the key issues they may encounter, in implementing Church HIV/AIDS Programs. Please note that this is not an exhaustive description, but rather a selective description that gives a few examples.

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### TASK(s):

- Ask learners if they know the political and economic situation of HIV/AIDS in Africa (citing Zambia)
  - Ask: Have the learners ever followed the budget allocation for HIV/AIDS and how HIV/AIDS impacts development?
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### 7.3.1 SPECIAL TOPIC: POLITICAL ISSUES

#### Parliamentary acts related to HIV/AIDS

Zambia has an officially recognised national multi-sectoral AIDS coordination body, the National HIV/AIDS/STI/TB Council (NAC) established in 2002 through an Act of Parliament. NAC also has a functional secretariat led by the Director General. NAC has an active government leadership and participation through representation by permanent secretaries

of line ministries and includes civil society representatives and the private sector (NAC, GRZ 2006). The NAC board comprises 15 members with five members representing civil society organisations, one representing people living with HIV and AIDS and two representing the private sector (UNGASS 2010).

### Political will in relation to HIV/AIDS

As a way of providing a supportive political environment, high government officials were said to speak publicly and favourably about HIV efforts in major domestic forums at least twice a year including the president, other high officials and officials in regions and districts (UNGASS 2010). A high level, Cabinet Committee of Ministers on HIV and AIDS (established in 2000) works closely with Ministry of Health (MoH) and NAC to provide policy direction, supervision and monitoring of the implementation of HIV and AIDS programmes, particularly in the public sector.

## 7.3.2 SPECIAL TOPIC: ECONOMIC ISSUES

### HIV/AIDS and Poverty

HIV/AIDS brings about poverty in various ways: the one infected could be the bread winner and his/her absence from work in most cases signals absence of resources for the family. It may be the affected, the caregivers who at times have to give up work or cut down on their working hours to care for the sick – this means less income for the families' upkeep.



Even where the infected and affected still hold on to their work, the amount of money involved in the care takes its toll on the family finances in terms of nutrition and future investments for the family. As family members sicken household labour which is used to generate income and food resources is reduced and food production and other economic

ventures suffer impoverishing the household. As household poverty deepens, children are withdrawn from school initiating a cycle of lack of education and poverty. Widows and children are particularly vulnerable, especially in rural areas, where most people live subsistence lives.

On the national level, resources that could have been channelled for production will be diverted towards the treatment of HIV/AIDS and so economic development is in most cases held back. Most NGOs now, who would otherwise be funding economically viable programmes have shifted their priorities in “favour” of HIV/AIDS to try and restore the health of the people who are the basic raw material for any productive work to take place.

### **7.3.3 SPECIAL TOPIC: SOCIAL ISSUES**

#### **Extended family**

The few surviving members in families (nuclear and extended) are overburdened by responsibilities of caring for the many orphans (whose parents’ lives have been claimed by HIV/AIDS) left by their relations. Where some of the orphans are also HIV positive, there are extra challenges. Because of the heavy burden, sociologically, economically, some shun the responsibilities, hence the influx of children on the streets. Although there may be other reasons for children to be on the street, the bottom line is that we are seeing a reshaping of the Zambian extended family structure and the roles and responsibilities it used to play in the care of orphans. We are witnessing a reduction in the number of caring uncles, aunties, brothers, sisters, cousins, etc. out there, who are willing to take in and care for vulnerable younger relatives.

#### **Differently-abled People and HIV/AIDS**

Zambia has the Disability Act which prohibits discrimination against people with different disabilities but to respect them and provide them the necessary care as would be any other citizen of Zambia (UNGASS 2010).

#### **Street Kids and HIV/AIDS**

The promotion and protection of human rights is explicitly mentioned in the HIV policy and strategic documents. The National HIV and AIDS/STI/TB Policy and the National HIV and AIDS Strategic Framework (NASF) (2006-2010) both recognise this issue. There is no specific law/policy for OVC and other vulnerable groups, but where such is the case, the NASF identifies the adoption of a human rights approach as a key guiding principle (UNGASS 2010).

#### **Refugees**

This category is to be treated as above: human rights approach as a guiding principle. The Bible also sheds more light in the situation: “you shall not molest or oppress an alien, for you were once aliens yourself in the land of Egypt”. God reminds the Israelites about how they sought refuge in Egypt (Deut. 24:17-18). Nobody knows when one can be a refugee especially in our present world of political instability. Suffice it to say that an HIV infected ‘alien’ needs as much support as the infected indigenous Zambian.

## TOPIC 7.4 - HUMAN RIGHTS ISSUES

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### TASK(S):

- Ask learners to discuss in groups what human rights are and especially in relation to immigration/migration policies.
  - Ask: what does the Zambian law have to say about wilful infection of HIV on another
  - Role play: depicting an HIV infected person who has been referred to an ART clinic where the caregiver explains what ARVs are and the process of accessing them. The caregiver should emphasise that receiving ARVs when recommended by a doctor is a right which should not be denied.
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### 7.4.1 SPECIAL TOPIC: UNDERSTANDING HUMAN RIGHTS

These are rights endowed on every person by virtue of their birth. The rights have a biblical foundation in Genesis 1: 27 “male and female he created them...” God is the author of human rights which dictates that humans be dignified not because of who they are in society but because of what they are: God’s creation. Human rights are not merited, they are inborn.

On December 10, 1948 the General Assembly of the United Nations adopted and proclaimed the Universal Declaration of Human Rights. These are rights applicable to all universally without any exceptions. Following this historic act the Assembly called upon all member countries to publicise the text of the Declaration and “to cause it to be disseminated, displayed, read and expounded principally in schools and other educational institutions, without distinction based on the political status of countries or territories.” This Declaration is the standard measure of achievement for all peoples and all nations, to the end that strive by teaching and education to promote respect for these rights and freedoms and by progressive measures, national and international, to secure their universal and effective recognition and observance both among the peoples of member states themselves and among the peoples of territories under their jurisdiction.

### 7.4.2 SPECIAL TOPIC: HIV POLICY AND HUMAN RIGHTS

The promotion and protection of human rights is explicitly mentioned in the HIV policy and strategic documents. The National HIV/AIDS/STI/TB Policy and the NASF (2006-2010) both recognise this issue. The HIV policy recognises that ‘HIV and AIDS negatively touches and impacts fundamental rights. There have, for instance, been cases involving job redundancies and abrupt loss of income on account of the HIV or AIDS status of an employee....indeed, it has now been established that there is a correlation between the HIV/AIDS epidemic and the abuse of human rights.’ The NASF further identifies the adoption of a human rights approach as a key guiding principle (UNGASS 2010).

### Access to Antiretroviral Therapy (ART) Care and Support

Access to Antiretroviral Therapy (ART) is a right for all the infected. The service providers should be able to direct their patients to the centres where such services are availed. Unit

one gives the criteria of when therapy should commence on the HIV/AIDS infected person. All who meet the criteria should not be discriminated against for whatever reason – there should be no justification for denying anyone access to treatment. The Declaration of Human Rights (article 23) proclaims that Health is a human right for every human being.

Zambia as a country has policies on free services for HIV prevention and antiretroviral treatment and HIV-related care and support interventions and there are steps to implement these policies (UNGASS 2010).

- (i) The Ministry of Health through the health facilities provides HIV prevention services including distribution of free condoms.
- (ii) There is a policy on free ARVs in government clinics.
- (iii) Government also facilitates training of caregivers to ensure effective home based care to PLHIV and orphans.
- (iv) There is free HIV testing and PMTCT services for pregnant women visiting government health institutions for antenatal.
- (v) There are also ‘free’ HTC and services in government clinics and male circumcision is offered freely in government health facilities.

Challenges such as shortage of medical personnel and insufficient food distribution and at times ARTs are there and are some of the areas where more serious intervention needs to be given. It is important to note here that these free facilities can only be accessed if they are known. It is imperative then, that, people requiring such help be made aware of what is available for them. Having these services is one thing, making them known to the public is another issue.

Additionally, in Zambia, the costs of accessing services are very high, particularly for the 60% of Zambians who live in poverty. Transport costs to and from health facilities can be very high, and can in fact serve as an insurmountable barrier to accessing services for some. Costs associated with some laboratory test are also high and can serve to deny service and access to the very poor. It is for these and other reasons that HIV/AIDS is a social justice issue and therefore the epidemic finds itself very much at the heart of the responsibilities of an HIV-compassionate and HIV-competent Christian Church.

### **7.4.3 SPECIAL TOPIC: WILFUL INFECTION OF HIV TO ANOTHER**

“Wilful” transmission of the virus from one who is infected to another, who is not infected, refers to an “intentional” act. This means the infected is fully aware of his/her status as being positive and deliberately or consciously chooses to have sex with an uninfected person who is not aware of the status of ‘this’ partner who makes him/her believe otherwise. When wilful infection is suspected and proven, the person infected thus, may take the case to the court of law. This is covered under the “The Anti-Gender-Based Violence Act” of 2010 of the Republic of Zambia, Article 3 which interprets an abuse as: *conduct that harms or is likely to cause harm to the safety, health or wellbeing of a person.* Wilful infection is a conduct that causes this harm to the unsuspecting ‘partner’. The wilful

infection of another person is a violation of human rights; it impinges on the right to enjoy good health.

## RECOMMENDED READING

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## CONCLUSION

It is our hope that the content of the manual has provided adequate working knowledge, skills and attitudes to the learners, who will in most cases be trainee pastors and church leaders. Through the facilitator/instructor, the learners will be enabled to internalise the message of HIV/AIDS in order that they may be well placed to handle HIV/AIDS issues for both the infected and affected. For the pastors in making, the importance of transformation being brought about by this new found knowledge so that they are people who “practice what they preach” cannot be overemphasised. This implies that the leaders of the Church are to be authentic witnesses of the message contained herein before they can successfully help to transform others.

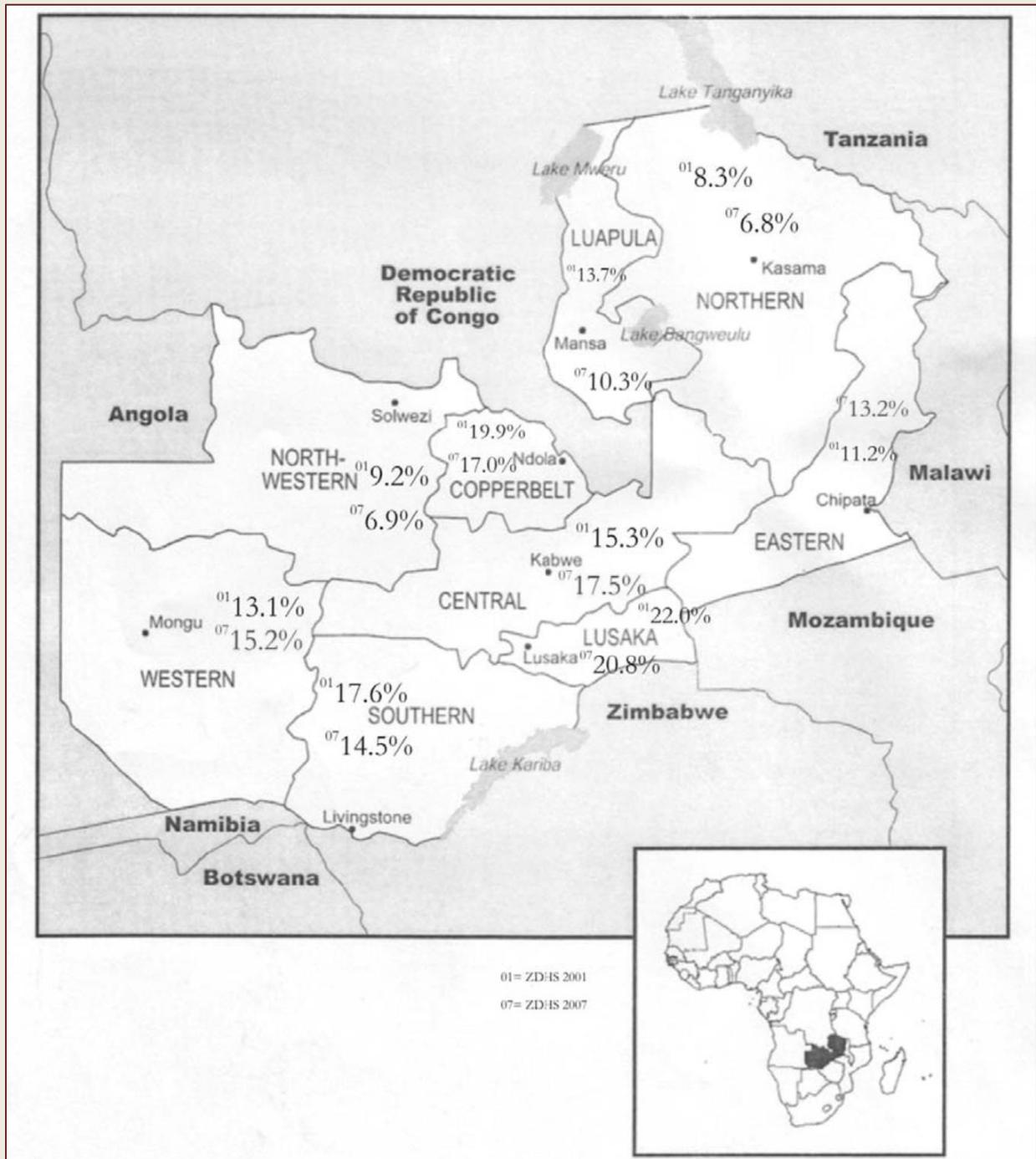
The problem of the HIV/AIDS epidemic in Zambia requires concerted efforts from all stake holders. Through the tasks appropriately identified, the learners will be enabled to look at the HIV/AIDS issues from a wider perspective. Through in-depth discussions, learners will come to the realisation of the magnitude of the problem and its complexity and accord the epidemic unswerving attention that will lead to various and appropriate mitigations.

We also hope that the content that has been put together in this manual will go a long way in enabling the Church to effectively provide knowledge about HIV/AIDS; managerial skills in developing and implementing effective prevention programmes; knowledge regarding human sexuality; skills in caring for persons living with HIV/AIDS; leading congregations in participating and celebrating HIV/AIDS sensitive liturgies/sermons; skills in providing support for care providers who experience burnout; theological understanding regarding how scriptures may be utilised to provide a positive framework for effectively addressing HIV/AIDS; knowledge regarding networking with governmental agencies, NGOs and other sectors working in the HIV/AIDS arena and also meet the goal of serving as a vital resource to the leadership of the Church as it strives to make a meaningful difference in addressing Africa’s greatest crisis of the 21st Century – HIV/AIDS.

Finally, we hope this manual will contribute towards building a more HIV-competent Zambian church, one learner and/or leader at a time, so that the Church can increasingly respond to HIV/AIDS with love and compassion, according all PLHIV and those affected the dignity, hope, and respect they deserve, and the opportunity for healing that can only come from God.

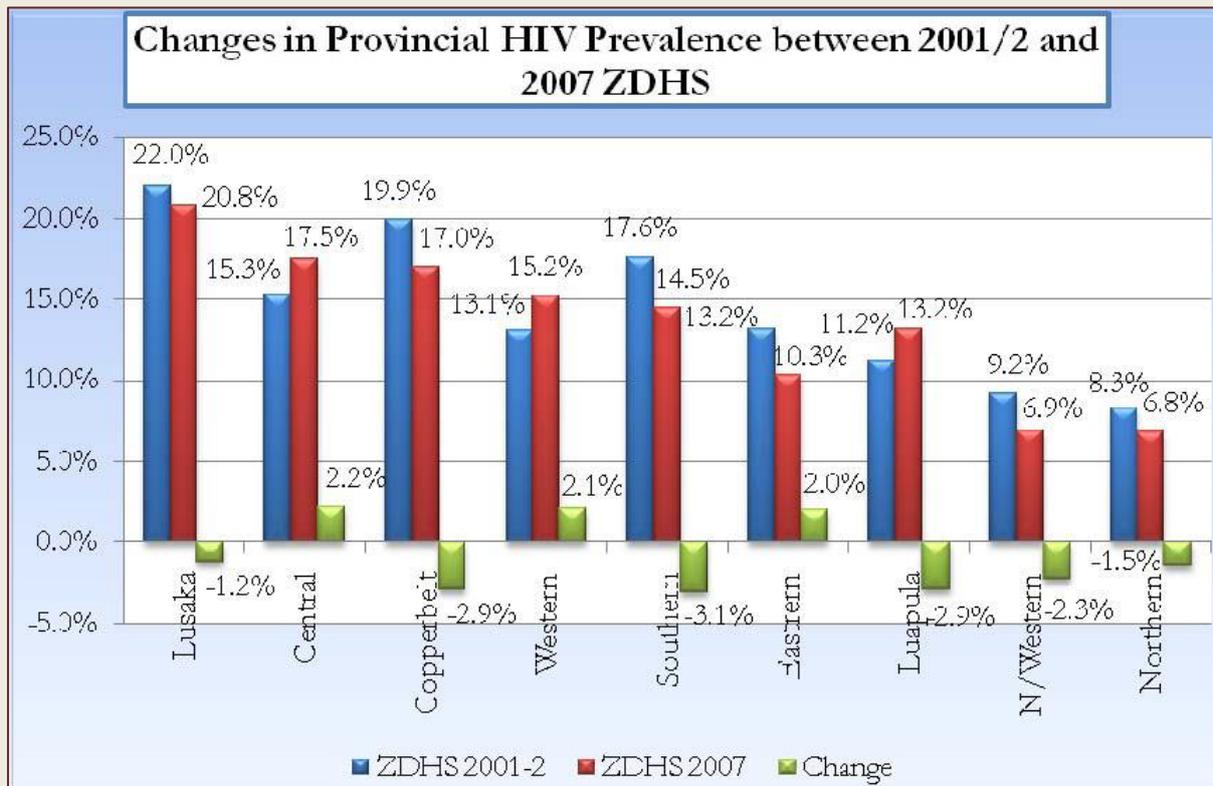
## APPENDICES

### APPENDIX 1 – PREVALENCE OF HIV IN ZAMBIA BY PROVINCE



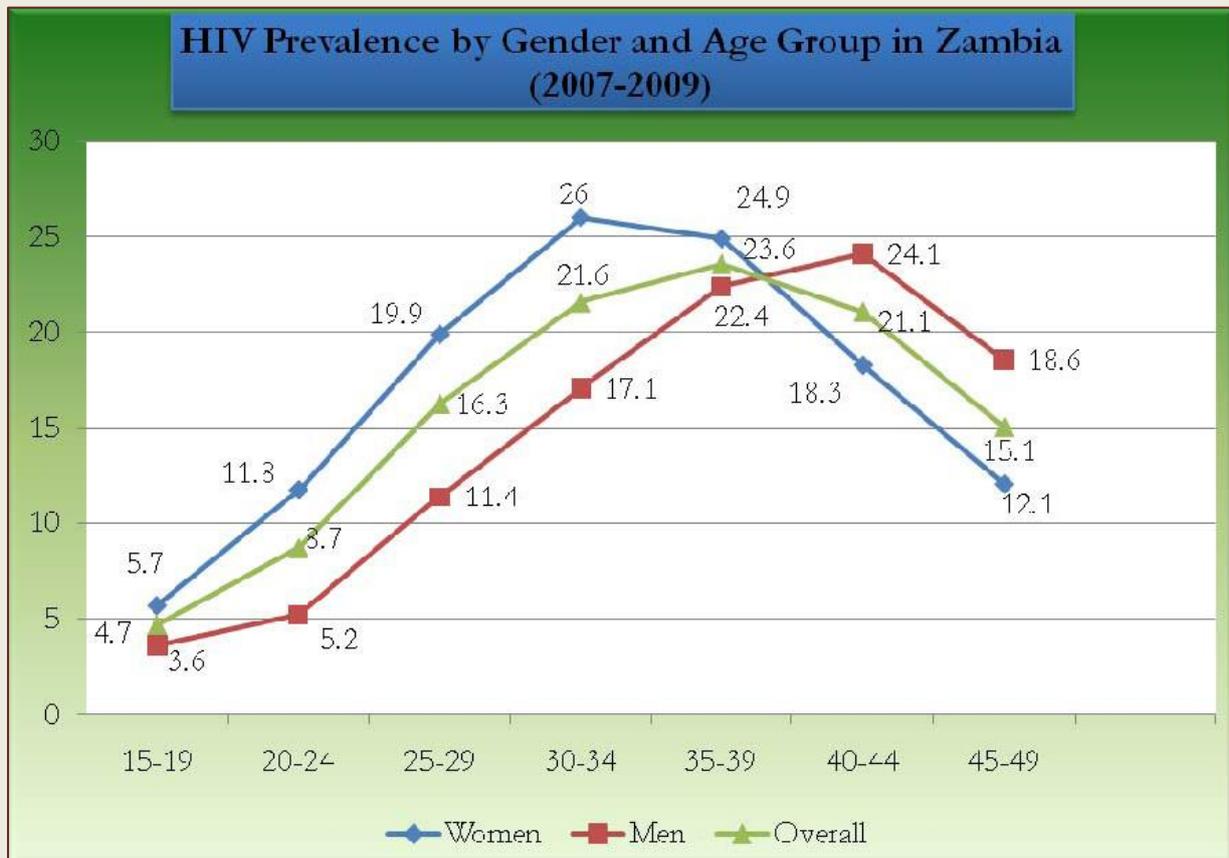
Source: (UNGASS 2010)

## APPENDIX 2 – CHANGES IN PROVINCIAL HIV PREVALENCE



Source: (UNGASS 2010)

### APPENDIX 3 – HIV PREVALENCE BY GENDER AND AGE GROUP IN ZAMBIA (2007-2009)



Source: (UNGASS 2010)

## APPENDIX 4 – TRADITIONAL AND CULTURAL PRACTICES WHICH DRIVE HIV INFECTIONS IN ZAMBIA

Cultural/Traditional Practice	Purpose/belief	Issues to consider
Dry sex: Removal of natural vaginal secretions before or during a sexual act using herbs, drugs or a cloth.	To Increase friction To please a man To enhance a man's performance For maximum pleasure	Causes irritation or inflammation Enhances HIV transmission
Sperm bath: Smearing semen on the baby on the first sexual encounter (act) after delivery	To strengthen the baby and protect from communicable diseases	Consider infected parent/s Tender skin of child Micro cuts Discordant couples
Marital shave: The removal of pubic hair from each other by married persons (usually followed by a sexual act).	Mutual hygiene To enhance trust/faithfulness Monitoring the reproductive health of spouse Stimulant for coitus	Discordant couples Micro cuts (minor bleeding) Secretions (vaginal/semen) Re-infections The use of condoms, in the Church denominations where this is an option
Post coitus wiping: Some women smear semen on their thighs after every sexual act.	To demonstrate affection for the man. To strengthen the marriage bond Semen is believed to increase the woman's skin smoothness.	Discordant couples Micro cuts
Sexual cleansing: A customary practice that forces a widowed person to have sexual relations with the dead spouse's sibling.	To make the widowed spouse feel (psychologically) free from the dead partner's spirit.	The deceased may have died of AIDS or related condition
Tattoos: Minute cuts on the skin made deliberately with a sharp instrument e.g. razor which may be shared among close family members. Some do suck blood or even rub tattoos with each other	Medicinal Family bonding or budding Ethnic identification	Shared instruments Blood contact Infected family member
Beauty tattoos: Tiny scars made on the woman's forehead, thighs, belly and around the waist	Beauty, Identification Medicinal (fertility), Stimulant for coitus, To enhance coitus (when man touches/feels the scars)	Shared instruments Blood contact Infected family member
Breast milk related: Apart from breastfeeding, women squeeze breast milk onto a baby's genitalia and into the eyes	To clean the urethral meatus To "sweeten" the sex organs To treat eye infections To neutralize poison Antidote for vermin for spitting cobra	Consider an infected woman

Wet nursing: A breastfeeding mother breastfeeding a dead woman's baby	Nutrition	Consider an infected woman/child
Initiation ceremonies: that include circumcision (male and female) Enlargement of penis and elongation of labia using herbs or pulling	Traditional education To prepare adolescents for adulthood responsibilities including sex	Shared instruments Proof of manhood/maturity Hyper-sexuality and or cross infection STIs Reported sexual supremacy or satisfaction
Sexual intercourse with a child or an old woman	To get rid of (cure) HIV infection Purification To chase evil spirits To enhance business prowess	Infected perpetrator Child abuse Rape
The wife assistant (in Bemba ' <i>impokeleshi</i> ): A young sister or cousin is appointed, with blessings/consent from the parents and the current wife, to become the second wife and assist the elder one with house chores and other marital responsibilities	To relieve pressure from the aging woman To maintain the man within the family To have more children from the same man To retain wealth within the family	Increased HIV incidence rate where one is infected
Cutting fire wood: Traditionally done by the men or husband's male relative in his absence. Fire wood keeps the family warm.	To provide family support To sustain entertainment within the family To provide protection against outsiders	Risk of extra-marital sex by migrant worker's spouse

## APPENDIX 7 – LITURGY ON WORLD AIDS DAY

The World Health Organization declared the first World AIDS Day in 1988. The day, 1 December, was quickly established as one of the world's most successful commemorative days and is now recognized and celebrated by a diverse range of constituents every year around the globe.

Then, in 1997, recognizing the need for year-round campaign activity for HIV and AIDS, UNAIDS launched the first year-long World AIDS Campaign. In June 2001, the United Nations General Assembly held a Special Session on HIV/AIDS where governments agreed to a set of targets and goals to fight AIDS in a Declaration of Commitment. Following the session, UN agencies and governments started to organize themselves around the promises outlined in the Declaration. Now, civil society is also seeking to ensure its campaigning and advocacy efforts are similarly coordinated through a strengthened World AIDS Campaign.

World AIDS Day is an important opportunity when the Church community should bring attention to the global AIDS epidemic and emphasize the critical need for a committed, meaningful and sustained response. The global theme for World AIDS Day from 2011-2015, as selected by the World AIDS Campaign, is "Getting to Zero." Backed by the United Nations, the **"Getting to Zero"** campaign focuses on the goals of zero new infections, zero discrimination and zero AIDS related deaths (UNAIDS 2005).

## APPENDIX 8 – EXAMPLE OF ORDER OF SERVICE FOR WORLD AIDS DAY

(This participatory reading, together with some aspects of this service order first appeared in Musa W: Dube, ed. *Africa Praying: A Handbook on HIV&AIDS Sensitive Sermon Guidelines and Liturgy*, Geneva: WCC, 2003, pp.88-95)

### **Call to Worship**

Creator God, shine your light upon us.

Saviour of the world, quench our thirst with your living waters.

Spirit of power and fire, renew our strength.

Opening Song:

“Oh Lord my God when I am in awesome wonder” (Stuart K. Hine, 1885)

*(or any other appropriate song on creation and life)*

### **Participatory Scripture Reading: Genesis 1**

#### **Reader 1**

In the beginning when God created the heavens and the earth

The earth was formless and void...

Then God said, "Let there be light."

And there was light...

*ALL: And God saw that the light was good.*

#### **Reader 2**

And God said, "Let there be a dome in the midst of waters..."

"Let the waters under the sky be gathered together in one place,

And let the dry land appear"

And it was so...

*ALL: And God saw that it was good.*

#### **Reader 3**

Then God said, "let the earth put forth vegetation

Plants yielding seed and fruit trees of every kind on earth"

And it was so...

*ALL: And God saw that it was good.*

#### **Reader 4**

And God said, "Let there be lights in the dome of the sky..."

Let them be for signs and for seasons and for days and years..."

And it was so...

*ALL: And God saw that it was good.*

#### **Reader 5**

And God said, "Let the waters bring forth swarms of living creatures

Let the birds fly above the earth across the dome of the sky..."

So God created...

*ALL: And God saw that it was good.*

And God said, "Let the earth bring forth living creatures of every kind..."  
And it was so...

*ALL: And God saw that it was good.*

**Reader 6**

Then God said, "Let us make humankind  
In our image, according to our likeness..."  
So God created humankind in God's own image  
In the Image of God, God created them  
Male and female God created them...

*ALL: God blessed them...*

**Reader 7**

And God said, Be fruitful and multiply  
And fill the earth ... 'See, I have given you  
Every plant yielding seed that is upon the face of the earth  
And every tree with seed in its fruit  
You shall have them for food...  
And it was so...

*ALL: God saw everything that God had made  
And indeed it was VERY good.*

*Chorus: This little light of mine, am gonna let it shine*

**Prayers of Praise and Thanksgiving**

**Leader 1: (Lighting a candle)**

Creator God, you are beautiful in your created world.

ALL

You are beautiful in the trees that swing and in the wind that blows.  
You are beautiful in the stars that shine and in the sun that rises and sets.

**Leader 1**

Creator God, you are beautiful in the animals that creep and roar.

ALL

You are beautiful in the faces of our families, friends--in all people.  
The earth and the heavens tell of your beauty and goodness.

*Chorus: We are walking in the Light of God*

**Leader 2: (Lighting another candle)**

Creator God, on this World AIDS Day

We remember that we have been living with HIV for 32 years.

ALL

We remember that we are a world living with HIV.

We remember the courage and challenges of living with HIV.

**Leader 2**

Creator God, on this World AIDS Day

We remember that you have not brought us this far to leave us.

ALL

We remember, oh Lord, that you will never leave us or forsake us.

We remember that you will always be with us.

*Pause to light candles: At this point, the congregation may be invited to silently light candles for orphaned children, people living with HIV, caregivers, activists, committed leaders, those who have gone to be with the Lord, and others.*

*Chorus: We are walking in the Light of God*

Leader 3: (Lighting another candle)

Creator God, on this World AIDS Day

We thank you, for you continue to create the earth and the heavens.

ALL

Your hand continues to create us from a formless void and darkness.

Your hand continues to create order and interconnection in your creation.

**Leader 3**

Creator God, on this World AIDS Day

We thank you, for you continue to light the world with your presence.

ALL

Your healing light shines through our bodies and communities.

Your healing light embraces us, testifying of your unfailing presence.

*Chorus: We are walking in the Light of God*

**Leader 4: (Lighting another candle)**

Creator God, on this World AIDS Day

We thank you, for you have honoured every person with your image.

ALL

We thank you, for we see your image in all of us, in all people.

We see your image in us, people living with and affected by HIV.

**Leader 4**

Creator God, on this World AIDS Day

We thank you for the HIV and AIDS caregivers, activists, professionals, planners and leaders.

ALL

We thank you, for in their work, Oh God, you continue to light the world with your love.  
We thank you for the medicines that have prevented deaths, saved children from becoming orphans, and restored health.

Chorus: *We are walking in the Light of God*

**Prayers of Confession and Rededication**

Scripture Reading: John 4: 1-15

*(After the reading, a short sermon may be preached)*

Chorus: Spirit of the living God  
Spirit of the living God, fall afresh on me;  
Spirit of the living God, fall afresh on me.  
Melt me, mould me, fill me, use me.  
Spirit of the living God, fall afresh on me.  
Spirit of the living God, move among us all;  
make us one in heart and mind, make us one in love:  
humble, caring, selfless, sharing.  
Spirit of the living God, fill our lives with love.

*Daniel Iverson, 1926*

ALL: A Prayer of Repentance

Creator God, we repent, for we have sinned against you and your creation.  
While you made all creation sacred and very good  
We have marred your creation; we have not kept the whole creation sacred.

Creator God, we repent, for while you created all people in your image  
We have denied millions of people their God-given dignity, due their identities,  
differences and HIV status.

Creator God, we repent, for while you gave resources to all people  
We have denied millions food, medicine and justice  
We have made many vulnerable to HIV infection and sent millions  
To preventable deaths

Forgive us Lord, and renew our commitment to your sacred justice and love of creation.

Chorus: *Spirit of the living God*

**Leader 1: (Using water, pour it on a potted plant)**

Merciful God, on this World AIDS Day  
Renew our energy and light us afresh with your light of love.

ALL

Renew our energy, for 35 million of us are living with HIV.

Renew our energy, for 62% of us who need medicine for HIV, still await access.

**Leader 1**

Merciful God, on this World AIDS Day  
Fill us with reverence for your sacred creation.

ALL

Fill us with your spirit to proclaim justice to the oppressed and marginalized.  
Fill us with the courage to build structures of justice within our families and communities.

Chorus: *Spirit of the Living God*

**Leader 2: (Using water, pour it on a potted plant)**

Merciful God, we present ourselves as a living sacrifice.  
Send us Lord, for your creation still groans under the challenges of HIV and AIDS.

ALL

We present our hands to you, send us to work healing in our regions.  
We present our feet to you, send us to bring healing in our countries and world.

**Leader 2**

Merciful God, we present ourselves as weak vessels.  
Pour your spirit of power upon all flesh, fill our mouths with your prophetic words.

ALL

Strengthen us to work towards zero new HIV infections and zero discrimination.  
Strengthen us, oh Lord, to dedicate ourselves towards zero AIDS-related deaths.

Chorus: *Spirit of the Living God*

Face to Face: *Holding the hands of your neighbour and looking at them, say:*

“I have seen you  
I have seen your eyes, eyes like mine  
I have seen God in your eyes  
I have heard you  
I have heard God in your voice”

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