AN EXAMINATION OF PENTECOSTAL CHURCHES' CARE AND SUPPORT FOR PEOPLE LIVING WITH HIV AND AIDS: A CASE STUDY OF NORTHMEAD ASSEMBLY OF GOD AND GOSPEL OUTREACH FELLOWSHIP

BY

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A dissertation submitted to the University of Zambia in partial fulfilment of the requirements for the award of the Degree of Master of Education in Religious Studies.

THE UNIVERSITY OF ZAMBIA
2014.

DECLARATION

I**, NOREEN MWILA PHIRI,** declare that AN EXAMINATION OF PENTECOSTAL CHURCHES' CARE AND SUPPORT FOR PEOPLE LIVING WITH HIV AND AIDS: A CASE STUDY OF NORTHMEAD ASSEMBLY OF GOD AND GOSPEL OUTREACH FELLOWSHIP is my own work and has not been previously published or presented anywhere, and that all the sources that were consulted have been indicated and acknowledged by means of complete references.

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3. **Signed…… Date: …..……..…….**

DEDICATION

This dissertation is dedicated to my family. A special feeling of gratitude goes to my loving mother, Catherine Mwape Phiri and my late grandmother, Esnala Mwenzi Banda, whose words of encouragement and tenacity ring in my ears. My children, Chileleko, Mwenzi and Nchimunya have never left my side and are very special. I also dedicate this dissertation to my husband, Dr. Liberty Mweemba, who has been a great source of inspiration and motivation. Finally, this dissertation is dedicated to all those who believe in the richness of learning.

ACKNOWLEDGEMENTS

Dr. A. Cheyeka has been an ideal research supervisor. His sage advice, insightful criticisms and comments, and patient encouragement aided the writing of this dissertation in innumerable ways. I would also like to thank staff at Northmead Assembly of God and Gospel Outreach Fellowship churches whose steadfast support was greatly needed and is deeply appreciated.

ABSTRACT

The study examined Pentecostal churches' care and support to people living with HIV and AIDS in Zambia. Using qualitative method, a descriptive study was undertaken at Northmead Assembly of God and Gospel Outreach Fellowship churches where a model of home-based care was implemented that links hospitals, clinics, and home-based care in a continuum. Data were collected from people living with HIV and AIDS, their caretakers, health care workers, and community members using semi-structured interviews, observation, and recording of conversations. The study revealed that Pentecostal churches are actively involved in the care and support of people living with HIV and AIDS through education, the establishment of clinics, provision of testing and counseling services, antiretroviral drugs and operation of orphanages. However, the study revealed that there was no transparency and accountability in the way resources from donors were utilized or raised from within the programmes operated by the churches. The study also revealed that most people paid huge sums of money to access services offered by the church even though the Church publicised the provision of such services for free. The study recommends that Pentecostal churches should do more in the care and support of people living with HIV and AIDS as their current work was limited in scope and magnitude. The study also recommends that future research should examine in-depth the systems of accountability and transparency in the way resources are utilised in the Church in order to prevent personal enrichment among Church leaders.

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ABBREVIATIONS AND ACRONYMS

HIV	-	Human Immune Deficiency Virus
AIDS	-	Acquired Immune Deficiency Syndrome
ARVs	-	Anti-retrovirals
PLWHIV	-	People Living With HIV
UNAIDS	-	United Nations Programme on HIV and AIDS
PAOG	-	Pentecostal Assemblies of God
PAOC	-	Pentecostal Assemblies of Canada
ARTs	-	Anti-retroviral Therapy
Go Centre	-	Gospel Outreach Fellowship Centre
PLWHA	-	People Living With HIV and AIDS
RNA	-	Ribonucleic Acid
HTLV	-	Human T-cell Leukemia Virus
ICASA	-	International Conference on AIDS and STDS
STDs	-	Sexually Transmitted Diseases
CBOH	-	Central Board of Health
MOH	-	Ministry of Health
MOE	-	Ministry of Education
RCZ	-	Reformed Church in Zambia
MMD	-	Movement for Multiparty Democracy
NGOs	-	Non Governmental Organizations

CHAPTER ONE

INTRODUCTION

1.1 Overview

The Church in sub-Saharan Africa and Zambia in particular has often been maligned, vilified, ignored and praised for their role in the fight against HIV and AIDS. Such divergent reactions from scholars, activists, and development officials are unsurprising given the diversity of church responses to people living with HIV and AIDS (Patterson, 2011). For instance, Chitando (2008) places HIV and AIDS within a larger context of poverty, poor governance, and underdevelopment in Zambia by arguing that both government and the church should pay greater attention to people being decimated by poverty and disease. In contrast, Jesuit Centre for Theological Reflection (2007) takes a narrower approach by stating that AIDS is a question of individual morality. It contends that condom use provides a false sense of security and does not fit into the rubric of fighting the pandemic since it facilitates the continuance of multiple sexual relations or pre-marital sex.

The above can also be compared to the actions of Prophet Peter Bolowade, a Nigerian national, operating a church in Zambia. The prophet insists that he cures his followers of HIV and AIDS through prayer and healing services (Njokotoe, 2010). His actions illustrate the belief in the power of the indivisible, spiritual realm to overcome the physical world's problems (Patterson, 2011). In contrast to this, consider the Catholic Church's response to the immediate physical needs of people living with HIV and AIDS in Zambia. This approach is premised on the understanding that a combination of physical and spiritual support can improve the quality of life of people living with HIV and AIDS (PLWHA).

The foregoing illustrates the points along the spectrum of church responses to HIV and AIDS in Zambia. This provides a model of contrasting the models of care and support to people living with HIV and AIDS. However, the focus of this study was to examine Pentecostal churches' care and support to people living with HIV and AIDS with Northmead Assembly of God and Gospel Outreach Fellowship Church as case studies.

1.2 Background to the Study

The HIV and AIDS in sub-Saharan Africa is a devastating reality, and the country of Zambia is one of its prime victims with a prevalence rate of approximately 14.3 per cent of the adult population. More than 1.1 million people are living with HIV and AIDS. Life expectancy has fallen from 50.4 years in 1980 to less than 45 in 2010-2012 (Ministry of Health, 2012). Furthermore, the mounting morbidity and mortality of the epidemic places increasing pressure on Zambia's public health sector. For instance, the needs of HIV and AIDS patients created a demand for healthcare that was beyond the capacity of hospitals and clinics in 2000 occupying close to half of the beds in main referral hospitals (UNAIDS, 2006). For a country reeling in poverty, the pandemic exacerbates the range of economic, political and social challenges.

People living with HIV and AIDS need care and support. This may vary according to many factors which include stage of illness, personal responsibilities, number of dependents, residential location, socio-economic status, level of stigma in community, and availability of healthcare services (Thandizani, 2007). Their needs include assistance with such domestic chores as cooking, cleaning, laundry, and fetching water or firewood and with such personal tasks as bathing, dressing wounds, help with exercise and transport to health centres. These are some of the needs which no other institution than the Church can adequately deal with in Africa (Anglican United Nations Office, 2007). In addition, Mkandawire (2009) argues that the Church is an influential institution in Africa, operating a number of health centres and schools. It is strategically positioned to tackle the HIV and AIDS pandemic owing to the following factors:

a) **Compassionate Ministry**: The Church's mandate in mitigating HIV and AIDS is from God. According to James Chapter 1 Verse 27, "True religion that pleases God is to take care of orphans and widows in their hour of need."

b) **Grassroots Structure**: The Church in Africa and Zambia in particular has permanent structures present at grassroots level in most of the communities, unlike other Non-Government Organizations or even the government.

c) **Holistic Approach**: HIV and AIDS is not only a health issue but also include economic, social and spiritual dimensions. Therefore, there is no other institution

than the church with an advantageous position to holistically and effectively tackle the problem from all these fronts.

d) **Behavioural Change Message**: It is generally agreed that behavioural change is probably the only sure solution to deal with the HIV and AIDS crisis. The Church, being a strong advocate for high moral principles, is the best vehicle to effectively address this.

The role of Churches in mitigating the spread and impact of the HIV and AIDS pandemic is therefore very crucial. As such, this study examined Pentecostal churches' care and support for HIV and AIDS patients in Zambia.

1.3 History of Pentecostal Churches

Pentecostalism in this study was represented by the two Pentecostal churches; Northmead Assembly of God and Gospel Outreach Fellowship Church. The two churches were selected as they command a huge following of members among people of the Pentecost faith.

1.3.1 Historical Background of Northmead Assembly of God

Pentecostal Assemblies of God (PAOG) was introduced in Zambia by Pentecostal Assemblies of Canada (PAOC). The work of PAOC in Zambia commenced in 1955 in the Fort Jameson area, now Chipata, and later extended to the Copperbelt province. The Pentecostal pioneers opened a Bible College in 1967 at Mwembeshi with only two students. Reverend Glen Kauffeldst served as Principal and emphasised good ministerial training and focused on the burgeoning cities of Zambia. Pentecostal Assemblies of God have now spread to every province of Zambia and are found in nearly every town. Northmead Assembly of God (NAOG) is called so because it is located in Northmead area, one of the townships of the city of Lusaka (Northmead Assembly of God, 2012).

Generally, NAOG has been involved in taking care of the sick especially those afflicted by the HIV and AIDS pandemic. It is also involved in the spiritual and medical healing ministry. Through the 'Circle of Hope' clinic situated in Makeni area, the Church provides services such as HIV and AIDS testing and counselling

and administration of ARTs alongside pastoral counselling and prayers (Northmead Assembly of God, 2012).

NAOG has also been involved in providing Home Based Care services. In this programme, trained volunteer care-givers visit patients in their homes to provide care and support in the form of food and clothes as well as psycho-socio support in ways that offer encouragement and comfort among others (Northmead Assembly of God, 2012).

1.3.2 Gospel Outreach Fellowship Church

Gospel Outreach Fellowship Church popularly known as 'Go Centre' was introduced in Zambia by Reverend Helmut Reutter and his wife Esther who have been preaching in Zambia since 1992 when they first came to Zambia. The Reutters were under Apostolic Faith Mission Church but decided to come up with their own Church (Gospel Outreach Fellowship Church, 2012).

Go Centre embodies a passion of bringing the gospel of Jesus Christ to Zambia in word and deed. As a practical way of preaching the gospel, the Church has developed schools, vocational training centres, clinics and a university in the country. Through Chreso Ministries, the social arm of Go Centre, the Church cares for 18,000 people suffering from HIV and AIDS in Lusaka, Livingstone, Kabwe and Siavonga districts (Gospel Outreach Fellowship Church, 2012).

Through Fountain Gate Children's Home, the Church provides a home for orphans as a way of dealing with the increasing number of orphans in Zambia. The Children's Home's vision is to be a centre of the highest quality and thus invests in know-how and activities aimed at significantly changing lives of the vulnerable children and the sick through health care and education services. The sick are attended to at the Church's clinic which directly deals with HIV and AIDS issues apart from medical related conditions (Gospel Outreach Fellowship Church, 2012).

1.4 Statement of the Problem

The Catholic Church and other mainline Protestant Churches are well known for their care and support of HIV and AIDS patients as well as care and support for those orphaned

due to AIDS. For instance, the Catholic Church runs Hospices and Orphanages; the Salvation Army is known for its facilities and programmes for HIV and AIDS patients at Chikankata hospital while the Reformed Church in Zambia has facilities and programmes for HIV and AIDS victims at Nyanje and Kamoto hospitals. There is hardly anything written about what Neo-Pentecostal Churches do. What people hear, are just claims that they provide the sick with spiritual healing by laying hands on them. They too like the Catholic and other mainline Protestant churches provide care and support to the infected and affected through hospital care and provision of orphanages. This study, therefore, aims to explore the nature of Pentecostal churches' care and support for HIV and AIDS patients and those orphaned because of AIDS with specific reference to the work of Northmead Assembly and Gospel Outreach Fellowship churches.

1.5 Purpose of the Study

The magnitude of HIV and AIDS in Zambia is alarming and has the potential to cripple further the developmental strides achieved (Chitando, 2008). Therefore, there is need for all stakeholders to be equipped with knowledge and information with regards to the disease and be fully conversant with the role of the Church in curbing the pandemic. However, the researcher notes, in this regard, that no research has ever been done in Zambia to examine Pentecostal churches' care and support to HIV and AIDS patients.

This study therefore was motivated to gather and document information on Pentecostal churches' care and support to HIV and AIDS patients in Zambia. The cursory observation made by the researcher prior to the study was that Pentecostal churches did not seem to be seriously involved in the fight against HIV and AIDS. Therefore, the study findings could hopefully be an eye opener to the Church; making it possible for religious leaders to play their expected role in curbing the disease. Map International (2006) asserts that since the beginning of the AIDS epidemic, the Church has held very judgemental reactions towards the infected and that some of its members declare that the disease is God's righteous judgement of sexual sin.

1.6 Significance of the Study

The examination of Pentecostal churches' care and support to HIV and AIDS patients is valuable in that there is no literature documented on it in Zambia. Most studies that have

been conducted on HIV and AIDS intervention by churches leave a gap that has to be filled. This study's findings will therefore add to the existing literature and form a basis on which further research could be conducted.

In addition, this study is significant in that it highlights the role of churches in the fight against HIV and AIDS and acts as an invitation to churches to review their own work of care and support for people living with HIV and AIDS.

1.7 Research Objectives

General Objective

The aim of the study was to undertake an examination of Pentecostal churches' care and support for HIV and AIDS patients in Zambia.

Specific Objectives

The specific objectives of the study were:

i) To establish Pentecostal churches' programmes designed to support HIV and AIDS patients.

ii) To assess the methods used by Pentecostal churches to care for HIV and AIDS patients in Zambia.

iii) To find out the challenges Pentecostal churches face in providing care and support to HIV and AIDS patients in Zambia.

1.8 Research Questions

i. What programmes have Pentecostal churches designed to support HIV and AIDS patients in Zambia?

ii. What methods do Pentecostal churches employ in caring and supporting people with HIV and AIDS?

iii. What challenges do Pentecostal churches face in taking care of the HIV and AIDS patients?

1.9 Delimitation of the Study

The study was carried out in Lusaka District. Lusaka District was chosen because it is home to prominent Pentecostal churches. Furthermore, the researcher was able to meet staff, pastors and patients who offered valuable time and provided information which helped in achieving the aims of this study.

1.10 Limitations of the Study

The limitations faced included securing interviews and having respondents actually make themselves available for interviews. In addition, HIV and AIDS is a sensitive subject hence informants did not volunteer as much to give out some information on HIV and AIDS patients. The most serious limitation was the lack of secondary sources on the subject matter of study. Despite the above, the researcher was able to gather adequate data as most of respondents displayed honest in their responses.

1.11 Definition of Terms

Epidemic: Refers to a large number of cases of a particular infectious disease outbreak confined to a small area, town or country.

Hospice: It is a place where the chronically ill and dying are taken care of.

Immoral: Not conforming to acceptable standards in sexual behaviour.

Palliative: Refers to a medical speciality focused on pain, stress and other debilitating symptoms of serious illness without removing its cause.

Pandemic: This refers to an illness or disease that affects the population of a large area. It can also be a global outbreak of a disease.

Pastor, Clergy, Reverend: People ordained and authorized to conduct religious worship.

Pentecostal: Churches that emphasise the work of the Holy Spirit and the fundamentals of the Bible.

Retrovirus: A virus containing RNA as the genetic material that causes cancer in animals and HTLV in humans.

Stigma: The negative thought or attitude about a person or group based on a prejudiced position by people.

1.12 Conclusion

The chapter provided an introduction to the study and endeavoured to give the broad background to the study by stating the problem, purpose of study, significance of the study, research questions, and research objectives. The chapter also provided the limitation and delimitation of the chapter. The next chapter provides the literature review of the study.

CHAPTER TWO

LITERATURE REVIEW

2.1 Overview

This chapter provides a review of related literature on care and support to HIV and AIDS patients among Protestant churches. It attempts to show the current knowledge and understanding of Christian care and support to people living with HIV and AIDS. The chapter also provides information on the advent and impact of HIV and AIDS in Zambia, its prevalence, and extent of the nature of care and support as practiced by churches. A conclusion to the chapter will be provided at the end.

2.2 Advent and Impact of HIV and AIDS in Zambia

The HIV and AIDS epidemic has been in existence for so many years now and has continued to pose serious social, economic and political problems in Zambia. The first HIV case in Zambia was isolated in 1984 and declared a "major public health threat" in 1986 (Bujra and Baylies, 2000). On the global scale, it remains unknown as to when exactly the disease started but scholars like Iliffe (2006) suggest that the symptoms of the disease were first observed on a fifteen year sexually active American youth who died in 1969. At the time, it was unknown that HIV would grow into an epidemic and become part of the global HIV and AIDS pandemic. The sufferings caused by the HIV and AIDS epidemic and its impact demand that the Church and individual Christians respond with urgency and empathy. This epidemic was declared a National Disaster requiring an emergency response at the ICASA – International Conference on AIDS and STDs in Africa held in September, 1999 in Lusaka, Zambia (Thandizani, 2007).

Among the poor the pandemic has had a very serious effect because of an already vulnerable economic situation in which they are found. Poor people may not be able to afford either the cash or the opportunity costs of medical treatment. Hence they may carry untreated sexually transmitted infections and other conditions that make it easier to become infected with HIV. Their limited accessibility to health care is frequently aggravated by the non-availability of the necessary medicines within those services. Their

poverty may push poor women and children to trade sex for income as a survival strategy, with all the attendant risks of becoming infected (Kelly, 2011). In addition, the impact of the HIV and AIDS epidemic is devastating and multi-sectored, affecting education, health, agriculture, human resource and transport. Communities have been robbed of fathers, mothers including children, and the country of highly qualified personnel and potential development (UNAIDS, 2006).

The number of orphans left behind by deaths of a parent or both will continue to increase from the current figure of 1.8 million (SHARe II, 2011). The social safety net of the extended family for orphaned children and others in extreme need is already over-stretched and inadequate to cope with the additional burden. Children in nearly every household not only have to suffer physical deprivation but also the stress and psycho social trauma of witnessing chronic illness (associated with weight loss, rejection, stigma, isolation, job losses, poverty and fear) and painful deaths of their loved ones including siblings. This leaves very deep wounds in the lives of orphaned children resulting in depression, insecurity and anger (UNAIDS, 2006).

2.3 HIV and AIDS Prevalence in Zambia

Globally, the HIV infection has continued to spread at an alarming rate with particular focus on sub-Saharan Africa. In Zambia, the Ministry of Health (2005) estimates that one million adults and children were living with HIV and AIDS at the end of 2004. According to the Central Statistical Office (2003), the national HIV seroprevalence among 15 - 49 year old adults was about 16 per cent. The mode of transmission has been predominantly heterosexual. Mother-to-child transmission is also significant. In 2005, the joint United Nations Programmes on HIV and AIDS (UNAIDS), the agency that coordinates all United Nations programmes on AIDS predicted that without continued large-scale commitment to fight AIDS, eighty million Africans would die from the disease by 2025 (UNAIDS, 2005a).

While AIDS is a global problem which has continued to spread at an alarming rate, sub-Saharan Africa has been particularly hard hit (Patterson, 2011). Kelly (2010) adds that in 2008, an estimated 2.7 million new HIV infections occurred worldwide. In the same year, 1.4 million Africans died from AIDS (UNAIDS, 2009a). Kelly (2010) further adds that an estimated total of 82,700 adults together with 9, 000 children became newly infected with

HIV in the year 2009 in Zambia. In every region of the world, the number of those who become infected annually exceeds the number of those who die of AIDS. The decrease in the number of deaths from AIDS as compared to the increase of those being infected has been due to the availability of antiretroviral drugs (ARVs) which enable infected people to live longer and continue to spread the virus.

Although data on HIV prevalence needs to be more readily available on a consistent and timely basis, sufficient information exists to draw a reasonably reliable picture of what is happening with HIV and AIDS in Zambia. The Central Board of Health (CBoH) has been organising Expert Group Meetings to evaluate existing data and reach conclusions about the status of the epidemic in Zambia (Ministry of Health, 2010). In reality, AIDS affects African countries differently with each experiencing its own unique epidemic. HIV epidemics are classified into four types; low-level, concentrated, generalised low-level and generalised high-level. In low-level epidemics, HIV prevalence is below 1 per cent in the general population and less than 5 per cent in key populations with greater HIV infection risks (UNAIDS, 2009).

In the concentrated, generalised low-level and generalised high-level epidemics, HIV prevalence in key populations is more than 5 per cent although prevalence in the general populations differs. Countries with generalised high-level epidemics such as Zambia have indicated that the prevalence of AIDS in Zambia is growing at a faster rate and hence posing a great challenge to the economy and to the provision of social welfare. The spread of the disease has reached an advanced stage (UNAIDS, 2009).

2.4 Government Efforts to Combat HIV and AIDS

AIDS has become a full-blown development crisis and its social and economic consequences are felt widely not only in health but in education, industry, agriculture, transport, human resources and the economy in general (UNAIDS, 2008). Some of the serious implications of HIV and AIDS include dramatic decline in individual health and family welfare, threat to community welfare and cohesion and extreme strain on national health systems (Aruwa, 1998). In response, the government of the Republic of Zambia came up with measures to counteract the effects of HIV and AIDS. One measure taken by the government to show concern was when the late President Mwanawasa declared HIV and AIDS a national emergency and promised to provide antiretroviral drugs. On 13th

August 2005, HIV and AIDS patients started receiving ARVs in all government clinics and hospitals. While advances in HIV and AIDS continue to be made, an HIV and AIDS vaccine has yet to be developed; hence making the virus and the disease a terminal condition for which there is no cure (Munalula, 2012).

While poverty does not cause AIDS, it facilitates the transmission of the virus and makes the treatment impossible to afford (as the drugs need food supplements), thus accelerating death from AIDS related illnesses. Consequently, it multiplies the social impact of the pandemic. AIDS accelerates poverty and poverty accelerates AIDS. The number of people living in poverty has already increased by 5 per cent as a result of the epidemic, hence, jeopardising efforts to reach the United Nations Millennium Summit Goal by the year 2015 (Smith and McDonagh, 2003). In as much as drugs are provided by donors, HIV and AIDS continue to worsen the already overburdened responsibility of poverty and disease eradication in the country.

2.5 Importance of HIV and AIDS Prevention

HIV prevention is action or a set of actions taken by individuals, couples, communities and/or nations to slow down or even stop the spread of HIV infection from one person to another (UNAIDS, 2010). Successful HIV prevention in Zambia would save the lives of many Zambians and prevent many HIV-related illnesses. Zambia is a high HIV prevalence country, meaning that it has a high number of people living with HIV, in relation to the total population. According to Central Statistical Office (2007), Zambia's HIV prevalence for adults aged 15 - 49 years is estimated to be 14.3 per cent. This means that approximately 14 out of every 100 adults in Zambia are living with HIV, hence the need for prevention.

Prevention is very important even for those who are already infected with HIV and AIDS as it prevents patients from becoming re-infected with HIV and other sexually transmitted infections (STIs), and also prevents people from transmitting HIV to others (USAIDS, 2010). The church is also encouraging positive prevention as it is a strategy to promote healthy sexual relationships, improve people's health, well-being and self-esteem and assist one to take an active role in reducing the further transmission of HIV. Positive prevention is a part of positive living as it involves taking measures that will improve the

quality of life. This may help a patient feel better and approach life positively in a holistic manner and address physical, emotional and mental needs (USAIDS, 2009).

Without successful HIV prevention, the AIDS burden would continue to grow, exerting an ever-increasing physical, psychological, social and economic toll on individuals, families, communities and the nation as a whole. Therefore, the Church needs to play an even greater integral role in decreasing the rates of HIV infections through its message of morality. Successful HIV prevention today may translate into a healthier nation with better health services, better education, better schools, better roads and more development tomorrow for the country (SHARe II, 2011).

2.6 How the HIV and AIDS Spread can be prevented

Until recently, prevention interventions have primarily targeted HIV negative people in an effort to support them avoid infection. However, with greater access to antiretroviral therapy (ART) and the associated increase in quality of life for people living with HIV and AIDS (PLWHA), it has become apparent that prevention responses must also recognise and address the needs and desires of PLWHA (USAID, 2010). Positive prevention needs to be implemented within an ethical framework that respects the rights, needs and responsibilities of people living with HIV and AIDS. The Church, with the influence of political and community leaders, can assist reduce the spread by ensuring that a supportive legal and policy environment exists. In addition, community and family members also can support PLWHA to adopt a positive lifestyle. Positive prevention represents a synergy between prevention, treatment, care and support (USAID, 2009).

Integral to preventing the spread of HIV and AIDS is behavioural change. HIV is spread by certain types of human behaviour which can be controlled by changes in those behaviours (Ministry of Education, 2008). The term “behaviour change” broadly includes modification in any behaviour that increases the risk of HIV infection, including multiple sexual partners, sex with a sex worker, intravenous drug use, and sex without a condom with a partner whose HIV status is unknown (Wilson, 2006). However, when most Church leaders and pastors refer to behaviour change, they tend to mean abstinence before marriage and marital fidelity. In fact many Church leaders argue that increased condom use does not fit into the rubric of behaviour change as it does not require people to modify their actions or commit themselves to relationships.

Working with families affected by HIV and AIDS involves monitoring behaviours because their experiences are extremely valuable for inculcating behaviour change in a wider community. Caring for PLWHA helps to make the community more aware of these people and their problems. Churches and Faith Based Organisations' care helps to make the pandemic more of a reality for those not infected with the virus (Shorter, 1998). Furthermore, caring for HIV and AIDS patients helps the community learn about the problems faced by the victims. It also helps care-givers to understand the patient better. Moreover, involving the affected people can inculcate behaviour change with the community they live in because they could be living examples of faithful / positive living (Shorter, 1998). Therefore, associating with people of similar problems can give some comfort and motivation in life. PLWHA need help to cope with the problem and live positively. In this way behavioural change will be inculcated in many people's lives.

2.7 The Involvement of Faith Based Organisations (FBOs)

In 2001, FBOs tabled a statement at the United Nations General Assembly Special Session (UNGASS) on their role in responding to the HIV and AIDS pandemic. Noting that they were among the many actors in the global response, the participating organisations offered their many specific resources and strengths, acknowledged that they had not always responded appropriately to HIV and AIDS and expressed regret for instances where they had contributed to stigma, fear and misinformation (UNAIDS, 2001).

In many respects this was a frank summary statement of the involvement of the Christian churches in response to HIV and AIDS. They are actors. They capitalise on their numerous advantages. They have accomplished much but they also made mistakes from which they continue to learn valuable lessons.

The statistics on the provision of care and treatment give some idea of the extent of Church involvement in the response to the pandemic. A Vatican estimate is that, across the world, 45 per cent of AIDS care and treatment is provided by governments, 27 per cent comes by the Catholic Church, a further 16 per cent by other FBOs and 12 per cent by non-governmental organisations, some of which are faith-related (Barragan, 2007).

In many African countries like Zambia, the Christian churches are especially prominent in their response, through their health associations, religious organisations and communities. According to UNAIDS (2011), various Christian health associations in Africa, working in parallel with government health ministries, provide about 40 per cent of all health care in Lesotho, 45 per cent in Zimbabwe, 48 per cent in Tanzania, 47 per cent in Liberia, 40 per cent in Kenya, and 30 per cent in Zambia. Archbishop Desmond Tutu of South Africa estimates that together with their related organisations, the churches are providing over 60 per cent of the HIV community programmes in sub-Saharan Africa (Nkomzana, 2007).

These are remarkable statistics that bespeak extensive dedication and commitment, especially when it is recognised that the majority of the Church and related community responses are relatively small-scale undertakings, which started as initiatives of concerned individuals – pastors and others – who reached out in efforts to lessen the pain, suffering and isolation of the socially marginalised.

2.7.1 The Response of the Catholic Church

The Catholic Church is understood as a 'doer' of theology. This means that the Church's theology is by and large practical. In other words the Church's theology is underpinned by works of mercy. This faith accompanied by actions in the Catholic Church is not so conspicuous among Protestant churches which are characterised by preponderantly 'talked theology'. However, there are exceptions to this and generally, Protestant churches have come to respond too in dealing with the HIV and AIDS scourge (Kelly, 2008; Cosstick, 1987).

The Catholic Church is identified as the world's largest provider of AIDS care accounting for more than 25 per cent of the global support for those infected or affected. As a huge organisation with more than 120 million adherents, the Catholic Church is a substantial actor on the HIV and AIDS issue. This is particularly the case in southern and eastern Africa where countries have high HIV prevalence and sizeable Catholic populations (Patterson, 2011). World over there is praise and appreciation for the work the Catholic Church and its members' performance in caring for the sick especially through Home-Based Care and in responding to the needs of orphans and vulnerable (Kelly, 2010).

The Catholic Church emphasises prevention of HIV infection as the mainstay of international and national responses to the pandemic. Therefore, care and support for those infected and affected by HIV and AIDS are inseparable elements of an effective response to HIV and AIDS pandemic (Pathfinder International, 2000). The Catholic Church attempts to provide a better life to those infected through campaigns and education for the elimination of humanly debilitating diseases such as AIDS (Jesuit Centre for Theological Reflection, 2011).

In Zambia, Kasisi and Nyumba Yanga Orphanages are some of the places where most children orphaned by HIV and AIDS related cases are cared for and supported by the Catholic Church. Most Catholic Parishes in Lusaka have established community Home-Based care units which take care of the chronically ill. The care-givers provide PLWHA hope to live longer and strength to deal with illness and challenges and also help them to mitigate the impact of HIV and AIDS (Njuguna, 2003).

Care and support for the sick in general has been part of the Catholic Church's mission for a long time. This has been seen in the building of many hospitals wherever the Church has been established. According to Kelly (2010), the Catholic Church has responded to the HIV and AIDS epidemic in five principal areas: prevention; care and treatment; mitigation of the impacts of HIV or AIDS on those infected or affected; spiritual accompaniment; and advocacy for the social services. The Church cares for the sick especially PLWHA in many areas through their Hospices. They provide good care and support to both the infected and affected.

The Catholic Church in line with its mission of healing and its social teaching, enshrined in its Vatican II documents, extends her help towards the caring of the sick. The Catholic Bishops have asserted that "there should be proper treatment of AIDS victims; there should be care for them preferably in their families where the local community can be involved'' (Komakoma, 2003). The Catholic Church in her area of care also helps the families of those affected. The fact that not all families may be able to provide for their sick members, especially in the later stages of the disease, means that the introduction of institutional care which is similar to a home would be imminent (Zambia Episcopal Conference, 2003). Thus the Catholic Church tries to render care

and support to the people infected with HIV and AIDS and those who have cancer by giving them shelter through Hospices.

While the work of the Catholic Church has received appreciation, it is contented that the Church is not doing enough and that the Church perpetuates the catastrophe. For instance, the Bishops will tell a young man that he should not have sex before marriage. But if he falls to temptation is it not better that he should use a condom? That, according to the official line of the Catholic Church is absolutely forbidden (Patterson, 2011). What seems surprising about this is that an institution with unmarried clergy with little understanding of marriage, let alone of the love that can exist between two people of the opposite sex or in short term affairs are keen to jump onto the band-wagon of Christian Puritanism and state their disapproval and dislike for human sexuality (Ham, 2004). This absolute trust in the Church is doing very little good for Africa and Zambia in particular. The Church should be guiding people down the right path and not abandon all reason to blind faith.

In addition, Ham (2004) contends that the Catholic Church together with other religious groupings have fought government in Zambia and Malawi in its attempt to deal with the catastrophe right through the vital years from 1995 to 2002. This has been done through the Church's objection to the widespread distribution of condoms. Cynics say that this objection is a call to 'make lots of babies for God', which has resulted in 'make lots of orphans for God', giving it a lot of 'good works to perform', caring for them all. This approach can be said to be hypocritical for a Church that seems to show care and support for those afflicted yet refuses to deal with the root cause of the problem.

2.7.2 The Catholic Hospice Care in General

As already stated, the Catholic Church's work for the HIV and AIDS patients has been through their hospices. The term 'hospice' comes from a Latin, word 'hospis' meaning host and guest. The Catholic hospices are community-based, not-for-profit programmes serving people worldwide since 1988. Catholic hospices provide responsive end-of-life care for patients of all ages and faiths, and assist families in caring for a loved one with reverence and dignity at the most vulnerable time in life's journey (Catholic Health Service, 2011). Dixon (2004) further states that hospices are aimed at providing a place

where those terminally ill can find peace and security in a specialist environment with a particular expertise in symptom control.

Hospices are usually separate from hospitals, are independently funded and seek to help people die well by caring for them as whole people, physically, emotionally, socially and spiritually (Dixon, 2004). Hospice and hospice care involve a philosophy of care rather than a specific building or service. This philosophy spread fast from the 1970s onwards, in the UK at first and then elsewhere because traditional medicine seemed obsessed with cure and had little time for the incurable. At the same time, those with symptoms such as pain were often very badly treated. Indeed, hi-tech medicine has sometimes lost touch with the needs of people (Dixon, 2004). Thus the drive to build hospices often came from relatives of the loved ones who had died badly. The Catholic Church adopted this philosophy to help combat stigma and loneliness which the patients and families faced.

When AIDS became more and more evident, most of those who were ill in many countries were treated at first by specialists in either sexually transmitted diseases or chest problems neither of whom had much experience of looking after the dying. The unit of care is not just for the person who is dying, but it is also there to provide emotional and spiritual support to the family, or the group of people around that person (Dixon, 2004).

The goal of any hospice or supportive care programme is to keep the patient as comfortable as possible by relieving pain and other discomforting symptoms. Care in the hospice should be able to help the patient and family accept that death can occur at any time (Kubler-Ross, 1970). Furthermore, hospice care helps the patients go through the five stages of suffering which are: denial, rage and anger, bargaining, depression, acceptance and waiting thus managing death as it is approaching (Kirkpatrick, 1998). It also offers support to both the patient and the family by helping them understand and manage what is happening.

2.7.3 The Catholic Hospice Care in Zambia

Hospice care was introduced in Zambia in 1989 by the Sisters of St. Charles Borromeo in Chilanga Township in Chilanga district. It was known as ‘Mother of Mercy’ and

upon its inception, the hospice started providing care for the terminally ill lying with HIV and AIDS. The Catholic affiliated hospice in Zambia was established through donations from individuals and Christian organisations. It has 120 beds and currently provides services to 350 low-income, terminally ill HIV positive people, many of whom have been shunned by their families and communities (Munalula, 2012).

According to Kaiser Family Foundation (2009), Mother of Mercy is one of the HIV and AIDS hospices in Zambia operated by the Catholic Church. Due to the good reception and care it has provided, the hospice was over burdened as a lot of people were requesting for hospice care. This prompted the Catholic Church to come up with other hospices in Lusaka such as Our Lady's in Kalingalinga and Mother Theresa's in Mtendere and other Zambian towns.

Hospices also offer support to both the patient and the family by helping them understand and manage what is happening in the patient's life. Hospices and supportive care view "family" in the broadest sense, including spouses, lovers, partners, children and any loved ones who form the patients' basis for social and emotional support (Chemack, 1997). The hospice provides pastoral care which people who are infected with HIV, their partners, relatives or friends need to help them cope with their own strong feeling of anger, sorrow, failure or guilt which are buried very deeply in their subconscious (Kirkpatrick, 1998).

2.8 The Work of Some Mainline Protestant Churches in Zambia

Throughout human history, religious groups have responded to human needs and this response is based on the moral teachings of their faith. The Church by its very nature and teachings is a caring community. Mainline Protestant churches such as the Reformed Church of Zambia and Salvation Army have actively been involved in the fight against the pandemic. Like Jesus Christ, the Church is called upon to show compassion and attend to the needs of those afflicted and suffering. In light of the HIV and AIDS pandemic, the Church is called to engage in the fight against the triple 'S' factor namely silence, shame and stigma as well as against discrimination, prejudice, injustice and oppression (Banda, 2008).

2.8.1 The Background of the Reformed Church in Zambia (RCZ)

According to the Reformed Church in Zambia (2011), RCZ is one of the biggest Presbyterian Churches in Zambia. It has 154 congregations spread across Zambia and consisting of over five hundred thousand members. They are served by more than 110 qualified ministers and more than 39 Evangelists. Many of its congregations are in the Eastern Province where the Church was first established. Congregations are grouped in a cluster called Presbytery and there are, currently, a total of 16 presbyteries in Zambia.

In order to be effective and efficient in its endeavour to serve the communities of Zambia and those beyond its borders, RCZ has in place desks and institutions that meet specific needs of the community. Both the desks and the institutions work closely with the local Church to ensure close monitoring of its activities (Reformed Church in Zambia, 2011).

The Church's involvement in the community covers a wide range of areas. These include health, education, sport, social welfare and general character building. The Reformed Church in Zambia has congregations stretching across the whole country. This has made service delivery, through the coordination of the relevant desks or institutions and the involvement of the local congregations ever more effective (Reformed Church in Zambia, 2011).

2.8.2 RCZ's Current Responses to HIV and AIDS

There exists very little literature on the current responses of the Church to HIV and AIDS. However, evidence exists to show that the Church understands that 'if you are not infected, you are affected' (Reformed Church in Zambia, 2011). This is attested by the existence of projects to assist PLWHA. These include conducting HIV and AIDS sensitisation, openly discussing the pandemic in Church, encouraging church members to care and support PLWHA in their communities, and providing free medication and medical staff services to PLWHA at its hospitals (Reformed Church in Zambia, 2012).

The Church has an AIDS Ministry Group, a group which ministers to AIDS patients in the area of care, support, nurturing and consolation. They are not a primarily evangelistic ministry in the sense of pressure to convert a person to a particular faith or morality. The group is involved in the free gift of self to others, echoing God's free gift

of divine self to humanity. It involves establishing, knowing and sharing a relationship characterised biblically as loving one's neighbour (Reformed Church in Zambia, 2011).

2.8.3 Care through Training

According to Reformed Church in Zambia (2011), the Church conducts training to church members on how to care and support PLWHA. This is conducted to ensure that church members help AIDS patients to see themselves worth in the eyes of God. Pastoral care is also offered and involves the ministry of oversight and nature offered by religious leaders to its community including acts of discipline, support, care, comfort and celebration. In a community riddled with HIV and AIDS and strong belief in God, pastoral care plays an integral role in alleviating the suffering of PLWHA (Gerkin, 1997).

In addition, RCZ exercise a far-reaching leadership philosophy through the trainings it offers to its church members. This is an important way to fight the AIDS pandemic because training is an essential method of refining performance in AIDS projects. Training has been a crucial element for the effectiveness of awareness programmes, giving care and treatment, counselling and responding to the concerns of PLWHA. Training is necessary as it allays people's fears and prejudices. These trainings include all departments in the Church ranging from pastors to Sunday school leaders. They train annually at the Booth Training Centre (Reformed Church in Zambia, 2011).

As a Church, RCZ sees counselling as an essential aspect of HIV and AIDS care. A big proportion of training is therefore directed towards the training of counsellors. Counselling enables PLWHA and their families to come to terms with the pandemic and to live positively. It also helps people to accept their status and it is one of the many roles of the church. The church does not only care for the sick and those infected with HIV, it also cares for their families as well. Families become collaborators with the church in dispensing care that the patients require. Therefore, families are also trained to give home-based care service required by the patients. The training involves basic nursing, hygienic procedures and control of disease. The church also trains PLWHA and their families on how to be economically empowered. Most AIDS patients are left without a dependable source of income because they are no longer employed. This is why the RCZ trains family members of the sick with marketable skills to enable them

support themselves and contribute to the income of the family (Reformed Church in Zambia, 2005).

Furthermore, RCZ strongly believe in community service and that for one to feel that they are a true Christian they need to be attached to community service. Through community service, the Church integrates PLWHA and various community service programmes in an effort to make them feel part of the community (Gerkin, 1997).

2.8.4 Care and Support through Health Services

The Church's legacy from Jesus Christ is healing in its entire dimension which includes physical and social, environmental, moral and spiritual (Cosstick, 1987). At physical level RCZ is tackling the pandemic through medical treatment at its hospitals. At psychological level, the Church provides pastoral counselling. At social level, the Church helps to keep families together by promoting reconciliation among family members and supporting the affected. In addition, education is provided to counteract discrimination and stigmatization as well as create an environment conducive for patients' care. The moral and spiritual levels are catered for through pastoral counselling and prayer. The Church also attempts to provide a voice for the voiceless through its advocacy programmes (Reformed Church in Zambia, 2011).

Through its Nyanje and Kamoto hospitals in Eastern province RCZ provides services such as counselling, anti-retroviral treatment and sensitisation programmes as a response to the pandemic (van Klinken, 2011). In addition, the Church uses resources including medical expertise, funding and medical supplies using a body of dedicated volunteers. Through its work at Nyanje and Kamoto hospitals, the Church has earned a reputation for its care and personal attention given to PLWHA (Reformed Church in Zambia, 2011). This is seen as putting the gospel in practice.

Medical personnel at Kamoto and Nyanje hospitals are directly responsible for HIV and AIDS outreach campaigns. The campaigns involve educating the people on the benefits of knowing one's status. They also advocate for abstinence and faithful sexual behaviour, while condom use is restricted for use among married couples. Apart from medical assistance, patients are regularly visited, given anti-retroviral drugs as well as nutritious food stuffs and toiletries (Reformed Church in Zambia, 2005).

2.8.5 Care and Support through other Community Services

Community outreach services have over the years become a common feature of RCZ's activities in providing support and care to PLWHA (van Klinken, 2011). Through such services, the Church provides pastoral counselling, medical treatment and moral support. In particular, women church members organize themselves in groups to visit different sections of the communities they live in (Reformed Church in Zambia, 2011).

RCZ provides spiritual and emotional support to bereaved families, making death and dying a time of reflection and spiritual growth. Widows, widowers and orphans are helped with food, clothing and shelter to enable them get through times of difficulty (Reformed Church in Zambia, 2005). In regard to tending for the afflicted, the Church has developed AIDS Policy Guidelines (see **Appendix I**).

2.9 The Background to the Salvation Army Church's Involvement in HIV and AIDS Programmes

The origin of HIV and AIDS programme under Salvation Army Chikankata Hospital in March 1987 was preceded by the diagnosis of a skin condition, *Kaposi's sarcoma*, in a patient in 1986, with another 37 more cases of AIDS diagnosed later at the end of that year (Silombe, 2002). As more patients with AIDS crowded the hospital wards, the idea to build a hospice was debated by the hospital staff and the community leaders and finally rejected. It was felt that the numbers of patients who would require care would soon overwhelm a hospice. Knowing that caring for the sick by families at home is an inherent strength of Zambian society, the home based care approach to helping PLWHA was adopted. The system involved the family, neighbourhood and community with Chikankata Hospital as the key player (Silombe, 2002). This approach has continued up to the present owing to the positive impact it has had on the community.

Salvation Army is the pioneer of many projects that deal with AIDS and are currently working together with the Catholic in the fight against the pandemic (Salvation Army Church, 2005). The Salvation Army claims to have also natured a lot of churches in many issues concerning AIDS and this includes the NAOG.

2.9.1 Chikankata HIV and AIDS Prevalence

Chikankata Hospital's Anti-Retroviral Therapy (ART) Clinic named *Muka Buumi* ("Mother of Life" in Tonga), together with the Voluntary Counselling and Testing (VCT) services were started on 1st September 2004. At the start of VCT, out of a total of 391 people tested, 276 of them were HIV positive. In 2005, the number of HIV positive people came down to 660 from a total of 1096 tested. The situation changed for the better in 2006, when for the first time, a fewer number of people tested positive for HIV as against those who tested negative, from the huge total of 2175. This was the largest number Chikankata Hospital has had in one year. The situation remained constant in 2007 when 1724 were tested positive.

The fact that HIV prevalence within Chikankata catchment area was on the decrease from 2008 through to 2012, paints a bright picture on the wall. It gives the idea that the rate of new HIV infections per year has also decreased, as a fall in incidence always precede the fall in prevalence. While statistics for 2013 are yet to be compiled and published, it will be wise and more accurate to agree, that the natural saturation of the HIV epidemic coupled with VCT services and behaviour change interventions carried out by Chikankata Hospital, both contribute to the fall in the incidence and prevalence of HIV in Chikankata catchment area (Silombe, 2013).

2.9.2 Salvation Army Involvement in HIV and AIDS Response

The Salvation Army is a faith-based community organisation that shows practical concern and care for the needs of people regardless of race, creed, status, colour, sex or age. The organisation is dedicated to encouraging social and economic development in the countries which it works. It operates social centres and cooperates with international relief agencies and governments alike to achieve these goals (Salvation Army Church, 2011).

Salvation Army's attitude towards people living with HIV and AIDS has been different from that of other Protestant churches. Though AIDS was perceived differently by individuals, the church welcomed AIDS patients in church without discriminating them and instead encouraged them to be tested and start treatment depending on the situation and outcome (Silombe, 2013). Salvation Army believes that health care can be greatly

expanded and influenced by the involvement of local family members and people from the community. With a minimum of training, communities can confidently and competently undertake health care relating to HIV and AIDS including distributing, administering, observing, monitoring and referring in relation to ART drugs (Salvation Army Health Services, 2005).

The Salvation Army has been involved with communities responding to HIV and AIDS over the past 28 years. The strength and capacity of communities has been demonstrated in many ways including, for example, the way that conflict is resolved in local culture. Reconciliation is an indicator of the fact that God comes near to people in the midst of the epidemic. Such experience is a reminder of the foundation to all health and healing work. The availability of ART is an opportunity, for health and healing, for thousands of people who are living with HIV and are in touch with the Salvation Army across the world (Silombe, 2013).

2.9.3 Care Services through Community Works

According to Salvation Army Health Services (2005), Home Based care service was introduced in Zambia by The Salvation Army Church in 1983. The Church saw that the best way to assist AIDS patients was by following them to their homes to see if they were well cared for and if they took their drugs at the right time. The trend has continued to date in the areas where community centres have been established such as Chelston and Kanyama, and other townships of Lusaka. The members of the church who are trained care-givers have continued to take care of the AIDS patients to many areas of Lusaka and other towns in the country.

Other HIV and AIDS services offered by the Salvation Army are Community Based Orphan programmes. The Salvation Army does not have any orphanage but assist the Orphaned and Vulnerable Children (OVC) through their foster families. They prefer having them kept by their foster parents because they do not want the OVC to lose out on social life. Salvation Army do not just provide to the orphaned child alone but also carter for every child in that family for the fear of discrimination. The experience has been that, if an OVC receives new shoes alone, the rest of the children would pass bad comments on the one who had received new clothes and the child would remain in isolation. So the Salvation Army makes sure that if a family is keeping an OVC, all the

children in that house will receive the same clothes and the rest of the family members will benefit from the given foodstuffs (Salvation Army, 2007).

2.9.4 Response through the Health Services – Chikankata Hospital

The Church has a hospital which is in the Southern province of Zambia. Since the discovery of HIV and AIDS in Zambia, the Salvation Army has had compassion to assist the AIDS patients. Chikankata hospital has a well equipped laboratory which detects CD4 count and offers VCT services as well as treatment. The hospital is not just open to the Salvation Army members but also the general public (Salvation Army, 2007).

The Salvation Army HIV and AIDS approach in Africa has expanded over the many years with the help of participatory programme designs coordinated by a regional (inter-country) facilitation team. The team facilitates concepts transfer rather than activity transfer, based on the belief in community capacity to determine its own response (Salvation Army, 2008).

2.10 Pentecostal Churches' Attitude and Response to HIV and AIDS

HIV and AIDS have disturbed peoples' lives the world over especially in countries like Zambia where the socially disadvantaged seem to be the majority. Some of the factors fuelling HIV and AIDS in Africa include: migration, gender inequality, negative sex orientation and lack of respect for human rights (Dube, 2008).

With these challenges, the church must be there to preserve life and offer hope to the hopeless. Yet the attitude towards HIV and AIDS patients in most of the Pentecostal churches is discouraging. Most of the Pentecostal churches' official position on HIV and AIDS is not clear. It is not surprising to find, for example, in ZAOGA and Lion of Judah, that there is both an acceptance of the reality of HIV and AIDS and non-acceptance of HIV and AIDS patients. This dilemma calls for the Pentecostal churches' urgent attention as it does not heal the souls of the affected and infected. This dilemma is linked to exclusion. Miroslav (1996) rightly observed that 'exclusion' transgresses against 'binding', where one is driven out of space either as nonentity or a superfluous being-that can be disregarded and abandoned. In other words exclusion can result in not recognising the other as someone who in his or her otherness belongs to the pattern of

interdependence as in the case of HIV and AIDS patients. Interestingly, the disease has not even spared Pentecostal leaders such as pastors, elders and deacons. Some have died while others are living with the disease.

However, with the level of stigma that is attached to it, a lot of Pentecostals are afraid of opening up such that they remain strangers from the day they realised they were HIV positive. Chitando and Gunda (2007) have rightly observed that the church has unfortunately been implicated in the stigmatisation of people living with HIV and AIDS, where the Bible is used against such people. Most of the Pentecostal church preachers are armatures in their artistic display of people living with HIV and AIDS as a 'cursed lot'.

2.10.1 The Pentecostal Message of Purity and the Concept of 'Holiness'

The Pentecostal churches usually give the following five reasons for the existence of the HIV and AIDS disease: the fall of man, Satan, punishment for disobeying God's commands and the natural consequences of sin. In most cases, people living with HIV and AIDS have accepted their status as a curse from God. This has led most HIV patients who are Christian to shy away from accessing ARVs, let alone getting tested when one's health is deteriorating. What is clear is that most of the Pentecostal churches are a product of the Holiness Movement, where there is so much emphasis on purity in the believers' lives. This 'Holiness' concept is the contributing factor to the negative attitude towards HIV and AIDS patients. Despite people living with the disease being excluded in subtlety, they are also denied of protecting themselves from exposure to further infections or boosting of their immune system through ARVs. Usually members are told to choose between prayer and medication. If people choose prayer, the search for treatment and counselling by professional counsellors automatically stops, putting HIV and AIDS patients at risk and immense pressure. Most of them stop taking the ARVs as a way of showing their faith in the healing power of God (Dube, 2008).

2.10.2 Exclusion and its Consequences

Believers living with HIV and AIDS are not fully equipped to face life by living with the disease. So the Jesus' message of hope towards all who are sick from all types of

diseases is made void when it comes to HIV and AIDS patients. The HIV and AIDS patients feel too diseased to survive more years as a result of what they experience on a daily basis. Thus, patients long on daily basis to shed off this cloak of death they are presented with. The socially excluded HIV and AIDS patients are exposed to the everyday life of condemnation. Passing a judgment on those living with HIV and AIDS is an act of exclusion, sometimes characterised by use of adjectives which are more than expressions of exclusionary personal or communal attitude (Wiesel, 1990).

The church has not learnt anything on this aspect of stigmatisation and the fight for the welfare of those living with HIV and AIDS. Much of the public awareness on HIV and AIDS led by Pentecostal churches is nothing less than condemnation and damnation of people living with HIV and AIDS (Manchingura, 2012). The Pentecostal message on abstinence is commendable but abstinence should not be used as a measurement of one's morality or lack of it. It is important to note that the Church is justified in emphasizing against pre-marital sex for the adolescent and the unmarried. Their position is supported by the biblical texts and also the African culture.

However, the problem only comes when all patients of HIV and AIDS are put under the broader brand of immorality. The image created is too difficult to take and too much to comprehend, whenever the sermons that remind those living with the disease about their impending death and second suffering in hell. A senior Pastor in the Apostolic Faith Mission argued that:

> Symbolic exclusion experienced in most of the Pentecostal churches, especially Apostolic Faith Mission, is often influenced by the distortion of the reality about HIV and AIDS and its effects on the church. The exclusionary sermons about HIV and AIDS and people living with the virus are not simply ignorance about the disease but sometimes a deliberate misconstruction to serve our interests of being seen as in charge: yet not realising the effects it has on the HIV and AIDS patients. Such sermons divide the church, creating a conflict between those living with the disease as the "condemned" and those without it as the "favoured" (Manchingura, 2012).

HIV and AIDS are then seen as monsters that came as a result of the consequences of the sin of immorality, hence the theology of 'splitting'. This is where patients are excluded as 'them sinners, losers' and 'us, holy winners'.

2.10.3 Pentecostal Beliefs and Practices in Relation to HIV and AIDS

In most of the Pentecostal churches, the following practices are censored: adultery or fornication, pre-marital sex, violence and use of condoms in whatever circumstances. The message is on complete abstinence in any type of sexual relation for partners that are not married, for physical affection displayed between unmarried men and women through hugging, holding hands, cuddling and even kissing is strictly prohibited. In the Apostolic Faith Mission church, women are discouraged from putting on trousers, mini or short skirts. Long skirts with long blouses and covered hair are taken as virtues of a decent woman. Long trousers and mini-skirts are taken as a form of dressing for "women" that feature in beer-halls and night clubs where they get the HIV virus. Sexual issues are usually a guarded field that cannot be discussed openly. If discussed, for example, in the Men's Fellowship or Ladies' Fellowship or Couples Seminars, the emphasis is on faithfulness and prayer in case of somebody yoked with an unfaithful partner (Dube, 2008).

The understanding is that God will restore that unfaithful partner to become faithful. Though this noble idea may stabilise marriages, it does not equip the affected partner on the procedures to take so as to be safe from the disease. Nothing is ever said about the use of protective methods in case of an unfaithful partner. Sex is a subject of much unabashed conversation (Wiesel, 1990).

It is not surprising that the trend in the church on sexuality is a clear influence from the African religio-cultural world view where sexual issues are coloured with privacy and secrecy. Usually in public people can talk but it is not easy to understand, as symbolical language is invoked for the sake of children or the generality of people. This secrecy or silence around AIDS is often related to the stigma attached to the sickness. In the Zimbabwean public space, there are many people who succumbed to the virus but people are not free to say the truth about the disease; even if they might be so sure about their suspicion that their relative is HIV positive or died from the disease. No one would dare let the cat out of the basket (Manchingura, 2012).

2.10.4 The Status of Women and HIV and AIDS

Women are usually the most affected patients of the HIV and AIDS, as most African societies are highly masculine or patriarchal, encouraging women to remain in marriages that expose them to the disease. Yet it has been observed that the institution of marriage does not protect women. In some African countries rates of infection among married women are higher than those among the unmarried, sexually active women. The African women often do not have the power to negotiate safer sexual practices like the use of condoms. Men decide what is good for the women when it comes to sex, for instance, when, where and how the sexual act takes place (Dube, 2008).As a result, women are put at the receiving end as servants of men.

It is not surprising that the church has been found wanting in the protection of women within and outside the marriage institution. For instance, when it comes to condoms use, as shown in their agreement to Pope Benedict XVI message that: “condoms were not the answer to the continent's fight against HIV and AIDs and could make the problem worse.” The Pope’s position is widely accepted and is the dominant thinking for most Christian groupings especially Pentecostals (Dube, 2008). It is good that the Pope spoke on behalf of the broader Catholic Church but it is women who are the most affected. It is also clear that it is mostly men who want to speak on behalf of women as shown by the Pope. What is also of interest is that the Pope feels that the African continent should not embrace the use of condoms but it is the same continent that has been ravaged by the epidemic.

At face value the fidelity teaching sounds noble but it does not address the practical issues faced in marriages. For married women the church prescribes fidelity and yet this does not address married women yoked to non-believing husbands who do not subscribe to the fidelity and moral uprightness teachings of the church. This leaves the position of women in marriage weak, as they cannot successfully apply the biblical principles they get from the Church without the co-operation of their spouses. Additionally, one of the Christian virtues of a good wife is for a woman not to have autonomy over her own body. Her body belongs to her husband, who despite being promiscuous and uncomfortable with the use of condoms, cannot be denied sex. As

earlier stated, an African woman is not expected to negotiate for safer sex even in instances where they know that spouses have been unfaithful. Culturally elders and aunties encourage women to bear with their husbands. This is the same advice they get from the Pentecostal church leadership couched in words like: 'you need to pray, fast and have trust in the Lord'. Whether the HIV virus respects such faith and trust in the Lord is nobody's guess but what is clear is that many young and faithful Christian women find their way to the grave much earlier (Manchingura, 2012).

In light of the issues addressed above, most Pentecostal churches have been found wanting in areas of care and support. Instead, they have heavily relied on faith to heal and trust in God to turn things around. This has presented a problematic situation in dealing with the pandemic from a religious point of view given the polarity of ideas on how HIV and AIDS could be dealt with. In contrast to the above, a few Pentecostal churches have been able to show care and support to people living with HIV and AIDS.

Some aspects of the response of Pentecostal churches' to HIV and AIDS, such as the number of hospitals and clinics that the churches are responsible for, can be clearly determined to a small-scale. In addition, much less is known about other aspects, such as the multitude of small-scale faith-based programmes and faith-inspired initiatives taken by communities and individuals. Some may be so small and locally based that the religious mother body may not be aware of them (UNICEF, 2003). Moreover, very few have been documented. Nevertheless, it is possible to make some general statements about the response of Pentecostal churches in Zambia to HIV and AIDS:

- Since the mid-2000s there has been an increase in the number of churches health and wellbeing programmes, many of them responding directly to HIV and AIDS. There is an overwhelming desire to be more effective against the epidemic.

- Responses range across the continuum of prevention, care and support, treatment and rights, and are often holistic in nature, attending to the physical, social, emotional and spiritual dimensions of individuals.

- They are perceived to be contributing to health, wellbeing and the struggle against HIV and AIDS in both tangible and intangible ways. It is this

combination that distinguishes them and gives them strength. The tangible features include compassionate care, material support and curative interventions, while the intangible refer to spiritual encouragement, sharing of knowledge and moral formation.

- Some see the role played by these churches as helping people at an individual level rather than seeking social change at the public and collective level (Kelly, 2010).

The actual activities of religious and faith-based organisations are diverse. Home-based care and visiting the sick are among the most common activities at community level. Activities centred on the sick are generally supported by religious leaders and congregation members, and sometimes have the support of local medical personnel. An important activity often related to home-based care is support for orphans, with two interventions predominating: the integration of orphans into families and direct material support in the form of food or ensuring access to school education. In addition, they frequently undertake activities aimed at increasing knowledge about HIV and AIDS within their congregations and communities, with some providing advice and encouragement in relation to voluntary counselling and testing (Kelly, 2010).

Patterson (2011) contends that the Church's response to the intricacies of the epidemic are nuanced and ultimately, political. In other words, the Church's response to HIV and AIDS reflects the fact that political and religious life cannot be easily divided in Africa (Ranger, 2008; Gifford, 1998). Religion has entered the public square through representation in AIDS policy-making and funding institutions, and through religious leaders who demand state services or donor attention to HIV and AIDS. As politicians from Kwame Nkrumah to Frederick Chiluba recognised, religion is a powerful political asset.

2.11 Conclusion

This chapter has shown that Protestant churches are engaged in provision of care and support to HIV and AIDS. Like the Catholic Church, they are engaged in the provision of HIV and AIDS programmes including Home Based Care, counselling and provision of ART. The chapter notes that the Reformed Church in Zambia like the Catholic

Church is not doing enough especially in the area of prevention. They seem preoccupied dealing with PLWHA. As shown, the plethora of programmes and activities they have established to care and support PLWHA has been substantial while neglecting to deal directly with the issue of prevention through its conflicting messages. Furthermore, the chapter shows that prevention forms a critical component in reducing the cases of PLWHA. Unlike the Catholic Church clergy, Protestant churches' clergy are in a better position to understand the institution of marriage and love that may exist between two people. As a result, they can offer more insightful direction in dealing with HIV and AIDS. As shown, HIV and AIDS will continue to grow until the Church and other institutions embark on effective measures to dealing practically with the issue of prevention as regards condom use.

CHAPTER THREE

METHODOLOGY

3.1 Overview

This chapter provides a description of the methods which were applied in conducting the study. It is organised under the sections: research design, study location, target population and sample design and size, sampling procedure, data collection and analysis. A description of the research credibility and trustworthiness, dependability as well as ethical considerations will be given. A sum up of the main issues emanating from the chapter will be given at the end.

3.2 Research Design

The study used the qualitative method of research. This was used because of the need by the researcher to capture and collect in-depth data and the various multifaceted aspects of care and support for HIV and AIDS patients by Pentecostal churches. Furthermore, the approach enabled respondents to freely express their opinions, thoughts and understanding about the subject. The research design employed was the case study. This was used because of its ability to present the researcher with real life situations. According to Yin (1994), a case study is an empirical inquiry that investigates a contemporary phenomenon within real life context when the boundaries between phenomenon and context are not clearly evident and in which multiple sources of evidence are used. This attribute of the case study enabled the researcher to comprehensively study Pentecostal churches' care and support for people living with HIV and AIDS.

3.3 Study Location

The study was carried out in Lusaka District, the capital city of Zambia. This is because Northmead Assembly of God and Gospel Outreach Fellowship which were the main focus of the study are located in Lusaka. Furthermore, the two churches have their headquarters in Lusaka with well established structures than in any other town in Zambia.

This therefore influenced to a great extent the usefulness of the data collected and relevance of the findings reported.

3.4 Target Population

The Northmead Assembly of God and Gospel Outreach Fellowship are fully functional and operational churches in Lusaka, Zambia. They are Pentecostal churches with a large following of members. These two churches were selected for the following reasons:

Easy of Accessibility: the churches were easily accessible to the researcher which resulted in substantial reduction in costs related to transport, accommodation, food and other essential amenities.

Knowledge: the churches were selected because they had respondents who were knowledgeable and possessed the information related to the study. Furthermore, they understood the languages of the researcher which where English, Nyanja and Bemba, making communication much easier.

Convenience: the respondents could easily be found within their established institutions of providing care and support to HIV and AIDS patients. In addition, the respondents were much more responsive to participating in the research as the value of the study was clearly understood.

3.5 Sample Design

The study used the non-probability sampling design. Within this design, the sampling technique used was purposive sampling. This technique was used because it enabled the researcher to purposively select a sample of respondents with reliable and relevant information to the study. Those purposively selected included church leaders, patients and staff members.

3.6 Sample Size and Sampling Procedure

The sample size of 30 respondents was purposively selected using pre-set criteria described below. This sample size was chosen because it was easy to manage and valid generalisations could still be made. Furthermore, it was selected to avoid saturation in which new data collected would not be adding value to the study.

The following pre-set criteria were used to purposively select the sample:

Staff members: staff members responsible in the care and support of HIV and AIDS patients in the respective churches as well as clinics. Furthermore, the staff members had to have 3 or more years of work experience. All those who did not meet the pre-set criteria were excluded.

Church leaders: church leaders who had worked at management level for 3 or more years directly in the care and support of HIV and AIDS patients. In addition, church leaders also included those that had worked in the care and support of HIV and AIDS before and may have been re-assigned to perform other duties and responsibilities.

Patients: patients who were suffering from HIV and AIDS and receiving care and support provided by Northmead Assembly of God and Gospel Outreach Fellowship Churches. These were to be found at the clinics or any facility or programme operated by the two churches.

3.7 Data Collection

According to Kombo and Tromp (2006: 99), data collection is "the gathering of information in order to serve or prove some facts. In order to gather the required data, more focus was devoted to generating data through primary sources of information using the data collection methods and instruments described below:

Interviews

According to Dexter (1970), an interview provides access to the content of the situation and makes the researcher have deeper meaning about the reality of what is being studied. In addition, interviews provide access to what is inside a person's head, makes it possible to measure what a person knows (knowledge or information), what a person likes or dislikes (values and preferences) and what a person thinks (attitudes and beliefs) (White, 2005). Interviews may be structured or unstructured. The researcher used unstructured interviews to extract information because this enabled the researcher to probe what was being said by the respondent by asking for further clarifications there and then. Furthermore, unstructured interviews were used as they allowed the researcher to be flexible and free to move around.

Participant Observation

Observation is a method in which the researcher takes field notes on the behaviour and activities of individuals at the research site (Cresswell, 2003). Dexter (1970) refer to the data obtained through observation as 'live'. Participant observation, in particular, is a strategy where the researcher actually lives and works among the people being observed or studied. Participant observers live as much as possible with the individuals they are investigating, trying to blend in and take part in their daily activities. The participant observer watches what people do, listens to what they say, and interacts with participants (LeCompte and Preissle, 1993). According to White (2005), the purpose of observational data is to describe the setting that was observed; the activities of the participants that took place in that setting; and the people who participated in those activities and their contributions. Participant observation was used because the researcher was interested in seeing the care and support that was being offered to HIV and AIDS patients. The researcher participated in cleaning the homes of the sick, pretended to be a student in craft works and taught the orphans at the orphanage. This assisted the researcher not to dwell on personal assumptions and interpretations but rather make comparisons of the observations with those of the participants.

3.8 Data Analysis

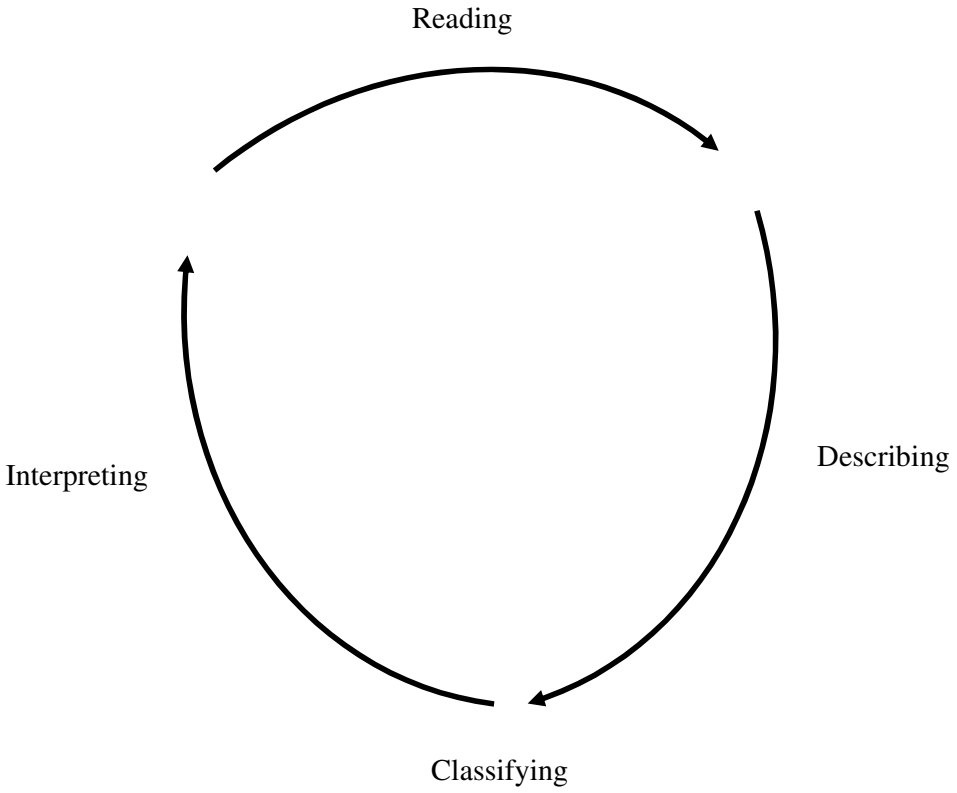
According to Berg (2004), the initial task in analysis of qualitative data is to find concepts that help make sense of what is going on. These concepts about data analysis start arising during data collection and that marks the beginning of the analysis as the basis for its analysis. Data analysis actually involves scrutinising the acquired information and drawing conclusions. The acquired information is the raw data and may consist of words and sometimes visual materials such as photographs and primary field notes supplemented by documents and interview scripts.

Data analysis proceeds in tandem with data collection (Yin, 1994). In other words, it takes place simultaneously with data collection. The first step is that of managing the data so that they can be studied. It involves a cyclical process of: becoming familiar with the data and identifying main themes in them; examining the data in-depth so as to provide detailed descriptions of the settings, participants and activities (describing); categorising and coding of pieces of data and physically grouping them into themes (classifying); and

interpreting and synthesizing the organised data into general conclusions (interpreting) as shown in Figure 1.1 below.

Figure 1.1

Steps in analysing qualitative data



Source: (White, 2005: 186)

Data in this study were generalised from interviews and observations and were analysed alongside data collection. Data were categorised and arranged according to key concepts which corresponded with research questions, and were presented in narrative form. Data analysis was done manually and involved comparing what was said and what was observed.

3.9 Credibility, Transferability and Dependability of Research Findings

Credibility involves establishing how believable or true the findings are from the participants' perspective (Trochim, 2001). Credibility and trustworthiness are considered important elements of research. Bryman (2004) argues that even when a researcher gives a participant his/her findings to validate, at the end of the day the presentations of the findings will depend on the researcher's impression and prediction. Credibility and trustworthiness in this study were provided by continuously comparing what was said with what was observed. The use of multiple data collection procedures also contributed to the credibility of the findings.

In addition, results of the research can be generalised to another similar context or setting (Trochim, 2001). Case studies have been criticised for their inability to generalise the research findings due to the uniqueness of the social world of study and small size of the sample. It should, however, be argued that transferability of research outcome in this study is possible by comparing the findings with churches other than Pentecostal churches in the country. Transferability was also made possible by detailed description of field experiences covering the research methods and all that occurred in the field during and after research.

Furthermore, dependability involved repeating the research with the same participants, same context but at different times in order to replicate the findings. Like in transferability, dependability is difficult to achieve in a case study due to small size of the sample and uniqueness of the phenomenon studied. Most importantly, the change of time has repercussions on the findings as it may alter the perceptions participants have had on the phenomenon (Trochim, 2001). However, with the data collection techniques used, the researcher was able to assess contextual factors. This helped the researcher to make a good judgement of what had been recorded and observed. Therefore, dependability in this study was made possible by scrutinising verbatim interview transcripts and using actual words uttered by the respondent. Furthermore, the researcher has given detailed explanation of the whole process of data collection. Besides, the use of multiple techniques to collect data was an added advantage.

3.10 Ethical Issues

The first ethical issue was that of getting permission to conduct a research at Church. In order to collect the desired information, the researcher also put into consideration the participants. An introductory letter was obtained from the Assistant Dean, Post Graduate Studies at the University of Zambia, School of Education. Kombo and Tromp (2006) have emphasised that the researcher requires a research permit before embarking on the study. In line with this, the researcher sought and obtained permission from the two church administrations. Ethical consideration in this area included respecting respondents as human beings. This was done by being sensitive to their cultural norms and making sure that the study did not cause any physical and psychological harm to any respondent. The other ethical consideration was about ensuring the patients' right to privacy and the need for confidentiality. The researcher assured the respondents of total confidentiality although she was not allowed to interview the patients from Gospel Outreach but was only able to interview the relatives of the patients. In some cases, patients who volunteered were interviewed. The patients were interviewed to obtain valuable information about how they were cared for.

3.11 Conclusion

The chapter has explained the methodology that was used to extract data and how data was analysed. The chapter provided details on the procedures which were followed during data collection and analysis to ensure credibility, transferability and dependability of the research findings. The chapter also included a discussion on the approach to qualitative research and outlined various strategies that were employed to ensure vigour in the research. It has also described the ethical issues adhered to in the study.

CHAPTER FOUR

PRESENTATION OF THE FINDINGS

4.1 Overview

This chapter presents the findings on Pentecostal churches' care and support for HIV and AIDS patients in Zambia. The respondents profile is given first. This is followed by the presentation of findings on Pentecostal churches programmes and methods designed to support HIV and AIDS patients. The challenges of Pentecostal churches in providing care and support are highlighted later. A sum up of the main issues emanating from the presentation of findings will be provided at the end of the chapter.

4.2 Pentecostal Churches' Programmes and Methods

4.2.1 Northmead Assembly of God Church

Northmead Assembly of God Church has actively responded to the challenges of HIV and AIDS in Zambia. When asked about how NAOG has responded to HIV and AIDS, Bishop Joshua Banda said:

On the continent of Africa, there was literally no family that is untouched by HIV and AIDS. If the Church gives attention to the area of meeting needs related to HIV and AIDS, then the Church will truly have an opportunity to meet human needs. And in a sense, the Church will have an opportunity to do mission. The Church should not look at people just as candidates for heaven; they have a life to live here on earth. There is need for an opportunity to deal with that. It is from this vision that the Northmead Assembly of God established several projects in response to some of the challenges raised by the HIV and AIDS crisis in Zambia. These include provision of food, free anti-retroviral drugs, testing and counselling as well as home based care services.

The following are the programmes the church has designed to meet the challenges of HIV and AIDS:

Circle of Hope Clinic

At the forefront of the church's response to HIV and AIDS epidemic has been the Circle of Hope Clinic. The clinic is located in a sparsely populated area in Makeni, South-East of Lusaka. It is described by:

Stereological concern which is the belief in the eternal conscious bliss of the true believers in Christ and also in the eternal conscious punishment in the lake of fire of all Christ rejecters

The clinic operates just like any other clinic albeit a private clinic. It is mainly donor funded. However, some family members indicated that they paid a fee for some of the services provided at the clinic although administrators claimed that the services were free.

The study revealed that the clinic provides counselling and treatment, and organises community outreaches to sensitise people and promote behavioural change. They provide care and free special treatment to a small group of people though they claimed that when they had sufficient funding they could care for more than six thousand people and three thousand five hundred on free special treatment.

The study also revealed that the clinic has a well equipped laboratory with special equipment for detecting CD4 (glycoprotein that is found primarily on the surface of helper T cells) and X-ray machines with well qualified laboratory technicians.

Holistic Care

Holistic care involves providing the patient with the physical, psychological, social, spiritual and cultural gifts and needs which are special to that person. All these are met in one way or another by pastors who have special days when they share the word of God with the patients. Some church members in their individual capacity also visit the sick and take food and toiletries to them. The patients are also counselled by psycho-socio counsellors and at times by pastors.

In an effort to provide holistic care to HIV and AIDS patients, church administrators are also part of the staff running the affairs of the church clinics. One administrator described it as:

The care through the provision of drugs and nutritious food is not limited to HIV and AIDS patients. It transcends to patients suffering from different ailments related to autoimmune and mimesis diseases among others.

Since the clinic is small and unable to admit patients, those who are very sick are put on observation for hours during which a drip is administered. And when the patient gets better, he or she is discharged. If the condition worsens, the patient is then referred to the University Teaching Hospital.

The patients interviewed reported that the care they received from the church was better than the care they received from government clinics. Some patients said:

The environment inside and outside the clinic premises is so clean and that personalised care is always given whenever they visit the clinic. The pastor or church leader would in a caring tone greet you and ask you how you are doing. He would then proceed to find out if we have been taking our medication promptly and if we have been praying. The pastor would then ask that we pray with him after which he would read a bible passage and give us words of encouragement. An opportunity is then given to us to express our thoughts and opinions on what we are going through. Thereafter, the t pastor would ask us to remain positive and adhere to the prescriptions.

Sometimes, some patients would have tantrums – nurses and the pastors usually remain so helpfully and understanding. They would respond in a caring manner and constantly reassure us that all will be well.

Staffs at the clinic were so caring and spoke with us [patients] with compassion, care and encouragement. They never spoke to us with intense harshness as one would experience in a government clinic.

Home Based Care Services

The church offers home-based care services to HIV and AIDS patients. It was revealed that when the patient was sent home after receiving treatment, a trained care-giver

would be assigned to that patient so that he or she continued helping the family to take care of the patients.

It was observed that home-based care services are limited to ensuring that patients take medication on time and live in a clean environment. Care-givers would in their individual capacity help with food but there was no institutional programme to provide nutritious food to patients to accompany the uptake of drugs. Staff explained that:

The church stopped providing food owing to limited funding to its cause of providing home-based care services. As a result, the church has had to scale down on most of the home-based care services. Given an increase in funding, the church would introduce most of the activities and perhaps add more people on its programme.

As a result, some church members in their individual capacity and out of Christian charity would help patients with food as explained that:

When we see that the family has no food, some of us provide food to patients in our individual capacity. At times we extend a hand of help to those suffering and destitute based on conviction, belief and in-working of the Holy Ghost. It is Christian duty to do so and every child of God should be a blessing to others.

Lazarus Project

Alongside the clinic there is the Lazarous Project which strives to rescue, rehabilitate and reintegrate street children and children orphaned by AIDS. Bishop Joshua Banda had this to say about it:

We as a Church have compassion for street kids because they are vulnerable to infections. So, the Church had to find ways of bringing these children closer to the Church. As a way of rescuing them, the Church thought of opening homes to help them have shelter and food. The Church started with only ten homes in the catchment to accommodate these children. Since the number of street kids was increasing by the day, the Church saw the need of looking for other homes to accommodate them.

It remains unclear if the project is still in existence as those interviewed indicated that there was such a project but there was nothing to show on the ground on the existence of the project.

Operation Paseli

In the Northmead area where the Assembly of God church building is located, it was discovered that NAOG reaches out to sex workers through Operation Paseli, named after the road where the church is found and which at night becomes a prostitution zone. Bishop Joshua Banda explained as follows:

This project aimed at helping women and rescuing them from their kind of work. The Church believed that this kind of work would definitely lead people to spreading HIV and AIDS. For prevention's sake, the Church came in to sensitise people to stop their way of life.

The research also revealed that the Church was running a mothers' programme which was meant to empower women with skills. Women rescued from prostitution and who benefitted from the programme said:

We appreciate the skills acquired from the Operation Paseli Project as we are able to live positively. The Church managed to incorporate us in projects that were beneficial to our livelihood. We are able to make different things such as scones and cakes for sale and made money at the end of the day and are able to support our families. Others have become tailors and make various outfits such as suits, ladies Chitenge wear, uniforms for different schools and other items which they sell and earn a proper living.

4.3.2 Gospel Outreach Fellowship Centre Church

Go Centre is a young Church which has also responded actively to the challenges of HIV and AIDS in Zambia. This was precipitated by the challenges of HIV and AIDS that Reverend Reutter and Mrs. Reutter faced in their ministry at the Church. Furthermore, out of compassion, the Church thought that it could do something to help. Therefore, many ideas were suggested by the Gospel Outreach family (Go Centre Church members) which they believed would assist the Church take care of people infected and affected by HIV and AIDS.

The following are programmes the Church designed to meet the challenges of HIV and AIDS:

Go Centre Clinics

The findings revealed that Go Centre has two clinics, one of which is a mobile clinic. The stationary clinic is concerned more with providing ART and VCT services. To a less extent, some medical services such as malaria treatment and treatment of other diseases related to HIV and AIDS such as tuberculosis are also provided. The clinics are not restricted to church members but are also open to those who wish to seek treatment from there.

The stationary clinic commonly known as Chreso Ministries ART and VCT centre runs like any other clinic in Zambia with qualified staff. The findings further revealed that the clinic has 5 qualified nurses who work on contract basis and are paid per month. There is also a qualified medical doctor who visits the clinic on appointment. Furthermore, the clinic relies on clinical officers who assume the responsibilities of a doctor where necessary. The clinic also has qualified counsellors and community health workers (diploma holders) who assist the patients in times of need. All these are paid by the Church.

The staff at the clinic stated the following with regards to free provision of food to HIV and AIDS patients:

Where resources are available, the Church also provides nutritional foods such as soya porridge (commonly known as herpes) and soya beans. In the event that there are limited resources, the Church often is unable to provide food. In such cases, the Church would divert the scarce resources to those patients who barely can afford to buy food. Those deemed capable of purchasing food are advised the different types of nutritional food they could buy to ensure that the patients remain healthy.

The study revealed that the clinic offers free consultations, medication, laboratory investigations (CD 4, Viral Load, HBC and GOT). The patients who go for laboratory investigations are given their results as soon as possible.

One patient described the services at the clinic in the following words:

The environment is very clean and medical workers are always available such that patients are not subjected to long queues. There are chairs and benches where patients sit as they wait for their turn to come. The medical staff are friendly and attentive in dealing with us.

Another patient expressed satisfaction by stating that:

I had lost hope of living when I tested HIV positive because I thought all was lost. I thought I would die soon but here I am. I am grateful to the professional conduct and services at the clinic. I think the frustration most people go through in government hospitals would have taken a toll on me…I don't think I would still have had the hope to live again and have a positive attitude towards life.

The Church's mobile clinic provides services at the doorstep of people. A special vehicle is used to carry all the necessary equipment and medication for the VCT team. The study further showed that clients that often use the mobile clinic are registered to the clinic and are allowed to call the clinic if they are very sick and will be followed at home and receive treatment or will be picked and taken to the hospital.

Voluntary, Counselling and Testing Centre

The researcher found that Gospel Outreach has a big clinic with a well organised VCT room. Staff said that:

HIV and AIDS counselling is one way which can assist people come to terms with reality of knowing their status. It is very difficult decision to make yet becomes a burden remover once one knows their status and accepts the situation. For this reason, the centre offers psychological and pastoral counselling. It provides HIV and AIDS education and awareness campaigns in schools, churches, companies and prisons.

Primary and Secondary Education

Gospel Outreach Fellowship strives to serve Zambian communities with life changing programmes in the area of education. Data revealed that Go Centre has schools in different towns of Zambia. One member of staff said:

These schools help orphans and vulnerable children access education free of charge. Most orphans and vulnerable children usually have problems accessing high quality primary and secondary education. For this reason, Go Centre schools provide high quality education to such children for free and at a minimal charge to those that come from well to do family.

More prominent one among all of these is the Fountain Gate Orphanage which does not only offer education services, but is also a home for orphans and vulnerable children. Surprisingly, most pupils at the school pay fees whether orphan or not. One member of staff said:

There are few orphans in all the schools operated by the Church with the majority of them paying schools in one way or the other. Most of those who do not pay schools are usually children of teachers who have a special arrangement with the school administration. For instance, there have been cases where a child orphaned by the death of their parent who was a teacher receives a waiver where a certain amount is deducted from the dues that are supposed to be given by the surviving spouse and children.

Through what is known as Gospel Outreach Christian Academy (GOCA), the Church has been providing preschool, primary and secondary education to Lusaka based children since 1994. The Church also has a boarding school for girls known as Mubuyu Christian Academy (MCA). One staff member said:

GOCA is one of the social arms of the Church. The Church believes in action and wants to empower people with education and provide healthy facilities where they can. The school currently has over 600 pupils enrolled from preschool to secondary.

The Church claims to provide free education to more than a quarter of all those enrolled, this translates to more than 150. However, the findings revealed that those who were on free education were about 15 and these included teachers' children under a waiver arrangement with the school administration. As one official at the school explains:

The majority of pupils under the Church school programmes pay school fees and to be precise they are less than 15. This number also includes teachers' children who are on school waiver programme.

Fountain Gate Children's Home

Fountain Gate Children's home is an Orphan Care Centre established by Chreso Ministries and was officially opened in September 2009. It is located 12 kilometres east of Lusaka International Airport turn-off on the Great East Road. The centre currently hosts 150 orphans. Part of the project runs a private basic school.

The findings showed that children at Fountain Gate are well fed. They have tea with bread in the morning and fruit juice and snacks at 10:00 hrs. They then have lunch at 12:30 hours and snacks at 16:00 hrs after prayers. The children have their supper at 19:00 hours.

The orphanage is clean and has spacious rooms. There are banker beds in each room which houses three people. Each child has a bathing kit which has soap, bathing towel, lotion, toothbrush and toothpaste.

Vocational Training

Vocational skills training programmes started way back in the early 1990s at the inception of the church. The Ladies Department of the Church organised courses in catering, tailoring and designing. However, in 2000 the Church went commercial by registering with the Ministry of Science and Technology to provide training in accredited courses and programmes. Reutter said:

The institution is open to all who qualify and can afford to pay the school fees. Running such an institution is very expensive, so to have it run smoothly, the institution is commercially run.

This therefore means that all the students who are enrolled at the centre pay fees. The Church has however, allowed some widows to learn free of charge. Others who are benefitting from this institution are the former pupils from GOCA and Fountain Gate who obtained school certificate. Once they make a grade 12 certificate, they are given an opportunity to acquire skills from this institution free of charge.

The study further revealed that currently the institution is running courses in Hotel and Catering Management, Food Production, Food and Beverage, and Tailoring and Designing as well as courses in Cookery. They also offer skills training and short courses in Computers.

Holistic Care and Support

The findings showed that the Church's holistic care helps the terminally ill have regained strength. A member of staff said:

Those who had lost hope of living have through church counselling, care and support received hope to go on with their lives.

The Church has achieved this through weekly visits to the homes of patients. Through home-based care, patients receive personalised care and support. It was observed that family members who lost their sick relatives often thanked the clinic and church administrators for their services.

4.4 Challenges Faced by NAOG and Go Centre in providing care and support

As shown above, Pentecostal churches are increasingly becoming more and more responsive and active in the fight against HIV and AIDS using social and medical methods in addition to spiritual means. They are implementing a number of HIV and AIDS programmes as described above. However, they are still grappling with a number of challenges as described below:

a) Inadequate technical staff such as clinicians, nurses and laboratory technicians

Most people who work here (clinic) are part-time employees with only a few of them working as permanent employees. This is because of limitations in financial resources. This also affects the availability of other resources such as specialised and skilled man-power.

The number of required nurses is way too low given the demand for the services. For instance, one nurse can be expected to deal with 200 cases in a day. This usually creates a challenge for staff to deal with so many patients.

Because of limited personnel, we have resorted to hiring staff on part-time such as doctors who come to the institution for a few hours on particular days of the week. This means that nurses have to schedule critical cases on days that a doctor is expected to be available.

b) Lack of specialised personnel with skills in behavioural change

Most counsellors and other staff may not be sufficiently qualified. This is because the people we are able to hire are not as qualified in terms of work experience and academic credentials. However, we believe in Jesus to provide sufficient power to alter behaviours once people give themselves to God.

c) Poor information management system at all levels and poor information sharing

We do not have qualified personnel to handle records management. As such, we rely on some individuals we train ourselves to manage files and follow through procedures to ensure that patients receive the appropriate service.

d) Donor conditionality attached to certain HIV and AIDS projects

Donor conditionality affects the provision of a variety of services as most funding may come in to be used for a specific purpose such as construction of a hospital and avoid other critical areas needed to smoothly operate the hospital.

e) Inadequate resources at implementation level

There are usually limited resources at implementation especially if the top leadership are greatly involved as this may result in allocating more allowances for themselves (administrators and church leaders) and using such privileges to promulgate their authority and control over resources.

CHAPTER FIVE

DISCUSSION OF FINDINGS

5.1 Overview

This chapter presents the discussion of the findings on Pentecostal churches' care and support for HIV and AIDS patients. The Pentecostal churches' programmes and methods are discussed together as the churches' do not recognise either as separate from the other. Instead, they are used interchangeably. This will be followed by the discussion on the challenges Pentecostal churches encounter in providing care and support. A sum up of the main issues emanating from the discussion of the findings will be provided at the end of the chapter.

5.2 Pentecostal Churches' Programmes and Methods

The findings of the study show that although it is small in scale, Pentecostal churches attempt to provide holistic and comprehensive care across a continuum to PLWHA. This involves providing support for PLWHA and their families through a network of resources and services. The continuum includes care between hospital and home over the course of the illness. The care incorporates clinical management and care, education, prevention, counselling, palliative care and social support.

Orphans are an extremely vulnerable sector of the population. Not only are they subjected to all forms of abuse and exploitation but their situation often limits their choices. There is little motivation to consider the risks of HIV when day-to-day survival is all they can cope with. Therefore, it is commendable that Pentecostal churches' care and support programmes range from providing institutional care, home-based care, to fostering adoption of abandoned and HIV positive children. Thus, the Pentecostal churches effort to deal with orphans improves their plight to better livelihood and ensures that the HIV and AIDS epidemic is not reinforced. However, the Pentecostal churches have not done

enough to provide psychosocial support, the training in parenting skills for child headed households, skills training and life skills provision to orphans.

Church members at the Pentecostal churches indicated that the care and support interventions carried out by the church were coordinated. However, it was found that communication regarding these care and support initiatives such as home-based care, financial support, meals or orphan care seemed to be minimal among the church leadership and between the leadership and those in need of the services. Thus, although some good initiatives do exist, there is a lack of clarity in the churches about what programmes are available and for whom they are intended.

The assistance offered by the Pentecostal churches to PLWHA include both tangible and intangible components. The latter clearly predominated, whereas the former was usually reserved for extreme situations such as during the terminal stages of AIDS-related illness or funerals. Furthermore, the assistance was usually small in scale and episodic; it was neither organized nor controlled by the church leadership. Congregation leadership was involved mainly in infrequent, larger-scale actions that required pooling of meagre congregational resources. In addition, Church leaders' involvement in HIV and AIDS assistance to non-members of their churches could be perceived by outsiders as attempts to spread their influence beyond the ranks of their congregations. These perceptions, and the resulting tensions among church leaders and members, hinder interfaith congregational cooperation initiatives.

The potential of Pentecostal churches in the fight against HIV and AIDS remains underutilized. This underutilization stems, in part, from limited practical exposure to HIV and AIDS cases, in part from church financial constraints and from inter-church ideological tensions and organisational rivalries. As the health and social burden of HIV and AIDS mounts, it becomes increasingly critical to remove the barriers to greater utilisation of religious organisations.

Critical areas of attention among Pentecostal churches in care and support of PLWHA include encouraging both members and non-members to use voluntary counselling and testing services, providing support for access to antiretroviral therapy, and supporting antiretroviral therapy adherence on a large scale. Success of voluntary counselling and testing and antiretroviral therapy is obstructed not only by individuals' material and

financial constraints but also by the stigma and similar social barriers, the emphasis of Pentecostal churches on compassion and solidarity may prove an effective mobilisation tool.

Pentecostal church service provision poses a challenge to principles of equality and non-discrimination where religious ideology influences service provision itself. The latter is of particular concern for people who fall outside of what is deemed as "appropriate sexuality", including women having sex outside marriage, Lesbian, Gay, Bisexual, Transgender and Intersex people (LGBTI) and sex workers. Dube (2008) analysis of discrimination in HIV and AIDS health service provision for African LGBTI people points out the problematic role that Church-supported services have played given that staff often hold homophobic attitudes and may actively stigmatise LGBTI people coming in for services. Examples include publicly humiliating clients presenting with anal sexually transmitted infections (STIs), service providers giving personal opinions regarding people's sexual choices, or actively denying services to clients whose preferences they disapprove of. This in turn discourages LGBTI people from seeking further support for their sexual health concerns. In contrast, it should be acknowledged that that the Church's support may be perceived as supporting their 'unbiblical' sexual practices. But then, Christians are entreated to show compassion even to those considered heathens in accordance to what the bible teaches.

Pentecostal churches are developing a supportive stance regarding ARVs and science-based treatments for HIV-related illnesses, and therefore becoming integral in rolling out biomedical treatment. However, there is a problematic trend emerging among some Pentecostal and charismatic churches which advocates support for faith healing to "cure" HIV and opportunistic infections. This includes contesting the efficacy of medicines, and encouraging patients to cease anti-retroviral therapy and sometimes treatment for opportunistic infections such as tuberculosis in order to receive the healing power of faith. This raises concerns because many people in these Pentecostal churches have been flying to Nigeria to be healed by an influential pastor and televangelist, T. B. Joshua, who makes public claims to be able to heal people of HIV and other chronic illnesses. This is retrogressive in light of care and support to PLWHA given the fact that some people have died even after being declared healed by the televangelist (Dube, 2008).

In view of the aforesaid, it should be noted that the devastating impact of AIDS has led many people to seek answers and meaning from various sources, including Christianity. Peoples' understandings of, and responses to, HIV and AIDS are therefore often filtered through religious beliefs in a process that seeks to "make the unfamiliar familiar" by anchoring understandings of the new phenomenon of HIV and AIDS into peoples' pre-existing understandings of the social world (Wiel, 1990). One particular framework through which HIV and AIDS has often been interpreted is that of Pentecostal churches. Since HIV infection is primarily transmitted through sex, which typically Pentecostal churches emphasise should only occur in the marriage of a sexually monogamous man and woman, people come to understand and associate HIV and AIDS with immoral behaviours, linked to the underlying assumption that HIV and AIDS should not be a risk for those who adhere to the teachings of the Church.

Whilst this serves to assist those trying to make sense of their everyday lives in a context of HIV and AIDS, the anchoring of understandings of AIDS within such a framework leads to church members framing HIV and AIDS in images of sin and punishment, perpetuating HIV and AIDS-related stigma. This study identified this relationship. Pentecostal church-goers found shame-related HIV and AIDS stigma to be closely associated with religious beliefs. Most respondents believed HIV and AIDS was a punishment from God. Similarly, a third of respondents argued that PLWHA had not followed the word of God through engaging in sinful actions (immoral behaviour).

The study found that there was an associated tendency for Pentecostal churches to speak more of HIV prevention, and less of the challenges of living with HIV and AIDS and undergoing treatment, or of the potential role of church members in supporting PLWHA. Furthermore, there was not much that the church was doing in supporting and caring PLWHA. Instead, most activities were small in scale and mainly spearheaded by volunteers. In addition, HIV prevention messages preached in churches were often limited to abstinence and fidelity (reinforcing dominant church moralities and understandings of sexuality), which sometimes clashed with 'mainstream' HIV prevention campaigns. For instance, church leaders regarded pro-condom health messages as sinful, based on their belief that those who adhered to church teachings would not need condoms. This implicitly stigmatised anyone wishing to use a condom. More widely, it was suggested that within church groups, condoms have come to

represent ‘a tool for unfaithful people’ or for those who have premarital sex. This highlights how mainstream messaging about condoms may contradict the positions adopted by powerful churches, highlighting the need to involve church leaders in discussions about the design of health campaigns.

HIV and AIDS, condom use and immorality are linked in a way that risks undermining HIV prevention efforts through suggesting that only non-believers are at risk, with church members less likely to feel at risk of contracting HIV or to think they need to use condoms. Church members distance themselves from the ‘immoral people’ that HIV prevention messages target. This study observed that people who self-identified as religious were less likely to display HIV-preventive behaviours than those who attached less importance to religion. Similarly, findings in Zambia by Dube (2008) suggested that whilst membership of a church was likely to lead to first sexual experience at a later age, members were less likely to use condoms once they started to have sex.

An additional issue linked to the close association between HIV and AIDS, sexuality and shame was the extent to which this limited open discussion of HIV and AIDS by church leaders, thereby reinforcing HIV and AIDS-related stigma. Exploring the extent to which church groups fuelled stigma, Manchinguna (2012) found that whilst many southern African church leaders did not condemn HIV and AIDS management strategies, their self-identification as ‘holy’ people prevented them from developing new and creative ways of talking about sex and HIV transmission, in the light of the taboo nature of discussions of sexuality within church settings. More so, it limited the scale to which care and support PLWHA would be provided.

This study found that there was little care and support offered to Mother-to-Child related issues. Although church leaders seemed to understand and retain the knowledge, only a fraction had discussed MTCT in their churches. One contributing factor could be the challenges of discussing new problems and solutions using old speech and traditional theology. In Tanzania, for example, many church leaders lacked the vocabulary and confidence to talk about HIV and AIDS-related care and support and were reluctant even to try to do this because of continued opposition of senior pastors (Wiel, 1990).

The anchoring of HIV and AIDS within existing Pentecostal church frameworks of meaning contributes to low involvement in HIV and AIDS care and support through

rendering it literally 'unspeakable' in terms other than immorality and shame. Furthermore, churches' framing of HIV and AIDS within discourses of immorality and sin fore-grounds 'bad' individuals and their specific behaviours in understanding HIV transmission, rather than opening opportunities for discussions of the social roots of HIV and AIDS (e.g. in factors such as the interface of poverty, age and gender in some settings). This limits the possibility of critical thinking around stigma and providing care and support which would be the starting point for the development of more constructive and less stigmatising understandings of, and responses to, HIV and AIDS.

5.3 Challenges faced by Pentecostal Churches in Provision of Care and Support to PLWHA

a) Inadequate technical staff such as clinicians, nurses and laboratory technicians. Circle of Hope is a relatively large clinic although limited the number of staff. Data reveals that the clinic has 5 nurses, 2 clinical officers, a pharmacist, 1 laboratory technician and the same doctor who goes to Go Centre clinic. This undoubtedly puts a strain on the limited number of staff who have to deal with a lot of patients. The number of patients who go there is overwhelming because of the good care and hospitality patients receive. Hence, more staff load is needed so that patients are followed up well. The scenario is the same at the two clinics operated by both churches. Besides the help being rendered by the care-givers, more nurses and doctors are needed especially to do proper follow ups on those who come for review.

b) Lack of specialised personnel with skills in behaviour change. Data shows that the two churches have not invested resources in behaviour change at the clinic level who are specialised. Rather, there is heavy reliance on Pastors to provide counselling and perhaps effect behaviour change. This approach maybe insufficient in bringing about behaviour change. Highly skilled personnel should be employed to focus on behaviour change among all the people including those living with HIV and AIDS.

c) Poor information management system at all levels and poor information sharing. Due to the heavy reliance on the Church Pastor or Bishop to handle all management issues, there appears to be lack of continuity when the Church Pastor or Bishop is not around. This may negatively affect the operations of the clinic. Furthermore, poor information sharing may also result in smooth operation of activities. Most of the information especially those

related to how much funding is received may not be easily shared among other staff in operational management.

d) Donor conditionality attached to certain HIV and AIDS projects. Donor conditionality affects operations of these HIV and AIDS interventions in that donors may decide to support other areas of care and support and leave out the most critical ones. For instance, donors may release funding to support Voluntary Counselling and Testing and leave out funding to expand the number of people on ART.

e) Inadequate resources at implementation level. The two clinics receive funding from local and international institutions such as Children's AIDS Fund of the United States. Due to the fact that staff have to be motivated with good pay and several other entitlements funds may be in short supply to implement the project. In other words, funding received may not fully capture the costs these institutions incur in carrying out the operations. This may affect full implementation.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1 Overview

This chapter presents the conclusion and recommendations of the findings on Pentecostal churches' care and support to HIV and AIDS patients. The conclusion is made first and then followed by the recommendations.

6.2 Conclusion

This report has shown Pentecostal churches' care and support to people living with HIV and AIDS. It has shown too the motivation, scale and capacity of these churches to provide sustainable care. However, to be scaled up, these programmes require resources. The most obvious kinds of resources they need are material, such as the supplies required to deliver care. But funding is also requisite in that specialized programmes to combat HIV and AIDS must be housed and staff must be paid. The ability of any one faith group to grow a programme - including securing staff, facilities, and supplies is often dependent on donations, grants, and collaboration.

Less apparent but no less important, these churches require assistance in the management and assessment of their programmes. They operate with too few staff, minimal office equipment, and few conveniences. They rarely have time and resources to assess and refine programmes and management structures. Simply keeping up with the latest developments in treating the disease and those it affects can be daunting. Faith-based staff also rarely has time to meet and learn from one another, and thus operate in isolation. Needless to say their compensation is minimal, and some work as volunteers.

Consistently it is clear that Pentecostal churches' programmes can better grow with resources that can be secured through partnerships with non-governmental organizations and government agencies. The scale-up of programmes launched by Pentecostal churches often rests on their ability to link to resources that tap their inherent capacities. Collaboration can provide linkages that help grassroots programmes thrive.

Based on the experiences of the churches visited for this report, the researcher has come to recognize the strengths shared by faith-based organizations that enable them to excel in addressing HIV and AIDS: a compassionate perspective, an emphasis on education and training, adaptability, a holistic perspective, leadership, and an on-the-ground understanding of the communities they serve. Considering these qualities, one might decide to engage a faith-based organization in opportunities to provide care.

In general, the care and support that Pentecostal churches are carrying out can be classified as basic. These are not full-scale programmes but are interventions carried out from the local resources and materials mobilised by the local church and implemented by volunteers with little effort and prioritization from the top leadership with limited financial capacity given as the excuse which might seem to be a greater motivation too.

The key care and support activities being implemented by the church to address the HIV and AIDS epidemic include general HIV and AIDS awareness and sensitisation and preaching of abstinence especially to the young people. Little attention is given to address the complexities of married people with unfaithful partners especially women. The interventions by the church are mostly carried out by the volunteers and by the church leaders through sermons which is deemed too insufficient to have any major impacts on the general populace as a whole. In other words, the HIV and AIDS awareness programme is limited to those that attend church service with little effort made to include a wider sphere.

The least care and support activity the church is carrying out is condom distribution. This is because the church is emphasising abstinence among the young people as the best method of prevention from the HIV infection. The other least intervention is Prevention of Mother-To-Child Transmission (PMTCT) of HIV. This depicts the level at which the church remains oblivious to the intricacies that transmit HIV and AIDS. The main care and support activities the church is undertaking is counselling and home care support to the families affected by HIV and AIDS. This is mainly done by church groups mostly volunteers.

There is a strong need for Pentecostal churches to develop new theologies, that is, systems of representation and understanding that can assist church leaders in developing a more explicit and confident role for the church to play in supporting PLWHA. Such

theologies could, for example, challenge stigma through emphasising those aspects of the Christian message that potentially advocate the forgiveness of sinners; the empowerment of women; a compassionate understanding of the impacts of poverty and other social inequalities on behaviour; and recognition of the inherent dignity of all human beings. While there may be resistance to such a move in some church circles, the researchers' review has highlighted evidence that some churches have been able to transform their values and attitudes to provide non-stigmatising care and support for people affected by HIV and AIDS. Furthermore Pentecostal churches should not only contribute to care and support, but also explicitly examine the role they can play in combating HIV and AIDS-related stigma, opening up further spaces for the development of less stigmatising responses.

6.3 Recommendations

- Churches claiming to run schools for the vulnerable with money from overseas donors should appropriately use donated funds for the intended purposes.
- Neo-Pentecostal churches should consider establishing in-patient facilities like other churches have done.
- Go Centre should provide free education to vulnerable as stipulated in their brochure.
- Go Centre should also consider running Fountain Gate Orphanage as a school for orphans rather than a private school for non-vulnerable children.

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APPENDICES

Appendix I

Reformed Church in Zambia's HIV and AIDS policy

1. The RCZ recognises that HIV and AIDS is a disease of pandemic proportion in Africa and Zambia has one of the highest infection rates. The RCZ acknowledges that the disease is a problem in communities and church organisations nationwide and that church members are infected and are dying of HIV and AIDS leaving behind those who are infected by the disease such as widows and orphans.

2. The RCZ accepts and promotes a scientific approach to the nature, transmission and treatment of HIV and AIDS.

3. The RCZ accepts transmission of the HIV and AIDS takes place mainly through sexual contact, but can also be spread through contaminated blood transfusion and unsterilized needles. An infected woman can transmit the disease to her infant during pregnancy or delivery or while breast-feeding.

4. The RCZ recognises that AIDS is mainly a sexually transmitted disease and states emphatically that HIV and AIDS is not a result of witchcraft as some people claim. This claim is strongly refuted.

5. The RCZ recognises that there are some innocent victims for example faithful wife or husband infected through the immoral behaviour of the spouse, and children born from infected parents as well as a small minority who are infected by other means especially through blood transfusion.

6. The RCZ accepts that the HIV is the virus that causes AIDS. HIV destroys the ability of human body to fight off infections, which attack. It weakens the immune system, making the body open to different infections and unable to recover from other diseases. RCZ also accepts that a person can be infected with HIV for a long time without showing any symptoms of the disease.

7. All people are encouraged to evaluate their own lives and to adopt lifestyles that do not violate God's commandments, especially those concerning sexuality and marriage.

8. Sexual abstinence before marriage and faithfulness in marriage are strongly emphasised as the biblical norm. All church members should be living examples of sexual purity.

9. Those who are getting married for the first time or second time are advised to be given correct counsel before marriage to help them make right choices to avoid infections in the marriage.

10. Voluntary counselling and testing for HIV and AIDS is recommended and mutual openness before marriage of couples.

11. The use of condoms is recognised by the church as an effective way of prevention for both, this does not imply that the RCZ approves of or encourages sexual immorality.

Appendix II

Interview guide for the Pastors of the two churches

1. For how long have you been in this ministry?
2. When did the idea of ministering to the HIV and AIDS patients begin?
3. As a minister of the word of God, what programmes have you put in place to help people living with HIV and AIDS both spiritually and materially?
4. What kind of care does your hospital provide?
5. How many patients do you talk to everyday on average?
6. How often do you go to the hospital?
7. What have you learnt from the patients about your care and support you provide?
8. What kind of care do you offer as a pastor?
9. How do you assist the families for these patients?
10. What kind of patients have you dealt with?

Appendix III

Interview Guide for the Church Administrator

1. How many patients can this hospital accommodate?
2. What is your role as an administrator of this hospital?
3. What kind of care do you offer to both the patients and the people that take care of the patients?
4. How long do you keep the patients in this hospital?
5. Are you dealing with referral cases or patients just come to your hospital on their own or they come through home based care?
6. Who are the care givers in this hospital?
7. Are they trained? If so, what qualifications do they have?
8. For how long has this hospital been in operation?
9. Have you ever had any complaints from patients concerning the care and support offered to them?
10. What are the conditions of being admitted into this hospital?
11. Does hospital care continue even when the patients have been discharged?

Appendix IV

Interview Guide for Nurses

1. How long have you been working in this hospital?
2. Do you face any challenges in handling the terminally ill? [Explain to me the nature of challenges]
3. What kind of help do the terminally ill need?
4. Do you think the patients here receive better care than those in government hospital?
5. Do you have time to chat with the patients? [How often do you see them?]
6. If so, how often do you do it?
7. Do you interact with their family members as well?
8. What kind of worries do they express about their sic family members?
9. Are you happy working with the administration and staff here?

Appendix V

Interview Guide for Family/Relatives to the Patients

1. When did you bring your relative to the hospital?
2. How have found this hospital's care?
3. Would you say the kind of care offered by this hospital is better for your patient than that from the general hospital?
4. Are you free to discuss issues concerning the welfare of your patients with the administrators, pastor and nurses?
5. What relief has the church through the hospital provided to you as a family?
6. Do you think there is need for the church to establish more church hospitals?