THE CHURCH AND DISASTER MANAGEMENT: THE ASSEMBLY OF GOD CHURCH (AOG) AND HIV/AIDS IN LUSAKA, ZAMBIA

By

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DECLARATION

I wish to declare that this thesis, "The church and Disaster Management: The Assembly of God Church (AOG) and HIV/AIDS in Lusaka Zambia" submitted for the qualification of a Master's degree in Disaster Management at the University of the Free State, in the Faculty of Natural and Agriculture Sciences, is my original and independent work, and has not been presented for a degree in any other university. All the sources used in this work have been acknowledged by means of references.

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Darris W. Clement Date

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Me A. Ncube Date

DEDICATION

To my Saviour Jesus Christ for giving me strength and courage, my loving wife Olive and daughter, Macwani, for their warm love, support and understanding.
You are the best.

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This is to certify that, I Clement West Darris hereby grant full copyright of this thesis to the University of the Free State.

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LISTS OF ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
AOG	Assembly of God Church
ARV	Anti-Retroviral
CBDRM	Community-based disaster risk management
CBO	Community-based organisation
CoH	Circle of Hope clinic
CSO	Central Statistical Office
DFID	Department for International Development
DRR	Disaster Risk Reduction
DMC	Disaster management continuum
DFID	Department for International Development
FBOs	Faith-based Organizations
HIV	Human Immunodeficiency Virus
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
IMF	International Monetary Fund
IFRCFCS	International Federation of Red Cross and Red Crescent Societies
LCMS	Living Conditions Monitoring Survey
MOH	Ministry of Health, Government of the Republic of Zambia
MOHCBH	Ministry of Health Central Board of Health
MTCT	Mother-to-Child Transmission
NAC	National AIDS Council
NAPCP	National AIDS Prevention and Control Programme
NASC	National AIDS Surveillance Committee
NGO	Non-Governmental Organization
NHASF	National HIV/AIDS strategic framework
PLWHA	People Living With HIV/AIDS
SADC	Southern African Development Community
SAP	Structural Adjustment Programmes
SLF	Sustainable Livelihood Framework

STDs	Sexual Transmitted Diseases
STIs	Sexual transmitted infections
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational Scientific and Cultural Organization
UNDP	United Nations Development Programme
UNICEF	United Nations International Children's Fund
VCT	Voluntary Counselling and Testing
WCC	World Council of Churches
WDI	World Development Indicators
WHO	World Health Organisation
WWW	World Wide Web
ZDHS	Zambia Demographic and Health Survey
ZDMA	Zambia Disaster Management ACT
ZHDR	Zambia Human Development Report
ZCC	Zambia Council of Churches
ZNBC	Zambia National Broadcasting Commission

GLOSSARY

This study accepts and adopts the standard definitions of terms as they are presented in key medical and other authority sources (e.g. dictionaries).

Database: A collection of information and data stored in a computer (i.e. computer file or CD-ROM and or flash drive) in a systematic way

Disaster: A serious disruption of the functioning of a community or a society causing widespread human, material, economic or environmental losses which exceed the ability of the affected community/society to cope using its own resources

Disaster risk reduction: The systematic development and application of policies, strategies and practices to minimise vulnerabilities and disaster risks throughout a society, to avoid (prevention) or to limit (mitigation and preparedness) adverse impact of hazards

Disease: Any abnormal condition of the body or mind that causes discomfort or distress to the person affected or those in contact with the person

Epidemic: A sudden unusual increase in cases that exceeds the number expected on the basis of experience

Response: The provision of emergency services and public assistance during or immediately after a disaster in order to save lives, reduces health impacts, ensure public safety and meet the basic subsistence needs of the people affected

Risk: The probability of harmful consequences, or expected loss (of lives, people injured, property, livelihoods, economic activity disrupted or environmental damaged) resulting from interaction between natural or human induced hazard and vulnerable/capable condition

Risk assessment: A methodology to determine the nature and extent of risk by analysing potential hazards and evaluating existing conditions of vulnerability that could potentially harm exposed people, property, services, livelihoods and the environment on which they depend

Risk factors: Habits, characteristics or factors which can increase one's likelihood or odds of developing HIV/AIDS

Risk reduction: The conceptual framework of elements considered with the possibilities to minimize vulnerabilities and disaster risks throughout a society, to avoid (prevention) or to limit (mitigation and preparedness) the adverse impacts of hazards, within the broad context of sustainable development

Vulnerability: The characteristics and circumstances of a community, system or asset that make it susceptible to the damaging effects of a hazard

Preparedness: The knowledge and capacities developed by governments, professional response and recovery organizations, communities and individuals to effectively anticipate, respond to, and recover from, the impacts of likely, imminent or current hazard events or conditions

ABSTRACT

We live in an era of unprecedented disasters, both in severity and frequency. With the increasing unpredictability of disasters and their impacts on vulnerable populations, the consequences of disaster put many lives and livelihoods at stake. The emergence of HIV/AIDS pandemic has brought multi faceted challenges among the Zambian population especially in the capital city, Lusaka. Churches have attracted controversy for how they have dealt with AIDS: they have been criticized for moral stigmatism, yet lauded for their charitable works. HIV/AIDS poses a challenge to every person, community and organization to such an extent, that nearly every organization, Churches included, should have some policies and programmes to deal with the pandemic. The Church is one institution that because of its proximity to communities, as well as its ubiquity within many contexts, is able to respond compassionately and quickly to those infected and affected by the HIV/AIDS disaster. Indeed, for decades the Church has been helping communities mitigate, prepare for, and recover from disaster. In view of the fact that the Zambian government in Lusaka cannot deal with the increasing complex impact of the HIV/AIDS pandemic, the Circle of Hope Family Clinic (CoH) a project under (AOG) Church and other organizations within Lusaka came on board, and augmented government efforts to try and alleviate the human suffering due to the pandemic. In this study, my purpose was to examine what the (AOG) through (CoH) is doing at the grass-roots level in Lusaka to deal with the impact of HIV/AIDS. The study reveals that to achieve this enormous task, the Church must be transformed in the face of the HIV/AIDS crisis, in order to become a force for transformation-bringing healing, hope and accomplishment to all infected and affected by HIV/AIDS. The Church is and should be an agent of God's change by contributing to the communities in which she is located.

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INTRODUCTION TO THE STUDY

1.1 INTRODUCTION

> *We could not have designed a more frightening disease if we had tried. If we could play at being Satan for the day, charged with the task of designating an epidemic to undermine both the developed and undeveloped countries of the world at the end of the twentieth century, then the blueprint for the design would incorporate many of the features of AIDS* (Connor & Kingman, quoted in Saayman & Kriel 1991:154).

Disasters are events, which disrupt the lives and livelihoods of people and cause large-scale social or economic damage such as oil spills, drought, floods, epidemics or major fires. Kumar (2008: xv) defines disaster as a catastrophic occurrence, a sudden or major misfortune that disrupts the basic fabric and normal functioning of a whole society or a community within it. It is an event or series of events which give rise to casualties, damage to or loss of property, infrastructure, essential services, or means of livelihood on a scale which is beyond the normal capacity of the affected communities to cope with unaided. Furthermore, he described the types of disasters that can affect people or communities as sudden-onset and slow-onset.

Disasters can be classified in terms of the speed of the onset. Sudden-onset or sudden natural disasters are natural calamities triggered with or no warning whose adverse impact is on humans, activities and economies (Rutgerhauer, 2011). The effects of sudden-onset disasters unfold over a short period of time; these include floods, earthquakes and storms (UNDP, 2004) Slow-onset or creeping disasters refer to situations such as ecological degradation, drought and epidemics that reduce people's abilities to engage in sustainable livelihoods (according to *Zambia Disaster Management Act* (ZDMA) (2010). Slow-onset disasters can unfold over a long period of time and even alongside and within developmental processes (UNDP, 2004). Wisner, *et al.* (2004) state that slow-onset disasters such as famine, the even slower HIV/AIDS pandemic can unfold over a period of 30-80 years or more.

In this study the researcher will consider the role of the Church in disaster management. The Church in this context means the body of Christ according to the Bible of the Christian faith. Some quotations relevant to the study will be used as part of literature and these will be from the King James Version of the Bible.

According to Burger & Brynard (2001) HIV/AIDS has been a "silent" epidemic as people seemed to close their eyes hoping that the truth would not be a devastating reality, a disaster with peculiar characteristics. The HIV/AIDS disaster contains all the ingredients of a disaster, and therefore it could be argued that HIV/AIDS should be managed according to disaster management principles and objectives, and especially according to a slow-onset disaster category. About 30 years into the pandemic, its devastating impact on social and economic lives of the people has not abated. According to UNAIDS (2011), it is estimated that 33 million people are living with HIV worldwide. Nearly 70% of those infected are found in Africa and women (constituting about 60% of those infected) are disproportionately affected by the pandemic in the region. In 2011 two million people were said to have died of AIDS-related complications in Africa UNAIDS (2011). The southern part of Africa has remained the epicentre of the epidemic. The HIV/AIDS pandemic ought to be identified as a disaster that is quietly and slowly unfolding.

HIV/AIDS has become part of the everyday life of most of the villages, towns and cities of Zambia. This pandemic is not what you can wish away or what you can just pray away, it is a reality and we are living with it. HIV/AIDS was regarded as a problem for non-Christians alone; however, HIV/AIDS is a disease that knows no religious identity. Christians and non-Christians alike are affected and being infected by the disease. Without a doubt, HIV/AIDS is present among us and it is not going away any sooner. According to (Wangari 2008) the first case of HIV in Zambia was reported in 1984 while HIV/AIDS was declared a national disaster in 2004 by the Republican President, Dr Levy Patrick Mwanawasa who offered to subsidize Antiretroviral Therapy (ART) to those who could afford the subsidized treatment. HIV/AIDS has changed the lives of people in many different ways. It is now agreed that HIV/AIDS is not merely a health challenge, but has also become a security and development problem (Murphy, 2004).

Today it is generally accepted that HIV/AIDS is not just a moral issue, but a critical health problem needing practical and relevant interventions to both its spread and the alleviation of suffering. More than 1.1 million people are living with HIV/AIDS in Zambia (UNAIDS/WHO, 2006:487). One of the huge challenges facing Zambia in this regard is to find a way to manage the HIV/AIDS disaster within the country. Successful management requires a holistic and integrated multi-sectoral approach highlighted by disaster management principles. However, it is worth mentioning that the Zambia government is indeed involved in various initiatives in an attempt to manage this epidemic successfully.

Disasters have a profound effect on communities and livelihoods. It is imperative to note that disasters are often dormant and unresolved problems rooted in failed development processes. Often disasters can be averted, mitigated or made less destructive, by reducing risks in communities. Managing and reducing the risk of disasters are some of the fundamental aims of development. According to the World Bank (2008):

> *Developing countries suffer the greatest costs when a disaster hits – more than 95 per cent of all deaths caused by disasters occur in developing countries; and losses due to natural disasters are 20 times greater (as a percentage of GDP) in developing countries than in industrialized countries*.

Few would dispute that there is an increasing trend of disasters. Regardless of the size of the disaster, for example HIV/AIDS, the impact is first felt within the immediate families then on a local level and the country at large (UNAIDS 2009). There are a number of factors that contribute to this. The following factors influence the consequences of the HIV/AIDS epidemic:

- Lack of financial resources.
- Time to work with each community in its efforts to prepare for such disaster.
- Local institutions and agencies not receiving the information in time to cope with or minimize the impact.
- Failure to put into practice the knowledge that has been gained, as well as a failure to expand upon that knowledge.

1.2 BACKGROUND AND RATIONALE OF THE STUDY

1.2.1 BACKGROUND TO THE STUDY

It has now been three decades since the emergence of HIV/AIDS and millions of people across the globe are still suffering from its impact. Millions of people are living with HIV/AIDS globally, while two thirds of these people live in sub-Saharan Africa of which Zambia is a member State (United Nations, 2004; Joint United Nations Programme on HIV/AIDS [UNAIDS], 2007). We live in a world which is slowly but surely being ravaged by the pandemic. It is obvious that one cannot speak about Africa as a continent without mentioning the monster HIV/AIDS. Sadly this is becoming true not just for Africa, but for the world at large. HIV/AID is everywhere and it has changed the lives of people in many different ways. It is now part of emergency and development problems (Avert, 2011). By far the world's worst-affected region, sub-Saharan Africa is now home to about 22 million out of about 33 million people living with HIV/AIDS (UNAIDS, 2011). The eight Southern Africa Development Community (SADC) countries have the highest HIV adult prevalence rates in the world with 21.5% in Zambia (IOM, 2003:8).

The AIDS pandemic has devastated communities and increased the burden of poor and marginalised people. It has destroyed hope and stability, orphaning vast numbers of children (Tearfund, 2007). One of the major reasons for this is poverty, and according to Avert (2009), the economically poor citizens are the worst affected. Infection with the Human Immuno-deficiency Virus (HIV) and the subsequent progression to Acquired Immune Deficiency Syndrome (AIDS) is a global pandemic that has reached every corner of the world (Jackson, 2002).

Against this background, governments, NGOs, faith-based organizations and other stakeholders, have been driven to intensify substantial campaigns to educate their communities about the deadly disease. No doubt different means of mitigating this deadly pandemic are being tried in different parts of the world, especially among the economically disadvantaged populations. As stated in the previous paragraph, the scale of the pandemic

presents a fundamental challenge to Zambia, Africa and the world at large. Long-term commitments are necessary to prevent the spread of HIV infection and to mitigate the impact. Many HIV positive persons are now able to live as long as possible and in good condition due to the availability of Antiretroviral Therapy. (Mombe, 2005) state that what is still lacking is political commitment and sharing of information on HIV, particularly in the rural areas. Hope is possible only if resources and efforts are mobilised to empower people living with HIV and caregivers with useful information on HIV, and how to manage it with the most accessible and affordable means (Mombe, 2005: 15).

1.2.2 ASSEMBLY OF GOD CHURCH (AOG) PROJECTS

In this research, the area of concern is the involvement of the Assembly of God Church (AOG) Lusaka in disaster mitigation, in this case the HIV/AIDS pandemic. The (AOG) Church Lusaka embarked on a wide range of empowerment projects such as: The Lazarus Project, Operation Paseli, Sonshine School and Circle of Hope Family Care otherwise known as (CoH). Brief explanations of the various projects are outlined below.

- *The Lazarus Project*: This project was established in 1999. Our goal at The Lazarus Project is to rescue, rehabilitate (educate and train for employment) and to transform homeless, hopeless street kids in Lusaka Zambia. With fifty-five children seven to eighteen years old under our care the work has just begun. Life never ceases to amaze us as a project when we discover the families of these children and reunite them (Northmead Assembly, 2011). It is against this backdrop that the project exists to reintegrate displaced children with their families and strengthen family values.

- *Operation Paseli*: While having launched the Lazarus Project in 1999, the (AOG) Church started an outreach programme that targeted commercial sex workers who could be seen parading the streets. The outreach was named "Operation Paseli" after the name of the street where the Church is located. Training courses in skills included: tailoring and designing, batik and tie and dye, nutrition and cookery, microfinance management, basic home care, among others. Since inception, the programme has had four graduation ceremonies (Northmead Assembly, 2011).

- *Sonshine School*: The Sonshine School, a ministry of (AOG) Church, is situated along Katima Mulilo Street in Olympia Park. The school formerly called Jack and Jill, was opened in the 70s. The Sonshine School is committed to the vision of its host Church, meeting the needs of the community (Northmead Assembly, 2011).

- *Circle of Hope Family Care (CoH)*: CoH was launched in 2003 in the on-going wake of the HIV/AIDS pandemic. The clinic is a fully fledged medical facility and offers free Anti Retroviral therapy to thousands of people. Clients come from different places, even far off places; receive voluntary counselling and testing before treatment is commenced. In this way the (AOG) Church is aggressively combating the negative impacts of the HIV scourge (Northmead Assembly, 2011).

My focus is on the (AOG) CoH project which is directly involved in the HIV/AIDS pandemic by providing counselling, education, testing and administering drugs and medication in an effort to contribute to the Lusaka community since the government alone cannot adequately deal with the issue within the country (Northmead Assembly, 2010). A recent study in Zambia revealed that:

> *Better treatment outcomes can be obtained when primary caregivers/guardians are aware of HIV testing, care and treatment services and believe accessing them will make a difference in the children's lives as well as their own* (Bolton-Moore, et al., 2007:116).

With HIV/AIDS in low-income areas in Lusaka, the Churches particularly AOG through CoH has been providing medical care and counselling in the bid to curb the spread of the pandemic within Lusaka. Churches have continued to contribute and to work with other agencies in order to assist in recovery and reconstruction within communities. Yet many studies of community-based disaster risk management (CBDRM) tend to overlook the role of the Church in disaster management. UNICEF (2003: 9) has observed that religious leaders are in a unique position to alter the course of the pandemic, because when they speak their followers religiously listen and follow them. It is against this background that

the study will focus on the role of the Church in disaster management. It should be noted that when CoH is mentioned in the study that I am referring to the AOG HIV/AIDS Family Clinic Project.

1.3 RATIONALE OF THE STUDY

This study is justified on a number of grounds. Firstly, it responds, to global concern about the role of the Church in mitigating the impact of HIV/AIDS pandemic. The study provides answers to the concerns of the community about the role of the Church towards HIV/AIDS. Secondly, the findings should generate interest and create awareness about the contribution made by the Church in community sustainability. Thirdly, such awareness is expected to motivate further studies into the phenomenon "The Church and disaster management". Finally, the study is expected to suggest interventions on behalf of those affected and infected with HIV/AIDS and to establish the implications of not being involved as a Church.

According to Mouton (2001:48) the first phase of any research project involves transforming an interesting research idea into a feasible, researchable research problem. Burns and Grove (2005:203) state that a research topic identifies the area of concern with the aim to gain a better understanding of the problem. In line with these observations, the researcher intends to outline the research steps that are taken to transform his interest about how AOG Church in Zambia is mitigating the impact of HIV/AIDS into empirical evidence.

1.3.1 PRELIMINARY LITERATURE STUDY

HIV/AIDS pandemic is one crisis that has catapulted the African continent into global limelight, particularly during the past decade (Afe, 2005). The pandemic has been acknowledged as the foremost development issue facing many African countries (Zambia inclusive) and the foremost threat to the survival of its teeming population (The World Bank, 2000). To date, the pandemic has defied medical, therapeutic and curative measures, thus gradually eroding the fabric of our societies and leading to more than 60 million

people worldwide living with the disease (Freeman, 2008 iv). Thirty-one years after HIV/AIDS had been discovered it became crystal clear that it was more than just a medical phenomenon. It pervaded all spheres of our lives, be it economic, political, social, cultural or spiritual (UNAIDS 2009). It was more than just an individual problem, for it affected communities, families, countries, continents and the world at large.

HIV/AIDS cannot be considered in isolation as it not only impacts on the physical and mental health of individuals and population, but it also affects socio-cultural structures, traditions also impacts on economies, education, food security and many other issues. HIV/AIDS needs a multi-sectoral approach as it is a cross cutting issue. Prevention, treatment and care and impact mitigation need to go hand in hand. In the light of Church's response to the arrival of this scourge, the AOG has demonstrated their involvement in disaster management as a Church as they engaged in community empowerment through four of her community projects "The Lazarus Project, Operation Paseli, Sunshine School and Circle of Hope Family Care Clinic." For the purpose of this study, this research will be focused on the Circle of Hope Family Care Clinic where HIV/AIDS patients are cared for and get their antiretroviral treatment and counselling.

The AOG Church in Zambia has been part of disaster management in spite of the popular impression about Churches as a religious group that is mainly concerned with the supernatural. According to Harry (1972:392) the popular impression about religion is that it is concerned with the supernatural only, and has very little to do with the day-to-day life of man. However, a close examination will reveal that this popular impression is not wholly correct. Nürnberger (1998:46) disagrees with the popular impression when he said:

> *Contrary to the popular misconceptions the biblical faith does not primarily (let alone exclusively) focus on the spiritual needs of human but expected to respond with a clear commitment to the fundamental covenant on which social cohesion depended, thus to abrogate all other religions (ideologies), and to uphold a just social order as codified in God's law.*

Churches and synagogues were once the central instrument for social change and restoration Verhaeghe (2009:8). Limited research has been done to describe how the Church assists to provide better care to those affected and infected.

Global statistics has proven in 2009 that 35.3 million people are living with HIV/AIDS in the world; 24.2 million of them live in sub-Sahara Africa. Adults and children that are newly infected are two million. Since its outbreak, HIV/AIDS has killed 22 million people worldwide. In 2009 a record of 1.5 million deaths was recorded by sub-Sahara Africa (UNAIDS 2009).

1.4 PROBLEM STATEMENT

The first case of HIV/AIDS in Zambia was reported in 1984 and since then the number of people living with the virus or the disease has increased dramatically, according to (NASF, 2010) an estimated 82, 681 adults were newly infected with HIV (59% women, 41% men) with 226 new adult infections, and 25 new paediatric infections occurring each day. The government of Zambia has designed and implemented several prevention and mitigation measures against the pandemic. The pandemic has made swift and devastating advances, to the extent that it has reached crisis-level proportion (Suite 101, 2011). According to World Health Organization (WHO) by 1989, a survey of hospital patients in the capital city Lusaka, found that 17.5% were infected with HIV. Despite the growing prevalence of the virus, Lusaka was slow to respond to the concern. The HIV pandemic has had a devastating impact on Zambia and one in every seven Zambian adults is now believed to be living with the virus (Healthdev, 2011).

Life expectancy at birth has dropped to about 42 years old, compounding the country's economic concerns and exacerbating the forces that have made Zambia one of the poorest and least developed nations in the world (NASF, 2010). By the 1990s, it was estimated that 20% of the population had become infected with HIV. This rise in prevalence led the World Health Organization (WHO) to develop a National AIDS Advisory Council in Zambia.

Lusaka Province in particular has been hard hit by the HIV/AIDS pandemic. The National AIDS Council citing the 2001/02 Demographic and Health Survey states that 16% of the adult population aged 15 to 49 are HIV positive (NAC, 2008). For many years the statistics of people infected by the virus had been at 20 % (NAC, 2003:16). However, the recent reduction from 20 to 16% is still alarming, and it calls for concern and effort from all stakeholders to join together in the fight against the HIV/AIDS pandemic. According to the Zambia Demographic and Health Survey (ZDHS) conducted in 2001 – 2002, 16% of adults tested were HIV positive, 13% for males and 18% for females. Nearly one-third of females in the 30 - 34 age group were HIV positive and levels were higher than males in all five the age groups except for 40 to 44 and 45 to 49. ZDHS testing conducted in each province in Zambia showed a higher HIV prevalence rate for females, except in the North-Western Province where it was at the same level as males, around 10%. The highest rates were found in Lusaka Province where the research was focused, 19% for males and 25% for females (ZDHS) conducted in 2001 – 2002.

In keeping pace with the government's commitment, dedication and contribution to fighting HIV/AIDS, the Churches in Lusaka have resorted to establishing HIV/AIDS prevention programmes, including education and counselling departments within their communities. To this effect, the Church in Zambia, more importantly the AOG Church Lusaka, has embarked on a multi-sectoral approach, established a department, built a centre called Circle of Hope Family Care Clinic (CoH) where HIV positive persons receive care and support services, including counselling, testing and treatment. Ross (2002: vi) reminds us that:

> *It is only when the Church becomes the leading symbol of healing in a situation of HIV/AIDS and poverty then it will be a blessing to all those who are living HIV negative lives and those who struggle to bring care, support love and comfort to the orphans and widows and more especially to all those living with HIV/AIDS.*

The Church should not lag behind, but it should set the pace of showing the love and care for all people with HIV/AIDSs and who are living in poverty. In recent times some Christians and Church-related institutions in Zambia have been involved in the education, mitigation and prevention programmes and in caring for people living with HIV/AIDS.

UNICEF (2003b: 9) observed that religious leaders were in the unique position of being able to alter the course of the pandemic.

When they speak their followers will religiously listen and follow them. Religious leaders can shape social values increase public knowledge and influence opinion; support enlightened attitudes, opinions, policies and laws; redirect charitable resources for spiritual and social care and raise new funds for prevention, care and support and promote action from grass roots to national level. Pastors and Church leaders have a ready audience - their Church members. In spite of everything the response of Churches has been inadequate and has in some cases not been able to make the positive impact envisaged. In 1987 the World Council of Churches (WCC) Executive Committee noted that, "through their silence, many Churches share responsibility for the fear that has swept our world more quickly than the virus itself" (WCC, 1997:99).

According to WCC (1997:77-90) the Church as a body of Christ is a community of healing and compassion. The Church as a community should demonstrate the ever-loving kindness of God's faithfulness in order to bring to people who have been affected and infected with HIV/AIDS God's warmth and love (Louw, 2006). By the preaching of the Good News, the Church espouses the message of social and individual wholeness. For the Church all people, regardless of their gender, class ethnicity, race, age and religion are created in God's image and likeness (Genesis 1-2). This is further accentuated by Jesus when he said he came that all may have life and have it in fullness (The Bible, John 10:10). Jesus' ministry was centred around healing of diseases unconditionally (The Bible, Mark 1:29-34), forgiving sins and breaking the stigma associated with leprosy by touching lepers and restoring them back to social health (The Bible, Mark1:40-45), taking sides with the poor and the socially marginalized thereby restoring hope to the hopeless (The Bible, Matthew 9:10-13). HIV/AIDS presents a challenge to the Church in its commitment to upholding God's covenantal relationship with his people in every aspect of their daily lives. This challenge relates to the way the Church sees itself and understands its mission as a healing, worshipping and prophetic community. Within the Church, it is vital that everyone can feel welcome and receive pastoral support.

Religious values entail equal treatment and regard for all manner and strata of people, therefore human worth and dignity as well as identity and eccentricity should be enjoyed by all types and classes of people, no matter their status in life. Who we are as God's Church of care, gives expression to the God we worship. Kysar (1991:144) states emphatically that the mission of the Church arises from the love God has for creation and the Church is commissioned as God's agents to care for persons. The social ministry of the Church arises from an image of God founded on the biblical witness. According to Lovell (1980: x) *the brotherhood of man is a central concept in Christianity and concern for the welfare of others is a key characteristic of the Christian way of life*. A theology of hope and love must be complemented by practical care, which not only aims to improve people's quality of life within their community, but also demands action in the wider world.

Concisely, biblical teaching, the gospel of Christ and Church traditions provide adequate framework for the Church to serve God's people in the HIV/AIDS era. On the other hand, the Church's close connection with families, individuals and the community; its availability even in the most remote quarters, puts it in the centre of HIV/AIDS care. The Church has a central role to play in the fight against HIV/AIDS; it ought to be there for the sick, the dying, the bereaved, the widower, the widow and the orphaned, offering care and hope in the gospel of Jesus Christ. The Church by its very nature should be involved in intervention strategies in order to save lives. The Churches in Zambia need to revisit its understanding of its identity and God's mission in as far as the challenge of HIV/AIDS is concerned. The purpose of God's love and justice as manifested through Christ is for the common good of all humanity and the ultimate well-being of all people who are created in God's image as stated in Genesis 1:27 (The Bible).

The Church is the community of people called by God to bear witness to God's reconciliation, healing and transformation. As part of the civil society, it has the spiritual and moral responsibility for ensuring that all citizens in Zambia enjoy their full rights. Far from being powerless victims of HIV/AIDS, those affected and infected in Zambia must be treated with respect and dignity. Human beings respond to love, care and shelter, as basic needs. Besides, as a community of compassion and healing, the Church is a collection of human resources, who are able and willing to reach out to God's creation. The Churches

have strengths, they have credibility, and they are grounded in communities. This offers them the opportunity to make a real difference in combating HIV/AIDS. To respond to this challenge, the Churches must be transformed in the face of the crisis, in order that they may become a force for transformation – bringing healing, hope, and accompaniment to all affected by HIV/AIDS (WCC, 2001:3). Therefore this research aims to describe and evaluate the response of the AOG Church in Lusaka, to the challenges of HIV/AIDS, which has adversely impacted on the country's population.

1.5 THEORETICAL FRAMEWORK

In analyzing the Church involvement in disaster management the following two theoretical models will be used; disaster management continuum (DMC), the 1999 Sustainable Livelihood Framework (SLF). It will be supported and substantiated by the Zambia Disaster Management Act (Zambia, 2010) when necessary.

The disaster management continuum discusses stages in disaster management and the author shall find out whether this was applied by the AOG Church, in managing HIV/AIDS. The SLF model shall be used to assess sustainability livelihoods of those affected and infected by the disease and how the Church became involved in ensuring that victims were helped, through programmes that created survival skills for them. The Zambian *Disaster Management Act* of 2010 is the guiding legislation on disaster management, and issues related to policies and strategies. Mitigation by different stakeholders in executing any HIV/AIDS activities is also done according to the Act. The National Aids Council (NAC), a statutory body derives its strategies from the Zambian government's Ministry of Health and the author will carry out a literature review on how the council collaborated with the Church in Zambia regarding HIV/AIDS. There are many authors on the subject, and in this study; a number of them will be discussed, especially those whose work is on sub-Saharan Africa where HIV/AIDS is still high.

1.6 RESEARCH QUESTIONS

- What is the Biblical foundation of the AOG's view on disaster management?
- What is the driving force behind AOG HIV/AIDS programme?
- How effective is the AOG response and management of HIV/AIDS in Lusaka, and by how much has AOG impacted on the Lusaka community?
- Does AOG satisfactory meet the needs of the community, if not, what recommendation can be suggested to improve the response?
- Does AOG not create a dependency syndrome in the Lusaka community?
- If AOG were to stop these programmes will the community uphold the *status quo*?

1.7 AIM OF THE STUDY

To describe and evaluate the disaster management projects of the AOG through (CoH) in Lusaka as a model of how the Church can contribute to alleviating real-world problems (AIDS in particular) and enhance lives and livelihoods opportunities of the community.

1.8 OBJECTIVES OF THE STUDY

- To identify factors that makes it necessary for HIV/AIDS interventions by AOG.
- To assess how AOG programmes impact on the livelihoods of the community in Lusaka, for example children and women.
- To analyze the relevance of AOG in addressing HIV/AIDS and socio-economic aspects of the Lusaka community.
- To determine the sustainability of AOG programmes vis-à-vis sustainable development.

1.8.1 ASSUMPTIONS OF THE STUDY

- The respondents would give correct information.
- The Church bureaucracies will not hinder the progress of the study.

- The management of the programmes will facilitate/support the investigation.
- Secondary data on the operations of the programmes being undertaken is available.

1.9 THE RESEARCH DESIGN

According to Burns and Grove (2005:40) the research design is the structured framework of a study that guides the researcher in the planning and implementation of the study. This study will follow a qualitative design (Leedy & Ormond, 2005:134) of findings of AOG HIV/AIDS interventions. The study covers AOG church CoH HIV/AIDS project in Lusaka the capital city of Zambia.

1.9.1 THE RESEARCH METHODOLOGY

The study will be explanatory in nature as it will focus on disaster management and the Church. The study employed qualitative data gathering methods. Such methods are anchored on the attitudes, values and beliefs of the study population.

1.9.2 QUESTIONNAIRE

Questionnaire survey was adopted in order to elicit information from research respondents. The questionnaire captures data on disaster management and the Church. Furthermore, the questions were focused on how the AOG had contributed to the community through the CoH HIV/AIDS project and the coping capacity of the community in relation to AOG intervention.

1.9.3 INTERVIEWS

The study made use of interviews. The use of interviews was linked to the expectation that through semi structured interviews, interviewed persons in CoH were likely to express their views spontaneously in a relatively openly designed interview situation. According to Flick (1998) certain open-ended questions must be used in the interview situation as a form of interview guide.

1.9.4 DATA COLLECTION

The study made use of instruments as semi-structured questionnaires and it applies for key informants and beneficiaries in CoH project.

1.9.5 SAMPLING

The study has covered (AOG) CoH HIV/AIDS project in Lusaka and 46 respondents were picked up. All of the beneficiaries were those for whom the program was designed and currently receiving services from on going CoH HIV/AIDS program.

1.10 RESEARCH LIMITATION

The issue of disaster management is a broad and multi-sectoral one, thus it requires broader consultation than any specialised subject in order to get all facts straight, correct and accurate. It is worth mentioning in this study that dealing with a wider scope in limited space of pages and time will entail a great deal of hard work. The study is indeed challenging as it tries to focus on how much the AOG Church is involved in disaster management. There lies the rather obvious issue of the subjectivity of the topic of the Church's involvement in disaster management. As a result of this, it may prove difficult to approach this audacious topic, and alleviate as much bias as possible through critical views of theory and interpretation throughout the study.

Furthermore, there is a limited amount of current research on the Church's involvement in disaster mitigation. There will be literature gaps in reviewing the cultural beliefs and narratives of disaster and the Church's involvement in addressing this area, because not many documents on the work of Churches in disasters are documented. However, this challenge did not deter the accomplishment of the study and its purpose. Owing to budgetary and time constraints it was recognised that the development of resource mobilisation was a time demanding task that required research, a mission of its own. In some cases, the days allocated for each sectoral visit were insufficient. In other cases, the

short notice given by the Church in notifying them about the mission did not afford sufficient time to prepare all the meetings and documentation required.

1.10.1 SIGNIFICANCE OF THE STUDY

Although the study is site-specific, its conceptual basis should be transferable and adopted by other Churches in Zambia, elsewhere in Africa and beyond. The findings will propose innovative strategies to be used by other Churches when involving in faith-based projects. It is hoped that the results of this research may ultimately help to raise the quality of love, attention and care offered to those in need of social support. Some of the study significance and value include:

- Providing an understanding of the Biblical foundations with which other Churches can be involved, and with the view of integrating the disaster risk reduction/mitigation strategies.
- To explore areas such as meetings and workshops for all local church leaders on DRR practices, and to think creatively how the Church can incorporate the entire community of faith into the DRR process.
- To assist in educating Churches in Zambia, Africa and beyond on the need to redefine or expand their mandate in order to address the physical needs of the community, especially and specifically needs related to disasters.
- To assist in establishing the importance of the Church as key civil society institution that has strong presence in various cultures, and can assist with disaster mitigation and preparedness in local context.
- Contributing to the improvement of how the Church can challenge harmful myths and assumptions that it is not concern with the social life of man and how it can influence and shape values in their communities and wider societies by addressing common cultural beliefs such as fatalism.

1.11 DEFINITION OF TERMS

For the purposes of this study the followings terms are thus defined:

1.11.1 CHURCH

In this study this term denotes a Christian Church, its leaders, members and teachings (Francis & Liverpool, 2008). According to Blackman (2007) Church is a sustainable community of local Christian believers, accessible to all, where worship, discipleship, nurture and mission take place. The Church can be referred to therefore, as the body of Christ, made up of all believers in Jesus Christ.

1.11.2 ASSEMBLY OF GOD (AOG) CHURCH

Assembly of God (AOG) Church is a Christian Church in Zambia located at Plot 2131 Paseli Road, adjacent to the Northmead Shopping Centre in Lusaka Zambia.

1.11.3 ASSEMBLY OF GOD (AOG) CHURCH-BASED PROGRAMMES

This term refers to social programmes, projects and Christian-oriented organizations that are run by AOG in order to address various negative situations in Lusaka Zambia such as HIV/AIDS.

1.11.4 CIRCLE OF HOPE FAMILY CLINIC (CoH)

The Circle of Hope Family Clinic (CoH) is equipped with medical facility to offer free Anti Retroviral Therapy (ART) to thousands of people.

1.12 DESCRIPTION OF CHAPTERS

The chapters in this study shall be presented as follows:

Chapter 1 is introducing the research. This will outline the rationale for the chosen topic, problem statement, objectives, purpose and motivation of the research, significance of the study, definition of terms, preliminary literature review, aims and assumptions of the study. Furthermore, this chapter will highlight the clarification of terms.

Chapter 2 is centred on the history and description of the study area and clarification of key concepts. This chapter highlights the issues of the community in terms of social economics factors of the study area.

Chapter 3 will look at literature on the Church and community and the four projects within Lusaka which will be reviewed in order to develop a conceptual framework of the study.

Chapter 4 will examine the methodology the researcher will use to gather data.

Chapter 5 shares the concept of the findings.

Chapter 6 will present conclusions and recommendations.

1.13 CONCLUSION

This chapter introduced the study on the disaster management and the Church: a case study of AOG Church community projects in Lusaka, Zambia. It also outlined the general overview of the research topic, the research problem and objectives, the aim of the study, theoretical framework, and research methodology limitations of the study and the structure of the study.

CHAPTER TWO

BACKGROUND AND GENERAL OVERVIEW

2.1 INTRODUCTION

This chapter will discuss the background of Zambia as a nation, Lusaka as the capital and the most densely populated province, and the question of HIV/AIDS in Lusaka Zambia. However, the researcher would like to start this discussion by positioning Zambia as a country. In its four decades of independence the republic has been a unified and peaceful country that enjoys vast land and water resources with one of the lowest population densities in the world. Despite this, Zambia remains one of the Africa's poorest countries: according to (Embassyofireland, 2011) it ranked 165 out of 177 countries on the UN Human Development Index 2007. Over two-thirds of the population live below the national poverty line of less than a dollar a day; many of them in congested urban sites called compounds.

2.2 A BRIEF HISTORY OF ZAMBIA

According to Mulenga (2007:2), history and archaeology show that by the year 1500, much of modern Zambia was occupied by Bantu-speaking horticulturalists. These farming people were identified as ancestors of Zambia's present inhabitants. Early humans inhabited present-day Zambia between one and two million years ago. Today the country is made up of almost entirely of Bantu-speaking peoples. According to (Infoplease, 2010) empire builder Cecil Rhodes obtained mining concessions in 1889 from King Lewanika of the Barotse and sent settlers to the area soon after. By the end of the 19th century, diverse parts of what was to become Northern Rhodesia were administered by the British South African Company. From 1953 to 1964, Northern Rhodesia was federated with Southern Rhodesia now Zimbabwe and Nyasaland, now Malawi in the Federation of Rhodesia and Nyasaland. In 1963 this Federation was disbanded.

On 24 October 1964 Zambia became a politically independent republic and adopted a multiparty system of government. However, for what was to be a threat to national unity and peace, Zambia embraced a one-party style of governance in December 1972. Close to the end of November 1991 the people of Zambia voted unanimously for multi-party politics to be restored (Infoplease, 2010). According to World Development Indicators (WDI), the Zambia population was estimated to be 11.9 million and it had a growth rate of 2.4% per annum in 2008. Zambia is a low income country, overwhelmed by 78 and 53% or rural and urban poverty, respectively (CIA, 2008). It is faced with decreasing social indicators, particularly its life expectancy, which at birth is only 42 years, and a maternal mortality as high as 830 in 100 000 pregnancies (WDI, 2008). Recent figures according to (WDI, 2008) show that Zambia is 35% urbanised. The figure has not changed much since the 1980s when the copper industry attracted rural people to the urban areas (World Bank, 2002).

Zambia is a landlocked country in south-central Africa covering an area of 752, 612 square kilometres (approximately 2.5 per cent of Africa). It is surrounded by eight other countries (Infoplease 2010). It shares borders with the Democratic Republic of Congo (DRC) Tanzania in the north; Malawi and Mozambique in the east; Zimbabwe and Botswana in the South; Namibia in the southwest and Angola in the west. Zambia is mostly a plateau that rises to 8,000 ft (2,434 m) in the east. Administratively, Zambia has nine provinces and 72 districts. Two of these nine provinces, namely Lusaka and the Copperbelt are predominantly urban. The remaining provinces—Central, Eastern, Northern, Luapula, North-Western, Western, and Southern—are predominantly rural provinces. According to UNAIDS/WHO (2006: 487), more than a quarter of Zambia's estimated population of 11,668,000 live in two of these urban areas. Meaning that the rest Zambia is very sparsely populated especially the west and the north-east regions of the Country. Zambia lies between 8 and 18 degrees south latitude and between 20 and 35 degrees east longitude. It has a tropical climate and vegetation with three distinct seasons: the cool dry winter from May to August, a hot dry season during September and October, and a warm wet season from November to April. Zambia has four main rivers, namely Luapua, Luangwa, Kafue and Zambezi. It has major lakes such as Mweru, Bangweulu, Tanganyika and of course the man-made lake, Kariba.

Figure2.1: Zambia, 2005 *(Source: UI, 2005)*

According to Central Statistical Office (CSO) (2011) Zambia population has risen significantly from 11.9 million in 2008 to 13,046,508. The initial results of the 2010 national census also revealed that Lusaka had the highest number of eligible voters at 19% population. According to the preliminary results of the 2010 national census released by the (CSO), Lusaka's population jumped to 2,198, 999 from 1, 391, 329 in 2000.

Lusaka is the capital and largest city of Zambia, as well as its chief administrative, financial, and commercial centre. The main languages spoken in Lusaka are English and Nyanja. It is located in the southern part of the central plateau of the country, at an elevation of 1300 m (4256 ft) (Micc, 2011). Lusaka has a population of 3,100 000 (2007 estimate) and is considered one of the fastest growing (in terms of population) cities in Africa. The name *Lusaka* derives from a Lenje village once located on the site that was named after the village's headman, Chief Lusaka, which according to history, was located at Manda Hill, near the Zambia National Assembly building (Newworldencyclopedia, 2011). Lusaka has become a popular urban settlement for Zambians and tourists alike. It has become home to a diverse community of foreigners, many of whom work in the aid industry as well as diplomats, representatives of religious organizations and some business people.

2.2.1 THE ECONOMY OF ZAMBIA

Zambia has a mixed economy made up of two sectors: a modern urban sector that geographically can be found along the line of rail traversing from north to the south, and a mainly rural agricultural sector. Since the country's return to the practice of multiparty politics in 1991, a liberal market-oriented economy was established. This action saw the government owned enterprises sold into private hands. Unfortunately, the entire nation depends heavily on copper exports and mining, which has deteriorated drastically. Every effort made to reduce reliance on copper exports by diversifying the economy through the formation of import substitution government-owned business enterprises, did not check the economy's 'free fall'. The International Monetary Fund (IMF) and World Bank introduced to a stagnating Zambia economy during the 1980s, Structural Adjustment Programmes (SAP) which did not benefit the country. McKinley and Weeks (2006) state that the structural adjustment programmes did not yield economic prosperity, but only increased the poverty of the majority of Zambians. McKinley and Weeks further reiterate debt relief is not at fault: the fault lies with the conditions under which it is disbursed. From 1980 to 1993, per capita income declined by 3.1% annually, reaching US$300 in 1998. According to Economist Economic Review (1997), real government health expenditure declined by 41% from 1970 to 1984. In the absence of increased revenues, health services remain reliant on unsustainable external grant or loan funds.

Today Zambia is said to be one of the poorest and least developed nations in the world. Poverty has been identified as a serious hindrance to the well-being of many and disruption of lives. The SARPN (2005), states that Zambia is one of the World's poorest countries. The 2003 Human Report ranks Zambia's Human Development Index at unbelievable 163 out of a total of 175 (poorest) countries (2005:197). There is no doubt that Zambia remains one of the world's poorest countries, with a major national debt and a weak currency (Zambia-travel-guide, 2011). In the mid 1990s, even until 1997, its prospects looked good. GDP growth was about 6.5%; inflation had been reduced to 24% (down from 187% in 1993); a prolonged decline in manufacturing was being reversed; non-traditional exports were expanding at a rate of 33% a year; and the privatisation programme was being hailed as one of Africa's most successful.

Zambia has its main economic activities (mixed) concentrated along the line of rail, while agriculture sector is most concentrated in the rural parts of the country. At independence, Zambia inherited a dualistic economy that was heavily dependent on the mining sector for employment, foreign exchange earnings and government revenue (Elliott & Perrault, 2001). The Zambian Government based its development strategy on copper earnings, which accounted for 90% of all earnings and nearly 50% of the gross domestic product. It has embarked on programmes that will aid economic diversification and thus reduce the economy's reliance on the copper industry. This initiative sought to take advantage of the country's rich resource base by promoting tourism, agriculture, gemstone mining, and hydro-power (Elliott & Perrault, 2001).

2.3 THE HIV/AIDS SITUATION IN ZAMBIA

Zambia's first AIDS cases were identified in the mid 80s (WHO, 2011). Bwalyakafumbe (2011), states that only one year later 17.5% of hospital patients in the capital Lusaka were found to be HIV-positive. Within two years of the first report of AIDS in the country the National AIDS Surveillance Committee (NASC) and National AIDS Prevention and Control Programme (NAPCP) were established to coordinate HIV/AIDS-related activities. Given that it takes about 9.4 years from zero-conversion to AIDS, and about 9.8 months from AIDS to death (Morgan, *et al.,* 2002; De Walque, 2004; National HIV/AIDS /STI/TB Council, 2004). In the absence of antiretroviral drugs (ARVs), it seems that human immune virus has been in the Zambia population since the mid-to-late 1970s.

By the early 2000s, the HIV/AIDS pandemic had become a hazard. It was no longer limited to the "at risk" populations such as commercial sex workers and their clientele, migrant workers, and long distance truck drivers, but had spread into the general population. According to the National HIV/AIDS /STI/TB Council (2006) the main mode of HIV transmission in Zambia was heterosexual sexual intercourse which accounted for almost 80% of infections, while mother-to-child transmission accounted for most of the other 20%. Less than one per cent was estimated to be through contaminated blood products, such as needles and sharp instruments, and sex between men. All sections of Zambia's estimated 13

million populations were affected by the epidemic, though some sections, such as the rural populations, had considerably lower HIV/AIDS prevalence rates compared to the urban population.

UNAIDS/WHO (2007) states that HIV/AIDS epidemics, tend to be different from one region to another within the same country, and amongst different age groups. For instance, the Zambian Government's poverty reduction strategy paper for 2000-2004 cites national prevalence rates of 14% in rural areas, and 28% in urban areas in the 15-49 age group.

The Zambia Poverty Reduction Strategy Paper (2002-2004) states although the epidemic is showing signs of stabilisation in urban areas, the rates continue to rise in some rural areas. Currently, about 20 per cent of the adult population aged 15 to 49 are living with HIV/AIDS. The studies in Ndola revealed a prevalence rate of 32 per cent among females and 25 per cent among males. About eight per cent of boys and 17 per cent of girls aged 15-24 are living with HIV and the prevalence rate is up to 40 per cent among teachers. In June 2000, there were 830,000 people over the age of 15 years living with AIDS. Of these 450,000 were women while 380,000 were men. The peak ages for HIV among females are 20 to 29 years while for males is 30 to 39 years. Young women aged 15 to 19 are five times more likely to be infected compared to males in the same age group.

The impact of HIV/AIDS in Zambia is seen in all sectors of life and there have been suggestions that the country's developmental priorities have been over-ridden by the pandemic (National HIV/AIDS/STI/TB Intervention, 2002-2005). In response to the crisis, the Zambian Government declared HIV/AIDS a national disaster and developed a multi-sectoral approach to deal with the pandemic.

The map (Figure 2.2) shows the prevalence rates for each of the nine provinces of Zambia. The more urbanised provinces, Lusaka, Copperbelt, and Southern have the highest prevalence rates. Nonetheless, all the provincial prevalence rates are generally high, exceeding 10% in all but two provinces. Although there are differences in the provincial prevalence rates, the figures indicate that there is no province in Zambia that does not have a serious HIV/AIDS epidemic.

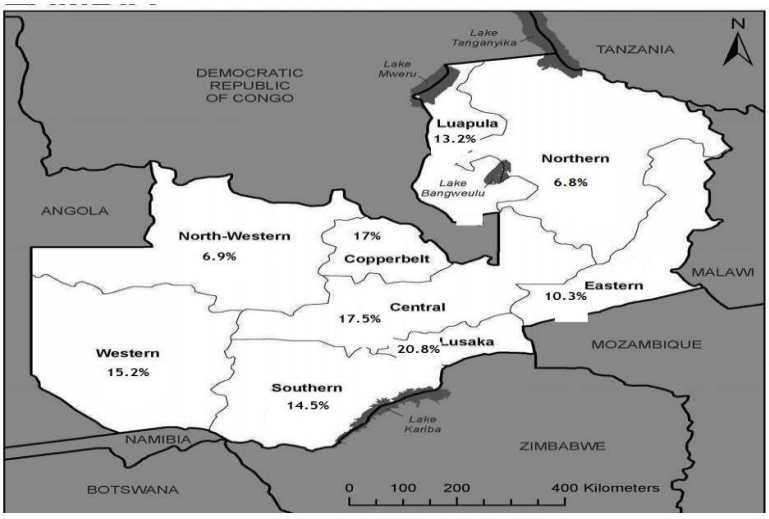


Figure2.2: Zambia 2007 HIV/AIDS prevalence map

(Source: *figures and map adopted from 2007 ZDHS)*

Despite the fact that knowledge of HIV/AIDS is almost universal in Zambia, only 39% of men and 36% of women have comprehensive knowledge about the modes of HIV transmission and prevention (ZDHS, 2007; CSO *et al.*, 2009). Two in ten men have had an HIV test at some point in their lives, according to the 2007 ZDHS. Such low levels of transmission modes and zero-status knowledge present serious hindrances to efforts to reduce the transmission of HIV in Zambia. Low knowledge levels of transmission modes and zero-status mean people may not take adequate measures to protect themselves and/or their sexual partners against HIV infection. Infection levels are therefore likely to increase at a faster rate than if people had adequate knowledge to protect themselves and their partners. Low knowledge levels may thus be contributing to the continuing spread of the HIV in Zambia.

Among the factors considered to facilitate the prevalent transmission of HIV in Zambia are the high levels of poverty, estimated at 68% of the population living below the national poverty line and 53% living in extreme poverty (CSO Zambia, 2005); high population mobility, social and cultural beliefs and practices such as widow inheritance and sexual-cleansing of widows (National HIV/AIDS/STI/TB Council, 2003); stigma, inadequate information, education and communication as found in the (disaster management continuum) about HIV/AIDS, gender issues such as the dominance of male interests and

lack of self-assertiveness on the part of women in sexual matters resulting in women's inability to negotiate safer sex, drug and alcohol abuse, and prison confinement (National HIV/AIDS/STI/TB Council, 2003; MOH Zambia, 2005). The presence of high levels of other untreated curable sexual transmitted infections (STIs) such as syphilis four per cent and five per cent in adult women and men respectively (CSO, *et al.*, 2009), and herpes which cause genital sores, facilitate higher viral transmission rates. All of which exacerbate the HIV/AIDS incidence (Oster, 2005). According to (ZDHS, 2007) the analysis shows that HIV/AIDS prevalence is highest in the age groups with the highest STIs (6.8% in the 30-34 age group, and 10.4% in men in the 40-44 age group).

TABLE 2.1: ZAMBIA DISASTER PROFILE

Disaster	Place of occurrence	People affected
Floods	Most districts but usually localized – Eastern, Central, Lusaka, Western and Luapula provinces	Those living in low areas those living in unplanned peri-urban settlements
Droughts	Most districts in Southern and Western provinces	Subsistence farmers
HIV/AIDS Epidemics/diseases (malaria, cholera)	All parts of the country Rural areas Unplanned peri-urban settlements	Poor communities-low or no income groups
Crops and livestock diseases	All parts of the country	Mostly small scale farmers
Refugee influxes	Northern parts of Zambia	Refugees and people living in border areas
Bush fires	Rural parts of Zambia	Rural communities
Mining disasters	Copperbelt/Mining towns	Miners and surrounding areas

(Source: Zambia Red Cross Society.,2003)

2.3.1 HIV TRANSMISSION AND STATUS OF THE EPIDEMIC IN ZAMBIA

In Zambia most HIV infections are the consequence of unprotected heterosexual sex. People who have many sexual partners and relationships increase the risk to both themselves and their partners. A number of factors can greatly increase and exacerbate the risk of HIV transmission disease (STD) in one or other partner. STDs are very common in Zambia: it is estimated that around a million cases occur each year (CBOH, 2003:20). The high-risk of traditional practice of "dry sex" is also widespread. During dry sex, plants extracts are used to reduce lubrication (Chimfwembe, 2006:45), often causing genital ulcerations through which HIV can more easily enter the body. It is the researcher's opinion

that many sexually transmitted diseases could be avoided if people consistently used condoms. However, for a lot of people to do so, requires overcoming substantial practical cultural or religious obstacles.

Without access to preventive drugs, most non-sexually transmitted HIV infections are passed from mother to child. Zambia is one of the worst affected by the HIV/AIDS pandemic in the sub-Saharan African countries. It is estimated that the prevalence rate is about 16% in the 15-49 age group, and about one million Zambians are infected with HIV, of which over 200,000 are in need of antiretroviral therapy this is according to the National HIV/AIDS strategic framework (NHASF) (2006-2010). This unpleasant scenario is well documented in the Government of the Republic of Zambia-Ministry of Finance and National Planning: Advocacy for Action: Zambia's response to HIV/AIDS, which states that Africa with 11% of global population is the site of 70% of all HIV infected individuals. Thus the affected are more. Africa has accounted for 75%-80% of global AIDS deaths, and 95% of the world's orphans are in Africa. Over 6.5 million AIDS orphans are in sub-Saharan Africa; and by 2010 this will have increased to 15.3 million among an overall orphan population of 21.8 million. In 16 Africa countries, ten per cent or more adults live with the infection, and in the Southern African region, one in four women from birth to 29 years is infected (Ministry of Finance2001:12).

According to NHASF (2006-2010), the epidemic is characterised as follows:

- Feminisation of the epidemic with women 1.4 times more likely to be HIV infected than men, and infection rates among young women aged 15-24 years are four times higher than those for young men in the same age group.
- HIV rates vary considerably among and within provinces ranging from eight per cent in Northern Province to 22% in Lusaka Province and higher prevalence in urban areas with 23% of urban residents HIV infected as compared to 11% rural areas.
- Nearly 80% of HIV transmission in Zambia is thorough heterosexual contact exacerbated by the high-risk sexual practices, gender inequality, high levels of poverty, stigma and discriminatory practices and high prevalence of sexually transmitted infections and tuberculosis. The remaining 20% is predominantly due to mother-to-child transmission during pregnancy, at birth or while breastfeeding

- It is estimated that 7.7% of young people, 24-25 years are HIV infected.

As indicated by NHASF (2004-2010) the prevalence is significantly higher among women compared to men especially for those below the age of 35. Overall, women are more likely to be HIV infected than men, which makes them more vulnerable with prevalence rates of 17.8% in the 15-24 age group. Cross-generational sex and transactional sex makes younger girls more vulnerable to HIV infection than males their own age. Prevalence among women is highest between the ages of 30 to 34 and is thought to be (NHASF, 2006-2010) as indicated earlier, the result of high levels of social and economic vulnerability, inadequate access to life skills and information, low levels of negotiation skills, and unequal protection under statutory and customary laws and traditions.

NHASF (2006-2010) further states that nearly 80% of HIV transmissions in Zambia is through heterosexual contact. This mode of transmission is further exacerbated by the high-risk sexual practices, poor socioeconomic status of women and high prevalence of STIs. The remaining 20% is predominantly due to mother-to-child transmission during pregnancy, at birth or while breastfeeding. Furthermore, they state that on per cent is through contaminated blood and blood products, use of needles and sharp instruments and sex between men (NAC, 2004).

2.3.2 HIV/AIDS PREVALENCE IN ZAMBIA

The United Nations estimates the global adult prevalence rate at less than one per cent adults in 15-49 age group (Figure 2.3). This rate is estimated at five per cent in sub-Sahara Africa (UNAIDS/WHO, 2007), and 16% in Zambia (MoH Zambia & National AIDS Council, 2008). United Nations considered a prevalence rate above one per cent as a very serious epidemic. HIV-infection rates and prevalence in Zambia are influenced and exacerbated by a combination of cultural, economic, social and demographic factors. As indicated, the Ministry of Health/Central Board of Health MoHCBH (1999) estimated the average national HIV-prevalence rate among the adult population at 19.7%. Prevalence is highest in the urban areas where, in some locations such as Lusaka prevalence has been between 27% and 30% according to (UNAIDS, 2001).

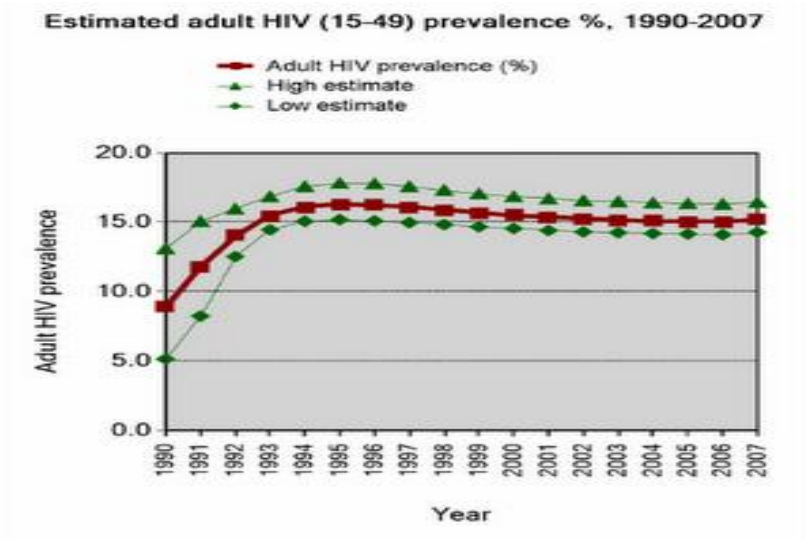


Figure 2. 3: Zambia 2007 HIV/AIDS prevalence graph

(Adapted from: anuinlusaka.blogspot.com 2010)

Given the high population mobility between urban and rural areas, the much lower reported prevalence rates in rural Zambia seems lower than that of the urban prevalence rates. For the purpose of this study the researcher has chosen to document four districts with the highest prevalence in the country, but concentrating on Lusaka the study area.

The four provinces in Zambia with the highest prevalence rates are Lusaka, Luangwa, Kitwe, and Ndola. With the exception of Luangwa, these districts are predominantly urban. Rural populations have an average prevalence of 13.5%, but ranges from as low as four per cent to highs of more than 20%. In urban areas, prevalence ranged between 27% and 28% (Zambia Ministry of Health, 1999) as shown in the Table 2.2

TABLE 2.2: FOUR DISTRICTS WITH THE HIGHEST HIV PREVALENCE RATES

District	(Province)	Average Prevalence rate (%)
Lusaka	(**Lusaka**)	29.5%
Luangwa	(**Lusaka)**	28.7%
Kitwe	(Copperbelt)	28.7%
Ndola	(Copperbelt)	28.7%

(Source: Ministry of Finance and National Planning, 2002)

The CSO/MoH (2002) states that the preliminary report of the ZDHS 2001-2002 indicates that among adults in the 15-49 age group, the national HIV-prevalence average rate is 15.6%. Lusaka is the central focus for the purpose of this study.

The determinants of the HIV prevalence in Zambia have been identified as: high mobility and internal migrations; high levels of poverty; low social and economic status of women; early sexual activity and some cultural practices; high prevalence of sexual transmitted illness (STIs); multiple sexual relations; a largely young population. Among the macro determinants are the impact of the Structural Adjustment Programme (SAP) and the high debt burden (Kapwepwe & Siamwizia, 2001).

2.4 HEALTH NEEDS AND SERVICES IN ZAMBIA

Zambia embarked on an extensive programme of health reforms in the early 1999s with the stated aim being to *…provide the people of Zambia with the equity of access to cost-effective, quality healthcare as close to the family as possible…* (MoH, 2005b:1)

According to (MoHCBH, 1998) Zambia's greatest health challenges are child survival, reproductive disease burden and malaria. With infant and child mortality rates of 108 and 197, one in ten children die before age one, and one in five die before age five. ZDHS (1996) states that infant and child mortality increased from 92 and 161 in 1977 to 108 and 197 respectively in 1997. The major cause of ill health among Zambian women arise from their reproductive roles, with maternal mortality, HIV/AIDS and sexually transmitted infection contributing to over half of the disease burden. Maternal mortality in Zambia is increasing: current estimates range from 649 (1996 DHS) to 940 (WHO, 1996) per 100,000 but (UNFPA, 1996) estimates rates of 1,400. Zambia's HIV epidemic, analyzed below, is among the world's severest. Orobaton, *et al*. (2001) describe HIV/AIDS in Zambia as "an embodiment of dynamic complexity", and therefore recommend responses, which "share properties similar to that of systems thinking" in order to have "best prospects for producing tangible and long lasting results" (Senge, 1994: 214). It is these tangible and long-lasting results that have motivated the AOG in Lusaka Zambia and continue to guide their actions and the principles they represent.

2.5 ECONOMIC FACTORS

According to Zambia Ministry of Finance (2003) since 1992, the government has continued to pursue stringent fiscal policy measures aimed at stabilizing the macroeconomic environment, and achieving sustainable economic growth. During the period from 2000 to 2004, the Zambian economy registered positive real growth at an average rate of 4.6% per year, which is higher than the average rate of 4.4% projected for the period from 2001 to 2005 (MoFNP: TNDP,2002-2005). Despite the improvement in GDP growth rate, it is still inadequate to have significant changes in the standard of living and health status in Zambians. The MoFNP (2002) states that it is estimated that the economy must consistently grow at 7-8% per annum for at least ten years, in order to achieve the desired people-level impact. HIV/AIDS is a major social and economical challenge to the development process in Zambia.

During the period from 2000 to 2004, the Zambian economy registered positive real growth at an average rate of 4.6% per year, which is higher than the average rate of 4.4% projected for the period from 2001 to 2005 (MoFNP: TNDP, 2002-05). Despite the improvement in GDP growth rate, it is still inadequate to have significant changes in the standard of living and health status of Zambians. It is estimated that the economy must consistently grow at seven per cent to eight per cent per annum for at least ten years, in order to achieve the desired people-level impact (NHASF, 2006).

TABLE 2.3: SELECTED KEY MACROECONOMIC INDICATORS, 2000-2004

Indicator	Unit	2000	2001	2002	2003	2004
Real GDP Growth	%	3.6	4.9	3.3	5.1	5.0
GDP	US$ 'Mil.	3,239	3,640	3,776	4,318	5,409
Inflation Rate (Year-end)	%	30.1	18.7	26.7	17.2	17.5
Domestic Fiscal Deficit	%GDP	-	-	3.3	5.1	1.9
Exchange Rate	K/US$	3,111	3,608	4,307	4,743	4,772
% GHE to GD	%	-	7	6	6	6

(*Source: Ministry of Finance and National Planning: Macroeconomic Indicators and Economic Reports)*

It is the researcher's opinion that high mobility of special social and work-based groups puts the people of Zambia at risk because they are away from the security and stability of

home and tend to engage in high risk sexual behaviour, at times for monetary and material favours. This includes long distance truckers, cross-border traders, refugees, fish mongers and uniformed security personnel (NHASF, 2006-2010). The high levels of poverty directly or indirectly promote behaviours which create vulnerability to HIV/AIDS. In sequence, the consequences of HIV/AIDS can lead to poverty resulting in a byzantine and mutually re-enforced inter-relationship between HIV/AIDS and poverty, where the majority of the poor are women. As a result of poverty, preventable and treatable diseases have taken an enormous toll on the poorest people in Zambia.

2.6 POVERTY SITUATION IN ZAMBIA

This section provides a brief analysis and assessment of poverty situation in Zambia. According to Zambia Human Development Report (ZHDR, 1998) as stated by UNDP (2001) Zambia's present poverty situation is the result of more than two and a half decades of decline in the economy, in public services, and virtually in all major indicators of human development. Zambia at independence in 1964 was one of the richest countries in Africa. The government was able to provide free and almost universal social services to its citizenry. Today Zambia is classified as one of the poorest countries in Africa. As indicated by Anderson (1995:9) much of Zambia's economy decline is attributed to the failed past policies that led to an unbalanced and unsustainable economic structure within the country.

A Zambian poverty study conducted by the United Nations Children's Fund (UNICEF, 1998:33) states that the immediate manifestation of poverty in Zambia have grown to such an extent that the country can be said to be experiencing a social crisis. According to this study, among the most critical indicators of this social crisis are worsening problems of public health, and life expectancy, which has no doubt deteriorated due to the HIV/AIDS pandemic. Furthermore, the study concludes that under these circumstances the ability of the population to cope with day-to-day living standards has been drastically diminished as many people have unnecessarily adopted unhealthy lifestyles that threaten their present and future welfare. The study further states that roughly six million people equivalent to a poverty line is employed as a measure of poverty, that line is constructed based on the food basket approach as provided by Central Statistics Office (CSO, 1998:11). According to

World Bank (1998:2) most Zambian poverty studies argue that if the poverty line is reduced to cater only for basic nutritional needs, most Zambians will fall below the line.

Despite the introduction of the 1980s Structural Adjustment Programmes (SAP) the poverty situation worsened, the reforms were neither sustained nor systematic and could not benefit the country; rather the country came plummeting downward. It is clear that the SAP has not worked for the majority of the people of Zambia as it was intended as we experience drastic decline in school enrolments, and rises in mortality and mobility rates (ZHDR, 1998). Those who have been hit the worst are the poor, both in urban and rural areas, although living standards of the middle and the upper-income groups have been eroded as well. A World Bank study conducted in (1998) shows that in 1991 about 69% of all Zambians lived in households with expenditure below a level sufficient to provide in basic needs. The same study maintains that poverty prevalence stood at 76%, and was more pronounced and severe in the remote districts of provinces contributing to the influx of people into urban areas. The latest figure from the Central Statistics Office's Living Conditions Monitoring Survey (LCMS) (2004), suggests that the total poor people in rural areas is 86%, while in urban areas is 56%. The study further states that there are 17% of people living above the poverty line in rural areas, while 44% are in urban areas as indicated by Table 2.4.

TABLE 2.4: EXTREME POVERTY TRENDS (1991-2004)

	1991 (%)	1993 (%)	1996 (%)	1998 (%)	2004 (%)
All Zambia	58	61	53	58	53
Rural	81	84	68	71	53
Urban	32	24	27	36	34
Province					
Central	56	71	59	63	63
Copperbelt	44	28	33	47	38
Eastern	76	81	70	66	57
Luapula	73	79	64	69	64
Lusaka	***19***	***24***	***22***	***35***	***29***
Northern	76	72	69	66	60
North Western	65	76	65	64	61
Southern	69	76	59	59	54
Western	76	84	74	78	73

(Source: CSO, 2004).

Generally, the urban poor live in unplanned squatter settlements (commonly known as shanty compounds) on the outside edge of urban centres, where lack of legal status and

provision of basic community services, for example health, clean water and electricity, exacerbate and constrains their productivity. Closely related to this is the fact that most of the urban poor survive by engaging in the informal economy, through unregulated street vending and illicit activities, which increases the exposure to HIV/AIDS the poverty induced and poverty-causing pandemic. Poverty makes people vulnerable to risky behaviours for HIV, and this is further aggravated by the loss of the main income earner or earners in the prime of their lives due to HIV/AIDS which pushes many families into poverty − and the cycle repeats itself.

As stated by De Waal, (2003) , UNAIDS (2006) and International Federation of Red Cross and Red Crescent Societies (IFRCFCS) (2008), HIV/AIDS disproportionately affects young adults-individuals who should be in their prime productive years. Not only do those individuals and their families suffer, so do societies that desperately need their income-generating capacities and intellectual and social capital for overall development purposes-now and in the future. According to (*Lusaka Times*, 2010:23, April 17) the World Bank country economist Julio Revilla observed that poverty levels in Zambia remain high in rural areas despite the country recording a reduction from 68% in 1996 to 59% in 2006, furthermore, he reiterated that poverty reduction is a difficult goal to achieve through budget process on annual basis adding that government should concentrate on public goods such as education and health.

Underlying the poverty incidence within the provinces are the general economic decline in the country, weak market linkages and the presence of HIV/AIDS, in addition to the aggravating prevalence of HIV/AIDS, the price of the main cash crop has fluctuated considerably at both the district and provincial levels as a result of inconsistent government policies, large increase in the price of fertiliser (which increased by three-fold during 1998 to 2003), competition from neighbouring countries Tanzania and Malawi, and long distances to viable markets (FAO, 2004).

2.7 HIVAIDS AND OTHER CHALLENGES IN ZAMBIA

As indicated earlier, Zambia has one of the world's most devastating HIV/AIDS epidemics, and it is one of the worst affected within the sub-Sahara Africa countries by the epidemic (National HIV/AIDS Council, 2006). The estimated prevalence rate in 2006 was16% among the 15-49 age group, and about 1.1 million Zambians were infected with HIV/AIDS (National HIV/AIDS Council, 2006; UNAIDS, 2009)as indicated in Table 2.4. This could be attributed to the rate at which HIV/AIDS has continued to engulf the country. Against this background, different steps to mitigate the disease have been taken, and in 2001 Zambia was one of the 189 members of the United Nations General Assembly Special Session (UNGASS) that signed a declaration of the commitment to take action on HIV/AIDS (NAC, 2008) in the areas of leadership, prevention, treatment care and support, reducing vulnerability and upholding human rights (NAC, 2009). In 2006, the unprecedented impact of the epidemic on Zambia continued and made the then minister of health, Angela Cifire, to regret that:

> *The HIV epidemic has been with us for almost two and half decades, during which period we have continued to experience its unprecedented impact on all aspects of our lives. Since mid 1980s, AIDS epidemic has claimed hundreds of thousands of lives; it has caused many youth and children to be orphaned and in many cases homeless; it has eroded and weakened our socio-economic systems and changed our way of life. The reality of HIV/AIDS is no longer an issue of debate, but a painful challenge that has been felt, and continues to be felt by all in Zambia* (Cifire NAC, 2006).

The scenario in Zambia is that HIV/AIDS is more prevalent in the two urban centres of Lusaka and the Copperbelt as indicated in Table 2.5. But a point worth mentioning is that, the most vulnerable population to the epidemic are the poor in the rural areas and in the urban slums who are least able to protect themselves from HIV/AIDS or to cope with the impact of the epidemic.

TABLE 2.5: BASIC HIV/AIDS STATISTICS, ZAMBIA

Number of people living with HIV/AIDS	1100 000
Adults aged 15 to 49 prevalence rate	15.2%
Adults aged 15 and up living with HIV/AIDS	980 000
Women aged 15 and up living with HIV/AIDS	560 000
Children aged 0 to 14 living with HIV/AIDS	95 000
Orphans due to HIV/AIDS aged 0 to 17	600 000
Deaths due to HIV/AIDS	56 000

(Source: UNAIDS, 2009)

The number of children and youths infected/affected by HIV/AIDS in Table 2.5 is indeed alarming and needs immediate intervention. On the other hand, the children and youths losing their parents due to the disease are also very high as shown in Table 2.5. Apart from the above statistics, the HIV/AIDS prevalence is of a great concern especially among the population in the 15-49 age group. According to UNAIDS (2008) this age group is categorized as the most productive citizens in Zambia, especially in terms of income generating activities such as employment and other family income activities.

2.8 CONCLUSION

This chapter discussed the background, gave a general overview and brief archaeological history of Zambia as a nation. Zambia is surrounded by eight other countries which make it a landlocked country. It has a mixed economy made up of two sectors: a modern urban sector that geographically can be found along the line of rail traversing from north to south, and a mainly rural agricultural sector. An assessment of the poverty situation in Zambia according to Zambia Human Development Report, presents the poverty situation as a major problem, as a result of decades of decline in the economy, in public services, and virtually in all major indicators of human development. The HIV-infection rates and prevalence in Lusaka Zambia are influenced and exacerbated by a combination of cultural, economic, social and demographic factors. The high levels of poverty directly or indirectly promote behaviours which create vulnerability to HIV/AIDS. Orobaton, *et al.* (2001) describe HIV/AIDS in Zambia as "an embodiment of dynamic complexity", and therefore recommend responses, which "share properties similar to that of systems thinking" (Senge, 1994) in order to have "best prospects for producing tangible and long lasting results.

CHAPTER THREE

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

3.1 INTRODUCTION

This chapter handles the literature review and the theoretical perspective. The theoretical framework is employed as a tool to assist in improving our understanding of disaster management and livelihoods, particularly the livelihoods of the poor as they are affected with HIV/AIDS. The disaster management continuum (DMC) model, the Department for International Development (DFID) (1999) the Sustainable Livelihood model will be used to evaluate the effectiveness of preparedness, mitigation, response, recovery and reconstruction as supported by different stakeholders involved with the problem of HIV/AIDS. The Zambian *Disaster Management Act* (2010) will be used to support and substantiate the two models when necessary.

Research has found that in some countries in Africa, especially in Kenya and Uganda, governments and Churches have excelled in collaborating and developing strategies to fight HIV/AIDS (Francis & Liverpool 2008; Cunningham, *et al.* 2009; Lindley, *et al.*, 2010). These strategies include addressing gender disparities, and creating awareness programmes which comprised among other things, education on methods of HIV-prevention and HIV-transmission, blood screening before transfusions and the use of disposable sterilised needles in hospitals, as well as the use of condoms. Communities are encouraged to abandon risky cultural practices such as widow inheritance, unsafe circumcision and sexual cleansing (Oloo, 2004). A survey conducted in Zambia and Lesotho reveals that two-thirds of all HIV/AIDS responses are provided by faith-based organisations (ARHAP, 2006). According to USAID (2007) between 30% and 50% of all formal health care in Africa is provided by Church-based organisations.

Perry (2006) state that the very nature of a disaster encourages risky behaviour through the break down of society, which increases power struggles and gender violence as well as stress and boredom. Risk in respect to HIV/AIDS is determined by individual behaviour

and situations such as having unprotected sex, having multiple partners, having an untreated sexually transmitted disease or sharing needles when injecting drugs. In addition the lack of resources can exacerbate the need to buy or obtain food through sex, which in turn leads to people's vulnerability to HIV/AIDS which can increase due to the prevalence rate. NHASF (2006-2010) states that nearly 80% of HIV transmission in Zambia is through heterosexual contact. This mode of transmission is further exacerbated by the high-risk sexual practices, poor socioeconomic status of women and high prevalence of sexually transmitted infection (STIs). Furthermore people who are already infected and affected by HIV/AIDS will find it harder to provide a coping mechanism.

The National HIV/AIDS Strategic Framework 2006-2010 (2006:vii) hints on this concern in the following excerpt: "*As much as poverty makes people vulnerable to risky behaviours for HIV, the loss of the main income earner or earners in the prime of their lives due to HIV/AIDS is pushing many families into poverty - and the cycle repeats itself*". This framework (2006) goes further to state that the HIV/AIDS epidemic is as much a development concern as it is a health concern because it is making the poor poorer hence becoming even more vulnerable to HIV/AIDS. While at first HIV/AIDS was thought to be an exclusively medical problem, it soon became clear that it has a socioeconomic impact on human development. There are factors that exacerbate the spread of HIV/AIDS. HIV/AIDS have been responsible for the breakdown of many families, creating and putting a burden on the most vulnerable sectors of society, especially women and children through loss, in many instances, of breadwinners. Stokke (1991:41) states that '*poverty is one crucial factor, the situation of women is another, cultural and religious conditions constitute a third set of factors"*.

The rising prevalence of HIV/AIDS reduces productivity, raises costs, and reduces individual saving and company's costs. Stokke (1991) states that a group made more vulnerable is orphans whose parents died from HIV/AIDS. Consequently, according to NHASF (2006-2010) Zambia has continued to witness a breakdown in social service delivery, reduction in household incomes and a less than optimal national economic growth rate necessary for overall national development. Although the HIV/AIDS epidemic has spread throughout Zambia and to all parts of its society, some groups are especially

vulnerable as observed by Avert (2009). Avert (2009) notes that young women and girls in economically poor situations are most affected by HIV/AIDS. The management intent of the NASF 2006-10 is not to replace the need for partners to have their own plans, but rather to:

- Support coordinated, prioritised and knowledge-based scale up of the response.
- Facilitate broad ownership of the response by all partners and practical partnerships for the implementation of the response.
- Represent joint strategic direction of all partners.
- Enable the involvement of key sectors and decentralised levels in all stages of the process.

3.2 THEORETICAL FRAMEWORKS

Disaster management is defined by the *Disaster Management Act* (Zambia, 2010:78) as a continuous and integrated multi-sectoral, multi-disciplinary process of planning and implementation of measures aimed at the following:

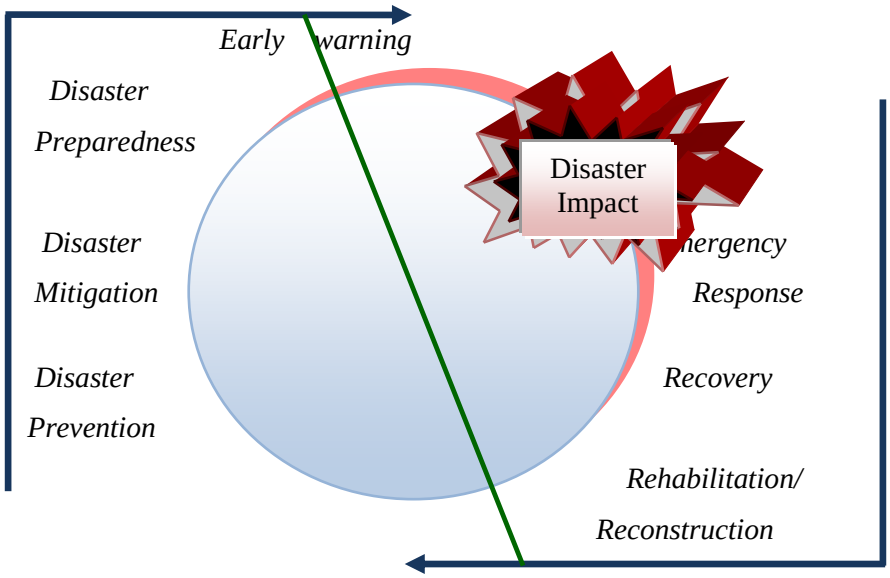
- *Prevention or reducing the risk of disasters.*
- *Mitigating the severity or consequences of disasters.*
- *Emergency preparedness.*
- *A rapid and effective response to disasters.*
- *Post-disaster recovery and rehabilitation.*

3.2.1 THE DISASTER MANAGEMENT CONTINUUM (DMC)

Disaster management is a continuous process of prevention, mitigation, preparedness, response, recovery and rehabilitation or development. According to Carter (1991) while the cycle is often portrayed in other forms, the important point is that the format should indicate that "*disaster and its management is a continuum of inter-related activities; it is not a series of events which start and stop with each disaster occurrence*". One of the major goals of disaster management as in this case, HIV/AIDS, is the continuous promotion of

sustainable livelihoods, protection and recovery for those who are infected and affected with the disease, when this is achieved, people have a greater capacity to deal with the HIV/AIDS and their recovery is fast and more enduring. Disaster management in its entirety entails the integration of pre-and post-disaster activities in order to safeguard lives against any disaster such as HIV/AIDS.

Pre-disaster risk reduction phase



Post-disaster recovery phase

Figure 3.1: The disaster management continuum cycle

Disaster management continuum (disasterriskreduction, 2011)

The disaster management continuum consists of a number of phases, each requiring a different range of response activities. The DMC has two phases, pre-disaster risk-reduction and post-disaster recovery phases respectively.

Phase A: the pre-disaster which includes the following:

- *Prevention*: activities aimed at providing outright avoidance of adverse impact of hazards
- *Mitigation*: ongoing structural and non-structural measures undertaken to limit the

impact of natural or human induced hazards

- *Preparedness*: activities and measures aimed at ensuring effective response in an emergency and its impacts, this includes early warnings and education

The emphasis in the pre-disaster phase is on reducing the vulnerability of communities. The pre-disaster phase is when there is knowledge and planning in place toward preventing a disaster, which has not or may have occurred (IS-393 1998). Prevention, mitigation and preparedness include all measures aimed at avoiding and reducing the impact of a disaster in this case HIV/AIDS. These are activities that involve measures to limit the adverse impact of HIV/AIDS and its spread. Examples of mitigation are education about HIV/AIDS, abstinence, sexual protection, protecting and providing support for orphans and the vulnerable, providing social protection for people made vulnerable from the effects of HIV/AIDS and possibly setting up businesses for those that are vulnerable. HIV/AIDS mitigation in Zambia requires a multi-sectoral approach. No wonder the government, according to NHASF (2006-2010) agreed with cooperating partners and programme implementers that HIV/AIDS was more than a health problem and required a broad-based multi-sectoral approach to address the many facets of the epidemic.

Phase B: the post-disaster recovery which includes the following:

- *Response*: the provision of assistance and/or intervention during or after a disaster to meet the life preservation and needs of those affected
- *Recovery*: decision and actions taken after a disaster with the view to restoring living conditions of the stricken community
- *Rehabilitation/reconstruction*: this period involves actions that enable the rebuilding of a community to start functioning again

According to UNISDR (2009: 23) the post-disaster phase is known as recovery phase, and it is defined as *"the restoration, and improvement where appropriate, of facilities, livelihoods and living conditions of disaster-affected communities including efforts to reduce disaster risk factors."* The recovery phase begins soon after the emergency has been ended and is ideally pre-planned to delineate clear responsibilities, policies and strategies for action (UNISDR, 2009). It is during this phase that assistance begins with a joint

damage and needs assessment with relevant partners in order to identify priorities. This phase can be of an immediate, short-term or protracted duration and it should include activities such as providing relief to the affected communities such as food, shelter and medical services (Tuscoema, 2011). This phase involves search and rescue activities. If a disaster occurs, response and relief have to take place immediately. Rescue of affected people with distribution of basic supply.

It should be noted that disaster management is not only reactive, but it is also proactive. Since disaster management is a continuous and integrated multi-sectoral, multi-disciplinary process of planning and implementation, all stakeholders must contribute to the various phases of the disaster management continuum in order to reduce their impact on the community. During these phases, Non-governmental and community-based organizations (CBOs) usually play an important role. This is what informed the AOG's contribution to being involved with those that are infected and affected with HIV/AIDS in risk reduction.

3.2.2 DISASTER RISK REDUCTION (DRR)

Sub-Saharan Africa according to Whiteside (2002) is stricken by a generalised HIV/AIDS pandemic that will only reach its peak approximately by the year 2022. The pandemic contributes to vulnerability in various ways according to De Waal and Whiteside (2003). Understanding patterns of vulnerability, risk and capacity (for example classes of people that are vulnerable as a result of HIV/AIDS − women and children) would be useful for the purpose of DRR. Consequently, knowledge about them could result in interventions aimed at assisting these vulnerable groups of people to become productive members of society, by assisting affected children stay in school when their parents die and/or providing small-scale businesses for the infected and affected. It is essential to note that it is easier to take into account issues of household wealth and other assets (human, social, physical and natural) as different households would be differently equipped to deal with the effects of HIV/AIDS. Investing in the community can go a long way in reducing the risk of HIV/AIDS especially if CoH incorporate the two phases of the continuum into their programmes.

For AOG CoH HIV/AIDS project to reduce the impact of HIV/AIDS in Lusaka, there must be knowledge development of the subject HIV/AIDS, ownership of issue and staff, continuous development within the Church while making available the necessary tools for the staff. In doing so, the (AOG) CoH HIV/AIDS project will be able to access and to make distinction between hazards and disasters, and to recognize that the effect of the former upon the latter is essentially a measure of the society's vulnerability. AOG Church can identify risk, by looking at the hazard in this case HIV/AIDS, the vulnerability level of community, and their coping capacity. If the vulnerability is high, and the coping capacity is low, then the risk of the community will also be high. In as much as the AOG church is dedicated to assisting in reducing the community's HIV/AIDS impact, it must reduce its vulnerability and increase its capacity through education and services provided to the Lusaka community.

By conducting risk analysis, the AOG can identify the Lusaka risks towards HIV/AIDS and plan a strategy on overcoming theses risks by including the two phases of DMC. HIV/AIDS risk analysis could be conducted at community level by assessing three variables of disaster risks which are hazard, vulnerability and capacity. The ISDR (2002) proposes that a disaster is a function of the risk process which results from the combination of hazards, conditions of vulnerability and insufficient capacity to cope or reduce the potential negative adverse consequences of risk. This is well illustrated by Sphere Project (2004:3).

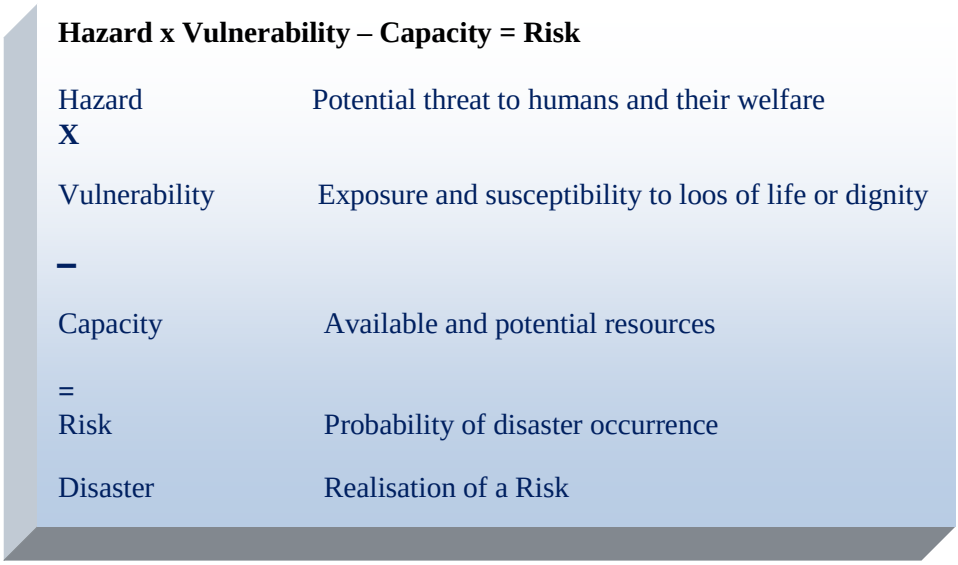


Figure3.2: The risk equation

Adapted from Sphere project module 4 (2004:3) Sphere and disaster preparedness.

The disaster risk equation is expressed in relation to risk, hazard, vulnerability, manageability and capacity. The equation suggests that risk is a function of hazard, vulnerability and capacity of the affected community. The formula as maintain by Garatwa & Bollin (2002) is thus: (R = H x V/M x C) which represents that disaster risk is directly affected by the hazard.

$$\textbf{Risk} = \frac{\textbf{Hazard x Vulnerability}}{\textbf{Manageability x Capacity}}$$

Source: Garatwa & Bollin 2002

A risk analysis focuses on identifying the characteristics of hazard; in this case (HIV/AIDS) how it affects people or a community; the degree of their vulnerability; and the capacity to cope with HIV/AIDS. The vulnerable in society especially sex workers, children and women should be assisted off the street and job opportunities create for them, as well as educate them on the impact of HIV/AIDS, safe sex and knowing one's status. AOG should seek to increase public awareness to understand risk, vulnerability and disaster reduction, promoting public awareness of known benefits and limitations of different types of alternative remedies so as to enable people make informed choices to live a healthy life style.

3.3 SUSTAINABLE LIVELIHOOD FRAMEWORK (SLF)

The road to the development of the household livelihoods framework is well documented elsewhere (Carney, 1998). Sustainable livelihood framework (SLF) is a tool designed to improve our understanding of livelihoods, it has been developed to understand and improve the livelihoods of the poor (DFID, 1999). It is a useful framework to utilise in addressing HIV/AIDS since it draws attention to the various processes and multiple interactions between factors that indeed affect livelihoods. The aim is to reach lasting results by supporting people to reach sustainable livelihoods, and sustainability is therefore a key word (Carney, *et al.,* 1998). In order to get a better understanding of the concept 'sustainable livelihood,' the two words are clarified in the quotation below:

> *A livelihood comprises the capabilities, assets (including both material and social resources) and activities required for a means of living. A livelihood is sustainable when it can cope with and recover from stresses and shocks, maintain or enhance its capabilities and assets both now and in the future, while not undermining the natural resources base* (DFID, 1999:1).

"*The sustainable livelihoods framework presents the main factors that affect people's livelihoods, and typical relationships between these. It can be used in both planning new development activities and assessing the contribution to livelihood sustainability made by existing activities*" (SLF guidance sheet, 1999: 1). It is obvious that SLF is people-centred as it focuses on people's livelihood. According to Bengtsson and Bengtsson (2005: 24-25) the sustainable livelihood framework helps to define different factors in people's lives that provide or constrain their opportunities. It can therefore give an understanding of especially poor people's lives. The framework can be used as a checklist of important issues that affects livelihoods of people:

> *In its simplest form, the framework view people as operating in a context of vulnerability. Within this context, they have access to certain assets or poverty reducing factors. These gain their meaning and value through the prevailing social, institutional, and organizational environment. This environment also influences the livelihood strategies –*

ways of combining and using assets – that are open to the people in pursuit of beneficial livelihood outcomes that meet their own livelihood objectives (DFID, 1999).

The SLF further appreciates the fact that poverty is not a stable or a permanent condition, but rather contends that poor individuals and households move in and out of relative poverty depending on available opportunities at their disposal and the shocks and stresses to which they are exposed. The livelihoods approach takes as its starting point not deprivation, but the 'wealth of the poor' (UNDP, 1998). This section investigates the roots of livelihood approaches and examines the key concepts of demarcation that highlights livelihoods and vulnerability context. It presents a brief outline of different livelihoods and explores the concepts of assets, capabilities and activities that characterise household livelihood strategies, and further investigates the interconnectedness between these elements. Seeley (2002) promotes the use of the DFID's SLF and says that in employing this framework it allows one to uncover the impact of the HIV in distorting lives and livelihoods, while at the same time taking into account that HIV/AIDS is merely one aspect of the lives of people infected/affected by HIV. Consequently we must move our focus beyond the health impact and discover the various impacts of HIV/AIDS on livelihoods outcomes. In addition, it allows one to identify the strategies people develop to mitigate the impacts of HIV/AIDS on their livelihood.

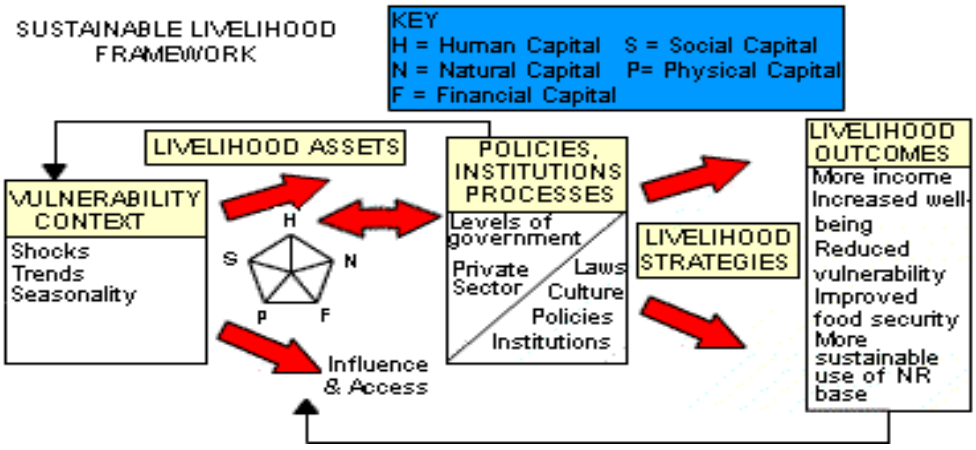


Figure 3.3: Sustainable Livelihood Framework

(Source: Carney 1999)

Being a people-centred framework, the livelihoods model places considerable emphasis on the strategies adopted by the poor, who are considered to be the 'custodian' of their personal circumstances and the context in which they live. However, Moser (1998) takes issue with this stance, arguing that poor households and individuals often lack access to information, broader overviews and experiences outside their immediate neighbourhoods, thereby compromising their ability to devise the best possible livelihood strategies. The framework starts with the vulnerability context in which community's and people live their lives and the livelihood assets or the capacities which they possess. Then it looks at how transforming structures for example institutions and processes generate strategies that lead to livelihood outcome. The factors that make up the vulnerability context are important because they have a direct impact upon people's assets and the livelihood options that are open to them as well as their strengths to reduce vulnerability. SLF presents three main categories of vulnerability: trends, shocks and seasonality.

3.3.1 VULNERABILITY CONTEXT

Bengtsson and Bengtsson (2005: 24-25) state that these are all factors that have direct impact on people's assets and the way they live their lives to secure their livelihoods. These factors make up the vulnerability context. The vulnerability context is the situation in which people live. People's lives are affected by events which they clearly have no control over, such as: trends, shocks and seasonality. The factors that make up the vulnerability context are important because they have a direct impact upon people's assets and the livelihood options that are open to them. The vulnerability context is the part of the framework that lies furthest outside people's control. According to SLF guidance sheets (1999:4*)*:

> *In the short to medium term and on an individual or small group basis there is little that can be done to alter it directly (though there are exceptions: for example, direct intervention to diffuse conflict). Most externally-driven change in the Vulnerability Context is a product of activity at the level of Transforming Structures and Processes (e.g. changes in policy).*

HIV/AIDS can be considered as an external shock that threatens the livelihood options and outcomes of a household. Some people in society are more vulnerable to the risk of HIV

infection than others, for example women in poorer households are more vulnerable to HIV infection than women from more affluent households (Booysen, 2001; DAG, 2003). The vulnerability context is to assist the infected and affected to become more resilient and better able to cope and capitalise on its positive aspects. This can only be achieved by supporting poor people to build up their assets.

Trends are long-term and usually large-scale changes that may affect people's livelihoods positively or negatively. Trends can for example be population trends, resource trends, economic trends, and governance and politics trends. They particularly have important influence on rates of return from chosen livelihood strategies. HIV/AIDS is one of many factors contributing to underlying vulnerability, both through its impact on food security, social, economic and political impact at a macro level. Therefore the impact can be seen as vulnerability trend.

Shocks are more unpredictable events such as for example human health shocks (epidemics such as HIV/AIDS) one of the most common shocks that impoverishes poor households is illness (Kabir, *et al.*, 2000), conflict and crop/livestock health shocks. All of these can destroy assets directly, and especially HIV/AIDS can force people to dispose of assets as part of coping strategies. Resilience to external shocks and stresses is an important factor in livelihood sustainability. HIV acts as a shock to the household through illness and death. HIV/AIDS is increasing the food security of significant numbers of households, adding extra burden to the already vulnerable (Harvey, 2004)

Seasonality refers to the seasonal shifts, which can occur in prices, production, food availability, health and employment opportunities. HIV/AIDS can render people unproductive and further deepen their poverty. This is one of the greatest and most enduring sources of hardship for poor people.

3.3.2 THE IMPACT OF HIV/AIDS ON LIVELIHOODS ASSETS

Since HIV/AIDS has been discovered it posed a threat with potentially shattering effects on a household's ability to secure its immediate well-being and adjust to future shocks. The devastating impact is huge, affecting every fibre of household and the community. Assets are a range of tangible and intangible stores of value which (Swift, 1989: 11) can be converted into resources to pursuit one's livelihood strategies or to respond to stress and shocks.

HIV/AIDS can be seen as a shock which affects people's lives in many different ways. People's assets or capitals, all suffer from distress caused by the pandemic (Bengtsson & Bengtsson, 2005). It is often people in their most productive age who become infected. According to (Hammarsköld, 2003) the group that has or is positioned to take over the responsibility for the economic and social development in the society, becomes weaker. Scoones, (1998) states that in order to create livelihoods; households must combine their different capital endowments. Different households are seen to construct their livelihood strategies by drawing on five capitals as seen depicted in Figure 3.4 below.

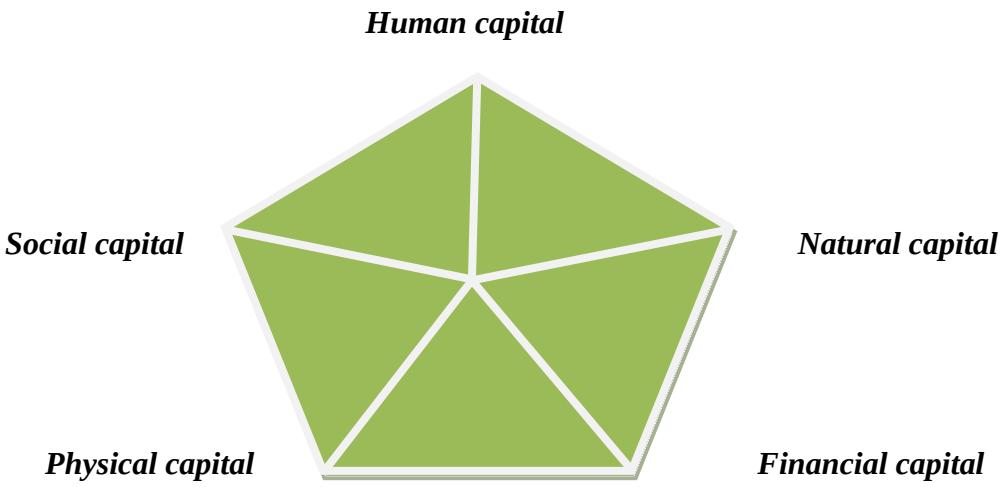


Figure 3.4: The asset pentagon

(Source: DFID 1999-2000)

As Rakodi (1999) points out, the assets available influence the scope for a household to improve its well-being, both directly by increasing its security, and indirectly by increasing people's ability to influence the policies and organisations which govern access to assets and define livelihood options. The asset pentagon (Figure 3.4) lies at the very core of the livelihoods framework within the vulnerability context. According to SLF guidance sheets (1999:5) the pentagon can be used to show systematically the variation in people's access to assets, the idea is that the centre point of the pentagon, where the lines meet, represents zero access to assets while the outer perimeter represents maximum access to assets.

Access to only one of these capitals is not enough for someone to achieve the livelihood outcomes wished for, especially not for poor people living with HIV/AIDS who often have very limited access to all of these capitals. Although it is worth mentioning that a physical asset can generate multiple benefits, for example if someone has access to land (natural capital) they may be well-endowed with financial capital as they are able to use the land not only for direct productive activities, but also as collateral for financial loans which they can use to take care of themselves and to afford anti-retroviral ARV drugs to keep them healthy.

The SLF can be used for assessing vulnerability and the key elements of this approach are the five livelihood assets or capitals (human, financial, social, natural and physical capital), while the vulnerability context is viewed as shocks, trends and seasonality, which are used as influence and access of transforming structures for the livelihood strategies and outcomes as depicted in figure 5. The DFID (1999) states that sustainability is often linked to the ability to cope and recover from stresses and shocks as well as maintain the natural resource base. The SLF approach focuses on people's strengths and the ability to cope. It is believed that people need a certain range of assets to reach and attain a positive livelihood as they are all important to human lives.

If one of the capitals improves as indicated earlier, it usually affects the other capitals in one way or another. It is contended by the framework that an individual or household's ability to escape or reduce vulnerability is dependent upon both their initial asset endowment and their capacity to manage and transform their assets. As Meikle, *et al.*

(2001) correctly draw attention to, the existence of assets is not sufficient for individuals/households to build sustainable livelihoods. The most distinct and widely referred to impact of HIV/AIDS on households relates to the loss of human capital. To secure well-being and cope with the challenges of economic, social, physical and political environments, households are said to adopt livelihood strategies that draw on these five forms of capital (Stokes, 2003*).* The livelihood strategies people engage in depends partly upon their livelihood assets or the capital that is at their disposal, HIV/AIDS or the consequences of HIV infection, that is, illness, death and stigma can erode livelihood capital. To get a good understanding of the negative consequences HIV/AIDS can have on people, each capital is here discussed, showing some possible impacts of HIV/AIDS. The HIV/AIDS epidemic has in-depth impacts across all sectors of society more especially the health sector; in the hardest hit countries such as Zambia the epidemic has had devastating consequences for the economy, education, public welfare, government, the labour force. It is estimated that seven million agricultural workers have died from AIDS since 1985 and FAO (2002) estimates that another 16 million of the agricultural force in sub-Sahara Africa could die by 2020.

- *Human capital* – the human capital refers to skills, knowledge, ability to labour, good state of health and physical capabilities (Carney, *et al.*, 1998; Scones, 1998). Education is another influence on human capital, and it can be affected since families might have to withdraw their children from school while in many instances children forced out of school become heads of households. The human capital is a key element since knowledge and ability to work are required in order to make use of any of the four capitals (DFID, 1998).

  Above all, human capital represents good health which is very important as it enables people to pursue different livelihood strategies and achieve their livelihood objectives. Good health and nutritional status is also key component of human capital as they relate to people's productivity and working potential (Jafry, 2000). As a result of the importance of human capital which appears in the generic framework as a livelihood asset, and as a means of achieving livelihood outcomes the AOG stands to educate people on the effect and impact of HIV/AIDS on families and individuals. HIV/AIDS

affects human capital in a number of ways. Firstly, it adds to the burden of illness on a household Harvey (2004). There is no doubt that illness related to AIDS is particularly damaging because it is often chronic, and above all prolonged affecting prime-age adults. It should be noted that HIV/AIDS reduces both labour of the person who is infected and of the people who are affected, and who care for the sick.

Nutritional inadequacy also affects people's working capacity as it diminishes their strength and energy to carry out physical work. HIV/AIDS has a negative impact on people's nutritional status and as a result their productivity through an increase in resting energy expenditure, a reduction in people's food intake and complex metabolic alterations that result in weight loss and wasting (Piwoz & Preble, 2000, Wiegers, 2007). Many people regard ill-health or lack of education as core dimensions of poverty and thus overcoming these conditions may be one of their primary livelihood objectives (SL guidance sheets, 1999). AOG has dedicated and invested their time and finances to promote human capital by training victims that are affected and infected with HIV/AIDS. The human capital is affected in many different ways. One way it is affected is that HIV/AIDS means loss of working capacity. Another consequence when people get sick and die is that important knowledge and experiences are lost. The human capital assets losses engendered by HIV/AIDS affect other livelihood assets particularly financial capital. As income decreases the expenditures often increases, as more money is spent on healthcare (Nkurunziza & Rakodi, 2005).

Harvey (2004) states that HIV/AIDS damages the transfer of knowledge from one generation to the next, due to the death of adults in their prime and by the fact that children are often withdrawn from schools as a response to HIV/AIDS and in quoting Ayieko, (1998) 'just one-tenth of orphan-headed households' possessed adequate knowledge of agricultural production techniques. Arndt (2000) in his analysis ran a computable general equilibrium model for the South Africa productive sector over a period of 1997-2010 and concluded that South Africa's Gross Domestic Product (GDP) would be 17% lower in the AIDS scenario set-up.

TABLE 3.1: SLF GUIDANCE SHEETS: HOW TO BUILD HUMAN CAPITAL FOR THE POOR

DFID sustainable livelihoods objective: Improved access to high-quality education, information technologies and training and better nutrition and health.		
Direct support to asset accumulation	**Indirect support (through Transforming Structures & Processes)**	**Feedback from achievement of livelihood outcomes (virtuous circle)**
♦ To health/education/ training infrastructure. ♦ To health education training personnel. ♦ To the development of relevant knowledge and skills (these should be developed with and made readily available to the poor).	♦ Reform of health/education/ training policies. ♦ Reform of health/education/ training organizations. ♦ Change in local institutions – culture, norms – that limit access to health/education/ training (e.g. for women).	♦ Health status is directly related to income/food security (with relevant knowledge). ♦ High income is often reinvested in education. ♦ Reduced vulnerability can reduce birth rate (with knock-on effects on nutrition and labour).

(Source: SL Guidance Sheets 1999)

As human capital is being developed through education and the right information, the poor is able to develop a sustainable livelihood.

♦ *Social capital* – the social capital is the social resources upon which people draw in pursuit of livelihood objectives such as social networks and connections, memberships of groups, access to institutions in society, and trustworthy relationships that facilitate co-operation, reduce transaction costs and provide some basis for informal safety nets amongst the poor (Carney, *et al.*, 1998; Scones, 1998). The impact of HIV/AIDS on social capital needs to be considered both in terms of organisations and institutions and in terms of the customs and practices that influence people's livelihoods (Harvey, 2004). The social capital is also about people's ability to influence civic and political institutions (DFID, 1998). One of the major problems linked to HIV/AIDS is stigmatization, which can lead to weakened social networks (Hammarsköld, 2003). Stigmatization as a result of infection can limit social linkages and networks (for example family and community members), thus limiting access to resources (Van Lierre, 2002:7; Drimie, 2002:8).

  Social capital is said to be notoriously difficult to measure, but qualitative information from a range of studies suggests that it is becoming increasingly overstretched by the

growing demands related to HIV/AIDS (Rugalema, 1999; Shah, *et al.*, 2002; De Wall & Whiteside, 2003; Harvey, 2004; Nalugoda, *et al.*, 1997). Because of the impact of the virus on people, those who generally would have been involved in politics and in community work are not able to be so (Economic Justice Update, 2002). When people are linked together through common norms and agreement they may be more likely to form new organizations to pursue their interests. This is one capital that informs the AOG to get connected to the society that is affected/infected with HIV/AIDS.

The social capital can be of great importance when someone is affected by HIV/AIDS since households often draw much of their support from family, neighbours, informal organisations and community institutions (Stokes, 2003). According to Moerbeek (2001) in contrast to social network benefits, it has its limits and in fact can also turn sour. For example while social networks can provide benefits by facilitating access to scarce resources, it also entails having claims made upon one's resources (Scones, 1998) Particularly, in times of stress such as HIV/AIDS these claims can over stress social networks; social capital can be negatively affected by HIV/AIDS.

- *Natural capital* – this refers to natural resources, stocks from which resource flows and services are derived such as land, forests, water, marine/wild resources, air quality, bio-diversity and environment. Livelihood activities are regarded as unsustainable when they damage the natural resource base by contributing to desertification, soil erosion, salinisation, etcetera (Chambers & Conway, 1992). A disease such as HIV/AIDS can negatively affect the natural capital; this means the family might have less opportunity and money to invest in their land making them to sell off the land in order to raise money for their upkeep. DAG (2003) states that because the virus impacts disproportionately on economically active individuals, and those who would under normal circumstances be in the prime of their lives, human labour essential for the working of the natural capital, for example soil in rural areas, is lost.

  HIV/AIDS may affect natural and physical capital through its impact on land tenure and land rights, and the possible sale of key productive assets. Widows and orphans may lose their access to land following the death of male household head (Drimie, 2002,

2003; Mphale *et al.,* 2002; Aliber & Walker, 2003; Harvey, 2004). Within the sustainable livelihoods framework, the relationship between natural and the vulnerability context is particularly close. Many of the shocks that devastate the livelihoods of the poor are themselves natural processes that destroy natural capital (e.g. fire that destroys forests and floods destroys agricultural land).

- *Physical capital* – the basic infrastructure and producer goods are needed to support livelihoods. According to Ellis (2000) physical capital is important for households to facilitate livelihood diversification. Infrastructure components include affordable transport, secure shelter, adequate clean water supplies, and clean affordable energy, sanitation and access to information. Producer goods are the tools and equipment that people use to function more productively. Physical capital is one of the important ingredients to people's ability to respond to livelihood shocks such as HIV/AIDS, as it enables them to meet the rising costs of illness and death. The physical capital can be affected by HIV/AIDS when households are forced to sell their things like tools, livestock and equipment (Bengtsson & Bengtsson, 2005). The following components of infrastructure are usually essential for sustainable livelihoods according to DFID (1999). A livelihood approach to physical capital can include improving clean water supply, encouraging an affordable transport service. The poor must have access to physical capital in order to improve sustainable livelihood. The DFID supports the direct provision of producer goods to the poor.

- *Financial capital* – this capital refers to the financial resources people have and use to achieve their livelihood objectives (Scones, 1998). It can be savings, remittances, credits or pensions, which provide them with different livelihood options. According to Neiland and Béné (2004:140) low income, low savings and difficult access to credit restrict the potential to develop the financial capital of any given individual or community. As Drimie (2000:11) emphasizes, HIV/AIDS affects economic growth. However its most acute impact is felt at the level of the household. Households affected by HIV/AIDS may have less access to credit due to stigma or because they are seen as more likely to default (World Bank, 1999; Lundberg & Over, 2000). HIV/AIDS puts a

severe strain on households' financial capital because of high medical bills, funeral costs transport, drugs and related transport expenses. Illness due to HIV/AIDS can be very costly for households. According to Harvey (2004), in order to meet these additional costs, people may have to draw their savings and sell key assets such as jewellery and livestock to meet the demand of caring for those infected with HIV/AIDS.

In addition, HIV/AIDS impacts financial capital because of reduced income from being on and off from the workplace, business or farmland as a result of sickness and death. HIV/AIDS can mean a financial strain on a household as a result of absenteeism from work. The death of household members can lead to a loss of productivity, as households lack sufficient labour to maintain a livelihood. Other household studies have shown falls in income following adult deaths from HIV/AIDS (Bechu, 1998; Menon, *et al.*, 1998; World Bank, 1999; Nampanya-Serpell, 2002).

When looking at a household, community, individual or other group, the model can be used to show the strengths and weakness of different types of asset, their relative importance and the linkages between them. Assets are destroyed and created at different stages as a result of the trends, shocks and seasonality of the vulnerability context. Access to only one of these capitals is not enough for someone or household to achieve the livelihood outcomes desired, especially not for poor people who often have very limited access to all of these capitals. As Meikle, *et al.* (2001) correctly point out, the existence of assets is not sufficient for individuals and households to build sustainable livelihoods.

3.3.3 TRANSFORMING STRUCTURES AND PROCESSES

Fundamental to the livelihood perspective is the analysis of formal and informal organisational and institutional factors that influence livelihood outcomes (Scoones, 1998). These are referred to as policies, institutions and processes; dimension of a livelihood approach. The structures and processes constitute the social and institutional context in which livelihoods are constructed. Policies, institutions and processes dimension comprises

a range of issues that influence people's lives, including formal and informal organisations at various levels and the services they provide, institutions, policies, social relations, participation, power, authority and processes such as decentralisation which influence household's access to assets and resources (Ellis, 2000; Goldman, *et al.*, 2000). Furthermore they shape the vulnerability context and set opportunities for pursuing various strategies (Pain & Lautze, 2002).

There is no doubt that policies have a major part to play in influencing the livelihood of communities or individuals. It should be noted that policies are usually formulated and implemented in order to meet the needs of the community at different government levels and influence household decision-making and their access to and control over livelihoods assets (DFID, 1999). AOG in Lusaka must revisit its policies in community building especially HIV/AIDS in order to meet up with the needs and demands of its congregation and the community at large. 'Structures' are organizations in society, both public and private, that affect people's livelihoods. For example by giving services, implementing policies or legislations. For example by giving services, implementing policies or legislations. The 'processes' aspect of this component is a connecting factor relating to the processes of change in policies and institutions to improve the performance of government and private agencies that have the capacity to positively influence livelihood prospects and choices (Ellis, 2000). Structures and processes are important to keep in mind since they have a large impact on people's lives.

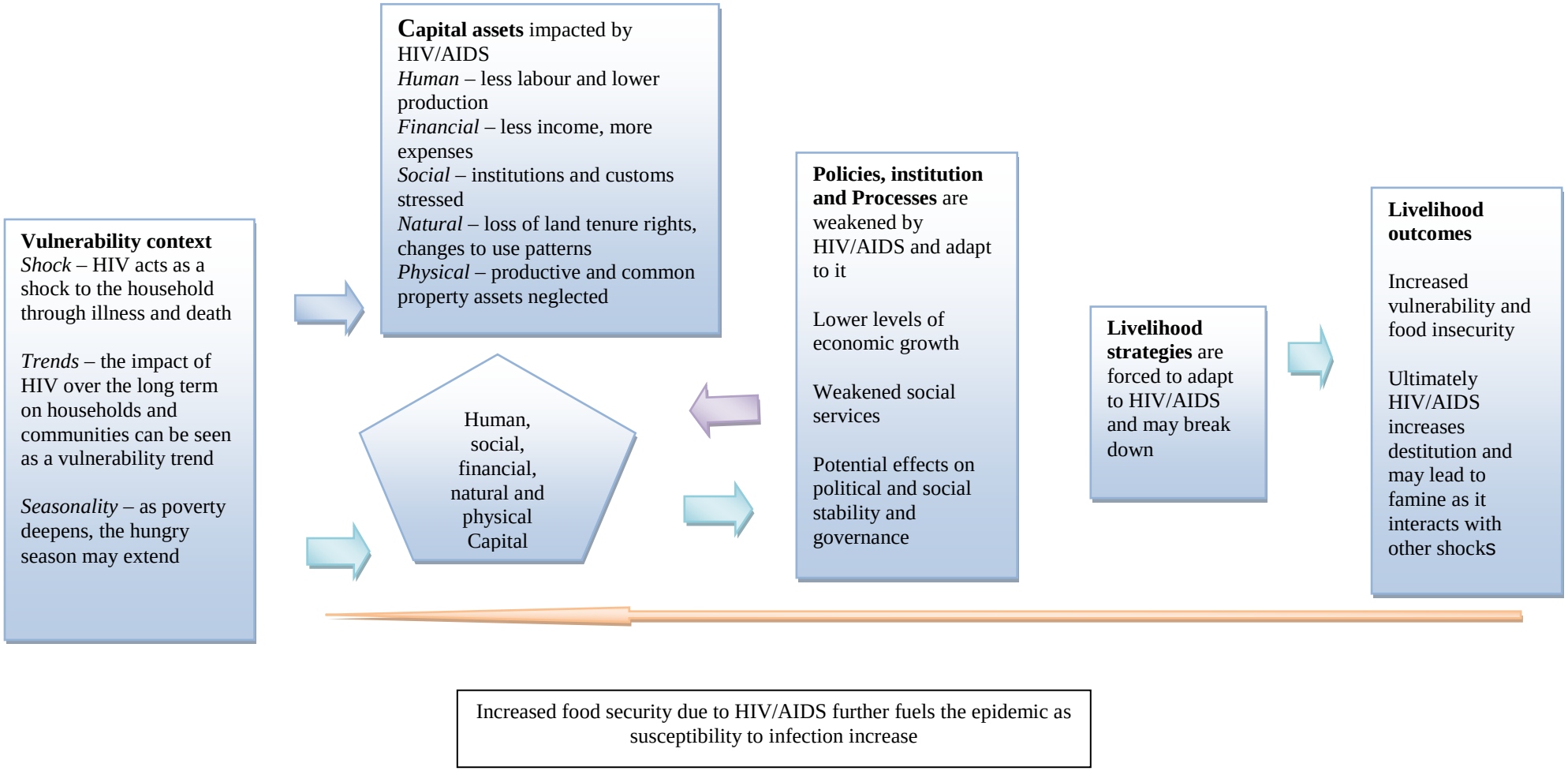


Figure3.5: Sustainable livelihoods in the context of an HIV/AIDS epidemic

Adapted from: Paul Harvey. Humanitarian Policy Group (HPG) Research report 2004

Structures and processes should be given an adequate amount of consideration as they are important elements that have a large impact on people's lives. They work at all levels of society, private as well as public, from households all the way up. John Twigg, Benfield and Greig (2001) argue that structures and processes are institutions, organizations, policies and legislation that shape livelihoods.

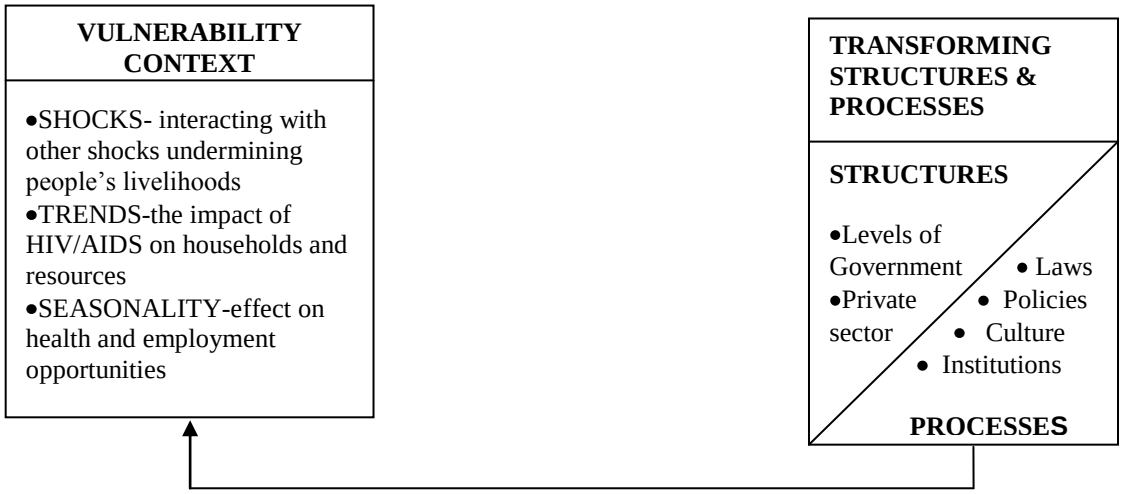


Figure3.6: Interaction between structures, processes & vulnerability context

Adapted from: Paul Harvey. Humanitarian Policy Group (HPG) Research report 2004

Processes establish the way in which these structures, as well as individuals operate. It can, for instance be institutions, legislation, policies, power relations and culture (DFID, 1999). The importance of structures and processes within the livelihoods framework cannot be overemphasised because they operate at all levels, from household to international arena and in all spheres. Their importance is because they determine access to various types of capital, to livelihood strategies and to decision-making bodies. Structures and processes are important to keep in mind since they have a large impact on people's lives as they determine:

a) Access to the five different types of capital, livelihood strategies and decision makers.
b) Terms of exchange between the different types of capital.
c) Economic and other returns from livelihood strategies.

There is a direct feedback between transforming structures and processes to the vulnerability context. Processes (policies) established and implemented through structures, affect trends directly and indirectly. For example, directly are fiscal policy/economic trends and indirectly are health policy/population trends. There is the tendency of cushioning or worsening the impact of external shocks such as a policy on the HIV/AIDS mitigation programme. Transforming structures and processes must be people oriented, that is, they must be formulated and developed to benefit the poor. This can be pursued and achieved by limiting the prevailing-elite controlled-governance to recognise the legitimate interest of the poor, for too long the poor have always played little or no part at all in the government affairs.

The magnitude and intensity of the effects of external shocks and stresses on both households and particular individuals within households depend on the nature of the type of shock or risk event experienced, household characteristics and the status within the family of the individuals in question. Some of the household characteristics that may influence risk levels include occupation, education levels, household size and composition, gender of the household head, and ethnicity/race (Kantor & Nair, 2003).

Structures include different levels of government as well as nongovernmental organisations, faith-based organisations and the private sector. It should be noted that non-governmental and faith-based organisations (AOG) play an important role in facilitating capabilities and choices for individuals and households (Farrington, *et al.*, 1999).

3.3.4 LIVELIHOOD STRATEGIES, COPING STRATEGIES

Accepting the fact that people infected/affected by HIV/AIDS have other pressing needs and concerns than just issues related to the HIV status, it is important to determine the impact that HIV/AIDS has on people and the strategies they employ to sustain their livelihoods. Livelihood strategies refer to the way in which people live to achieve their livelihood goals. Under the considerable influence of transforming structures and processes, the poor operating within the vulnerability context can choose to implement livelihood strategies in order to achieve livelihood outcome, for example more income-reduced

vulnerability, improved well-being, improved food security and more sustainable use of NR base (Figure 3.7). The hypothesis is that HIV/AIDS is a shock that impacts all level of assets. Human capital is lost through chronic illness and death of prime age labour as well as loss of skills and knowledge transfer. Anderson, *et al.*, (1994: 20) define strategy as *"the overall way in which individuals, and possibly collectives, consciously seek to structure, in a coherent way, action within relatively long-term perspectives"*.

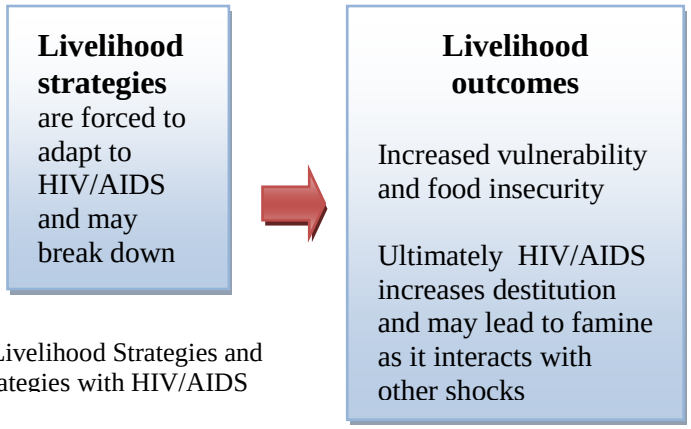


Figure 3.7: Livelihood Strategies and Coping Strategies with HIV/AIDS

Financial capital is undermined due to:

a) Increased health care & funerals expenditure.
b) Reduced income (through loss of productivity)
c) Decreased assets ownership (assets are sold to make up for lost income).

The magnitude of the HIV/AIDS epidemic and its distinctive characteristics mean that it is having a profound impact on people's livelihoods, particularly in sub-Sahara African countries where it is the worst-affected region. HIV/AIDS affects people's livelihood assets and the policies, institutions and processes that influence livelihoods. In turn, livelihood strategies are being adapted only in response to the HIV/AIDS epidemic, sometimes in unclear ways, and at other times households are unable to cope using their resources. The result can be seen in the livelihood outcomes of households, which become less food secure and more vulnerable to other shocks. An understanding of how HIV/AIDS affects livelihoods is a fundamental step in considering the role of HIV/AIDS in emergencies, and the appropriate contribution of the Church in response to HIV/AIDS.

No doubt since HIV/AIDS was first discovered, the body of research into the disease has been steadily growing. Today this research covers a wide range of Church participation in trying to mitigate the impact of the scourging disease and to assist in halting the spread thereof. A study in Zambia and Namibia found that 90% of all faith-based organization (FBOs) implement HIV/AIDS activities in the form of awareness raising, care and support, orphan support, counselling, spiritual support, home-based care, material support, prevention, and pre-schools and vulnerable children (Yates, 2003;Mfiseleni, 2010).

A study conducted by UNICEF (2003) in six countries in East Africa, found that FBOs support large numbers (that is, 150 000 or more) of vulnerable children, and some of these responses are faith-based (Foster, 2004). However, research also reveal that these strategies have not all been effectively implemented (Oloo, 2004). According to Mundy (2007) a pilot programme was conducted by Tearfund involving FBOs from Democratic Republic of Congo, Ethiopia, Kenya, Uganda, Malawi and Zambia. The programme was required to strengthen the capacity of these FBOs to monitor and evaluate their responses to HIV/AIDS. This sub-heading provided key findings regarding the spread of HIV/AIDS and its impact, and how the Church can be used as a tool for change.

3.4 IMPACT OF HIV/AIDS

3.4.1 AT THE GLOBAL LEVEL

UNAIDS sources has indicated that the AIDS epidemic is spreading at an alarming rate and it seems that nothing is going to stop the devastating feature of the disease. HIV/AIDS affects everybody without any distinction based on conventional boundaries, geographic location, colour, nationality, race, sex, age and or religion (Judy, 2003). Globally, HIV/AIDS is the fourth most common cause of death especially to the productive age force. The pattern of spread among countries varies within countries, for instance in urban and rural areas (UNAIDS, 2000). According to the 2005 UNAIDS report, the number of people living with HIV/AIDS continues to grow from 37 million in 2003 to 40.3 million in 2005.

Furthermore, the estimated total of people newly affected by HIV is close to five million, whereas the total of AIDS deaths is 3.1 million. HIV/AIDS has killed more than 25 million people since the materialization of the disease. Nowadays, HIV and AIDS infection reaches at the highest level with multi dimensional challenges (UNAIDS, 2005). Among the developed and developing nations the pandemic has indeed made gross differences. In the developed world, antiretroviral drugs and other supportive medicines are available to those affected by the disease, which reduce the speed of HIV infection to develop AIDS as opposed to those living in developing countries.

As a result of medication and technological advancement, the number of deaths due to the disease, decreases in the developed countries while developing countries such as Zambia are faced with death on a daily basis. For example in America AIDS-related deaths have decreased by approximately 70% from 1995 to 200; from 51,670 deaths in 1995 to 15,603 deaths in 2001 (Shalina & Suninder, 2004). Quite the opposite is happening in developing countries where AIDS is the most common disease, resulting in many forms such as HIV positive pregnancies and births, cut in overall life expectancy, and infant mortality. As different sources indicate, mother to child transmission of HIV is prevented in developed countries and reduced to below three per cent.

According to Shalina and Suninder (2004), few middle-income countries in Asia and South America have done prevention work on mother to child infection and obtained undeniable results. Women and children are more vulnerable when it comes to HIV/AIDS. With the exception of health problems, HIV has different impacts on women and children. The majority of women all over the world are at risk of contracting HIV because of their biological anatomy and exposed to social stigma and pressures. According to CWPA, (2005) some cultures impose a negative influence against women and do not allow them their rights. The HIV/AIDS pandemic disproportionately affects women who already carry a very hard burden in many African countries.

In addition women are often solely responsible for household and children, and have fewer financial reserves to fall back on as they face the risk of abandonment and/or abuse at the

hands of their partners when HIV/AIDS strikes. When family members fall sick as a result of HIV, it is most often the girls who will be removed from schools to nurse and care for those who are sick (Barnett & Whiteside 2002). In addition, children according to CWPA (2005) will most often lose the ownership of their father's property to close relatives and may be forced to leave their home. This increases their susceptibility to poverty and to the disease because they will probably marry at a young age, and will not have the benefit of an education. HIV/AIDS has a critical impact on the economic and social development as seen in livelihood assets.

3.4.2 THE IMPACT ON AFRICA

Statistics about the impact of HIV/AIDS world-wide is available, in an alarming state and overwhelming. In 2001, estimates of the United Nations Agency for AIDS (UNAIDS) indicated that over 40 million people were living with HIV/AIDS and that practically 25 million people have died of AIDS since the disease was first discovered in the early 1980s, and that 15.6 million children under 15 years, have lost either their father, mother or both parents as a direct result of AIDS (UNAIDS, 2001). While every nation in the world has been affected by this pandemic, it is, however, in Africa that the grip of HIV/AIDS has been by far, the deadliest. It was estimated as far back as 2002 that 28 million people in Africa were living with HIV/AIDS and sub-Saharan Africa of which Zambia is a member nation, had the highest HIV adult prevalence in the world. Well over two thirds of the HIV/AIDS related deaths (18 million or 72%) are from Africa (World Bank, 2002) and almost one in every ten adults in sub-Saharan Africa are HIV positive (UNESCO, 2002).

HIV/AIDS represents not only a tragedy at a human level, but also heavily affects the economic development of countries, many of which are already severely strained for resources. Cross country analyses conducted by the World Bank suggest that the region of Southern Africa is losing an estimated 0.7 to 1.0% per capita per year as a direct result of HIV/AIDS and that by the year 2010 it may have reduced the aggregate output by 15% to 20% (World Bank, 2002). By an estimate according to UNAIDS (2001) between 50% and 80% of hospital beds in Southern Africa are occupied by people with HIV related infections. UNAIDS (2003) warns that unless drastic action is taken, the devastation and

the damage that has already taken place are likely to be minor compared to what is still to come.

According to Avert (2011) two thirds of all people infected with HIV live in sub-Saharan Africa, although this region contains little more than ten per cent of the world's population. AIDS has caused immense human suffering on the continent. In addition to research carried out by Avert (2011) the most obvious effect of this crisis has been illness and death, but the impact of the epidemic has certainly not been confined to the health sector; households, schools, workplaces and economies have also been badly affected. In 2009 alone, an estimated 1.4 million adults and children died as a result of AIDS in sub-Saharan Africa of which Zambia is a member nation. It is on record that since the beginning of the epidemic more than 15 million Africans have died from AIDS. Although access to antiretroviral treatment is starting to lessen the toll of AIDS, fewer than half of Africans who need treatment are receiving it. The impact of AIDS will remain severe for many years to come (Avert, 2011).

The former UN Secretary General Mr. Kofi Annan on the impact of AIDS in Africa, made a staggering statement about the impact of HIV/AIDS when he said that between 1999 and 2000 more people died of AIDS in Africa than in all the wars on the continent (*The Guardian,* 2000). The death toll is expected according to *The Guardian* (2000) to have a severe impact on many economies in the region. In some nations, it is already being felt. Life expectancy in some nations is already decreasing rapidly, while mortality rates are increasing.

3.4.3 DIRECT AND INDIRECT IMPACTS

The HIV/AIDS pandemic has a multi-faceted impact on individuals, their households, families and communities. This multi-faceted impact is felt both by those that are infected by the disease directly, and by those who are indirectly affected through association. The impact of HIV/AIDS at the household level has long been recognised for the reason that AIDS tends to be more prevalent among prime-age working adults. Some of its impacts, like the morbidity and mortality of children and prime-aged adults can be regarded as direct

impacts, and focus has been on the consequences of these impacts around the world at the macro-level. It is, however, important to understand that most of the devastating and immediate impacts are worse and first felt at the micro-level, that is, at the individual and household levels (Whiteside, 2002; Veenstra & Whiteside, 2005).

Deaths among the prime-age working adults deprive households of their main income providers at a relatively early age. According to a study of patients at Mama Yemo hospital in Kinshasa, Zaire, found that for the 244 patients studied, 2,600 years of potential life were lost and that 73% of these years were attributed to premature mortality due to HIV/AIDS (Hassig, *et al.*, 1990; Siameja, 2011). It was stated that the study estimated the mean years lost at 30.6 years for HIV-positive patients and 21.3 years for non-HIV-positive patients. As a result of the direct impact on a household, single income-earner households may suffer as it can result in impoverishment of such households. Among poor households, the death of the income-earner can result in deepening their poverty state (Bloom, *et al.*, 1997; Nampanya-Serpell, 2000; Bloom, River Path Associates & Sevilla, 2001; Booysen, 2002).

The nature of the disease, as it progresses from HIV infection to development of AIDS and eventually death, is an important factor in the epidemic's impact on households. It is a well known fact that frequent illness characterises the progression of the disease from infection to development of full-blown AIDS. Consequently, an infected person needs frequent medical attention for prolonged periods during which the individual may not be able to work as expected. During this period, medical expenses may increase, as may other associated costs such as transportation, funeral costs transport and drugs as indicated in the financial capital (Bollinger & Stover, 1999; Bollinger *et al.*, 1999; Barnett & Whiteside, 2002).

Increased medical care costs for some households may lead to reduced consumption of other goods and services including schooling for children and food (Mahal & Rao, 2005; Wiegers, *et al.*, 2006). Often some households' increased care costs may lead to liquidation of productive assets which diminishes the households' ability to recover from other shocks and capitals (Kongsin, 1997; Bloom, River Path Associates *et al.*, 2001). Whenever AIDS sets in, the patient is usually plagued by one or more opportunistic infections which

eventually lead to death and closer to death; patients become bedridden and may need full-time care by their loved ones, which may also indirectly affect the loved ones' productivity. Growing attention has been given to the indirect impacts of HIV/AIDS, such as the effects of the epidemic on elderly people who are parents to those who are HIV positive and caregivers to affected grandchildren. In the studies conducted of the impacts of HIV/AIDS on elderly people, attention is mostly on their role as caregivers to the sick and orphans left by their adult children that died of AIDS (Saengtienchai & Knodel, 2001; WHO, 2002; Lindsey, *et al.*, 2003). Zambia National Broadcasting Commission ZNBC (7 August, 2011) a 24 year-old girl narrated how she left school at age 11 to nurse her dying father who was bedridden with HIV/AIDS.

The literature on household impacts, however, suggests that the impacts are not generally the same across all households experiencing AIDS prime-aged deaths (Barnett & Whiteside, 2002; Petty, *et al.*, 2004; UNAIDS, 2006; Siameja, 2011). They further argue that the initial economic conditions of the households and the characteristics of the deceased prime-age adult seem to be significant in determining how the households cope with prime-age mortality. Non-poor households have been found to be able to withstand the loss of a prime-age adult without sinking into poverty as stated by Mahal and Rao (2005). As such households may have sufficient savings to finance rising medical costs without impoverishing the household (Beegle, 2005). Reductions in labour supply and household's productivity are also some of the direct impacts of HIV/AIDS on households.

3.4.4 IMPACT ON BUSINESS SECTOR

There is no doubt that the HIV/AIDS epidemic has great impact on overall economic development of any country. The impact of HIV/AIDS on the business sector is correlated to the changes in the quantity and quality of labour. HIV/AIDS increases morbidity among the working-age population that makes up the labour force. Good health is increasingly seen as an important input into the productive process. According to (Kusanthan, 2002) in Zambia, where the majority of HIV infections have occurred, workers are particularly vulnerable to contracting HIV because of substantial level of sexual activity outside marriage and low levels of condom use. Workers productivity output declines as workers

health deteriorates. (Muwanga 2001) established that reduced productivity for any given level of employment and wages leads to increased production costs and reduced profitability for producers.

An analyses of a study carried out shows that HIV/AIDS was adding between 0.4 and 5.9% to the annual wage bills of large companies in South Africa and Botswana, "under a conservative set of assumptions" (Rosen *et al.,* 2004). HIV/AIDS affects the quality of labour through its impact on individuals' incentives to accumulate human capital as life expectancy declines, individuals may have fewer incentives to offer or invest in their own or their children's human capital. Labour productivity declines as the proportion of the less skilled younger workers in the labour force increases (Wobst & Arndt, 2004). Whenever one of the five livelihood assets is affected the others are affected as well in this case the human capital will invariably affect the physical capital (Pauly *et al*., 2002).

According to (Gladys, 2000) Zambia has reported an increase of HIV/AIDS related mortality and morbidity cases in workplaces, which has led to loss of trained personnel and has affected productivity and recruitment. A study of the impact of AIDS on 18 companies in Lusaka and Ndola found that many firms/institutions are experiencing irregular work attendance. This according to (Kusanthan, 2002) resulted to 'wasted' training as some of the trained workers are constantly ill or die; high medical bills, frequent funeral costs and reduced productivity and profit. (Ministry of Health, 1997) gave example at Chilanga works, where hours lost due to illness and funerals increased threefold from 13,380 hours in 1992/93 to 43.370 hours in 1994/95.

3.4.5 IMPACT ON ORPHANS

It is difficult to overemphasise the emotional trauma and hardship that children affected by HIV/AIDS are forced to bear. The epidemic not only causes children to lose their parents or guardians, but in some cases their childhood as well. One outcome of the high adult rate is the increase in the number of orphaned children, AIDS claims the lives of people at an age when most already have young children, more children have been orphaned by AIDS all over the world. Of the estimated 1.2 million orphans in 2005, an estimated 710,000 were

AIDS orphans (MOH, 2005; UNICEF, 2005). According to (National HIV/AIDS/STI/TB Council, 2004) the number of orphans doubled between 1992 and 2002, a period coinciding with rising AIDS-related mortality in Zambia. As stated by (Abebe & Aase, 2007; Mishra & Bignam-Van Assche, 2008; Salaam, 2004; UNICEF, 2004; UNICEF *et al.*, 2004), AIDS-related mortality is more pronounced in prime-age adults, one of its main impacts on affected societies is the creation of a large number of orphans. AIDS orphans according to (UNICEF *et al*., 2004) are commonly defined as young people up to 18 years of age who have lost one or both parents to an AIDS-related cause. As a result of HIV/AIDS related incidence, many children are now raised by their extended families and some are even left on their own in child-headed households thereby exposing their vulnerability. As parents and family members become ill, children take on more responsibility to earn an income and care for family members.

It has been reported in Zambia by FAO (2003) that, of 766 households sampled in a survey conducted in three rural districts, 31% were caring AIDS orphans. Furthermore, the study reports that there has been an increase in households fostering orphans because of HIV/AIDS related mortality, which places an additional burden on affected households (FAO, 2000). Many of these orphans are reportedly made to perform disproportionately more household chores than non-orphaned children in the household and being treated more like house servants (Barnett & Whiteside, 2002; UNICEF, 2004; UNICEF, UNAIDS, & USAID, 2004). As AIDS-related mortality increases, the number of orphans is expected to increase as well. The number of orphans left behind by deaths of a parent or both will continue to increase from the current figure of 1.2 million (National HIV/AIDS/STI/TB Council, 2004, 2006). The increase in the number of orphans, primarily due to HIV/AIDS, in Zambia, as in other high prevalence countries, poses a serious threat to availability of a sufficiently educated and trained labour force in the future and social and economic development issues.

3.4.6 IMPACT ON THE ELDERLY

(Wiegers *et al.*,, 2006; Wilson & Adamchak, 2001; Zimmer, Dayton, & UN Population Council, 2003) made a profound contribution to the understanding of the HIV/AIDS impact on the elderly when they said that elderly people are taking on increasing responsibility for raising their family members' children. As HIV/AIDS mortality increases in the 15-49 year age group, the responsibility for raising their children is falling increasingly on their older and usually retired or unemployed parents. The stress on the elderly of looking after young children is significant.

3.4.7 IMPACT ON GOVERNANCE

The impact on governance cannot be underestimated (Moran, 2004; De Waal, 2003). If AIDS reduces the number of experienced government labour force, governance of the country may be at risk, as may be its economic growth. With failed governance, the end result for all citizens becomes a source of concern. In most of the sub-Saharan Africa countries the AIDS epidemic is no longer restricted to particular at-risk groups like commercial sex workers, long distance truck drivers or injecting drug users. Let it be known that HIV/AIDS -related morbidity and mortality are occurring at all levels of society including high ranking government officials. It is of the researchers' opinion that bad or inefficient government decisions may lead to policies that do not promote but hinder economic growth as well as protect or benefit the poor within the society. If AIDS reduces the number of experienced government labour force, governance of the country may be at risk, as may be its economic growth (De Waal, 2003; Moran, 2004).

3.4.8 RESPONSES OF FAITH-BASED ORGANISATIONS

The aim of the study was to examine the role of the AOG in the management of the HIV/AIDS disaster in Lusaka Zambia. To fulfil this aim, the research searched for background literature to the responses of Faith-based organisations.

The World Council of Churches (WCC) and the All Africa Council of Churches (AACC) in November 2001, organised a conference on the African Churches' involvement in HIV/AIDS (Breetvelt, sd:1). Subsequent to the call of the WCC was the conference held by its member body in Zambia, namely the Zambia Council of Churches (ZCC) also in 2001. At this conference, the ZCC developed a "*Strategy to fight AIDS"* and a call was made to Churches in Zambia to join hands with the government in the fight against HIV/AIDS (ZCC 2001). A study in Zambia found that 90% of all FBOs implement HIV/AIDS activities in the form of care and support, spiritual support, orphan support, home-based care and prevention (2006). A survey conducted in Namibia found that 90% of FBOs in that country also implement HIV/AIDS activities in the form of counselling, spiritual support, awareness raising, home-based care and support homes for orphaned and vulnerable children (Yates, 2003).

Furthermore, in spite of the various responses to the impacts of AIDS pandemic by different organisations including Churches, little is known about people's perceptions and opinions about the role of the Church-based programmes to mitigate and address the needs of people living with HIV/AIDS in their communities.

Cunningham, *et al.,* (2009) suggest that the Church's involvement in the fight against HIV/AIDS has been characterised by the following:

- Care and support activities
- Orphan support
- HIV advocacy and rights
- HIV/AIDS de-stigmatisation
- HIV prevention

Maluleke (as cited by Haddad, 2005:29) states that the motto of the Church in the fight against HIV/AIDS is "*while we in the Church not all be infected, we all can be infected and once one member of the body is infected, we are certainly all infected".* This unique oneness that prevails in the Church makes it an institution ideally placed to play a role in the fight against HIV/AIDS.

3.5 FACTORS INFLUENCING THE SPREAD IN ZAMBIA

The causes which bring the erratic spread of HIV/AIDS epidemic are generally unprotected sex with multiple partners. In terms of those factors that can exacerbate the sporadic spread of HIV/AIDS, and which the church-based programmes can address, the researcher, following a review of literature, identified (1) poverty, (2) cultural and traditional practices, (3) stigma and discrimination (4) multiple sexual partners, (5) gender inequality and (6) women and sexually transmitted diseases. There are additional factors that promote the direct spread, just to mention but a few. The major ones are cited below.

3.5.1 POVERTY STATUS

People are said to be living in poverty when they lack the fundamental requirements for human existence such as sufficient food, shelter and clothing (Giddens, 2004). The poverty situation in Zambia cannot be overemphasised. The poverty situation of the country creates a fertile breeding ground for the high prevalence of HIV/AIDS. There is a high rate of unemployment and economic migrants that also leads to high-risk sexual behaviour and a high rate of prostitution. Rose-Innes (2006) indicates that poverty caused by *inter alia* unemployment and an inadequate welfare system, is one of the contributing factors to people's vulnerability to contracting HIV. The HIV epidemic has disproportionately affected the most impoverished regions of the world, and within affected countries such as Zambia. Among the poor, the pandemic has had a very serious effect because of an already vulnerable economic situation in which they live. This increases their vulnerability to prostitution and malnutrition.

Poverty, disease, famine, and economic instability are among many factors. As stated by (Medscape, 2011) poverty is seen as a key factor in the transmission and HIV/AIDS can impoverish people in such a way as to intensify the epidemic itself. Poverty leads to poor nutrition, which weakens the immune system, making poor populations more susceptible to infectious diseases. It is universally known that poverty-stricken populations focus more on their daily survival than their health and are stymied by a crushing sense of powerlessness

which leads to hopelessness and, in some cases, to risky behaviours including prostitution. The impact of the HIV/AIDS epidemic is devastating; communities have been robbed of breadwinners, fathers, mothers including children, and the country of highly qualified personnel and potential development. Poverty in Zambia is reinforced by the sociocultural systems that perpetuate gender inequality as men control productive resources, such as land as well as the social infrastructure of decision-making and value systems. According to UNICEF (2006) the net effect of all this is the continued subordination of women, a reality that plays out in HIV infection as ultimately women are socioculturally and economically disempowered, and are not able to negotiate safer sex.

3.5.2 CULTURAL AND TRADITIONAL PRACTICES

Quite a number of harmful traditional practices that have been practised for a long time have a high potential of spreading HIV. In Africa, polygamy is a social practice used to ensure the continued status and survival of widows and orphans within family status and this has been cited as one of the key drivers of the AIDS pandemic (Rose-Innes, 2006; medscape, 2011,). There are some religions and cultures which allow polygamy. Female genital mutilation, traditional make up like tooting face skin and ears, etcetera are among other factors. There are also cultural barriers which are termed as taboo such as to talk about sex within the family and the community. Abduction and early marriage have contributed to the spread of HIV/AIDS (National HIV/AIDS/STI/TB Council, 2004).

Putting young African girls at risk of contracting HIV/AIDS is the false belief that men can rid themselves of HIV/AIDS by engaging in intercourse with a virgin. Because of this gross misconception, many young African girls have been raped and subsequently, infected with the virus. Some of these cultural norms and practices continue to be exposing people to HIV infection (Rose-Innes, 2006). Cultural practices such as *lobola* (bride price) contribute to women's cultural vulnerability to HIV/AIDS. According to a study conducted by WCC (2003) about women indicate that their husbands often treat them as if they are *"owned*" because the man had paid *lobola* to marry her. This bizarre treatment of women by men as property extends to the couple's sexual relationship, with the husband expecting sex on demand, without giving the woman an option to say no or to negotiate for protected sex

(Iipinge, *et al.,* 2004). In most cases men become suspicious and angry of their women when they request the use of a condom.

3.5.3 STIGMA AND DISCRIMINATION

According to Chitando and Gunda (2007), stigma has a close relationship with discrimination, more often than not, stigmatisation becomes the justification for discrimination. In the social context of HIV/AIDS pandemic, stigma is a mark that is attached to certain objects, particularly human beings, which makes them feel less important in their communities because of the stigma attached to HIV/AIDS. This is according to UNAIDS definition of stigma:

> **Stigma** has ancient roots. It has been described as a quality that significantly discredits an individual in the eyes of others. It also has important consequences for the way in which they come to see themselves. Importantly stigmatization is a process within a culture or setting; certain attributes are seized upon and defined by others as discreditable or unworthy. Stigmatization therefore describes a process of devaluation rather than a thing. Much HIV/AIDS-related stigma builds upon and reinforces negative thoughts. People with HIV/AIDS are often believed to have deserved what has happened by doing something wrong. Often those wrong doings are linked to sex or to illegal and socially frowned- upon activities, such as injecting drug use. Men and women who become infected may be seen as homosexuals, bisexual or having had sex with prostitutes. Women with HIV/AIDS are viewed as having been promiscuous or having been sex workers. The family and community often perpetuate stigma and discrimination, partly through fear, partly through ignorance and partly because it is convenient to blame those that have been infected first (UNAIDS 2002:8)

Stigmatising is described as being disgraceful or unworthy of inclusion in the community which often would lead to discrimination and isolation. This is often the daily experience of people living with HIV (Chitando & Gunda, 2007). Hope and Cope (2008) suggest that HIV/AIDS are stigmatised due to the association with “immoral” or “sinful” sexual behaviour such as drug addiction, homosexuality, commercial sex work or multiple sexual

partners. Furthermore, religious or moral beliefs may also lead some people to believe that being infected with HIV is the result of moral transgressions (such as promiscuity, being perverted or deviant sex activities).

God is seen as one whose love is inclusive of the foreigner. According to Kysar (1991), God's concern for human welfare in not limited to those of a particular religious community. According to WCC (2003:3) the Church was accused of promoting stigmatising and discriminating attitudes based on fear and prejudice, and of pronouncing harsh moral judgements on those infected by HIV. Religious leaders have fuelled the stigma and discrimination by the way they talk about HIV/AIDS – for example, saying that AIDS is a punishment from God and that infected people are sick through their own fault (Haddad, 2005).

On 25-28 November 2001 a global consultation on the ecumenical response to the challenge of HIV/AIDS was held in Nairobi, Kenya which marked the beginning of a new era for the Church's commitment to engage with the problem of HIV/AIDS. The consultation forum took a resolution that all Churches had to take up their responsibility to overcome stigma and discrimination within their own structures and community, while continuing to be a voice of moral strength that demanded that communities, nations and wider society respect the rights and dignity of people living with HIV (WCC 2001). As established, the Church has been given a moment of opportunity to rethink its mission and transform its structures in order to become a place of redemption, hope and healing (Haddad, 2005).

3.5.4 MULTIPLE SEXUAL PARTNERS

Having multiple sexual partners influences the spread of HIV/AIDS amongst the community. People who have many sexual partners have an increased risk of acquiring the HIV virus from those partners (Shalina & Suninder, 2004). Commercial sex workers have a particularly high risk because of the large number of different clients they have. Many young women become sexually involved with numerous male friends or clients in exchange for financial support. The prevalence of HIV throughout Africa is consistently higher

among prostitutes compared with the general population. Medscape (2011) found that the prevalence of HIV among sex workers was 75% in Kisumu, 69% in Ndola, 55% in Cotonou, and 34% in Yaoundé while 36% of street prostitutes and 15.3% of prostitutes working as bar hostesses in Djibouti were HIV-infected. The fact that married people travel without their spouses increases their risk for extramarital sex with commercial sex workers, who have much higher rates of HIV infection than the general adult population.

3.5.5 GENDER INEQUALITY

As stated earlier, women are more vulnerable to HIV infection and they are unable in most cases to negotiate safe sex as it is not always favoured by culture. Owing to cultural and religious barriers, they have no right to select their mate and even after death of a husband, the widow will be inherited by a brother or close relatives. In many sub-Saharan African countries, a man's property, including his wife, passes to his adult sons or brothers after his death. The fate of African widows ranges from disinheritance and forceful deprivation of property to the mandatory observance of harmful rituals. One of these traditional rituals is widow inheritance, a practice whereby the widow agrees to marry her husband's younger brother to continue as a member of the family. If a man died of AIDS and had infected his wife or wives as the case may be, the younger brother(s) will automatically become infected. However, a younger brother may be HIV-infected and, upon marrying his deceased brother's wife or wives, will infect her or them. Recounting the lethality and impact of HIV/AIDS especially on women in Sub-Saharan Africa, Lewis, (2004) asserted that "gender inequality is what sustains and nurtures the virus". Lewis, (2004) further stated that, "the saddest thing is that the pandemic increasingly has a woman's face; gender inequality in the face of AIDS is fatal.

3.5.6 WOMEN AND SEXUAL TRANSMITTED DISEASES (STDs)

One of Zambia's major health problems is STDs. According to Ratnam and Meheus (1983) STDs in 1983 constituted between five to ten per cent of all clinic attendances at outpatient clinics. Figures showed in Central Province, a predominantly rural area in Zambia, in 1990 that 17.7% of all adults within that province attended a clinic for treatment of an STD.

(Ebrahim, *et al.*, 1992) reported that at a Lusaka based STD clinic the percentage of women who had a previous STD rose from 17.7% in 1985 to 49% in 1992. Other sexually transmitted diseases are a contributing factor to HIV/AIDS prevalence in Zambia.

3.6 CHURCH IN HEALTH SERVICE RENDERING

Duan, *et al.* (2005) established that throughout history Church organisations played significant roles within the health service delivery environment, developing Church-based health programmes that addressed a broad range of health issues such as alcoholism, breast cancer, cholesterol, care-giving for the aged, and other social issues such as HIV/AIDS. According to WCC (2004) faith-based organisations responded to the specific needs of PLWHA in terms of material support and nutritional programmes and the distribution of food parcels, setting up support groups for faith community members who were living and affected by HIV/AIDS, as well as pastoral care.

There is a strong presumption that the Church, driven by the love of God, can turn the tide and minister empathetically to people living with HIV. According to Kysar (1991) the witness of the Church community to the care of God for the total human welfare, is found in healing and proclamation, in liberation and serving and in caring and providing. The mission of the Church arises from the love God has for creation and the purpose of its mission is to love even as Jesus' life and ministry has been comprised of love.

Consequently, the Church through counselling strategies and HIV/AIDS programmes, has the ability to restore hope to people living with HIV. Many Churches have implemented a wide range of interventions, mainly focusing on interventions and programmes to provide care and support to people living with HIV/AIDS (PLWHA). Dube, as cited by Fredericks (2008:11), states that if the Church takes up the challenge to embody and represent Christ by caring for the sick, the naked, the thirsty, the strangers, it can enable even those who are infected with HIV to die with hope, love and dignity. Furthermore, Fredericks (2008), citing Magezi, calls this type of care a congregational home-based pastoral care which draws on the concepts of "*ubuntu"* and *"koinonia"* (fellowship), which according to the

researcher, is a concept long and widely embraced and practised by the African People who have lived as communities throughout the ages.

'*Ubuntu*' according to Alistair (2011) is used to describe a particular African worldview in which people can only find fulfilment through interacting with other people. Thus is represents a spirit of kinship across both race and creed which unite mankind to a common purpose. Bishop Tutu (2000) would concur when he said "*Ubuntu is very difficult to render into Western language…it is to say, 'My humanity is caught up, is inextricably bound up, in what is yours'…"* The Church is called to be her brother's keeper (Genesis 4:9). Part of the responsibility as Christian Church is to exercise compassion and love for others in tangible ways. The Church should feed the hungry, comfort the sorrowing, and visit the sick. All of God's created images are entitled to respect and to dignity, whether HIV infected or affected.

The poem below by an anonymous Grade11 South African student (2000) reflects the basic Christian teaching that in the midst of pain, suffering and despair, God is able to change the hopeless situation (HIV/AIDS) into one of hope through the power of love.

AIDS
is so limited
It cannot cripple love
It cannot shatter hope
It cannot corrode faith
It cannot take away peace
It cannot kill friendship
It cannot shut out memories
It cannot silence courage
It cannot invade the soul
It cannot reduce eternal life
It cannot quench the spirit
Our greatest enemy is not disease
But despair

Anonymous Grade-11 Student (2000)

The Church is recognized throughout history to be the Body of Christ through which God would demonstrate His love, kindness, care and mercy. According to (Jones, 1980; Kysar, 1991,) the community of God's people is commissioned as God's agents of care for God's creation. The Church by its very nature should be involved in intervention strategies

spiritually, emotionally, mentally and physically in order to save lives. The Church needs to revisit its understanding of its identity and God's mission in as far as the challenge of HIV/AIDS is concerned. The purpose of God's love and justice as revealed through Christ is for the profit of all humanity and the ultimate well-being of all people who are created in God's image (The Bible, Genesis 1:27).

The Church has a central role to play in the fight against HIV/AIDS, it ought to be there for the sick, the dying, the bereaved, the widower, the widow and the orphaned, offering care, hope, courage, friendship, peace, faith and hope in the gospel of Jesus Christ. Kysar (1991:144) states emphatically that the mission of the Church arises from the love God has for creation and the Church is commissioned as God's agents of care for persons. It is from such understanding that the Church should mitigate the impacts of HIV/AIDS acknowledging that God has placed on the shoulders of civil society organisations a burden to care; in particular Churches which are an important part of community to, inspire by their religious beliefs; instil fear and values through teachings, faith and serve the community.

3.6.1 CHURCH IN ADDRESSING SAFETY, IDENTITY AND MORALITY

Van Dijk (2007:314) in terms of vulnerability differentiates between "*Morality"* and *"spiritual safety"* in which the former refers to moral guidance and the latter to ways of addressing vulnerability against stigma, suffering and social insecurity. Furthermore, Van Dijk (2007) regards the role of the Church in addressing safety, identity and morality as enhancing people's *"capacity to effectuate change in social situations"* it is of the researchers opinion therefore, that the Churches' strong areas of influence includes guiding people directly on issues of morality, Christian identity, the spiritual bases of disease, rules of family life and sexual activity. Maluleke (cited by Dumezweni 2004:14) strongly believes that the Church should be at the cutting edge to make a difference in mitigating the impact of HIV/AIDS.

Churches are respectable if those living with HIV/AIDS are stigmatised or discriminated against by society. The Churches can and should give a voice to the voiceless. The Church

should be deeply involved in care and support as well as being able to articulate needs. This means according to WCC (2004) that the Churches have a duty to use their positions of influence to advocate with government and donors on access to treatment, including treatment for opportunistic infections and antiretroviral therapy.

3.7 CONCLUSION

In this chapter, the disaster management continuum (DMC) model and the 1999 Sustainable Livelihood model in which the concept of sustainable livelihood was explained as well as the multiple impacts of HIV/AIDS on all people. From the literature on the impact on global level, impact on Africa, direct and indirect impacts, and impact on the business sector, impact on orphans, impact on the elderly and impact on governance it is clear that HIV/AIDS has considerable negative impacts on the population and some sectoral economic activities. HIV/AIDS has direct and negative effects on households' production and exchange entitlements by decreasing the quantity, quality, and income earning activities. This study's review of existing literature highlights the diversity of ways in which HIV/AIDS affects livelihoods as well as the devastating ways in which households are impacted and how they respond to the epidemic. To mitigate the HIV/AIDS impact on the poor as indicated in our literature review, calls for good governance and workable policies that benefit the poor.

CHAPTER FOUR

RESEARCH METHODOLOGY

4.1 INTRODUCTION

This chapter focuses on field research. The methodology used in this study will be described as well as the rationale for the study design. In conclusion, the ethical considerations regarding the study are explained.

4.2 THE RESEARCH DESIGN

The research design is a set of guidelines and instructions to be followed in conducting the research. Babbie and Mouton (2001) point out that, "*qualitative researchers attempt always to study human action from the perspective of the social actors themselves. The primary goal of studies using this approach is defined as 'describing and understanding' rather than 'explaining' human behaviour"*. To address and achieve the research objectives as stated in the first chapter, this study will investigate and analyse the life situation of the respondents in Circle of Hope Clinic (CoH) in Lusaka, Zambia using the qualitative method. One of the major distinguishing characteristics of a qualitative research method is that the researcher attempts to understand people in terms of their experience, understanding and how they perceive issues that cannot be obtained in a quantitative research method (De Vos, Strydom, Fouche & Delport, 2002). 46 participants from CoH were used in this research. The researcher preferred qualitative design because it offered the researcher the opportunity to focus on finding answers to the questions centred on the impact of the Church and disaster management.

The researcher employed qualitative approach primarily because it was more likely to present a true picture of people's experiences, attitudes and beliefs. In this regard interviews were conducted in order to extract simple factual information from the interviewees. Face to face interviews were conducted using open-ended questions with the aid of an interview

guide. The purpose of using an interview guide was to collect comprehensive and relatable information.

4.3 DELIMITATION OF THE OBSERVATION

The participants in this study were drawn from AOG HIV/AIDS project in Lusaka, Zambia. The researcher made a conscious decision to gather data from beneficiaries rather than from the programme coordinators of the centre. Four reasons informed this decision:

- Firstly, beneficiaries are directly involved with the programme and therefore tend to know about their own needs, and how the programme impacts their lives rather than the coordinators.
- Secondly, due to their daily/weekly routine of clinic attendance, these individuals have developed a strong relationship and trust amongst themselves and with other people infected with HIV and affected by HIV/AIDS within and outside the centre.
- Thirdly it is the researcher's opinion that beneficiaries are well placed to provide answers to the characteristics, problems and potential of Church-driven HIV/AIDS programmes without being biased.
- Fourthly, the focus of the study was on how the people directly involved in the programme, perceived the role of the Church in disaster management (HIV/AIDS).

4.4 THE STUDY SITE

The study site where respondents were interviewed was (CoH) situated in Lusaka, Zambia. Permission to conduct the study at the centre was sought and granted by the programme director and the leadership in charge of the centre.

4.5 METHOD USED TO COLLECT DATA

Monette, *et al.* (2005:89), asserted that one of the aspects of refining a research problem is to decide whether to use one or two broad strategies towards research, namely qualitative or quantitative research. Like quantitative methods, qualitative methods are empirical and

systemic (Padgett, 1998:17). The study employed qualitative methods. Such methods are better suited to gather information on values, attitudes, and beliefs of any study population. The researcher's choice of a qualitative method was based on the objectives of the study, which was a contributing factor of data collection during the course of fieldwork. The primary data collected by the researcher from the field of work especially came from the interviews that were conducted amongst the CoH clinic clients. The secondary data was collected by reviewing of literature such as journals, books, newspapers and press statements.

The researcher will explore the concept of HIV/AIDS disclosure and relationships and the role of the Church, and will subsequently figure out what can be the Church's response to the challenges of HIV/AIDS. Instead of engaging with clients just to achieve treatment goals, I became listener seeking knowledge and understanding, playing a role as a participant observer. Question construction that did not bias the interviewee were drawn and shared with the clients.

4.5.1 SAMPLING THE PROGRAMME BENEFICIARIES

As earlier stated, to recruit and sample beneficiaries as respondents, the study relied on the help and cooperation of the programme director and caregivers who announced the study and its aims and scope to the programme recipients (beneficiaries), and requested they attend to the researcher for the duration of two weeks and three days that the field work lasted. Getting the beneficiaries together was not as difficult as was anticipated. However, some days proved problematic due to heavy rainfalls over a period of data gathering. With the assistance of the programme director, the research that was undertaken with a sample of 46 respondents was drawn from different CoH respondents. The researcher acknowledged the importance of interviewing the CoH respondents in order to have a holistic awareness and understanding of how the AOG Church is involved in HIV/AIDS management, and to understand the impact of the programme on the Lusaka community. It is the researcher's opinion that the sample as guided by the programme director was fairly representative of the HIV/AIDS beneficiaries' population and would provide a collective voice of the clientele in CoH in Lusaka.

4.5.2 THE QUESTIONNAIRE

A structured questionnaire was developed based on the objectives of the study (see Appendix 2). The questionnaire comprised four main sections, each of which dealt with a specific area related to the objectives of the study. The questionnaire included both open-ended and closed questions. The four question areas culminated in the development of the following sections:

Section A: *Demographic information of the respondents***:** in this section the study sought to obtain information on the background characteristics of the respondents, for example gender, age group and educational level which the researcher believed might have relevance to this study.

Section B: *Status disclosure and relationships:* the researcher sought to find if respondents knew their HIV statuses and to whom they would prefer to disclose their status. The researcher wanted to know what the respondents feared most about their status, for example being blamed by the partner or being the target of HIV-related stigma and so on.

Section C: *The role of the Church in HIV/AIDS mitigation:* the researcher wanted to find out about the respondents' perceptions of the role that the Church ought to play in mitigating HIV/AIDS issues.

Section D: *Circle of Hope social support and its impact:* in this section the researcher wanted to establish and determine how long the respondents had been involved in the Church-based HIV/AIDS programme and its impact on the respondents lives. Finally the researcher wanted to obtain more information on what changes or improvements the respondents thought could enhance the programme.

4.6 DATA CAPTURING AND INTERPRETATION

The completed questionnaires were checked thoroughly by the researcher. No questionnaire was discarded as all of the 46 were sufficiently completed to be incorporated in the analysis. The completed questionnaires were coded, and the codes captured on the computer. The data was captured and analysed using the Statistical Programme for Social Scientists (SPSS, version 16), and tabulated by the researcher for the report writing.

A system of univariate analysis as described by De Vos (1998) was used to reduce and sort the collected data. The analysis was concerned with the description or summarization of individual variables in a given data set. Babbie and Mutton (2004) describe univariate as the examination of cases on only one variable at a time. In the next chapter, the researcher will systematically review the data, and find what important factors emerge, and then share the findings. The goal of the study was to examine the role of the AOG in the management of HIV/AIDS disaster in Lusaka Zambia.

The researcher heeded the advice of Richard and Morse (2007:171) that phenomenological data analysis was a process of reading, reflection and writing and rewriting that enabled the researcher to transform the lived experiences of the interviewees. Huberman (cited by Richard & Morse 2007: 47) listed six analytical strategies that were used in different ways in different methods in qualitative research, namely:

- Meeting and coding data as data records were created.
- Recording and reflections and insights.
- Sorting and sifting through the data to identify similar phrases, relationships, patterns, themes, distinguishing features and common sequences.
- Seeking patterns or processes, commonalities and differences and extracting them for subsequent analysis.
- Gradually elaborating a small set of generalisations that covered the consistencies discerned in the database.

- Confronting these generalisations with a formalized body of knowledge in the form of constructs or theories.

4.7 ETHICAL CONSIDERATIONS

According to Strydom (2002:63), ethics are defined as a set of moral principles that are suggested by an individual or group, are subsequently widely accepted, and offer rules and behavioural expectations about the most correct conduct towards experimental subjects and respondents, employers, sponsors, other researchers, assistants and students. This ethical principles were considered and adhered to in this study. Ethical issues were observed in all aspects of the research. The researcher was reminded by Smith (1988:283), that the integrity of research, whether scientific or humanistic, refers to the extent to which researchers adhere to the standards or rules of scientific research. The standards of conducting research include appropriate methods of collecting and analysing data and generally agreed upon ethical guidelines for collecting, analysing and publicizing research.

Ethical considerations for this study included gaining permission from the programme director and coordinators of the CoH to conduct a study at their institution and were assured that they would be given feedback on the findings of the research after completion. The aim of the study was explained to the participants. Prior to the interview, participants were informed that participation was voluntary, and that they had the right to withdraw from the study at any time, should they feel like doing so. The reason was because HIV/AIDS is a sensitive issue. The required consent letter developed for the research contained information explaining the participants' right to anonymity and confidentiality (see Appendix 1).

4.8 CONCLUSION

This chapter focused on methodology, choice for qualitative research method of the study, followed by the description and explanation of the techniques for gathering data and strategy for data analysis. Finally, attention was paid as to how the requirements for correct

ethical procedure were complied. In the next chapter the researcher presents and discusses the findings based on the interviews of the study.

CHAPTER FIVE

PRESENTATION AND DISCUSSION OF FINDINGS

5.1 INTRODUCTION

This section details the analysis of data following the discussion of the research findings. The findings relate to the research questions that guided the study. Data were analyzed to examine, describe and explore the role of the AOG in the management of the HIV/AIDS disaster in Lusaka Zambia. Data were obtained from questionnaires, completed by 46 respondents. A total of 46 questionnaires were administered and all questionnaires were usable for this study. As indicated earlier, all the respondents complied and completed the questionnaire as they were readily available to share in the contribution of the Church towards HIV/AIDS mitigation. The questionnaire comprised of four sections and data generated will be presented as follows:

- The first section deals with demographic and background information of the respondents by looking at gender, age, qualifications, occupation and marriage status.
- The second section comprises of data describing status disclosure and relationships.
- In the third section data obtained from analysis of the role of the Church in HIV/AIDS mitigation will be examined.
- The fourth section deals with the programmes of CoH for example, social support and its impact in the lives of the respondents.

5.2. POPULATION OF THE STUDY

As shown in Table 5.1, there were 46 respondents. The table illustrates the distribution of the survey questionnaire respondents according to gender. (67%) of the respondents were females, while 33% were males. The fact that there were more women in the sample than men is not by design; and these gender imbalances indicate that females are more

vulnerable and exposed to the pandemic (HIV/AIDS) as they are unable, to negotiate safer sexual relationships due to factors such as cultural expectations or economic dependence (Iipinge, *et al.*, 2004). As indicated by NHASF (2004-2010), the prevalence is significantly higher among women compared to men especially below the age of 35.

5.2.1 DEMOGRAPHIC DATA

In this section, background information of the respondents is presented and analysed in order to show the distribution of the respondents by their gender, age group, educational level, occupation and marital status.

TABLE 5.1: GENDER DISTRIBUTION

		Frequency	Per cent	Valid per cent	Cumulative
Valid 1	**Female**	**31**	**67.4**	**67.4**	**67.4**
2	**Male**	**15**	**32.6**	**32.6**	**100**
Total		**46**	**100**	**100**	

5.2.2 AGE OF RESPONDENTS

Participants were asked to indicate the age category appropriate to them as seen in Table 5.2 below. All 46 (100%) participants responded to the questionnaire.

TABLE 5.2: RESPONDENTS BY AGE

	Frequency	Per Cent	Valid per cent	Cumulative
Age group				
Below 20	**4**	**8.7**	**8.7**	**8.7**
21 – 25	**2**	**4.3**	**4.3**	**13.0**
26 – 30	**9**	**19.6**	**19.6**	**32.6**
31 – 35	**12**	**26.1**	**26.1**	**58.7**
36 – 40	**8**	**17.4**	**17.4**	**76.1**
41 – 45	**5**	**10.9**	**10.9**	**87.0**
46 – 50	**3**	**6.5**	**6.5**	**93.5**
51 – 55	**2**	**4.3**	**4.3**	**97.8**
56+	**1**	**2.2**	**2.2**	**100**
Total	**46**	**100**	**100**	

(26.1%) of the respondents were in the 31-35 age categories. This is the prime age, more active and productive according to UNICEF, *et al.*, (2004). This scenario of young HIV/AIDS victims calls for an effective HIV/AIDS mitigation programme from all

stakeholders in order to minimize the spread and devastation of the pandemic. This alarming statistics again calls for an effective HIV/AIDS evaluation programme to assist, stabilise and integrate the respondents into the society again, as their age denotes some energy and desire to achieve more in life.

One reasonable explanation for the relatively young respondents being vulnerable could be attributed to the high levels of social and economic vulnerability, inadequate access to life skills and information, low levels of negotiation skills, and unequal protection under statutory and customary laws and traditions (NHASF, 2006-2010). It could also be attributed to the fact that the respondents are filled with anxiety, which may be influenced by the weight of their personal responsibilities, for example being young parents and as a result want to make ends meet by involving in activities that promotes the spread of HIV.

In this study the connection between age and those who are infected with HIV/AIDS was statistically significant (98%) as shown in (Figure 5.1). It indicated that the pandemic had a negative impact on all spheres as noted in Chapter 3 of this study; impact at the global level, direct and indirect impacts, on business sector, on orphans, the elderly and on governance. These findings signify negative impact.

5.2.3 DISTRIBUTION OF RESPONDENTS BY EDUCATIONAL LEVEL

In the 46 respondents that were interviewed it is observable that more of the respondents (59%) have secondary education as shown in Table 5.3, (26%) have some form of tertiary education while (11%) had only primary schooling experience. (2%) of the respondents lacked any form of schooling whatsoever another (2%) dropped out of school.

TABLE 5.3: LEVEL OF EDUCATION OF RESPONDENTS

		Frequency	Per cent	Valid per cent	Cumulative
Valid	1 No Schooling	**1**	**2.2**	**2.2**	**2.2**
	2 Primary or below	**5**	**10.9**	**10.9**	**13.0**
	3 Secondary School	**27**	**58.7**	**58.7**	**71.7**
	4 Tertiary	**1**	**2.2**	**2.2**	**73.9**
	5 Other specify	**12**	**26.1**	**26.1**	**100**
	Total	**46**	**100**	**100**	

5.2.4 OCCUPATIONAL DISTRIBUTION

Table 5.4 presents (30.4%) respondents as self-employed. In their explanation, they stated that they did some business on a small scale, for example street-side trading. Among the respondents (30.4%) were unemployed and some pensioners while (21.7%) of them were civil servants. As cited by Mbirimtengerenji, (2007) HIV infection is mostly confined to the poorest who constitute most of those infected in Africa. It is of the opinion of the researcher that, it is not that information, education and counselling activities relating to HIV/AIDS are not likely to reach the poor, but that such messages are often irrelevant given the reality of their livelihood experience. Poverty is a critical factor in the spread of HIV/AIDS, unemployment can exacerbated the spread.

TABLE 5.4: RESPONDENTS OCCUPATION

	Frequency	Per cent	Valid per cent	Cumulative
Valid 1 Student	**5**	**10.9**	**10.9**	**10.9**
2 Farmer	**1**	**2.2**	**2.2**	**13.0**
3 Merchant	**2**	**4.3**	**4.3**	**17.4**
4 Civil servant	**10**	**21.7**	**21.7**	**39.1**
5 Self-employment	**14**	**30.4**	**30.4**	**69.6**
6 Other specify	**14**	**30.4**	**30.4**	**100**
Total	**46**	**100**	**100**	

5.2.5 MARITAL STATUS

The findings indicate that the majority of the respondents, (41.3%) as shown in Table 5.5 below were married and still living together at the time when the interviews were conducted. Seven participants (15.2%) were single, another 15.2% of the respondents were in relationships and 19.6% were divorced while 8.7% were widowed.

TABLE 5.5: RESPONDENTS MARITAL STATUS

	Frequency	Per cent	Valid per cent	Cumulative
Valid 1 Single	**7**	**15.2**	**15.2**	**15.2**
2 Married	**19**	**41.3**	**41.3**	**56.5**
3 Divorced	**9**	**19.6**	**19.6**	**76.1**
5 Widowed	**4**	**8.7**	**8.7**	**84.8**
6 In relationship	**7**	**15.2**	**15.2**	**100**
Total	**46**	**100**	**100**	

Marriage is regarded as a sacred moment of celebration and a landmark in adult life (Mbirimtengerenji, 2007). Unfortunately, the practice is not the same when one, a woman in particular is a victim of HIV/AIDS in the family. Sometimes young married girls are exposed to torture, abuse and the risk of the deadly HIV/AIDS infection. In Africa, polygamy is a social practice used to ensure the continued status and survival of widows and orphans within family status and this has been cited as one of the key drivers of the AIDS pandemic (Rose-Innes, 2006; Medscape, 2011). WCC (2003) indicate that husbands often treat their wives as if they are *"owned*" because the man had paid lobola to marry her.

Women living with HIV/AIDS may be treated very differently from men in some cultures; this is common where they are culturally, economically and socially disadvantaged. The fact that the majority of the respondents (41.3%) are married, chances are high that HIV/AIDS can easily spread. It is therefore important that married couples should be expected to embrace fidelity, which might decrease the spread of HIV/AIDS within the community. An observation made from the findings of this study is that, the majority of the respondents who were married were men and those divorced were women. This then is the assumption that when women are found to be HIV positive, they are divorced. Simultaneously one may conclude that men who are found HIV positive receive unwavering support from their spouses.

5.3 KNOWLEDGE OF STATUS AND DISCLOSURE

In this section, the researcher sought to determine whether respondents attached to the CoH programme knew their own status. Figure 5.1 shows that (98%) of all the respondents and

beneficiaries indicated that they had been tested for HIV and knew their HIV status. Only one person (2%) stated otherwise.

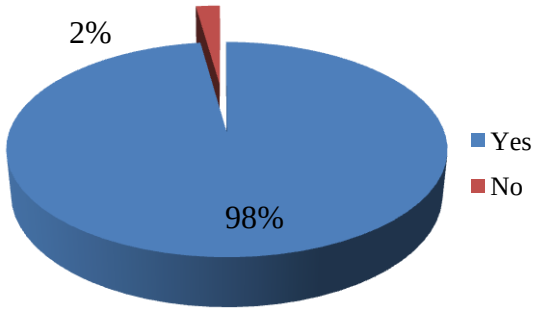


Figure 5.1: Knowledge of HIV status

The respondents were asked to respond to a list of common fears that they might have which could influence them; the results are shown in Figure 5.2 below. The entry that received the smallest portion of "don't know" responses was the one that asked whether those respondents feared being left by their partner (2.2%) stated don't know. Of the respondents indicated that they "don't know" (4.3%), of the respondents indicated that they "don't know" for fear of being blamed for infection by their partner, and another (4.3%) indicated "don't know" for being discriminated against. The other 10.9% of respondents "don't know" because they feared being disowned by families or being the target of HIV-related stigma and losing their jobs.

The entry that received the largest portion of what the respondents feared most was the one that asked the respondents whether they were afraid of being the target of HIV-related stigma. The respondents (60.9%) indicated "yes" they feared being stigmatised. The study found that respondents felt that the fear of stigma and discrimination in the Church community prevented people from seeking help or joining support groups that would have provided safety. Most often it prevented people from seeking treatment for HIV/AIDS. There were those (56.5%) who feared being left by their partner, (54.3%) feared being discriminated against, while (50%) feared being blamed for infection by partner, another (50%) feared being disowned by families. Finally (32.6%) respondents feared losing their jobs. It consequently seems clear that fear of stigma and discrimination is still a big

problem for many people in Lusaka, and that the Church still has to work hard to address these negative attitudes. Although there were respondents who indicated "I don't care attitude" like one of the respondent stated, "After all I am positive stigma or being blamed will not change my status". When asked if they feared being left by their partners, (41.3%) respondents stated "no". Another revelation was that of being discriminated against and (41.3%) said "no".

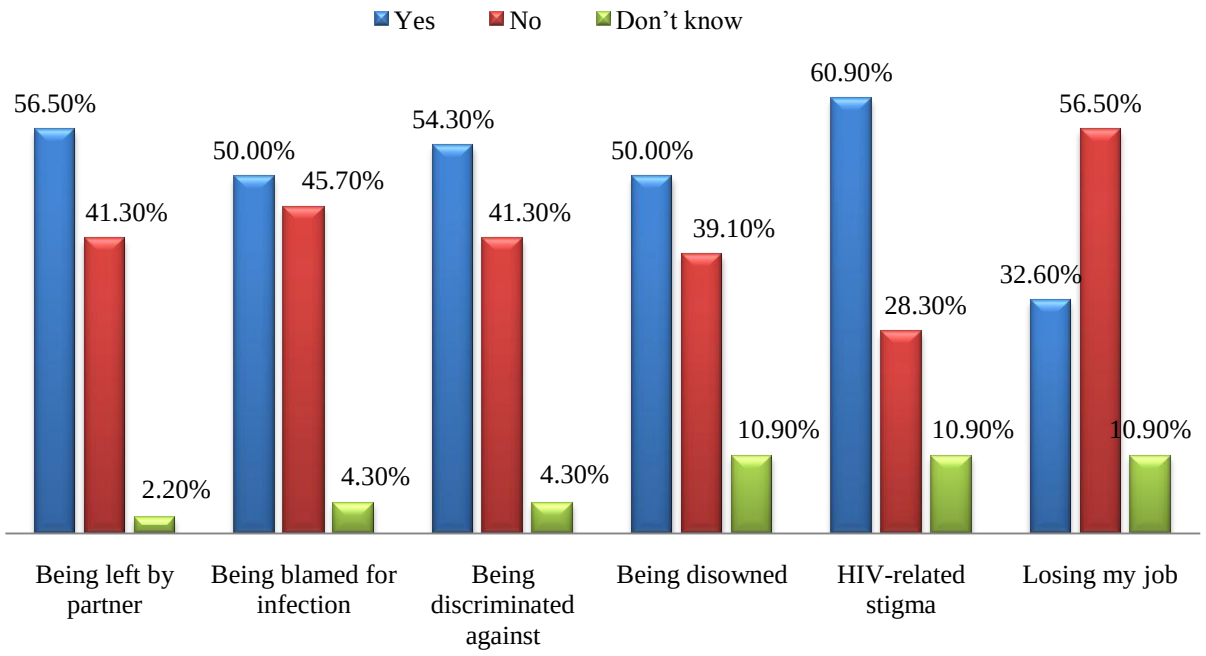


Figure 5.2: Perceptions of possible consequences of HIV positive respondents

Of the respondents (45.7%) indicated that they did not fear being blamed for infection by their partners, while (28.3%) respondents said they did not fear being the target of HIV-related stigma. In addition, (56.5%) of the respondents who knew their status had nothing to fear in terms of losing their jobs. The entry that received the largest portion of "yes" responses in Figure 5.2 above was (60.9%) the fear that individuals would be the target of HIV-related stigmatisation. The entry that received the largest portion of "no" responses was the one that asked whether the respondents feared losing their jobs; (56.5%) responded "no".

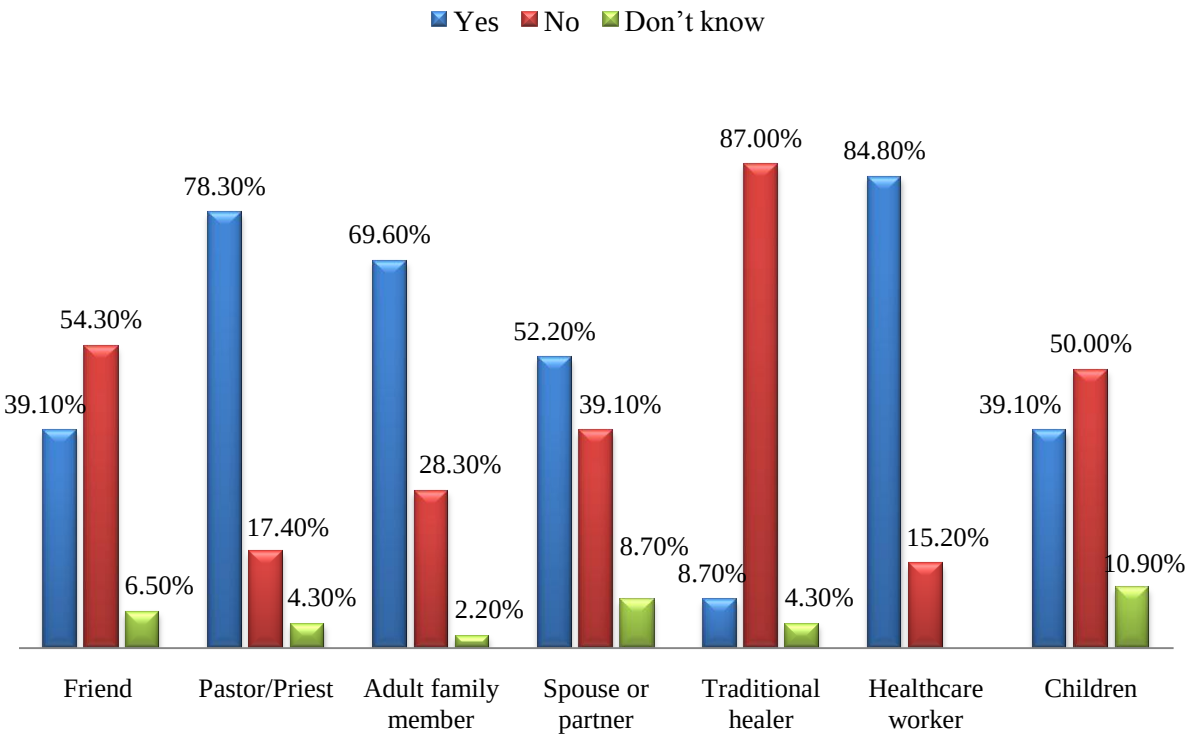


Figure 5.3: People to whom respondents would disclose their HIV status

Figure 5.3 shows the results of the question entry which sought to discover from the respondents "who they consider disclosing their status to". The highest proportion of affirmative answers to whom they would disclose their status, were health care workers (84.8%) and the priest (78.3%). Some of the main reasons mentioned by most respondents as to why people should reveal their status to the pastor or priest were that a priest would provide spiritual and psychological support. Surprisingly (39.1%) of the respondents would not tell their spouses, at the same time (50%) respondents said they would not disclose their status to their children either. Such attitude is dangerous as non-disclosure to a partner or spouse could jeopardise their lives and expose them to the risk of infection. This again is another factor that influences the spread of HIV/AIDS in Lusaka. Non-disclosure has many implications, and in particular for the relationship between spouses. Respondents, (69.6%) admitted that they would disclose their status to an adult family member; spouse or partner (52.2%), to a traditional healer (87%) of the respondents said "no". From the above illustration the conclusion is that the Church has some level of influence over the communities in which they are located.

5.4 PERCEPTIONS OF ROLE OF CHURCH

For many years, HIV/AIDS were seen as the problem of people living outside the Church. However, Churches now have to accept that HIV/AIDS is present among Church members. Four question entries tested the views of the respondents regarding what they thought to be the role of the Church in addressing and mitigating HIV/AIDS (see Appendix 2). The first was whether they thought that the Church had a role to play in HIV/AIDS mitigation whatsoever; the second entry was to investigate among those respondents who felt that the Church had a role to play, what they thought the role should be; the third entry was to explore among those who felt that the Church had no role in this regard, why they felt that way; and the fourth was to probe the understanding of those who felt the Church had a role to play why the Church should be involved in HIV/AIDS mitigation. The responses to these questions are shown below in Figure 5.4 and Table 5.6.

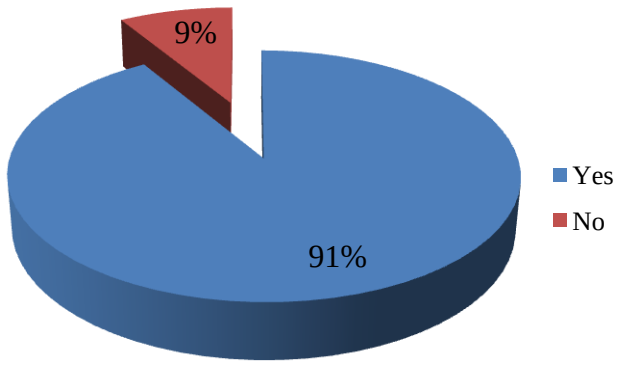


Figure 5.4: Whether the respondents think the Church has a role to play in HIV mitigation

As illustrated in Figure 5.4 (above), the majority of the respondents (91%) felt strongly that the Church had a role to play while (9%) of the beneficiaries felt that the Church had no role to play in this respect. Possible reason for this might be that the beneficiaries felt that the Church was to mind spiritual issues, as one of the beneficiaries indicated "the Church is supposed to be where people go to serve and worship God not a place where they are burdened with 'sin' like HIV/AIDS issues. Another reason might be the possibility that beneficiaries felt the Church could not provide a cure for HIV. It might be possible that beneficiaries did not have information on what the Church could do or had done regarding

the issues of HIV/AIDS. Furthermore, there might be a possibility that beneficiaries who believed the Church should be involved in addressing and mitigating HIV/AIDS, felt that the Church was a community where people still had regard and respect for the priest and what was preached.

This substantiates the argument that religious leaders are in the unique position of being able to alter the course of the pandemic as stated by UNICEF (2003b:9). When they speak, their followers will religiously listen and follow them. Pastors and Church leaders have a ready audience - their Church members who are eager to hear their leaders tell them what to do.

TABLE 5.6: RESPONDENTS' VIEWS ON ROLE OF THE CHURCH

	%
Spirituality i.e. prayer and teachings	40.7%
Speak out about sex / abstinence	15.6%
Create awareness among members and community	10.4%
Financial assistance	8.3%
HIV/AIDS support programmes	5.1%
Embrace people living with HIV/AIDS without discrimination	4.2%
Encourage testing before marriage	2.7%
Network with other social groups	2.1%
Bring back moral standard through preaching	2.2%
None	8.7%
Total	**100%**

As depicted in Table 5.6 above, among the (91%) as seen in Figure 5.4 respondents who felt that the Church had a role to play, the majority of the respondents (40.7%) listed the spiritual responsibility of the Church to pray for people living with HIV, teaching, sharing and giving spiritual support. The respondents affirmed that prayer had a way of conditioning the heart to have peace, with great upliftment. Furthermore, respondents indicated that the power of prayer was something nobody should doubt. One of the respondents nodding his head when he indicated that prayer should be part of the measure used by the Church said, "There is power in prayer".

The impact of HIV/AIDS cannot be underscored, it has devastated the population and we cannot afford to ignore the physical, emotional and spiritual needs. Of the respondents (15.6%) believed the Church had to speak boldly about sex and the reality of HIV/AIDS within us; (10.4%) respondents stated that the Church should create awareness through HIV/AIDS programmes to sensitize the people, (8.3%) of the respondents indicated that giving of financial/material support would bring the establishment to those living with HIV/AIDS. There was (5.1%) in support of HIV/AIDS support programmes, and (4.2%) stated that the Church should embrace people living with HIV/AIDS and show them love. Those were the topmost priority areas expressed by respondents who believed the Church could play a fundamental role in HIV/AIDS mitigation.

5.5 UNDERSTANDING CHURCH INVOLVEMENT

In terms of the respondents' understanding why the Church should be involved in HIV/AIDS mitigation, (91%) of the respondents felt that for a long time the Church had a misconception and stood against HIV/AIDS epidemic rather than be involved in prevention and control. Nevertheless, AIDS impact has affected many of Church members directly or indirectly at all levels. The respondents felt that HIV/AIDS was living within the four walls of the Church; the priest was affected, elders and member were all affected.

The Church could prevent and control the spread of HIV/AIDS as cited earlier; the Church has opportunities to creating awareness amongst the people about the overall nature of HIV/AIDS. Respondents felt that the Church could mobilise and educate members and communities to develop networks to support people with HIV/AIDS. Daily Church pastoral services should include HIV/AIDS education and should be one of the components of a Church programme; the Church can take a strong advocacy on AIDS victims. Respondents felt the Church had the answer to HIV/AIDS reduction. Some, nine percent of the respondents felt that the Church was a holy place of service and worship to God therefore the Church should not be involved in HIV/AIDS intervention, as it was considered to be exacerbated through licentiousness and the sin of immorality.

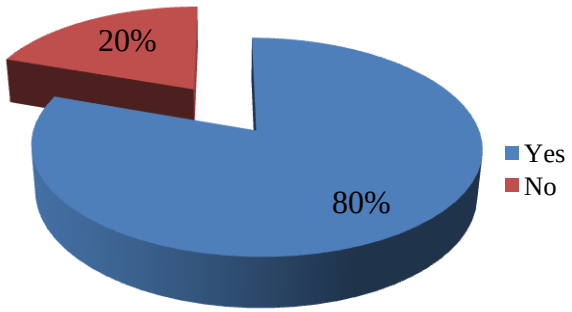


Figure 5.5; Respondents living on CoH Programme

5.6 PERCEPTIONS OF SUPPORT AND IMPACT OF PROGRAMMES

The study showed that (80%) of the respondents were direct beneficiaries of the programme, and (20%) of the respondents represented those who benefited indirectly from the programme by bringing their family member(s) to the CoH for treatment. Some of the respondents had been involved in the CoH programme for ten years or less as shown in (Figure 5.6) below. A significant finding was that (41.3%) of all the respondents had been on the programme for up to one year. Another substantial finding was that (39.1%) of the respondents had been on the programme for four years or less. All of these findings substantiate the argument that the Church is involved in disaster management. There are indications that some of the respondents have been on the programme for ten years and more.

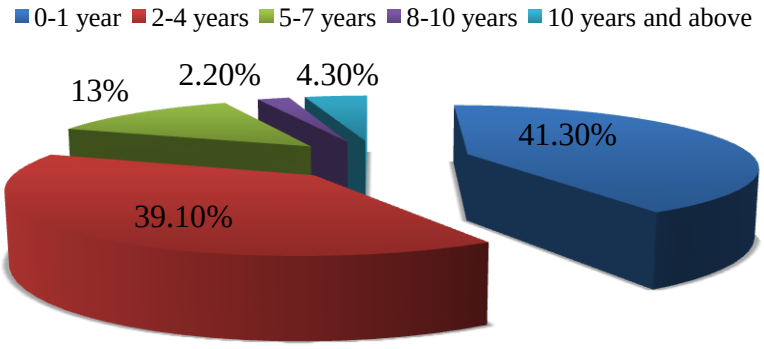


Figure 5.6: Time spent in the CoH programme

When confronted with the question as to what extent the programme provided space of expressing and sharing in HIV/AIDS matters, (83%) of the respondents indicated that they were given enough room to express themselves. However, (17%) of the respondents suggested that they were given limited space to express and share in HIV/AIDS matters as shown in Figure 5.7 below.

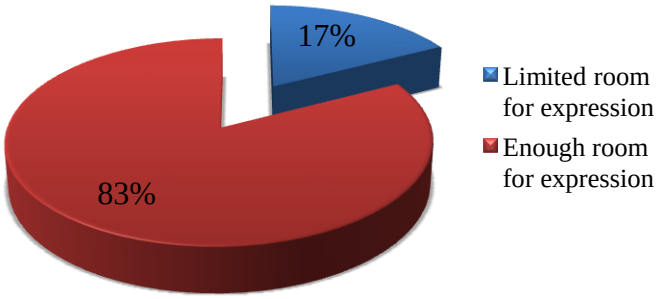


Figure 5.7: Opportunity given to participate in sharing on HIV matters

Furthermore, the respondents were asked whether expressing and sharing in the matters of HIV/AIDS had helped them to address the challenges they faced as a result of their status, and (50%) of the respondents felt that sharing and expressing themselves within the community of CoH regarding HIV matters, had given them the courage they needed to help others and to be positive about life in general. Others, (28%), felt that sharing had made them to be positive in life, while (20%) of the respondents felt strongly that participating in sharing helped them to help others with similar problems. However, two per cent indicated that lack of expression had made her withdrawn.

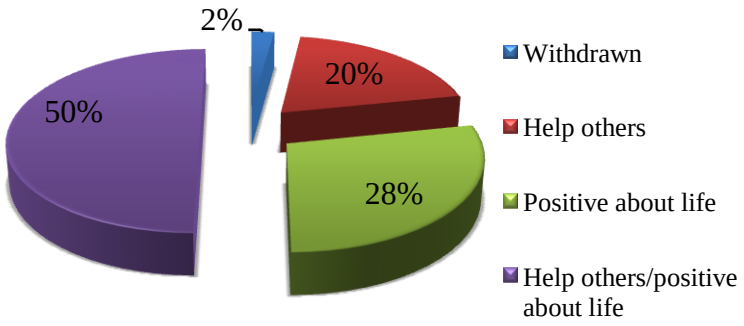


Figure 5.8: Addressing challenges on HIV matters

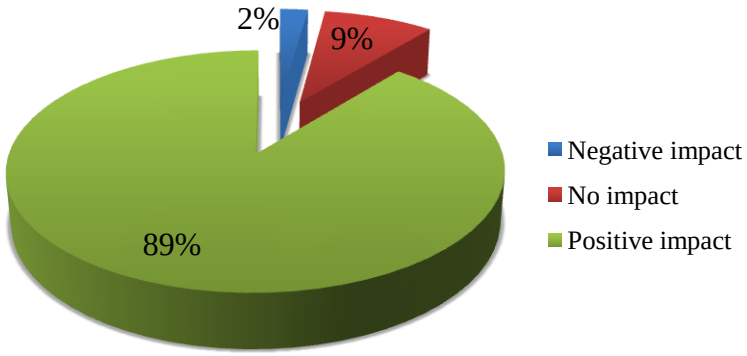


Figure 5.9: Respondents' perception and programme impact rating

Respondents were asked to evaluate the impact that the CoH HIV/AIDS programme had on them. As shown in Figure 5.9 above, the majority of the respondents (89%) indicated that the programme had had a positive impact on their lives. Respondents were further asked to elaborate on their perception of the impact of the CoH HIV/AIDS programme on their lives as it was not enough for the researcher to accept the positive impact without probing to justify as to why they felt that way. Because most of the respondents indicated that the programme had a positive impact on their lives, only the reasons put forward by these respondents will be discussed.

The responses given by the respondents recorded clothes, food and material support as the main reason why they felt positive about the CoH programme's impact on their lives. Respondents were asked to reveal whether the CoH programme offered services such as food parcels, counselling, shelter and voluntary testing and antiretroviral therapy. The responses were quite amazing as respondents testified to the many provisions made available to them. The responses to these entries are shown in (Figure 5.10) below.

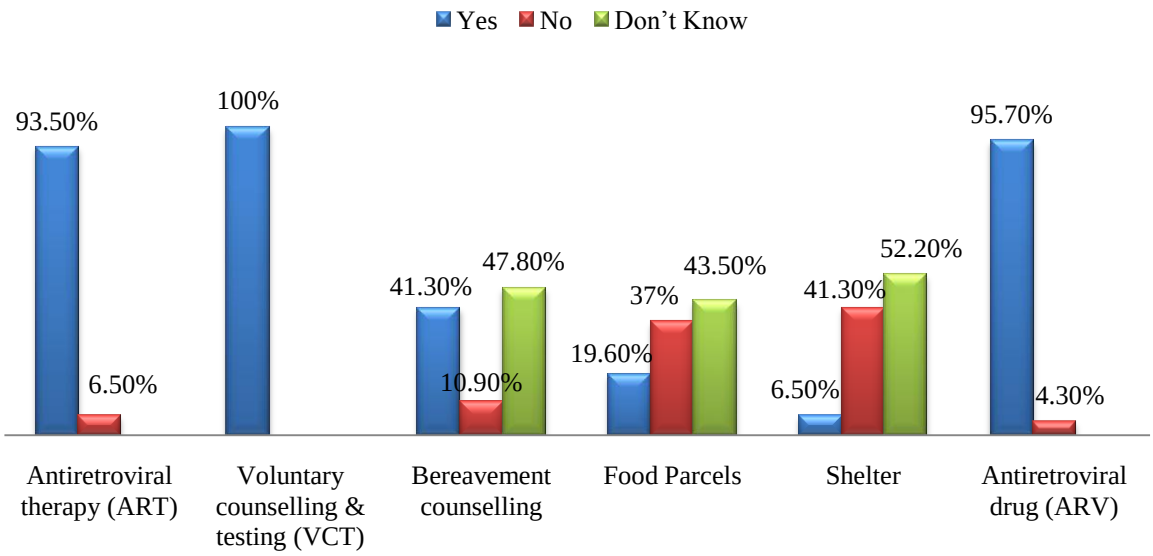


Figure 5.10: Types of services offered by CoH programme

Responding to the services provided by the CoH, (93.5%) respondents affirmed that the centre provided antiretroviral therapy, while (6.5%) stated that they "don't know" if they provided such services. To the researcher's amazement, an overwhelming (100%) of the respondents indicated that the centre made provision for voluntary counselling and testing (VCT) as that was said to be among the first issues the CoH centre dealt with. In terms of bereavement counselling, (47.8%) respondents indicated "don't know" if such services were given, although (41.3%) of the beneficiaries affirmed that they had benefited from such services. The entry that received the largest proportion of "don't know" responses was the one that asked whether those respondents were aware of the CoH provision of shelter. The respondents (52.2%) of them indicated "don't know", however, (41.3%) indicated affirmatively. There were (19.6%) who confirmed that food parcels were part of what CoH provided, (37%) of the respondents stated otherwise while (43.5%) of the respondents indicated "don't know".

5.7 SERVICES RESPONDENTS BENEFITED FROM

In this study the researcher wanted to discover which of the CoH programme services respondents felt they benefited from. The responses to these questions are illustrated in Figure 5.11. More than half of the respondents (78.3%) established that they benefited from

the antiretroviral therapy (ART) provided by the centre. Another (82.6%) indicated that they benefited from voluntary counselling and testing (VCT), and an overwhelmingly, (82.6%) respondents indicated that they benefited from the provision of the antiretroviral drug (ARV). Regrettably, the CoH centre seemed not to be doing well enough in other vital aspects of the respondents' lives in terms of bereavement counselling, food parcels and shelter provision. As indicated in Figure 5.11, (67.4%) respondents stated that they did not benefit from the provision of bereavement counselling. Another shocking number was when asked whether the respondents benefited from food parcels, (80.4%) of the respondents indicated negative, and again another (84.8%) respondents indicated that they did not benefit from shelter provision.

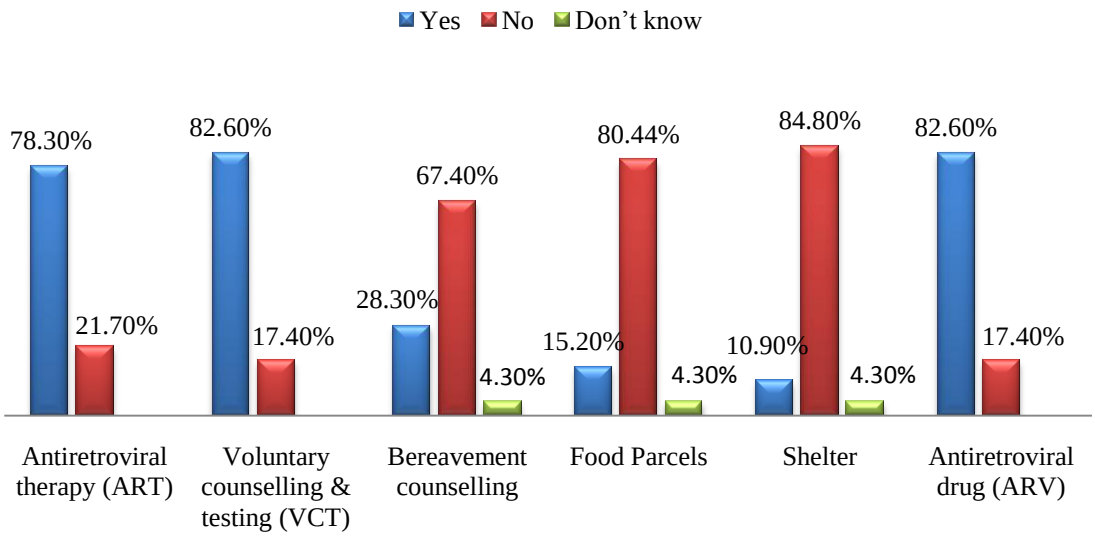


Figure 5.11: Reactions to the question "which of these services do you benefit from at CoH

The above responses in figure 5.11 shows that smaller proportions of respondents indicated that they accessed bereavement counselling, food parcels and shelter through the CoH centre programme. Only (28.3%) of the respondents benefited from bereavement counselling. The responses in terms of food parcels indicated that (15.2%) of the beneficiaries accessed this type of services. Only (10.9%) of the respondents accessed shelter. In terms of the findings, the support and provision of ARV, ART and VCT offered by the CoH programme was accessed by considerable proportions of the respondents, while other services such as shelter, food parcels and bereavement counselling were not readily available.

5.8 RESPONSES WHETHER CIRCLE OF HOPE DOING ENOUGH

Question 46 in the questionnaire sought to determine if CoH was doing enough to empower the respondents. Respondents were presented with a three in one question that addressed their mental, emotional and spiritual empowerment by the CoH programme, and respondents were asked to elaborate on their given answers. Of the respondents (78%) indicated "yes" as shown in Figure 5.12. The respondents felt that the centre was empowering them in these three areas; the largest reasons given for the spiritual entry was in the area of prayer, Bible teachings, spiritual counselling, and the assurance to know that God is not punishing them for the sins committed. The basic teachings of the spirituality are that God created man and woman in His image with equal dignity and worth. Through the preaching of the Word hope is built in our hearts as stated by one of the respondents.

Emotionally, respondents felt that they had been empowered to love and to forgive themselves first and then those around them who might be in similar situations. In addition, respondents indicated that they had been empowered to stand strongly against stigmatisation. The last item presented was mental empowerment and respondents indicated that they were provided with psychological support through counselling which enabled them to be mentally strong to handle the issues relating to HIV/AIDS, as noted by one of the respondents "when you are not mentally prepared for the news of being HIV positive surviving the pandemic becomes a struggle even when you are on ARVs. Many people's health becomes deteriorated as soon as they learn they are HIV positive". Mentally CoH prepare beneficiaries to handle the situation as disclosed and so they grow with it. The responses given by the respondents gave support to why they felt positive that the CoH programme was empowering them in those three areas.

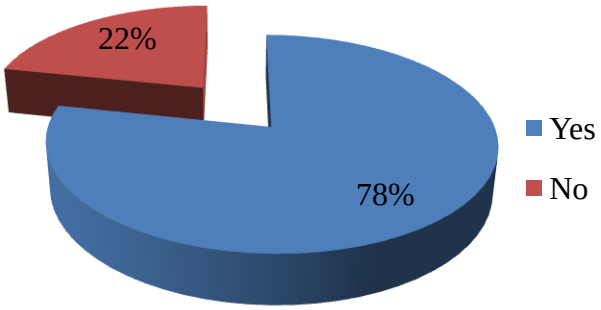


Figure 5.12: Respondents reactions to spiritual, emotional and mental empowerment

The responses to question 48, sought to extract examples of what the respondents felt the Church should bring in addition to what it was already doing in the CoH HIV/AIDS project. Of the respondents (15.6%) indicated "do not know", while (25.6%) of the respondents suggested that the Church should involve other organisations, especially the state as partners so that the burden could be lighter on them. Because of the nature of HIV/AIDS which needed much food and good nutrition to combine with ARVs the Church should endeavour to make available enough nutritional food. Furthermore, the Church should engage their clients to see who qualified for loans, for respondents felt that the Church should help beneficiaries access loans, food and manpower. Some respondents (13.4%) felt that Church services should feature HIV/AIDS sessions in which the congregants were taught about HIV. A few,(10.4%) of the respondents felt the Church should constantly be engaged in educational workshops with the infected and the affected, while (9.6%) suggested that those in need should have access to food parcels and shelter. There were (6.3%) respondents who recommended that the Church should encourage more willing volunteer workers. Other suggestions made are tabulated in Table 5.7.

TABLE 5.7: HOW CHURCH MITIGATION PROGRAMMES CAN BE IMPROVED

	%
Partner with state to develop workable policies and assist in providing financial support	25.6%
Do not know	15.6%
Church services should feature HIV/AIDS sessions	13.4%
The Church should endeavour to hold educational workshops with the infected and affected	10.4%
Those in need should have access to food parcels and shelter	9.6%
There ought to be more willing volunteers	6.3%
The Church should have life skills development programmes	5.4%
Leadership in Church should be tasked with the provision of social, physical and spiritual support	5.4%
Churches should work in collaboration with other willing stakeholders	4.3%
Encourage people to go for HIV test	3.0%
All client should be respected and treated as equal	1.0%
Total	**100%**

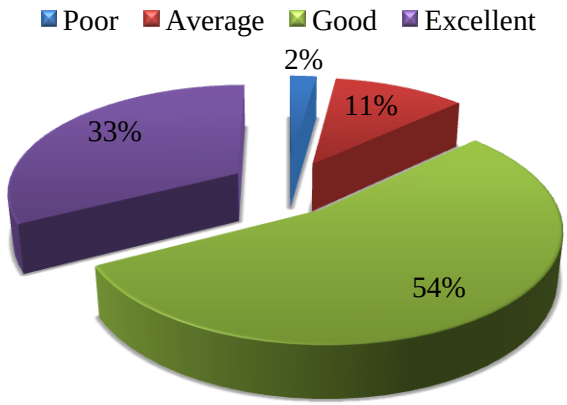


Figure 5:13: Respondents perception of CoH services provided

When asked to rate the service provided by CoH, (54%) responded it was good, and (33%) respondents scored the services they received from CoH as excellent. When asked to elaborate, the respondents said they believed that CoH had put together the programme and services for the support of the vulnerable and needy. Furthermore, the respondents felt that spiritual support in the form of prayer, putting in place HIV/AIDS programmes; advocacy, psychological support and material support were areas in which they believed CoH's services were excellent in dealing with HIV. Only (11%) of the respondents rated the services as average; however, two per cent rated the services as poor. When asked to

elaborate, the respondent felt that the services were very poor and average, the reasons were as follows; they did not provide enough food for all clients, they should increase the number of their field workers, place the fieldworkers on salary to avoid lack of concentration on the clients in CoH, and station a permanent pastor at the centre who could counsel on spiritual matters on a daily basis.

Furthermore, the respondents quoted financial constraints as the major obstacle faced by those implementing Church-based HIV/AIDS programmes, and felt if the Church had more support from other stakeholders they would perform better. Those and many more were the reasons given by respondents who felt the centre was doing enough as their service provider. A study by Rhodes, Hergenrather, Wilkin and Jolly (2008) found that Churches, though they have limited resources, provided beneficiaries spiritual support, a sense of belonging and of community, and they also provided physical shelter to homeless and poverty-stricken. This finding resonates with the fact that the Church has and is involved in disaster management, in this case (HIV/AIDS) mitigation, but needs to intensify their effort in meeting more of the physical needs than just the spiritual. Christian Churches' area of influence includes the spiritual, directly guiding people on issues of morality, sexual activity, Christian identity and rules of family life.

TABLE 5.8: RESPONDENTS' ADDITIONAL COMMENTS

	%
None	55.7%
Safe sex practice	15.4%
Access to grants and pensions	8.5%
Skills development	5.2%
Capacity building / empowerment	4.6%
Formation of support groups / awareness campaign e.g. youth fellowship	3.6%
Collaborating with other Churches, counsellors and social workers	3.3%
Seek the role of the government	2.4%
Availability of required resources by HIV/AIDS victim	1.3%
Total	**100%**

The last but not the least in the questionnaire was when the researcher urged respondents to comment on issues that they might consider as relevant to CoH HIV/AIDS mitigation that were not attended to at some stage in the interview. As shown in Table 5.8 above, (55.7%) of the respondents did not add anything more. On the other hand, issues mentioned by the rest of the (44.3%) respondents were safe sex practices, stating that the Church should not be too religious to want to talk about sex (15.4%), access to grants and pensions (8.5%), skills development (5.2%) and run capacity building programmes for the community to solve their problems using their local resources (4.6%).

It was also suggested that some of the staff members needed to be updated in terms of new developments regarding HIV. There should be continuous development training and workshops for the staff members. The Church should provide intensive training to counsellors to equip them with the required skills. The Church should adhere to ethics by maintaining the confidentiality of data collected from beneficiaries, for the disclosure of information was a serious breach of confidentiality that might damage the relationship of trust between Church and the beneficiaries. Respondents expected the Church to ensure adherence to medication, encouraging people to test for HIV, working with doctors, train lay-care workers. Finally the Church should teach their followers not to discriminate.

5.9 CONCLUSION

In this chapter the data generated in this study was presented and discussed. The wide range of issues covered represents base-line information on the perceptions of programmes offered by the CoH and the beneficiaries on the role of the AOG HIV/AIDS programme mitigation. AOG HIV/AIDS mitigation programme has played a crucial role in terms of the HIV/AIDS mitigation of the Lusaka community in which they operate, through implementing different types of HIV/AIDS projects and programmes. The next and final chapter of the dissertation summarises relevant findings in relation to the stated research objectives.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1 INTRODUCTION

The aim of this study was to examine the role of the AOG in the management of the HIV/AIDS disaster in Lusaka, Zambia. This study was designed to find out how the respondents perceived the involvement of the Church in HIV/AIDS prevention, protection and mitigation. The questions that the researcher posed have enabled him to come up with an explanation regarding the Church's role and views on the Church and disaster management, in this case in a number of different HIV/AIDS related issues. It emerged that the Church was conversant with the numerous HIV/AIDS related issues that included the causes, what it was, ways through which the disease is transmitted and way of preventing, controlling and mitigating it.

This study has attempted to describe and evaluate the disaster management (HIV/AIDS) project of the AOG Church in Lusaka Zambia. As observed in our discussion, significant research on HIV/AIDS has been done to determine the causes and impact of the pandemic in Zambia, and what exacerbates the spread. As noted in this study, the eight Southern Africa Development Community (SADC) countries have the highest HIV adult prevalence rates in the world with 21.5% in Zambia (IOM 2003:8). Zambia is one of the countries in SADC that have been hard hit with the problem of HIV/AIDS and poverty. Zambia remains one of the Africa's poorest countries. According to Embassyofireland (2011) it ranked 165th out of 177 countries on the UN Human Development Index 2007. Over two-thirds of the population live below the national poverty line on less than a dollar a day − many of these in congested urban sites called compounds.

6.2 CONCLUSIONS

This study has shown that living with HIV/AIDS is a challenge. Participants in the study have described HIV/AIDS as disheartening because it brings pain, stigma, misery and anxiety. Just like in many countries, in Zambia people living with HIV/AIDS have their needs, which most of the times are not met. The majority of HIV/AIDS victims are women. According to Dube and Kanyoro (2004) nobody can underestimate the reality of HIV/AIDS crisis in Africa especially its implication on women. This disease is spreading at an alarming rate and particularly impinges on the most productive and sexually active age group, between 15 and 45 years (NHASF, 2006-2010). Furthermore NHASF (2006-2010) states that women appear to be particularly vulnerable to the disease and 1.4 times more likely to be HIV infected than men. As the study findings show, most respondents were women. Central Board of Health/Ministry of Health (1999) identified HIV/AIDS as being rampant in Zambia, and has a serious impact on urban settings more than on rural. NHASF (2006-2010) and NAC (2004) further stated that nearly (80%) of HIV transmission in Zambia is through heterosexual contact. This mode of transmission is further exacerbated by the high-risk sexual practices, poor socioeconomic status of women and high prevalence of STIs. The remaining (20%) is predominantly due to mother-to-child transmission during pregnancy, at birth or while breastfeeding.

At the beginning when AIDS issues started in the early 80s, the Church perceived HIV/AIDS as God's punishment for sinners and wrong doings (Dube & Kanyoro, 2004); consequently, most CChurches were reluctant to get involved in prevention, protection, control and mitigation. Gennrich (2007) concurs when she says if the Church sees AIDS as God's punishment for promiscuity, then we fundamentally misunderstand the root cause of AIDS, and miss the real point about where Church should be involved. Nevertheless, when the HIV/AIDS issues began affecting the fibre of the society, including Church members, the Church was compelled to see HIV/AIDS as any other disease that should be tackled.

Birdsall (2005) affirms in some studies that the attitudes of religious organisations are changing towards the epidemic. This is why the AOG is playing a crucial role in the fight against HIV/AIDS. Sources gathered from respondents at CoH centre indicate that

Churches need to be more involved in mitigating, protecting and preventing the impact of HIV/AIDS and reduce the spread.

The Bible (Luke 18:2-8) speaks of the parable of the woman and the judge. The passage features Jesus telling a story about persistent prayer to his disciples. According to (Dube & Kanyoro, 2004:3) persistent prayer is equated with the action-oriented search for justice and refusal to live in oppression and exploitation until justice is established. God is a God of justice – a God who grants justice to the marginalized and oppressed. Dube & Kanyoro (2004) indicate that HIV/AIDS is a social injustice-driven epidemic that must be tackled with the love and compassion of God. Compassion for others in the face of their misfortunes does not arise in the vacuum; it comes from the love of God which is shared abroad in the Christians hearts (The Bible, Romans 5:5). As the Church, we are called to be a compassionate community. (The Bible, Ephesians 5:1) states therefore to be imitators of God as dear children. As imitators of God, we are to respond to persons in distress, misery and anxiety with actions motivated by compassion. The Church is to follow the example of Christ's love by reaching out to the untouchables of the society. According to Hoffman and Grenz (1990) among the modern day's untouchables "lepers", the Church must place persons living with AIDS in that category and reach out to them with compassion. The Church is compelled by the divine compassion to minister to those in need, including persons struggling with AIDS.

The AOG is one of the FBOs in Lusaka, Zambia that is currently working on different activities like provision of ART, VCT, bereavement counselling, ARV, care and support, capacity building to prevent and control HIV/AIDS in fulfilling God's mission of compassion. An examination of the contents of diverse activities of AOG Church in Lusaka Zambia and HIV/AIDS management shows, that even though the Church is spiritually specific, they provide a wide range of HIV/AIDS related activities in the form of HIV prevention, mitigation, awareness and education, which are spotted mainly in the services that CoH provides. Further investigation shows that 80% of the respondents are directed beneficiaries of the CoH programme, further proving that the Church is involved in disaster management. The Church gives spiritual, moral and material support to as many clients that are registered at CoH. In view of the above, AOG Church can be said to be a significant

player within Lusaka Zambia in disaster management in this case, HIV/AIDS. This is in line with the growing body of evidence in the contributions made by the AOG Church through Circle of Hope Clinic (CoH).

As earlier stated, the Church has power and influence to be listened to by the followers and using this, it can mobilize local communities for different activities like home-based care, education and income generating activities. The Church can achieve these and more by mainstreaming HIV/AIDS programmes into different sectors of development. The Church's respect for existing norms and values of the community can be used as leverage to mitigate the impact of HIV/AIDS. Muturi (2007), conclude that faith-based organisations has become a crucial partner in HIV/AIDS as they are known to shape social norms, beliefs, attitudes and people's realities concerning sexual self-understanding. The AOG Church involvement in the prevention and mitigation of HIV/ADS may perhaps clear ethical problems as well as encourage Church communities to have more response against HIV/AIDS. As observed from our study, the prevention activities implemented by the Church to address the HIV/AIDS epidemic include general HIV/AIDS awareness and sensitization and preaching of abstinence especially to young people and these interventions, are basically carried out by the CoH centre.

The assembly of God Church Lusaka, Zambia has broken the silence about the epidemic in the way they are involved in mitigating the pandemic. AOG are people of faith who strive to bring joy to devastated lives by being involved in HIV/AIDS prevention and mitigation programmes and by so doing, God's grace and healing is entering the world. This proves true that the Church has strength and influence over communities in which they are located. WCC (2001) states that Churches have strengths, credibility, and they are grounded in communities. This offers them the opportunity to make a real difference in combating HIV/AIDS. To respond to this challenge, the Churches must be transformed in the face of the HIV/AIDS crisis, in order that they may become a force for transformation – bringing healing, hope, and accompaniment to all affected by HIV/AIDS.

The AOG in Lusaka in accordance with the disaster management circle has mapped out strategies in order to increase awareness and knowledge of the modes of transmission of

HIV, and the methods through which persons within the Church and the community at large, especially the youth, may protect themselves. The Church also advocates voluntary counselling and confidential testing as part of its preventive and mitigation method. Additionally, the AOG has developed practices within the health facilities under its supervision that leads to the reduction of HIV through their teachings.

The AOG in Lusaka Zambia recognises the fact that "all life is sacred and created by God". This causes the Church to commit itself to do everything possible and positive to mitigate and prevent the further transmission of HIV/AIDS within Lusaka, Zambia, hence the establishment of circle of hope family clinic (CoH). In order to preserve the sacredness of this life, the AOG in Lusaka as part of its HIV preventive method, has committed itself to systematic teaching, which promotes abstinence from sex for the unmarried and mutual fidelity among married couples as well as rehabilitating those that are infected/affected.

One notable thing in this investigation was the consistency between the views of the respondents on the role the Church should play in the containment of the AIDS pandemic. While the respondents acknowledged the existence of HIV/AIDS and the need to check and contain its spread, it emerged that the Church had much more to do to assist in preventing and mitigating the disease (see Table 5.6). The respondents felt that the Church should not just focus on individuals' spiritual well-being, but should develop some form of programmes to bring about awareness among their flock and the community at large. Thus, the respondents felt that the task of mitigating, preventing and educating the people on HIV/AIDS related issues rested squarely on the shoulders of the Church, the government and other stakeholders.

Despites some of the beliefs of the nine per cent respondents (see Figure 5.4) who felt the Church should mind and concentrate on spiritual matters, 91% of the respondents felt that the Church had a lot to offer, and that the Church should intensify its effort in combating the pandemic. They believed the Church could play a vital role in the fight against the HIV/AIDS by speaking out about sex/abstinence, creating HIV/AIDS awareness among members and community, building resilience, embracing people living with HIV/AIDS without discrimination and to offer counselling services to the infected and affected. These

can be achieved by employing the risk-reduction objectives otherwise known as "CARDIAC" Wisner, *et al.* (2007:330).

*C = **Communicate** understanding of vulnerability*
*A = **Analyse** vulnerability*
*R = focus on **Reverse** of PAR model*
*D = emphasize sustainable **Development***
*I = **Improve livelihoods***
*A = **Add** recovery`*
*C = extend to **Culture***

The Church can be involved in the protection, prevention and mitigation of the epidemic by first acquiring knowledge concerning the nature of hazards, vulnerabilities and capacities in this case HIV/AIDS. The second is to build on capacities that allow patterns in daily life to change in ways that will increase personal and social protection. Thereafter, public awareness follows by informed action, which is the core requirement to reduce vulnerability and to develop resilient households, localities, communities and societies (Wisner, *et al.*, 2007).

The study found positive perceptions about Church and HIV/AIDS disaster management programmes. These findings concur with the findings of Gathigia (2006) who indicate that Churches demonstrate a greater commitment to society, as compared to other political, social and economic institutions. The study finds that the challenges encountered by the Churches in the course of programme implementation are financial limitation; hence the respondents feel the Church must be encouraged to solicit for financial assistance from the state and other stakeholders particularly those NGOs involved in the fight against HIV/AIDS in order to increase knowledge of HIV/AIDS, as well as accessing materials to help in equipping the Church members to fight against HIV/AIDS. Furthermore, the Church must collaborate with other churches. The study finds that the inability of Churches to cope with large numbers of people seeking support from them present numerous complexities as they cannot simply be managed and provided for. Partnership can also help the Church in accessing the services of resourceful people who can be hosted in their Churches regarding awareness programmes in the Churches.

The respondents demonstrated substantial knowledge and judgment of the Church and disaster management programmes and the role that such programmes played in preventing and mitigating HIV/AIDS, with the exception of beneficiaries who lacked some understanding, particularly with respect to antiretroviral therapy, voluntary counselling, testing, and the antiretroviral drug. Judging from the responses given when respondents were asked to state what they expected the Church to do in addition to what it was already doing, it became apparent that some respondents were concerned mainly about receiving shelter and food, as opposed to medical assistance. At the same time, respondents felt that the Church should involve other organisations especially the state, as partners so that the burden can be lighter on them. Furthermore, respondents stressed that the Church should engage their clients to see who qualified for loans, as they felt the Church should help beneficiaries access loans, food and manpower. Church services should feature HIV/AIDS sessions where congregants were educated. The Church could also assist in providing life skills development programmes for the infected and the affected.

In conclusion, policy makers need to be made aware of the urgency of addressing HIV/AIDS, reducing the stigma and discrimination attached to the disease among the general population, and in particular among the Churches or faith-based organisations, through more aggressive prevention efforts and a wider dissemination of information, education and communication materials. Church and FBOs are abundant throughout Lusaka, Zambia, Africa and the world at large, driven by their ethical and moral obligation, and are well placed to offer HIV/AIDS services to people infected with HIV and affected by HIV/AIDS.

In this respect, Church-based programmes can play a central role in disaster management in increasing people's capacity to affect changes to address the destitution created by HIV/AIDS. In working hard to meet the needs of the community and to alleviate their burdens in terms of HIV/AIDS, the AOG Church has invested in programmes that will help reduce the impact of the HIV/AIDS disaster in Zambia. However, there are still room for more concerted effort to be made in order to bring the rampaging disease to a halt. The Church is free and open to members and local community to offer services like support and care, counselling, spiritual, advocacy and the like.

6.3 SUGGESTION FOR FURTHER RESEARCH

As indicated, this study was conducted using random sampling of population related to the AOG (CoH) HIV/AIDS programmes. The researcher strongly proposes that a review of similar nature of the study be carried out in a much broader spectrum in towns and townships (popularly known as compounds) on the fringes of Lusaka so as to establish a broader view of the impact of HIV/AIDS and how Churches are involved in the mitigation, preparedness and reduction.

The researcher feels that there is need for further research in the Lusaka area. More research in this area could equip Churches with the necessary knowledge and skills for dealing with HIV/AIDS issues among their congregants. In view of the number of people who do not know their HIV status and the ostensible fear and concern of disclosing a positive status, further studies could assist in determining greater and increased understanding of how exactly Church-based programmes can address such questions in innovative ways. Also, there is need for further studies to be carried out to determine the nature, scale and scope of the contributions made by the Assembly of God Church Lusaka, Zambia.

6.4 RECOMMENDATIONS

The problem of HIV/AIDS is not going to go away at the click of the finger. The number of people living with HIV is likely to rise unless there is a considerable fall in the number of new infections. When the physical cause or risk of a potential hazard is not completely eliminated the prospective for injury, loss and death can be reduced based on the measure, structure and policies put in place. Lusaka Zambia will continue to face huge challenges in the field of HIV/AIDS prevention, care, and will suffer the epidemic's terrible impact for many years to come. For this reason, it calls for the Church and all stakeholders to be involved in the prevention and mitigation exercises. Many Churches that fight HIV/AIDS occasionally do not include HIV/AIDS programmes on their year plan and do not have

HIV/AIDS policies. Churches in this group may not even have budget for HIV/AIDS response and do not have monitoring or follow-ups.

It has been argued in this study that the economic environment prevailing in Zambia has contributed immensely to high levels of HIV infections and poverty. Also, our study has shown a change in the attitude of Church leaders. From condemnation, a shift has taken place to compassion, solution seeking and or even tolerance. However, the change in attitude towards the disease does not, provide and supply enough resources needed to tackle the HIV/AIDS epidemic.

- From the findings of this study, it came out clearly from the participants that HIV/AIDS programmes should be established in the Church by including it in their yearly programmes, just like the other programmes that they considered to be important. By including HIV/AIDS programmes in the year plan, the Church will be able to monitor, and analyse their impact with ease focusing on areas that need improvement.

- HIV/AIDS has a devastating nature and ravage millions of different segments of the population. It requires collaborative efforts from state, FBOs, NGOs, and others. Especially Churches who are presently involved in HIV/AIDS prevention and control, should stand firm in their stand and initiative in fighting the pandemic.

- As indicated by the participants, government, institutional humanitarian agencies and donors should encourage and provide financial support for FBOs to carry out sound HIV/AIDS prevention and mitigation activities, because Churches have credibility, and they are grounded in communities.

- In the era of HIV/AIDS, which is a sign of the present time, programmes in the Church should be reviewed to incorporate some social changes to meet the needs of the community in which the Church lives.

- The Church should strengthen their partnership with the department of health and other stakeholders or institutions to increase its capacity to deal with HIV/AIDS.

- Volunteers should be encouraged by means of financial support and incentives in relation to current market prices and exchange rates.

- HIV/AIDS infected and affected more women as it is seen from the study. To alleviate such kind of pressure upon women, priority should be given to them in education, and empower capacity building to be self-supportive and productive.

- HIV/AIDS awareness creation should be part of the Church; focusing on the youth, marriages, reproductive health and family planning.

- Well-trained volunteers who have current information about HIV/AIDS should give HIV/AIDS awareness raising activities. There should be selected educators to disseminate proper information among the Churchgoers and the community at large.

- Churches should give place to professional as well as spiritual counselling to maintain and build hope of desperate HIV/AIDS patients.

- The final aspect of the AOG strategy toward prevention and mitigation should be to increase the institutional capacity of its health facilities to correctly diagnose and treat sexually transmitted infections.

REFERENCES

Afe, A. 2005. A walk for Africa: combating the demon of HIV/AIDS in an African Pentecostal Church–the case of Redeemed Christian Church of God: the challenge of HIV/AIDS to Christian theology. Journal: Scriptural International Journal of Bible, Religion and Theology in Southern Africa, Vol 89 pp 396-405

Alexander, D. 2000. Confronting Catastrophe - New Perspectives on Natural Disasters. Oxford: Oxford University Press. pp.282.

Aliber, M. & Walker, C. *et al*. (2003) *The Impact of HIV/AIDS on Land Rights in Kenya,* Draft report.

Alistair, B.E. Ubuntu 2011: African History Glossary. [Online]. Retrieved from: http://africanhistory.about.com/od/glossaryu/Ubuntu.htm [2011, April 9]

Anderson, C.R. 1995. *The Effective Pastor, a Pastoral Guide to the Ministry Chicago*. The Moody Bible Institute.

ARHAP. (2006). Mapping religious health assets. [Online]. Retrieved from: www.arhap.uct.ac.za/downloads/ARHAPWHO_ch2.pdf [2010, November 26]

Arndt, C. & Lewis, J.D. (2000). The Macro Implications of HIV/AIDS in South Africa: A Preliminary Assessment. Journal of South African Economics, Vol. 68, 5, pp. 856-87

Avert. (2009). *The History of AIDS in Zambia*: [Online]. Retrieved from: http://www.avert.org/aids-zambia.htm [2011, May 1]

Avert. (2011). HIV/AIDS impact in Africa. [Online]. Retrieved from: http://www.avert.org/aids-impact-africa.htm#ref1-4 [2011, July 27]

Ayieko, M. (1998). *From Single Parents to Child Headed Households:The Case of Children Orphaned by AIDS in Kisumu and Siaya Districts*, UNDP HIV and Development Programme.

Babbie, E.R & Mouton, J. (2001). *The Practice of Social Research*. Cape Town: Oxford University Press Southern Company.

Barks-Ruggles, (2001). Meeting the global challenge of HIV/AIDS. The Brookings Institute, Policy brief number 75, April. [Online]. Retrieved from: http://www.brook.edu/comm/policybriefs/pb75.pdf [2010, November 10]

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

Barton, B.B. *et al.*, 2000. *The Holy Bible: Life Application.* Grand Rapid: Zondervan Publishing House.

Bechu, N. (1998). The Impact of AIDS on the Economy of Families in Côte d'Ivoire: Changes in Consumption Among AIDS-affected Households', in M. Ainsworth, L. Fransen and M. Over (eds) *Confronting AIDS: Evidence from the Developing World*, selected background papers for the World Bank Policy Research Report.

Beegle, K. (2005). Labour Effects of Adult Mortality in Tanzanian Households. *Economic Development and Cultural Change, 53*(3), 656-683.

Bengtsson, E. & Bengtsson, I. (2005). Where we can't cure we can care: A Participatory evaluation of Home Based Care Project in Zambia.

Berg, B.L. (2007). *Qualitative Research Methods for Social Sciences*. 6th ed. USA: Pearson.

Birdsall, K. (2005). Faith Responses to HIV/AIDS in South Africa. [Online]. Retrieved from: www.global.ucsb.edu/orfaleacenter/luce/luce08/documents [2011, April 26]

Blackman, R. (2007). Partnering with the local church. Tearfund roots: resourcing organisations with opportunities for transformation and sharing.

Bloom, D., Mahal, A., Christiansen, L., de Silva, A., de Sylva, S., Dias, M., *et al.* (1997). Socio-economic Dimensions of the HIV/AIDS Epidemic in Sri Lanka. In D. Bloom & P. Godwin (Eds.), *The Economics of HIV and AIDS. The Case of South and South East Asia* (pp. 155-263). Oxford: Oxford University Press.

Bollinger, L., & Stover, J. (1999). *The Economic Impact of AIDS in Zambia*: The Futures Group International.

Bollinger, L., Stover, J. & Riwa, P. (1999). The Economic Impact of AIDS in Tanzania (Research report): The Policy Project.

Bolton-Moore, Mubiana-Mbewe, M., Cantrell, R., Chintu, N., Stringer, E., Chi, B., Sinkala, M., Kankasa, C., Wilfert, C., Mwango, A., Levy, J., Abrams, E., Butery, M. & Stringer, J. (2007). Clinical Outcomes and CD4 Cell Response in Children Receiving Antiretroviral Therapy at Primary Health Care Facilities in Zambia. *JAMA*, October 24/31, Vol. 298, No. 16.

Booysen, F. & Summerton, J. (2001) HIV/ AIDS, Poverty and Risky Sexual Behaviour: Evidence from South Africa. Department of Economics and Centre for Health Systems Research & Development, University of the Free State, South Africa

Booysen, F. l. R. (2002). HIV/AIDS and Poverty: Evidence from a Household Impact Study conducted in the Free State province, South Africa. Paper presented at the DPRU Conference, Johannesburg, 22-24 October 2002.

Brandhild, L. & Lüning, H. (2007). A history of HIV and AIDS in Zambia [Online]. Retrieved from: http://healthdev.net/site/post.php?s=4007 [2011, May 1]

Bradt travel guides. (2011). Economy Zambia [Online]. Retrieved from: http://www.zambia-travel-guide.com/bradt_guide.asp?bradt=1094 [2011, March 3]

Breetvelt, J. [sd]. Church, theology and HIV/AIDS: African churches‟ involvement in the struggle against HIV/AIDS. [Online]. Retrieved from: www.scrib.com/doc/33693548/African-Churches%E2%80%99-Involvement-inthe-Struggle-Against-HIV-AIDS [2011, April 28]

Burger D, & Brynard, P.A. (2001). HIV/AIDS – The slow onset disaster: *Disaster Management Perspective and Challenges into the new Millennium.* The Journal of Public Administration. Vol. 36, no. 2. June 2001.

Burger. D. & Brynard, P.A. (2001) Journal of Public Administration •Vol. 36, no. 2• HIV/AIDS - The slow onset disaster: Disaster Management Perspectives and Challenges into the New Millennium.

Burns, N. & Grove, S.K. (2005). *The practice of nursing research conduct, critique and utilisation.* 5th ed. Philadelphia: WB Saunders.

Carney, D. (1998). Sustainable Rural Livelihoods. What contribution can we make? Papers presented at the Department for International Development's Natural Resources Advisers' Conference. DFID.

Carney, D (1998). "Implementing the Sustainable Rural Livelihoods Approach" in Carney, Diana ed. (1998*). Sustainable Rural Livelihoods What contribution can we make*. London: DFID.

Carter, W. N. (1991). *Disaster Management: A Disaster Manager's Handbook*. Manila: Asian Development Bank.

Central Statistical Office, Zambia – National Statistics. [Online]. Retrieved from:

www.zamstats.gov.zm/ [2011, August 8]

Chambers, R. & Conway, G. (1992). 'Sustainable rural livelihoods: practical concepts for the 21st century'. Brighton: Institute of Development Studies.

Chimfwembe, R. (2006). The Roman Catholic Church and the United Church of Zambia Challenged by HIV and AIDS: *which results in creating poverty among Zambian People*. University of Pretoria. South Africa

Chimfwembe R. (2006). Incidence of poverty by rural/urban. [Online]. Retrieved from: http://www.ccjp.org.zm/sap_mon23.htm [2011, April 14]

Chitando, E & Gunda, M.R. (2007). HIV and AIDS, stigma and liberation in the Old Testament. *Exchange* 36(2):184-197.

Common Wealth Parliamentary Associations (CPA). (2005). The Role of Parliamentarian in Combating the HIV/AIDS Pandemic. New Delhi, India. (unpublished)

Coppola, D.P. (2007). *Introduction to international disaster management*. Burlington, MA: Elsevier.

Creswell, J.W. (1998). *Qualitative inquiry and Research Design. Choosing among five traditional*. California: Sage publications Inc.

Cunningham, S.D., Kerrigan, D.L, McNeeley, C.A. & Ellen, J.M. (2009). The role of structure versus individual agency in churches' responses to HIV/AIDS: A case study of Baltimore city churches. *Journal of Religion and Health* 28: 22-97.

Davis, I. & Wall, M. eds. (1991. *Christian Perspectives on Disaster Management*: a training manual, London: Tearfund & IRDA.

Davis, I. & Wall, M. eds. (1992). *Christian Perspectives on Disaster Management.* London: Interchurch Relief and Development Alliance.

Definition of the Church [Online]. Retrieved from: http://christinity.about.com/od/churchandcommunity/a/thechurch.htm [2011, May 17]

Desmond Tutu, (2000). No Future Without Forgiveness: *A personal overview of South Africa's Truth and Reconciliation Commission.* [Online]. Retrieved from: http://africanhistory.about.com/od/glossaryu/Ubuntu.htm [2011, December 13]

De Villiers P. G. R. (1978). *Liberation Theology and the Bible. University of South Africa*. Muckleneuk Pretoria.

De Vos, A.S., Strydom. H., Fouche. C.B. & Delport, C.S.L. (2002). *Research at Grassroots for Social Sciences and Human Sciences Professionals.* Pretoria. Van Schaik,

De Waal, A. (2003b). Why the HIV/AIDS pandemic is a structural threat to Africa's governance and economic development. *Fletcher Forum of World Affairs, 27.2*, 6-24

De Waal, A. & Whiteside, A. (2003) 'New Variant Famine: AIDS and Food Crisis in Southern Africa', *The Lancet,* 362, 1,234–1,237.

Development Action Group (DAG). (2003). *The Impact of HIV/AIDS on Sustainable Livelihoods: Living with HIV/AIDS in Khayelitsha*, South Africa.

DFID Department for International Development. (1999/2000). *Sustainable livelihoods guidance sheets*. London.

Drimie, S. (2002) *The Impact of HIV/AIDS on Land: Case Studies from Kenya, Lesotho and South Africa.* Rome: FAO.

Drimie, S. (2003) 'HIV/AIDS and Land: Case Studies from Kenya, Lesotho and South Africa', *Development Southern Africa,* vol. 20, no. 5.

Dube M.W. & Kanyoro, M.R.A. (2003-2004). Grant Me Justice! *HIV/AIDS & Gender Readings of the Bible.* Cluster Publications. South Africa.

Duan, N. Fox, S, Derose, KP, Carson, S & Stockdale, S. (2005). Health education and behaviour: Identifying churches for community-based mammography promotion: lessons from the LAMP study. [Online]. Retrieved from: http://www.sagepub.com/cgi/content/abstract/32/4/536 [2011, July 18]

Dumezweni, B. (2004). Enhancing the agency of families affected by AIDS: Strategies for the church at Ilinge Township, Queenstown. Masters dissertation at the School of Theology & Development, University of KwaZulu-Natal.

Economic Justice Update. (2002). The Implications of AIDS for SA Economy, Fair Share, School of Government, University of Western Cape. Economist Economic Review (1997). Zambia country report, Economist, London.

Elliot, H. & Perrault, P. (2001). *Increasing the performance of agricultural research in Zambia: further issues for the Agricultural Sector investment Program.* Report to the World Bank. The Hague: ISNAR.

Ellis, F. (2000). *Rural Livelihoods and Diversity in Developing Countries.* Oxford: Oxford University Press.

Embassy of Ireland. (2010). Overview. [Online]. Retrieved from: http://www.embassyofireland.co.zm/home/index.aspx?id=73811 [2011, April 13].

Evidence from the Developing World, selected background papers for the World Bank Policy Research Report.

FAO. (2002). *HIV/AIDS, Food Security and Rural Livelihoods*. FAO Fact Sheet. Rome, Food and Agriculture Organization of the United Nations

FAO (2004). 'HIV/AIDS, Gender Inequality and Rural Livelihoods: The Impact of HIV/AIDS on Rural Livelihoods in Northern Province'. Baseline Survey Report. Rome: FAO.

Farrington, J., Carney, D., Ashley, C. & Turton, C. (1999). 'Sustainable Livelihoods in Practice: Early Applications in Concepts in Rural Areas'. Natural Resource Perspective no. 42. London: ODI.

Fredericks, MT. (2008). HIV and AIDS: Mapping theological responses in Africa. [Online]. Retrieved from: www.brill.n//exch [2010, November 13]

Flick, U. (1998). An introduction to qualitative research. London: SAGE Publications

Fox, M. (1991). *Creation spirituality: Liberating gifts for the peoples of the earth*. New York: Harper San Francisco.

Francis, SA & Liverpool, J. (2008). A review of faith-based HIV prevention programs. *Journal of Religion and Health* 48(1):6-15.

Garatwa, W. & Bollin, C. (2002): Core Terminology of Disaster Reduction. Dsaster Risk Managment - A working concept. Eschborn, Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) [Online]. Retrieved from: http://www2.gtz.de/dokumente/bib/02-5001.pdf, [2011, May 4]

Garbus, L. (2003). HIV/AIDS in Zambia: *Country AIDS Policy Analysis Project*. University of California San Francisco.

Gathigia, AM. (2006). The experience of people living with HIV/AIDS and how the response of Faith-Based Organisations has influenced their coping and quality of life. [Online]. Retrieved from: http://www.psychology.unp.ac.za/presentations/conference/index.asp?sub=viewarchive&year=2004 [2011, October 29]

Gennrich, D. (2007). The Church in an HIV+ World: A *Practical Handbook*. Cluster Publication. South Africa

Giddens, A. (2004). *Sociology* 4th edition Oxford: UK Blackwell.

Gladys,D. (2000). Personal Communication, Zambia HIV/AIDS Business Sector Project, 1 Chikwa Road, Anglican Cathedral of Holy Cross Grounds, Lusaka, 2001.

Goldman, I., Carnegie, J., Marumo, M., Munyoro, D., Kela, T., Ntonga, S,. & Mwale, E. (2000). 'Institutional Support for Sustainable Rural Livelihoods in Southern Africa: Framework and methodology'. Natural Resource Perspectives no 49. London: ODI.

Haacker, M. (2004). The Impact of HIV/AIDS on Government Finance And Public Services. In M. Haacker (Ed.), *The Macroeconomics of HIV/AIDS*

Haddad, B. (2005). Reflections on the church and HIV/AIDS. *Theology Today* 62(1): 29-37.

Haankuku, C. (2010). WDI (World Development Indicators) (2008). *World Development Indicators: Zambia.* [Online]. Retrieved from: http://wdi.gdnet.ws:9999/ext/DDPQQ/report.do?method=showReport [2011, April 13].

Harvey, P. (2004). HIV/AIDS and humanitarian action: Westminster. United Kingdom

Hassig, S. E., Perriens, J., Baende, E., Kahotwa, M., Bishagara, K., Kinkela, N., (*et a)l*. (1990). An Analysis of the Economic Impact of HIV Infection Among Patients at Mama Yemo Hospital, Kinshasa, Zaire. *AIDS, 1990*(4), 883-887.

Hauer, R. (2006). SLOW ONSET DISASTER. [Online]. Retrieved from: http://www.rutgerhauer.org/rutgerhauer.org/disaster.php [2011, August 8].

Hauer, R. (2006). Sudden-onset and slow-onset of a disaster. [Online]. Retrieved from: www.rutgerhauer.org/disaster.php [2011, January 6].

History of HIV in Zambia. [Online]. Retrieved from: http://www.suite101.com/content/overview-of-hivaids-in-zambia-a70819 [2011, May 7]

Hope and Cope. (2008). A place for parents of HIV+ children. [Online]. Retrieved from: http://hopeandcope.blogspot.com [2011, September 18]

Hoffman W.W & Grenz, S.J. (1990). AIDS ministry in the midst of an epidemic. Baker Book House Company. USA

Iipinge, S. et al, 2004. *The Relationship Between Gender Roles and HIV Infection in Namibia.* Windhoek: University of Namibia.

IS-393 1998. *FEMA Independent Study Program: International to Mitigation*. Emmitsburg: Emergency Management Institute

IS-1. N.d. *Emergency Manager: An Orientation to the Position.* Emmetsburg: Emergency Management Institute.

International Federation of Red Cross and Red Crescent Societies (2008). The disasters report: *focus on HIV and Aids 2008*. Geneva Switzerland

International Organization for Migration. (2003). Mobile Populations and HIV/AIDS in the Southern African Region: *Desk Review and Bibliography on HIV/AIDS and Mobile Populations*. Switzerland. International Organization for Migration

ISDR (2002). *Living with Risk:* a global review of disaster reduction initiatives, New York: ISDR.

Jackson, H. (2002). AIDS in Africa-Continent in Crisis. Zimbabwe. SAFAIDS

Jafry, T. (2000). 'Women, Human Capital and Livelihoods: An Ergonomics Perspective'. Natural Resource Perspectives no. 54. London: ODI.

Judy, K. (2003). *HIV /AIDS Nursing Secretes*. Philadelphia. Hanley and Belefus Inc.

Kabir, M.A., Rahman, A.A., Salway, S. & Pryer, J. (2000). "Sickness among the urban poor: a barrier to livelihood security." Journal of International Development 12(5): 707-22.

Kantor, P. & Nair, P. (2003). "Risks and responses among the urban poor in India." Journal of International Development 15(8): 959-67.

Kapwepwe, M. & Siamwiza, R. (2001). *CORDAID HIV/AIDS Programmes Assessment:* Zambia

Khanna, B.K 2005. All you wanted to know about Disasters. New Delhi: Jai Bharat Printing Press.

Kofi A. (2000). *The impact of AIDS in Africa*. Eternal link: Victoria Britain
'More die of Aids than war in Africa'. The Guardian,

Kongsin, S. (1997). Economic Impacts of HIV/AIDS Mortality on Households in Rural Thailand. In G. Linge & D. Porter (Eds.), *No Place For Borders: The HIV/AIDS Epidemic and Development in Asia and the Pacific* (pp. 89-102): St. Martins Press.

Kumar, A. (2008). *Global disaster management*. SBS Publishers & Distributors PVT.LTD: India.

Kusanthan, T. (2000). Behavioural Surveillance Survey. Zambia HIV/AIDS Business Sector Project, DFID Project Support Unit, Burton Court, Lusaka, 2001.

Kysar R. (1991). Called to care: Biblical Images for Social Ministry. Minneapolis, (MN): Augsburg Fortress.

Lakha, R. & Moore, T. (ed.). (2004). *Tolley's Handbook of Disaster and Emergency Management Principles and Practice.* Croydon: LexisNexis.

Langan, J.C & James, D.C. (2005). *Preparing Nurses for Disaster Management*. New Jersey: Pearson Prentice Hall.

Leedy, P.D. (1980). *Practical Research: Planning and Design.* 3rd ed. NY: Macmillan Publishing Company.

Leedy, P.D. & Ormrod, J.E. (2005). *Practical Research: Planning and Design*. 8th ed. Upper Saddle River, NJ: Prentice Hall.

Lewis, S. (2004). AIDS has a woman's face: Keynote speech at the Microbicides 2004 stressing the centrality of sexism to the pandemic. New York: MS Magazine

Lindley, L, Coleman, J, Gaddist, B & White, J. (2010). Informing faith-based HIV/AIDS interventions: HIV-related knowledge and stigmatizing attitudes at Project F.A.I.T.H. churches in South Carolina. *Public Health Reports* (1): 12-20.

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

Lovell, G. (1980). *The Church and community development: An Introduction.* London. Chester House Publications

Lundberg, M., Over, M. & Mujinja, P. (2001). *Sources of Financial Assistance for Households Suffering an Adult Death in Kagera, Tanzania*. Washington DC:World Bank.

Lusaka Times Wednesday 01 December (2010). Zambia: Zambia's poverty levels is still high in rural areas. [Online]. Retrieved from: http://www.lusakatimes.com/2010/12/01/zambia-s-poverty-levels-high-rural-areas/ [2011, June 9].

Mahal, A., & Rao, B. (2005). HIV/AIDS Epidemic in India: An Economic Perspective. *Indian J Med Res* (April 2005), 582-600.

Maxwell, J. A. 1996. Qualitative Research Design: *An Interactive Approach. Applied Social Research Methods Series Vol.41*. California. Saga Publications, Inc.

Mbirimtengerenji, N. 2007. Is HIV/AIDS Epidemic Outcome of Poverty in Sub-Saharan Africa? *Croat Medical Journal*. 48:605-617.

Meikle, S., Ramasut, T. and Walker, J. (2001). Sustainable Urban Livelihoods: Concepts and Implications for Policy, London: University College London, Development Planning Unit Working Paper No. 112.

Menon, R. et al., (1998) 'The Economic Impact of Adult Mortality in Households in Rakai District, Uganda', in M. Ainsworth, L. Fransen and M. Over (eds) Confronting AIDS:

Merriam, Sharan. (1994). *Fallstudien som forskningsmetod*. Lund: Studentlitteratur.

Mfiseleni S. C. (2010). Perception of the role of church-based programmes in addressing HIV and AIDS: *a study in the Durban inner-city area*. [Online]. Retrieved from: http://www.uir.unisa.ac.za/bitstream/handle/10500/3946/dissertation_cele_m.pdf [2010, December 19]

Ministry of Finance: 2001. Ministry of Finance and Economic Development Interim Poverty Reduction Strategy Paper. Lusaka: Government Printers.

Moerbeek, H.S. (2001). *Friends and foes in the occupational career: The influence of sweet and sour social capital on the labour Market*. Dissertation Series no. 73. Amsterdam: Thesis Publishers.

Mombe, P. (2005). *Rays of hope: managing HIV and AIDS in Africa*. Nairobi: Paulines Publications Africa.

Monette, D.R., Thomas J., Sulivan, T.J. & DJong, C.R. (2005). Applied social research: a tool for the human service. Belmont, CA: Brooks/Cole-Thomson Learning 6th edition.

Morgan, D., Mahe, C., Mayanga, B., Okongo, J. M., Lubenga, R., & Whitworth, J. A. G. (2002). HIV-1 Infection In Rural Africa: Is There A Difference In Median Time To AIDS And Survival Compared With That In Industrialized Countries? *AIDS, 16*, 597-603

Moser, C. (1998). "The asset vulnerability framework: reassessing urban poverty reduction strategies." World Development 26(1): 1-19.

Mouton, J. (2001). How to succeed in your Master's and Doctoral Studies. Pretoria: Van Schaik Publishers, 1st edition

Mouton, J. (2006). How to succeed in your Master's and Doctoral Studies. A South African guide and resource Book. Van Sheik Publishers. South Africa

Mphale, M.E. Rwambali & Makoae, M. (2002). *HIV/AIDS and Its Impacts on Land Tenure and Livelihoods in Lesotho,*unpublished report for the FAO.

Mundy, D. (2007). Strengthening the capacity of African faith-based organizations to monitor and evaluate their responses to HIV. [Online]. Retrieved from: http://tilz.tearfund.org/webdocs/Tilz/Topics/hiv/aids/resource [2011, July 20]

Murphy, L.L. (2004). HIV/AIDS and Humanitarian action Insights from US and Kenya-based Agencies. Overseas Development Institute London.

Muturi, N. (2007). Faith Based Initiatives in responses to HV/AIDS in Jamaica International. [Online]. Retrieved from: www.usaid.gov/our_workglobal_health/aids/countries/afr. [2011, April 29].

Muwanga, F.T. (2001). Private Sector Response to HIV/AIDS in Swaziland -Impact, Response, Vulnerability and Barriers to Implementation of workplace HIV/AIDS prevention programmes. Unpublished manuscript.

Myers, B.L. (1999). Walking with the poor*: Principles and practice of transformational development.* Mary knoll: Orbis.

Nalugoda, F., *et al*. (1997) 'HIV Infection in Rural Households, Rakai District, Uganda', *Health Transition Review*, supplement 2 to vol. 7, pp. 127-40.

Nampanya-Serpell, N. (2000) *Social and Economic Risk Factors for HIV/AIDS Affected Families in Zambia,* paper presented at the AIDS and Economics Symposium, Durban.

Nampanya-Serpell, N. (2000). *Social and Economic Risk Factor for HIV/AIDS-Affected Families in Zambia (some research findings).* Paper presented at the AIDS and Economics Symposium, Durban, South Africa.

National HIV and AIDS Strategic Framework (NASF) 2011-2015 (25th November 2010) *Toward improving the quality of life of the Zambian Peopl*e. Zambia

National HIV/AIDS/STD/TB Council. (2001). Preliminary Strategic Report. Lusaka: National AIDS Council.

National HIV/AIDS/STI/TB Council. (2003). *National HIV/AIDS/STI/TB Intervention Strategic Plan 2002-2005*. Lusaka, Zambia: National HIV/AIDS/STI/TB Council, Zambia.

National HIV/AIDS/STI/TB Council. (2004). *The HIV/AIDS Epidemic in Zambia. Where Are We Now? Where Are We Going?* Lusaka: National AIDS Council.

National HIV/AIDS Council, Zambia. (2006). *Zambia National HIV/AIDS Strategic Framework 2006-2010*.Lusaka: NAC.

National HIV/AIDS/STI/TB Council. (2006). *National HIV And AIDS Strategic Framework 2006-2010*. Lusaka: National AIDS Council. (pp.198-258). Washington, DC: International Monetary Fund (IMF).

Neiland, E.A. & Béné C. 2004. *Poverty and small-scale fisheries in West Africa. Food and Agricultural Organization of the United Nations.* Netherlands: Kluwer Academic Publishers.

New World Encyclopedia. Lusaka. [Online]. Retrieved from: http://www.newworldencyclopedia.org/entry/Lusaka [2011, April 17]

Nkurunziza, E. & Rakodi. C. (2005). Urban household livelihoods and HIV/AIDS. International Development Department School of Public Policy. Birmingham

Oloo, NP. (2004). Ministry in the context of HIV/AIDS. The church's mission: gender and HIV/AIDS among the Luos of East Africa. [Online]. Retrieved from: http://trn.sagepub.com [2011, April 9].

Orobaton, N. Mukuka-Chilaika, C. Mutonyi, S. Mukwakwa, C & Mlewa, A (2001). Responding to the dynamic complexity of the HIV/AIDS epidemic in Zambia: The case of community-based Thandizani NGO (unpublished).

Oster, E. (2005). Sexually transmitted infections, sexual behavior, and the HIV/AIDS epidemic. *Quarterly Journal of Economics, 120*(2), 467-515.

Over, M. (2004). Impact of the HIV/AIDS Epidemic on the Health Sectors of Developing Countries. In M. Haacker (Ed.), *The Macroeconomics of HIV/AIDS*. Washington: International Monetary Fund.

Padgett, D.K. (1998). *Qualitative methods in social work research, challenges and rewards*. Thousand Oaks. London. New Delhi: Sage Publications.

Pain, A. & Lautze, S. (2002). 'Addressing Livelihoods in Afghanistan'. Kabul: Afghan Research and Evaluation Unit.

Pauly, M. V., Nicholson, S., Xu, J., Polsky, D., Danzon, P. M., Murray, J.F., *et al*. (2002). A General Model of the Impact of Absenteeism on Employers and Employees. *Health Econ, 11*, 221-231.

Peace Corps. (2001). Center for Field Assistance and Applied Research Information Collection and Exchange. Washington

Petty, C., Selvester, K., Seaman, J., & Acidri, J. (2004). *The Impact of HIV/AIDS on Household Economy*: Save the Children, UK.

Piwoz, E.G & Preble, E.A. (2000). 'HIV/AIDS and Nutrition: A Review of the Literature and Recommendations for Nutritional Care and Support in Sub-Saharan Africa'. Washington DC: Academy for Educational Development.

Perry, F. (2006). External Mainstreaming HIV/AIDS in Disasters Work Book. Tearfund Disaster Management Team, July 2006

Rakodi, C. (1999). "A capital assets framework for analysing household livelihood strategies." Development Policy Review 17(3): 315-42.

Rhodes, SD, Hergenrather, KC, Wilkin, AM, & Jolly, C. (2008). Health promotion practice. [Online]. Retrieved from: http://hpp.sagepub.com/cgi/content/-abstract/9/2/159 [2011, May 19].

Richard, L. & Morse, J.M. 2007. *Readme first for user's guide to qualitative methods*. London, New Delhi: Saga Publications, 2nd ed.

Ross, R.K. (2002). *Following Jesus and fighting HIV/AIDS*. Edinburgh: Saint Andrews Press.

Rosen, S., Vincent, J. R., Macleod, W., Fox, M., Thea, D. M., & Simon, J. L. (2004). The Cost of HIV/AIDS to Businesses in Southern Africa. *AIDS, 2004*(18), 317-324

Rose-Innes, O. (2006). HIV/AIDS, the South African culture, sociocultural aspects of HIV/AIDS. Available at: http:209.85.229.132. [Online]. Retrieved from: www.health24.com/medical/condi [2011, April 13].

Rubin, A. & Babbie, E. (1992). Research methods for social work. Pacific Grove. 2nd edition

Rugalema, G. (1999) *Adult Mortality as Entitlement Failure: AIDS and the Crisis of Rural Livelihoods in a Tanzanian Village,* PhD thesis, Institute of Social Studies, The Hague.

Saayman, W & Kriel, J (1991). Towards a Christian response to AIDS. *Missionalia* 19:2 (August), 154-167 1992. *AIDS: The Leprosy of our time? Towards a Christian response to AIDS in Southern and Central Africa.* Johannesburg: Orion

SACC. (2001). *Strategy to fight AIDS is vital*. Johannesburg: South African Council of Churches

Scoones, Ian. (1998). "Sustainable rural livelihoods, a framework for analysis" *IDS workingpaper 72*. [Online]. Retrieved from: www.ids.ac.uk/ids/bookshop/wp/wp72.pdf [2011, August 8].

Senge, P. (1994). The fifth discipline: The art and practice of the learning organization (First paperback ed.) New York: Doubleday.

Shah, M., Osborne, N., Mbilizi, T. & Vilili, G. (2002) *Impact of HIV/AIDS on Agricultural Productivity and Rural Livelihoods in the Central Region of Malawi.* Lilongwe: CARE International.

Shalina, M & Suninder K.S (2004). *Understanding AIDS. Myths, Efforts and Achiev*ements. Kul Bhushai. Nangia A.PH publishing corporation New Delhi

Siameja S.K. (2007). Measuring the impact of HIV/AIDS on economic development in Zambia. Waikato, New Zealand

Smith, M.J (1978). American Religious Organizations in Disaster: A Study of Congregational Response to Disaster. Mass Emergencies.

Smith, M J. (1988). *Contemporary communication research methods.* California: Wadsworth Publishing Company.

Spirgi, E.H. (1979). *Disaster management: comprehensive guidelines for disaster relief.* Switzerland: Hans Huber Publishers:

Stokes, C. S. (2003). Measuring Impacts of HIV/AIDS on Rural Livelihoods and Food Security. Rome, FAO

Stoke, O. (ed) (1991). Sustainable development. *Papers from the 6th EADI General Conference 1990.* UK: Frank Cass & Co. Ltd.

Strydom, H. (2002). Ethical aspects of research in the social sciences and human services professions. In Devos, A.S. (ed). *Research at Grassroots.* 2nd ed. Pretoria: van Schaik publishers.

Swift, J. (1989). 'Why are rural people vulnerable to famine?' *IDS Bulletin* 20(2): 8-15.

Tearfund, (2007). Disaster Management Team Good Practice Guidelines: HIV & AIDS Mainstreaming. [Online]. Retrieved from: http://tilz.tearfund.org/Topics/Disaster+Management/Cross+cutting+issues+good+practice.htm [2011, June 13].

The People of Zambia. [Online]. Retrieved from: http://www.zambiatourism.com/travel/hisgeopeop/history.htm [2011, October 29]

The Sphere Project. (2004). *Humanitarian Charter and Minimum Standards in Disaster Response*, London, Oxfam Publishing

Tversky, B., Kugelmass, S., & Winter. (2011) Tuscaloosa County. The Emergency Management Cycle. [Online]. Retrieved from: http://www.tuscoema.org/cycle.html [2011, June13]

Twigg, J. & Benfield G. (2001). *Hazard Research Centre, Disaster Management Working Paper 2/2001*

UI. (2005g). Landguiden länder i fickformat –Zambia – Karta. [Online]. Retrieved from: www.landguiden.se/ [2011, April 9].

UNAIDS, (2000). Guide lines for studies of the social and economic impact on HIV/AIDS. Geneva, Switzerland

UNAIDS. (2003). AIDS Epidemic Update: UNAIDS.

UNAIDS/WHO. (2007). *2007 AIDS Epidemic Update*. Geneva: United Nations.

UNAIDS. (2006). *Report On The Global HIV/AIDS Epidemic*. Geneva: Joint United Nations Programme on HIV/AIDS.

UNAIDS .(2009). *Zambia Country Report 2008*. Lusaka: UNAIDS Publications.

UNAIDS Press Release. (2000, February 2004). AIDS Devastates Health Sector In Africa: African Health Ministers Meet to Intensify Efforts Against Epidemic. [Online]. Retrieved from: www.thebody.com/unaids/africa.html [2011, April 15].

UNAIDS. (2001). The Impact of Voluntary Counseling and Testing: A global review of the benefits and challenges. [Online]. Retrieved from: http://www.unaids.org [2011, September 26].

UNAIDS. (2006) Report on the Global AIDS Epidemic. [Online]. Retrieved from: http://www.unaids.org/en/HIV_data/2006GlobalReport/default.asp [2011, April 26].

UNAIDS (2006). UNAIDS Country Profile. [Online]. Retrieved from: www.unaids.org/en/Regions_Countries/Countries/zambia.asp [2011, May 6].

UNAIDS .(2008). *Report on Global AIDS Epidemic.* [Online]. Retrieved from: http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008 [2011, May 4].

UNICEF, UNAIDS, & USAID. (2004). *Children On the Brink*. New York: United Nations.

UNDP (United Nations Development Programme) (1998). Poverty in Transition. New York, UNDP.

UNDP. (2004). Reducing Disaster Risk – A challenge for Development. United Nations Development Programme, New York.

UNDP. (2001). Human Development Report 2001. Oxford: Oxford University Press. [Online]. Retrieved from: http://www.worldbank.org/poverty/mission/up1.htm2004:1 [2011, June 5].

UNFPA. (1996). State of World Population. UNFPA, New York.

UNESCO. (2000). Towards an African Response: UNESCO's Strategy for HIV/AIDS Education in Sub-Saharan Africa (2002-2007). Dakar, Senegal: UNESCO.

UNICEF. (2006). *Girls, Women and Children and HIV/AIDS in Eastern Africa:* UNICEF

UNICEF. (2004). *Africa's Orphaned Generations*. New York: United Nations Children's Fund.

UNICEF – Publications - (2003). What Religious Leaders can do about HIV/AIDS. [Online]. Retrieved from: www.unicef.org/adolescence/index_19024.html [2011, December 14].

UNICEF. (2003). Mapping religious health assets. [Online]. Retrieved from: http://www.arhap.-uct.ac.za/downloads/ARHAPWHO_ch2.pdf [2011, June 29].

UNICEF. (2003). Mapping religious health assets. [Online]. Retrieved from: http://www.arhap.-uct.ac.za/downloads/ARHAPWHO_ch2.pdf [2011, May 1].

UNISDR Terminology on disaster risk reduction (2009) [Online]. Retrieved from http://www.unisdr.org/eneg/terminology/UNISDR-terminology-2009-eng.pdf [2010, April 13].

United Nations. (2002). *Living with Risk. A global review of disaster reduction initiatives*. Geneva, Switzerland

United Nations Development Programme (UNDP), 2004. *Reducing Disaster Risk: A Challenge for Development.* [Online]. Retrieved from: www.undp.org/cpr/disred/documents/publications/rdr/english/rdr_english.pdf- [2011, March 24].

United Nations. (2004). *The impact of AIDS*, Department of Economic and Social Affairs/Population Division, United Nations Report. United Nations Publication. [Online]. Retrieved from: http://www.un.org/esa/population/publications/AIDSimpact/AIDSWebAnnounce.htm [2011, March 28].

United Nations General Assembly. *Fifty-seventh session. A/res/57/256. 2003. International Strategy for Disaster Reduction.* [Online]. Retrieved from: http://www.unisdr.org/eng/about_isdr/basic_docs/GA-resolution/a-res-57-256-eng.pdf. [2011, March 28].

Uys, H.H.M. & Basson, A.A. (2005). Research Methodology in Nursing. Cape Town and Midrand: Creda Communication.

Van Dijk, R. (2007). The safe and suffering body in transnational Ghanaian Pentecostalism: Towards an anthropology of vulnerable agency, in *Strength beyond structure. Social and historical trajectories of agency in Africa,* edited by M. de Bruijn, R. van Dijk & JB Gewoud. Leiden: Hotei. Pp 312-333

Van der Linde. T.C. (2007). An Investigation into the Implementation of Disaster Management Activities at South Africa Academic Institutions and the Development of a Comprehensive Disaster Management System. UFS Free State.

Van Lierre, M. J. (2002). HIV/AIDS and Food Security in Sub-Saharan Africa Paper presented at the 7th Annual ECOWAS Nutrition Forum Banjul, the Gambia, 2-6 September. [Online]. Retrieved from: http://www.sahims.net/doclibrary/Documents/briefcases/hivaids/estherl_AIDSfoodsecuritypaperECOWAS.pdf [2011, July 13].

Veenstra, N. & Whiteside, A. (2005). Economic impact of HIV, *Best Practice and Research Clinical Obstetrics and Gynaecology,* Vol. 20, No. 30, Pp.1-14.

Verhaeghe, M.K. (2009). A Garden of Eden, Garden of Resilience: *The Role of the Local Church in Addressing Cultural Dimensions in Disaster Mitigation.* Oxford Brookes University

Vest, N. (2000). Desiring life: Benedict on wisdom and the good life. Cambridge: cowley Publishers.

Walters. D.(2010). Failure of Zambia's nationalisation programme: *Exploring the Factors that Precipitated the Collapse.* [Online]. Retrieved from: http://www.consultancyafrica.com/index.php?option=com_content&view=category&layout=blog&id=82&Itemid=226&limitstart=15 [2011, August 8]

Wangari, N. (2008) ZAMBIA IN THE FIGHT AGAINST HIV/AIDS. [Online]. Retrieved from: http://zamwa.wordpress.com/2008/08/29/zamwa-in-the-fight-against-hiv-aids/ [2011, February 17].

WCC Study Guide. (1999). Facing AIDS Education in the Context of vulnerability HIV/AIDS. Geneva: WCC Publication.

WCC. (2003). Responses of the faith-based organisations to HIV/AIDS in Sub-Saharan Africa. [Online]. Retrieved from: http://www.hopeforafrica.-net/NIH.html [2011, August 8].

WCC. (2001). Plan of Action: The Ecumenical response to the challenge of HIV/AIDS in Africa. [Online]. Retrieved from: http://www.wcc-coe.org/wcc/news/press/01/hivaids-lan.html. [2011, August 17].

Welcome to Northmead Assembly of God. [Online]. Retrieved from: www.northmeadassembly.org [2011, November 17].

WHO. [pdf] ZAMBIA. [Online]. Retrieved from: http://www.who.int/hiv/HIVCP_ZMB.pdf [2011, June 13].

Wiegers, E., Curry, J., Garbero, A., & Hourihan, J. (2006). Patterns of Vulnerability to AIDS in Zambian Households. *Development and Change, 37*(5), 1073-1092.

Wiegers S.E. (2007). Gender Vulnerability to AIDS and its research implications. Wageningen University Netherland.

Wikipedia Encyclopaedia. (2011). Emergency Management [Online]. Retrieved from: http://en.wikipedia.org/wiki/Emergency_management#cite_note-haddow-0 [2011, April 1]

WISC. (2005). Vulnerabilities to Natural Hazards: Models and Application on Landslides Risks in La Paz, Bolivia. World International Studies Conference, Bilgi University, Istanbul, Turkey, 24-27 August 2005.

Wisner, B., Blaikie, P., Cannon, T. & Davis, I. (2004). *At Risk: Natural Hazards, People's Vulnerability and Disasters.* 2nd ed. London: Routledge.

Wobst, P. & Arndt, C. (2004). HIV/AIDS and labor force upgrading in Tanzania. *World Development, 32*(11), 1831-1847.

World Bank (1999) *Confronting AIDS: Public Priorities in a Global Epidemic.* Oxford: Oxford University Press.

World Bank. (2002). *Implementation completion report on a credit to the Republic of Zambia for an agricultural sector investment program.* Washington, D.C.: World Bank Report No. 24444.

World Bank (2002). *Education and HIV/AIDS: A Window of Hope*. Washington DC: The World Bank.

World Council of Churches (2001). Plan of Action: The Ecumenical Response to HIV/AIDS in Africa. Global Consultation on the Ecumenical Response to the Challenge of HIV/AIDS in Africa, 1-10, 2004. Facing AIDS : The Challenge, the Churches Response. Geneva: WCC Publications.

World Council of Churches (2001). Plan of Action: The Ecumenical Response to HIV/AIDS in Africa. *Global Consultation on the Ecumenical Response to the Challenge of HIV/AIDS in Africa*, 1-10.

World Health Organization. (1995). Global prevalence and incidence of selected curable sexuallytransmitted diseases: Overview and estimates. WHO/GPA/STD, Geneva.

World Health Organization. (1996). Investing in health research and development. WHO, Geneva.

World Bank.ca. (2008). Disaster Risk Management. [Online] (Updated 2009). [Online]. Retrieved from: http://web.worldbank.org/WEBSITE/EXTERNAL/TOPICS/EXTURBANDEVELOPMENT/EXTDISMGMT0/,,menuPK:341021~pagePK:149018~p1PK:149093~theSitePK:341015,00.html [2011, November 17].

Yates, D. (2003). Bottlenecks and drip-feeds – Channelling resources to communities responding to orphans and vulnerable children in Southern Africa. [Online]. Retrieved from: http://www.jlica.org/pdf/BottlenecksanddripfeedsChannelling [2011, July 15].

Zambia. (1996). Demographic and Health Survey: Central Statistical Office, Lusaka.
Ngugi, EN., Wilson, D., Sebstrand, J., Plummer, FA & Moses, S. (1996). Focused interventions among vulnerable groups to reduce HIV transmission in Africa. Journal of Infectious Diseases, 174 (2), S240-S247.

Zambia Central Statistical Office and Central Board of Health. (2002). Zambia Demographic and Health Survey 2001-2002, Measure DHS+ ORC Macro, Calverton, Maryland, USA, October, Preliminary report.

Zambia Central Statistical Office and Central Board of Health, (2007). Zambia Demographic and Health Survey 2007. Provincial Adult HIV/AIDS Prevalence Rates, Zambia.

Zambia National HIV and AIDS Strategic Framework. (2006-2010)

Zambia Poverty Reduction Strategy Paper 2002-2004 [pdf] Ministry of Finance and National Planning Lusaka.

Zambia Red Cross Society. 2003. Vulnerability Capacity Assessment: *Sinazongwe District Zambia.* Lusaka.

Zambia. Central Board of Health/Ministry of Health. (1999). Zambia HIV Sentinel Surveillance. Time Trends in the HIV Epidemic in the 1990s. Lusaka, Zambia.

Zambia.Central Statistical Office. (1996). Zambia Demographic and Health Survey Lusaka: 1997.

Zambia. Central Statistics Office. (2001). *Living Conditions in Zambia 1998*. Lusaka: CSO.

Zambia. CSO. (2005). *Living Conditions Monitoring Survey 2004*. Lusaka: Central Statistical Office, Zambia.

Zambia. CSO. (2005). *Living Conditions Monitoring Survey 2004*. Lusaka: Central Statistical Office, Zambia.

Zambia. CSO, MOH, Tropical Diseases Research Centre (TDRC), University of Zambia, & Macro International Inc. (2009). *Zambia Demographic and Health Survey 2007*. Calverton, Maryland, USA: Central Statistical Office [Zambia] and Macro International Inc.

Zambia. MoH (2005). *National HIV/Aids/STI/TB Policy* (Government Ministry Report). Lusaka, Zambia: Ministry of Health, Government of The Republic of Zambia.

Zambia. MoH [Zambia]. (2005). *National HIV/Aids/STI/TB Policy* (Government Ministry Report). Lusaka, Zambia: Ministry of Health, Government of the Republic of Zambia.

Zambia. MoH & National Aids Council. (2008). *Zambia Country Report: Multi-sectoral Aids Response Monitoring and Evaluation Biennial Report 2006-2007*. Lusaka, Zambia: Government of the Republic of Zambia.

Zambia. Ministry of Health/Central Board of Health. (1998). National strategic health plan 1998-2000, Ministry of Health, Lusaka.

Zambia. Ministry of Finance: (2001). *Ministry of Finance and Economic Development Interim Poverty Reduction Strategy Paper*. Lusaka: Government Printers.

Zambia. Ministry of Finance and Economic Development. (2003). *Interim Poverty Reduction Strategy Paper*. Lusaka: Government Printers.

Zambia. Ministry of Health. (2005b). national health strategic plan 2006-2010, Ministry of health.

Zambia's population reaches 13 million. [Online]. Retrieved from: http://www.tireworldexports.co.za/zambias-population-reaches-13-million.html [2011, June 14].

APPENDIX A: LETTER TO PARTICIPANTS

Dear research participant

I am Rev. Darris W. Clement carrying out a study on **THE CHURCH AND DISASTER MANAGEMENT:** *An in-depth case study of the Assembly of God Church (AOG) HIV/AIDS Project in Lusaka* as part of my Masters Degree studies at the University of the Free State Bloemfontein. The aim of this research is to describe and evaluate the disaster management projects of the AOG in Lusaka (Circle of Hope Family Clinic) otherwise known as (CoH) as a model of how the church can contribute to alleviating real-world problems (AIDS in particular) and enhance lives and livelihoods opportunities of the community. Objectives of the study are: (a) to identify factors that make it necessary for HIV/AIDS interventions by AOG (b) to assess how AOG programs impact on the livelihoods of the community in Lusaka (c) to analyze the relevance of AOG in addressing HIV/AIDS and socio-economic aspects of the Lusaka community (d) to determine the sustainability of AOG programs vis-à-vis sustainable development.

Participants' names will not be used in the research and will be kept confidential. The researcher undertakes that all information provided by the participants will be treated as strictly confidential and for academic purposes only.

Disaster Management Training and Education Centre (DiMTEC)
Faculty of Agric & Natural Sciences
University of the Free State
Cell: +27 73 569 1550; Hm: +27 51 447 7750

INSTRUCTIONS:

1. **Kindly respond to all questions as truthfully as you can**
2. **Please fill in with correct information and mark 'X' where applicable**

APPENDIX B: QUESTIONNAIRE

SECTION A: DEMOGRAPHIC INFORMATION

1. Gender

Female	Male
1	2

2. Age group

Below 20	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56+
1	2	3	4	5	6	7	8	9

3. Educational level

No schooling	Primary or below	Secondary school	Tertiary	Other specify
1	2	3	5	6_____

4. Occupation

Student	Farmer	Merchant	Civil servant	Self-employment	Other specify
1	2	3	4	5	6_____

5. Marriage status

Single	Married	Divorced	Never married	Widowed	In Relationship
1	2	3	4	5	6

SECTION B: STATUS DISCLOSURE AND RELATIONSHIPS

6. Do you know your HIV status?

Yes	No
1	2

Which of the following do you fear? (Please mark with “X” all possible options)

		Yes	No	Don’t know
7	Being left by my partner	1	2	3
8	Being blamed for infection by partner	1	2	3
9	Being discriminated against by friends	1	2	3
10	Being disowned by family	1	2	3
11	Being the target of HIV-related stigma	1	2	3
12	Losing my job	1	2	3
13	Other (specify) _____ _____			

Who among the followings would you disclose your status to? (Please mark with “X” all possible options)

		Yes	No	Don’t know
14	Friends	1	2	3
15	Pastor/Priest or religious leader	1	2	3
16	Adult family member	1	2	3
17	Spouse or partner	1	2	3
18	Traditional healer	1	2	3
19	Healthcare worker e.g. doctor/nurse	1	2	3
20	Children	1	2	3
21	Other (specify) _____ _____			

SECTION C: THE ROLE OF THE CHURCH IN HIV/AIDS MITIGATION

22. Do you think that the church has a role to play in HIV/AIDS mitigation?

Yes	No
1	2

23. If 'YES' please state what you think the role of the church should be in addressing issues of HIV/AIDS._____
_____

24. If 'NO' kindly state your reason._____
_____

25 What is your understanding of why the church should be involved in HIV/AIDS mitigation? _____
_____

SECTION D: CIRCLE OF HOPE SOCIAL SUPPORT AND ITS IMPACT

26. Are you on circle of hope family care clinic project programme?

Yes	No
1	2

27. How long have you been on this programme?

0-1 year	2-4 years	5-7 years	8-10 years	More than 10 years
1	2	3	4	5

28. To what extent does this project provide a space of expressing and sharing in HIV/AIDS matters?

No room for expression	Very limited room	Enough room for expression
1	2	3

29. How has this helped you to address the challenges you faced as a result of your status?

Withdrawn	To help others	To be positive about life	2 and 3
1	2	3	4

30. How would you rate the impact this programme has had on your life, please tick the most appropriate:

It had a negative (detrimental) impact	It had no impact	It had a positive (beneficial) impact
1	2	3

31. Elaborate _____

_____

What are the services the CoH programme project provides in respect to HIV/AIDS?

		Yes	No	Don't know
32	Antiretroviral therapy (ART)	1	2	3
33	Voluntary counselling and testing (VCT)	1	2	3
34	Bereavement counselling	1	2	3
35	Food parcels	1	2	3
36	Shelter	1	2	3
37	Antiretroviral drug (ARV)	1	2	3

38	Other (specify) _____ _____

Which of these services do you benefit from at the CoH?

		Yes	No
39	Antiretroviral therapy (ART)	1	2
40	Voluntary counselling and testing (VCT)	1	2
41	Bereavement counselling	1	2
42	Food parcels	1	2
43	Shelter	1	2
44	Antiretroviral drug (ARV)	1	2
45	Other (specify) _____ _____		

46. Is CoH doing enough to empower you mentally, spiritually and emotionally to experience life abundantly?

Yes	No
1	2

47. Elaborate

_____

_____

48. What do you expect the centre and the church to do in addition to what it is already doing in the CoH project? _____

_____

49. How would you rate CoH clinic service provider?

Very poor	Poor	Average	good	Excellent
0-1	2-4	5-6	7-8	9-10

50. Why? _____

_____

51. Any other comment relating to CoH that you may want to elaborate on?

_____

_____

THANK YOU FOR YOUR CO-OPERATION