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ABSTRACT

COMPREHENSIVE CARE: PASTORAL CARE OF PEOPLE LIVING WITH HIV/AIDS IN THE PILGRIM WESLEYAN CHURCH IN ZAMBIA

by

Stephen Sitali Kakungu

This study presents a comprehensive pastoral care model that can be adopted by churches to help care for people living with HIV and/or AIDS (PLWHA) in the Pilgrim Wesleyan Church of Zambia (PWCZ). This model can help church leaders and congregants to provide comprehensive care to PLWHA. The model of care can help meet the spiritual needs, physical needs, social needs, livelihood needs, psychosocial needs, psychological needs and biomedical needs of PLWHA. This pastoral care model is holistic, integrative and collaborative in nature.

PLWHA have multiple needs that cannot be addressed by the classical pastoral care models. Classical pastoral care models focus on meeting spiritual needs at the expense of the physical, socio-economic, livelihood and the medical needs. The purpose of this study was to evaluate the pastoral care practices to PLWHA in the Pilgrim Wesleyan Church and to develop a comprehensive pastoral Care model sensitive to the needs of PLWHA.

This research was a qualitative study that utilized case studies of four local churches, personal interviews and a focus group. The sample for this study included leaders and congregants from the four local churches. The leaders for this study were the four pastors, five deacons, and five deaconesses. The congregants for this study were the three PLWHA and three members from each of the four local churches.

The findings in this study indicated that there were no planned pastoral care practices for PLWHA in the Pilgrim Wesleyan Church of Zambia. Secondly, the available spiritual care and compassionate ministry is too general and inaccessible to PLWHA and their families. Third, local Pilgrim Wesleyan Churches are significantly silent regarding HIV/AIDS and PLWHA in their respective congregations. Fourthly, all the participants identified a need for a specific ministry of care for PLWHA in the Pilgrim Wesleyan Church. Finally, almost every leader and congregant in the Pilgrim Wesleyan Church are affected significantly by HIV/AIDS.

DISSERTATION APPROVAL

This is to certify that the dissertation entitled
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A Dissertation

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In Partial Fulfillment
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Doctor of Ministry

by
Stephen Sitali Kakungu

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Stephen Sitali Kakungu

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TABLE OF CONTENTS

ABBREVIATIONS	Page vii
LIST OF TABLES	viii
LIST OF FIGURES	ix
ACKNOWLEDGEMENTS	x
CHAPTER 1 PROBLEM	1
Introduction	1
The Problem Stated	12
Purpose	14
Research Questions	14
Research Question #1	14
Research Question #2	15
Research Question #3	15
Definition of Terms	15
Comprehensive Care	15
Pastoral Care Practices	15
Classical Pastoral Care Model	15
Comprehensive Pastoral Care	16
Holistic Care	16
Compassionate Ministry	16
Ministry Intervention	17
Context	17
Overview of Zambia	18

Poverty in Zambia.....	20
Breakdown of Communal Care Practices	20
Urbanization.....	20
Orphans	21
The Pilgrim Wesleyan Church of Zambia	21
Methodology	22
Participants.....	23
Instrumentation	23
Data Collection	24
Data Analysis	25
Generalizability.....	25
Theological Foundation	26
Trinitarian Theology of Mission.....	26
Trinitarian Ministry.....	27
Overview.....	27
CHAPTER 2 LITERATURE.....	29
Introduction.....	29
People Living with HIV/AIDS	30
Needs of PLWHA	31
Contemporary Care Models.....	32
Practical Theology Care Models.....	40
Inherent Evils of HIV/AIDS	41
A Gospel without Compassion	41

Scope of Pastoral Care	42
Qualities of Pastoral Caregivers in HIV/AIDS	43
Weaknesses of Classical Pastoral Care Models	44
Purpose Driven Care Models	44
HIV Competent Churches	45
Church Assets in Provision of Care	45
Congregational Home-Based Care	46
Support Groups for PLWHA	46
Pastoral Care Moral Advocacy	47
Biblical Theological Framework	47
Trinitarian God	49
Trinitarian Mission	49
Trinitarian Ministry	53
Trinitarian Care	53
Care of the Sick in the Old Testament	54
Care of the Sick in the New Testament	56
Care of the Sick in Church History	60
Care of the Sick in Some African Traditions	64
Research Design	64
Summary	66
CHAPTER 3 METHODOLOGY	69
Problem and Purpose	70
Research Questions	71

Research Question #1	72
Research Question #2	72
Research Question #3	72
Population and Participants.....	72
Design of the Study.....	73
Instrumentation	74
Expert Review.....	75
Reliability and Validity.....	75
Data Collection	76
Data Analysis	77
Ethical Procedures	79
CHAPTER 4 FINDINGS.....	81
Problem and Purpose	81
Participants.....	82
Research Questions	87
Findings for Research Question #1	88
National Leaders’ Perceptions of Care Practices.....	88
Pastors’ Perceptions of Care Practices.....	92
Deacons’ Perceptions of Care Practices	96
Focus Group Discussion	100
Congregants’ Perceptions	102
Findings for Research Question #2.....	113
Findings for Research Question #3.....	113

National Leaders' Perceptions	114
Pastors' Perceptions	117
Deacons' Perceptions	117
Deaconesses' Perceptions	118
Members' Perceptions	122
PLWHAs' Perceptions	123
PLWHA and Caregivers' Perceptions	124
Focus Group	125
Valley View Caregivers Club	125
Summary of Major Findings	126
CHAPTER 5 DISCUSSION	128
Major Findings	128
The Effect of HIV/AIDS on Leaders, Members, and PWCZ	130
A Need for Leadership and Policy Guidelines	131
No Pastoral Care and Support Aimed PLWHA in the PWZ	132
Inaccessible Compassionate Ministry to People Living with HIV/AIDS	136
A Major Gap in Care Since WHIZ Ceased to Function in Zambia	136
Marked Silence concerning HIV/AIDS in the PWCZ Local Churches	137
Caregivers as Family Members of PLWHA	139
The Perceived Required Care and Support for PLWHA and Their Families	140
Best Practice Already Established in Care and Support for PLWHA	142
Implications of the Findings	146

Limitations of the Study.....	146
Unexpected Observations	147
Recommendations	148
Postscript.....	151
APPENDIXES	
A. Focus Group Protocol	152
B. Demographic Instrument.....	154
C. Research Questions	155
D. Expert Review Evaluation of Tools	157
E. Letter to the National Superintendent.....	159
F. Consent Form.....	161
G. Participants.....	162
WORKS CITED	163

ABBREVIATIONS

AIDS—acquired immunodeficiency syndrome

APCA—Association of Palliative Care

ART—antiretroviral therapy

ARV—antiretroviral drugs

CBO—community-based organization

CHBC—community home-based care

CD4—the white blood cells weakened by HIV

FBO—faith-based organization

HBC—home-based care

HIV—human immunodeficiency virus

ICBC—integrated community-based care

MOH—Ministry of Health

NGO—non-governmental organization

PEPFAR—President’s Emergency Plan for Relief

PLWHA—people living with HIV/AIDS

PWCZ—Pilgrim Wesleyan Church of Zambia

STI—sexually transmitted infections

TWG—technical working group

UNAIDS—United Nations AIDS

VCT—voluntary counseling and testing

WHO—World Health Organization

LIST OF TABLES

	Page
Table 2.1. Scope of Care.....	43
Table 3.1. Steps for Data Analysis.....	79
Table 4.1. National Leaders (N=4)	83
Table 4.2. Munali PWC Participants (N=15).....	84
Table 4.3. John Howard PCZ (N=24).....	85
Table 4.4. Sianakanga PWC (N=13).....	86
Table 4.5. Zimba PCZ (N=17).....	87
Table 5.1. Care & Support framework.....	150

LIST OF FIGURES

	Page
Figure 1.1. Map of Zambia	19

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CHAPTER 1

PROBLEM

Introduction

This study focuses on the comprehensive pastoral care administered to people living with the human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS; PLWHA) in the Pilgrim Wesleyan Church of Zambia (PWCZ). This chapter explores the background of the problem and presents my assertion that the global problem of HIV/AIDS is particularly problematic in sub-Saharan Africa. Furthermore, classical pastoral care models have proven inadequate in meeting the needs of PLWHA because the pastoral care focuses on meeting spiritual needs of the congregants. In this chapter, I also will explore this problem's context, develop a problem statement, state the research questions guiding this study, examine briefly the research design and methodology, explain the limitations of the study, and declare the assumptions framing my research.

In Zambia, if a person is not infected with the virus, then he or she is affected via spouse, relative, workmate, colleague, neighbor, or church member infected or affected by HIV/AIDS. This statement indicates the magnitude of the problem of HIV/AIDS in Zambia. Very few Zambians can say they have not been impacted by HIV/AIDS. Even in the church, the leaders and members are also affected at personal, family level and through workmates who are affected by HIV/AIDS. In spite of the silence about HIV/AIDS in the church, PLWHA are in the local churches, and they need comprehensive care and support.

According to Alice Amoako Ansah-Koi, PLWHA have needs arising from HIV/AIDS and they need care and support in many areas of their lives (ii). I observed these needs to be true as I served in various contexts. I served as clinical officer, pastor, and denominational leader. I observed that PLWHA have psychological and emotional needs arising out of being HIV positive. When their CD4 count was low, they needed treatment for opportunistic infections and to be put on ARVs. When they reached the stage of AIDS, they needed nursing care from either the nurses or caregivers. When they reached this stage, their work and income was affected. The income of the family and education of children was also affected. While they were on ARVs, they also needed nutritional support. The burden of care became a challenge to the family. The need for community home base care arises. Many caregivers focus on specialized needs of PLWHA. Biomedical caregivers focus on diagnosis, treatment and prevention of HIV transmission. While psychosocial counselors, focus on counseling. As for pastoral caregivers, they focus on meeting spiritual needs and occasional handouts and home visits. Most churches use classical pastoral care models that are not sensitive to African contextual issues. Classical pastoral care models are inadequate in meeting the multiple needs of PLWHA because the focus is on meeting spiritual needs. As a result, with this research I explored the need for a comprehensive, holistic, integrative, and collaborative approach to pastoral care.

This study arose from three contexts, namely, a clinical context, a pastoral context, and a leadership context. From 1985 until 1994, I worked as clinical officer in Zambia's Ministry of Health. Throughout my clinical experience, in accordance with the nature of HIV/AIDS, I observed that care needs existed on a continuum ranging from

voluntary counseling and testing (pretest, posttest, crisis counseling, and ongoing counseling), antiretroviral therapy (ART) for HIV-positive persons with low CD4 counts, opportunistic infection management, and pain management. Then I served as a pastor from 1994 until 2004. While serving as a pastor, I discovered firsthand the unique spiritual needs and issues facing PLWHA, including stigma, and rejection, as well as unanswered questions PLWHA were asking about God, the Church, their life, sickness, death etc. I also observed that PLWHA needed counseling to address the emotional or psychological needs associated with a positive diagnosis and its related stigma. As HIV develops into AIDS, PLWHA have physical needs, socioeconomic needs, and, family situations, and the need for community involvement and the care of HIV/AIDS orphans. From 2004 to 2010, I served as the overseer of the Wesleyan Church in Zambia. I observed church leaders', pastors', and church members' silence regarding HIV/AIDS and the plight of PLWHA. Of all the churches I visited, I do not remember any sermon that included discussion of the challenge of HIV/AIDS and the needs of PLWHA. Furthermore, in all aspects of pastoral care ministry of the church, including preaching and teaching, I observed a complete lack of integration or discussion of HIV/AIDS, PLWHA, and the orphan challenge. While the Ministry of Health called for a multi-sectoral response and collaboration with the community-at-large, local churches did not take advantage of the possibility of networking with government institutions and other caregivers. Worse still, pastors, deacons, and caregivers seemed at a loss when dealing with the multiple needs of PLWHA. While existing models for pastoral care proved suitable for meeting spiritual needs, they were inadequate in meeting psychosocial, socioeconomic, biomedical, and livelihood needs of PLWHA and the society.

These reasons informed my motivation to explore the need for a comprehensive, holistic, integrative, and collaborative pastoral care model sensitive to the needs of PLWHA in the Wesleyan Church of Zambia and in the communities served by this denomination. Classical pastoral care models do not meet the multiple care needs of PLWHA adequately, since these classical models focus almost exclusively on meeting spiritual needs. While pastoral caregivers often indicated a desire to provide more thorough care, they possessed limited knowledge and skills regarding HIV/AIDS and how to offer proper care to PLWHA.

Background of the Problem

The problem of HIV/AIDS is not only global, and in sub-Saharan Africa, but is also a Zambian problem. Although HIV/AIDS affects the globe, it immensely affects sub-Saharan Africa, southern Africa, and my beloved country Zambia. Nontando M. Hadebe says that HIV is a virus that causes AIDS, and AIDS is characterized by a number of diseases that are associated with HIV/AIDS (11-12). Jean Garland and Mike Blyth state that HIV stands for human immunodeficiency virus and the virus infects humans only. AIDS stands for acquired immune-deficiency syndrome. AIDS is not inherited but acquired through contact with HIV. The virus is transmitted when one has sexual intercourse with one who has the HIV virus, when one is exposed to infected blood or fluids or from mother to child during pregnancy. Garland and Blyth explain that the virus weakens the CD4 cells. The normal CD4 count range is between 650 and 1250 cells per cubic millimeter. PLWHA commence ARVS when the CD4 cells are below 350 (21-24). According to the Kara Counseling Manual, HIV 1 is found in sub-Saharan Africa and HIV 2 is found in West Africa (18). Michael J. Kelly, states that inspite of the

discovery of ARVS, the cure for HIV/AIDS has not been found (5). Therefore, the battle with HIV/AIDS continues to be a challenge and all stakeholders will need to work together in the fight against the epidemic.

Global HIV Picture

Globally, the state of PLWHA has improved due to the availability of ARVS. According to the 2010 United Nations AIDS Report on the global AIDS epidemic, more than five million people were taking ARVs. In 2009, 1.2 million PLWHA accessed ARVs. From 2004 to 2009, the deaths of PLWHA reduced tremendously due to ARVs. Between the year 2001 to 2009, in thirty-three countries, HIV reduced more than 25 percent, and twenty-two of these countries are in Sub-Saharan Africa (8). According to Kelly, in 2010, only five million PLWHA in less developed nations out of all who needed ARVs received ARVs (6). This information reveals that many who needed ARVs could not access them.

Sub-Saharan Africa

Sub-Saharan Africa has a bigger share of the numbers of PLWHA compared to other regions. The UNAIDS *Global Report* reveals that 22-24 million PLWHA live in sub-Saharan Africa. In 2009 about 1.4 million people died of AIDS and 1.9 million people became infected with HIV. Sub-Saharan Africa has more than fourteen million orphans due to HIV/AIDS. The countries most affected by HIV/AIDS were Ethiopia, Nigeria, South Africa, Zambia, and Zimbabwe (8).

According to Akakulubelwa Munalula of the council of churches in Zambia, the effect of HIV has been on social capital, population, structures, and economic growth. Furthermore, Munalula states that sub-Saharan Africa has the challenge of providing care

to PLWHA and the provision ARVs, controlling new infections and caring and supporting AIDS orphans and their affected families. Archbishop Desmond Tutu also reveals that sub-Saharan Africa has the largest number of adults and 90 percent of children living with HIV. He says that in some African countries, almost one in every ten people is living with HIV (x). The challenge of HIV/AIDS is real in sub-Saharan Africa, and the church in Africa faces the challenge of caring and supporting PLWHA and their families.

Zambia Picture

Zambia is one of the countries in sub-Saharan Africa experiencing the impact of HIV/AIDS. The Ministry of Health reveals that by the year 2009, one in every seven adults was living with HIV, about 83,000 adults were infected with HIV, and about two hundred new infections appeared each day. The main route of transmission was through sexual intercourse (78 percent), mother to child during delivery (21percent), and other roots of transmission (1 percent). In the age group 15-49 year olds, the HIV/AIDS rate was 14 percent, which was higher in urban areas than in and higher among females than among males (*Zambia Country Report* 4-8).

The above mentioned information reveals that HIV/AIDS is a reality in Zambia. In addition, the care and support should target the young people, the women, and urban populations. The fight should also target the root causes of HIV/AIDS. Therefore, all stakeholders, including the church, should be concerned about the reality of HIV/AIDS and the impact on PLWHA.

Impact on Zambia

HIV/AIDS has impacted Zambia negatively. The young people are the ones who are directly affected. Furthermore, the life span of these young people is reduced to less than 50 years old, especially if they will not access ARVs. Statistics reveal that about one million people in Zambia are living with HIV. HIV has also impacted the home, the marketplace, and the public and private sectors. The effect of HIV/AIDS on human resource has also affected the socio-economic and development of Zambia. In 2009, 50 percent of the 690,000 orphans in Zambia were AIDS orphans. The family is greatly affected, especially when the breadwinner is sick or dies (*Scale Up Plan 41*). This information indicates that Zambia's institutions are threatened by HIV/AIDS. The family, the school, the community, and the very economy of the nation are greatly threatened by HIV/AIDS. Since the Church of Jesus Christ is in the community where HIV/AIDS is threatening the very people it is called to serve, it cannot ignore the problem.

Response to HIV/AIDS

The Zambian Government is one of the Governments in Sub-Saharan Africa that has provided leadership in the fight against HIV/AIDS. It has shown commitment and seriousness in providing care and support to PLWHA. This commitment has been seen by the kind of leadership exhibited in the battle against HIV/AIDS. The government created a number of leadership support structures:

- To provide policy direction.
- To head the national multi-sectoral response.
- To provide a health sector response;
- To formulate policies related to HIV/AIDS (*Scale Up Plan 1*).

The government of Zambia also realized the importance of the fight against HIV/AIDS. In 1984, the government established committees to coordinate the prevention and control of AIDS. The various committees were tasked to coordinate surveillance on HIV infections trends, health education, and blood safety and the coordination of a multi-sectoral response (*HIV/AIDS in Zambia* 55). The churches can also learn from the Ministry of Health how leadership and structures are important in the fight against HIV/AIDS. The government also took certain measures as part of its response to HIV/AIDS. It embarked on gathering information on behavior related to HIV/AIDS, the cost of managing the fight against HIV, the existing interventions, formulated laws and policies to guide the fight against HIV/AIDS, encouraged girl education and strengthened the health care system in order to manage the HIV epidemic (*HIV/AIDS in Zambia* 58-59). The church also needs information on HIV/AIDS, the existing interventions and its own internal and external resources in order to fight against HIV/AIDS.

The government also mobilized leaders from all sectors of life, including religious leaders to provide leadership in the fight against HIV/AIDS. Political leaders were encouraged to use their influence to fight HIV/AIDS and stigma. Leaders from all sectors of life were encouraged to educate their constituents to make sure HIV was on the national agenda and strategic planning. All leaders from all sectors of life were welcomed into various committees and encouraged to fight stigma, discrimination and HIV/AIDS (*HIV/AIDS in Zambia* 59). The PWCZ can also mobilize its leadership and equip them to engage its constituents on HIV/AIDS. The various leaders from the whole denomination can be educated and trained to fight stigma and discrimination against PLWHA.

In the fight against HIV/AIDS, leadership is a critical factor in influencing the community. Religious leaders have great influence not only in the church, but also in the community. Many people, including the church thought that HIV/AIDS was a medical problem. However, the epidemic's impact on all sectors of life led many people to begin acknowledging that HIV/AIDS was more than a medical problem. Church medical ministries along with the government of the Republic of Zambia were among the first groups to respond to the HIV/AIDS crisis, which resulted in a biomedical psychosocial approach or model of care. Church health institutions were among the first to use the aforementioned approach to include spiritual aspects of care. Home-based care then emerged in order to decrease the burden on overstretched medical institutions. Finally, an integrative approach is emerging, in which aspects of palliative care and home-based care is integrated into the aforementioned model. However, many churches have continued using the classical pastoral care model that focuses on meeting spiritual needs of the sick to the detriment of their livelihood and psychosocial needs. Religious leadership is needed in order to influence the perceptions and to provide the relevant care and support to PLWHA.

Pilgrim Wesleyan Church

The Pilgrim Holiness Church of America started the Pilgrim Wesleyan Church of Zambia in 1933 (*Pilgrim Wesleyan Discipline* 2). From the church's inception, both the founders and the local leaders espoused a holistic perception of ministry. In the past, PWCZ has responded to the socioeconomic, physical, and spiritual needs of the community. As such, Wherever the PWCZ planted a church, a clinic, a school, and agriculture ministry grew out of the spiritual outreach ministry. With the HIV epidemic

affecting all sectors of life and community in Zambia, PWCZ needs to join the fight against HIV/AIDS, especially since HIV affects many church members, relatives, and community members. In many cases, when husbands and breadwinners die, they leave behind orphaned children or wives not prepared to work outside the home. In some cases when both parents have died, grandparents end up caring for the children. The health caregivers in government hospitals and the families of PLWHA have experienced the burden of HIV/AIDS.

PWCZ medical ministry has responded to HIV/AIDS with a biomedical, psychosocial, and spiritual model of caring for PLWHA. Medical professionals in the church health institutions are church members and they have also experienced the impact of HIV/AIDS. However, most local churches have remained silent regarding the issue of HIV/AIDS and PLWHA. HIV/AIDS is still perceived as a medical problem and not the part of the core business of the church. The increasing number of affected people and orphans calls for a comprehensive pastoral care ministry to PLWHA.

Pastors are faced with a challenge to provide care to PLWHA since the existing pastoral care models were suited for providing spiritual care. Classical pastoral care models fail to address adequately the multiple needs of PLWHA since they are focused on meeting spiritual needs of the members and the community. The classical pastoral care model does not address the socioeconomic and psychosocial needs of PLWHA. Pastoral care needs to provide a theologically relevant caring and healing ministry for PLWHA. This study explored the possibility of a comprehensive, holistic, integrative, and collaborative pastoral care model for PLWHA. Through the research process, I

continually sought to discover characteristics of a comprehensive pastoral care model for meeting the multiple needs of PLWHA in the Pilgrim Wesleyan Church.

In order to provide comprehensive pastoral care to PLWHA, pastors need the appropriate biblical and theological foundations of missions and ministry. The pastoral caregivers need a biblical perspective of ministry, of human beings as well as the appropriate care models to help them provide care and support to PLWHA. Such a pastoral care model should be biblically grounded, holistic, integrative, and collaborative in nature. Pastoral caregivers can learn from the Triune God who owns the mission, ministry, and caregiving to PLWHA. Pastoral caregivers can integrate care practices from other care models and then collaborate with other care providers such as social workers, health care workers, community-based organizations and the government. Health institutions, hospitals, clinics, nongovernmental organizations (NGOs), and community faith-based organizations use a number of contemporary models in caring for PLWHA. Existing contemporary care models other than pastoral care models also fail to meet all the needs of PLWHA when they leave out the spiritual needs of PLWHA. For instance, the biomedical care model focuses on HIV diagnosis, ART therapy, opportunistic infection management, and pain management; while the psychosocial counseling care model focuses on voluntary counseling and testing.

A number of studies have been done on pastoral care. However, no study has examined PLWHAs' comprehensive pastoral care needs based on Trinitarian theology of pastoral care, human personhood as viewed from God's perspective and the Wesleyan tradition of holistic care.

The Problem Stated

PLWHA have multiple needs not met by classical pastoral care models because these models are focused on meeting spiritual needs rather than psychosocial and livelihood needs. The needs of PLWHA range from the need for HIV diagnosis, asymptomatic stage needs, symptomatic stage needs, treating opportunistic infections, end life care, orphans, and socio-economic needs. In addition, PLWHA must be able to access the care, and the care must address the wide range of needs. Therefore, for the church to provide spiritual care, mere home visits and mere encouragement, is to ignore the holistic needs of PLWHA. Sue Parry writes, “A comprehensive response integrating prevention, care, support and treatment for the HIV infected and affected is needed within the social reality of the communities we serve” (29). The Catholic Church has been in the forefront in providing comprehensive care to PLWHA and their families. Most churches focus on meeting spiritual needs of PLWHA, ignoring the rest of the needs arising out of HIV/AIDS.

HIV/AIDS is a multi-sectoral problem rather than a mere biomedical problem because it affects the biomedical, psychosocial, physical, socioeconomic, nutritional aspects, and spiritual aspects of life. Furthermore, the family’s livelihood and resources are affected creating more problems for the families of PLWHA. When parents are sick or die, children and the elderly parents are left to look after children. The church cannot continue offering handouts without dealing with the real problems. With the growing understanding of the challenge of HIV/AIDS, governments, health care providers, and other care providers have realized that HIV/AIDS affects the whole human person and all

sectors of life. As such the care needs and care burden poses a challenge for the healthcare system, the family, caregivers, the community and the church.

The Wesleyan Quadrilateral framework provides a method for theological reflection on the issue of care for PLWHA. This framework is composed of four elements: Scripture, tradition, reason, and experience. Albert Outler introduced the quadrilateral as a theoretical structure for theological reflection (Thorsen 5). Its four foundations are the basis for formulating Christian teaching and practice. Therefore, in this study, I explore the teachings of the Scripture on God, human beings, sickness, and the healing ministry of the Trinitarian God. I also look at the church in history to discover the beliefs and practices for sick persons. Finally, I use reason and experience to relate HIV/AIDS and the plight of PLWHA to the teachings of the Scripture. The comprehensive pastoral care and support model emerged from theological reflection according to the Wesleyan quadrilateral. The Wesleyan pastoral care model based on Wesley's ministry to sick people is comprehensive, holistic, integrative, and collaborative in its service provision.

In order for PLWHA to receive adequate care, a comprehensive, holistic, integrative, and collaborative pastoral care model is necessary. Such a model for pastoral care is possible if pastoral caregivers adopt Trinitarian theology, particularly God's view regarding humanity (Gen. 1:26-27), creation (Gen. 1-2), and the fall of humankind (Gen. 3). In addition, pastoral caregivers must learn from the Trinitarian mission to redeem humankind (John 1) to wholeness, and God's invitation to the Church (Matt. 28:18-21; John 20:21) to carry on God's mission. Accordingly, comprehensive pastoral care is part of God's mission to bring about wholeness and can have a significant impact on PLWHA

while addressing the wide spectrum of needs. A pastoral care model with a biblical theological framework based on the Trinity, creation, human personhood, the Fall, and God's pursuit to restore humans to wholeness through the Church, will empower PLWHA for abundant life.

Purpose

The purpose of this study was to evaluate the effectiveness of current pastoral care practices with PLWHA in PWCZ and to develop a comprehensive pastoral care model that meets the holistic needs of the PLWHA. In order to collect data related to the problem and purpose, I formulated three research questions.

Research Questions

The following research questions helped gather data on the effectiveness of the current pastoral care practices to PLWHA and develop a comprehensive pastoral care model that is sensitive to the diverse needs of PLWHA.

Research Question #1

What are the current pastoral care practices for PLWHA in the local churches of the PWCZ? I utilized semi-structured interview protocols, individual interviews, and focus group discussions as instruments in this study. I also analyzed the available documents such as annual reports, and policies in order to gather data on pastoral care practices. I purposely chose four local churches and interviewed the leaders, congregants to identify specific pastoral care practices used by the PWCZ. I interviewed the leaders (i.e., pastors, deacons, deaconesses), and members, both PLWA and non-PLWHA.

Research Question #2

How effective are the current pastoral care practices to PLWHA as perceived by church leaders, congregants, and PLWHA? For this research question, I used a semi-structured interview protocol, individual interviews, and focus groups to determine the effectiveness of the pastoral care practices of the PWCZ.

Research Question #3

What changes in the current pastoral care model would increase its effectiveness in meeting the needs of PLWHA? Through this question, I hoped to determine which care practices the PWCZ should pursue in order to address the gaps in pastoral care and develop a model that meets the needs of PLWHA.

Definition of Terms

In this section, I define the terminologies as used in this study.

Comprehensive Care

For the purpose of this study, comprehensive care refers to a care model that meets the multiple needs of PLWHA, their families, and the community.

Pastoral Care Practices

Pastoral care practices involve the culture of care and the activities the leaders and the congregants perform in response to the needs of PLWHA and their families. Furthermore, these activities are directed at meeting the needs of PLWHA in the church and communities.

Classical Pastoral Care Model

The classical pastoral care model focuses on the worship needs, evangelism needs, fellowship needs, and teaching needs of congregants and the community without

addressing the psychosocial and livelihood needs of PLWHA. The pastoral care model continues with what it calls *the core business of the church* while ignoring contemporary issues such as HIV/AIDS, poverty, unemployment, gender inequality, gender-based violence, and abuse of citizens' rights. The model does not meet the socioeconomic, political, and developmental needs of its members or PLHWA.

Comprehensive Pastoral Care

This model of care encompasses prevention, treatment, care, and support to PLWHA in the church and community. It focuses on the holistic needs of PLWHA. This model integrates HIV/AIDS in the ministries of the church and also integrates care models from social science that are in agreement with the teaching of the Scriptures. As such, comprehensive pastoral care features networking, and collaboration with bio-medical and psychosocial caregivers, social workers, and other organizations involved in the care of PLWHA.

Holistic Care

Holistic care views people as whole beings and provides care for the whole person according to spiritual needs, psychological needs, social needs, economic needs, nutritional needs, cultural needs, biomedical needs, and palliative needs.

Compassionate Ministry

Compassionate ministry occasionally gives handouts to the orphans, the sick, and the vulnerable in the church and community. Most local churches have a department for compassionate ministry to those who are vulnerable.

Ministry Intervention

Through this study, I sought to evaluate the effectiveness of current pastoral care practices in local churches of the PWCZ in order to develop a more responsive comprehensive pastoral care model to meet the multiple needs of PLWHA in the PWCZ. This study utilized a qualitative design with case studies of four local churches in the PWCZ. In order to obtain data on the problem, fulfill the purpose of the research, and find answers to the research questions, I drew participants from the four local churches in the PWCZ. The participants were leaders and congregants. The leaders were the four pastors, five deacons, and five deaconesses from each of the four congregations. The congregants included three PLWHA members and three non-PLWHA members from each of the local churches. I also collected data from four national leaders who are policy makers. I personally conducted one-to-one interviews, semi-structured interviews, and focus groups and analyzed any available documents.

Context

The setting of this study is the country of Zambia. An overview of Zambia and the PWCZ will serve to place this study in its proper context. During the 2012 World AIDS Day, Paolo Marandola made the following statement:

War against HIV is far from over.... Medical interventions alone will not sort out the pandemic. If in Zambia, 75,000 people die every year and 82,261 are newly infected... The scale up of access to ART still means that we are considering only those with CD4 below 350 and not those with CD4 above 350 who are HIV positive health and sexually very active.
(qtd. in the Post 3)

According to this information, the problem of HIV/AIDS is more than a medical problem. Furthermore, not every HIV positive person has access to ART. This lack of access to ART eventually will mean that HIV positive persons living in Zambia, will

soon progress to full blown AIDS status. The National AIDS Council also revealed during the World AIDS Day that 16,200 girls aged between 15 and 24 were among those persons infected by HIV last year. Furthermore, the National AIDS Council chairperson, Bishop Joshua Banda, revealed, “[E]very hour, about three youths were infected.... [I]n 2011 alone, two of those infected were girls.” He further said that Zambia had 69,000 new infections (3).

Overview of Zambia

Zambia’s population was estimated to be thirteen million in 2010 and seventeen million in 2006. Most Zambians lived in the rural than urban settings (65 percent of Zambia is rural compared to 35 percent urban). The Copper belt province has the largest population followed by Lusaka (15 percent compared to 13.5 percent). Lusaka province is the most urbanized with 82 percent of the population in urban centers; (Central Statistical Office, Living Conditions xxix).

Zambia is one of the landlocked countries in Southern Africa, being surrounded by Mozambique, Zimbabwe, Malawi, Tanzania, Congo Democratic Republic, Namibia, Botswana, and Angola (CSO, Living Conditions 1). The map of Zambia shows the location of the study in two sites: Lusaka City andimba, a new district situated near the tourist capital of Livingstone (see Figure 1.1).

ZAMBIA



Source: Zambia Demographic Health Survey.

Figure 1.1. Map of Zambia.

Poverty in Zambia

The Central Statistics Office (CSO) reports that Zambia is one of the world's poorest countries. The majority of Zambians live in rural areas. In 2010, the rural population was poorer than that of urban areas. In 2006, 80.3 percent of persons in rural areas lived below the poverty line while 29.7 percent in urban areas lived below the poverty line. According to this report 62.4 percent of female-headed households lived below the poverty line in 2010. In 2006, 67 percent female-headed households were living below the poverty line (CSO Living Conditions xix). This information indicates the magnitude of poverty in Zambia. The implications are that when female-headed homes are affected by HIV/AIDS, the economic situation of the family grows worse in the existing context of poverty.

Breakdown of Communal Care Practices

A breakdown of communal care structures exists due to poverty, urbanization, and unemployment challenges existing in Zambia. Alfred Kalembo discusses how the extended family provides care and support to vulnerable members of the family. He mentions colonialism, urbanization, and the search for employment in urban Zambia as some of the negative influences in the African communal care system (5-13). Therefore, the breakdown of the communal care system leaves sick persons in the hands of children and old parents without the necessary resources to provide comprehensive care to PLWHA.

Urbanization

The CSO report indicates that Lusaka province was the most urbanized with more than 82 per cent of the population living in the urban areas in 2010 (CSO Living

Conditions xxix). The cities have also a bigger share of HIV infection rates than rural areas. Many city people are so busy. They no longer appreciate the African communal care system. This high rate of busyness has an effect on the care of PLWHA. Accordingly, if neither the government nor the church provides structures for care and support in the cities, then the burden becomes greater on the families of PLWHA.

Orphans

Zambia has a large problem with its number of orphans. According to the CSO report,

- In 2010, 15.8 percent of the population were orphans.
- In 2010, 56.5 percent of the orphans were paternal orphans.
- In 2010, 28.7 percent of the orphans were double orphans.
- Maternal orphans numbered 14 percent in 2010 (CSO Living Conditions xxix).

Zambia has a problem of orphans in addition to the challenge of HIV/AIDS, and some of these orphans are as a result of HIV/AIDS.

The Pilgrim Wesleyan Church of Zambia

The context of this study is the Pilgrim Wesleyan Church of Zambia. The PWCZ was established in 1930 by the Pilgrim Holiness Church of America. In 1968, the Wesleyan Methodist Church and the Pilgrim Holiness Church merged to become the Wesleyan Church. In Zambia, the church combined its two previous names, calling it the Pilgrim Wesleyan Church (PWCZ Discipline 136). The PWC is most predominant in the southern province of Zambia, followed by Lusaka and the Eastern part of Zambia. The PWC exists in nine provinces of Zambia. The PWCZ has a registered membership (called

covenant members) of 32,228 and 490 churches as of 2012 national conference (*PWCZ, 17th National Conference*). The church has a demographically diverse national leadership consisting of men, women, youth, and both clergypersons and the laypersons. The national superintendent oversees the denomination and is assisted by the assistant national superintendent, the national secretary, and the national treasurer. Covenant members of the church elect national leaders, district leaders, and local church leaders (*PWCZ Discipline 136-42*).

The PWCZ has several ministries as part of its mission in Zambia, including a medical ministry with a hospital and three clinics or health centers. The evangelistic and missions ministry is responsible for taking the church's ministries to the rest of the country and to other countries such as Malawi and Uganda. Other auxiliary ministries are the men's ministry, the women's ministries and the youth ministries (*PWCZ, Discipline 157-56*). Following its last national conference, the PWCZ established a new ministry effort, the social ministry, charged with promoting social and economic empowerment in the church and the communities served by the church (*17th National Conference*). The church also has a Bible college that trains its pastors for the pastoral ministries of the denomination.

Methodology

PLWHA have multiple needs that cannot be met by classical pastoral care models. Classical pastoral care models are focused on meeting spiritual needs while ignoring the psychosocial, socioeconomic, livelihood, and physical needs of PLWHA. The purpose of this study was to evaluate the pastoral care practices towards PLWHA in

the Pilgrim Wesleyan Church of Zambia; and to develop a more comprehensive pastoral care model that is sensitive to the needs of PLWHA.

Participants

This was a qualitative study that used case studies of four local churches and a purposive sample of key leaders, local church leaders, congregants and PLWHA. I interviewed the key leaders because they are the policy makers who determine the direction of the church. In Africa, if change is to take place, the leaders have to be involved. The followers have great respect for their leaders and easily follow what the leaders perceive to be important. I selected the pastors, deacons, and deaconesses because they provide pastoral care to the congregations and the community. I interviewed members in order get their perceptions on the care practices of the local churches. Finally, I also interviewed PLWHA because they are affected directly by HIV and AIDS. The participants were from both rural and urban settings. Since the church exists in both urban and rural contexts, I chose two local churches from Lusaka City and two from Zimba town in the southern part of Zambia. I also interviewed caregivers because they also are involved directly in the care of PLWHA.

Instrumentation

I used individual interviews and focus groups in order to obtain data from the participants. In qualitative studies, the researcher is the primary instrument; therefore, I conducted the interviews with the pastors, deacons, deaconesses, members who are non-PLWHA, and members who are PLWHA. To gather data on pastoral care practices to PLWHA and to develop a comprehensive pastoral care model for PLWHA, I used two instruments in this study. I administered a semi-structured interview guide during

individual interviews and a semi-structured interview protocol for the focus groups. I administered a semi-structured interview guide to leaders, pastors, and PLWHA who did not want to participate in focus group discussions. For focus groups, I administered a semi-structured interview protocol (five deacons, five deaconesses, three members who are non-PLWHA and three PLWHA). The interview guide consisted of three sections designed to answer the three research questions. I used researcher-designed interview questions for both personal interviews and focus group discussions to obtain data on pastoral care practices towards PLWHA. I used the same questions for both personal interviews and focus group discussions. The purpose of using the same questions was to promote consistence and to obtain the perceptions on care practices towards PLWHA. Finally, analyzed the data, and reported the findings, to the leaders and congregants.

Data Collection

First, I sought permission from the overseer of the church. The national superintendent authorized me to conduct the research in the two districts of the Pilgrim Wesleyan Church. He even suggested that I select churches from Lusaka andimba to represent the urban and rural churches. I made an appointment to meet with the district overseers. The district overseers provided authorization to carry out the research in the four local churches. Next, I contacted the pastors and set interview dates. Before the interviews were conducted, I explained the purpose of the study and its benefits, and then I asked for participants' consent to participate in the study. I also explained that participation was voluntary and that they were free to withdraw from the study at any time. In addition, I explained to the participants that they would receive no remuneration for participating in the study. However, I also told them the ways in which the findings

might benefit leaders, congregants, and PLWHA. Once participants gave their consent by signing the consent form, I then went ahead to conduct the interviews. I conducted the interviews at venues convenient to the participants and at a specified time, lasting one hour. I collected data from leaders (four pastors, five deacons, five deaconesses) and congregants (three non-PLWHA members and three PLWHA members) from each of the four local churches, using a semi-structured interview protocol, individual interviews, and focus group discussions. I explained to participants my reasons for recording the responses and how I planned to use the information. I assured the participants of confidentiality in the process of the study. I used pseudonyms instead of actual participants' names. I also analyzed the annual conference reports of the national conferences and local church conferences in order to obtain data regarding care practices and activities carried out by the church towards PLWHA.

Data Analysis

This qualitative study used collective cases of four local PWCZ churches. I developed a matrix of responses from the various participants in order to identify the themes. I color-coded similar responses in order to identify the themes.

Generalizability

This study was limited to the four local churches in the PWCZ. As such the findings can be generalized only in the PWCZ and other local churches in the same area as the PWCZ. The results of the study are of significance to leaders and congregants of local churches in the provision of leadership and comprehensive care to PLWHA. The limitation of the study is that only the perceptions of the key leaders, pastors, deacons, deaconesses, members, and PLWHA from the four local churches provided the basis of

the conclusions on care practices towards PLWHA. I did not involve leaders, deacons, members, and PLWHA from other churches.

Theological Foundation

This study rests upon Trinitarian theology of mission and ministry with a focus on pastoral care for PLWHA. The ministry of care flows out of the Trinitarian God who himself is missional in creation, in the Fall of humanity, and in the sending of God the Son. The Incarnation, ministry, suffering, death, and resurrection of Jesus Christ are all part of the activities of a missional God. The life and ministry of Jesus Christ and the sending of the Holy Spirit and the Church are part of God's missional activities.

Trinitarian Theology of Mission

According to Stephen Seamands, God the Father, the Son, and the Holy Spirit exemplify mission and ministry. Mission began with God and was the first attribute of God before he gave the Church the mission mandate. According to Seamands, mission begins with the Triune God as the sending God. He states that according to the Scriptures, God the Father sends the Son; the Son sends the Holy Spirit; and, the Father, the Son, and the Holy Spirit send the Church into the world. God's mission begins with creation of humans in God's image (Gen. 1:26-27). Therefore, the owner of missions and ministry is God and not the church (*Ministry* 160-61). God's mission in the world reveals how human beings are very important in the sight of God. For God to send his only Son into the world and to allow humans to crucify him and to die such a death reveals the importance of human beings. Therefore, human beings have value, dignity, and worthy. Even with the Fall and loss of the relationship with God (Gen. 3), God still goes on a mission to find and reconcile human beings to himself (Gen. 12; John 1; 3:16). He

dresses Adam and Eve with leaves (Gen. 3:20) and embarks on a journey of seeking human beings to be reconciled to him.

Trinitarian Ministry

The coming of the Lord Jesus Christ on earth was part of God's mission to restore human beings to wholeness, which was lost (Gen. 3; Luke 4:8-19). Jesus preached, taught, and healed sick people (Matt. 4:23-25). The psalmist looks at God's creation and celebrates the human being as important in God's plan, wondering how God so cares about the human being who is created a little lower than angels (Ps. 8). Jesus' healing ministry is also explored as a source of theory for care of PLWHA. Jesus serves as a model for ministry in preaching, teaching, and healing sick persons. He not only focused on proclaiming or teaching, but he took time to bring wholeness to the physically challenged, the outcasts, and the sick. In Matthew 25, Mark 1:40-45, and Luke 10:25ff, he gave an example of how humans ought to care and support one another by being in solidarity.

Overview

I completed this study in order to evaluate the pastoral care practices with PLWHA in the PWCZ and to develop a comprehensive pastoral care model sensitive to the multiple needs of PLWHA. Participants included leaders and congregants in four local churches, representing the 490 local churches in the PWCZ. The participants were church leaders, specifically consisting of one pastor from each of the four local churches and five deacons and five deaconesses from each of the four local churches. The congregants in the study included three members who are PLWHA and the three members who are non-PLWHA from each of the four local churches.

In Chapter 2, I review the literature concerning PLWHA, their needs, the care continuum, the existing contemporary care models, and the biblical and theological foundations for the study. The biblical and theological foundation focuses on the Trinitarian mission and its effect upon the Church's mission and human personhood and how these foundations relate to care and healing for PLWHA. I also discuss the theology of care and healing found in the Old and New Testaments, historical views regarding the theology of care and healing, and the Wesleyan tradition of pastoral care for sick persons.

Chapter 3 describes in detail the methodology I used in this research, and Chapter 4 presents the analysis of data. In Chapter 5, I discuss the findings of this study and offer an interpretation of these findings in comparison with the literature and the theological framework. Along with the conclusion, I offer recommendations for a comprehensive pastoral care model that responds to the needs of PLWHA.

CHAPTER 2

LITERATURE

Introduction

Classical pastoral care models are inadequate in addressing the multiple needs of PLWHA since they focus on meeting spiritual needs of worshippers and the community. PLWHA have multiple needs not met by classical pastoral care models because these models focus only on meeting spiritual needs rather than on psychosocial and livelihood needs. These needs exist on a continuum ranging from the need for HIV diagnosis, asymptomatic stage needs, symptomatic stage needs, and treating opportunistic infections, end-of-life needs, orphans, and socioeconomic needs. In addition, PLWHA must be able to access the care, and the care must address their wide range of needs. The purpose of this study was to evaluate the pastoral care practices to PLWHA in the Pilgrim Wesleyan Church and to develop a comprehensive pastoral care model that is sensitive to the needs of PLWHA.

The following sections present a review of the literature on PLWHA, their needs, and the best-practice care models in the context of HIV/AIDS. Then I explore the biblical-theological framework based upon the Wesleyan Quadrilateral. This construct provides the theological framework for reflection on the challenge of HIV/AIDS and the care of PLWHA. I also present biblical theology of ministry, which is founded on Trinitarian theology, with particular exploration of Trinitarian theology, Trinitarian mission, Trinitarian ministry, and God's perspective of human beings. Human beings deserve holistic care because they are created in the image of God and they are created whole. Therefore, pastoral caregivers cannot focus only upon meeting spiritual needs.

The soul and the spirit are embodied; therefore, caregivers cannot neglect the physical and socioeconomic needs of human beings. The Old and New Testaments, the early Church, the Wesleyan movement, the Catholic social service model, and the African communal model all feature care for the sick.

People Living with HIV/AIDS

Tutu speaks to the way in which HIV/AIDS affects multiple sectors of society:

HIV impacts not just individuals ... but also households, entire communities and countries at large. We are now witnessing many homes headed by children who need care themselves. We are recalling grandparents from retirement to give care to those affected and infected. Moreover, women, who are often the backbone of families in Africa, are disproportionately affected by HIV, due among other factors, to gender inequalities and sexual violence. (x)

HIV/AIDS affects more than PLWHA; it also affects family and community. PLWHA have multiple needs that arise out of HIV/AIDS. Classical pastoral care models cannot address these needs. These needs may be physical, emotional, psychological, social, spiritual, and biomedical. According to Kunyima Banda, an HIV activist, the problem of HIV/AIDS stigma still exists in Zambia. Banda states, “We find again that stigma is high in the families, they don’t accept family members that are HIV positive. Even now we still have experiences where they are being excluded from family gatherings because they perceive them as sick” (qtd. in the Post 7). Philip Jenkins reveals how some African Christians read and interpret the Bible in the era of HIV/AIDS. Some have interpreted HIV/AIDS as a plague sent by God, similar to the Egyptian plague, while others think HIV/AIDS is due to sin against God (80-81).

Needs of PLWHA

PLWHA have diverse needs requiring the attention of caregivers. J. Uwimana and P. Struthers study revealed that some of the needs of PLWHA include the need for pain management, medical needs, psychosocial needs, financial needs, home-based care, nutritional support, and symptom management. Their study also revealed that caregivers do not attend to palliative care needs. Furthermore, their study used a mixed methodology of both quantitative and qualitative research. The study sample consisted of 306 participants (PLWHA, health care workers, and coordinators of HIV/AIDS clusters). The data was analyzed separately and then triangulated (Uwimana and Struthers 575-85).

A study by M. Agbonyitor identified the needs of PLWHA as including the need for protection from discrimination, lack of money, food, transportation to clinics, and lack of closer access to antiretroviral drugs (303-12). In another study on the needs of PLWHA, De Loenzien M. includes the failure of PLWHA to keep up with their outpatient appointments, the stigma, and the lack of workplace safety measures and association of HIV/AIDS with drug use as areas of need. In this study, focus groups and interviews collected data from thirty PLWHA and twenty-two volunteers concerning their experiences in home-based care programs and possible areas of improvement (141-48). PEPFAR describes the scope for meeting the needs of PLWHA:

- The stage when people living with HIV have no symptoms,
- When PLWHA have symptoms of sickness or end of life issues,
- Psychological needs, spiritual needs, social care needs, prevention needs, and nutritional needs,
- Care of orphans, issues of livelihood, and gender inequalities, and

- Integration of care and collaboration of caregivers (President's Emergency Plan, *Zambia Operational Plan Report 52*). This section highlights the range of needs and the scope of the care needed. The continuum of needs can be overwhelming for caregivers without collaborating and networking with other caregivers.

Contemporary Care Models

Best practices exist in the field of care for PLWHA, and caregivers use these practices globally and in sub-Saharan Africa. PWCZ can integrate these best practices in its current pastoral care practices. A review of relevant literature discovered the following care models for PLWHA.

Voluntary counseling and testing (VCT).

VCT serves as the entry point for accessing comprehensive care for PLWHA. Counselors are specialized to provide pretest, posttest, and ongoing psychosocial counseling. Once a person is diagnosed as HIV positive, the counselors refer the person to medical caregivers who will perform a thorough biomedical examination before commencing ART. Kennedy Chola Mulenga, describes two phases of HIV and AIDS counseling: pre- and post-HIV test. The pretest counseling determines the reasons for desiring the test, explores past history of risk behavior, and presents the opportunity to educate the counselee on prevention of transmission of HIV.

Biomedical care.

The Ministry of Health has well-trained health workers who are able to manage or treat illnesses related to HIV/AIDS (*Management of Opportunistic Infections v-viii*). The role of biomedical care is to ascertain whether one is HIV positive or negative. Once the diagnosis is made, the doctors need to find out the CD4 count. If the CD4 count is below

350, then ART is warranted. Health caregivers also have the role of managing opportunistic infections and monitoring the intake of ART. The medical caregivers also see the PLWHA monthly while they are taking ARVs. They advise on nutrition and how to access the available care in the community. When opportunistic infections are contained, they refer PLWHA to the nearest clinic and home-based care for ongoing care and support (*Management of Opportunistic Infections vii-vii*). The church needs to advise and encourage its members to go for VCT. Furthermore, the church can collaborate with the health institutions in order to make VCT accessible to its members and community.

Home-based care (hbc).

The home-based model of care has proven very helpful in providing holistic care to PLWHA. Mwiya Mundia, states that hbc is one of the best care models in providing care to PLWHA. The hbc serves as a vehicle for meeting various needs of PLWHA. This model of care has proven helpful as a means of providing physical, emotional, spiritual, and palliative care to terminally ill persons (Mundia 20).

The African Palliative Care Association (APCA) study identified several hbc models used in sub-Saharan Africa. Some models focus on

- Providing care in the homes,
- Incorporating hbc in hospice care,
- Incorporating hbc into orphans and vulnerable children care and
- Incorporating hbc into hospital departments.

The study also revealed that the common hbc models are

- Community hbc (chbc),
- Integrated community-based home care (ichbc),

- Hospice care with hbc services.
- Hospital-supported hbc services, and
- Outreach services that include hbc (APCA i).

These care models indicate the integration of elements of other care models in order to improve the care of PLWHA.

In order to meet the holistic needs of PLWHA, in Zambia, the National Aids council has defined the standards for community hbc organizations. These standards are holistic and cover the areas of prevention, treatment, care and support, human resources, and management of HBC (National AIDS Council iii). These standards provide guidance on how care and support should be provided to PLWHA. The standards also cover the various needs of PLWHA in a comprehensive way.

Palliative care model. Palliative care focuses on end-of-life needs of PLWHA and the care they require. The care involves management of pain and the care and support required for a person to have a dignified death. According to the U.S. President's Emergency Plan for AIDS Relief, palliative care "aims to achieve optimal quality of life for PLWHA and their families and to minimize suffering through mobilizing clinical, psychological, spiritual, and social care throughout the entire course of HIV infection" (*HIV/AIDS Palliative Care* 3). This care provides relief from physical pain and psychological pain due to sickness from which one will not recover. This care encompasses the management of physical pain, promotion of emotional and mental health, provision of spiritual, and social and practical care of the sick person (African Palliative care Association, online article). Palliative care is concerned with the welfare of the sick person and addresses the end of life issues facing PLWHA.

Livelihood care.

Mekonnen Dinku's study reveals that HIV/AIDS plays a significant role in impoverishing PLWHA. HIV/AIDS increases poverty by reducing household assets, social, human, financial and natural capacities. Therefore, he carried out a study to find ways of reducing the long term impacts of HIV/AIDS. The purpose of the study was to examine the effectiveness of income generating activities in the life of PLWHA. Data was collected by using questionnaires, focus group discussions, and in-depth interviews. Both quantitative and qualitative research methodologies were used. The findings were that PLWHA who participated in income generating activity had better livelihoods than PLWHA who did not participate in any income generating activity. The other finding was that income-generating activities have a disadvantage with an added cost of monitoring and mobilizing resources (viii-ix). The church can collaborate with banks and micro-finance organizations in providing capital for livelihood of PLWHA.

Mundia reveals a shift in needs of PLWHA from medical needs to the need for livelihood empowerment. He recommends economic empowerment for PLWHA and collaboration with other sectors in order to meet the need for empowerment (20). The church should consider the above mentioned findings in order to meet the livelihood needs of PLWHA.

Prevention of infection.

Prevention of infection is also another model of care giving. This response focuses on dissemination of information, educating on HIV/AIDS and communication of information and knowledge on HIV/AIDS. According to the Ministry of Health, interventions to reduce HIV infection through heterosexual route should involve

- Reducing the number of sexual partners,
- Delaying sexual activity among young people
- Using condoms,
- Controlling sexually transmitted diseases, and
- Encouraging voluntary counseling and testing (*HIV/AIDS in Zambia* 55-58).

I was aware that Faith Organizations do not encourage promotion of condoms to those who are not married. However, the church can promote abstinence and faithfulness in marriage.

Another form of preventive care is the prevention of transmitting the disease from mother to child. The Ministry of Health provides care to mothers and the unborn through promoting the prevention of mother to child transmission and the screening of blood before transfusion (*HIV/AIDS in Zambia* 53-54). The Church can partner with the Ministry of Health in providing prevention of mother to child infection.

Spiritual care.

PLWHA have unique spiritual needs compared to the rest of church members. Therefore, pastoral caregivers who provide traditional care without integrating HIV/AIDS are not sensitive to the needs of PLWHA. While PLWHA need salvation and the usual ministries, they have unique needs that cannot be addressed by the usual church ministry. Spiritual care should address the questions PLWHA have regarding God's role in their lives. Seamands encourages all who are wounded to bring their woundedness to the wounded healer who is Jesus Christ. The pain of being HIV positive and the threat of HIV/AIDS should be taken to the wounded healer who is Jesus Christ. Seamands encourages the wounded to come to the cross of Christ in order to find spiritual healing.

Jesus Christ knows the meaning of being wounded by stigma and is familiar with all kinds of suffering (*Wounds* 9-21).

Comprehensive care. Parry says that comprehensive care involves HIV prevention, treatment, care, and support for PLWHA. In addition, it encompasses impact mitigation, advocacy, care of orphans and vulnerable children, and research (72). De Loenzien's study reveals that PLWHA, their families and health workers, perceive comprehensive care and treatment as very important and recommend that social and psychological care should be integrated into biomedical care for PLWHA.

Comprehensive care involves using several interventions and given at various sites (e.g., the hospital, home, community, or hospice; 141-48).

Biomedico-psycho-socio-spiritual care model.

The biomedico-psychological-socio-spiritual care model is common in mission hospitals and in some government hospitals. In addition to providing biomedical care, mobile hbc and chaplaincy services are integrated. The hospital may provide nutritional care, hbc kits to community caregivers, and psychosocial counseling as in the case of Zambia. Edith Khakasa Chemorion examined the possibility of integrating spiritual care to the biomedical psychosocial model of care. Chemorion used the qualitative methodology and a case study of the mission hospital in the Reformed Church of Kenya. The purpose of the study was to address the spiritual needs of PLWHA not found in the biomedical-psychosocial care model. The researcher used oral interviews, written interviews, and participant observation. Chemorion found that PLWHA had unmet spiritual needs that the medical care model could not address (iv-v).

Case management in comprehensive care.

Case management is one of the tools social workers use in facilitating care to people under their care. Case management is a tool that social workers and health caregivers use to access the continuum of care. It is “a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual’s holistic needs, through communication, and available resources to promote quality, cost effective outcomes” (12th Case Management Conference). The elements of case management are:

- Planning,
- Facilitating,
- Advocating for options and services to meet an individual’s needs, and
- Using communication and available resources to provide quality cost-effective care.

Pastoral caregivers can be trained how to manage care giving to PLWHA through case management. The pastoral caregivers can also collaborate with other care providers involved in a client’s system of care such as family, employers, service provision organizations, and other health providers. If PLWHA have to receive comprehensive care and access the whole spectrum of care, then integration of principles of case management in the care of PLWHA should be considered by caregivers.

World Hope International (WHI) model of care.

The WHI model is based on Jesus’ model of care (Luke 4:40). Jesus is seen as passing on the care model to his disciples and empowering his disciples to continue with

the healing ministry. WHI, like Jesus, extends compassion to PLWHA and orphans by collaborating with caregivers who are members of PWCZ local churches. This model works through local churches, families with orphans, and PLWHA . World Hope International used the following strategies to provide care to PLWHA and orphans:

- Economic empowerment of family caregivers,
- Care and support to orphans and PLWHA, and
- Training of caregivers in caregiving.

This faith-based organization targeted the youth in schools and communities and equipped them on how to make right choices. In 2010, WHI experienced the following care and support outcomes:

- Provided care to 32,567 orphans and vulnerable children,
- Provided care to 89,876 PLWHA and orphans,
- Trained 3,417 caregivers to orphans and PLWHA,
- Provided 8,921 people with counseling and testing for HIV/AIDS, and
- Provided 45,009 youth with prevention programs (WHI *An Outpouring of Love* 12-13).

WHI was motivated to provide care to PLWHA and orphans by Christ's compassion and continued mission on earth. The church is also called to continue in Christ's mission, ministry, and vocation of care.

The 40 developmental asset care model. The young people in Zambia are the ones directly affected by HIV/AIDS. The best approach to providing care and support to the young people is to have a positive approach, such as the one the Search Institute developed. This approach is called the 40 Development Assets for adolescents. It is based

on forty positive qualities that empower youth to live positively. Once the youth develop these qualities, they become more caring, more responsible, and more productive. The forty positive characteristics are derived from eight principles:

- Support from the caring community
- Empowerment from the leaders,
- Life in an environment that sets boundaries and expectations,
- Positive use of time,
- Desire to keep learning,
- Development of positive values,
- Development of social competencies, and
- Development of a positive outlook on life (“The Development Asset Profile”).

This model can be used to develop young people who are either just HIV positive or are recovering from illnesses related to HIV/AIDS. The model can also be used to develop young people who have an HIV-negative status

Practical Theology Care Models

A number of researchers in practical theology have explored a number of pastoral care models in the era of HIV/AIDS. These care models have been proven as helpful in the care and support of PLWHA. Thomas Muhomba indicates that AIDS poses a challenge to theology of care for PLWHA. He further says that HIV/AIDS is a big challenge to the church because it forces the church to revisit its theology of care giving and to find new ways of doing ministry (Muhomba, Abstract). HIV/AIDS exposes some of the evils humans can inflict on fellow human beings who are HIV positive or those who are living with HIV/AIDS.

Inherent Evils of HIV/AIDS

In order to respond adequately and comprehensively to the problem of HIV/AIDS and the plight of PLWHA, Christopher J. H. Wright emphasizes the need to understand the evils hidden in the epidemic. He describes the evils accompanying HIV/AIDS:

HIV/AIDS invades life, and threatens with death; it induces prolonged physical suffering, anxiety, pain and decay; It spreads in many ways, primarily through sexual intercourse; it thrives on gender inequalities; it does not respect innocence; It creates orphans and widows; It destroys the hope of the young; It creates psychological trauma, panic, guilt, self hatred, anger, violent revenge, and despair. HIV/AIDS causes and exploits poverty; it exposes the world imbalance of resources; It creates reactions in the church like condemnation and deceit; and it is a disease that affects every aspect of human life e.g. labour, productivity, procreation, pleasure, faith, education, physical health and mental health. It also affects the unborn, the infant, the child, the youth, adults and grandparents. (435-37)

Wright gives a vivid picture of how evil HIV/AIDS can be and how it affects various people. The emergence of HIV/AIDS has exposed the church's attitude towards those who are HIV positive. The church must reflect seriously on the impact of HIV/AIDS on PLWHA and their families. It must understand the magnitude of the problem on the family and community. HIV/AIDS attacks the dignity, the value, and the honor of human beings. The prevailing perceptions and attitudes devalue PLWHA in the local churches and communities.

A Gospel without Compassion

HIV/AIDS has posed a challenge to classical pastoral care models since these models focus on meeting spiritual needs only. Richard Stearns paints a vivid picture explaining that the gospel has a hole in it when Christians focus on personal salvation:

The idea behind The Hole in Our Gospel is quite simple. It's basically the belief that being a Christian, or follower of Christ, requires much more than just having a personal and transforming relationship with God. It

entails a public and transforming relationship with God. It also entails a public and transforming relationship with the world. (2)

Stearns also cites Johnny Cash's song which states, "You are so heavenly minded and you're no earthly good" (2). The church today and its leaders prepare people who are so spiritual that they are irrelevant to the community. Classical pastoral care models focus on meeting the spiritual needs at the expense of social economic needs, and livelihood needs of human beings.

Scope of Pastoral Care

Vhumani Magezi presents the scope of pastoral care as healing, sustaining, guiding, reconciling, nurturing, liberating, and empowering (137). This care model gives a number of elements for pastoral care to PLWHA and their families (see Table 2.1).

Table 2.1. Scope of Care

Pastoral Care Function	Historical Expression	Contemporary caring and counseling expression
Healing	Anointing, exorcism, saints and relics, characteristic healers	Pastoral psychotherapy, spiritual healing, counseling and therapy
Sustaining	Preserving, consoling, consolidating	Supportive caring and counseling, crisis counseling, bereavement caring and counseling
Guiding	Advice giving, devil-craft, listening	Educative counseling, short-term decision making, confrontational counseling, spiritual direction
Reconciling	Confession, forgiveness, disciplining	Marriage counseling, existential counseling (reconciliation with God)
Nurturing	Training new members in Christian life, religious education	Educative counseling, growth groups, marriage family enrichment, growth enabling care through developmental crises
Liberating		Raising awareness about sources of oppression and domination in society
Empowering		Encouraging one to develop one's own alternatives

Source: Magezi 137.

Qualities of Caregivers in the Era of HIV/AIDS

Mulenga presents the qualities needed for pastoral caregivers for PLWHA. He says that pastoral caregivers should facilitate the healing of broken relationships. The caregivers must not condemn PLWHA and their families, but should come alongside PLWHA. They should teach on life after death, and all members of the church should be

active in care. He describes the clergy's role as that of equipping the congregants to provide pastoral care to PLWHA (10).

Weakness of Classical Pastoral Care Models

David J. Bosch explains the weaknesses of classical pastoral care models. He says that the current crisis in pastoral care has arisen due to the ordained ministry monopolizing pastoral care and neglecting the whole congregation. Ministry is supposed to be carried out by all congregants and not the pastor alone. Bosch says that Jesus chose the twelve apostles and commissioned them to be ministers instead of the priests of his day (467). Accordingly, Bosch's claims agree with Paul's teaching in Ephesians 4, where leaders are advised to understand their role as that of equipping the congregation to provide pastoral care. Johan Janse van Rensburg and Johann Breed state that the previous pastoral care models were inadequate due to separation of pastoral care and charity. These care models focused on providing mere encouragement from the Bible, giving advice and prayer. The models did not empower the recipients to find solutions to their problems.

Purpose-Driven Pastoral Care Model

Rick Warren mentions a number of reasons why most churches are not relevant. He says that the reasons have to do with what drives these churches. For instance some churches in Zambia are driven by tradition. Other churches are driven by the personality of the leader of the denomination. Personality-driven care model is common in Africa where the leader determines what should be done in the church. His or her vision, even when not shared by the church members, moves the church forward. Finances, buildings, events, seekers, or programs drive other churches (77-80). Churches planted by Western

missionaries in Africa seem especially driven by programs that have nothing to do with helping the poor, the vulnerable, or unemployed or fighting corruption, injustice, and HIV/AIDS. Warren recommends the purpose-driven church as the biblical model.

HIV Competent Churches

Parry presents a framework leaders of churches can use in responding to HIV/AIDS. She explains how churches can become competent in the fight against HIV/AIDS. The book is divided into four parts. The first part of the book explains why churches need to be HIV competent. In the second part, she describes inner competence, which involves the need to deal with stigma and discrimination both individually and collectively. Then in the third part she outlines the three essential steps in bridging between inner and outer competence. She describes the change that should take place before people engage in caring for PLWHA. She challenges caregivers to understand HIV and the challenges of PLWHA. Finally, in part four she presents seven processes involved in developing competency in care giving. Theological and technical competence is required in order to provide the care needed by PLWHA. This part also emphasizes the point that the church is called to bring more than programs and medicines to PLWHA. Instead, the church is called to restore dignity and bring hope in a compassionate way (8-9). Caregivers surely need inner and outer competency in order to provide comprehensive care to PLWHA. As for pastoral caregivers, the caregiving should have a biblical theological foundation. Thereafter, the caregivers need the technical knowledge about HIV/AIDS and the best practice in HIV/AIDS care and support.

Church Assets for Provision of Care

Garland and Blyth describe the church as well positioned to address most aspects of the HIV/AIDS pandemic. The church is in the community and country and its influence can be an asset. The church has resources that can facilitate the care and healing of PLWHA. The church has resources such as love, care, support, and justice. Values such as abstinence and faithfulness in marriage can be used to fight the battle of HIV/AIDS. However, inspite of the all these resources, the church has also been known for stigmatization and discrimination (101-09). In addition, the church has medical ministries that have some of the best-trained professional care providers in the nation of Zambia. The church has both tangible and intangible assets.

Congregational Home-Based Care

Magezi recommends that the congregation is key to providing home-based pastoral care to PLWHA. The congregation is called to continue in the mission of God to care and support human beings here on earth and in the life to come. The church is given stewardship of the gospel, which is God's means of extending hope and salvation to PLWHA. Pastoral care is also viewed as a congregation role and not the pastor's role alone. The church as the people of God is also expected to engage in care and support of PLWHA as a practical response to HIV/AIDS (iii). The congregation, which is the people of God, has resources like small groups, where members experience love, acceptance, prayer, and community. The caregivers can encourage PLWHA to form support groups and also to provide care to each other. The church can form hbc ministries in order to provide care and support to PLWHA. The diaconal ministries can be part of HBC ministries in the local churches.

Support Groups for PLWHA

Japhet Ndhlovu advocates for the creation of fellowship groups (circles of hope) for PLWHA in local churches. The small fellowship groups (circles of hope) provide care and support to People living with HIV. The foundation of circles of hope is based on the African practice of sitting around the fire or under a tree. In African traditional life, the circle of people under a tree creates a place for fellowship, where people come together to brainstorm and resolve communal issues. Surrounding someone with people who care and love that person offers safety and hope. The circles of hope provides a means for providing care and healing among PLWHA. They can face issues together and even counsel each other in a welcoming environment. I tend to agree with Ndhlovu that small communities for PLWHA provide a healing atmosphere where they can discuss issues facing them and also provide fellowship (187-224).

Pastoral Care Moral Advocacy

Pastoral caregivers need to be moral advocates for God in the context of dehumanizing conditions like HIV/AIDS. Pastoral moral advocacy involves caregivers continuing in God's mission to human beings who are either dehumanized by sin or conditions like HIV/AIDs or fellow human beings (Anderson 218-23). When pastoral moral advocates come along side the PLWHA, they begin to experience life without stigma and discrimination, and their lost dignity is restored. Pastoral caregivers should go beyond mere preaching and become moral advocates for PLWHA. PLWHA experience emotional and psychological trauma when the church fails to advocate for their needs and care. When the church ceases to be the place for social and communal development for PLWHA, the Triune God is grieved.

Biblical Theological Framework

Parry writes to the church about the importance of addressing the threat of HIV both theologically and practically:

[C]oming to terms with HIV, AIDS, the resulting impact, and developing appropriate effective responses has been a hard learning curve especially for faith based organizations.... In reaching out, we need to ensure that our actions are socially relevant and culturally appropriate as well as being theologically and technically sound. (8-9)

Classical care models are satisfied with mere home visits, prayer, and mere encouragement as sufficient care for PLWHA. Some pastoral caregivers think that caring and supporting PLWHA is not a core business of the church. The perception is that the government, non-government organizations, and specialized faith-based organizations are responsible for the fight against HIV/AIDS.

In this section of the study, I presented the Wesleyan Quadrilateral as the framework for theological reflection on HIV/AIDS and PLWHA. The framework provides the basis for looking at Scriptures, tradition of the church, the role of reason, and the role of human experience in the era of HIV/AIDS. *The Book of Discipline of the United Methodist Church* presents the Wesleyan Quadrilateral as the basis for theological reflection on pastoral care (78-90). Don Thorsen also presents the Wesleyan Quadrilateral from his studies of Wesley's theological reflection (1-5). The Wesleyan Quadrilateral presents four criteria for theological reflection: the Scriptures, tradition, reason, and experience (5-32). The first element of the framework, which is Scriptures, provided the biblical teaching about God, human beings, the problem of sickness, and the response to the plight of human beings. The second element is followed by the role of tradition (historical church theory and practice) in formulating the response to the plight of the sick

in the era of HIV/AIDS. I also used reason in my reflection of the role of Scripture, tradition, experience, and culture in my study of the care of PLWHA. The Scriptures reveal what God says about himself, humanity, challenges of humans, and the solutions to these challenges. Tradition helps to look at theological beliefs and practices of the church in history on care giving. Reason helps to reflect on Scripture, tradition, and the contemporary means of solving the problem of caregiving. While experience helps people reflect on whether the biblical-theological solution, the practices of the church in history, and the contemporary practices are relevant to the problem at hand. Given my Wesleyan heritage, I looked to the Wesleyan quadrilateral as the underlying theoretical framework for this study. Using the first element of the Wesleyan Quadrilateral, which is Scripture, I first explored Trinitarian theology and related it to God's mission, ministry, and the manner in which God's mission shapes the Church's mission practice to the world of the sick.

Trinitarian God

The Bible presents God as Father, Son, and Spirit. The Scriptures reveal that God refers to himself in the plural (Gen. 1:26; Isa. 6:8), refers to the Spirit of God as God (Gen. 1:2; Isa. 63:10-14), refers to the Messiah as God (Ps. 2; Isa. 9:6), refers to the Trinity (Matt. 3:13-17; 28:19; John 14:15-23), and refers to each person of the Trinity as God. The Father is referred to as God (Matt. 6:6-15 7:21); the Son is also referred to as God (John 1:1-18; Col. 2; Heb. 1:8-10); and, the Spirit is referred to as God (Mark 3:29; John 15:26; 1 Cor. 6:19-20). The Scripture refers to the Triune God in both the Old and New Testaments (Milne 5-79).

Trinitarian Mission

In the Scriptures, the Triune God is on the mission to create human beings as part of his first mission:

Let us make mankind in our image, in our likeness, so that they may rule over the fish in the sea and the birds in the sky, over the livestock and all the wild animals, and over all the creatures that move along the ground. So God created mankind in his own image in the image of God he created them; male and female he created them. (Gen.1:26-27, NIV).

In this text the Triune God reveals himself as a missionary from the very beginning. God the Son comes into the earth on a mission to redeem human kind (John 1; cf Gen. 1). The Apostle Paul in Romans 3:21-26, reveals Jesus Christ as the Son of God and the redeemer. In Matthew 28:18-20, the Triune God is revealed by Jesus Christ (Lewis 243-84). The Triune God is missional right from creation, in the mission of the Jesus Christ and of the Holy Spirit. Seamands states that the church talks and sings about the Triune God who is the Father, the Son, and the Holy Spirit without understanding the meaning (*Ministry* 10). According to him, Trinitarian theology is the foundation of ministry in care and support ministry to fellow human beings. The Triune God invites human beings to participate in the life of the Trinity, and ministry flows from that community. The Trinity reveals the nature of God, the Christian life, and ministry. Seamands presents seven characteristics of Trinitarian life and ministry, which can transform the ministry of care to PLWHA. The Trinity reveals the Triune God existing as one in community of Father, the Son, and the Holy Spirit. The Trinitarian community is the foundation of human personhood. Therefore, to be a human being is to be made in the image of God, which is one of relationship, communion, and community. From Trinitarian theology, the church can learn the principles that govern human interaction and the life and ministry of

care giving which are: equality, submission, relationships, and individual differences (18-19). The implication of this teaching is that the church of Jesus Christ needs to create spaces for community and relationships. Therefore, a church that does not value small groups and community is a contradiction of what it is supposed to be. The church should be a community and a place where individuals and families can learn how to relate and promote wholeness. For instance, a church can promote small communities for PLWHA to interact and provide care for each other. The church itself is to be a community where PLWHA can feel safe and protected from stigma and discrimination. The church is supposed to be place where love and care is experienced in community.

The foundation of Trinitarian ministry is to be in community and fellowship with the Triune God. Caregivers come from the community of fellowship with the Triune God and other believers and move into the community to serve others. Caregivers and PLWHA experience joyful intimacy modeled by the Triune God. In the first place, anybody outside the community of the Trinity is invited to experience salvation. Thereafter, the believer can experience the joy of not only community, but the joy of being in love with God. When the caregiver and the PLWHA are in community with the Triune God, they have the privilege of being in an intimate relationship with God and each other. Stigma and discrimination have no room in the Trinitarian community. Jesus demonstrates how to be intimately related to the Father and the Holy Spirit in John 17. He not only prays for himself but also for those outside the Trinitarian community and all believers.

When the Triune God originally created human beings, they were perfect and whole. Human beings enjoyed a loving relationship with God and were free from

sickness or disease. When Adam and Eve sinned against God, they lost the loving relationship with God and each other (Gen. 3). Since the Fall, human beings have lost the loving relationship and are now vulnerable to sickness and death (Gen. 3). Even with the fall, God has been on a mission to restore humans to the loving relationship and wholeness (Gen. 1:15). The mission to restore human beings to a loving relationship with him, belongs to God. He is the first missionary as evidenced in the Trinitarian mission.

Wright states that mission begins with God with a mission (Gen. 1-2) and is then passed on to humanity (Gen. 1:27-28; 2:15), to Israel (Gen. 12:1-19), then to Jesus with a mission (Isa. 42; 49:6; Ps. 2:7; 2 Cor. 5:19), and finally to the church with a mission (Luke 24:45-47; Isa. 43:10-12; Wright 62-67).

Mike Rynkiewicz also states that mission belongs to God (*missio Dei*). He says mission belongs to the three persons—Father, Son, and Holy Spirit. According to Rynkiewicz, even creation is part of God's mission. Creation is the Triune God reaching out in self-giving love to create others and invite them into the Trinitarian loving relationship and community. Creation is the Triune God extending his community by creating others in his image. The Triune God declares his creation as good and empowers creation to be fruitful and multiply and be a blessing to the rest of God's creation. Even with the fall, the Triune God goes on a love mission to restore human beings (Gen. 3:8-24).

In Genesis 1-2, human beings were created in the image of God for a purpose. They were created to form communities characterized by reaching out, self-giving, and other embracing love. Human beings are created to continue with the mission of God and to be ambassadors for God's mission. When human beings fail to carry his mission, the

Triune God sends one of the persons of the Trinity on the mission to redeem human beings (John 1; 3:16). Jesus Christ then incarnates by entering into society in a human form (John 1). He comes into society in a non-threatening manner in order to restore the wholeness that was lost in Genesis 1-3. He becomes a refuge and identifies with the poor, vulnerable, and the sick in society. When he begins to minister, he introduces the Trinitarian ministry. He identifies himself as a missionary for the Father in heaven. He announces his mission:

The Spirit of the Lord is on me, because he has anointed me to proclaim good news to the poor. He has sent me to proclaim freedom for the prisoners and recovery of sight for the blind, to set free the oppressed free to proclaim the year of the Lord's favor. (Luke 4:18-19)

Jesus introduces Trinitarian ministry by being sent by God the Father and by being anointed by the Holy Spirit to bring forth wholeness and healing to human kind.

Trinitarian Ministry

Jesus Christ introduces the Trinitarian ministry in Luke 4:18-19. The Trinitarian ministry begins with the God the Father who sends God the Son. In order to carry out the Trinitarian ministry, Jesus is anointed by the Holy Spirit to bring the good news of salvation. The scriptures reveal the Triune God in mission and now involved in ministry to human beings through Christ (Luke 4:18-19). The nature of this mission and ministry is all about reaching out, self-giving, and welcoming others into fellowship. God the Son also invites the Church to participate in the Trinitarian mission and ministry. In the book of John, Jesus invited the church to participate in the mission of God. Jesus said, "As the Father sent me, I am sending you" (John 20:21, NIV). Since the Triune God is a missionary by nature, and human beings are created in the image of God, human beings

ought to be missional. The church should be characterized by reaching out to fellow human beings who need care and support.

Trinitarian Care

Comprehensive care is based on the Triune God who has given humanity the human worthy (Gen. 1-2; 9). According to the Old Testament, human beings are created in the image of God (Gen. 1-2). This image of God gives human beings dignity, honor, and worth. The Triune God defines how a human being is to be treated. In fact, the Triune God demonstrates the importance of a human being by the Incarnation, suffering, death, and resurrection of the Son of God the Lord Jesus Christ.

Care for the Sick in the Old Testament

According to the Old Testament Scriptures, the Jewish people were also faced with the challenge of sick people. The biblical-theological foundation of Old Testament care for human beings arises out of the concept of the image of God. According to the Old Testament Scriptures, human beings were created in the image of God:

Let us make mankind in our image, in our likeness, so that they may rule over the fish in the sea and the birds in the sky, over the livestock and all the wild animals, and over all the creatures that move along the ground. So God created mankind in his own image in the image of God he created them; male and female he created them. (Gen.1:26-27)

The implication of the teaching that humans were created in the image of God was that humans were of value and thus needed to be protected by God and fellow human beings. Therefore, in Genesis 9:6, God creates precedence that human beings were to be protected by law. The Scripture states that human life is to be protected. The biblical theology of the value of human beings lays the foundation for the care and protection of

human beings in spite of the race, class, color, or religion. James R. Estep, Jr. explains the meaning of being human by citing Psalm 8:

When I consider your heavens, the work of your fingers, the moon and the stars, which you have set in place, what is mankind that you are mindful of them, human beings that you care for them? You made them a little lower than the angels and crowned them with glory and honor. You made them rulers over the works of your hands; you put everything under their feet.... (3-6)

Estep says that being human comes from being made in the image of God. They bear the image of God, which distinguishes them from the rest of creation. The image of God in human beings defines God the creator. Estep goes on to say that Psalms 8 reveals the value of human beings. He believes the term image and likeness reveals that humans are representative of God and signifies that humans are holistic and whole (7-9). Scriptures present a human being as whole and does not separate the body, soul, and spirit as most caregivers disembodied a human. This image of God in human beings requires that human beings be treated with dignity and honor. Wright also agrees, "All human beings have dignity and equality" (423). Therefore, the church of Jesus Christ is to reflect the value, dignity, and honorable position of human beings in its life and ministry.

Estep presents four views on what the image of God means: the substantive view, the functional view, the relational view, and the teleological view (14-15). These views are describing human beings from different angles. However, the human being is whole and cannot be divided into parts.

Stearns develops his theology of care from the Old Testament teaching of justice and mercy. He points out that God expects Christians to promote justice and mercy. He develops this understanding from the teaching of Micah. In Micah, he believes that God is challenging his people to live up to the way of mercy and justice (Mic. 6:8). The

second text, which he relates to what God expects of human beings in caregiving, is Isaiah 58. The worshipers are busy with their business as usual (e.g., with their prayers and fasting), yet they neglected issues of justice, oppression, the hungry, the poor, strangers, and the naked. In fact, the text says that they turned away from their own flesh and blood and claimed to be worshipping God. Stearns says that God is not satisfied with worshipers who are busy with rituals and liturgies ignoring the social economic and livelihood issues of fellow human beings. These believers were neglecting the care and support of their fellow believers like some churches are doing in the context of HIV/AIDS. The kind of worship that pleases God is one where the worshipers are concerned about the plight of fellow human beings. According to Stearns, the other text that Christians of today may consider to remove from the Scriptures is Matthew 25 where Jesus identifies with the thirsty, the stranger, the naked, the sick, and prisoners. According to Jesus, failure to care for the sick and vulnerable is failure to worship him (Stearns 54-59). Some interpreters have said that this text refers to the apostles or disciples of Jesus (France 355). Joe Kapolyo describes divergent views on who the brothers are in Matthew 25. Scholars are divided on whether the texts refer to the need, and the poor or missionaries of Jesus Christ (1164). However, the context mentions the needy and not the missionaries of Christ. I tend to agree with interpreters who see the needy as the object of care in this text.

Care for the Sick in the New Testament

In the New Testament, Jesus Christ introduces a holistic ministry of care and support to those who are vulnerable. In fact the Incarnation, the suffering, death, and

resurrection reveals how much God cares about a human being. Jesus Christ moves into the community preaching, teaching and healing all manner of illnesses and diseases.

Samaritan care model (Luke 10:25-37).

In the book of Luke, Jesus established the importance of caring for the sick and vulnerable in society. In Luke 10:25, an expert of the law asked Jesus how to obtain eternal life, and Jesus answered the lawyer by asking him what the Scriptures say. The man replied that one has to love God with all of his or her heart, all the soul, all the strength, and the entire mind. Jesus narrated a story about a person who was beaten by robbers and left for dead. Three people, including a Jewish priest, a Levite, and a Samaritan found the man who needed care and healing. The Jewish priest and the Levite passed by without stopping to help the injured man. What made these two religious persons fail to help the half dead person was their concern for maintaining religious purity (Morris 189). Similarly, churches have reasons why they fail to respond to the plight of PLWHA. Only the Samaritan took time to stop and to attend to him and to take the injured man to the hospital. Then Jesus asked the man in the text which of the passers-by was actually a true neighbor. The Good Samaritan took time to attend to the wounded man and proved to be the good neighbor. In this passage, Jesus taught about care for the vulnerable and the sick for any human being in need. He revealed that human beings are valuable and worth of care in spite of race and faith. This care is not only for those in the faith community but also for any human being who is in need of care and support. PLWHA are human beings worthy of the dignity and honor of care and healing (Luke 10:25-37). PLWHA are objects of God's love, care, and compassion.

The Samaritan care model provides both the theoretical and praxis of care to PLWHA. First, the caregiver, who is the Samaritan, had no relationship with the person who needs care. The only relationship was the human solidarity between the care provider and the vulnerable person. Second, the caregiver took his time to attend to the injured person on the street. He also might have had a program waiting for him, but because a fellow human being was in need, he responded to the need. The priest and the Levite ignored the plight of the injured person. Third, the caregiver attended to the wounds of the injured person. Fourth, the caregiver used his own resources and transport to take the injured person to the hospital. Fifth, the caregiver helped the injured person with the admission process to the hospital and even paid the medical bill. He also promised to come back to check on the sick person. PLWHA have various needs that both individual Christians and the congregation can address. In the case of the Good Samaritan, the caregiver did his part and then referred the sick person to other caregivers at the hospital.

Jesus' care model (Mark 1:40-45). A man with leprosy came to Jesus Christ and said, "[I]f you are willing, you can make me clean" (Mark 1:40). Jesus responded, "'I am willing,' he said, 'Be clean'" (Mark 1: 41). The leprosy left him and he was cured. Jesus sent him away at once to the religious priest for cleansing. The leper broke the rules of Leviticus 13-14. The leprous person was supposed to wear torn clothes and leave his or her hair uncombed. That person had to cover his upper lip and cry out, "Unclean, unclean." He or she was an outcast, separated from the community (Lev. 13:45-46). This leper broke the silence and the rules of the religious community and reached out to Jesus for care and support.

Ben Witherington III, describes the response of Jesus to the plight of the leper:

Jesus heals the man anyway and we are told quite specifically that he touched him, which stands in contrast to what we find in 2 Kings 5:10. This would certainly render Jesus unclean, but the issue of Jesus' view of the Levitical laws is not really fully broached until Mark 7. One could argue that Jesus was willing to incur uncleanness in order to help others, but this seems an inadequate assessment because we are nowhere told that Jesus, like the man he heals, ever went through the ritual cleansing after this encounter. What Mark will suggest in chapter 7 is that Jesus believed that with the in breaking of God's dominion these rules about clean and unclean, and indeed also various Sabbath rules, were obsolescent. Such rules had fulfilled their purpose, but now the Holy One of God had appeared and a new state of affairs was at hand. (103-04)

Jesus welcomed the outcast and fulfilled the contextual laws in the community. He ministered to persons who were discriminated and experienced stigma. He also reinterpreted the law regarding treatment of lepers, the touch of lepers, and empowerment for the leper. In the era of HIV/AIDS, ministers need to reinterpret the prevailing negative teachings or perceptions regarding PLWHA. PLWHA need the compassion, touch, and love as part of care and support. Jesus also affirmed the man as a person of worth, thereby empowering him and confirming his faith. Jesus revealed how he valued human beings in spite of their condition. He was approachable even by the outcasts. He was not like the spiritual leaders of his day who ignored the lepers in order to fulfill their cultic worship requirements. He cared for "the least of these" (Matt. 25:45), persons who were stigmatized, lacked basic human rights, and were sick. In the era of HIV/AIDS, PLWHA are treated like lepers, even when HIV cannot be contracted by association, touch, eating together, exchanging clothes, shaking hands, touching, or using the same utensils. The church needs Christians and church leaders to help the congregants and the rest of people in society to view PLWHA as human beings who need holistic salvation. Church leaders must reread God's story in relation to the sick and value of human beings.

According to society, the leper was unclean, infectious, and outcast. Even the religious leaders had nothing to do with him. Out of desperation and having heard about the man who was able to command nature and cure diseases, he came to Jesus to be cleansed and healed. Jesus healed him and cleansed him. He sent him to the priest to fulfill the law for society in order to be integrated back to society. People living with HIV/AIDS are also isolated in churches by silence, attitudes, and lack of care for them. They are silent about their status because of the fear of rejection, stigma, and the attitude of society. Some churches that are supposed to be places of refuge, care, and healing are not hospitable to people living with HIV/AIDS. Jesus' life and ministry reveals that human beings are worth of dignity, care, healing, and salvation.

Care of the Sick in Church History

Gary B. Fernigren states that the belief and practice of care for the sick is grounded in the Scriptures and the Christian faith. The early Church belief and practice for care of fellow human beings was founded on the Jewish Scriptures. The early Church believed that human beings were created in the image of God. The teaching that humans were created in the image of God influenced the provision of care for fellow human beings. The teaching was taken from Judaism, which taught that human beings were a reflection of God (97). This teaching reveals that human beings have worth and need to be protected.

Christians have practiced compassion toward sick persons since the early Church. Christianity contributed to the formation of medical care ministries. The idea of medical care or care for the sick in the non-Christian world did not exist. Family and friends rather than civic leaders bore the responsibility of caring for sick persons. In addition, no

policies, hospitals, or programs existed for sick, homeless, and vulnerable people.

Christianity contributed to the idea of charity for the needy (Fernigren 86-87).

The early Church in the first century had several structures for ministry, including diaconal ministry. Diaconal ministry took care of social and physical needs of the church members, sick people, widows, and orphans. Preference was given to widows and orphans and the vulnerable. The monastic movement contributed to the formation of hospitals and ministries of caring for the sick and vulnerable. Basil of Caesarea established the first hospital and organized houses for the purpose of caring for the sick and vulnerable persons. The idea of hospitals spread from Caesarea to the rest of Western Europe. Most of these houses or hospitals provided palliative care (Fernigren 124). Bishops mobilized the churches and the lay leaders to care for sick and vulnerable people during the plagues (113-14). The implication of this practice in church history affects how bishops and church leaders today should provide leadership to the church in the era of HIV and AIDS.

Care of the sick in Wesleyan church tradition. Randy L Maddox states that during Wesley's time, pastors offered medical care as part of their pastoral care. Wesley developed a structure of pastoral care that included lay men and women in the provision of care to the faith community and the community at large. Wesley's pastoral care included visiting the sick persons three times in a week. The pastoral caregivers were concerned about the spiritual, health and livelihood of the community. Wesley believed caregivers were supposed to facilitate wholeness in their ministry practice. He believed and practiced Christian participation in God's present healing ministry to both soul and body (5-8). According to Maddox, the following were Wesley's belief and practice:

- He affirmed both divine and medical healing and valued both professional, traditional medicine and divine healing through prayer.
- He believed in the connection between the physical, emotional, and spiritual health. When one area is affected then the other dimensions also are affected.
- He promoted preventive care (e.g, proper diet, water, exercising in fresh air, rest, sleep, and bathing in cold water).
- He promoted herbal medicine and chemical medicines and extended care to the larger community.
- Wesley integrated medical care to his pastoral care to the sick. He wrote a medical manual, practiced preventive medicine, practiced divine healing, and appreciated both medical care and herbal medicine (10-26).

Randy L. Maddox and Paul T. Walls state that salvation encompasses spiritual transformation, societal transformation, care for the body or sick, care for the environment, and involves the whole earth. The Wesleyan pastoral care model in church history was holistic and integrative. The pastoral caregivers were concerned about the whole being and not only the spiritual component.

Evangelical response to HIV/AIDS. Evangelicals have come to terms with the controversy between evangelism and social concern. Still, some conservative Christians still struggle with the idea that the gospel encompasses both salvation for the soul and the body. Some churches that have not responded to the fight against HIV/AIDS have been influenced by this controversy. Wright states that the greatest problem facing human beings is the HIV/AIDS epidemic. He recommends a comprehensive, missional response to HIV/AIDS and PLWHA, encompassing the following:

- Compassionate care for the sick and dying,
- Care that includes widows and orphans,
- Promotion of HIV/AIDS to leaders, the church, and community,
- Acknowledgement and reparation of the medical, political, economic, and cultural and justice issues,
- Preparation of psychosocial counselors, and
- Sensitive evangelism in the context of HIV/AIDS (433-39).

The call for comprehensive and holistic care and support comes not only from the Roman Catholic Church and PEPFAR but also from evangelical leaders.

Catholic social teaching on HIV/AIDS. The Roman Catholic Church has been one of the leading churches in the fight against HIV/AIDS. The Church has been holistic in its approach to care and support to PLWHA. According to Kelly, a relationship exists between Catholic social teaching and the principles guiding their response to HIV and AIDS. He describes the relationship between the Catholic Social teaching and the principles that guide care to PLWHA:

[T]here is a remarkable correspondence between much that is contained in the church's social teaching and the principles that guide the response to HIV and AIDS. Both are rooted in the concern for the human person and the exercise of human rights. (7)

The Catholic social teaching is based on the Scriptures and the papal writings. The social teachings provide guidance to the leaders and the parishes on social issues. The high view of the human person based on the Scriptures guides the Roman Catholic Church's response to HIV/AIDS. The Church integrates knowledge from other disciplines in the pursuit of solutions to the problems of human kind. However, the

Roman Catholic Church does not integrate any knowledge from other disciplines unless the principles are in agreement with the Scriptures and papal teachings (Kelly 7-8). Best practices from biblical theology, the history of the church, and knowledge from other disciplines can guide caregiving to PLWHA.

Care of the Sick in Some African Traditions

In the African setting, especially in Zambia, the care of the sick is a communal responsibility. Both the nuclear and extended family are involved in the care of the sick family member. The women are the ones who care for sick and the terminally ill persons.. The elderly in the community even prepare the dead for burial. The community also participates in the care of the sick. M. T. Speckman brings out the philosophy behind the communal responsibility to care for one another. He cites the African proverb: “Umntu ngumntu ngabantu,” meaning that people are nothing until they realize that they have a responsibility towards others. Furthermore, the proverb brings out the fact that individuals belong to others (41). However, due to urbanization, poverty, and unemployment in the country, the traditional structure for caring for the sick is breaking down.

Research Design

The purpose of this study was to evaluate the effectiveness of current pastoral care practices to PLWHA in PWCZ and to develop a comprehensive pastoral care model sensitive to the needs of PLWHA. The problem, purpose, and research questions guided my research plan. As such, in this qualitative study, I used field interviews to create case studies of four local churches in the PWCZ. I used researcher-designed, semi-structured interview protocols and focus groups to collect data about current pastoral care practices

with PLWHA from the leaders and congregants of the four local churches. The population of this study was the church leaders and congregants: a representative sample of four pastors of the four churches, five deaconesses, five deacons, three members who are non-PLWHAs and three members who are PLWHA from each of the four local congregations in the PWCZ.

The participants were the leaders and the congregants from the four local churches. The participants were a representative population of four churches (two urban and two rural) from a total of 250 local churches. Accordingly, four pastors, five deacons, and five deaconesses composed the leadership part of the sample, and three members who are non- PLWHA and three members who are PLWHA composed the rest of the sample population.

I used one-to-one interviews and focus groups in order to obtain data from the participants. I conducted the interviews with the pastors, the deacons, deaconesses, PLWHA, and non-PLWHA. To gather data on pastoral care practices to PLWHA and to develop a comprehensive pastoral care model for PLWHA, I used two instruments in this study: a semi-structured interview protocol and focus groups. A semi-structured interview protocol was administered to leaders (four pastors, five deacons, five deaconesses) and congregants (three PLWHA and three non-PLWHA). The interview protocol consisted of four sections designed to answer the three research questions. The data was analyzed, and the findings were reported back to the leaders and congregants.

First of all, permission was sought from the overseer of the church. A letter of authorization was given by the national superintendent to conduct the research in the two districts of the Pilgrim Wesleyan Church. I made an appointment to meet the district

Overseers. The district overseers provided letters of authorization for me to carry out the research in the four local churches. The pastors were contacted and interview dates were set. Before the interviews were conducted, I explained the purpose of the study and its benefits, and then I asked for their consent to participate in the study. I explained to the leaders and congregants that they were free to withdraw from the study at any time during the research. I also explained to the participants that participation was voluntary and that remuneration would be given for participating in the study. However, I explained to the participants the benefits of the findings to the leaders, congregants, and PLWHA. Before commencing the interviews, I asked for consent from the participants. Once consent was granted by signing the consent form, I then went ahead to conduct the interviews. The interviews were conducted at the venue convenient to the participants and at a specified time lasting one hour. Data was collected from leaders (four pastors, five deacons, five deaconesses) and congregants (three PLWHA and three non-PLWHA), by using a semi-structured interview protocols and focus groups. The participants were informed of the reason for recording the responses and how the information was going to be used. I assured the participants of confidentiality in the process of the study. I used pseudonyms instead of the participants' actual names of the participants.

The interview sessions were transcribed into a word processor and a hard copy was made. Each hard copy was analyzed several times in order to identify the codes and themes. The emerging themes were taken to the focus groups for further discussions.

Summary

This chapter reviewed literature on PLWHA, their needs, and the contemporary care models in the field of biomedical and social sciences. I also reviewed literature on

care models in practical theology in the era of HIV/AIDS. Since my context is Africa, I also looked literature at African communal caregiving. Finally I presented my biblical-theological framework.

The biblical and theological framework also revealed Scripture's teaching that God (the Trinity) created humans in his image (Gen. 1:26-27), and he created humans whole. Following the Fall of humankind (Gen. 3), God is still on a mission (Gen. 3, 12-15) to restore humans to wholeness (John 1, 3; Luke 4:18). He invites the Church to join his mission (Matt. 28:19-20; John 21) of restoring humans to wholeness (1 Thess. 5:23). The literature review indicates that Jesus' ministry and the Church in history has provided a comprehensive and holistic pastoral care model to the sick. Historically, the Church introduced the idea of hospitals and care for the sick based on the biblical teaching of creation in the image of God (Gen. 1-2). Even the Wesleyan movement's theology and practice in history reveals that the Church has been comprehensive and holistic in ministering to the sick. Wesley, the father of Methodism, modeled a holistic, integrative, and collaborative ministry to the sick.

Therefore, the PWCZ should explore the possibility of comprehensive and holistic pastoral care to PLWHA as part of its ministry. Pastoral caregivers must view humans as image bearers of God, valuable and worthy of dignity, care, and support. According to the literature surveyed, a number of care practices or care models are available for care providers. These models have evolved over time as knowledge of HIV/AIDS has increased.

According to the literature, the first model to develop was the biomedical care model, which specialized in diagnosing HIV through laboratory testing and providing

ARVs. However, with time, biomedical caregivers discovered simpler ways of diagnosing HIV through voluntary counseling and testing. Everyone in Zambia, is being encouraged to take an HIV test in order to know whether one is HIV positive or not. The introduction and the use of ARVs helped improve the lives of PLWHA. The third model of care is home-based care. When PLWHA are discharged from the hospital, they are cared for in their homes. Mobile teams from the local clinic, family, and community members continue to provide care and support in the homes. The need for ongoing care, end-of-life issues, and care of survivors has led to the integrating palliative care to other types of care offered for PLWHA. The fifth means is the livelihood care model. Since PLWHA can now live positive lives and receive quality health care, livelihood care has become a necessity. PLWHA need income, food, and assistance in looking after their families. The last model has been the use of chaplains as part of the biomedical caregiving and the provision of spiritual care to PLWHA. HBC has integrated spiritual care through chaplains and pastors from local churches. The chaplains focus on meeting spiritual needs only. Most of the care models have, over time, integrated pastoral care into their respective care models in order to meet the spiritual needs of PLWHA. This study suggests that pastoral caregivers move beyond meeting only the spiritual needs of PLWHA and begin offering comprehensive pastoral care. In order to provide comprehensive pastoral care, a holistic perspective of human beings is advocated in the care of PLWHA. Integration of elements of contemporary care models and collaboration with other care providers is recommended. The holistic and comprehensive care model should be based on biblical theology and historical theology of caregiving.

CHAPTER 3

METHODOLOGY

In this chapter, I present the research design and describe the methods I used to collect the data, determine the pastoral care practices to PLWHA, and develop a comprehensive pastoral care model. In this study, I used a qualitative research design with case studies of four local churches.

According to John W. Creswell, research methodology offers a number of options for data collection, analysis and interpretation (6). For instance, in this study, I chose qualitative research methodology instead of quantitative methodology. In quantitative studies, the methods and the literature guide the study, and the study contains statistical analysis and interpretation. While with qualitative study, the methods emerge as the research occurs. Furthermore, qualitative studies use open-ended questions, interview data, document data, audiovisual data, text and image analysis, themes, patterns, and interpretations (46-56). Creswell presents five assumptions that guide qualitative studies or research. The first one is that reality can be seen from many angles. The second assumption is that the researcher is close to the participants. The third assumption is that values of the researcher and the researched are taken into consideration. The fourth assumption is that the subjectivity and involvement of the researcher lead to using inductive methods (73)

Creswell also describes qualitative research as the process of understanding the meaning participants give to the problem at hand. The process of research involves using inductive methods in order to develop findings. The questions and findings emerge from the participants and their context (4). Creswell states that qualitative research is also

interpretive, descriptive in nature, and studies people in their settings. Creswell writes that qualitative research is “an investigative process where the researcher gradually makes sense of a social phenomenon by contrasting, comparing, replicating, cataloguing and classifying the objective of the study” (161). Therefore, qualitative research is inductive, descriptive, interpretative, holistic, and discovery oriented.

In this study I used a qualitative research approach with case studies of four local churches of the PWCZ. Creswell says that case study research involves the study of an issue explored through one or more cases within a bounded system. In this case study, I use a collective study approach where case studies illustrate a single issue (74). This collective case study used two urban churches and two rural churches to represent urban and rural churches in the Pilgrim Wesleyan Church of Zambia. I interviewed national leaders who are policy makers, pastors, deacons, deaconesses, and congregants who are PLWHA and who are not. I used both one-on-one interviews and focus group discussions to elicit information from these participants. Since most of the participants were semi-literate, both methods were necessary. Even for the congregants, I used one-on-one interviews where possible as well as focus group discussions. With the non-PLWHA congregants, I used focus group discussions to elicit information. When needed, I used one-on-one interviews.

Problem and Purpose

PLWHA have multiple needs not met by classical pastoral care models because these models are focused on meeting spiritual needs rather than psychosocial and developmental needs. The needs of PLWHA are diverse, depending on the course of the illness. In addition, PLWHA must be able to access the care, and the care must address

the wide range of needs. This study presents a comprehensive pastoral care model that can be adopted by churches to help care for people living with HIV/AIDS in the Pilgrim Wesleyan Church of Zambia. The model can help church leaders and congregants provide comprehensive care to PLWHA. The model of care can help meet the spiritual needs, physical needs, social needs, livelihood needs, psychosocial needs, psychological needs, and biomedical needs of PLWHA. This pastoral care model is holistic, integrative, and collaborative in nature.

Classical pastoral care models are focused on meeting spiritual needs at the expense of physical, socioeconomic, livelihood, and medical needs. The purpose of this study was to evaluate the effectiveness of current pastoral care practices with PLWHA in PWCZ and to develop a comprehensive pastoral care model that meets the holistic needs of these individuals.

Research Questions

In order to gather data on pastoral care practices, I formulated three research questions. I used personal interviews and focus group discussions. I interviewed national leaders of PWCZ and local church leaders and members of four local churches. Interviews take place when a researcher asks one or more participants some questions and then records the answers. The researcher conducts unstructured open ended interviews or semi-structured interviews in order to gather data (Creswell 225, 641). For this study I used one to one interviews to get data from national leaders, pastors and some members of the local churches who were not comfortable to participate in a focus group discussion. In order to get shared understanding of pastoral care practices to PLWHA, I also used focus group interviews. Focus group help the researcher to get views from

individuals and from the whole group. A focus group is used to collect data through interviews of a group of four to six people (Creswell 226-27).

Research Question #1

What are the current pastoral care practices for PLWHA in the local churches of the PWCZ? I utilized semi-structured interview protocols and focus group discussions as instruments in this study, in order to identify specific pastoral care practices used by the local churches of the PWCZ. I targeted local church leaders who are pastors, deacons and deaconesses, congregants who are PLWHA and those who are not HIV positive for this study.

Research Question #2

How effective are the current pastoral care practices to PLWHA as perceived by church leaders, congregants, and PLWHA? For this research question, I used a semi-structured interview protocol, one-to-one interviews, and focus groups in order to determine the effectiveness of the pastoral care practices of the PWCZ.

Research Question #3

What changes in the current pastoral care model would increase its effectiveness in meeting the needs of PLWHA? Through this question, I hoped to determine which care practices the PWCZ should pursue in order to address the gaps in pastoral care and develop a model that meets the needs of PLWHA.

Population and Participants

Creswell defines a population as the set of elements with the same characteristics upon which the research focuses (151). The population of this study consisted of the leaders and congregants of four local churches in the Lusaka district (Urban) and the

Zimba district (rural). These churches were a representative sample of the 490 PWCZ local churches. From each of the four churches, I selected the pastor, five deaconesses, five deacons, and six church members, three who were PLWHA and three who were not. I also interviewed national leaders who are policy makers in order to answer the three research questions.

Design of the Study

The design was a qualitative study that used case studies of four local churches. Since this study aimed to obtain an in-depth understanding of pastoral care practices to PLWHA, I collected data from the leaders and congregants of four local churches. The leaders were the four local church pastors, five deacons and five deaconesses from each of the four local churches. The congregants included three PLWHA and three non-PLWHA from the four local churches in the Pilgrim Wesleyan Church of Zambia. The four Churches were representative of the 490 Pilgrim Wesleyan Churches. The four pastors from each of the four local churches were representative of the 250 Pilgrim Wesleyan Church Pastors.

I took the following steps in order to research this problem. First, in March 2012, I obtained permission from the overseer of the denomination who then informed the two district overseers to authorize the local church pastors, deacons, deaconesses, congregants, and PLWHA to participate in the study. With the authorization from the overseer, I communicated with local church authorities. The pastor and the leaders were requested to facilitate the process of obtaining participants for the research. The pastors helped mobilize the participants by explaining the reason for my presence. Once permission from the local church was sought, I arranged to have a meeting with the

pastor in order to explain the study and its benefits. Then I discussed the plan and agenda for meeting the pastor, the deacons, deaconesses, non-PLWHA congregants, and PLWHA congregants. I set up the interview in advance through the pastor, allowing them to review the agenda and questions. I asked for permission to record the interviews by taking notes. I had to contact the pastors to confirm the date and to send a reminder with a set of questions. When the day of the interview arrived, I went to the venues before the scheduled time. I had to make sure that the agenda, interview protocol, consent forms, and my notebook were in place. I prepared the room before the participants arrived. Before the interview, I had to explain the purpose of the meeting and the expectations for the group discussion. I explained the importance of confidentiality and respect for the views of others. Then I introduced and explained the consent form. I asked the participants to sign it. After the interview, I presented the data to the participants to verify whether the record was a reflection of the group discussion. I also obtained permission from participants in order to use the information in my final report.

Instrumentation

I used researcher-designed instruments to elicit information from the leaders and congregants. The first instrument was the demographic questionnaire (see Appendix A). The second instrument, the semi-structured interview protocol, was used to obtain data from the leaders and congregants of the four local churches. It consisted of three research questions. The first research question had four related questions (numbers 1, 2, 3, 4). The second research question had two questions (numbers 5, 6,). The third research question had three questions (numbers 7, 8, 9, 10; see Appendix B).

I collected information from the leaders and congregants from each of the four local churches of the PWCZ. To evaluate the pastoral care practices to PLWHA and to develop a comprehensive pastoral care model for PLWHA, I interviewed the leaders in April 2012 and used focus group discussions and personal interviews for the leaders. In May and June 2012, I facilitated focus group discussions for congregants to elicit data regarding pastoral care practices to PLWHA and how to make the pastoral care practices more effective. The interview and focus group protocol had three sections answering the three research questions. The data was analyzed and reported back to the focus groups to discuss the findings from the other groups. Finally, I recorded the data and analyzed it for themes.

Expert Review

I sent my interview protocol for an expert review at Asbury Theological Seminary who critiqued the research questions and made recommendations for improving the interview protocol. Following the recommendations of the expert reviewer, I made adjustments to the interview protocol.

Reliability and Validity

An expert reviewer evaluated the instruments in order to make the instruments more focused. Two PLWHA helped interview PLWHA who were not comfortable having me interview them. Therefore, I had to meet with the two assistants to explain the study and how the interviews were to be carried out. The two assistants who are PLWHA are also trained medical workers. My wife, who also is a registered nurse, helped me in recording the information from the participants during the interviews. The research assistants were all medical workers who were familiar with research. However, I had to

orient them to the study and how to use the instruments, so that they could be conversant with the instruments and the research. Third, I have been meeting with my reflection team during the development of the proposal in order to obtain their input. The two assistants who are PLWHA were part of the reflection team.

Data Collection

Creswell asserts that data collection in a qualitative study involves the following aspects: First, the researcher has to set the boundary for the study. Therefore, I limited my study to four PWCZ local churches. Second, it involves collecting information through observation, interviews, documents, and the establishment of a protocol for recording the information. I collected information using individual interviews, and focus group discussions. Third, qualitative research analyzes the language and words of participants to get their meaning. Fourth, data is collected in the setting of the participants and at their convenience. Fifth, qualitative data is well analyzed in order to get what the informants are saying. Sixth, qualitative research involves the participants in their reality. Finally, qualitative studies are creative and involving (148).

The use of semi-structured interviews in this study enabled me to handle sensitive topics with individuals as well as gain insight into the study. With regard to the use of focus group interviews, I realized that issues unlikely to emerge in the one-to-one interview were more likely to come out in focus groups. Therefore, I had to use personal interviews and focus group interviews as a complementary source of data collection. I envisaged that this method would further enable me to gain insight into group views and experiences of PLWHA in relation to the pastoral care provided by the local churches.

I collected data from the leaders (denominational leaders, four pastors, five deacons, five deaconesses) and the congregants (three members without HIV/AIDS and three members with HIV/AIDS) from each of the four local churches, making a representative sample of forty-eight leaders and twenty four congregants. During the focus group interviews, I personally took notes and my wife also recorded the information from the personal interviews and focus group discussions. These notes were later discussed with the research assistant after the interview. Creswell maintains that written notes, audio recordings, or audiovisual recordings can be used in data collection and that more than one copy should be kept, including backup copies of computer files. Therefore, I had to save the interview information on my laptop and flash drive. As indicated, permission was sought from the overseer of the church and district overseers. Letters of authorization were taken to the district overseers. The district overseers authorized the local churches to participate in the study. The pastors were contacted and interview dates set up. The interviews were conducted at the specified place and time lasting one hour. Data was collected from the leaders and congregants by using personal interviews, and focus groups. The participants were informed that the interviews were going to be recorded, and I explained how the information was to be used. I assured the participants of confidentiality. The participants signed a form of consent before proceeding with the interview.

Data Analysis

The process of data analysis involved making sense out of text and image data, preparing data for analysis, moving deeper and deeper into understanding the data. Data

analysis involved representing the data and interpreting a larger amount of data. I followed Creswell's recommendations for data analysis:

1. I engaged in a process of continual reflection about the data and asked analytical questions, writing memos throughout the research. As I collected data, I also analyzed the data. Creswell states that qualitative data analysis is done at the same time as data collection, making interpretations and writing reports.

2. I collected open-ended data based on responses to general questions and then developed an analysis from the information received from the participants.

3. I analyzed data for themes and participants' perspectives. From the data, few themes emerged (see Table 3.1).

Table 3.1. Steps for Data Analysis

Purpose	Steps Taken
Steps 2-7 Validating the accuracy of the information, an ongoing process	Step 1. Collecting raw data (e.g., transcripts, field notes, images)
	Step 2. Organizing and preparing data analysis
	Step 3. Reading through all data
	Step 4. Coding the data (hand & computer)
	Step 5. Themes/Description
	Step 6. Interrelating themes/description
	Step 7. Interpreting the meaning of themes/description

Source: Creswell 185.

The record of the interview sessions was transcribed into a word processor, and a hard copy was made. Each hard copy was analyzed several times in order to identify themes that were emerging from the codes. The emerging themes were taken to focus groups for further discussion. Finally, I transcribed the data from the focus groups and then analyzed the emerging themes.

Ethical Procedures

The nature of this study required me to consider issues of ethics in the process of carrying out the study. The research involved collecting data about PLWHA from leaders and congregants. Therefore, I had to plan ahead how I to handle information about the participants with care and sensitivity. I explained the importance of confidentiality in order to protect the participants and to develop trust and to keep the trust and integrity of the research. I had to decide in advance how to handle misconduct. I met with participants and discussed how to address the issue of confidentiality. I planned ahead to use pseudonyms for the participants.

I sought permission from the participants before the interview. The names and particulars of the participants were not disclosed. I assured the participants that I would use the information for academic purposes and the names and particulars would not be disclosed in any form. The PLHWA participated in the study on a voluntary basis. The HIV/AIDS status of the participants was not discussed nor disclosed.

CHAPTER 4

FINDINGS

Problem and Purpose

PLWHA have multiple needs not met by classical pastoral care models because these models are focused on meeting spiritual needs rather than psychosocial and developmental needs. The needs of PLWHA exist on a continuum, ranging from HIV diagnosis, asymptomatic stage needs, symptomatic stage needs, treatment of opportunistic infections, end-of-life issues, orphans, and socioeconomic needs. In addition, PLWHA must be able to access the continuum of care, and the care must address the wide range of needs. Parry writes, “A comprehensive response integrating prevention, care, support and treatment for the HIV infected and affected is needed within the social reality of the communities we serve” (29). The PEPFAR and the Roman Catholic Church have been in the forefront in advocating for and providing comprehensive care to PLWHA and their families. Most churches focus on meeting spiritual needs of PLWHA, ignoring the rest of the needs arising due to HIV/AIDS.

HIV/AIDS is no longer merely a biomedical problem; instead, the problem of HIV/AIDS also affects psychosocial, physical, socioeconomic, nutritional, and spiritual aspects of life. With the growing understanding of the challenge of HIV/AIDS, governments, health care providers, and other care providers have realized that HIV/AIDS affects the whole human person and all sectors of life. As such, PLWHA have biomedical needs, psychosocial needs, physical needs, socioeconomic needs, legal challenges, spiritual needs, and the need for home-based care. The care needs and care

burden poses a challenge for the healthcare system, the family, caregivers, the community, and the church.

This study presented a comprehensive pastoral care model that can be adopted by churches to help care for PLWHA in the PWCZ. The model can help church leaders and congregants provide comprehensive care to PLWHA. The model of care can help meet the spiritual needs, physical needs, social needs, livelihood needs, psychosocial needs, and biomedical needs of PLWHA. This pastoral care model is holistic, integrative, and collaborative in nature.

The purpose of this study was to evaluate the effectiveness of current pastoral care practices with PLWHA in PWCZ and to develop a comprehensive pastoral care model that meets the holistic needs of the aforementioned individuals.

Participants

This research was a qualitative study that utilized case studies of four local churches, personal interviews, and focus groups. The sample for this study included leaders and congregants from four local churches. The leaders for this study were the four pastors, five deacons, and five deaconesses. The congregants for this study were three PLWHA and non-PLWHA from the four local churches.

In order to gain an overall understanding of the denominational response to the needs of PLWHA, I interviewed denominational leaders who were the policy makers (key stakeholders). These leaders set the vision, mission, objectives, and strategies in order for the denomination to attain its goals. The board is composed of the national superintendent, the assistant national superintendent, the representatives for theological education, educational ministries of the church, health institutions, schools owned by the

church, men's organizations, women's organizations, youth organizations, and three members at large. At the 2010 national conference, the National Board of Administration made a resolution to the national conference to include a National Director of Social Ministries on the National Board. The national conference accepted this resolution and elected a social ministry director. This position was created in order to address the contextual issues of poverty, HIV/AIDS, and the socioeconomic empowerment of the members, and other vulnerable groups. I interviewed the key leaders in order to gain their corporate perception of the pastoral care practices to PLWHA in the PWCZ. The total number of national board members interviewed was four. This number gave me the corporate perceptions on the effectiveness of the pastoral care practices in the PWCZ. These leaders included National Superintendent Rev. Dr. Alfred Kalembo, the National Director of Social Ministries Genesis Katowa, National Director of Christian Education Flevia Kaluba, and Renorah Ngandu, a member-at-large.

Table 4.1. National Leaders (N=4)

National Board Member	Gender	Age Range	Profession/Position
National superintendent	M	50-55	Denomination leader/local church pastor
Social ministries director	M	55-60	Retired accountant/local church leader
Christian education director	F	35-40	Former World Hope International country director/local church leader
Member at large	F	35-40	Local church pastor/NBA member/student

Case study one—Munali PWCZ. Munali PWCZ is an urban church situated near the University of Zambia. Most of the members and their children live in low

densely populated areas. Most of the members are graduates of universities and colleges and are working. The vision of the church is to “Reach Urban People with the Word of God.” When welcoming members, leaders used the phrase, “A place to belong and a place to become.” Therefore, I purposely chose this church to represent urban churches in low populated areas. Most members of this church were college and university graduates and professionals in their respective fields of work (see Table 4.2).

Table 4.2. Munali PWC Participants (N=15)

Participants	Gender	Age Range	Profession/Position
1 Pastor	M	40-45	Clergy/university level
2 Deacons	M	35-55	Master's level
4 Deaconesses	F	35-55	Ranging from diploma level-master's
3 Members (non-PLWHA)	F	20-25	High school & college level
5 Members (PLWHA)	F	25-40	Certificate level/university level/businesswomen, teachers

In order to gain an understanding into the current pastoral care practices for PLWHA at Munali PWCZ, I conducted personal interviews with the pastor, two deacons, and four deaconesses. In addition, I held a focus group with three female members and three female members who are PLWHA at Munali PWCZ. The other two female (PLWHA), I had personal interviews with each one of them at Munali PWCZ.

Case study two—John Howard PWCZ. I purposefully chose John Howard PWCZ to represent urban churches in areas with high population density. I conducted a personal interview with the pastor, followed by focus group discussion with the five deaconesses, and another focused group with the deacons. The three female members

were part of the focus group for deaconesses. The three male members were also part of the deacons' focus group (see Table 4.3).

Table 4.3. John Howard PCZ (N=20)

Participants	Gender	Age Range	Profession/Position
1 Pastor	M	35-40	Clergy
5 Deacons	M		Business people, teacher, other workers
5 Deaconesses	F		Housewives, business people, widows
3 Male members & 3 female members	M & F		Business people
3 PLWHA	F		Professional, working, widow, housewife

Case studies 3 and 4—Sianakanga PWCZ and Zimba PWCZ. The third and fourth case studies were purposely chosen to represent rural churches. These two churches were chosen from Zimba, a rural town near Livingstone. The president recently elevated Zimba to be a town and a district. Initially, this small town was under Kalomo district. It is situated about a forty-five-minute drive from Livingstone town. The Pilgrim Wesleyan Church has a cluster of churches in this district. The PWCZ has a hospital and a basic school as part of its ministry in the district. In this church, I conducted a focus group discussion composed of the pastor, the deacons, deaconesses, and members of the church (non-PLWHA and PLWHA; see Table 4.4).

Table 4.4. Sianakanga PWC (N=13)

Participants	Gender	Age Range	Profession/Position
1 Pastor	M	40-50	Clergy
3 Deacons	M	20-30 30-40 40-45	Small business people, teachers, subsistence farmers, and other workers
4 Deaconesses	F	20-30 30-40 40-55	Housewives, business people, widows
3 Male Members & 3 Female members	M & F	20-30 30-40 40-55	Teachers, subsistent farmers Small business
2 PLWHA	F	30-40 40-45	widow, housewife, farmer

Sianakanga PWCZ was chosen to represent rural churches from the villages. Most of the members were subsistence farmers; a few worked at the PWCZ hospital. One male PLWHA was from another church. He joined the participants because he used to be supported by World Hope International Zambia (WHIZ), which was working in this church. The pastor arranged one focus group discussion for me with all the participants, including PLWHA.

The last case study was Zimba PWCZ. The pastor arranged for me to meet three female PLWHA separately in a focus group and then a focus group composed of the pastor, deacons, deaconesses, and six members of the church. Both focus group discussions took place in the afternoon at Zimba PWCZ on Sunday, 14 July 2012 (see Table 4.5).

Table 4.5. Zimba PCZ (N=17)

Participants	Gender	Age Range	Profession/Position
1 Pastor	M	40-50	Clergy
5 Deacons	M	20-30 30-40 40-55	Small business people, teachers, subsistence farmers, and others workers
5 Deaconesses	F	20-30 30-40 40-55	Housewives, business people, widows
3 Male Members & 3 Female members	M & F	20-30 30-40 40-55	Teachers, subsistent farmers, small business
3 PLWHA	F	30-40 40-50	Widow, housewife, farmer

I formulated the following research questions in order to gain an understanding of the current pastoral care practices for PLWHA and to develop a comprehensive pastoral care model that is sensitive to the needs of PLWHA.

Research Questions

Three research questions guided this study: (1) What are the current pastoral care practices for PLWHA in the local churches of the PWCZ? (2) How effective are the current pastoral care practices to PLWHA as perceived by church leaders, congregants, and PLWHA? And, (3) What changes in the current pastoral care model would increase its effectiveness in meeting the needs of PLWHA? In this qualitative study, I utilized three sources to collect data: document analysis, individual interviews, and focus group discussions. From the structured coding, several themes emerged from the data. Therefore, the themes are presented as they relate to each of the research questions. Although the names of the churches and some participants are not mentioned, their words are included to support the data.

Findings for Research Question #1

The data from both leaders and congregants indicates that no care or support practices are aimed at PLWHA within the local churches. Even though the leaders, congregants and PLWHA were significantly affected by HIV/AIDS, the PWCZ has not responded to the fight against HIV/AIDS, nor has the church established care and support practices for PLWHA.

National Leaders' Perceptions of Care Practices

National superintendent Alfred Kalembo indicated that HIV/AIDS had affected him “personally ... since family members and church members are affected. We have to provide care and support to the family and church members who are affected.” He also responded that due to HIV/AIDS, he had witnessed decreased productivity, loss of jobs, deaths of breadwinners, loss of personnel, and much suffering. I further asked him how the leadership of the PWCZ had responded to the HIV/AIDS challenge. Kalembo’s response was, “As a denomination we are behind in this area. We have not responded properly to the plight of PLWHA.” I asked Kalembo if he was aware of any pastoral care practices to PLWHA in the local churches. His response was, “I am not aware of any pastoral care practices in the local churches.” Kalembo went on to say that the church initially responded by partnering with an international faith-based organization called World Hope International Zambia. WHIZ is the social ministries wing of the Wesleyan Church in North America and has branches in most Wesleyan Churches globally. Before, WHIZ international ceased its operations in Zambia, it worked alongside some PWCZ local churches. The only other known response was through the auxiliary ministries (women and youth ministries). These two ministries responded by using the strategy of

giving information, educating their constituents, and communicating about the challenge of HIV/AIDS. The national office responded by establishing the social ministries department mandated to address issues such as poverty, unemployment, and HIV/AIDS.

Before WHIZ ceased to operate in Zambia, the organization partnered with PWCZ local churches to provide care and support to orphans, PLWHA, and caregivers. WHIZ worked with caregivers to establish projects called trusts to provide some caregivers who had orphans and PLWHA in local churches that had partnered with WHIZ were funded by WHIZ to run income-generating projects and purchase supplies for orphans and PLWHA.. WHIZ also trained caregivers to run home-based care for PLWHA. Every quarter WHI provided food, blankets, and hbc kits to caregivers for PLWHA. Apart from this arrangement, the local churches did not provide any planned information, education, or communication activities on HIV/AIDS (IEC), psychosocial counseling, hbc, livelihood care, and palliative care. According to Kalembo, the church has no proper response, care, or support aimed at PLWHA.

The second national leader I interviewed was Genesis Katowa. The interview took place at the national headquarters of the PWCZ. Since I had worked with Genesis Katowa, and he was aware about my studies, he was eager to participate in the study. I explained the nature of the study and the purpose and benefit to the care of PLWHA in the PWCZ. He consented to participate in the study by signing the consent form. I asked him in what way HIV/AIDS had affected him, his family, and the local church. First, he revealed that HIV/AIDS was real to him in that he had relatives with HIV/AIDS. He revealed that his family was affected due to relatives, orphans, and church members who needed care and support. Furthermore, he revealed that he was keeping orphans due to

deaths of parents. His family was providing physical care and funding to the hospital for the sick. In the local church, the members directly affected needed interventions such as provision of financial support, food, and care.

Katowa revealed that national leadership responded by developing an HIV/AIDS policy, although it was not yet approved by the national board and national conference. However, in some way, the church has a policy, since the national board of administration and national conference of the PWCZ approved the social ministries department and the national director was appointed. The denomination still had to appoint or elect district and local church social ministries directors. He also indicated that implementation and decentralization of the social ministries in districts and local churches was still lacking. He revealed that the national leadership had responded by developing the Fountain of Hope ministry. This ministry was started by the national office to educate leaders and members on HIV/AIDS. Finally, the PWCZ responded to the challenge of HIV/AIDS through medical ministry in four regions of the Southern province. According to Katowa, leadership needed to formalize the policy, to decentralize and implement social ministries policy, and to develop a manual to guide pastors on HIV/AIDS.

I asked Katowa what kind of care and support was available to PLWHA in the local churches. According to Genesis, the local church where he belongs formerly worked with WHIZ. The local church had participated in a poultry project in order to help PLWHA and orphans generate income. Through this program, WHIZ provided food, hbc kits for caregivers to PLWHA, and training for caregivers on how to care for orphans and PLWHA. He also mentioned that the church had a compassionate ministry, which

occasionally gave supplies to the vulnerable members of the church. The women and youth ministries sometimes educated their respective constituents about HIV/AIDS.

The third national leader I interviewed was Flevia Kaluba. Mrs. Kaluba was a former executive director of WHIZ. Kaluba revealed that she was personally affected as she has close relatives who were directly affected. As a family they had to provide care and support to relatives who were living with HIV/AIDS. As far as she was aware, the local churches had no planned activities on the care of PLWHA. However, before WHIZ ceased to exist in Zambia, the families who had orphans and PLWHA were given care. This care involved providing information, educating and communicating on HIV/AIDs to the youth in the church and in some high schools. WHIZ also funded projects for PLWHA's, orphans', and caregivers' livelihood. At least quarterly, the caregivers, orphans, and PLWHA were provided with food, school supplies, and other necessary items. WHIZ also trained hbc caregivers and provided them with kits for the care of PLWHA.

The fourth national leader I interviewed was a female clergy who was a member of the national board. Like other leaders, she said that she was not aware at the time of any care and support to PLWHA in the local churches. When she was a pastor of a congregation, the local hospital and World Vision worked with the local churches in the fight against HIV/AIDS. She also stated that she was not aware of any care and support in the PWCZ local churches in her district.

The fifth leader I interviewed was four hours away from Lusaka. I sent him a letter and the interview protocol requesting him to answer the questions in his own time. The fifth leader answered the research questions and sent the responses by e-mail.

However, he answered the questions from his local church point of view. The first question asked how HIV/AIDS had affected him, his family, and his local church. He responded that he had close relatives and orphans who were directly affected. Second, he was involved in an hbc club that had identified twelve clients. Furthermore, they provided hbc services and supplies. Next, I asked him about the ways in which his local church responded to HIV/AIDS and the plight of PLWHA. He responded, "The church has responded by offering prayers, sympathy and empathy in order to alleviate psychological feelings of PLWHA and the affected." He also revealed that his local church had a fund-raising basket for the compassionate ministry. The church members donated money and materials that were given to the needy. As an hbc club, they had adopted orphans who had lost parents in the past year. He also explained that in general the pastor and a few committed members provided home visitations and prayer. This leader also revealed that the church had no deliberate intervention policy or systematic program. Only prayers were prominent. The church had no planned program except for individuals who were affected as a result of taking care of their relatives. The themes that emerged were the problem of HIV in the church, the care and support of PLWHA and orphans provided by relatives, prayers and home visitation by the local church, a general compassionate ministry by the local church to those who are vulnerable, and no planned care and support for PLWHA by local churches.

Pastors' Perceptions of Care Practices

I began the interview by asking the first pastor about the ways in which HIV/AIDS affected him, his family, and his local church. His response was similar to those of the national leaders. Primarily, HIV/AIDS had affected him due to members and

friends who were directly affected. When asked about the ways in which his local church had responded to HIV/AIDS and PLWHA, the pastor said, “Unfortunately, we have been dormant and in slumber.” He went on to explain that the church was in the process of formulating a policy:

The evangelism department is formulating a compassionate ministry policy that would give guidance on how to care for orphans, vulnerable children, the aged, and PLWHA. The document is in circulation, and the church is waiting for the policy document so that it would guide the leaders and members on the best way to respond.

However, he mentioned that the church had adopted some orphans and were providing care and support (e.g., food, school fees, and financial assistance). At the moment, those members who needed help were allowed to apply for assistance from the church. I also asked the pastor if the local church observed any specific pastoral care practices with PLWHA. The pastor was very honest to say that the church had no planned pastoral care for PLWHA. The church did not have any ministry to PLWHA. However, the leaders and the church were ready to give care to PLWHA if they requested assistance. I also asked if any ministry existed to PLWHA in terms of prevention, voluntary counseling and testing, hbc, livelihood care, palliative care, or spiritual care to PLWHA. Again the pastor was very honest to say the church did not have any ministry of caring and supporting PLWHA. However, the church was ready to provide care and support for interested persons. In terms of prevention, the pastor revealed no specific programs or planned ways to inform, educate, and communicate on HIV/AIDS. He was very honest even to say that he had never preached a sermon related to HIV/AIDS. He also revealed that PLWHA were very quiet, and only one member was open enough to receive the pastor’s counseling and referral to the hospital for VCT and medical attention. From my

observation and the responses of the pastor, this church seemed willing to respond to the needs of PLWHA if those individuals indicated the need for help. However, if the church and PLWHA were silent, PLWHA would not access care from the church. When asked about the pastoral care practices currently available to PLWHA in his church. The pastor revealed that if PLWHA opened up, the church would respond in every possible way to provide care to PLWHA and orphans. At the time of the interview PLWHA were not accessing any direct care related to their HIV/AIDS status. The themes that emerged from the interviews were as follows: HIV/AIDS affected the pastor due to relatives and members who were affected. the local church and PLWHA are both silent, a compassionate ministry policy, which had integrated HIV/AIDS, was in circulation, they had no planned care practices to PLWHA, and they had no planned VCT promotion, networking with clinics, hbc services, palliative care, or spiritual care directed at PLWHA. The pastor also revealed that the majority of the members were independent people who did not expect help from the church. However, some members and all PLWHA indicated that they needed some aspect of help in one way or another. Most PLWHA were independent and either working or doing business. However, a few of PLWHA who were interviewed indicated the need for nutritional care, livelihood care, and pastoral care from the church.

The second pastor I interviewed was from an urban church that had partnered with WHIZ before WHIZ ceased to operate in Zambia. I conducted a personal interview with the pastor. The interview took place in his office in John Howard PWCZ. The second pastor responded that HIV/AIDS was affecting attendance in the church because some members were sick and dying. He also pointed out that PLWHA were stigmatized

and discriminated against. The loss of breadwinners had an impact on children and women. He revealed that the effects of HIV/AIDS were evident due to orphans, widows, widowers, single mothers, increased pastoral work, and increased financial expenditures.

The pastor discussed the available care and support to PLWHA:

There is nothing happening and I have nowhere to point a finger. There is nothing happening. We have members who are positive, so we need programs like prevention, care, hbc, livelihood care, and palliative care. The only care that is there is mercy ministry [compassionate department which occasionally meet the needs of the vulnerable] and the pastor's basket [occasional supplies for the pastor], which is shared with the vulnerable. The only care, once in a while is the provision of food, clothes, and books to the vulnerable.

Like the first urban pastor, this pastor was honest enough to acknowledge that the church had no care or support aimed at PLWHA. They only provided the occasional support for vulnerable people in the church and community. The pastor went on to say, since he was a new pastor, his vision was to provide care and support to the orphans by raising the standard of schooling at the church and to fight for sponsorship for the vulnerable children. He intended to work with social welfare officers and other organizations concerning the provision of care to PLWHA and orphans. The pastor also indicated that WHIZ formerly funded livelihood projects and provided support to PLWHA and orphans. However, WHIZ would get the funds that were raised by the projects. WHIZ would only provide supplies through the funds occasionally. According to the pastor, both WHIZ and the local church missed the purpose of serving orphans and PLWHA. He believed that the church also was supposed to provide care and support to PLWHA and orphans. The church was supposed to use the tithes and offerings from the members for meeting the needs of PLWHA and the vulnerable. The themes that came out of the interview included the following observations: HIV/AIDS affected the church; they had

no care and support aimed at PLWHA; the compassionate ministry (mercy ministry) was inadequate in meeting the needs of PLWHA. The second pastor described a need for leadership in the provision of care and support to PLWHA, and the local church needed to include care for PLWHA in its budget. While John Howard church had a compassionate ministry, it was all aimed at vulnerable people. It was inaccessible and inadequate for meeting the needs of PLWHA. From the pastor's response, the church has no deliberate pastoral care practices for PLWHA. The third and fourth pastors, who are both from the rural district, opted to participate in the focus group discussion. However, their responses to the question about the existing pastoral care practices was to say that none were aimed at PLWHA except for the usual pastoral home visit aimed at every member of the church.

Deacons' Perceptions of Care Practices

I conducted individual interviews with two deacons in case study one. In case study two, I used a focus group discussion of deacons, three members who were male and non-PLWHA. The deacons and members who are non-PLWHA agreed to participate in the focus group discussion. They signed the consent form. I gave an overview of the questions and then the discussion commenced. I asked the group how the problem of HIV/AIDS affected them, their families and the church. All the deacons and members present agreed that HIV/AIDS had affected them. They were affected since parents were dying, leaving orphans; the children's life paths were cut short because their parents had died. The number of widows and widowers was on the increase, causing a loss of strong members, which affected human resources in the local church. They had no visible care and support for PLWHA in the local churches. Even though they provided compassionate

ministry, it was inaccessible to PLWHA. The plan of action did not integrate HIV/AIDS. The church did not tackle HIV/AIDS. Most of the participants had experienced deaths due to HIV/AIDS in their families and were supporting orphans. The church was affected financially, and the burden of care was on the increase. The focus for the church had changed due to the problem of HIV/AIDS, and growth was also affected.

Next, I asked the deacons how the local church had responded to the challenge of HIV/AIDS and PLWHA. The deacons revealed that the church was quiet on the problem of HIV/AIDS and PLWHA. They were all of the view that no response could speak to the challenge of HIV/AIDS. According to the deacons, a committee was formed and an attempt was made by this group to sensitize the church on HIV/AIDS. Some of the responses were that those who are positive are not open. They feared rejection and stigma. They had no counseling available. The local church leadership needed to develop a program to care and support PLWHA and their families. Clearly the church has been affected by HIV/AIDS. Only the women ministries, youth ministries, and the group that had started disseminating information on HIV/AIDS carried out any visible activity on HIV/AIDS. The available charity ministry was inaccessible by PLWHA because it was too general. Leadership needed organized to provide care and support for PLWHA.

The following themes emerged from the deacons. First, the church was silent and had no visible response. Second, the church had no care or support; compassionate ministry in the local church was inaccessible to PLWHA. Third, the church did not tackle HIV/AIDS. Fourth, HIV/AIDS was not integrated in the action plan of the church. However, the couples, and youth ministries had made attempts to include the topics of HIV/AIDS in their action plans. The participants were of the view that the church did not

have any planned activities on prevention, hbc, and livelihood care. They also indicated that they needed to teach children, families, and the church on HIV/AIDS.

In case studies three and four, I conducted focus group discussions composed of the pastor, deacons, deaconesses, members who are non-PLWHA, and members who are PLWHA. They were of the view that the church gives no physical help. The church only offered home visitations, encouragement, and prayer. However, when the pastoral team visited, they did not probe to find out what the real problem was.

Deaconesses' Perceptions of Care

I conducted individual interviews with all the deaconesses in case study one because I could not get them into a focus group discussion. In case study two, I conducted a focus group discussion composed of deaconesses and three female members of the local church. I met the five deaconesses and three members in the church building after the Sunday church service. After introducing myself to the participants, I explained the purpose of the research and the benefits. I also explained to the participants that involvement was voluntary and that they were free to withdraw at any time. They all agreed to participate in the interview. They signed the consent form to indicate their willingness to participate. I conducted a focus group discussion with seven participants. One did not attend.

I asked them how HIV/AIDs were affecting them, their families, and the local church. Their responses were as follows: They feel lonely. They lack accommodation and income. They suffer the burden of helping and mental effects, such as mental anguish, worry, fear, and loss of dignity. They also have suffered the death of relatives and breadwinners and a resulting lack of food. Other responses indicated that one was

affected because her neighbor is affected. In addition, they see problems with people hiding their status and thus having no access to ARVs, resulting in suicide. All the participants were of the view that HIV/AIDS affects almost everyone and the church.

Next, I asked how the church responded to HIV/AIDS and PLWHA. The participants said the church was silent on the subject and had no teaching on HIV/AIDS. Other participants thought that approaching anyone about the issues of HIV/AIDS is difficult. The participants were of the view that the problem of HIV/AIDS was in the church and that those affected were not open to sharing. They all agreed that they had difficulty telling who was HIV positive or had AIDS. One deaconess indicated that during home visits to the sick, she could guess whether the sick person could be HIV positive. The participants also indicated that one of the effects of HIV was an increase in the number of sick people. The participants also said that those who were HIV positive did not reveal their status. They observed silence and fear. The following were the conclusion to the question on the response of the church to HIV/AIDS: The deaconesses were of the view that there was no teaching on HIV/AIDS, and there was no integration of the HIV/AIDS in the teaching ministry of the church.

Next, I asked what care and support was provided to PLWHA and their families in the church. The participants described the care in the local church. The first participant noted that no care was provided for PLWHA unless the local church was to begin a ministry to care for PLWHA. The second respondent said that nobody was promoting care and providing training. The only available care was general, not deliberate. The following themes emerged from the discussion. First, the problem of HIV/AIDS was real

in the local church. Second, the church was silent on HIV/AIDS. Third, no deliberate care and support was present for PLWHA in the local church, but they were needed.

Focus Group Discussion

I conducted a focus group discussion composed of the pastor, the deacons, deaconesses, and members of the local church who are non-PLWHA. I asked them how HIV/AIDS was affecting them, their families, and the local church, and the pastor responded. He had been affected because some of his brothers and sisters were affected. When someone in the family is sick, he has to travel, meaning spending money. When family members are admitted to the hospital, because he is near the hospital, he has the responsibility of looking after them. The cost of travel, sickness, and hospitalization was real. He revealed that he had four known relatives who were HIV positive, and they had orphans in the family.

In another focus group discussion composed of the pastor, the deacons, deaconesses, and a PLWHA member; I asked the group how HIV/AIDS was affecting them as individuals, as a family, and as a local church. A deacon revealed that they had sick relatives (e.g., brothers and sisters). Another one said, “The death of breadwinners and the change of focus to the sick [is evident]. Some members were HIV positive and sick.” A deaconess followed, noting “the loss of family members, nursing the sick, and the care of orphans.” A PLWHA openly described his situation:

I am affected as the head of the family. Maybe I was movious [i.e., sexually promiscuous] or not movious or maybe my previous wife [was positive]. The problem has come and it affects us. I am not very free; my family is big. I lack finance to support them.

I asked them in what way the church had responded to the challenge of HIV/AIDS. A deaconess responded by saying, “The church is not really responsible. They would have

done something. The church had a program, but it ended. WHIZ used to provide food, mosquito nets and counseling.” A PLWHA interjected: “This church, I am happy with it because it is the only church in Zimba that helps people spiritually, physically, emotionally and had a ministry to PLWHA.” A deaconess described her situation:

I am affected because my brothers are sick and one died last week. We used to help as a church, but now there is no WHIZ. As a Christian and pastor’s wife, PLWHA come to me, and I have nothing to give them but prayer and encouragement.

Another deaconess went on to describe the care available to PLWHA:

The sick people lack help and assistance. The only help for PLWHA is the caregivers who only give spiritual care, nursing, and home care but no physical help (e.g., food). The caregivers occasionally give personal help to PLWHA, but not from the church.

A PLWHA indicated, “The focus now is on the sick and there is also failure to open up. If you help caregivers, you are helping me and PLWHA. There are no hbc kits and caregivers are working in isolation from the local church.” Caregivers and PLWHA describe the gap left by WHIZ and the need for help from the local churches.

The themes that emerged from the discussion were that spiritual care is available (e.g., home visits, prayer, and encouragement from the Word of God); individual caregivers occasionally provide support (e.g., food, cleaning and nursing); no physical help is provided (e.g., food, HBC kits for caregivers). The focus of families is on caregiving now. WHIZ care and support was helpful. Caregivers need resources to provide care to PLWHA. The local churches need to work with caregivers who were trained with WHIZ.

Congregants' Perceptions (non-PLWHA)

In case study one, I conducted an interview with three youths who were aged between 20-25 years old. These congregants were non-PLWHA. Among the three participants, one was a trained HIV peer educator. The participants were of the view that nothing was happening in the local church concerning care and support of PLWHA.

Congregants' perceptions (PLWHA).

I had both individual and focused group interviews with the four PLWHA at the first PWCZ local church. The first PLWHA I interviewed was a 40-year-old female with six children. She revealed that HIV had impacted her personally since she was HIV positive. She experienced discrimination and could not even visit friends and relatives because of her HIV-positive status. I asked her to tell me her experience of being found HIV positive. She described her experience in the following way:

At first, my husband was coughing, and losing weight, appetite. I told my husband that we need to go for the HIV testing. He refused and said, "If you know you are sick, you can go. But as for me I am not going." He continued to complain of fever and occasional cough, but he still refused. For me, I knew that he was not well because I was told his previous wife died because of HIV/AIDS. My husband's relatives are the ones who told me. He continued to refuse and to say, "They are just giving you bad stories." Therefore, based on the information from my husband's relatives, I went for the HIV test. They told me that I was HIV positive. I told him to go also. I told him that the hospital wanted both of us for counseling. He accepted to go after a month. After counseling us, he accepted to do the HIV test. He was found to be HIV positive. His CD4 count was found to be 58 and my CD4 count was found to be 300. They counseled both of us and advised us not to blame each other. After a month, I started taking ARVs. I have been taking ARVs for two years now and am still taking ARVs. There are no effects now. I have only shared my HIV status with the pastor and one elder in the church. The response of the pastor was good. The pastor and the elder encouraged us and prayed with us. We felt encouraged with the care and support of the pastor.

Next, I asked her what kind of care she received from the church. She received prayer and encouragement. When her husband was sick, the church provided occasional food

supplies, encouragement, and prayer. I further asked her what care and support the church was giving to PLWHA. Her response was that the church was providing prayer and encouragement. According to her, they had no counseling, hbc, livelihood care, or palliative care. The pastor and his family provided food and transportation to the hospital and even bought medicines. In terms of spiritual care, it was composed of home visits, prayer, and encouragement through Scripture. In terms of support to her children, the church did not provide any care and support.

The second participant was a 42-year-old female, a widow with one child. She was a business person and had finished ninth grade. I opened the interview with prayer. I explained to her the purpose and benefits of the study to the church. I also indicated to her that participation was voluntary and that she could decline to participate in the study. I also stated that even during the interview, she was free to withdraw. I elaborated the reason why she had to sign a consent form. She accepted to participate in the interview and signed the consent form.

I began the interview by asking her how HIV/AIDS was affecting the community. She revealed that HIV was a problem in the community. She went on to say that PLWHA encouraged each other at the clinic. I asked her how HIV/AIDS had affected her, her family, and the church. She said that she was just going to tell me of her personal experience: “When you know there some things you cannot do. For instance, I am a single woman [widow]. I cannot be going out with other men.” Furthermore, she said, “Financially, I have not been affected because I am self-employed. Emotionally no.” I asked how HIV affected her local church. In terms of effect at the church, she said, “Not yet, we are not open, if we are open.” She went to describe her experience:

I learned after my husband passed away. My sisters encouraged me to go for VCT. I went to the clinic where I was first counseled and then the HIV test was done. I waited for a month for the results. The results were positive even with the subsequent HIV tests. Since my CD4 count was low, I was advised to commence ARVs. In the first few weeks, they observe you to determine whether your body is tolerating the medications. If you are okay, then you are given ARVs for a month. Now I take ARVs monthly. Every six months, I go to the hospital for tests. I have not declared my status to anybody except my family members.

I asked her why she had not shared with the pastor. Her response was, “Maybe I am shy; maybe I do not have that confidence.” I asked her if she knew anybody who had openly shared his or her status. She said, “No, but I know two who I meet at the clinic.” She went on to say, “I have never been visited by a pastor at home.” Next, I asked her whether she would share her status if a pastor visited her at home. She replied, “Maybe.”

I asked her to tell me about her experience at the clinic. She responded by saying, “We meet at the clinic from 08:00 to 1400 hrs, waiting to get medicines, and we encourage each other.” I asked her to tell me how the church was providing care and support to her. Her response was, “I am not aware of any care.” Next, I asked her to share with me how the church provided care in terms of prevention, education, counseling, hbc, livelihood support, and spiritual care. Her response was, “Well, in terms of awareness, one time, there was a group from the US. My church, never. No counseling, no hbc, no ministry, but at the clinic.” Further, she said, “There is no help with livelihood and spiritual care. For orphans, I think it is there. Transport money to school was given to one orphan at one time.” She went to say, “I think the church can help if we ourselves opened up, they can. I am not aware of any care and support that is available to PLWHA.” From the interview with the participant, the church clearly was ready to give the care if the need was presented.

The third PLWHA was a female participant was between 40-45 years old who worked. Furthermore, she was married with several children. The interview took place at her local church. I explained to her the purpose of the study and the potential benefits to the church and to PLWHA. I also explained that participation was voluntary and she could decide not to participate in the study. She accepted to participate in the study and signed the consent form. I began the interview by asking how HIV/AIDS had affected her. She responded by giving her experiences:

As an individual who is HIV positive, it has been a big challenge. Sometimes, you have a lot of questions. Why has this happened to me? A lot of questions come. It affects you in a way that if you want to do the work of God, “you feel” Jesus heals. People will say, why can’t Jesus heal her? It affected me to the extent that I did not want to do the work of God. Now I feel it doesn’t matter, and I can do the work of God. In 2002, it was really a hard time till last year in 2011. Even physically, especially those days when you feel the symptoms, you feel uncomfortable. In terms of the effect on the family, you are able to reveal to older ones and not young ones. The older children have joined me in prayer. I had reached a point of not taking ARVs. The doctors advised me to commence ARVs for the sake of my children. I had the symptoms from 2002, and I only went for VCT in 2005, and I was found to be HIV positive. My CD4 count was 44 for one year and eight months. I went on to the extent of questioning the results since my CD4 count was constantly at 44. From 2005, I was not on ARVs.... I was praying at the same time I was tormented that I would be asked why I was not taking ARVs. At times you think of the cause, and you think to yourself, it came due to sin. I was believing that I would receive a miracle. In 2011, I was counseled that I should take ARVs.

In the local church, the problem is that people do not come in the open.... Maybe because of stigma, judgment, rather keep it to themselves. People and PLWHA think it is death sentence.

I asked her if HIV/AIDS has affected the local church in any way:

In my own experience, you shun away from local programs because you think you are not worthy to participate. Some members cannot be active. Some people are not open; it is a closed thing. When you know that someone is HIV positive. It is important to find out how one is doing. Concern from others for one who is HIV positive is needed.

This narrative reveals a number of struggles that PLWHA experience and the need for the church to provide care and support.

The fourth and fifth PLWHA.

The fourth and fifth participants were female PLWHA and the interview took place at the local church in the afternoon. I began the interview by asking them how HIV/AIDS affected the community. The first participant gave her experience:

Each household is affected. In every family, these days, you find PLWHA. If you are not infected, you are affected. If one is negative, then you still find may be the father, the mother or sister or relative is affected. Families are affected. At individual level, it is difficult to accept. Why it has happened. You think of the children. I felt pity for myself. Then, there is stigma from relatives. As for me, my mother and my sister were not helpful and supportive; some understood. I just wanted to give up on everything. I was thinking, if my family can treat me this way. The counselors told that I could live. The counselors at the clinic gave me hope. They told me, “you know, your children; you are the only hope for your children. It does not mean its death. It’s like any other disease. You can take ARVs and live a normal life. Do not feel pity for yourself”. But I was very sick. A daughter of 12 years, she was the one taking care of me.

This interview revealed that HIV/AIDS affects almost every family; and that family members and the health caregivers are important in the provision of care and support to PLWHA.

Another PLWHA continued with the discussion by giving her personal experience of being HIV positive:

As for me, my family was there for me. My father is a pastor. I remember, when I went for VCT, I was with my dad. I disclosed to my relatives. My mother and siblings were there for me. However, there is need to sensitize, even today, what people say and believe (e.g., it is a demon to be cast out). You would rather keep quiet. There is still a problem with society. That’s why I would rather keep quiet. I would be open to my friends who are affected. Sensitization and stigma still needs to be addressed. The scenario is that there are families that are supportive (e.g., my family encouraged me to go for VCT). And then there are families that don’t support and they say it’s up to her, her husband died. My first test was negative and the

second test was positive. The government clinic provided psychosocial counseling. It's only the government clinics and Kara Counseling that provide information and education on HIV/AIDs in the community. The government and the Catholic Church are the ones mostly providing hbc. The Catholic Church provides meal, beans, cooking oil, and soya flour. At my local church, there are members who are PLWHA. But for the church, "all is well" the pastors take it, and yet a lot of people are affected. There is nothing done in the pulpit. This has not really come out in the church. It is difficult to discuss. For me, I feel the church is not doing well. The pastor should come out (e.g., Lusaka Baptist church is supporting those who are HIV positive). I feel the leadership should open up. The pastor should talk about it and give word of encouragement. The main problem is to start from there. All should not think that all is well. Just as my friend has found that her family is not supporting and the church is not supporting. The top leadership is not doing enough because they have not talked about it. So why talk about it.

According to PLWHA, the health institutions, the Roman Catholic church and Lusaka Baptist church are providing care and support to PLWHA. They also perceive the church as not doing well in giving information about HIV through the preaching and providing care to PLWHA. The church is silent and not communicating to its members the problem of HIV and AIDS.

The themes that emerge from this participant are the following. First, the role of family in care is important. Second, the role of VCT is important in accessing ARVs. Third, the government health institutions are providing the care and support needed by PLWHA. Fourth, the leaders can play a significant role in breaking the silence on HIV/AIDS. Fifth, the Catholic Church has a model of care and support that is meeting the needs of PLWHA. Next, I asked what kind of care and support was given to PLWHA:

There is nothing being done. I have been on the board of leaders for the church. There, we do not want to talk about it. We want to think all is well. There is no education and no sensitization. In this church, there are doctors, nurses, and counselors, and yet nothing is done. I have never heard a talk on HIV. If only the church can sensitize our children. There is also no spiritual care from the church.

According to the participant, she has been on the leadership board and she never heard any talk on HIV/AIDS. Furthermore, the local church has medical professionals and yet there is silence about the problem of HIV/AIDS.

The themes that emerged from this interview included the following observations: PLWHA suffer silently in the church; the church is also silent on HIV/AIDS; and, no care exists for PLWHA in the church. The local church has human resources to provide care and support for PLWHA, but the church is not utilizing them.

One PLWHA offered to write a testimony of her experience of the HIV status:

It is not easy being HIV positive. I felt as if I would die tomorrow when I discovered that I was positive. I had a lot of questions and asked, "God, why me of all the people in the world? I have just lost my husband, and now this? What have I done to be punished like this? What is it that I have done that other people haven't done? I got very sick and almost gave up. But thanks to my friend who is a nurse who encouraged me very much; she said, "That is not the end of the world." She said I could live a normal better life like any other person as long as am on ARVS. She said that my children have lost one eye, which is their beloved father. And if my family is not supportive while I was still alive, what more if they [children] lose the other eye, which they have now and look up to. She said to me, "Be strong and accept the fact that you will not die today or tomorrow because people die in road accidents and of malaria and other diseases at any time, and yet you who are on ARVs can prolong your life and see your children grow and complete their education. Here I am now proud of them. They have grown and I am grateful to the healthy workers who were there for me. I would not be alive today. All I can say is that being HIV positive is not a death sentence.

People living with HIV have questions about the reasons why they are HIV positive. They may think that they are HIV positive because of sin or that God is punishing them. They may also think that life is no longer worth living. Therefore, family members, friends, the church and the medical caregivers can play a vital role in encouraging them and counseling PLWHA to live a positive life. The family and local church should create a positive climate for PLWHA to live a positive life.

The themes that emerge from this testimony are helpful to caregivers of PLWHA. The first theme is that when one is found to be HIV positive, people have the perception that they will die. However, with encouragement, counseling, and treatment with ARVs for those whose CD4 count is low, PLWHA live like everybody else. Therefore, being HIV positive is not a death sentence. The second theme arises from the questions PLWHA raise about their status. PLWHA wonder whether their status is due to God's punishment. The third theme is the role encouragement plays in the lives of PLWHA. Health personnel, PLWHA, and the members of the church can make a difference in the lives of PLWHA by encouraging them. The fourth theme is the importance of ARVs in improving the lives of PLWHA. The last theme is the presence of stigma in some families who still struggle to accept PLWHA.

In case study two, I asked the pastor to request some PLWHA members to volunteer to participate in the study. I explained to the pastor regarding the need for confidentiality. Initially, two out of three appeared for the interview. The third one preferred to have a personal interview. The interview took place at John Howard PWCZ in one of the classrooms. All the participants were female. The language used was Tonga. Since I understand the language, I was able to interview the participants in Tonga; however, I had to write the responses in English. Once again I gave an overview of the study, its motive, purpose, and benefits to the church and to PLWHA. They all agreed to participate in the study, and they signed the consent form. I went on to ask them to tell me their experiences of being HIV positive. They both indicated that they were HIV positive. Participant one explained how HIV/AIDS had affected her and her family:

Healthwise, I am unfit. My husband's eyes were affected due to HIV/AIDS. My ninth-grade child was chased out of school due to

financial problems. My young sister, cousin, elder cousin, three children, and grand children are all HIV positive. In terms of support, it becomes difficult since most of my family members are affected. There is no one to care and support other family members because most of us are sick. However, the church helped when my husband was sick.

Another PLWHA revealed that she was aware of other members who were PLWHA since she meets them at the ART clinic when collecting drugs:

In the local church, the problem of HIV/AIDs is there. I know because we meet at the clinic when collecting medicines [ARVS]. I know about fifteen meet at the clinic. Others, I can tell from the signs or the way they look, but they fail to go for VCT.

The first participant went on to describe the care she received from the church:

Both of us with my husband became sick [HIV/AIDS], and we had to be nursed by relatives. We were encouraged by individuals to go for VCT. WHIZ brought food to the local church. The pastoral team visited because we were sick and did not know our status. The visitors from the church provided food, encouragement, and prayer. The care we received from the church was encouragement, food, visitation, and prayer.

The two participants agreed that no psychosocial counseling, information, hbc, livelihood care, or palliative care were provided by the church. They also indicated that declaring their status was difficult because the members could not keep confidences. Only WHIZ used to provide food staff and mealy meal (corn meal). However, since WHIZ ceased to operate in Zambia, no care and support are available to PLWHA. The following common themes emerged. First, PLWHA are in the local church. Second, PLWHA were directly affected and need care and support. Third, WHIZ used to provide care and support to PLWHA. Fourth, no planned care and support are available. Fifth, the women's and youth ministries were the only ones that had made an attempt to respond to HIV/AIDS.

The other two participants who were PLWHA preferred to be given the interview questions before answering them. From my observation, the reason they opted to be

given the interview protocol was that they had in the past shared their experiences of being HIV positive to me. They were also busy with work. The first participant shared the following personal experience:

I have lost many people dear to me; consequently, I have added responsibilities in my life. I have lost relatives and friends. I have an increased disease burden and work in the family. Some of my friends have left a child headed home. They have died left children to look after themselves. It is saddening. I have to deal with issues of stigma and disclosure among the people within the community. When parents die, people assume leadership roles at a tender age. In the local church, my church is silent. People fear disclosing their status.

The following response answered the question about how the local church handled HIV/AIDS and PLWHA:

My local church has turned a blind eye to HIV/AIDS and health-related issues though in my congregation, my pastor will refer some clients for VCT. In terms of creating awareness, the general scene is silent and passive. In terms of care and support, there is no evidence of any care/support specific to the PLWHA. If anything, it might be that they have not disclosed to the church. There is no platform to address issues of HIV/AIDS, despite the fact that Fountain of Hope has tried to stimulate congregations to start something. It seems people prefer help from the outside [USA] rather than starting something with their own effort. You can support people even without money [spiritual]. But it seems we think, seem to believe we need large amounts of money to bring PLWHA together and to care for them. The local church has not talked about HIV/AIDS, thus giving a platform for PLWHA to identify themselves and thus provide what they need or require. Care to the sick is provided in general, non-specific; the program initiated at the national level failed or is struggling to be accepted/implemented at grassroots.

In a focus group discussion of PLWHA, I asked how HIV/AIDS had affected them at a personal level, family level, and in the local church. One PLWHA responded by sharing her experience of being HIV positive:

I have no problem since I started medication, especially that I started medicines fast. My family is not affected. However, my sister was affected and it was costly [in those days]. Some church members are unable to do church work when ill. I have not disclosed to the church because I do not

know how they will react. I have no idea how the local church has responded to HIV/AIDS and PLWHA. I have no idea of any care and support to PLWHA. I have not seen anything. Neither have I seen any prevention or sensitization, any hbc, livelihood care, palliative care, nor any spiritual care. There are no activities.

The themes coming out from PLWHA were as follows. First, HIV/AIDS is real, and these participants were directly affected. PLWHA are in the church. Second, the local church is silent on HIV/AIDS and PLWHA. Third, churches provide no care and support to PLWHA. Fourth, PLWHA still suffer from stigma and discrimination. Fifth, PLWHA have no platform to come out in the open and ask for care and support. Sixth, while attempts have been made to provide care and support by the leadership, the efforts have not yet born fruit. In case study three, the PLWHA opted to be integrated in the focus group of deacons, deaconesses, and members who were non-PLWHA.

In case study four, all three participants were female, widows, and subsistence farmers. They looked thin and weak. They all said that HIV/AIDS affects them directly. One said, “As you can see, we are sick and weak. When you are sick and on ARVs, you need food. And yet we are sick and we cannot work. We have livelihood difficulties, especially food.” In terms of care from the church, they revealed that the church was silent:

We need help with food and money for small businesses. But the church did not respond. They have not shown any concern. The pastor only knew that we were HIV positive when WHIZ was giving food and supplies. The home visitation is too general. They are not deep enough to probe and find out why we are sick. The local church leaders are not willing to help us.

These participants all indicated the need for physical help because they were too weak to work in the fields. The key themes were as follows: (1) PLWHA need help from the

church because they are too weak to work but need food; (2) the church is silent and seems not to care; and (3) WHIZ has left a gap in care.

Findings for Research Question #2

The interviews with all the participants clearly indicated that no planned care and support were aimed at PLWHA since WHIZ ceased to function. Though compassionate ministry was part of the church programs, it was inaccessible by PLWHA and involved giving occasional donations to vulnerable persons. Because both the church and PLWHA were silent about giving and receiving care, PLWHA could not access help from the compassionate ministry. In one urban church, compassionate ministry was available to those who requested help. Only one couple who were both HIV positive accessed some assistance. When the husband died, the church facilitated the wife getting a job; however, the church did not support her children. The following themes came out of the interview and focus group discussions. The churches have no planned care for PLWHA and their families. The general spiritual care was inadequate. Compassionate ministry was not accessible to PLWHA. The women's and youth ministries were sensitizing their constituents on HIV/AIDS. The WHIZ package was effective according to PLWHA. Only one urban church pastor thought WHIZ was only effective in the beginning. Now a gap in care exists since WHIZ ceased to work with the church. The PWCZ auxiliary ministries (i.e., women's and youth ministries) were the only ministries that occasionally integrated HIV/AIDS sensitization to its programming.

Findings for Research Question #3

Research question #3 assumed that the Pilgrim Wesleyan Church has been providing care and support to PLWHA. The question also sought the perceived gap in

pastoral care practices and how members think the gap can be filled in order to meet the needs of PLWHA. After analyzing the responses from the participants, the Pilgrim Wesleyan Church clearly has no planned pastoral care practices to PLWHA. The church has no policy on HIV/AIDS that provides a vision for the whole denomination. However, the partnership with WHIZ in the past filled the gap that existed in the care and support of PLWHA. With WHIZ no longer operating, the PLWHA have no care and support. The participants also indicated that the compassionate ministry (mercy ministry) was not accessible to PLWHA. Finally, the participants indicated that spiritual care was inadequate because it was too general and involved mere home visits, prayer, and encouragement from the Word of God.

National Leaders' Perceptions

In order to obtain data on care practices from the leaders, I interviewed National Superintendent Alfred Kalembo, National Director of Social Ministries Genesis Katowa, National Director for Christian Education Frevia Kaluba, and a member-at-large in the national board of administration, Lenorah Ngandu. I conducted individual interviews with each one of them.

I asked Kalembo what he thought would be the care and support needed by PLWHA. According to him, the ideal care should be holistic and should involve spiritual care, physical and material support, help against job loss, and acceptance of PLWHA. He also mentioned the need for programs to train, educate the leaders and members about HIV/AIDS, and to provide food to PLWHA. Kalembo believes that the church should have a deliberate plan and program for ministering to PLWHA. In addition, the church needs data on the number of PLWHA in its congregation. Kalembo gave the following

recommendations to the local churches in order to improve the care and support. He said that David served the Lord in his generation, and so the church must serve God in this generation by providing care and support to PLWHA. He further said that the sons of Isaacher understood the times, so it the church had to understand the times and be relevant to the needs of PLWHA. When the church realizes that HIV/AIDS is in its midst, it will become the salt and the light of the world.

According to Katowa, the first action was for the national leaders to create an HIV/AIDS policy and then implement it. He believed the policy is already developed, so what was required was to implement the policy. One way is to create a social ministries department in every district and local church. This step should be followed by the appointment of local church social ministries directors. Katowa also said that PLWHA needed acceptance, love, care, spiritual care, and provisions. He also indicated that the church needed to allocate funds for assisting PLWHA. He provided the following ideas on how to make these moves effective:

The national leadership must create a definite program that will force leaders of various local churches to implement the HIV/AIDS policy. There must be definite steps to implement the policy. He also said that there must be a pastor's handbook that explains how to articulate the policy at the local church or include the policy on HIV/AIDS in the discipline of the Wesleyan church. There must be a dedication of certain weeks solely for HIV/AIDS. During the particular Sundays, the finances should be marked for the ministry to PLWHA. The policy is there, but the need is to implement it.

I asked him what his final recommendations would be in order to improve care and support to PLWHA. According to him, the policy is well articulated. Therefore, churches need to work hard with other organizations. As a church, he also recommended soliciting for funds in the church, from the government, and other international organizations.

Kaluba believes that the church should start providing the needed care and support. The first step is to train the church at all levels and then create some compassionate ministry. She also said that churches need to have some kind of ministry that gives policy guidance and teaches where to begin helping. Finally, I asked her if she had any other recommendations to the church in order to improve the care to PLWHA:

- The church begins with prevention since people lack information.
- The church also needs to look at the problem in the bigger picture.
- The church needs to get people involved in the ministry of care (e.g., by giving skills, empowering people, not just spiritually but also by providing support).
- The church can support PLWHA by providing home visitation, prayer, and food.
- The church needs to utilize existing assets. However, she also revealed that

the PWCZ does not have adequately prepared leaders who understand the times and perhaps learn from what others are doing in the care and support of PLWHA.

Kaluba, served as the country director of WHIZ before it ceased to operate in Zambia. The church can work with her to improve the care and support to PLWHA.

Ngandu was a female, trained clergy who has been active in her local church in the care and support of PLWHA. According to this participant, the care needed for PLWHA is as follows. First, church members need to be taught about HIV/AIDS. Second, the church should provide capital for livelihood care. Third, churches need to provide many caregivers training and encourage them to offer themselves to the ministry

of care. She also found a need for an office, good records, confidentiality, and mobilization of human and financial resources.

Pastors' Perceptions

The first pastor believes the church must have a ministry that will specifically look at the needs of PLWHA. Then, the rest, such as spiritual support, moral support, and finances will fall into place. Medical people can give information on matters of health, get involved at local clinics, provide food for affected families, and visit the PLWHA. Others areas of care needed were counseling and providing material support based on Matthew 25.

According to the second pastor, the church needs to meet physical needs (e.g., shelter, water, and sanitation). PLWHA also need empowerment for livelihood since PLWHA are now strong due to ARVs. They need skills to run small businesses. They also need psychosocial counseling and motivational encouragement. Orphans need to have their school fees paid. The church can promote care and support and sensitize its people. The church needs to have a deliberate work plan and budgeted activities for PLWHA to provide finances and to mobilize human resources for the care ministry.

Deacons' Perceptions

In case study one, the first deacon stated that the church must have a champion for the cause and should dedicate an office, with predictable office hours, to attend to cases of care and support. The church should also provide counseling and have a listening ear. It should also look out for needs of PLWHA. The church should realize that it exists to worship God and to meet the spiritual and physical needs of human beings. The deacon made the following recommendations in order to improve care and support to PLWHA:

- The pastor needs to champion the welfare of PLWHA and spend part of his or her time advocating for the needs of PLWHA.
- The pulpit ministry should integrate HIV/AIDS and the needs of PLWHA.
- The pastor needs to champion the cause, identify potential caregivers, and encourage members to volunteer to provide care. After all, Jesus went about preaching, teaching, and healing.

The second deacon in case study one indicated that the compassionate policy should be all embracing and give priority to HIV/AIDS. He also said that the church needs programs, strategies, personnel development, training, skills development, and a capacity for leaders and members.

The deacons in case study two concluded that PLWHA need love, teaching, and encouragement to declare their status. PLWHA need spiritual and emotional support, physical help, orphan care, finances, hbc, caregivers, entrepreneurship, and livelihood care. The anticipated barrier to providing this care and support could be a lack of motivated personnel, lack of educated leaders and members, and the stigma associated with HIV/AIDS. The deacons recommended that the church should tackle the contemporary problem and encourage unity. The church also needs to educate, strengthen families, to put the of HIV on the church's action plan, and form a department to deal with care and support for PLHWA. Other issues that need addressing are the provision of sex education and the facilitation of access to ARVs.

Deaconesses' Perceptions

Deaconess one revealed that PLWHA need care and support in several areas. They need nutritional care, spiritual and emotional care, encouragement, physical care,

nursing care, food, and finances for livelihood care. The church also needs to educate couples, families, and church on HIV/AIDS. Finally, the church should encourage PLWHA to take ARVs.

The church has several challenges and obstacles to address church before establishing the required care. Members need a place to go for counsel on issues of sexuality, marriage, HIV/AIDS, and divorce. People have no platform for church members to open up or to find help. The silence in the church on HIV/AIDS and members' fear of leaders in the church also needs changing. People need nutrition care and provision of finances or access to funding and more home visitations.

The second deaconess made the stated that PLWHA need spiritual care and moral support, acceptance, physical care, nursing, finances, encouragement, and education in the church. She also made the following suggestions:

First, the church should wake up and realize that HIV/AIDs is in the local church and is a community and national problem. Second, the church should make a deliberate move to guide the local church. Third, we do not have to wait for members to come to us. Fourth, we have members who fear to step on the local church doctrines. Many think that it is a taboo to talk about HIV/AIDS. Fifth, the church should consider coming up with VCT services, psychosocial counseling, care, and support. Sixth, the church should come up with a policy on HIV/AIDS. Other churches have policies on HIV/AIDS. It is difficult to come out in the open or to see the pastor, when there are no guidelines. For instance, if the policy was there, I would call on the pastor or deaconesses to say, "I have a challenge."

According to this participant, HIV is real and affects the members of the church.

Therefore, the church should provide leadership and guidance on how to deal with the problem of HIV and AIDS. The participant feels that there is no platform for those who are affected to come out in the open.

According to deaconess three, PLWHA need physical care, a platform where people can go, and moral support. She recommended that the church build a financial base, decide to start providing care and support to PLWHA, and provide a platform for members to share their challenges and counseling. Finally, the church is supposed to open up or speak out on HIV/AIDS.

Deaconess four indicated that PLWHA needed the following care and support. PLWHA need help monitoring the intake of ARVS (e.g., a relative who died was not taking the ARVs). The church also needs to provide food and a nutritious diet. It needs to allow PLWHA to give testimonies in the church, make them feel at home in the church, encourage them to be open, and help those who are affected. The following were her recommendations to the local church in order to improve the care and support: The church must be open; the pastoral team needs to be more deliberate and even call in other people to help address issues related to HIV/AIDS; and, the pulpit should be used to save lives and disseminate information on HIV/AIDS.

The fifth deacon stated, “The care and support needed is just encouragement spiritually for I can look after myself. But for others we need a deliberate program of meeting people’s needs. We need to supply food and to encourage them to take ARVS.” In urban churches, some members who are PLWHA are self-sustaining and all they require is to be encouraged and counseled. However, there are some who may need care and support in terms of income and food.

The deaconesses in case study two mentioned had several suggestions for the care the church can provide to PLWHA. The church needs to teach, provide spiritual care, and encourage members to go for VCT. They anticipated challenges and obstacles in order to

provide the required care, such as whether leaders will accept that the church starts providing the care and support. The church is challenged to find mature counselors who are able to keep confidences. The church needs to plan and organize a ministry to provide care to PLWHA. The church is challenged to find leaders who can work with the deaconesses in order to provide care and support to PLWHA. The deaconesses recommended the following:

- That the church encourage PLWHA,
- That the pastor help members grow,
- That the local church leaders open up and become advocates for PLWHA,
- That the leaders open up and become advocates,
- That the PLWHA be treated with love and acceptance, and
- That the care to PLWHA be visible.

Deaconesses' Perceptions

The participants gave the following steps towards dealing with challenges and obstacles to the development of the care and support ministry to PLWHA. The pastor should teach the members about HIV/AIDS. He or she should preach about HIV/AIDS and relate it to the Bible. The local church leadership should be open about HIV/AIDS and should advocate for the PLWHA. The church should mobilize financial resources in order to provide care to PLWHA. The deaconesses made recommendations for improving the care and support to PLWHA. The need for cooperation between the pastor and deaconesses in the care of PLWHA.. The church needs to show courage to start providing care to PLWHA. The church needs to provide food, clothing, and prayer. The church

needs to use its local resources, such as compassionate ministry and availability of caregivers.

Members' Perceptions

I interviewed three youths from an urban church. One of three youths had trained as a peer counselor. They ranged in age between 20-25 years. According to the three members, the care needed by PLWHA is genuine love rather than mocking love; spiritual care, counseling, and financial support to the needy. One member stated, "This love involves visiting and treating PLWHA like a normal person without stigmatizing and encouraging taking ARVs." The three youths believed that the church needed to several steps in order to overcome the challenges of starting a care ministry to PLWHA. The church needs to come up with an established group of members who are available to provide care and support to PLWHA. She stated, "For youths, the church has to pay them. There is nothing for free. The youth say, 'nothing for free.' In this church even the youth are busy like their parents. You find yourself alone." The youth was trying to emphasize the non availability of youths in the local church. The youths were as busy as their parents. One of the youths made the following recommendations in order to improve care and support to PLWHA: "One way people do not open up, they think, it is embarrassing. Since the mentality is that HIV/AIDS comes through unprotected sex, it is difficult to talk about it. So the church has to address this mentality." The participants who were youths seem to reveal that there is stigma in the local church. They recommended that the church should deal with the negative attitudes towards PLWHA. They also revealed that self stigma could be a hindrance to opening up by PLWHA.

PLWHAs' Perceptions

In case study one, one PLWHA talked about how to improve the care to PLWHA:

The church just needs to have a program for helping the needy. The pastor needs to encourage PLWHA to come together and assure them of confidentiality. The pastor should come out and then we will also come out in the open. The pastoral team can use the sermons and lessons as means of communicating on HIV/AIDS.

The members seem to know what the church should do in order to address the problem of HIV and AIDS. Most participants seem to indicate the need for advocacy for PLWHA and the use of preaching and teaching in the fight against HIV/AIDS.

In case study two, a PLWHA mentioned the following as the ideal care for PLWHA. First, caregivers need to love PLWHA. Second, the church should teach and encourage PLWHA. Third, the church needs to provide counseling, spiritual care, emotional care, and physical support, such as assisting with finances and adopting orphans. Fourth, the church needs to help families, provide hbc services, and train caregivers. Fifth, the church needs to provide entrepreneurship training for livelihood care.

In a focus group discussion, the participants believed that PLWHA need loans to improve their livelihood needs: the provision of food, spiritual care, HBC, and supervision of ARV intake. The church needs to make home visitations and teach congregations about HIV/AIDS.

In case study four, I conducted a focus group discussion composed of the pastor, the deacons and deaconesses, and the members who are non-PLWHA. I asked them to discuss the care needed by PLWHA. This focus group said that PLWHA need the provision of food, psychosocial counseling, and bicycles for transportation to hospital. I

further asked the group what the church needs to do in order to provide the care suggested. The group revealed that the church needs unity in order find a way to help those affected. The church needs to consider starting projects and raising money. The church can sit down, plan, and promote self-sustaining projects. In case study four, PLWHA made the following recommendations about the care they need: food, spiritual care, transportation to clinics, children's education, and shelter.

PLWHA and Caregivers' Perceptions

In a focus group of PLWHA and caregivers, the participants stated that the church can learn from the Roman Catholic Church care package, which provides hbc services and has a feeding program. The caregivers monitor the intake of ARVs, and psychosocial counselors are able to keep confidentiality. The leaders should include HIV/AIDS in the plan of action and open up by talking about HIV. They also need to deal with attitudes, such as placing a stigma on those with HIV/AIDS. The church should rise up and address the problem of HIV/AIDS. One PLWHA had this to say:

Some are dying in the church due to lack of information, education, and communication on HIV/AIDS. The church should wake up and stop sleeping. The church should integrate HIV/AIDS into its programs and also prepare members for eternity. The church should also create a platform where people can come out and even form support groups in the church. The clergy should be empowered with counseling skills. The church should talk about HIV/AIDS in the Bible study lessons and also address health-related issues. The clergy should be able to distinguish between physical ailments and spiritual. They should be able to refer cases to appropriate caregivers.

These comments reveal that PLWHA have knowledge about how to respond to the fight against HIV/AIDS. PLWHA can be utilized to plan, organize, and provide care ministry to fellow PLWHA.

Focus Group

In case study three, I conducted the focused group discussion composed of the pastor, the deacons, deaconesses, and three members of the church. The group mentioned the following as the care and support needed by PLWHA: provision of food, accommodation, water, medicines, monitoring of ARV intake, finance, and teaching. Each congregation should have a policy and also provide care to orphans. The church should educate its members and equip them with survival or livelihood skills. The group thought that the church should consider having seminars, breaking barriers, mobilizing resources, and understanding traditional and cultural barriers. Leaders and members need to see and experience PLWHA. The church should consider opening VCT centers, be compassionate, and keep confidentiality.

Valley View Caregivers Club

I sent the interview questions to a member of the Valley View Caregivers club who returned the following data about its care practices. According to this participant, Valley View Caregivers club has an effective home-based program. The club has identified twelve PLWHA around the townships in Choma town. The club provides care and support to the twelve PLWHA. The club members visit the homes of PLWHA and very often provide foodstuffs:

- 1 x 25 kg of cornmeal,
- 1 x 2 kg of sugar,
- 1 x 2 kg of dry small fish called kapenta,
- 1 x 2 kg of beans,
- 1 x 1 kg of salt,

- 1 x 1 bar of soap,
- 750 ml of cooking oil, and Washing paste for clothes
- The caregivers are also given them some food stuffs.

Summary of Major Findings

In order to evaluate the pastoral care practices towards PLWHA in the PWCZ, I conducted personal interviews and focus groups discussions and analyzed national conference reports in order to get data on care practices. I interviewed and conducted focus groups discussions with leaders and members of four local churches in the PWCZ. The following were the major significant findings of the research:

- HIV/AIDs affect leaders, members, and PLWHA in the PWCZ.
- The church needs leadership and policy guidelines on HIV/AIDS.
- The PLWHA in the PWCZ have no support exclusively for them.
- The PWCZ is providing general spiritual care and compassionate ministry.
- WHIZ left a major gap in the provision of care and support to PLWHA when it stopped providing assistance.
- The church is markedly silent on HIV/AIDS and PLWHA in the PWCZ.
- Caregivers are family members of PLWHA.
- Elements of care and support suggested by participants encompass the comprehensive care model (i.e., prevention, treatment, care, support, and mitigation of impact).
- Best practice exists in comprehensive care of PLWHA.

CHAPTER 5

DISCUSSION

Major Findings

The purpose of this study was to evaluate the effectiveness of current pastoral care practices with PLWHA in the PWCZ and to develop a comprehensive pastoral care model that meets the holistic needs of the aforementioned individuals. My beloved country Zambia is coming to terms with the challenge of HIV/AIDS. The impact on the nation and all sectors of life has been significant. HIV/AIDS either affects Zambians directly or indirectly.

According to the United National Development Plan (UNDP) HIV/AIDS news in August 2011, the number of PLWHA stood at 1,027,626 in Zambia. These figures represent people who are created in God's image and have been the object of God's unconditional love. The emergence of ARVs has tremendously improved the lives of PLWHA. With global funds being available to Zambia, PLWHA have been able not only to access ARVs but also to access comprehensive care through various governmental institutions, nongovernmental organizations, faith-based organizations, workplaces, and churches. With the improved lives of PLWHA due to access to ARVs, governmental institutions and other organizations have provided hbc, palliative care, and livelihood care to PLWHA. In spite of the many organizations fighting HIV/AIDS, the church can be part of the community by being fully involved in the fight against HIV/AIDS.

The greatest need now is the provision of care and support in the homes and community and comprehensive care in collaboration with other care providers. Therefore, the government has been promoting a multi-sectoral approach to caregiving and support.

While the Zambian church has been involved in the fight against HIV/AIDS, mostly, it has been the church-initiated FBOs involved directly in the fight against HIV/AIDS. However, the clergy, leaders, and members of the churches are not involved directly in the fight against HIV/AIDS. They have left the arena for comprehensive care to the so-called professionals.

Most churches continue with the traditional core business of the church without integrating HIV/AIDS into the life and ministries of the church. The church remains silent on HIV/AIDS and continues with the so-called “core business of the church.” Most of these churches provide general spiritual care; make occasional home visits, and occasionally provide handouts. PLWHA have multiple needs that go beyond spiritual care and mere home visits. They need management of opportunistic infections, adherence to ARVs, food, resources to support their families, and livelihood resources and palliative care.

The existing pastoral care models are inadequate in addressing the multiple needs of PLWHA. These pastoral care models are individualistic, insensitive to socioeconomic, and livelihood needs of PLWHA. These models are not sensitive to the multiple needs of PLWHA. They fail to address contextual problems such as socioeconomic, political, and developmental issues, gender inequalities, gender-based violence, poverty, corruption, and HIV/AIDS.

Therefore, the purpose of this study was to evaluate the current pastoral care practices to PLWHA in the PWCZ and to come up with a more sensitive pastoral care model that meets the needs of PLWHA. This model is founded on Trinitarian theology of mission, ministry, and care. The model views human beings (PLWHA) from a Trinitarian

perspective. The human being who is a PLWHA is valuable, has dignity, and is worthy of care and support. Because PLWHA are a representation of the Triune God, the Trinitarian God is always seeking for human beings to be in community with him and to restore them to wholeness and fullness of life (John 10:10).

The Effect of HIV/AIDS on Leaders, Members, and PLWHA

First, data from personal interviews reveals that almost every leader, member, and PLWHA indicated that they are affected directly or indirectly by HIV/AIDS. The pastors, leaders, members, and PLWHA who were interviewed had a relative, friend, workmate, or a church member who was affected by HIV. They were also burdened by the cost of care. As a clinical officer, a pastor, and a denominational leader, I seen how HIV/AIDS affects almost everybody. Since HIV/AIDS is in the family, the church, and community, the church needs to rise up to the challenge of providing care and support to PLWHA.

Kalembo says the following:

In the face of HIV/AIDS, which has continued to ravage sub-Saharan Africa, the Pilgrim Wesleyan Church cannot afford to watch the unfolding human tragedy. The Pilgrim Wesleyan Church is aware that it has not been spared from the effects of HIV/AIDS and has been magnanimous enough to admit that it has not responded adequately to the problem. (105-07)

According to the literature review, HIV/AIDS is real, and most researchers and social scientists have formulated care practices that have proven very helpful in the fight against HIV/AIDS. The fact that medical experts are able to recognize HIV/AIDS and use ARVs and that a lot of resources have been spent to try to address the challenge of HIV/AIDS is evidence enough for the PWCZ to rise up to the challenge. This finding needs to inform the theology and practice of ministry towards PLWHA. The PWCZ cannot continue with *business as usual* when HIV/AIDS is in the home of its members and the church. In fact,

ministry is about the Triune God, the care of human beings and nature. If the Triune God is the first missionary and has been on a mission to seek human beings to experience fullness of life, the church that has just been invited to join God on his mission and ministry cannot ignore the plight of human beings.

A Need for Leadership and Policy Guidelines

The interviews indicate the need for leadership in the fight against HIV/AIDS both at the national and local church levels. The participants agreed that the church needs leaders to break the silence and address the stigma and discrimination against PLWHA. The participants revealed that the Pilgrim Wesleyan Church of Zambia does not have a policy on HIV/AIDS. According to data from the interviews, the PWCZ has drafted a policy that was formulated between 2009 and 2010. The National Board of Administration and the National Conference have not yet approved this draft policy. The Social ministry, which addresses the crucial issues such as poverty, socioeconomic empowerment, and HIV/AIDS, was approved by the National Conference. The social ministry director was appointed; however, the ministry must be decentralized in the local church. The church has yet to formulate policy guidelines on the same. At the moment, nobody knows what the clergy are doing in premarital counseling in the era of HIV/AIDS. Furthermore, the local church leadership does not know how to integrate HIV/AIDS in the core business of the church. This year, during the World AIDS Day, the urban local church I attend did not mention anything about HIV/AIDS and the plight of PLWHA. In terms of formulating a policy for the local church, only one urban church, Munali PWC, has a written policy on compassionate ministry. The compassionate

ministry policy also integrates the global challenge of HIV/AIDS. In spite of this church having a policy, the leaders have not implemented it.

Leadership is needed in the fight against HIV/AIDS. The participants mentioned the necessity of policy guidance and the decentralization of the social ministry to the local churches. Furthermore, champions must advocate for the needs and care for PLWHA. These issues indicate the need for leadership in the fight against HIV/AIDS. The silence in the church and the failure of pastors to integrate HIV/AIDS in the life and ministry of the church also signal the need for leadership. One national leader pointed to the need for policy guidance and a manual for pastors on how to respond to the plight of PLWHA. According to the ministry of health literature on leadership and the fight against HIV/AIDS, leadership plays a critical role in advocacy, policy formulation, and the ability to deal with issues of stigma and discrimination. According to the biblical literature review, the Triune God provides an example of leadership in God's mission to create and redeem human beings. The Triune God was the first missionary, and Jesus' healing ministry also modeled how to respond to fellow human beings who are in need of care. This finding should inform the practice of leadership for the church. Roman Catholic Church leaders produce pastoral letters for their members to give them guidance on issues affecting the church. Leadership practice towards the plight of PLWHA may involve policy formulation, advocating for the implementation of the same, resource mobilization locally and abroad, and the training of leaders and local church pastors to understand the challenges of, policy towards, and ministry to PLWHA.

The literature review supports the idea that leadership is important in the fight against HIV/AIDS. For instance, the Zambia Ministry of Health outlines the role of

leaders in the fight against HIV/AIDS and states that the role of leaders is to share information about HIV/AIDS, advocate for policy dialogue, integrate HIV/AIDS in strategic planning, support HIV/AIDS endeavors, and use their influence to address stigma and discrimination (Ministry of Health, 59-61).

The leaders in the PWCZ need to provide leadership in the fight against HIV/AIDS. The literature review on theology of care and church history provides guidelines on how to care for the sick from Jesus' ministry (Matt. 25; Mark 1:40-45; Luke 10). Therefore, the PWCZ cannot continue with the same ministry without articulating its beliefs as the biblical way of responding to HIV/AIDS challenge. Furthermore, in the history of the church, the Bishops mobilized the deacons and Christians to provide care and to open homes for nursing the sick during plagues. Lastly, the Roman Catholic Church, Anglican Church, and United Church of Zambia have articulated their HIV/AIDS policies. The PWCZ can learn from the pastoral care practices utilized by other denominations.

The finding that the PWCZ has no policy on HIV/AIDS in the context where other churches have articulated their policies and the Council of Churches in Zambia has been encouraging member churches to formulate HIV/AIDs policies should inform ministry practice to PLWHA. The PWCZ needs to formulate its policy on HIV/AIDS. Wesley formulated policy manuals for his pastors on how to deal with the sick.

No Pastoral Care and Support Aimed at PLWHA in the PWCZ

All the participants agreed that local churches provide no pastoral care and support aimed at PLWHA. The only care available is the traditional pastoral care that does not integrate HIV/AIDS. The other care available is compassionate ministry, which

is aimed at any and all vulnerable members. All the participants apart from Munali Pilgrim Wesleyan Church's participants indicated that when WHIZ was operating in local churches, care and support was available to caregivers and PLWHA.

According to local church participants, the PWCZ local churches provide general spiritual care to its members and the community. All the pastors, deacons, deaconesses, members of the local churches, and members who are PLWHA revealed that the local churches are providing general spiritual care. General spiritual care was defined by participants as pastoral home visits, which focus on general spiritual welfare, prayer for the sick, and encouragement from the Scriptures. The general spiritual care was also described as pastoral visits that do not probe to find out individuals' real problem. The pastors do not even know which of their members are PLWHA. From the stories of PLWHA, they have unique spiritual issues that need specific counseling. Furthermore, PLWHA have spiritual needs that go beyond general spiritual care. PLWHA have issues of adherence to taking ARVs, the need for food, the need for care of orphans, the issue of livelihood care, and the need for end-of-life care. They may have opportunistic infections that need attention by medical professionals and home-based care by the community. The pastoral caregivers must understand the nature of the HIV status and the care needed (e.g., when one is in the symptomatic stage and related challenges). Even taking ARVs has its own challenges that need attention by caregivers. Biblical theology of ministry reveals that the Lord Jesus Christ did not offer general spiritual care to the masses. In fact, when he began his ministry, he declared that he was anointed not only to bring good news of salvation from sin but also to bring forth liberty and freedom (Luke 4:18). Biblical theology does not agree with the local churches' practice of offering general

spiritual care. Jesus Christ was able to deal with specific issues affecting the individuals he met. For instance, the leper in Mark 1:40-45 received a touch and healing from leprosy. In the story of the Good Samaritan (Luke 10), the priest and Levite were in a hurry to engage in their own matters, forgetting mercy and compassion for the person who was left for dead. In Matthew 25, the Lord Jesus Christ exhorted the believers to care for the sick and vulnerable. The church in history did not ignore the sick during the plagues; rather, its leaders mobilized the deacons and deaconesses to take care of the sick.

This finding informs the belief and pastoral practice of ministry to PLWHA in the PWCZ. The church needs to revisit the philosophy of ministry to PLWHA, which may involve reflecting on the life of the Triune God, his ministry to human kind, and the role of the church in this ministry. The church needs to be deliberate in giving care to PLWHA. The PWCZ needs to understand the multiple needs of PLWHA, and stigma and discrimination hinder PLWHA from accessing the available care. The PWCZ should consider collaborating with government health centers in providing VCT and ARVs to PLWHA in the church and community. The local churches can integrate home-based care as the means for delivering comprehensive care to PLWHA. The local church can also consider giving small loans to PLWHA so that they can run small businesses. The local churches can promote small communities for PLWHA and even encourage them to lead these groups. The local church can train PLWHA to be psychosocial counselors in the church and community. General spiritual care in the context of stigma, discrimination, and silence about HIV/AIDS is inadequate in providing care and support to PLWHA.

Inaccessible Compassionate Ministry to People Living with HIV/AIDS

The participants from the four local churches under study revealed that local churches have compassionate ministries. However, PLWHA are not accessing this care and support because of the silence, stigma, and negative implications of being identified as PLWHA. Local churches have not integrated HIV/AIDS into their compassionate ministries. The PWCZ has continued to provide the usual traditional core functional ministries of the church without integrating HIV/AIDS. Worship on Sunday continues as usual, ignoring the challenge of HIV/AIDS and PLWHA. The teaching ministry, the fellowship ministry, and evangelistic and missions endeavors of the church also continue without integrating HIV/AIDS and PLWHA. PLWHA struggle with stigma and discrimination, so they cannot open up to the compassionate ministry of the church. Therefore, this ministry is inaccessible to PLWHA and their families. Since the spiritual care and compassionate ministry is too general, PLWHA cannot access the care and support from the core ministries of the church.

A Major Gap in Care Since WHIZ Ceased to Function in Zambia

WHIZ used to provide care and support to caregivers and PLWHA. WHIZ trained caregivers and provided home-based care kits for caregivers to use when doing home visitations to PLWHA. WHIZ also provided funds for group projects run by caregivers and PLWHA. The PLWHA and caregivers used to receive food from WHIZ. The caregivers were given capital for generating income and food supplies to give to orphans and PLWHA in their homes. When WHIZ ceased to function in the Pilgrim Wesleyan local churches in Zambia, the caregivers and PLWHA were left alone without any support. More than 50 percent of board members of WHIZ were members of the PWCZ.

Therefore, the church leaders were aware that WHIZ was coming to an end and that caregivers and PLWHA would still need care and support.

WHIZ left a significant gap in care to PLWHA and their families. In this study, I discovered that the gap is real, depending on the setup of the churches. Most urban churches did not partner with WHIZ. The reason could be that these churches may have some reasonable resources and the members are able to access resources on their own. However, churches in highly populated areas and in rural areas have great financial limitation. All the caregivers and PLWHA in urban areas and rural churches indicated that WHIZ care and support was effective. Zimba PWC and Sianakanga PWCZ participants spoke highly of the support they used to receive from WHIZ. Since the church has no planned care and support to PLWHA and WHIZ is no longer providing the care, the caregivers and PLWHA have been left without any care and support. Caregivers in John Howard PWC and Sianakanga indicated the need for the local church leadership to consider working with them. At the moment, the caregivers are not linked to the local church leadership and resources in spite of being trained as caregivers. According to the literature review, community hbc service providers could have been linked to PLWHA who were under WHIZ. This finding informs the current leaders of the gap in care and support to PLWHA. Local churches should consider providing care to PLWHA. Compassionate ministry needs to be deliberate in providing care and support to PLWHA.

Marked Silence concerning HIV/AIDS in the PWCZ Local Churches

According to information from the participants interviewed, a marked silence surrounds HIV/AIDS and the plight of PLWHA. The AIDS day passed without any mention of the significance of the global challenge of HIV/AIDS. In both urban churches,

the two pastors indicated that mentioning HIV/AIDS in the local churches is almost taboo. In one urban church, two deacons mentioned that people have a perception that the church should focus on its core business. In the churches under study, trained health workers understand the magnitude of HIV/AIDS in the nation. The team that was tasked by the national office to sensitize the leaders and members of the PWCZ on HIV/AIDS has found resistance from the leaders and members to educate the local churches on HIV/AIDS. The members think that caring for and supporting PLWHA is the business of the government and health institutions. In some cases, pastoral care models seem to be insensitive to socioeconomic and political issues. In some cases, churches think that the business of the church is to focus on their core programs (e.g., worship, teaching of the Word, evangelism, fellowship, and auxiliary ministries). Biblical theology also reveals that the Jewish religion also forgot why they were chosen as a nation. They were supposed to be a light to the nations, but they became focused on themselves. In Micah 6:8, the prophet challenged the nation concerning their silence over injustice. In Luke 4:16-18, Jesus broke the silence over the oppressed and the poor. He announced that the time of their liberation had come. This finding of silence in the church is a contradiction of Scripture and the Christian faith. In church history, Christian leaders mobilized the church to care for the sick and the outcasts (e.g., lepers). According to PLWHA, the pastors need to preach, teach, and advocate for the rights of PLWHA. The moral advocacy care model can help pastors to come along side the PLWHA. Pastors can advocate for the care and support of PLWHA. This finding needs to cause the leadership and members of the PWCZ to advocate for PLWHA and break the silence. The leaders need to be champions of the cause of PLWHA and their families. This study clearly

indicates that the participants are of the view that the PWCZ cannot continue as they have been when HIV/AIDS affect its leaders and members. The PWCZ cannot say that its business is to continue with its traditional programs when its members are dying. One deacon in one urban church said that the PWCZ needs champions to herald the call to fight HIV/AIDS and to provide care and support to PLWHA. All PLWHA indicated that if the leaders break the silence, the climate in the local churches would change. When the climate and attitudes change, PLWHA will also open up. One PLWHA said, “Pastors should preach, preach and keep on preaching about HIV/AIDs and the need to provide care and support to PLWHA.”The silence is real and it needs to be broken so that PLWHA can find space to also open up about their challenges due to HIV.

Caregivers as Family Members of PLWHA

Caregivers are the family members of PLWHA and orphans. PLWHA receive care from family members and the government health institutions. WHIZ also worked with the caregivers who were family members of PLWHA and orphans. According to the literature review, home-based care is a joint ministry of care by family members, the community, the church, and health workers. According to personal interviews and the literature review, PLWHA and caregivers who are family members are overwhelmed by the burden of care. Biblical theology reveals that the church needs to care for the vulnerable (Luke 10; Matt. 25; Mark 1). Literature on Church history reveals that the church has been providing care to the sick and outcasts. Wesleyan theology reveals that Wesley trained his lay leaders and pastors to take care of the sick. The deacons and deaconesses visited the sick weekly. The literature review revealed that in the African context, the whole community cares for the sick.

The Perceived Required Care and Support for PLWHA and Their Families

According to my observations, the leaders, members, and PLWHA seem to have an awareness of the care and support needed by PLWHA and their families. The national leaders conceive a care and support model that has the following elements. The care and support should be deliberate and have leadership commitment. The care should encompass spiritual care, physical care, and livelihood care and should involve the education of leaders and members on HIV. Kalembo mentioned the need for deliberate and holistic care, including spiritual care, physical care, and material care. The social ministries director mentioned the need for leadership and HIV/AIDS policy implementation. The former director of WHIZ mentioned the need for a ministry, policy guidelines, and training for strategic leaders to lead this ministry. The pastors recommended a care model characterized by a deliberate ministry to PLWHA, livelihood care, physical care, spiritual care, counseling, and collaboration with other stakeholders. The two urban pastors mentioned the need to educate pastors on HIV/AIDS. The deacons recommended that leaders develop a compassionate policy, advocate for PLWHA (i.e., champion the cause of PLWHA and orphans), build leaders' capacity to provide leadership, and develop programs and strategies to address HIV/AIDS. The church provides physical help, hbc, livelihood care, counseling, age-level education on HIV/AIDS in the church, mobilization of resources, and asset mapping. The deaconesses recommended that the leaders should teach from the Bible on HIV/AIDS, sexuality, marriage, promiscuity, and divorce in the context of HIV/AIDS. The leaders should also advocate for PLWHA, provide physical help, and cooperate with deaconesses in the provision of care. The deaconesses also mentioned the need for discipleship, nursing, and

nutritional support. Other deaconesses discussed the need for love and acceptance, giving encouragement. They also thought that the church should train caregivers and psychosocial counselors, utilize internal resources, and overcome obstacles such as the silence, fear of leadership, resistance by leaders to provide the needed care, and mobilization of resources. Other areas of care mentioned by deaconesses were the need to be deliberate and the pastoral team's use of the pulpit for communication on HIV/AIDs and involvement of PLWHA. The members who were youths recommended that the church provide genuine love, spiritual care, counseling, removal of the stigma, visitation to PLWHA, and financial resources to meet the needs for PLWHA. Lastly, the caregivers (trained by WHIZ) and PLWHA recommended that the PWCZ learn the best practice from the Roman Catholic Church. The caregivers and PLWHA mentioned the following as the required care. They said that the Catholic Church have hbc programs, feeding programs, encouragement for the taking of ARVs, and counselors who are mature and keep confidentiality, They also encouraged the leaders and pastors to open up and create a platform for openness. They also emphasized the need to address the stigma and integrate HIV/AIDS in the life and ministries of the church.

The biblical theological reflection presents reasons why the church needs to care and support PLWHA. The first reason is that humans are created in the image of God and have value, dignity, and worth; therefore, Christians must be stewards of fellow human beings. The Trinitarian mission is a demonstration of how God values human beings. Jesus Christ gave care models in the New Testament, such as the touch care model of Jesus when he healed the leper. The other care model is the story of the Samaritan, which presents an ordinary caregiver using available resources. Matthew 25 also gives the

church ways of ministering to the sick by taking care of the marginalized. The church in history describes the model used by bishops who mobilized the clergy and members to develop homes for caring for the sick. The church in history also used the deacons and deaconess ministry to provide care to the sick and vulnerable. The Wesleyan integrative care model gives the church ways of ministering to PLHWA. Wesley used love as a means of facilitating healing. The Trinitarian community, African communal care, and circles of hope care model are examples of care models that facilitate healing to PLHWA.

Best Practice Already Established in Care and Support for PLHWA

The PWCZ can learn from the prevention strategies used by contemporary caregivers. The literature review and the study have revealed a number of contemporary care models for caring for PLHWA. The PWCZ can use or integrate the following care models in the context of HIV/AIDS.

Biomedical and social science care models. The first model the church can use is the behavioral change care model. While the ministry of health and nongovernmental organizations are using a care model that includes abstinence, being faithful and condoms, circumcision (ABC), the church can promote this model without including condoms outside marriage. The church can also use the 40 Development Asset model in prevention strategy. The second model of care is VCT, which the church can use in collaboration with the local clinics and NGO in the community. This model of care is important because, it is the door to knowing the status and accessing the available continuum of care. Biomedical care model covers VCT, CD4 count, the provision of ARVs, and the monitoring of individuals' health and the taking of ARVs. The PWCZ can collaborate and network with local health institutions in the provision of biomedical care.

The fourth model of care the PWCZ can adopt or use to collaborate with the health institutions and community organizations is the hbc care model. This model has been used as the means of providing comprehensive care to PLWHA. The church's social ministries can either form a congregationally based hbc or collaborate with existing community hbc programs. The fifth model is the palliative care model, which is focused on alleviating pain and suffering of those with chronic illnesses. The PWCZ can integrate elements of this model into congregational hbc, deacon/deaconess ministry, and its social ministries care ministry. The sixth model available is the provision of psychosocial counseling in the pastoral care ministry of the church. The caregivers can be trained in psychosocial counseling, or the church can collaborate with the local health institutions in providing this care. The seventh care model is the integration of chaplaincy into the church health and educational institutions. The last model the church can adopt or integrate in its ministries is the 40 Development Asset care model. This model can be used as one of the prevention strategies for HIV/AIDS in the youth ministries of the church.

Practical theology care models. The first practical theology care model the church can adopt is the pastoral moral advocate model. In this option, the caregivers become champions and advocates for PLWHA. The caregiver comes alongside the weak, the sick, and the stigmatized and breaks the silence. The caregiver does not only pray and encourage but speaks on behalf of God and the PLWHA. The caregiver stands against the systems, structures, programs, and doctrines that perpetuate the abuse of the weak and sick. This model does not promote silence like the classical care model. The caregiver

becomes the prophet of God on behalf of the PLWHA. The caregiver facilitates restoration of dignity, value, and the image of God in PLWHA.

The second care model is the touch care model of Jesus Christ from Mark 1. This model addresses the issue of stigma, discrimination, isolation, the silence on the plight of PLWHA, the evil structures and theological systems that promote the abuse of PLWHA, and the inaccessibility of care in the churches. This model is in contrast to the classical pastoral care models that are like the priest and the Levite in the story of the Good Samaritan who continue with the core business, ignoring the plight of the vulnerable. In this model, the leper accessed information, education, and communication about Jesus. He is equipped to rise above the religious and social cultural barriers, and he goes to Jesus, the ideal caregiver. In this model, Jesus as the caregiver rises above the religious and social systems that perpetuate the stigma and discrimination against lepers. He spoke out, touched the leper, and sent the leper to the clergy to fulfill societal requirements for entering back into community. In this model, both the caregiver and the PLWHA have a role to play in order to access the continuum of care. The PLWHA have to step out and speak, and the caregiver has to speak out and facilitate the comprehensive care available.

The third care model is the Samaritan care model. In this model of care, the sick person is too weak to speak out and define the scope of the problem. He or she is vulnerable and cannot exercise his or her rights. The sick person is at the mercy of the community. In this model, the priest and the Levite followed the classical care model as they were concerned about the temple worship and regulations. Therefore, they continued with their core programs, leaving the vulnerable behind. However, the Samaritan model presents elements of comprehensive care. The caregiver responds to the plight of the sick

and vulnerable by coming alongside him or her. The caregiver cleans the wounds, picks up the sick person, and takes the person to the hospital using personal transport. After leaving the sick person in the hospital, the caregiver goes to attend to his or her usual business.

The fourth model is the Wesleyan care model where pastoral care integrates biomedical care. The pastors are trained to handle basic health issues as they provide spiritual care. The pastoral caregiver is equipped with both spiritual and health promotion tools. In this model, the deacons and deaconesses are equipped to attend to the spiritual and physical care of members and the community.

The Wesleyan church tradition has a history of integrating spiritual care and medical science in the care and support of the sick. The PWCZ medical ministries are providing bio-medico-psychosocial and spiritual care to the four communities where the church is serving. Many denominations, including the Roman Catholic Church, have medical ministries that complement the government's efforts to provide medical health to rural areas. From the literature review, this finding is supported by the study of Chemorion concerning the church health institutions. The PWCZ medical ministry can also provide comprehensive care and support to PLWHA in the hospital and community. PWCZ is one of the churches in Zambia with health institutions that provide health care to the community. Care and support of PLWHA is part of the service these institutions offer to the community. The Wesleyan movement provided health care as part of its pastoral ministry. Therefore, the PWCZ is to be commended for offering this service like other churches, which are holistic in care and support.

Implications of the Findings

The implication of these findings is that the Pilgrim Wesleyan Church of Zambia needs to revisit its theology of ministry. The Trinitarian theology of ministry has revealed that mission, ministry, and the care for the sick is God's ministry. God has demonstrated how to respond to the sick in the Scriptures. If the Church is invited to join God in his mission to humankind, the church should conduct ministry according to the teachings of the owner of the mission. If Jesus cared for the sick, then the Church must follow the footsteps of the owner of the church. If Jesus healed the sick and fed the hungry with food, then the Church must also feed the needy. The early Church and the Church in history cared for the sick and vulnerable; therefore, churches have models to follow in caring for the sick. The Trinitarian care, African communal care and support system, and the early Church communal life should be a model for the PWCZ in addressing the care burden on children, grandparents, and widows. The Roman Catholic Church clearly articulates its teachings on the care and support of fellow human beings; therefore, the Pilgrim Wesleyan church of Zambia can learn from them how to respond to PLWHA.

Limitations of the Study

This multi-case study was carried out in four local churches of the Pilgrim Wesleyan Church of Zambia. It used a purposive sample of two local urban churches in Lusaka and two rural churches in Zimba District in the southern province of Zambia. The study was limited to two districts of Zambia and four local churches due to cost limitations. The data collected from the four local churches was reliable because I collected it from leaders, members who are non- PLWHA, and members who are PLWHA. I also looked at the annual reports for the district conferences and national

conference. Since I served as the national superintendent of the denomination, I was able to observe the pastoral care practices of the local churches. In this study I used three instruments, a demographic questionnaire, individual interviews, and focus groups. This study was focused on evaluating the pastoral care practices and establishing how care and support to PLWHA can be improved in the PWCZ. The study had limited validity in that only four local churches from the PWCZ provided data on pastoral care practices. I did not involve any other denominations or churches in the study.

Unexpected Observations

The first unexpected finding was that in spite of many years of government and other organizations providing education through giving information on HIV and encouraging a multi-sectoral approach to the fight against HIV, the PWCZ still remains silent. The silence seems to be a result of the perception that care and support for PLWHA is the responsibility of the government. The silence may also be due to the perceptions that care and support of PLWHA is not part of the core business of the church. The silence may be due to the perception that engaging in socioeconomic issues is against the teaching of the church.

The second unexpected finding was the gap in care left by WHIZ. WHIZ filled the care and support care gap that was not provided by the PWCZ. When WHIZ ceased to operate in Zambia, the caregivers, PLWHA, and their families were left without any care and support. This unexpected finding is a lesson to faith-based organizations that the budget for care ministries should not be donor dependent. Furthermore, the care gap is also a lesson to donors that when they suddenly withdrew from providing care, the PLWHA and caregivers are significantly affected.

The third unexpected finding is the inability of the leaders, members, and PLWHA to respond to the challenge of HIV/AIDS in spite of the effect of HIV on the church. The leaders and members are affected and they seem to know what to do but they are not responding to the challenge of HIV/AIDS.

The fourth unexpected finding is the lack of leadership and champions in the fight against HIV/AIDS in the PWCZ. The fifth unexpected finding is the inaccessibility of compassionate ministry by PLWHA.

Recommendations

The literature review has revealed that human beings are created in the image of God. Therefore, human beings have value and dignity and are worthy of care and support. I recommend that the PWCZ revisit how it perceives God's mission to restore the dignity of human beings. PLWHA are human beings who are valuable to God and society. I also recommend that the PWCZ base its theology of ministry to the sick on the Trinity. The Triune God is the first missionary and models how ministry and care should be done. According to the literature review and the participants of the research, the pastoral care model should have the following components.

The national and local church leaders should provide leadership in the fight against HIV/AIDS. The leaders and members indicated the need for leadership and a ministry in order to address the needs of PLWHA. The national leaders should formulate an HIV/AIDS policy, present it for ratification at the national conference, implement it, and decentralize it in the districts and local churches. The social ministries should be included in the PWCZ discipline. The leaders should Integrate HIV/AIDS in the Christian education and Bible College curriculum. The PWCZ should develop a pastor's

manual. The pastor's manual should include the policy, ministry team functions, terms of reference, and reporting system. The other recommendation is that all strategic leaders should be trained (i.e., national leaders, district leaders, social ministries directors at the district and local church level, PLWHA who are leaders and caregivers). Education concerning HIV/AIDS should be included in plans of local churches. The national director of social ministries should provide leadership by educating, and communicating about HIV/AIDS to districts and local churches.

Leadership in the local churches is needed in order to fight against HIV/AIDS. The local church leadership should implement the social ministries and HIV/AIDS policy, which may involve integrating HIV/AIDS in the planning and budgeting. The local church leaders need to appoint a social ministries director to represent PLWHA on the board. Churches also need social ministries teams. The local church leaders should mobilize the ministry team and appoint the ministry leader for care to PLWHA.

The pastoral care team should also be moral advocates for PLWHA. The pastoral team is responsible for advocacy for all vulnerable groups, including PLWHA. HIV/AIDS should be integrated in all leadership planning, action plans, budgets, and work plans (e.g., local board meetings and auxiliary boards meetings). The core ministries of the church should integrate HIV/AIDS. The worship ministries should integrate HIV/AIDS in preaching and teaching and dedicate certain Sundays for HIV/AIDS and PLWHA (e.g., candle lighting Sunday). The teaching ministry of the church should include HIV/AIDS. The fellowship strategy should integrate HIV/AIDS in small groups. The pastoral team and social ministry leaders should encourage formation of care groups for PLWHA. The auxiliary ministries such as the women, youth, men,

singles, children, and couples, should integrate HIV/AIDS in planning, action plans, budgeting, and reporting. The missions department should encourage the church to have a mission and ministry to PLWHA. The deacons, deaconesses, and caregivers should be trained to provide care to PLWHA. Table 5.1 summarizes the needs, care models, and stakeholders in the provision of care and support to PLWHA and their families

Table 5.1.Care and Support Framework

Needs	Care Model	Network/Collaboration	Intervention	Evaluate
Diagnosis	VCT	FBO or clinic	Psychosocial counseling or refer to clinic	
Positive status (CD4 low) or illnesses related to HIV	Biomedical Touch model Samaritan model	Refer to clinic or Case management	Network & collaborate with clinic, diaconal, circle of hope	
Discharged	HBC Palliative Diaconal ministry, circles of hope	CHBC, hospital hbc, social work department, other churches	Ministry team, diaconal ministry, congregational hbc, small group for PLWHA	Reporting to LBA
Income, family survival, food, orphans	Livelihood 40 Dev. Asset.	FBO, NGOs, church funds, food supply, school fees for orphans	Small loans, income-generating activities	Monitor & Evaluate
End of life issues	Hospice Palliative care diaconal ministry	Hospice, local clinic, home	Congregational hbc, diaconal ministry	
Theological questions	Spiritual	Chaplaincy, pastoral care,	Integrate in core ministries	
Need for info., education, & communication on HIV/AIDS	Prevention, 40 Dev. Asset, ABC & use of condom in marriage for church	Other stakeholders, local clinic, chbc, medical ministry	Abstinence, faithfulness, circumcision	
Silence, stigma, discrimination	Pastoral moral advocacy, circles of hope, touch model	Chbc, circles of hope	Advocacy Touch model	
Children, teens, youths, young adults vulnerability	40 development asset	Children ministries, scripture union, Evangelical students		

The following areas may need further research. First, research on the care and support provided by the churches mentioned in this research is needed (e.g., the Roman

Catholic Church, the Salvation Army, Northmead Assemblies of God, and Anglican Church care models). Second, a study on how these churches are integrating HIV/AIDS in the core ministries of the local churches would be helpful. Third, research to explore further the silence in the fight against HIV/AIDS in the PWCZ would help churches and PLWHA.

Postscript

This study has challenged my theology of ministry and theology of care for fellow human beings. I now see myself as being invited by the Triune God to participate in the care and support of PLWHA. One of the roles in which I see myself being involved while serving in the PWCZ is to be a champion and advocate for PLWHA. I also see my role in the church as one of being a facilitator in helping the local churches develop the culture of care and support for PLWHA. I will also be available to the PWCZ to facilitate the formation of the HIV/AIDS policy. Finally, I will be ready to share the findings of this study to the PWCZ and any other forum.

APPENDIX A

FOCUS GROUP PROTOCOL

Target Group: Leaders, Local church members, and PLWHA

Facilitator: Read protocol first as preparation

This tool is intended to find out the existing pastoral care practices to PLWHA and the extent to which the care practices are meeting the needs of PLWHA in the local church.

Focus groups should be segregated by gender and HIV status in order to reduce inhibition when sharing sensitive information. The facilitator should interpret the questions in the group's mother tongue; however, care should be taken to ensure that the essential focus of the study remains unchanged in the translation.

Format:

Welcome and introductions:

1. Introduce yourself and the recorders/scribes;
2. Thank participants for participation.

Describe the purpose and process for focus group discussions:

1. Understand the needs, care, and support practices for PLWHA.
2. Assess whether and how these needs are being met.
3. Encourage participation.
4. Explain how results of the discussion will be used.

Discussion:

1. Encourage everyone to participate.
2. Observe and record differing viewpoints within the group.

3. Periodically restate your understanding of the information shared to check for accuracy in your interpretation.

Summary and thanks:

1. Summarize information shared and check accuracy of your understanding.
2. Reiterate how the information is to be used.
3. Give thanks for participation.

APPENDIX B

DEMOGRAPHIC INSTRUMENT

Interview.....

Focus Group Discuss.....

Please indicate whether Interview or Focus Group Discussion

1. District:

2. Local Church:

3. Leadership Category:

Role	Female	Male	Methods
Pastor			Personal interview
Deacon			Personal interview & Focus Group Disc.
Deaconesses			Personal interview & Focus Group Disc.
National Leaders			Interview

4. Congregant Category:

Role	Female	Male	Methods
NON-PLWHA	2	2	Personal interviews & Focus Group Disc.
PLWHA	2	2	Personal Interview & Group Interview
Non Congregant	2	2	Personal Interview

APPENDIX C

RESEARCH QUESTIONS

1. Tell me how HIV/AIDS has affected you, your family, and the local church?
2. How has your local church responded to HIV/AIDS, PLWHA, and the families affected?
3. What care and support is available in your local church to PLWHA and the families affected?
4. In what way is the local church providing care and support to its members and PLWHA in the following areas:
 - 4.1. Prevention for HIV/AIDS through giving information, education, and communication.
 - 4.2. Psychosocial counseling and VCT.
 - 4.3. Home-Based Care for PLWHA.
 - 4.4. Spiritual care to people living with HIV/AIDS and the families affected.
 - 4.5. The livelihood care of PLWHA and the families affected.
 - 4.6. Palliative care to PLWHA (management of pain, sicknesses related to HIV/AIDS, and end-of-life care).
 - 4.7. Access to ARVs and treatment of related sicknesses to HIV/AIDS.
5. In which areas is the local church doing well and not doing well in the care and support of PLWHA?
6. In what ways is the local church integrating HIV/AIDS care and support in the life and ministries of the church?

7. What do you think is the care and support needed by PLWHA and the families affected?
8. What would be the challenges and barriers to providing the care and support needed by PLWHA in the local church?
9. What would be required for the church to start providing care for PLWHA and the families affected in the local church?
10. What other recommendations do you make to the local church in order to improve the care and support to PLWHA and the affected families?

APPENDIX D

EXPERT REVIEW EVALUATION OF TOOLS

Doctoral Candidate/Beeson Fellow

Asbury Theological Seminary, Northern Lexington, Wilmore, KY 43090

Asbury Theological Seminary, Wilmore, KY 40390.

Dear Dr. Royster,

I am a Doctor of Ministry student at Asbury Theological Seminary. The topic of my dissertation is, “Comprehensive Pastoral Care to People Living with HIV/AIDS in the Pilgrim Wesleyan Church Zambia.” The purpose of the study is to evaluate the pastoral care practices to people living with HIV/AIDS (PLWHA) in the Pilgrim Wesleyan Church of Zambia and to develop a comprehensive pastoral care model that will meet the needs of PLWHA. The following are the Research Questions:

1. What are the current pastoral care practices to people living with HIV/AIDS in the Pilgrim Wesleyan Church of Zambia?
2. How effective are the current pastoral care practices as perceived by the church leaders and congregants as compared to PLWHA?
3. What changes in the current pastoral care model would make it more effective in meeting the needs of PLWHA?

As part of my dissertation, I have developed an interview protocol based on the three research questions to collect data. I used two instruments—the demographic and interview protocol. The first instrument is a demographic data instrument. The second instrument is the interview protocol, which had uniform questions for the church leaders (pastors, deacons, and deaconesses), members of the local churches, and PLWHA.

I am in need of an expert review. Therefore, I am asking you to serve as one of my reviewers. I have included the two instruments, the demographic instrument and the interview protocol. Please evaluate the instruments and make some recommendations where I need to correct the instruments. I am requesting you to give me feedback before 20 February 2012. Thank you for your assistance.

Yours Sincerely,

Stephen Sitali Kakungu

Beeson Leader 2009

Asbury Theological Seminary.

APPENDIX E

LETTER TO THE NATIONAL SUPERINTENDENT

Stephen Sitali Kakungu
Asbury Theological Seminary
204 North Lexington Ave.
Wilmore, KY 40390

Rev. Dr. Alfred M. Kalembo,
Pilgrim Wesleyan Church of Zambia,
Box 30745, Makishi Road, Plot 90,
Lusaka, Zambia,
Dear Rev. Kalembo,

Re: Request for Permission to Conduct Research in Pilgrim Wesleyan Church of Zambia

As you are aware, I am a Doctor of Ministry student at Asbury Theological Seminary. The topic of my dissertation is, “Comprehensive Pastoral Care to People Living with HIV/AIDS in the Pilgrim Wesleyan Church in Zambia.” The purpose of the study is to evaluate the pastoral care practices to People Living with HIV/AIDS (PLWHA) in the Pilgrim Wesleyan Church of Zambia and to develop a comprehensive pastoral care model that will meet the needs of PLWHA. The following are the Research Questions:

1. What are the pastoral care practices to people living with HIV/AIDS in the Pilgrim Wesleyan Church of Zambia?
2. How effective are the current pastoral care practices as perceived by the church leaders and congregants as compared to PLWHA?
3. What changes in the current pastoral care model would make it more effective in meeting the needs of PLWHA?

As part of my dissertation, I am supposed to carry out a project that would be helpful to the ministry context. I would like you to grant me permission to carry out my research in four local churches in the Pilgrim Wesleyan Church. These are Munali Pilgrim Wesleyan Church, John Howard Pilgrim Wesleyan Church, Zimba Pilgrim Wesleyan Church, and Sianankanga Pilgrim Wesleyan Church. I have included my abstract of the dissertation. The sample will be four pastors, five deacons, five deaconesses, three PLWHA, and three non-PLWHA from each of the four churches. Your assistance will be highly appreciated.

Yours Sincerely,

Stephen Sitali Kakungu

Beeson Leader 2009

APPENDIX F

CONSENT FORM

Date:

Dear _____

I am a Doctor of Ministry student at Asbury Theological Seminary, Wilmore, Kentucky. I am conducting research on the topic, "Comprehensive Pastoral Care to People Living with HIV/AIDS." I would like to survey church leaders (pastors, deacons, deaconesses, members of the congregation). You have been selected from your local church as one invited to assist in the study.

I would like to assure you that the information you give will be kept confidentially. I will not use your name in whatever way or form. The information will be in a form where the identity of those who participate will not be known.

This research will be helpful to the local leadership, the congregation, and people living with HIV/AIDS (PLWHA). The results will help in the care and support of PLWHA. At the end of the research (three months time), the information will be destroyed. I will only keep the data in a form one cannot relate to the participants in person.

You must know also that you can decline to participate or you can withdraw during the research if you feel uncomfortable to continue to participate. Your participation is voluntary. However, I would like you to consider participation in the study so that you can contribute to the improvement of care given to PLWHA.

If you are willing to assist me in this study, please sign and date this letter below to indicate your voluntary participation. Thank you for your help.

Yours Sincerely,

Stephen Sitali Kakungu
BL2009
Asbury Theological Seminary

I have understood the instructions and conditions concerning the study by _____ and I agree to participate as requested. I also understand that I am free to withdraw from the study at any time and that the records of our conversations will be destroyed at the end of the study.

Signed _____

Date _____

APPENDIX G

PARTICIPANTS

Nature of Participants	Pastor	Deacon	Deaconess	PLWHA	Non-PLWHA
Gender					
Age					
Education					
Church					
Setting					
Number of Participants					
Where					
Method					

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