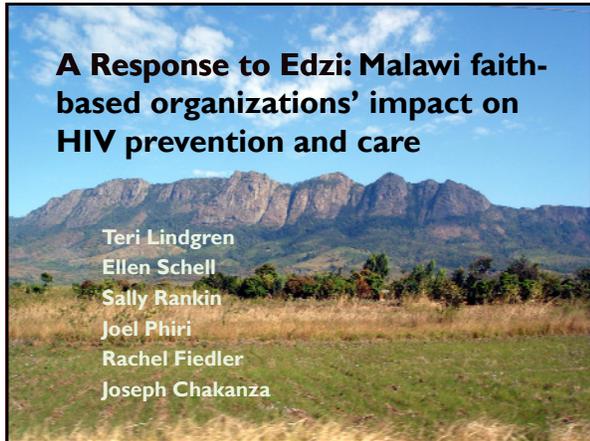


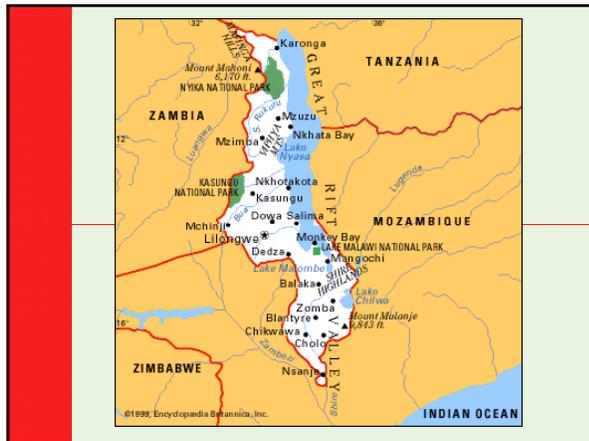
A Response to Edzi: Malawi faith-based organizations' impact on HIV prevention and care

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Background on Context

- Malawi is an small impoverished country in southern Africa
 - GNI per capita--\$320
- Current population is 15.9 million
 - 164 per square kilometer
 - 85% rural
- National HIV infection rate 12.6%
 - One Million living with HIV
 - HIV is second leading cause of death
- TB 164/100,000



Background to study for this paper: Faith based organizations

- Religious participation very important to Malawians.
- Faith-based organizations and their leaders critical to village and urban based infrastructure
 - Important in HIV prevention and care
 - Religious organizations provide much of the health care infrastructure including home based care for members.
- 55% of Malawians are Protestant; 20% are Roman Catholic; 15-20% or fewer are Muslim; and approximately 5% practice traditional religions.

Religious engagement



Overall study background

- Aims
 - To describe religious group strategies to prevent HIV infection and to care for people living with HIV/AIDS (PLWHA).
 - To describe the perceived power and influence exerted by religious groups on risk-taking and HIV care/mitigation behaviors from the perspectives of central leadership, local level leadership, and members at local levels.
- Study examines 5 religious groups: Muslim, Pentecostal, Baptist, Roman Catholic and Anglican to determine the extent and nature of their involvement in HIV-related activities.

Study Design

- Mixed method, cross-sectional design exploring perspectives of central and local leaders and members.
 - Qualitative: In-depth, semi-structured interviews
 - Qualitative description to analyse qualitative data
 - Quantitative: Structured questionnaire measuring risk and care behaviors and stigma of leaders and their members
 - Hierarchical analysis of quantitative data
- Triangulation of qualitative and quantitative data

Rural Interviewing

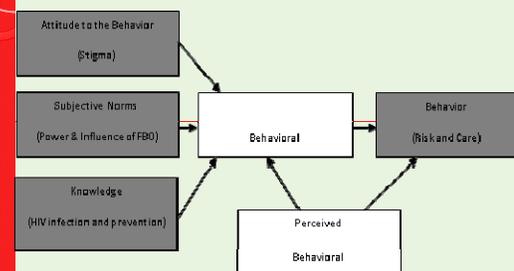


Focus of the paper

- Expand upon Garner's ** work which described the power and influence of South African Churches over the sexual behavior of members by:
 - Categorizing the power and influence of Malawi FBOs over the risk and care behaviors of their members
 - Testing the impact of FBOs influence on their members' risk and care behaviors using the theory of planned behavior (TPB)
 - Thematic analysis of qualitative interviews

** Garner, R. C. (2000). Safe sects? dynamic religion and AIDS in South Africa. *Journal of Modern African Studies* 38, 38:41-69.

Theory of planned behavior



(Ajzen, 1991)

Garner's Concept of Power and Influence

- Study conducted in South Africa with 4 churches
 - "Safe Sects"
- Four categories of power over members
 - Indoctrination
 - Exclusion
 - Religious Experience
 - Socialization
- Added Stigma and Hierarchy

Sample

- Purposive sample of 44 central level religious leaders, 75 local leaders, 137 FBO members and 44 PLWHAs were interviewed in-depth.
- Survey data was collected from the 75 local leaders and 8-10 members from their church/mosque for a total of 667 FBO members .

Sample

Level (n)	Gender % Male	Age Mean (SD)	% Rural
Central Leaders (44)	68.3	43.9 (10.3)	9.0
Local Leaders (75)	98.7	45.3 (11.3)	74.7
Members (667)	49.2	33.5 (12.7)	71.1

Process for determining power and influence

- Interview questions related to the 4 categories of power—central leaders, 20 local leaders and 40 members
- Analytical memo on each faith based organization (FBO) related to each category
- All team member scored each FBO
- Team meeting-reached consensus on FBO scores for each category

Comparative power and influence of FBOs over members behaviors- adapted from Garner (2000)

	Baptist	Pentecostal	Roman Catholic	Anglicans	Muslims
Indoctrination	4	5	4	2	4
Religious Experience	4	5	3	3	1
Exclusion	4	5	3	1	5
Socialization	4	5	3	3	5
Total score	16	20	13	9	15
Hierarchy	1	3	5	5	1

FBO leader impact on members' risk taking behaviors

Predictors	t-test	CI	P value
Power and Influence	1.792	-.002 to .032	.077
Leaders' Stigma Attitude	-1.070	-.067 to .020	.288
Hierarchy	-0.994	-.052 to .017	.324

FBO leader impact on members' care behaviors

Predictors	t-test	CI	P value
Power and Influence	1.804	-.009 to .180	.075
Leaders' Stigma Attitude	-2.102	-.249 to -.007	.039
Hierarchy	1.973	-.000 to .193	.052

Behavioral Exhortations

- “We start with telling people that they should be God-fearing. What that means is that when you fear God.. nothing bad can happen to you because you become a careful person”
- Not listening to God's word could have dire consequences: “because the people do not want to listen, things will change. There will be various diseases like the way it is now.

Knowledge Transfer

• Quality of Knowledge

- Leaders' limited knowledge
 - We tell the youth we should abstain because there is HIV but we just say that because we heard it from other sources, we really don't know much about that.
- Lack of knowledge re: modes of transmission
- Mis-information
 - ARVs confusion
 - Our pastor said: We can be taking the ARVs and at the same time we are also praying, or else you can just be praying

Knowledge Transfer

• Specificity of knowledge

- Most religious leaders speak generally about HIV
 - "there is that disease out there" and "the world is dangerous"
- Difficulty in talking about sex or even pregnancy
 - Talking about giving birth was "taboo" so "talking about sexual matters in church in the presence of everyone, we are uncomfortable."
- Explicit instruction is remembered
 - He [the pastor] says that if a person has a deep feeling about sex and wants to have sex with a woman, he should make sure that his penis is erect before putting on a condom.

Stigmatizing discourses

• Prevention messages-morality

- Focus on abstinence and being faithful but NO to condoms
- "Fail to abstain"
 - Our church encourages us on abstinence, this is number one. Another one is that if one *fails to abstain*, he must use a condom
- Failure to abstain produces disciplinary action
- Condom use labels one an "unfaithful member"

Stigmatizing discourses

• HIV testing

- We tell them that if from your birth you have observed the law of God properly there is no need for you to go for HCT; but if in the face of the truth you know inside your heart that you do a lot of things and are not faithful it is better that you go for HCT so that you reduce the spread of HIV/AIDS

• Disclosure

- There was someone who was tested and found positive, he never kept it a secret, he openly said it. ..We didn't discriminate but others were saying, 'why is he saying this, we thought it was supposed to be a secret.'

Summary

• Qualitative Data revealed

- FBO leaders are preaching/teaching about HIV and members are listening
- Limited knowledge impacted positive influence and explicit versus general knowledge was more effective
- Stigmatizing discourses have changed but continue to constrain condom use, testing and disclosure.
- Contrary to Garner, we found no "safe sects"
 - FBO leaders had no significant impact on their members risk behaviors
 - NO condoms except for those who *fail to abstain* leaves little room for people to make mistakes
 - Ignore the socio-cultural reality
 - Leaders' stigmatizing attitudes negatively impacted their members' care behaviors.

Implications for Nursing Practice and Research

- Health care providers need to engage more effectively and consistently with religious leaders as they could be important collaborators in community based HIV prevention and care
- Nurses are trusted professionals and active FBO members who can work with religious leaders to
 - ensure that leaders are transmitting accurate and complete knowledge about HIV to their members
 - to help them understand how expectations of being a good Christian or Muslim can inhibit open discussion of risky behaviors and reinforce stigma
- Further research is needed to develop effective and acceptable interventions that can be delivered through churches and mosques to religious communities in Malawi as they have the potential to reach many congregants, especially in rural areas.

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