

**0AN ANALYSIS OF THE ATTITUDES AND PERCEPTIONS OF CHURCH
LEADERS TOWARDS THEIR PERCEIVED LEADERSHIP ROLES IN HIV
PREVENTION IN THE MATABELELAND PROVINCE OF ZIMBABWE.**

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DECLARATION

I declare that: ***AN ANALYSIS OF THE ATTITUDES AND PERCEPTIONS OF CHURCH LEADERS TOWARDS THEIR PERCEIVED LEADERSHIP ROLES IN HIV-PREVENTION IN MATABELELAND PROVINCE OF ZIMBABWE*** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and this work has not been submitted before for any other degree at any other institution of higher learning.

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27 February 2015

Signature

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SUMMARY

This study investigated the attitudes of church leaders towards their perceived leadership roles in HIV prevention, using a sample of 85 clergy and lay leaders. Working from the premise that churches concentrate on care and support instead of HIV prevention, data were collected from Lutheran church leaders in Zimbabwe, using a questionnaire based on the constructs of the theory of reasoned action. The findings of this study suggest that the church is a potential source for HIV prevention. However, the capability to lead in HIV prevention was limited by barriers due to self-efficacy and cultural constraints, differences between communicator and audience, experiences and perceptions of the communicator and to some extent, institutional constraints. Programmers should focus on removing the barriers faced by the church leaders to improve their ability to lead in HIV prevention and strengthen prevention efforts.

KEY WORDS: attitude; clergy; church leaders; doctrine; Evangelical Lutheran Church; HIV and AIDS; HIV prevention; leadership roles; perception; Theory of Reasoned Action

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LIST OF ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ARVs	Antiretroviral drugs
ART	Antiretroviral therapy
CBOs	Community-based organisations
ELCZ	Evangelical Lutheran Church of Zimbabwe
FBOs	Faith-based organisations
FHI	Family Health International
HBC	Home-based care
HIV	Human Immunodeficiency Virus
ILO	International Labour Organisation
LUCSA	Lutheran Communion in Southern Africa
LWF	Lutheran World Federation
NAC	National AIDS Council
NBCS	National Behaviour Change Strategy
NGOs	Non-governmental organisations
PLHIV	Person living with HIV
PMTCT	Prevention of mother to child transmission
STI	Sexually transmitted infection
TB	Tuberculosis
TRA	Theory of reasoned action
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
UNISA	University of South Africa
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WCC	World Council of Churches
WHO	World Health Organisation
ZNASP	Zimbabwe National HIV and AIDS Strategic Plan

CHAPTER 1

SITUATING THE RESEARCH PROBLEM

1.1 INTRODUCTION

A number of authors have noted the potential of church leaders to provide leadership in the response to the AIDS epidemic (Green 2003; Muturi 2008; Zou, Yamanaka, John, Watt, Ostermann & Thielman 2009). However, limited research has been done to investigate how church leaders understand their own potential roles regarding taking a lead in curbing the spread of HIV infections.

The severity of the AIDS epidemic is still evident in Eastern and Southern Africa where in 2011, the two sub-regions accounted for almost 50 percent, (that is, 17.1 million of the estimated global total of 34 million) of all people living with HIV (UNAIDS 2013:9). According to UNAIDS, with nine out of ten countries, namely Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe recording adult HIV prevalence rates between 10 percent and 26 percent, Southern Africa remains the region most affected by HIV epidemic in the world (UNAIDS 2010:26; UNAIDS 2013:100). The persistently high HIV prevalence in Southern Africa calls for better and effective interventions that will prevent new HIV infections. The recently published report by UNAIDS indicate that community ownership and leadership in the AIDS response is critical to avert new HIV infections, save lives and restore respect and dignity of PLHIV (UNAIDS GAP Report 2014).

Determining the attitudes of church leaders concerning their own participation in the prevention of HIV is central to identifying factors that may influence their active involvement or the lack thereof, in the control of HIV infections. Knowledge of these factors may lead to defining strategies to increase participation of the leaders in HIV prevention. Such leadership involvement would create an enabling environment in which a new understanding of HIV control can emerge in more positive and less stigmatised ways.

This study sought to investigate the attitudes of church leaders with regard to the leadership roles they could play in HIV prevention in the Matabeleland Province of Zimbabwe. In 2001 and 2008, the UNAIDS' World AIDS campaign emphasised the theme of "leadership" in stemming the tide of HIV infection globally (Parry 2008:33-34). The understanding of such leadership can be investigated at various levels, such as at the family, community, national and global levels (UNAIDS 2008:194). Potentially, church leaders have a strong influence on their established community networks and are therefore essential partners in the response to the AIDS epidemic (Green 2003). UNAIDS (2008) affirms that by providing essential services, such as, providing home-based care to the sick and psychosocial support to persons living with HIV and those affected by HIV and AIDS, taking care of orphans, promoting tolerance and compassion, and advocating stronger action, faith-based groups are helping to spearhead the HIV campaign. Significantly, there is also a growing recognition of the role of churches and other faith-based organisations (FBOs) with regard to contributing to HIV prevention (Garner 2000; Gregson, Zhuwau, Anderson & Chandiwana 1999; Mukuka & Slonim-Nevo 2006; Muturi 2008).

Furthermore, FBOs have been among the first organisations to be involved in assisting people infected and affected by HIV and AIDS by rendering support and care (Parry 2008) and they continue to be involved in many activities concerning the epidemic response (Anozie 2011). However, some studies such as those done by Genrich and Brathwaite (2005); Zou *et al* (2009) suggest that many religious organisations have inconsistent attitudes and opinions regarding the moral and spiritual issues surrounding HIV and AIDS. Genrich and Brathwaite (2005) observe that while the majority of religious representatives recognised HIV and AIDS as a serious problem that requires a proactive response, other religious groups believed that strict "Christian conduct" was a preventive measure against acquisition of the HI virus and therefore, there was no need to discuss HIV in the church. In Tanzania, Zou *et al* (2009) found that churchgoers regarded PLHIV as individuals who did not adhere to the word of God by engaging in immoral sexual behaviour. Such attitudes resulted in the stigmatisation of persons living with HIV, thereby hampering the ability of individuals and families to access protective

measures against HIV infection, such as condoms.

Accordingly, the church's involvement in HIV prevention has not been maximised, resulting in missed opportunities to reduce HIV infections significantly, particularly in countries with more than 10% of the adult population living with HIV infection such as Swaziland, Botswana, Lesotho, South Africa and Zimbabwe (UNAIDS 2008:215). If the UNAIDS (2008:131) is correct in predicting that for every two people receiving antiretroviral treatment (ART), about five more people are infected with HIV, the HIV epidemic may be difficult to control if greater efforts are not made to prevent new infections. A recent report by UNAIDS (GAP Report 2014) has revealed that in Sub-Saharan Africa, 76 percent of adolescent girls lack comprehensive and correct knowledge about HIV (UNAIDS 2014). UNAIDS highlights, as one of the key lessons learnt, the need for a continued cultivation of a strong leadership around the HIV response in order to reduce new HIV infections by 50% by 2015 (UNAIDS 2013). Therefore, the focus of the response should not only be on treatment but also on prevention and the active involvement of all leaders, including church leaders.

It is important to note that there has been limited research on the possible impact of personal perceptions of church leaders, their beliefs and normative attitudes on the importance assigned to and intensity with which they participate in HIV-prevention.

This present study was conducted in the Matabeleland Province of Zimbabwe to ascertain the attitudes of the Lutheran church leaders regarding the prevention of HIV infections, given the high HIV prevalence (21%) in this province. This is a vital undertaking as it bridges the gap between theory and practice to identify possible barriers to participation that might lead to the development of new strategies for motivating church leaders to assume leadership roles in HIV prevention.

Before presenting the research problem and the objectives of the study, the researcher will give a brief overview of the role of the church in society, the

HIV epidemic in Zimbabwe and the involvement of the Lutheran Communion in Southern Africa (LUCSA) in the response to HIV and AIDS in order to situate the research problem.

Although church leaders are regarded as key role-players in the response to the AIDS epidemic, especially in countries with a high prevalence of AIDS-related diseases (Green 2003), conservative approaches to sex and sexuality limit open talks about HIV prevention in ways that are not associated with blame and shame. The retired Bishop of the Oslo Diocese, Church of Norway, urges the church to go beyond care services and to be more forthcoming in HIV prevention by supporting the “ABC strategy”, that is, by supporting abstinence, faithfulness and the use of condoms, thereby reducing stigma and discrimination (Stålsett, in LWF 2005:24). He calls upon church leaders, in particular, to play a leadership role in engaging and speaking about issues surrounding HIV and AIDS.

The reports of the end-of-phase project evaluation of the LUCSA HIV and AIDS regional programme in 2008 and 2012 highlighted that the majority of the Lutheran churches in Southern Africa were more involved in the provision of care and support than in HIV prevention activities (LUCSA 2008; LUCSA 2012). More specifically, a study by Haddad (2006) found that the perceptions of those who view themselves as “holier than others” created a barrier to finding creative ways for many Christian leaders of Southern African countries in terms of talking about sex and HIV transmission, as such discussions are still viewed as taboo in church settings.

Several studies indicate that churches are not adequately involved in HIV prevention due to conservative church doctrines and HIV-related stigma (Chin, Mantell, Weiss, Bhagavan & Luo 2005; LUCSA 2012; Masika 2008; Muturi 2008; Nürnberger 2005; Paterson 2009). This contradicts the premise that the work and teachings of churches should promote respect for the value of human life. The latter is precisely what HIV prevention campaigns aim to do, namely, saving lives and reducing human suffering. According to Masika (2008), religious leaders lack commitment in terms of HIV prevention

education due to barriers such as the low levels of education attained by individuals, limited HIV and AIDS knowledge, lack of skills and materials regarding planning and delivering HIV and AIDS education, as well as being unfamiliar with national policies pertaining to HIV and AIDS. The study by Masika was, however, not clear, whether attitudes played any role in the extent to which religious leaders participated in HIV prevention. The researcher found only a few studies that investigated the attitudes of church leaders in Africa in relation to the roles they could play in HIV prevention (Garner 2000; Gregson *et al* 1999; Mukuka & Slonim-Nevo 2006; Trinitapoli 2006). However, these studies focused on the influence of church membership on safer sexual behaviour, the type of HIV prevention messages promoted by religious leaders that mainly promoted abstinence and faithfulness and the church's attitude that is often stigmatising concerning persons living with HIV and those affected by AIDS. The Theory of Reasoned Action (TRA) suggests that there are conceptually independent predictors of intention to perform a behaviour caused by two factors, namely, attitudes and subjective norms.

The interface between the roles church leadership could play in HIV prevention and what the government expects of them as stated in the national HIV and AIDS strategic plans requires an overview of the situation in Zimbabwe and its national response to HIV.

1.2 PROBLEM STATEMENT

1.2.1 HIV and AIDS in Zimbabwe

Zimbabwe is one of the worst affected countries in the world, with an estimated 13.1% HIV prevalence rate among 15-49 age group in 2011 (UNAIDS 2012). The decline of the adult HIV prevalence rate from 23.7% in 2001 to 18.4% in 2005 and 13.1% in 2011 has been associated with sexual behaviour change, prevention of mother to child transmission and the high mortality rate (Gregson *et al*, cited in UNAIDS 2010; Zimbabwe Ministry of Health and Child Welfare, cited in UNAIDS 2010; UNAIDS 2012). However,

the latest reports from Zimbabwe indicate a rise in HIV prevalence to 15% in 2013 (UNAIDS 2013; UNAIDS 2014).

The country's prolonged economic problems that have left many people facing poverty are likely to increase the rate of new infections and at the worst, to reverse the decline in HIV prevalence. In the Zimbabwean provinces, the highest HIV prevalence rate in 2007 and in 2011 was in Matabeleland South, which reported an adult HIV prevalence rate of 21% (Measure Demographic Health Survey, quoted in Murimba 2010:19; Zimbabwe National Statistics Agency 2012). Without a deliberate effort to attain greater progress in reducing the rate of new infections further, a reversal of the socio-economic impact of HIV and AIDS on communities and sustaining gains in expanding access to treatment, may not be achieved (UNAIDS 2008). The recent increase in HIV prevalence in Zimbabwe, mentioned above, points toward an urgent need to step up prevention efforts as many people remain at risk and are vulnerable to HIV (UNAIDS 2013).

In Zimbabwe, the average life expectancy in 2006 was 34 years for women and 37 years for men (UNAIDS/WHO 2006:188). The main mode of HIV transmission is through sexual contact in a heterosexual relationship, which accounts for 80% to 90% of all HIV infections in Zimbabwe (Zimbabwe Ministry of Health and Child Welfare / National AIDS Council 2007).

Adults in their productive years (within the age group of 15-49 years), mainly women, fall within the age group severely affected by the epidemic and the death of mothers due to AIDS-related illnesses is depriving children of families and breadwinners. In this regard, the main factors said to contribute to the spread of HIV are economic, social and cultural factors. High unemployment levels in Zimbabwe since the height of economic crisis in 2008, present a serious socio-economic problem that results in cross-border trading with neighbouring and inter-continental countries, thereby exposing the unemployed, including women, to exploitation. The different forms of sexual behaviour associated with cross-border activities include having concurrent sexual partners, age-different sexual relations and prostitution, all known to

fuel the HIV epidemic (MOHCW 2009).

1.2.2 Zimbabwe's response to the AIDS epidemic

The prolonged socio-economic challenges referred to in section 1.2.1 above highlight the urgency of the need to strengthen national and multi-sectoral responses to address the key drivers of the epidemic and specific groups vulnerable to HIV infection (UNAIDS/WHO 2009; Duri, Stray-Pedersen & Muller 2013). Concerning vulnerable groups, studies by Mngadi *et al* (cited in UNAIDS/WHO 2009) and Khabotlo *et al* (cited in UNAIDS/WHO 2009) indicate that HIV prevention programmes in some Southern African countries, such as Swaziland and Lesotho, do not focus on people older than 25 years and those in stable relationships. Yet, these groups are estimated to account for more than two thirds of new HIV infections in sub-Saharan Africa (UNAIDS/WHO 2009:26).

The Zimbabwean National AIDS Council (NAC) coordinates the multi-sectoral response to the AIDS epidemic in Zimbabwe, with the goal of reducing the HIV prevalence rate to less than 10% in 2010 (NAC 2006) and HIV new infections among adults by 50% by 2015 (NAC 2011). The NAC developed the National Behaviour Change Strategy (NBCS) 2006 – 2010 in an effort to achieve less than 10% HIV prevalence and subsequently developed the Zimbabwe National HIV and AIDS Strategic Plan (ZNSP) 2011-2015 to reduce further new HIV infections among adults and children by 2015. It is important to note that the aim of both the NBCS and ZNSP was to motivate all stakeholders to respond according to key HIV prevention elements with regard to behaviour change, in terms of promoting faithfulness, reducing multiple concurrent sexual partners and promoting consistent condom use (NAC 2006; NAC 2011).

The National Behaviour Change Strategic Plan 2006–2010 promoted four outcomes, namely, increased leadership and gender equality as well as reduction of the stigma associated with HIV; increased risk reduction and safer sexual behaviour; improved health-seeking behaviour leading to HIV

prevention and improved national and sub-national institutional frameworks to address behaviour change. Significantly, the Zimbabwe National Behaviour Change Strategy listed faith-based organisations (FBOs) as key behavioural change agents in the promotion of faithfulness, pre-marital HIV testing and counselling, and post-test support structures to address the issue of multiple partners.

Furthermore, the ZNASP 2011-2015 focuses on four impact level results as stated below:

- Impact 1: HIV incidence reduced by 50% from 0.85% (48 168) for adults (2009) to 0.435% (24 084) by 2015.
- Impact 2: HIV incidence reduced among children from 30% in 2010 to less than 5% by 2015.
- Impact 3: HIV and AIDS related mortality reduced by 38% from 71 299 (2010) for adults and 13 393 for children (2010) to 44 205 for adults and 8 304 for children by 2015.
- Impact 4: The national multi-sectoral response to be improved: The National Commitments and Policies Instruments (NCPI) rating to be improved from 6.2 in 2010 to 9.0 in 2015.

The mandate to coordinate the multi-sectoral response to HIV and AIDS lies with the NAC while the Zimbabwe AIDS Network (ZAN) coordinates the response by the civil society. In the multi-sectoral approach, there is recognition of the important role played by faith and community based organisations in HIV response (NAC 2011; UNAIDS 2014).

Some faith-based organisations and government structures, such as those in Uganda and Senegal, have collaborated to bring about a decline in the practice of having multiple sexual partners. The use of programmes that mainly promoted mutual faithfulness, partner reduction and that addressed the vulnerability of both women and young people contributed to the decline in new infections, with a subsequent sharp decline in HIV prevalence. For example, in Uganda, the HIV prevalence among pregnant women declined

from 21.1% in 1991 to 6.1% in 2000 (Hogle, in Muturi 2008) and in Senegal, the age of the first sexual activity rose from 16.4 in 1993 to 17.5 in 1997 (Green 2003; Green, Halperin, Nantulya & Hogle 2006). Consequently, this raises a question about the extent to which churches in general and churches in Zimbabwe in particular, fully realise the importance of their involvement in promoting HIV prevention. Such involvement could make the church emerge as an enabling environment for critical thinking and dialogue regarding the socio-cultural aspects of HIV and AIDS and the related types of behaviour that increase vulnerability to HIV infection, as a way of enhancing prevention efforts.

1.2.3 The role of the church in society

Historically, the church has been at the forefront of development and change in many societies, shaping people's lives and attitudes and providing care and support for the sick (Green *et al* 2006; Parry 2008:8). Today, many churches are challenged by the task of HIV prevention since it is difficult to address HIV prevention without addressing issues such as religious beliefs and values in the light of sex and sexuality, relationship education for young people, gender roles, stigma and the messages of salvation preached by most churches (Paterson 2009:5-6). Effective responses to the AIDS epidemic calls for scaled-up and intensified interventions to make a critical difference (NAC 2011). This kind of response requires policy makers and community leaders, including church leaders, to address sensitive social factors that affect the transmission of the HI virus. For religious leaders in general and for Christian leadership in particular, this requires breaking the silence that surrounds HIV and AIDS. Thus far, while the discussion in this section has dealt with the church in general, the next section focusses on the Lutheran Church.

1.2.4 The role of the Lutheran Communion in Southern Africa in HIV prevention

The Lutheran World Federation's (LWF) consultation for Pan-African church leaders held in Nairobi in 2002, adopted an HIV and AIDS campaign that

exhorted all its member churches to break the silence surrounding HIV and AIDS. During this gathering, church leaders committed themselves to support "effective [HIV] preventive measures that can save lives" (LWF 2003). As a response and follow-up to this consultation, the Lutheran Communion in Southern Africa (LUCSA) placed the issue of AIDS very high on its agenda by developing a policy on HIV and AIDS (LUCSA 2004:2). The LUCSA regional office facilitates the on-going capacity building of its member churches to commit to and implement the LWF HIV and AIDS 2002 campaign (LUCSA 2004). Subsequently, the Lutheran churches in Southern Africa have responded by intensifying their efforts to implement a wide spectrum of HIV and AIDS interventions, including on-going psychosocial support for people living with HIV, prevention, home-based care and assistance to orphaned and vulnerable children (LUCSA 2005; LUCSA 2008; LUCSA 2012). In spite of the view that "prevention is better than cure", regrettably, HIV prevention has received the lowest priority within the many programmes run by the Lutheran churches as reported in the 2008 and 2012 end-of-phase evaluation reports (LUCSA 2008; LUCSA 2012).

Speaking about sexual matters both in the church in general and in many cultures is still taboo (Paterson 2009). This may be the reason why the clergy are not active in terms of HIV prevention, since speaking about HIV prevention may lead directly to talking about sexual behaviour. Where church leaders have facilitated open discussions on HIV prevention in an acceptable language to their members, HIV and AIDS liturgies have become part of the Sunday services and influenced greater discourse about HIV prevention. In contrast, the LUCSA evaluation reports show that some churches ignore HIV prevention completely or only preach about it periodically, while others preach about the topic more regularly and have even introduced HIV and AIDS prevention activities coordinated by professionals (LUCSA 2008; LUCSA 2012). Literature on the factors that influence church leaders' interest in or skills regarding addressing HIV prevention positively or negatively is limited. In a study to identify the complex institutional dynamics surrounding HIV prevention in the religious organisations of the US-based Asian immigrants, Chin *et al* (2005), recommend that future studies need to examine religious

leaders' attitudes towards HIV involvement and their perceptions of the risks posed by HIV to the communities they serve.

Importantly, the Western Diocese of the Evangelical Lutheran Church in Zimbabwe (ELCZ) established an HIV and AIDS programme, "Thusanang," in 1993, which operates in the Gwanda and Beitbridge Districts in Matabeleland South (ELCZ 2008). Thusanang is a term from the Sotho language, which means, "*let us help each other*" and professionals such as nursing personnel, manage the programme. Accordingly, the ELCZ Thusanang programme includes home-based and orphan care, income-generating activities for vulnerable children and to a lesser extent, youth peer education on HIV prevention. However, the 2009 evaluation report for the ELCZ HIV and AIDS programme found little evidence that church leaders played a leading role in HIV prevention at Thusanang (ELCZ 2009). In fact, the findings of the 2009 ELCZ evaluation indicate that the Lutheran church leaders are not at all participating actively in HIV prevention.

Church authorities are among those affected by HIV and AIDS in their daily work as the clergy are also dying of AIDS-related causes (Evangelical Lutheran Church in Germany 2007). This study by the Evangelical Lutheran Church in Germany highlights the impact of HIV and AIDS on the function of the clergy, in that pastors can scarcely cope with the additional burden of pastoral care and presiding at funerals because of the AIDS-related illnesses and deaths. Furthermore, parishes continue to lose members to AIDS and carry the burden of caring for the ever-increasing number of orphans and the chronically ill (Evangelical Lutheran Church in Germany 2007). The above scenario explains why the church community, particularly those in leadership, are called upon to prioritise and engage in active discussions on HIV prevention, involving all sectors of the church, including the clergy.

The World Council of Churches' (WCC) 2004 Plan of Action gives additional guidance with regard to areas of response that include the provision of care and support, risk reduction and impact alleviation measures (WCC 2004). One of the major milestones in the general churches' path towards developing a

constructive approach to HIV and AIDS was the statement of commitment released by religious leaders at the July 2004 International AIDS Conference in Bangkok, stating that: "HIV and AIDS knows no boundaries. All of our religious communities are living with HIV and AIDS...We will not rest until the promise of 'Access for All' and the hope of a world without HIV and AIDS is fulfilled" (Statement of Religious Leaders at the XV International AIDS Conference 2004). The WCC further called upon the churches to renew their "commitment to serve communities in the light of the changing face of the pandemic..." working with civil society to realise the UNAIDS goal of "Zero new infections, Zero discrimination and Zero AIDS-related deaths" (WCC 2011).

In spite of such commitments by the church leadership, controversy regarding condom use, sexuality issues and the stigmatisation of people living with HIV persists, hampering the effectiveness of many church programmes in Southern Africa (LUCSA 2008; LUCSA 2012). Moreover, these commitments have not translated into intensified HIV prevention programmes to reduce new HIV infections drastically as was achieved by Uganda and Senegal interventions described above under section 1.2.2.

Studies measuring the opinions of church leaders on HIV prevention highlight the potential of the church to influence the lives of its community. In this regard, Mukuka and Slonim-Nevo (2006) found that, overall, the leaders and members of several denominations of different churches in Zambia believe that the church is an influential partner in preventing the spread of HIV as it offers many preventive programmes for adolescents and their parents. This occurs despite the church's main doctrine that prohibits the use of condoms and condemns premarital sexual relations. On the other hand, Chin *et al* (2005) found that a number of South Asian and Chinese religious leaders support the idea of taking an active role in HIV prevention. However, religious policies prohibited involvement in conducting prevention initiatives for men who have sex with men and individuals engaged in non-marital sex as these practices are in conflict with their religious teachings.

1.3 FOCUS OF THIS RESEARCH

While recognition has been accorded to the potential role of the church and its response to HIV and AIDS, an exploration of information about church leaders' attitudes regarding their roles in HIV prevention and barriers to their active involvement, is lacking.

The researcher found little evidence in the literature review of church leaders playing a significant role in HIV prevention. Therefore, this study sought to ascertain the attitudes of the Lutheran Church leaders in the Matabeleland Province of Zimbabwe regarding the various leadership roles they could play in supporting or challenging norms that may hinder open discussion about HIV prevention.

The focus of this study was to investigate the attitudes of church leaders in the Matabeleland Province of Zimbabwe to provide the impetus for open discussions on HIV prevention as well as to explore the barriers that prevent them from contributing effectively to the control of HIV infections. This study considered the attitudes demonstrated by church leaders that can potentially explain both the barriers and facilitating factors regarding taking a lead in HIV prevention. The prime emphasis of this research was not to distinguish between the types of leaders, but to describe the attitudes (regardless of their positions in the church) of Lutheran Church leaders, as well as the subjective norms to which they adhere regarding their perceived leadership roles in dealing with HIV prevention in Zimbabwe.

Accordingly, this study applied the Theory of Reasoned Action to investigate these attitudinal factors and to answer the formulated research questions on the church leaders' attitudes and subjective norms regarding their perceived leadership roles in HIV prevention.

1.4 RESEARCH QUESTIONS

The multi-sectoral approach outlined in the Zimbabwe National HIV and AIDS Strategic Plan 2011-2015 recognises the important role played by faith- and community-based organisations in the HIV response (NAC 2011; UNAIDS 2014). The 2009 evaluation report for ELCZ HIV and AIDS programme and the subsequent evaluation in 2012, found little evidence that church leaders played a leading role in HIV prevention (ELCZ 2009; LUCSA 2012). Against this background, the following research questions guided this study:

- To what extent are Lutheran Church leaders involved in HIV prevention activities; given that Zimbabwe is one of the countries at the epicentre of the AIDS epidemics in Southern Africa?
- What are the attitudes of the Lutheran Church leaders towards taking leadership roles in HIV prevention?
- How do biographical variables, location of a congregation, position in the church, length of Lutheran membership, gender, age, education, involvement in HIV prevention activities and exposure to HIV training influence the attitudes of the Lutheran Church leaders towards HIV prevention? If so, where is the possible interaction?

The hypothesis to be tested in relation to research question 3 was:

- ***H₀: The variables are independent (there is no association)***
- ***H₁: The variables are dependent (there is an association)***

1.5 OBJECTIVES OF THE STUDY

The main objectives of this study were to:

- Determine the extent of the involvement of Lutheran Church leaders in HIV prevention activities.
- Describe the attitudes of Lutheran Church leaders towards taking leadership roles in HIV prevention.
- Explore how biographical variables location of a congregation, position in

the church, length of Lutheran membership, gender, age, education, involvement in HIV prevention activities and exposure to HIV training, may influence the attitudes of the Lutheran church leaders towards their leadership roles in HIV prevention.

1.6 RATIONALE FOR THE STUDY

Investigating church leaders' attitudes towards HIV prevention is essential to understanding the factors that enable some, but not all, to assume a leadership role in facilitating HIV prevention efforts. Developing strategies for church leaders' participation in HIV prevention activities is important, as it, subsequently, could contribute to a significant reduction in the HIV prevalence rate. This study could add to the body of existing knowledge regarding the attitudes of church leaders in the Matabeleland Province in Zimbabwe towards HIV prevention. Therefore, this study is an important undertaking as it bridges the gap between theory and practice in that Lutheran church leaders were part of the Pan African church leaders' forum which committed itself to actively engaging in HIV prevention activities in Nairobi in 2002 (LWF 2003). However, the LUCSA HIV and AIDS programme evaluation findings, to date, indicate limited actual leadership involvement in HIV prevention (LUCSA 2008; ELCZ 2009; LUCSA 2012). Accordingly, this study seeks to identify factors that, when addressed, could enable churches to empower the communities they serve to protect themselves from HIV infection. Thus, this study could contribute to an understanding of how churches can respond positively to issues regarding HIV as well as overcoming the debates on morality issues related to HIV infections and the stigmatisation of PLHIV and those affected by HIV and AIDS. Presently, the low level of involvement of church leaders in HIV prevention programmes, leads to lost opportunities to reduce new infections and the impact of the epidemic (LUCSA 2008; ELCZ 2009; LUCSA 2012).

1.7 RESEARCH DESIGN AND METHODOLOGY

A descriptive survey employing a self-administered questionnaire was used to meet the above-stated research objectives. The Theory of Reasoned Action guided this study. This study was conducted in four phases, namely, belief elicitation, questionnaire development, a pilot survey and the main survey.

In order to identify the important factors affecting church leaders in terms of taking a leading role by talking about the sexual risks resulting in HIV transmission and by providing HIV prevention advice to their parishioners and the clergy, the researcher conducted elicitation interviews with a sub-group of Lutheran church leaders.

Identification of these factors enabled the development of the questionnaire items for the main survey (Montano & Kasprzyk in Glanz, Rimer & Viswanath 2008). The questionnaire incorporated belief-based measures of church leaders' attitudes, subjective norms and particular external variables (namely, age, gender, exposure to HIV training, encounter with a person living with HIV or dying of AIDS-related illnesses, area in which the congregation was located and position in the church). The methodology of this study is discussed in detail in chapter 3.

1.8 THE RESEARCH SETTING

The study was carried out in Matabeleland South Province of Zimbabwe. Matabeleland Province lies to the south, southwest and west of Zimbabwe and comprises three provinces, namely, Bulawayo, Matabeleland South and Matabeleland North. The Matabeleland South Province, where the study was conducted, is a semi-arid region that receives very low rainfall in the country. The total population of the Matabeleland South Province in 2012 was 683,893 people (Zimbabwe National Statistics Agency 2012), as indicated in Table 1 below. Table 1 highlights that there are more females than males throughout the Matabeleland Province.

Table 1: Population by sex in Matabeleland Province (ZimStat 2012)

Province and Sex	2009		Total	2010		Total	2012		Total
	Male	Female		Male	Female		Male	Female	
Bulawayo	341,211	372,321	713,532	344,272	375,662	719,934	3003,346	349,991	653,337
Matabeleland South	325,755	362,003	678,758	328,678	365,251	693,929	326,697	356,926	683,893
Matabeleland North	358,832	384,124	742,956	362,052	387,570	749,622	360,776	388,241	749,017

The province shares a border with Botswana to the southwest and South Africa to the south as shown in Figure 1 below. In addition, there are four border posts in Matabeleland South Province, namely, Beit Bridge on the South African border and the other three at Plumtree, Maitengwe and Mphoengs on the Botswana border.



Figure 1: Map of Zimbabwe and the ten provinces of the country

Gwanda urban is the capital of the province with a population of 20, 227 people (Zimbabwe National Statistics Agency 2012). The town is located between Bulawayo and Beit Bridge. It is linked by both road and rail.

Economically, the Matabeleland South Province relies heavily on cattle ranging and goat-farming while socially, cross border travel is very high as people travel to neighbouring countries in search of jobs and trade. The few small gold mines in the province also attract in-country migrant labour with many workers separated from their wives for long periods throughout the year. These socio-economic factors have been associated with the high HIV prevalence rate of 21% in Matabeleland South Province (Zimbabwe National Statistics Agency 2012) as indicated in Figure 2 below.

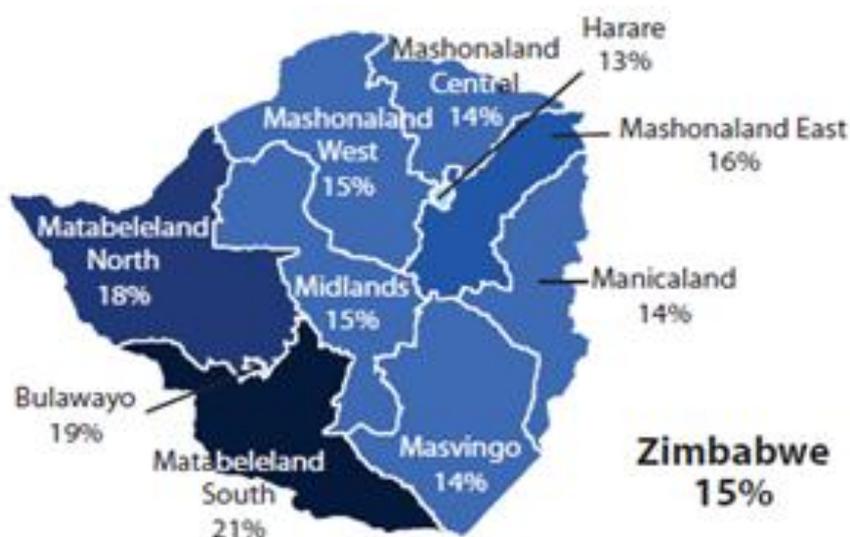


Figure 2: Adult HIV Prevalence in Zimbabwe by Province in 2012

Source: 2010-2011 Zimbabwe Demographic and Health Survey in ZimStat 2012

The HIV prevalence rate is high across all the Zimbabwe provinces, ranging from 13% in Harare to 21% in Matabeleland South as indicated in the map above in Figure 2.

The Zimbabwe Demographic and Health Surveys of 2005-2006 and 2010-2011 indicate a decrease in HIV prevalence in all the provinces except for the Bulawayo and Matabeleland South Provinces, where HIV prevalence increased by 2.1% and 0.2 percent respectively as shown in Figure 3 below.

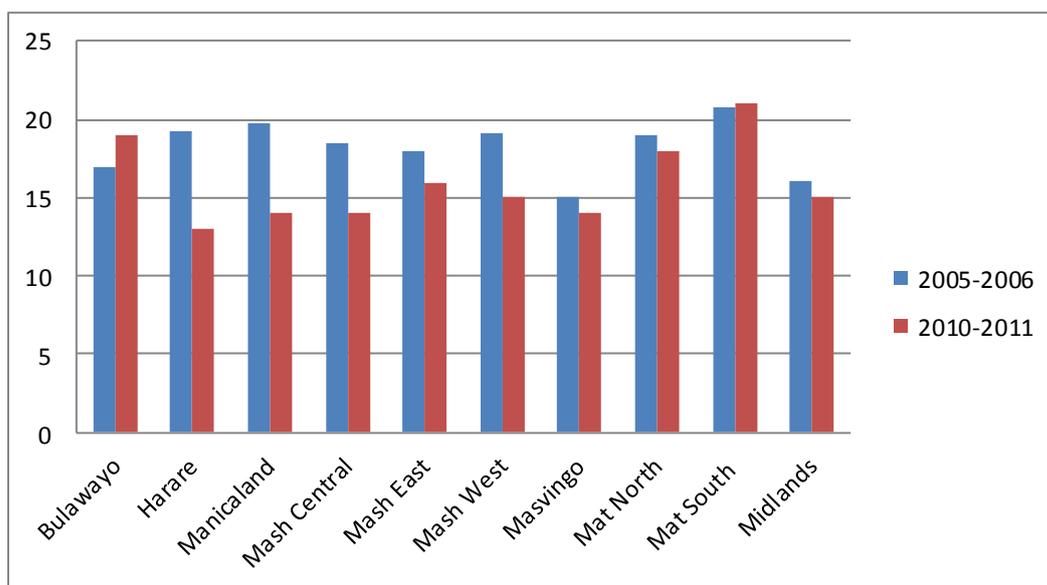


Figure 3: Comparison of HIV prevalence in 2005-2006 and 2010-2011
 Data Source: 2005-2006 ZDHS; 2010-2011 ZDHS

The Western Diocese of the Lutheran Church in Zimbabwe serves three provinces, namely, Bulawayo, Matabeleland North and Matabeleland South (ELCZ 2009, ELCZ 2011). The Diocese has two deaneries, the Northern and the Southern Deaneries. Table 2 below shows membership by province and sex. The Northern Deanery encompasses Bulawayo and Matabeleland North provinces with a total membership of 6,015 people.

Table 2: ELCZ Church membership by province and sex (ELCZ 2011)

Province	Parishes	2011		Total
		Male	Female	
Bulawayo	5	1,899	2,888	4,787
Matabeleland North	2	549	679	1,228
Matabeleland South	16	16,849	27,656	44,505

The Southern Deanery is a cluster of 16 parishes within the Matabeleland South Province and has a membership of 44,505 people, excluding children (ELCZ 2011). The Southern Deanery has a home-based care project called Thusanang, situated at the Manama Mission, servicing three parishes. The parishes organise various HIV and AIDS-related activities that range from awareness on HIV and AIDS, youth peer education programmes on HIV prevention, care and support activities for orphans and persons living with HIV

and impact mitigating projects, such as goat farming and beadwork.

1.9 DEFINITIONS OF KEY TERMS

Most scholarly disputes or misunderstandings stem from the application of different understandings of terms. To avoid this, in this section of the chapter, the researcher clarifies the following key terms used in the study:

1.9.1 Attitude

Since the study involved constructs related to the measurement of attitudes regarding the leadership role church leaders could play in HIV prevention, it is necessary to give a brief definition of this term. An “attitude” represents an “individual's disposition to respond favourably or unfavourably to an object, person, institution or event, defined by acceptance of attitudinal beliefs or opinions of a referent” (Glanz, Rimer & Lewis 2002:70; Terry, Gallois & McCamish 1993:1-14). In turn, Bohner and Wänke (2002:5) define an attitude as “a summary evaluation of an object of thought.” Thus, one can conclude that attitudes convey feelings about what people think of a particular issue or object and how they intend to behave towards this object or issue.

1.9.2 Bishop

To be a bishop in the Lutheran context entails assuming and accepting responsibility for the well-being of the church for the benefit of its members and pastors. This position inevitably requires the making of personal sacrifices and exhibiting an attitude of selflessness for the sake of promoting the ministry. A pastor is elected to the position of bishop and becomes consecrated as a Diocesan Bishop after having served in the Lutheran church for at least ten years. The required basic qualification is “a diploma from a recognised institution” with some experience in administration. This is the highest position a person can hold in the Evangelical Lutheran Churches worldwide and the term of office usually lasts until retirement age (ELCZ

2009:36-38).

1.9.3 Church

The “church” is often regarded as consisting of a unified body of believers who collectively proclaim a set of religious and/or spiritual beliefs, values and practices. According to Martin Luther (cited in Strasser 1999:4), the “church” is a group of people who come together to hear the Word of God and to receive the sacraments. Another definition is that the church is a group of people who believe in Jesus Christ. Alternatively, the church is the people called together by the Holy Spirit. In this regard, the church is not the clergy, the church hierarchy, church buildings or even the liturgy.

In the Apostle's Creed, Luther interpreted “the holy Christian Church” as the “communion of saints” or “community of the holy.” Althaus (cited in Strasser 1999), believes that Luther understood communion as the “sharing of goods among the believers, the giving and receiving of the members to and from each other, the becoming one with all others and working for one another.” In this study, the “church” refers to a local Christian community that prays together as defined by Martin Luther in the Apostle’s Creed.

1.9.4 Congregational Council

Congregational Council members are “full members of the Lutheran church” of “good standing” aged 21 years and above, elected to serve on an administrative committee of a congregation. The congregational administrative committee members are eligible for election onto a parish council. The following organs govern the ELCZ church: the Congregational Council, the Congregational Assembly, the Parish Council, the Parish Assembly, the Deanery Council, the Deanery Assembly, the Diocesan Council, the Diocesan Assembly, the Church Council and the Church Assembly. Each of the above organs may form committees for any other function as required (ELCZ 2009:9).

1.9.5 Church leadership

According to the Lutherans, Christian leadership is based on the teachings and example of Jesus Christ who came, not to be served, but to serve (Matthew 20 verse 28): Christian leadership, through the eyes of the Lutherans, is the "...call and art of weaving together of people through transformed and transforming relationships" (Geweke 2009).

1.9.6 Congregation

A "congregation" is a "recognised group of church members in one locality" under the leadership of a "deacon [deaconess] or a pastor duly called and appointed by the church authority" (ELCZ 2009:6).

1.9.7 Dean

A "dean" is a pastor elected to serve all the parishes and institutions of the deanery for ten years (ELCZ 2009:35-36).

1.9.8 Deanery

A deanery is a geographical area as decreed by the Diocesan Council containing all the parishes and institutions in that area, administered by a dean (ELCZ 2009).

1.9.9 Diocese

A diocese is the geographical area determined by the Church Assembly and run by a Diocesan Bishop (ELCZ 2009). The Western Diocese of the Evangelical Lutheran Church in Zimbabwe is one of three Dioceses of the Evangelical Church in Zimbabwe. The Western Diocese has one hundred congregations organised into twenty parishes in the Matabeleland Province of Zimbabwe.

1.9.10 Faith and doctrine

The ELCZ constitution does not make a distinction between faith and doctrine. It defines faith and doctrine as “the foundation upon which the Lutheran Church of Zimbabwe stands”. “Faith and doctrine” refers to:

- The Word of God, namely, the canonical books of the Old and New Testaments of the Bible
- The Creed of the Apostles, the Nicene and Athanasian Symbols and the pure Lutheran doctrine in accordance with the Small Catechism of Martin Luther and the unaltered Augustana Confession (ELCZ 2009:1)

1.9.11 HIV

The term “HIV” refers to the Human Immunodeficiency Virus that destroys the body’s ability to fight off infections and diseases and is mainly found in the blood and sexual fluids of an infected person and in the breast milk of a woman living with HIV (UNAIDS 2011).

1.9.12 AIDS

The term “AIDS” refers to the Acquired Immune Deficiency Syndrome that describes a collection of infections and diseases that develop in a person because of the immune system severely damaged by HIV.

1.9.13 HIV prevention

For the purpose of this study, the concept “HIV prevention” refers to those strategies or interventions promoted to offer individuals protection against the transmission of HIV through sexual contact, mother-to-child transmission and contact with the blood of a person infected with HIV. The promotion of this protection could also be in the form of advocacy.

1.9.14 Parish

A “parish” is a geographical area as ordered by the Diocesan Council containing one or more congregations supervised by one senior pastor (ELCZ 2009:10).

1.9.15 Pastor

A “pastor” is an ordained minister who provides and shows ongoing care and concern for a congregation or parish (ELCZ 2009:6).

1.9.16 Religion

As defined in *The Random House College Dictionary* (1988), religion is:

- A set of beliefs concerning the cause, nature and purpose of the universe, especially when considered as the creation of a superhuman agency or agencies, usually involving devotional and ritual observances and often having a moral code for the conduct of human affairs (The Random House of College Dictionary 1988:1114).
- A specific and institutionalised set of beliefs and practices generally agreed upon by a number of persons or sects, for example, the Christian religion; the Buddhist religion (The Random House of College Dictionary 1988:1114).

The Lutheran religion is a Christian denomination and “is a branch of the Holy Church universal” (ELCZ 2009:1).

1.9.17 Religious beliefs

The ELCZ considers the term “religious beliefs” to have the same meaning as religion. The concept “religious beliefs” offers an understanding of the

foundation upon which the Evangelical Lutheran Church in Zimbabwe is built to recommend the means of promoting positive attitudes among church leaders regarding communicating about HIV prevention.

1.9.18 Subjective norm

The term “subjective norm” refers to the likely influence significant others may have on the decision of a person to perform (or not to perform) a given behaviour (Glanz *et al.* 2008:71). This is associated with normative beliefs, which relate to a person’s perception regarding whether significant others approve or disapprove of his/her behaviour.

1.10 OUTLINE OF THE DISSERTATION

The dissertation is written in five chapters.

Chapter 1: Situating the research problem

This chapter discusses the significance of this study, the research problem, the aims and purpose of this research and the research questions and objectives. It also introduces the methodology of this study, describes the rationale for this research, and the research setting, as well as provide definitions of key terms.

Chapter 2: Literature review

This chapter deals with the following eight sections:

- Background of the Lutheran Church.
- Proactive prevention of HIV and the Christian tradition.
- Drivers of the AIDS epidemic in Southern Africa.
- HIV prevention interventions and programmes in Africa.
- An overview of the AIDS epidemic in Zimbabwe and recommended

prevention strategies.

- The church and its role in providing HIV and AIDS service.
- The church's leadership role relating to HIV and AIDS in Africa.
- The conceptual and theoretical framework employed in this study, namely the Theory of Reasoned Action.

Chapter 3: Research design and methodology

In this chapter, the research design and approach are discussed and further attention is paid to the description of the research setting. In addition, the sampling methods are dealt with as well as the methods used in the gathering and the analysis of the data. The trustworthiness of the findings and important ethical concerns are also highlighted.

Chapter 4: Data analyses and interpretation of results

In chapter 4, the results of the study are presented and interpreted.

Chapter 5: Conclusions, recommendations and limitations of the study

Based on the results discussed in chapter 4, the main conclusions of the study are presented in chapter 5 and recommendations are made which could guide future studies. In addition, the researcher discusses the limitations of the study.

1.11 CONCLUSION

This chapter presented an overview of the research problem and research questions. In addition, it discussed the significance and rationale of this study, the aims and purpose of this research and the research methodology used. Furthermore, the key concepts used in this study were also defined.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.1 INTRODUCTION

This chapter covers the literature regarding the drivers of the HIV epidemic in Southern Africa, global responses to HIV prevention and the role of the church - specifically the Evangelical Lutheran Church in Zimbabwe - in the response to HIV and AIDS, with particular emphasis on prevention. Additionally, the chapter provides a review of the background of the Evangelical Lutheran Church and the issues, which the Christian faith in general finds difficult to talk about, such as sex and sexuality, gender equality, drugs and commercial sex work. Lastly, the chapter provides details of the theoretical framework that guided this study.

Research on religion or faith-based organisations (FBOs) and the AIDS epidemics have often focussed on faith-based initiatives and response to these epidemics. Topics covered by these studies include the role of the church in HIV prevention, with debates on the way churches make a connection between HIV and “immoral” sexual behaviour and stigma, the influence of religion on sexual behaviour, as well as prevention methods of choice, including the controversy around condom use (Campbell, Skovdal & Gibbs 2011; Garner 2000; Gregson *et al.* 1999; Mukuka & Slonim-Nevo 2006; Muturi 2008). However, there is limited research that focusses on the measurement of the attitudes held by church leaders regarding their perceived leadership roles in HIV prevention.

2.2 DRIVERS OF THE AIDS EPIDEMIC IN SOUTHERN AFRICA

There are two types of HIV, namely, HIV-1 and HIV-2. HIV-1, commonly referred to as simply “HIV,” is the most common form in sub-Saharan Africa and globally (UNAIDS 2011). HIV-2, mainly found in West Africa, is less aggressive than HIV-1 and takes a long time to develop into AIDS, unlike HIV-

1 that takes on average 5 to 10 years from infection to the AIDS stage without treatment intervention (UNAIDS 2011). However, due to the movement of people, HIV-2 has spread to other parts of the world including the sub-Saharan Africa region, although it is still not as common as HIV-1. The main mode of HIV transmission in Southern Africa is through sexual contact (UNAIDS 2010).

Okaalet (cited in Paterson 2009:79) has singled out three main factors associated with the transmission of HIV in sub-Saharan Africa, namely, biological, behavioural, cultural and structural factors.

2.2.1 Biological factors

The biological determinants are those factors that increase HIV transmission through sexual contact. Research shows that young women are vulnerable to HIV infection due to their biological differences in comparison to men (UNAIDS 2010). In sub-Saharan Africa, the chances of an adolescent female being infected with HIV are as much as eight times higher than that of a male of the same age (UNAIDS 2010). Research also shows that male circumcision reduces HIV transmission for men by 60-70% (WHO/UNAIDS 2007). In addition, other biological factors such as the presence of sexually transmitted infections (especially with open wounds) and an injured or immature genital tract or pregnancy renders one highly susceptible to contracting HIV.

In Zimbabwe, a growing body of recent research has demonstrated an association between genital herpes, Herpes Simplex Virus-2 (HSV-2) and the acquisition of HIV infection. The increased likelihood of acquiring an HIV infection was approximately one and a half times higher among factory workers who had a prior HSV-2 infection (McFarland, Gwanzura, Bassett, Machekano, Latif, Ley, Parsonnet, Burke & Katzenstein 1999:1463-1464). In another study undertaken in Uganda and Zimbabwe, the susceptibility of women to HIV-1 infection due to HSV-2 increased by 42% in Uganda and 65% in Zimbabwe (Brown, Wald, Hubbard, Rungruengthanakit, Chipato, Rugpao, Mmiro, Celentano, Salata, Morrison, Richardson & Padian 2007). A

relatively recent study showed a prevalence of 89.3% for HSV-2 among HIV-1 positive Zimbabwean pregnant women (Munjoma, Kurewa, Mapingure, Mashavave, Chirenje, Rusakaniko, Hussain & Stray-Pedersen 2010).

The risk of transmitting HIV also increases during the period when the viral load in a person who has contracted HIV is high. This applies particularly to the early stages of HIV infection before the body has developed enough antibodies to fight the virus as well as at the advanced stage of the infection, that is the AIDS stage, when the immune system is weak (Powers, Poole, Pettifor & Cohen 2008). Furthermore, when there is no treatment intervention, babies are likely to contract HIV from their mothers during pregnancy, delivery or breastfeeding. This mode of transmission from mother to child is also known as vertical transmission. In addition, any condition that lowers an individual's immune system, such as malnutrition or tuberculosis, makes him or her more susceptible to HIV infection (Okaalet, in Paterson 2009).

Most of the aforementioned factors, namely, the presence of sexually transmitted infections, early engagement in sexual activities by young girls who have immature genital tracts and vertical transmission, are preventable. Some of the prevention strategies include the provision of accurate information on transmission and prevention, the promotion of individual behaviour change, for example, through the delay of sexual debut, condom use, encouragement to know individual HIV status through testing and counselling as well as the promotion of enrolment of pregnant women into prevention of mother-to-child transmission (PMTCT) programmes.

2.2.2 Behavioural factors

Behavioural factors refer to high-risk sexual behaviour of both men and women that expose an individual, particularly women, to a greater risk of contracting HIV. For example, according to Okaalet, these include engaging in unprotected sexual activities, having multiple sexual partners, early first sexual experiences (even more so in the case of girls than boys) and young

women having older sexual partners (Okaalet in Paterson 2009). Sexual violence is also a common factor, and includes rape and abuse of virgins by men who are infected with HIV, believing that they could be “cleansed” of their positive HIV status. Sexual violence against women or children may expose those abused to HIV transmission (Okaalet cited in Paterson, 2009). In Lesotho, for example, sexual violence is a major factor believed to compound the risk of HIV infection for women (UNAIDS 2010). In addition, alcohol consumption and the use of drugs may lead to risky sexual behaviour, thereby increasing the chances of HIV transmission.

The UNAIDS 2010 report points out that low levels of comprehensive knowledge of HIV and AIDS in sub-Saharan Africa continue to be a barrier, preventing the reduction of new infections. For example, in South Africa, about 2 million people living with HIV do not know they are infected, moreover, they do not believe that they are at risk of becoming infected and are unaware that they can transmit the virus to others (UNAIDS 2010). Meaningful responses to the epidemic must consider these factors as well and advocate for comprehensive HIV education for all, the promotion of gender equality and poverty alleviation to prevent the transmission of HIV and mitigate the impact of AIDS.

Church leaders are in a unique position to influence HIV prevention education and behaviour change among their congregation members in order to effect a reduction in high-risk sexual behaviours. Gregson *et al* (1999) find that spirit-type churches have more control over alcohol consumption and extra-marital affairs among their members than mission churches, thus reducing their congregants’ risk of HIV infection. The term spirit-type church, also known as Pentecostal, includes Zionist-type churches and refers to joyful forms of Christianity defined in terms of special gifts given by the Holy Spirit (Engelke in Nhamo 2011). In South Africa, Garner (2000) has found that the values and education of Pentecostal churches offered a protective measure against HIV infection as it minimised extra- and pre-marital sexual activity. Elsewhere in Africa, studies in Kenya, Ghana and Malawi have reported lower levels of HIV risky sexual behaviour (such as by remaining faithful within the marriage and

practising abstinence before marriage) among members of the Pentecostal, Evangelical and Deliverance churches (Addai in Nhamo 2011; Parsitau in Nhamo 2011). “Deliverance churches” combine the Pentecostal phenomenon and spirituality and are characterised by lively worship, speaking in tongues and high-spirited music. The name “deliverance” arose from Luke 4:18, which refers to Jesus’s freeing or deliverance of the “prisoners” or “captives”. The mission of the church is to preach good news to the poor and deliver the oppressed (Ballard 2014; Ukah 2007). Trinitapoli (2006) asserts that church leaders in Malawi are open to engaging their rural congregations in HIV and AIDS discussions. The potential for church influence regarding the control of HIV risky sexual behaviour, as discussed in this paragraph, provides a vital tool in HIV prevention education. Hence, church leaders need to take a leading role in changing people’s risky sexual behaviour.

2.2.3 Cultural factors

Cultural factors often make it difficult for an individual to protect himself/herself from exposure to HIV. These factors, such as polygamous unions, wife inheritance, gender inequality, sexual rights and reproductive health, genital mutilation and other risky practices that fuel the transmission of HIV, are usually part of cultural identity (Okaalet cited in Paterson, 2009).

The social construction of masculinity and femininity affects women negatively in many African settings, as the system condones male dominance that limits the rights of women, including not questioning the infidelity of their husbands. Socially assigning women and men to different positions, roles and consequently different behaviours defines how people relate to one another and creates gender inequalities, generally, tied to a power matrix (Nyoni 2008). Gender refers to the social identity of men and women and this has different implications for women in terms of their vulnerability to HIV and AIDS and manifests differently in terms of the economic, legal, cultural, religious, political and sexual status of women (CHGA 2008). The subordination of women, in many African countries, creates vulnerability to HIV infection through pressures to sustain economic survival, a lack of assets, and a lack of

protection against abuse and exploitation. Negotiation for safer sex becomes difficult for women because of their low social status and fear of violence. Furthermore, culturally, men marry women who are much younger than they are and who are sexually “naïve” or less sexually experienced. Having much older and sexually experienced partners carries a high risk of exposing women, even in marriage, to HIV infection. There is also a danger of young women seeking sexual satisfaction outside marriage, thus exposing them to risks of HIV infection.

Behavioural and cultural factors, as in the case of the biological factors mentioned above, demand a proper understanding of the linkage of HIV prevention to the forms of sexual behaviour and circumstances that define those behaviours for them to be addressed effectively (Nyoni 2008). Most African church leaders need to ensure that their HIV prevention programmes address sexual behaviours within the context of their communities and the realities of women’s lives.

2.2.4 Structural factors

Also important are the social, legal, economic and political factors that leave individuals vulnerable to HIV infection (Barnett & Whiteside 2002; Barnett & Whiteside 2006; Duri *et al* 2013; Nhamo 2011). The reviewed literature highlights a combination of broader factors that form a “backdrop” against which HIV spreads in Southern Africa. Some of these include the migratory labour system that increases the risk of HIV infection by separating couples. Limited access to education and gainful employment perpetuates the low social status women already have in many African countries. Many women end up being engaged in subsistence farming or low paying jobs. People living in poverty, women in particular, might engage in HIV high-risk sexual behaviour, such as “survival sex,” to fend for themselves and their families (Denis & Becker 2006; Isaksen, Songstad & Spissøy 2002; MOHCW/NAC 2004; Shisana & Letlape 2004).

Furthermore, researchers highlight the role played by changes in national

political economies and government responses, such as structural adjustment policies (SAPs) and debt as some of the factors shaping the spread of HIV in sub-Saharan Africa (Barnett & Whiteside 2002; Barnett & Whiteside 2006). Some of the effects of structural adjustment policies, which focussed on currency devaluation and trimming of state budgets among other things, included the retrenchment of public sector employees, privatisation and the introduction of user fees for public services and the inadequate provision of health services due to weak ministries of health. Barnett and Whiteside (2002) highlight the effect of SAPs in countries with a high prevalence of HIV and AIDS that led to removal of social support structures to care for sick family members as having ushered in the adoption of income-generating strategies to purchase food and meet medical and funeral costs. In many southern African countries, including Zimbabwe, food insecurity has forced many people to migrate in search of work, sell assets, take children out of school to seek employment or even end up engaging in sex work to obtain food, thus increasing their risks to HIV transmission (Muller *et al.* in UNAIDS 2010). Sustenance of sex education through traditional structures targeting young people in particular, has become difficult due to urbanisation (Ngande cited by Amanze in Chitando & Nickles 2010). The increasing burden of caring for sick relatives falls on women and girls disproportionately. Informal sector activities to boost their income, such as sex work, have increasingly exposed women to acts of violence. These structural factors contribute to gender inequalities and human rights abuses, which in turn, increase the risk of contracting HIV for vulnerable groups.

2.3 IMPACT OF HIV PREVENTION PROGRAMMES IN AFRICA

Multi-sectoral approaches to HIV prevention and the care and treatment and policies adopted by governments to guide their responses to the epidemic in sub-Saharan Africa, are yielding positive results in reducing new infections. The 2010 UNAIDS epidemic update indicates that the overall global AIDS epidemic has stabilised, with 22 countries in sub-Saharan Africa recording a decline of more than 25 percent in new HIV infections between 2001 and

2009 (UNAIDS 2010). The number of people newly infected with HIV in 2009 was 1.8 million compared to the 2.2 million people who became infected in 2001 (UNAIDS 2010:16). However, in Malawi, Mozambique, Namibia, South Africa, Zambia and Zimbabwe, with the exception of Angola, the HIV epidemic has stabilised at high levels of above 10 %, while Botswana, Lesotho and Swaziland remain above 23 percent (UNAIDS 2010) as illustrated by the graph in Figure 4 below.

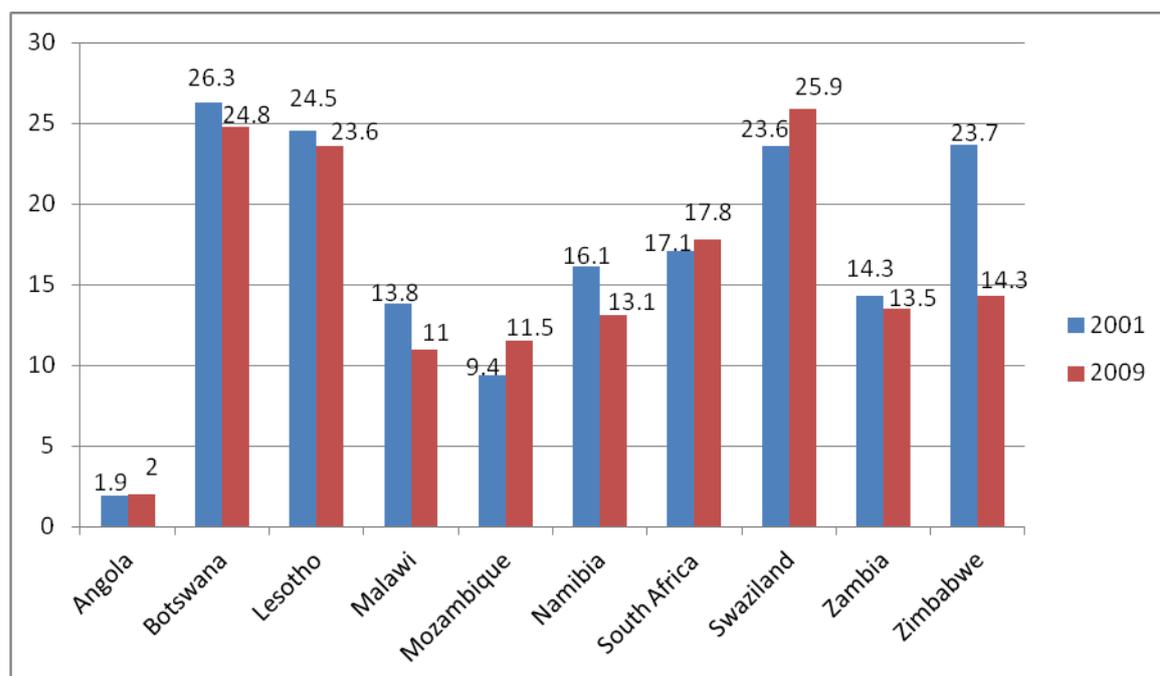


Figure 4: HIV prevalence among adults aged 15-49 years in Southern African countries: 2001 - 2009

Source: UNAIDS report on the global AIDS epidemic 2010, UNAIDS 2010.

For an effective response in controlling the spread of HIV infection, UNAIDS recommends that HIV prevention programmes include a combination of behavioural, biomedical and structural responses (UNAIDS 2010). The data in the 2010 UNAIDS update highlight key behavioural indicators related to the risk of HIV infection that attributed to the reduction of new infections, namely, a reduction in multiple sexual partnerships and sex before the age of 15 years as well as condom use.

In Namibia, the decline in HIV prevalence among young males and females aged 15–24 years from over 10 percent in 2007 to about 5 percent in 2009

was associated with increased knowledge on HIV prevention, higher age of sexual debut, reduced high-risk sexual behaviour and consistent condom use (UNAIDS 2010). The UNAIDS report further indicates that Namibia is the only Southern African country of the 10 countries world-wide that have achieved the goal of comprehensive correct knowledge of HIV among young people of 15-24 years exceeding 60 percent of that age group. Young people's comprehensive knowledge of HIV and AIDS were tested using indicators regarding factual knowledge of HIV transmission and prevention, knowledge of their own HIV status and HIV risk reduction options for themselves and others as well as an awareness of their own potential to become infected or infect others.

In Zimbabwe, preventative interventions have contributed to the reduction of adult HIV prevalence to 14.3% (MOHCW 2009). The main behavioural change contributing to the decline in new infections in Zimbabwe include a reduction in the proportion of men with casual partners and increased condom use with non-regular partners (UNAIDS 2010).

2.4 PROACTIVE PREVENTION OF HIV INFECTION AND THE CHRISTIAN TRADITION

In 2004, the World Council of Churches (WCC) advocated a shift in the view that HIV transmission is the result of immoral sexual behaviour. Of great significance was the realisation that the response to HIV and AIDS should go beyond a focus on sexual transmission to include poverty and socio-cultural factors, such as polygamy and transactional sex, which increase people's vulnerability to HIV infection (WCC 2004). Furthermore, the transmission of HIV can also take place through contaminated blood during blood transfusions, accidental exposure to blood and from an infected mother to her child during pregnancy, delivery or while breastfeeding (UNAIDS 2007). The WCC calls on churches and ecumenical movements to view HIV and AIDS as part of their congregations' social problems and stresses the need for churches to develop a theology that addresses the HIV epidemic. While

reflecting on human relations at communal and global levels, the WCC highlights the fact that an effective response to HIV and AIDS would entail the need for churches to reflect on a theology and ethics in the context of the epidemic. Furthermore, the WCC recommends that churches need to create social spaces in which a healing community can be developed that addresses issues pertaining to injustice and human rights violations (WCC 2004).

In *Acting in Hope*, Chitando (2007) challenges African churches to be “AIDS competent” by working towards the transformation of death-dealing practices such as burial services by strengthening life-enhancing preventative strategies, for instance, by promoting safer sex methods and gender equity. He argues that the quality of theological education and the ability to analyse cultural beliefs and practices critically in the context of HIV, determine the church’s response to HIV. Accordingly, Chitando calls for visionary leadership to review currently held beliefs and practices such as gender inequalities and patriarchal structures that act as obstacles that prevent theologians from responding to the epidemic effectively.

Parry (2008) posits that acknowledging the scope of the HIV epidemic and accepting that anyone within the church can contract the virus, is an essential prerequisite for the church to respond to HIV and AIDS competently. In order to achieve HIV competence, Parry suggests three key elements that should underpin the criteria for an effective response: leadership, knowledge and resources. With reference to “leadership,” Parry emphasises the importance of evident leadership at all levels to promote committed teamwork. The knowledge that she recommends needs to go beyond accurate and current information to include technical expertise and a broader understanding of the structural and social factors that shape or constrain behavioural change. Concerning resources, the church should maximise the use of existing resources that include financial, structural, human, spiritual, material and a wider range of partnerships (Parry 2008: 37-41). Parry declares that churches that have demonstrated a strong and committed leadership in HIV prevention, have achieved significant advances in their response to HIV.

Churches' central role in communities of a wide range of demographics, places them at a comparative advantage to secular organisations in terms of their ability to engage fully in HIV prevention among their constituencies (Eriksson, Lindmark, Axemo, Haddad & Ahlberg 2010). However, the fact that HIV transmission mainly occurs through sexual transmission poses a challenge in Southern Africa in terms of the traditional views of many churches that regard sex and sexuality as taboo topics.

This fact prevents many church leaders from delivering preventative messages in public (De Gruchy, in Haddad 2011; Haddad cited in Eriksson *et al* 2010; Olivier & Paterson in Haddad 2011). In a study of church leaders' HIV-prevention messages to young people in the Catholic Church, Lutheran Church and Assemblies of God congregations in South Africa, Eriksson *et al* (2010) identify three barriers to the involvement of church leaders in HIV prevention. The first barrier concerns dilemmas in breaking the silence on HIV and AIDS faced by church leaders due to a fear of being stigmatised by both the congregants and the hierarchy in an environment that lacks supportive policies. In describing the second barrier, "ambivalent HIV prevention messages from church leaders to young people", Eriksson *et al* (2010) highlight several issues pertaining to problematic messages. These messages include the concern that condom promotion might influence young people to be sexually active; talking about sex in public being regarded a taboo and the view that the onus is on parents to educate their children about issues of sex. The third barrier is the discrepancy regarding the assimilation of gender equality in HIV prevention messages. Church leaders associate violence against women with unemployment and advocate that teaching values and engaging boys in sport prevent gender-based violence.

Paterson (2009) asserts that for a long time churches have remained in their comfort zones where they did not have to confront the taboo on talking about sex and sexuality in public. Churches traditionally regard certain topics, such as sex and sexuality as taboo subjects, and hardly talk about gender inequality and the use of illicit drugs. Such subjects are deemed to be digressing from core Christian beliefs and the church's principal task of

preaching the gospel, which includes promoting sexual abstinence before marriage and faithfulness within marriage. Chin *et al.* (2005) conclude in their study that few church leaders are prepared to involve themselves in direct HIV prevention activities. With some exceptions, Chin *et al.* (2005) found that religious leaders' involvement in HIV and AIDS was weak, erratic and fragmented or inconsistent.

Kwitonda (2010), cites "communication and problematic integration of varying responsibilities" as characterising the plight of religious leaders and their expected roles in public health. Some of the ambivalent HIV prevention messages known to have positive and negative consequences include promotion of condoms. In this regard, Kwitonda highlights that being uncertain of the outcome of an action makes it difficult for church leaders to commit themselves to promoting comprehensive HIV prevention methods, as they believed that condom use would lead to committing adultery. This negative outcome would then be difficult for church leaders to reverse, hence their feelings of unease in promoting comprehensive HIV prevention methods.

Nürnbergger (2005) notes that the 2002 Plan of Action drawn up at a church leaders conference of the Lutheran Communion in Southern Africa (LUCSA) in June 2002 had not yet been implemented by the Lutheran Communion three years later. However, the evaluations of the LUCSA HIV and AIDS programme conducted in 2008 and 2012 showed that the 2002 Plan of Action has, indeed, been implemented by all the member churches although the response was at varying levels. These evaluations informed the review of the 2002 Plan of Action and the development of the 2008-2012 Strategic Plan and the 2013-2017 Strategic Plan that guided the LUCSA's response to HIV and AIDS (LUCSA 2008; LUCSA 2012; LWF 2013).

LUCSA is a voluntary non-profit fellowship of 15 autonomous and independently constituted Lutheran and Moravian Churches in 10 countries in Southern Africa, namely Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe (LUCSA Constitution 2007; LUCSA Constitution 2013; LUCSA Policy 2004; LUCSA

Policy 2010). The Lutheran population in this sub-region is approximately two million (LUCSA Policy 2010). The LUCSA Plan of Action aligns itself with the recommendations of the LUCSA workshop held in Bulawayo in May 2000, the commitments declared by the Pan-African Lutheran Church Leaders Conference on HIV and AIDS in Nairobi in May 2002 and the experiences in project implementation of the member churches (Nürnberg 2005).

The LUCSA Plan of Action aims to break the silence concerning talking about the sexual transmission of HIV to mitigate the impact of the epidemic. Nürnberg (2005:295) lists deep-seated deficiencies in spirituality and in church structures and functions that need attention. These include “problematic theological assumptions” that consider HIV and AIDS as punishments from God for sexual immorality and the view that issues of health and social responsibility lie with the state, not necessarily with the church whose mandate is only to preach the gospel. In addition, Nürnberg mentions the negative influence of some elements of culture such as taboos regarding sexual matters and the silence around superstitions, such as that sex with a virgin is a cure for HIV. Other factors include the fear of being stigmatised when church leaders become involved in HIV prevention, denial of possible HIV infection in families and congregations, ignorance of the impact of the pandemic on the life of the church and the secrecy around one’s HIV status due to the fear that disclosure might lead to discrimination. Nürnberg believes that addressing the deep-seated deficiencies discussed above will release the potential of the LUCSA communion to teach strong HIV prevention messages and contribute to a significant change in controlling the epidemic. However, Martin Luther both defended and limited the place and role of the church. For example, he stated that a person could not come to Christ without the church, but he also said that nothing in the universe, even unforeseen forces of evil, could deny an individual justification before God (Strasser 1999). Therefore, the church, as the body of Christ who healed the sick and reached out to the outcasts of the society, has a mandate to take an active role in HIV prevention to prevent suffering and not to leave the response to the epidemic to the government and other players alone.

A study by Agadjanian and Sen (2007) reveals that even though religious organisations may be involved in HIV prevention, their approach to HIV and AIDS usually works against their efforts. This is because FBOs tend to advocate pre-marital sexual abstinence and marital sexual fidelity as opposed to the secular approach, which encourages safer sex. Moreover, some religious leaders in Africa openly preach that HIV and AIDS are a punishment from God for sexual sins and that the use of condoms encourages promiscuity.

In the face of such critical views regarding the role of the church and its traditions in HIV prevention, some researchers and church authorities have defended the approach taken by churches in their responses to the epidemic. In an address at a Vatican meeting called “The Centrality of the Care for the Person in the Prevention and Treatment of Illnesses Caused by HIV/AIDS,” in Geneva in 2011, the Catholic Archbishop Tomas of the Holy See’s permanent observer at the United Nations defended the HIV prevention strategies promoted by the church (Vatican 2011). The Archbishop cited the research by Edward C Green that supported the Catholic approach and demonstrated that promotion of a more responsible sexual relationship approach required more than condom promotion to reduce new HIV infections. He explained that teachings on the dignity of the human person, the sanctity of marriage and sexual abstinence outside marriage and mutual and permanent fidelity within marriage led to false claims that the Catholic Church was not only an obstacle to effective HIV prevention, but was also responsible for the AIDS deaths of millions of people. Opposed to the promotion and distribution of condoms that he regards as “an incomplete ‘quick-fix’ HIV prevention approach”, he affirmed the commitment of the church to promote a “completely meaningful lifestyle for the person”, whether or not the person is living with HIV. The Archbishop declared that the church had engaged in advocacy actively to promote the dignity of persons living with HIV by eliminating discrimination against them and supporting their access to services. Furthermore, the advocacy roles of the church included: “advocating for a strong and continuing governmental commitment to the HIV response; monitoring of the processes promoting flexibility in the application of intellectual property rights and promotion of

universal access to HIV prevention, treatment, care and support of the infected and affected” (Vatican City 2011).

Not all scholars agree that church leaders have been actively involved in HIV prevention; there is general acknowledgement that the level to which they respond to it and the ways in which they deliver their prevention messages, vary widely across denominations (Eriksson 2011).

Assessing the attitudes of church leaders regarding taking leadership roles in HIV prevention has great value in mobilising them in the drive to realising the renewed HIV and AIDS Campaign of the Ecumenical Advocacy Alliance 2009-2012 (EAA 2009; EAA 2011). The Ecumenical Advocacy Alliance is “a global network of churches, church-related agencies and Christian organisations” that aims to strengthen the churches’ advocacy efforts in selected priority areas, namely, HIV and AIDS, global trade and food security (EAA 2009). Concerning support for the new targets set by the United Nations General Assembly (UNGASS) at its high-level meeting on HIV and AIDS in June 2011 in New York, the EAA members committed themselves to strengthening their advocacy role. The EAA intends to focus on overcoming all stigmatisation and discrimination, to mobilising resources and promoting accountability to enhance universal access to prevention, treatment, care and support by 2015 (EAA 2011). However, the EAA expressed concern that “the New York UNGASS Declaration (2011) did not prioritise behavioural changes related to HIV prevention, the needs of infants and children already living with HIV, treatment as a form of prevention and the funding gaps” (EAA 2011). The 2015 targets of the New York UNGASS Declaration (2011) include providing access to treatment to 15 million people, reducing the number of TB deaths among persons living with HIV by 50% and ending vertical transmission in which there will be zero transmission from mother-to-child.

2.5 THE CHURCH AND ITS ROLE IN PROVIDING SERVICES TO PEOPLE LIVING WITH HIV (PLHIV)

Most mainstream churches (Anglican, Roman Catholic, Methodist and

Lutheran Churches respectively) set up mission stations, schools, hospitals and clinics in Southern African countries to provide spiritual guidance, health care and education to their followers in the areas in which they operate (Evangelical Lutheran Church in Germany 2007). Currently, in this HIV and AIDS era, people expect churches to continue the important role of nurturing body and soul as their networks and infrastructure are widespread in many communities as well as in poor areas where government services are limited.

A study by the Evangelical Lutheran Church in Germany (2007) highlights that families as well as public and private institutions feel the impact of the AIDS through increasing illnesses, death, orphans, increased dependency and overburdened health care and social services. In addition, parishes are experiencing an increasing number of orphaned and vulnerable children as well as the chronically ill who need care. Furthermore, “the clergy have the additional burden of providing pastoral care and counselling to PLHIV and those affected, and of conducting the funerals of their church members lost to AIDS-related illnesses” (Evangelical Lutheran Church in Germany 2007).

Pastoral care and counselling, in addition to other care and support services, have become integral parts of the church’s response to the impacts of HIV and AIDS. Pastoral counselling focuses on spiritually-based counselling of individuals and families who are experiencing a crisis, such as, grief, injury or illness and it integrates psychological and spiritual health without imposing the beliefs of the counsellor on the client (Leshota 2011). Pastoral counselling therefore moves beyond the support and encouragement offered by faith-based communities and standard counselling as it weaves religion or spiritual needs into psychological therapy (Leshota 2011). Thus, the church plays a key role in minimising vulnerability to the impact of AIDS by becoming a healing community towards individuals and families affected by HIV and AIDS who face rejection, stigmatisation and death. By accepting, loving and supporting the affected, church members extend a hand of healing that manifests into self-value.

Religious institutions are an integral part of society in most African countries

because of the many services they offer, including educational support for orphans and vulnerable children, home-based care services, spiritual counselling and material support to mitigate the impacts of HIV and AIDS on affected families (Mukuka & Slonim-Nevo 2006).

However, despite this advantageous position held by religious institutions, their activities in HIV prevention are inadequate. Masika (2008) contends that in Malawi, religious leaders of the Baptist Church provide little education regarding HIV and AIDS to church members. The study contends that messages on HIV and AIDS are infrequent and often unplanned with no sermons or programmes devoted to this topic; instead, they are rather mentioned in passing during church services. The two topics that the church leaders tend to emphasise are abstinence and marital fidelity. Some researchers highlight the big gap in the role of the church leaders in terms of preventing HIV citing the lack of in-depth discussions and ambivalence regarding prevention measures concerning the preferred abstinence and faithfulness topics (Eriksson *et al* 2010; Trinitapoli 2006).

However, the potential of faith-based institutions as key stakeholders who could confront the challenges of HIV and AIDS is recognised and supported by many including governments, UNAIDS, the World Health Organisation (Anozie 2011: Van Deutekom 2007). Enhancing the church's role and its involvement in HIV prevention is critical in terms of influencing people's sexual behaviour and related decisions (Van Deutekom 2007:82).

A study in Zambia by Mukuka and Slonim-Nevo (2006) and another study on the Chinese and South Asian immigrants in New York City by Chin *et al* (2005) confirm that church leadership could actively engage in HIV prevention. The HIV prevention activities that religious institutions could pursue are, for example, the promotion of community norms to enhance HIV prevention and reduce stigma, develop partnerships for teamwork (Chin *et al* 2005) and promote condom use among married and unmarried adolescents and adults (Mukuka & Slonim-Nevo 2006). Church leaders not able to carry out direct HIV prevention activities, could create opportunities for their

members to discuss and challenge negative attitudes towards HIV and those affected by it (Campbell *et al* 2011).

On the other hand, whether the church's role in HIV prevention is positive, is debatable. In a study by Van Dyk and Van Dyk (2007), the researchers ask the question, "Does the church deliver?" Given the high prevalence of HIV globally, the church and church organisations could invariably play a pivotal role in its prevention. They have amongst their parishioners, people infected with and affected by the HI-virus. However, whether the role they play is positive or not, is also open to debate. These authors cite the positive roles the church plays through its teachings of love and care with regard to comforting others and fostering emotional strength and these offer a healing atmosphere for PLHIV. In addition, the Christian values of loving, care and acceptance help with developing positive attitudes concerning accepting the illness, reducing self-blame, enhancing self-acceptance and ultimately, have positive effects on health among PLHIV.

Unfortunately, certain negative aspects outweigh the positive ones. In this regard, many people living with HIV perceive the church to be unsupportive of the work in the response to AIDS epidemics and as being indifferent or outright negative in this regard (Hartwig, Kissioki & Hartwig, cited in Van Dyk & Van Dyk 2007). Negative attitudes, which persist among many people (for example, in South Africa) include the view that the church will condemn PLHIV because HIV continues to be associated with immoral and sinful behaviour (Van Dyk & Van Dyk 2007). Campbell *et al* (2011) have found that "framing HIV and AIDS" in the light of immorality and sin, limits the ability of many church groups to develop a constructive and less stigmatising understanding of, and responses to, HIV and AIDS. Link and Phelan in Parker and Birdsall (2005:5) define stigma as a process that "involves the social expression of negative attitudes and beliefs that contribute to processes of rejection, isolation, marginalisation and harm of others." Stigma may occur at an individual level based on understanding of oneself in relation to others.

In most African countries, religious organisations form part of an influential

social network. As such, they can promote or obstruct HIV prevention education. In a study undertaken by Zou *et al* (2009) in Tanzania, the researchers find shame-related HIV and AIDS stigma to be closely associated with religious beliefs amongst Catholic, Lutheran and Pentecostal church groups. Part of the major obstacle to a successful prevention drive relates to the perceived sexual immorality and promiscuity associated with the sexual mode of HIV transmission, as well as to a fear of acquiring HIV through casual contact with PLHIV, which automatically leads to the stigmatisation of those living with the virus or AIDS-related disease (Zou *et al* 2009). Shame-related stigma, which is closely linked to self-directed stigmatisation, can impact negatively on those members of the congregation affected to such an extent that they may tend to withdraw from church gatherings and the community for fear of blame (Deribe *et al*, Hutchinson *et al*, Medley *et al* in Zou *et al* 2009). Maluleke in Dube (2003) notes the importance of exploring the theological significance of HIV and AIDS. He asserts that development of an HIV and AIDS sensitive curriculum for pastoral training should address issues, such as, stigma, taboos related to communicating issues of sexuality in order to challenge the “inherited visions of theological education.” Maluleke recognises the role that the church plays in the lives of its followers. Consequently, the church needs to remodel its theologies to enable it to deal with the new challenges posed by HIV and AIDS.

In general, speaking about sexual matters, both in the church and in many cultures, is taboo (Paterson 2009). This influences the attitudes of the clergy regarding HIV prevention, since speaking about HIV prevention invariably leads directly to a discussion of sexual behaviour. However, HIV prevention in a church differs from place to place. The LUCSA 2008 Evaluation Report of its AIDS Action programme for the end of phase two (2006 to 2008) reveals that of the 10 HIV and AIDS focus areas that are prioritised in the LUCSA 2008-2012 strategic plan, none of the 8 countries had addressed all the response areas at church level. The countries included in the 2008 evaluation are Angola, Botswana, Malawi, Mozambique, Namibia, South Africa, Swaziland and Zambia. Zimbabwe was evaluated separately and later in 2009, due to elections in 2008 and the unstable political situation. The response areas

prioritised in the LUCSA 2008-2012 strategic plan include:

- Information, education and communication (IEC)
- Voluntary counselling and testing (VCT)
- Antiretroviral (ARV) treatment
- Referral to ARV services
- Treatment literacy programmes for people living with HIV
- Orphan and vulnerable children (OVC) projects
- Home-based care (HBC) programmes
- Legal and social support for vulnerable groups (other than OVC)
- Clinical pastoral care and counselling (CPCC)
- Youth peer education

Namibia and Malawi implemented the greatest number of programmes, that is, six and seven, respectively, out of the 10 focus areas stated above (LUCSA 2008). The most commonly implemented programmes were orphaned and vulnerable children (OVC) projects in 8 out of 16 (50%) member churches/Dioceses; home-based care (HBC) in 7 (44%); peer education in 5 (31%) and IEC in 4 (25%) churches (LUCSA 2008). The low level of implementation of prevention programmes by the Lutheran churches/dioceses as reported in the 2008 LUCSA Evaluation Report, points towards the limited discussions and activities on HIV prevention amongst churchgoers.

On the other hand, the LUCSA 2008 Evaluation Report indicates that in some churches and dioceses, pastors preach more regularly about this topic and have even established HIV and AIDS programmes that have expanded their sources of funding to implement activities focusing mainly on care and support of vulnerable groups, while a few activities focus on prevention as highlighted above. The funding sources indicated by churches/dioceses in Malawi, Namibia, and South Africa included the United Evangelical Mission, USAID, Bread for the World, PACT as well as Department of Health in South Africa (LUCSA 2008). However, in most cases, the clergy tend to leave HIV prevention education to the personnel appointed to coordinate these

programmes. The clergy and church leaders do not appear to play a strong role in HIV prevention, as their actual involvement in such programmes is limited.

Furthermore, pastors and other church leaders are also vulnerable to HIV infection. The existence of the International Network of Religious Leaders Infected or Personally Affected with HIV/AIDS (INERELA+) organisation is proof of the extent to which religious leaders are susceptible to HIV. It is clear that HIV prevention is “everyone’s problem”. Africa needs religious leaders who will transform the silent and condemnatory approach to HIV and AIDS to an open engagement with their parishioners on HIV education for prevention and elimination of stigmatisation and injustices against PLHIV (Hood 2006). Clifford (quoted in Hood 2006) recommends that, “the church must make its voice heard in order to change the structures that are assisting the spread of HIV. Most crucially, this means working to alleviate poverty by advocating for change”.

In spite of the efforts to highlight the important role of the church in dealing with HIV and AIDS, there is limited information about church leaders’ attitudes regarding their role in HIV prevention and barriers to their active involvement in controlling the epidemic. The African Religious Health Assets Programme (ARHAP)’s literature review acknowledges that there is a lack of information on religion and HIV/AIDS that explains the clergy’s motivations, commitments, attitudes, actions and relational or associational strengths based on their own self-understanding and world-views (Olivier, Cochrane, Schmidt & Graham 2006). It is essential for policy makers who want to maximise the involvement of faith-based institutions in HIV prevention to take the factors fully into account that might be a barrier to their active engagement.

2.6 THE LEADERSHIP ROLES OF CHURCHES REGARDING HIV AND AIDS

An increasing amount of support (financial and otherwise) for churches so that

they can respond to the AIDS epidemics, has resulted in a considerable amount of controversy with regard to the inconsistencies of HIV prevention messages among churches. In their *ARHAP literature review: Working in a bounded field of unknowing*, Olivier et al (2006:50) summarise the debates and interpretations concerning the issues surrounding religion and sexual health matters, by stating that:

The literature consistently argues back and forth – that religiosity prevents risky behaviour, and that it engenders risky behaviour; that abstinence works and that the focus on abstinence is harmful; that religious leaders should talk about sex, and that they cannot; that preaching is a moralizing process that leads to stigma, and that it is education leading to healthy behaviour change. A veritable storm of controversy rages over the use of condoms, especially in Catholic and some Muslim contexts - which have been recently renewed in the light of PEPFAR funding associations.

On the one hand, critics of religious groups and their responses to HIV and AIDS applaud churches for their positive contributions to mitigate the impacts of the epidemic, but there is still an ongoing debate in the literature regarding the leadership roles of churches with regard to HIV-prevention strategies. These on-going debates about the response of religious groups to the AIDS epidemic require a better understanding of church leaders' attitudes towards their leadership roles in HIV prevention. Studies that allow church groups to explore "the interaction between basic theological values, a sober view of [the HIV] reality and the often profound effect that the church has on people through its word and deeds" (Evangelical Church in Germany 2007:41) might help with developing strategies to mobilise a strong leadership response by churches to the AIDS epidemics.

Where there is a strong and committed leadership in HIV prevention, there has been significant advances in the response to HIV (Agadjanian & Menjivar 2008; Parry 2008). In Uganda, as stated by Hogle in Muturi (2008), the ABC (abstinence, being faithful and condom use) approach adopted by some major religious organisations in collaboration with the government as the country's main HIV prevention strategy, has been instrumental in the decline of HIV

prevalence in pregnant women from 21.1% to 6.1% between 1991 and 2000. Notwithstanding, people continue to perceive FBOs to be in opposition to the use of prevention measures such as condom use and sexuality education. As discussed earlier, many people regard conservative approaches to condom use and sexuality education propagated by Christian churches, notably the declarations and statements against condom use issued by the Roman Catholic Church, as obstructive to HIV prevention and as labelling people living with HIV as immoral sinners. Moreover, accusations against FBOs continue to hold them responsible for fuelling AIDS-related stigma and the discrimination attached to it. In this regard, HIV-related stigma might continue to be an obstacle to releasing the potential of the churches to shape social norms, beliefs, attitudes and people's realities concerning sexual self-understanding (Muturi 2008).

However, Muturi's study reveals that regardless of the negative view of the public towards the church's position on HIV and AIDS, people still believe that religious leaders are responsible for communicating with the public about important societal issues such as the risky types of behaviour contributing to HIV infection. Nevertheless, church leaders themselves do acknowledge the importance of their involvement because of their social influence as trusted and credible sources of information (Muturi 2008). However, the argument put across regarding the influence of some churches on sexual behaviour is that since the church preaches abstinence and fidelity, condom use in such relationships is not necessary since mutual fidelity presents no risk of the sexual transmission of HIV. This argument points towards a paradigm shift to move away from blaming churches for failures in controlling the spread of HIV. Rather, the focus should be on making a concerted effort, within both the secular world and religious circles, to maximise their comparative advantages to curb the spread of HIV competently.

The worldwide call by many governments for the increased involvement of faith-based communities in HIV-related activities has enhanced the opportunity for religious groups to take up an active role in HIV prevention (AIDS Action in Chin *et al* 2005). In the United States of America, a study

conducted by Chin *et al* (2005) confirms that on the basis of the church leaders' influence on Chinese and Asian immigrants' lives in New York City and their substantial roles in issues related to culture, morals and social relations, FBOs could shape social understanding of HIV issues. To allow this to happen, Chin *et al* (2005) recommend that religious institutions take up a leadership role in changing norms about discussing HIV and AIDS-related issues, as the study has found that fewer leaders were involved in direct HIV prevention activities, while more were involved with increasing basic awareness (Chin *et al* 2005). A study by the Evangelical Lutheran Church in Germany (2007:25) in Eastern Europe and Africa, takes its recommendation for effective HIV prevention further by urging partner churches "to shift from programmes of general preventive information toward programmes that enable each individual to translate various elements of the ABC prevention principles into a change of behaviour."

The Evangelical Lutheran Church in Germany (2007) calls on its partner churches to become active in HIV and AIDS advocacy work by lobbying governments and other sponsors to provide the required resources for improved access to prevention, care and treatment services. The strength of the community of churches, their agencies and membership in advocacy work and response to the epidemic resides in the developed networks of the churches around the world. The active involvement of the church community, locally and globally, in HIV and AIDS care and support activities forms the basis of its strength for responding to the epidemic. In addition, the strength of church communities comes from the infrastructure (church-owned schools, hospitals, clinics) as well as the respect and trust of their constituents. Parry (2003) also considers the moral and ethical competence for positive social change as playing a crucial role in influencing the social perception of communities on HIV prevention. The context described above, identifies church communities as critical players in the response to the epidemic and as having great potential in bringing about significant change in preventing the spread of HIV.

Zimbabwe, officially regarded as a Christian country, has seen the

proliferation of all types of Christian churches, especially after the attainment of majority rule in 1980. There are two basic types of churches, mainly the old mission type and the new, popular spiritual type. In a study conducted in two rural areas in the Manicaland Province of Zimbabwe, Gregson *et al* (1999) reveal that infant mortality is higher among communities within the mission type churches than the spiritual type. They assert that restrictive norms on alcohol consumption and extra-marital relationships in the latter type of churches possibly limit the spread of HIV and therefore reduce its impact on infant mortality due to AIDS-related illnesses, despite both of these types of churches discouraging pre-marital and extra-marital sex. They report the clergy or “prophets” in the spiritual type church claim to use guidance from the Holy Spirit to determine whether a member of their congregation has sinned or not. Gregson *et al* (1999) conclude that this, therefore, made church members follow church teachings faithfully and avoid pre- and extra-marital sexual activities, resulting in a lower risk of contracting HIV infection and consequently, of vertical HIV transmission.

These studies indicate that churches have the potential to influence the behaviour of their members. Little documentation exists on the impact of church leadership and their perceptions on prevention efforts. There is speculation that leadership attitudes and perceptions do hamper efforts to promote HIV prevention. The question can, therefore, be asked: what leadership roles are Lutheran church leaders playing to prevent the spread of HIV in their communities?

2. 7 BACKGROUND TO THE LUTHERAN CHURCH

Understanding the beliefs of the Lutheran church helps to gain insight into some of the norms that support the structure and identity of the institution. This section of the literature review does not attempt to discuss all the teachings of Lutheranism, but rather to highlight some aspects of the Lutheran doctrine pertaining to humanity.

According to Lutheran theology, the church is a group of believers who are simultaneously both “saints and sinners” (*simil iustus et peccator*) (Paulson 2004:187-193; Schramm 1946). This comes from the Bible’s story of the creation and the fall of Adam and Eve, which highlights the sinning of humans against God. The way to a new life paved for us all is through the death and resurrection of Jesus Christ and by His grace that saves us from our guilt. Martin Luther speaks of the church as the community of love, where all believers/saints are to serve others with Christ as the head that holds this common body together. As believers, Althaus (cited in Strasser 1999), translates Martin Luther’s phrase “communion of saints” to mean “sharing of goods among the believers, the giving and receiving of the members to and from each other, the becoming one with all others, and working for one another.”

The Lutherans’ view of humanity, therefore, are closely linked to responsibility and love, thereby raising fundamental ethical issues about how we behave towards each other. The Church of Sweden (2007) stresses that since the main mode of transmission of HIV is through sexual relations; it raises three main issues to which Churches should pay attention. Firstly, they must address issues pertaining to the body and sexuality, as our bodies are part of both our individual and social identity. In this regard, it is necessary to curtail further infections by educating the public regarding how to protect themselves and others against HIV transmission. The second issue regarding HIV raises concerns about solidarity and equality. This pertains to the need for combating discrimination, stigmatisation and denial of access to resources for effective responding to the HIV and AIDS pandemic. Thirdly, HIV raises a question about what makes life meaningful and in this regard, churches must help people find a way of continuing to live a life full of meaning and importance even when one faces a life-threatening illness.

The Evangelical Lutheran Church in Zimbabwe (ELCZ), founded through the activities of the Lutheran Church of Sweden Mission in 1903, became a member of the Lutheran World Federation in 1963 (ELCZ, 2008:1). The ELCZ initially concentrated mainly on the Mberengwa, Gwanda and Beitbridge

districts in the Midlands and the Matabeleland Provinces of Zimbabwe, where it was mainly situated in mission stations, but has now also spread throughout the country (ELCZ 2008:1). The church comprises three dioceses, namely, the Eastern, Central and Western Dioceses.

Under the section “General Aim of the Church” in the ELCZ Constitution (2009), it is stated that the foundation of the ELCZ is “the faith and doctrine,” which is built on the Lord Jesus Christ (ELCZ 2009). The Lutheran church disseminates its faith and doctrine through the teaching and preaching of the Word of God (the Bible), through healing and through the administration of the Sacraments, namely the Holy Baptism and Holy Communion. Furthermore, the church takes care of the sick and the suffering and endeavours to emulate the ministry of Jesus that sought for healing in wholeness, bringing about the integration of the religious and the societal outcasts and those facing discrimination. Such acts by the church communicate teachings of love and care that have the potential to increase positive support of PLHIV, reduce the HIV-related stigma and allow for effective HIV prevention efforts.

Importantly, the ELCZ constructed four mission stations with schools, hospitals and clinics to minister to their followers. Thus, the church has played three key roles that place it in a favourable position to respond to the challenges of the HIV epidemic. The first is the role of the Lutherans in ministering to the community. In this regard, the church has also been active in the new resettlement areas where people have relocated to build new homes in search of fertile lands, such as, in Bururwe in the Midlands Province of Zimbabwe (ELCZ 2008). As the church expands its coverage, it creates an opportunity for the church to use its potential influence in HIV prevention and to protect the rights and actively promote the well-being of the vulnerable groups such as women and children.

Secondly, regarding the role of the Lutherans as educators, the ELCZ has built 12 primary, secondary and high schools as well as Bible schools in which they train church leaders. In addition, they have built nursing schools for nursing assistants (ELCZ 2008) who are currently responsible for HIV

prevention and treatment follow-up. Furthermore, the ELCZ has promoted human development through education and shaped the values of many young people and communities. Formal education institutions give the church opportunities to help young people gain a good understanding of the risks of HIV infection and how they can protect themselves, shape opinions and promote issues of human dignity and justice among the clergy and health care providers.

Thirdly, concerning the role of the Lutherans with regard to health services, all four of the rural mission hospitals run by the ELCZ have become part of the national ART rollout points offering treatment and support systems to PLHIV (ELCZ, 2008). The church continues to be responsible for a large proportion of work carried out at its hospitals and clinics, including the treatment and prevention of HIV. Health professionals, among who are nurses trained at the ELCZ School of Nursing, carry out this work. Since the church leadership is responsible for the planning and implementation of its schools' programmes, which include Bible and nursing schools, it can be expected that the church leadership will be at the forefront of HIV prevention. The health interventions include community-based programmes, such as home-based care, giving educational support to orphans and the provision of material and nutritional support to the infected and their families.

The declaration by the Lutheran Communion in Southern Africa that "the body of Christ is HIV+", which refers to an understanding that when one part of the body is affected all parts are affected, is a theological motivation for churches to be involved in the response to HIV and AIDS. Myaka (2011) reviews the theological principle of one's response to HIV epidemic to that undergirding Martin Luther's response of not fleeing from the bubonic plague. This understanding further compels and enables churches to break the silence surrounding HIV and declare solidarity with persons living with HIV (LUCSA 2004; LUCSA 2010; Myaka 2011). In this context, it should be easier for churches to accept that HIV could also be spreading amongst church members and thus to prioritise HIV prevention.

By concentrating on rural areas, building churches, hospitals and schools, ELCZ has brought dignity and honour to the African population in the rural areas and has enabled them to stand up to the ravages of HIV and to restore the dignity and value of human life. Furthermore, the LUCSA Policy on HIV and AIDS states that the church “will support the use of scientifically-proven effective prevention measures, such as the appropriate use of condoms” (LUCSA 2010:6). Considering the background of the Lutheran Church, particularly, in Southern Africa, there appears to be no basis for the Lutheran beliefs and its practices to preclude HIV prevention by its leadership. On the contrary, the Lutheran church has all the credentials it needs to deal with HIV prevention.

Based on the beliefs set out above, Lutheran church leaders are called to fully realise the importance of their role in speaking out about the spread and prevention of HIV infection and the right to receive treatment and care. In collaboration with other relevant stakeholders, the Lutherans have the platform to strengthen the arguments for fighting poverty perceived to be a cause and effect of the AIDS epidemics (Church of Sweden, 2007).

2.8 CONCEPTUAL AND THEORETICAL FRAMEWORK

The conceptual framework provided by the theory of reasoned action was used to guide this study.

This study examined contributing factors in terms of the theory of reasoned action as reviewed by Montano and Kasprzyk (quoted in Glanz *et al* 2008). The theory states that behavioural intentions determine the choice of performing or not performing a particular behaviour. The theory further asserts that the most important determinants of behavioural intention are **attitudes** prior to performing the behaviour, as well as subjective norms. According to this theory, attitudes are determined by the individual’s beliefs, weighted by the evaluation of behavioural outcomes. One of the aims of this study was to describe the attitudes and subjective norms of church leaders regarding their perceived leadership roles in HIV prevention.

The researcher hoped that understanding church leaders' attitudes to HIV prevention would highlight some of the key issues regarding their motivation to assume a leadership role in HIV prevention.

2. 8.1 The theory of reasoned action (TRA)

Dillard and Pfau (2000: 259-286), citing Hale *et al*, state that the theory of reasoned action (TRA) explains behaviour as a function of behavioural intention, subjective norms and attitudes. The TRA states that behaviour involves a conscious decision, which is behavioural intention, on the part of the actor even in the absence of cooperation with others, thereby making the behaviour voluntary. Fishbein and Ajzen (quoted in Terry *et al* 1993: 8) assert that behavioural intention predicts the actual behaviour of people. There are two determinants of behavioural intention, namely, attitude toward the behaviour and subjective norms (see figure 5).

People's attitudes toward behaviour are derived from measures of their perceived beliefs regarding the consequences of performing a given behaviour (behavioural belief) compared with the value placed on each of the consequences, (outcome of behavioural evaluations) (Bohner & Wänke 2002:233; Terry *et al* 1993:8). These expectations could be either positive or negative. Behavioural beliefs, accumulated over a lifetime, make up attitudes that in turn influence behaviour in a motivational manner. In addition, behavioural belief is the trust that one has in performing a particular behaviour that will lead to a specific effect. Evaluation of the outcome is one's assessment of that specific consequence.

Subjective norms, as described by Fishbein and Ajzen (quoted in Bohner & Wänke 2002:234; Glanz *et al* 2002; Glanz *et al* 2008; Terry *et al* 1993) refer to individuals' perceptions of external pressure on them to perform a given behaviour (normative beliefs), and the person's motivation to comply with that pressure (motivation to comply). Subjective norms are derived from measures of beliefs about the preferences of significant others and the individual's

motivation to comply with their wishes.

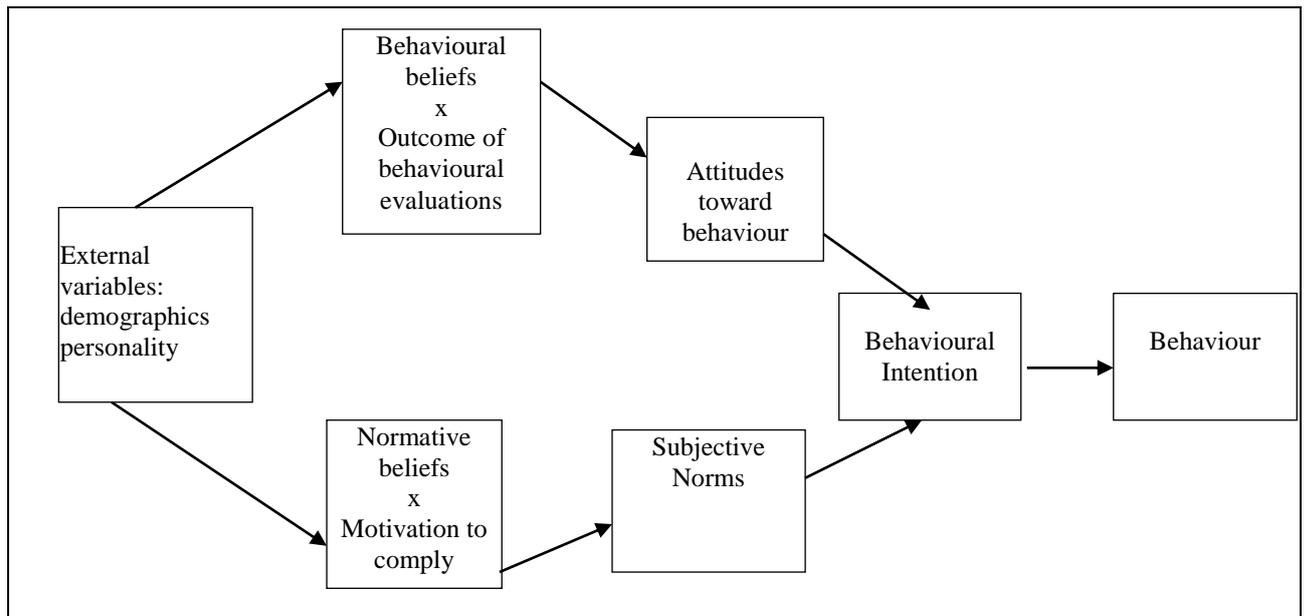


Figure 5: Representation of the theory of reasoned action (Adapted from Terry *et al* 1993: 9).

2. 8.1.1 The determinants of attitude and subjective norms

A person's attitude towards behaviour is influenced by his or her beliefs about the consequences, that is, the costs and benefits of performing behaviour. Normative beliefs are considered to reflect a person's judgment about whether other people, such as a family member or a friend, would think it to be a good idea to perform the behaviour.

2. 8.1.2 Application of the theory of reasoned action to HIV Prevention

Fishbein and Middlestadt (quoted in Terry *et al* 1993:44) recommend targeting specific populations for effective behavioural research and interventions. They advise researchers to examine the target population's salient beliefs (both behavioural and normative) about the behaviour of interest by conducting an elicitation study.

In applying the TRA, Glanz *et al* (2008:82) point out that it is critical to conduct

open-ended elicitation interviews to identify the relevant behavioural outcomes and referents for each particular behaviour and population under study. In this study, a small sample of not more than 20 individuals from a similar population of church leaders under study, of whom about half have performed or intended to perform the behaviour under study and half of whom have not performed the behaviour under study were selected for “elicitation interviews”. In the case of this study the behaviours under study were, *talking about the sexual risk of HIV transmission* and *giving advice about HIV prevention*. Accordingly, the participants were asked to provide two types of information. Firstly, the participants were asked to describe any positive or negative attributes or outcomes of performing the behaviours under study. Secondly, the participants were requested to describe any individuals or groups to whom they might listen, who either were in favour of or opposed to their performing the behaviour. After that, the data were analysed and used to identify the relevant attributes or outcomes of the behaviour and the relevant social referents. From this analysis, the main questionnaire was developed. The methodology of this study is discussed in more detail in Chapter 3.

2.9 CONCLUSION

Chapter 2 gave a review of the literature concerning HIV and AIDS prevalence and drivers of the epidemic in sub-Saharan Africa, HIV and AIDS education and prevention programmes, the role of churches in this regard and the national behavioural change strategies adopted by the Lutheran Communion in Southern Africa, inclusive of the Lutheran Church in Zimbabwe. In addition, the focus areas for responses to AIDS epidemics and the role of the faith-based organisations in HIV prevention were also highlighted. Lastly, this chapter concluded with a description of the theoretical constructs upon which the study is based.

The next chapter describes the methodology of the study in detail.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 INTRODUCTION

This study investigated the attitudes towards and perceptions of Lutheran church leaders regarding their roles in HIV prevention among church members. The study was conducted in the northern and southern Deaneries in the Western Diocese of the Evangelical Lutheran Church in Zimbabwe (ELCZ). As stated previously, the ELCZ-Western Diocese operates in three of the provinces of Zimbabwe, namely, Bulawayo, Matabeleland North and Matabeleland South.

To guide the investigation of church leaders' beliefs about and their contributions to HIV prevention, the researcher utilised the priorities established in the Zimbabwean national strategic plans, the Lutheran World Federation Action Plan and the Lutheran Communion in Southern Africa (LUCSA) Strategic Plan 2008-2012, as was stated in Chapter 1 of this dissertation (sections 1.2.2 and 1.2.4). The National AIDS Council (NAC) developed the Zimbabwean national documents, namely, the *National Behaviour Change Strategic Plan (NBCS) 2006–2010* and the *National HIV and AIDS Strategic Plan (ZNSP) II 2011–2015*. The Pan-African Lutheran church leaders developed the *Lutheran World Federation (LWF) Action Plan* in Nairobi in 2002 to support effective HIV prevention measures. The Lutheran Communion in Southern Africa developed the LUCSA Strategic Plans 2008-2012 and 2013-2017 to facilitate implementation of the commitment to respond to the AIDS epidemic. The Action and Strategic Plans mentioned above encourage a quantitative increase in leadership that commit themselves to creating a conducive environment for the implementation of HIV and AIDS policies. The aims are to break the silence surrounding HIV and AIDS; reduce the risk of acquiring HIV infections; support effective preventive measures that can save lives; reduce stigma associated with HIV and, promote impact mitigation by providing care, treatment and support to those affected.

This chapter describes the four fieldwork phases of this study, which were guided by the theory of reasoned action, namely, (1) the belief elicitation phase, (2) questionnaire development, (3) pilot study and (4) the main survey. The main survey, which employed a quantitative approach, was developed to measure the attitudes of church leaders towards their perceived leadership roles in HIV prevention. The results of the qualitative elicitation interviews informed the design of the questionnaire used in the survey. Furthermore, the research design, sampling design and procedures, measurement of variables, data collection procedures, data analysis and ethical considerations are also described in this chapter.

3.2 RESEARCH APPROACH

The research approach for this study included both qualitative and quantitative research methods.

A qualitative approach is a strategy of inquiry that allows a researcher to develop an initial understanding of a problem by going deeper into issues of interest and explore details related to the problem investigated (Bless, Higson-Smith & Kagee 2008:44). The main aim of qualitative methods is to give an in-depth description of an event or scenario as understood and interpreted by the research participants. The researcher employed a qualitative research method to elicit information – referred to here as “elicitation focus group discussions” - about the behavioural, normative and control beliefs held by church leaders concerning their leadership roles in HIV prevention. In this regard, focus group discussions were used to gain a first-hand understanding of participants’ accounts of their leadership roles in HIV prevention. The use of qualitative methods for the elicitation focus group discussions was an essential step to identify beliefs that are specific to particular behaviours of a population under investigation (Fisbbein in Glanz et al 2008). The information gathered through the elicitation focus group discussions allowed the researcher to develop survey questionnaire items that would specifically be relevant to the church leaders who were the focus of this study, rather than

solely adopting items that are available in the literature. The use of qualitative data collection methods (in this case, focus group discussions) aided the construction of scales to measure church leaders' beliefs about outcomes, sources of normative influence and barriers with respect to talking about HIV prevention to their parishioners.

As stated above, the main study used a quantitative research method. For the main study, the researcher employed a self-administered questionnaire as a quantitative data-collection method to examine church leaders' attitudes about their perceived leadership roles in HIV prevention. In the case of quantitative methods, researchers classify and count features and construct statistical models in an attempt to explain the problem at hand (De Vos, Strydom, Fouche & Delport 2005). Quantitative research aims to provide an explanation or description of a problem in numbers or quantities (Babbie 2007; Punch 2005).

By combining qualitative and quantitative research methods, the researcher employed triangulation to capitalise on the strength of the two approaches (Punch 2005). The concept of triangulation refers to a methodological strategy that uses more than one source of information and different data gathering methods to improve the accuracy of results or to allow for the emergence of new or deeper dimensions of a social phenomenon under study (Punch 2005). In the case of this study, focus group discussions were conducted with church leaders to inform the scale construction of the questionnaire items in order to measure their attitudes towards their perceived leadership roles in HIV prevention. Thus, the qualitative method facilitated the use of the quantitative research method for the main study in that information from focus group discussions provided the content for the questionnaire. According to Ajzen (2006), the utilisation of the results of elicitation focus group discussions facilitate the development of relevant measures of behavioural, normative and control beliefs so that the questions posed in the questionnaire resonate with the issues raised by the focus group discussion participants.

3. 3 RESEARCH DESIGN

As stated above, this study was designed to gather information through focus group discussions and questionnaires on some of the main beliefs regarding church leaders' attitudes towards their leadership roles in HIV prevention. The identification of these specific beliefs could help inform the design of subsequent initiatives that aim to increase the involvement of church leaders in promoting HIV prevention.

Punch (2005) describes a research design as the plan and structure used to provide credible answers to research questions and states that it includes “a strategy, conceptual framework, the question who or what will be studied and the tools for collecting and analysing empirical materials.” Non-experimental research designs allow researchers to describe existing characteristics at the time of the study, such as attitudes or relationships. A cross-sectional survey enables the collection of information from one or more groups at the same time (Babbie 2007).

As mentioned above in section 3.1, the fieldwork for this study was conducted in four phases, with the main study employing a quantitative non-experimental, descriptive design that used a cross-sectional survey for data collection (Glanz *et al* 2008).

These four phases will be discussed in detail below.

3.3.1 Phase 1: Belief elicitation

3.3.1.1 Objective

The objective of this phase was to elicit from a target population the factors that may affect what church leaders believe should be their leadership roles in HIV prevention, thereby enabling the development of questionnaire items based on these salient beliefs.

According to the theory of reasoned action, open-ended elicitation interviews are an essential step in the identification of commonly held beliefs (modal salient beliefs) and most frequently reported significant others (modal subjective norms) in the target population (Montano & Kasprzyk in Glanz *et al* 2008). The aim of the elicitation interviews is to explore and understand the behaviour from the perspective of the study population to ensure the relevance of the theoretical model to behaviours of different cultures.

In terms of the Theory of Reasoned Action, both individual and group semi-structured interviews are recommended methods for eliciting salient beliefs (Glanz *et al* 2002; Montano & Kasprzyk in Glanz *et al* 2008). A semi-structured interview guide refers to a series of questions that are open-ended (Bryman 2012). Using open-ended questions gives the interviewer latitude to probe more or ask further questions to exhaust responses and replies on specific issues. Given the low level of involvement of the church leaders in HIV prevention as reported in the LUCSA 2008 and LUCSA 2012 evaluation reports, focus group discussions were deemed the most appropriate method to stimulate discussion and provide a range of ideas and experiences about different approaches to HIV prevention (Bryman 2012). In addition, focus group discussions enable the researcher to gather greater amounts of data in a shorter period as compared to individual interviews (De Vos *et al* 2005). The dynamic characteristic of groups often can help members explore views and encourage contributions even from those who may not “open up” when interviewed individually.

Montano and Kasprzyk in Glanz *et al* (2008) emphasise that elicitation focus group discussions (assessing the range of beliefs of the population of interest) should be continued until “saturation”, that is, when no new ideas are elicited. It is also important that the person who facilitates the focus group discussion, probes for both negative and positive response to each question in order to ensure that components that are strongly associated with the target behaviour or topic being researched, are adequately identified. Failure to elicit adequate relevant issues pertaining to the behaviour being researched, will result in poor behavioural prediction and subsequent ineffective interventions

(Montano & Kasprzyk in Glanz *et al* 2008). The group facilitator should have adequate background knowledge on the topic being researched and be a good communicator in order to follow-up on critical areas of concern if focus group discussions are to provide information that can be used to develop specific interventions (De Vos *et al* 2005).

3.3.1.2 Participants and sampling procedures

The researcher initially made an appointment with the Bishop of the Western Diocese of the Evangelical Lutheran Church in Zimbabwe to explain the aims and objectives of the study. Following this, written approval (see Annexure B) to conduct the study was granted. The data was collected during two separate meetings, as described below that provided an opportunity to access large numbers of church leaders for the elicitation focus groups and main study's survey.

The first meeting took place when sixty church leaders attended a scheduled seminar in the Bulawayo South parish centre. The elicitation focus group discussions took place during this occasion. The church leaders were from two adjacent parishes that consisted of seven congregations of the Western Diocese of the Evangelical Lutheran Church in Zimbabwe in Bulawayo. The two parishes were, at the time of the study, serviced by one pastor. One parish, the Bulawayo South parish centre, was used to conduct the focus group discussions as the buildings for the second parish were still under construction.

Purposive sampling was used to select a small group of church leaders to participate in focus group discussions.

Purposive sampling is classified as a non-probability sampling technique in which the researcher selects a subgroup of the larger population to be studied based on how useful or representative that subgroup is to the main group to be studied (Babbie 2007).

Two focus group discussions were conducted in two separate breakaway

rooms of the Bulawayo South parish centre with 12 participants aged between 25 and 65 years in each focus group. Each focus group consisted of 5 males and 7 females. The breakaway rooms were of medium size with enough chairs to accommodate a group of 12 people comfortably. The researcher utilised the church catering services to provide refreshments for all the participants. The elicitation focus group discussions focused on church leaders alone. The participants were purposively selected to represent leaders of various church committees. The participants of the two focus group discussions were a sub-set of the church leaders that were to participate in the main survey study. The participants in the focus group represented each parish and included 4 Council members, 4 members from the Diakonia, Evangelism and Stewardship Committee (DESC), 4 representatives from the Women's fellowship group, 4 representatives from the Men's fellowship group and 4 representatives from the Youth group as well as 2 Sunday School Superintendents, 2 Lutheran League Service Fellowship and 1 pastor. Participants were asked if they had participated in HIV and AIDS activities in the past and about two-thirds in each group indicated that they had either been involved in care or support activities. When the researcher sought permission to tape-record the focus group discussions, some of the participants requested not to be audiotaped. As a result, the researcher did not use the tape recorder for both focus groups.

In view of the fact that the sessions were not going to be tape-recorded, the researcher discussed with the participants the importance of capturing their contributions as accurately as possible. The request to having two people to record the discussion sessions while the researcher moderated was accepted.

Two local research assistants and two LUCSA programme officers assisted the researcher with the facilitation and recording of the two focus group discussions. Two research assistants per group assisted in documenting the responses of participants during the group discussions by taking notes. Although the research assistants had conducted focus group discussions in the past, the researcher, nonetheless, had a short training session with them and covered the process of conducting a focus group, and defined the role of

the researcher as a facilitator and their role as note takers.

After the focus group discussions, all church leaders attended an awareness session on HIV and AIDS mainstreaming to broaden their knowledge on the concept, as a reward for participating in the elicitation study. During the invitation, a non-monetary incentive had been promised that included participating in the research, being provided a meal, and attending an awareness session on HIV and AIDS mainstreaming after the discussions. The awareness session on HIV and AIDS mainstreaming was conducted after the focus group discussions in order to minimise biased opinions by participants because information on mainstreaming could pre-empt the ideas on how church leaders would be involved in HIV prevention. The LUCSA programme officers and the researcher facilitated the awareness session. The church leaders benefited from the seminar as they gained knowledge on what HIV and AIDS mainstreaming entails, an approach that none of the Lutheran churches had implemented in the past.

3.3.1.3 Data collection method: focus group discussions

The researcher designed an open-ended discussion guide for the focus group discussions (Glanz *et al* 2002: 73, 78; Glanz *et al* 2008). Focus group discussions and interviews are a way of collecting data in a semi-structured way using a set of open-ended questions as a guide (Babbie 2007).

The researcher explained to participants of both focus groups the purpose of the focus group and reviewed the process of conducting a focus group discussion. These guidelines helped to ensure that both groups were conducted in a similar way and, thus, contributed to consistency.

In facilitating the focus group discussions, the researcher developed a rapport by addressing general issues from the guidelines provided to participants, explaining the purpose of the focus group, and reviewing the focus group “rules”, highlighting issues of confidentiality and respect for each person’s contributions. The researcher used probes to ensure that the group covered

all essential points with equal opportunity for all to speak while taking care that the conversation remained focused. Probes are follow-up questions that enable the researcher to explore further a point raised in more depth, using a standardised question such as “Could you say a little more about that?” or using the participant’s own words and phrases to avoid influencing the respondent (Bryman 2012). The use of probes gave the researcher the ability to maintain a good level of control over the discussions while ensuring that considerable latitude was exercised to allow the participants to express their views until all points were fully covered. Using focus group discussions made it possible for the researcher to record the ways in which church leaders described their leadership roles in HIV prevention.

To uncover factors that may affect church leaders’ decision to take up leadership roles in HIV prevention, the focus group discussion guide (see Annexure C) focused on two main actions: (1) "Talking to parishioners and the clergy about the risk of the sexual transmission of the HI-virus" and (2) "Providing advice on HIV prevention to parishioners and the clergy."

Francis, Eccles, Johnston, Walker, Grimshaw, Foy, Kaner, Smith and Bonetti (2004), recommend the description of the behaviour of interest, in this case, involvement of church leaders in HIV prevention, in terms of action, context and time. To develop questionnaire items that related to barriers, behaviour outcomes, consequences and normative influence for each of the two actions mentioned in the preceding paragraph, the participants were asked to think about a typical scenario in which they might discuss the risk of the sexual transmission of the HI-virus with their parishioners and clergy. With such a scenario in mind, participants were asked to describe *whether, how* and *under what circumstances* they, as church leaders, would talk to parishioners and the clergy about the sexual risk of contracting HIV and offer prevention advice to them.

The participants were further asked the following question: “What do you believe church leaders should be doing in providing leadership in HIV prevention?”

To elicit *behavioural beliefs*, two questions were asked to obtain information about the outcomes and consequences of taking or not taking the two main actions stated above (i.e. talking about the risk of the sexual transmission of HIV and providing advice about HIV prevention). The questions were “What do you see as the possible merits (in terms of the advantages and possible positive outcomes) of taking the actions and of not taking the actions?”, “What do you see as the possible demerits (in terms of disadvantages and possible negative outcomes) of taking the actions and of not taking the actions?”. The participants were further asked to consider these questions from their own perspectives, from the parishioners’ perspectives and the clergy’s perspectives.

To elicit *normative beliefs* for each of the two main actions stated above, the researcher asked four questions to determine possible sources of normative influence. The questions were “In your opinion, which persons, groups or organisations would be supportive to you in taking action one and in taking action two?” “Which persons, groups or organisations would be obstructive should you take action one, and should you take action two?” “Are there any other persons or groups who come to mind when you think about action one?” and, “Are there any other persons or groups who come to mind when you think about action two?”

Each focus group discussion lasted for about one and half hours to allow time for the researcher to explore thoroughly the participants’ feelings, beliefs, underlying attitudes, normative influences and barriers to their leadership roles in HIV prevention (Glanz *et al* 2008).

3.3.1.4 Analysis of data collected through focus group discussions

The data from the focus group discussions were content analysed. The analysis of the elicitation focus group discussions generated a list of concepts, namely, (a) barriers, (b) behavioural outcomes, (c) behavioural consequences and (d) normative beliefs regarding influence of significant others (social

referents) with respect to talking or not talking and providing and not providing advice about HIV prevention to parishioners and the clergy.

These concepts were categorised into themes that were grouped under the TRA constructs, “barriers”, “attitudinal beliefs” as well as “subjective norms”.

Firstly, the construct of *barriers* was used to reflect attitudes about factors within and outside the control of the church leaders that may affect them taking a lead in HIV prevention activities. In other words, the construct “barriers” reflected factors that might make it difficult to perform the target behaviour, (in this case, “talking about the risk of sexual transmission of HIV and providing advice about HIV prevention”). “Barriers” form part of the factors identified by Ajzen in Glanz *et al* (2002) when he proposed the theory of planned behaviour. The theory of planned behaviour addresses “facilitators and barriers” (perceived behavioural control) as factors outside a person’s volitional (voluntary) control that may affect intention and performance of a particular behaviour. Facilitators of the behaviour were not measured and therefore the theory of planned behaviour was not addressed in full in this study.

Secondly, behavioural outcomes and consequences, positive or negative, associated with the behaviour of the church leaders (in this case, the two main actions of “talking about the risk of sexual transmission of HIV” and “providing advice about HIV prevention”) were coded as *attitudinal beliefs*. Behavioural outcomes and consequences reflected, in other words, an individual’s beliefs about outcomes or attributes of performing these two main actions.

Thirdly, social referents that are likely to be supportive or obstructive of the church leaders’ target behaviour were coded as *normative beliefs*.

To increase the validity of the content analysis of the focus group responses, the research assistants and the researcher’s supervisor repeated the coding

process during which themes (barriers, attitudinal beliefs and normative beliefs) were identified. Content analysis in qualitative research entails extracting themes out of data and deriving categories that relate to the context being analysed (Bryman 2012).

3.3.1.5 Summary of the Elicitation Focus Group results

a) Salient beliefs about whether or not participants would carry out the two actions

To elicit whether or not, and, under what circumstance participants would talk to parishioners and clergy about the sexual risk of HIV and provide advice on HIV prevention to them, the participants referred to self-efficacy, cultural and institutional constraints as issues that would make it difficult for them to carry out the two actions. These constraints, which the researcher classified as barriers, included lack of confidence to address people with high social status, adults and in-laws (due to cultural norms and practices); own past risk behaviour; own HIV status not known; everybody now knows about HIV and AIDS and would be bored; and church not the right place to talk about HIV.

b) Salient beliefs about the advantages and disadvantages of the two actions (Behavioural Beliefs)

To elicit behavioural beliefs, respondents were asked about the merits in terms of advantages and possible positive outcomes of two behaviours. The first behaviour 'talking to parishioners and clergy about the sexual risk of HIV transmission' had four themes of advantages that described the behavioural beliefs. These included behaviour change as people become knowledgeable about prevention and disease management; getting tested and knowing own HIV status; reduction of stigma and discrimination; and reduced death rate. The fifth theme reflected on the outcome of talking to parishioners and clergy about the sexual risk of HV prevention as a disadvantage as it was perceived to encourage early onset of sexual activity among the youth. The themes for disadvantages of talking to parishioners and clergy about the sexual risk of

HIV prevention focused on denial that HIV is a problem, increased stigma, increased impact of HIV and AIDS resulting in increased number of orphans due to high rate of deaths including church members, and lack of support to PLHIV and the affected.

Concerning the advantages of the second behaviour, 'providing advice on HIV prevention to parishioners and the clergy', three themes emerged. These included reduction of new HIV infection; improved health-seeking behaviours and that PLHIV will live longer. Five themes described the consequences of providing advice on HIV prevention to parishioners and the clergy. These included prevention messages misconstrued to belittle pastors and to associate parishioners with promiscuity, family quarrels, promotion of condoms perceived as encouraging risky sexual behaviours and early sexual experimentation amongst young people, and that increased demand of condoms may result in reduced supply.

c) Salient beliefs about the views of important others (Normative Beliefs)

In the category of normative beliefs, respondents were asked who they thought would support or obstruct them in taking the two actions (talking to parishioners and the clergy about the sexual risk of HIV transmission and providing advice on HIV prevention). In terms of those who would support, six groups of social referents (PLHIV, the affected, the clergy, the government, LUCSA and other NGOs) were listed, each accounting for more than 80% of respondents. In terms of who would obstruct, the participants listed seven groups of social referents. These included those individuals who see themselves as "holy"; 'sugar-daddies and sugar mummies'; some of the pastors and some of the young people as they think that talking about HIV is not the business of the church; sex workers who may think that behaviour change will affect their 'sex work industry'; some political parties; other organisations who may fear competition.

3.3.2 Phase 2: Questionnaire development

3.3.2.1 Objective

The objective of phase 2 was to construct questionnaire items using the most salient beliefs that were derived from the content analysis of the information gathered through the focus group discussions. To construct the questionnaire items, these beliefs pertaining to barriers, attitudes and subjective norms were converted into a set of statements.

The statements used to construct questionnaire items for the TRA measures of “attitudes” and “subjective norms” reflected as much as possible of the actual wording used by the participants to echo the issues raised as recommended by Montañó and Kasprzyk in Glanz *et al* (2008). The reason for this is that the researcher felt that in developing the questionnaire, the use of the actual wording used by the participants during the focus group discussions would reduce item nonresponse error to some items or questions that might result, for example, from respondents not understanding or interpreting questions differently. Item nonresponse refers to when respondents provide information to some but not all questions in the questionnaire. According to Bryman (2012), the reasons for nonresponse may be due to sensitive questions, lack of knowledge or questions not understood or the questionnaire maybe too long, resulting in fatigue. Furthermore, the wording should also be simple and match the vocabulary level of the respondents regarding the topic of interest.

3.3.2.2 Questionnaire items

3.3.2.2.1 The use of Likert scales and Semantic differential scales

In this study, a combination of Likert scales and Semantic differential scales were used to measure attitudes. A Likert scale is a method that uses standardised response categories with end-points (such as the use of a four response category: “Strongly Disagree”, “Disagree”, “Agree” and “Strongly

Agree”) to determine the respondents’ views. These response categories allow the respondents to express their degree of agreement that might vary in terms of relative intensity. Semantic differential scales use a format that asks respondents to rate their response in terms of two opposite positions, such as, “healthy” and “unhealthy” (Babbie 2007: 171). Likert scales and Semantic differential scales in this study were used to measure the attitudes of the Lutheran church leaders toward HIV prevention in Zimbabwe.

3.3.2.2.2 *Content of the questionnaire*

The questionnaire (see Annexure D) had four sections:

- **Section one** (questions 1 to 6 of the questionnaire) covered background information with a series of questions designed to elicit demographic information about church leaders. Section one of the questionnaire included variables that Ajzen and Fishbein (in Glanz *et al* 2002) regard as “external variables” and these were: geographical location of the congregation served, position in the hierarchy in the church, and length of membership as well as age, gender and education level attained.
- **Section two** (questions 7 to 10 of the questionnaire) explored *involvement* in HIV prevention activities, *exposure* to training in HIV and AIDS and *personal knowledge* of any person living with the HI-virus. Section two of the questionnaire in other words explored the church leaders’ experiences with HIV and AIDS in terms of personal involvement in HIV and AIDS activities, exposure to HIV training and encounters with a person living with HIV or dying of AIDS in the family.
- **Section three** (questions 11 to 15 of the questionnaire) covered key TRA constructs concerned with the measurement of attitudes which were related to the *advantages and disadvantages of talking or not talking* and *providing advice* to parishioners and clergy about HIV prevention. In other words, section three of the questionnaire included a measurement of attitudes towards leadership roles in HIV prevention that were obtained, as

suggested by Ajzen and Fishbein in (Glanz *et al* 2002:70), by eliciting the relevant beliefs and determinants of behavioural intention to talk or not talk about HIV prevention and providing advice on HIV prevention through focus group discussions described above and set out in more detail below:

(a) Talking about the risk of sexual transmission of HIV

Concerning the first main action stated above, the measurement of attitudes was based on 12 factors identified from the elicitation focus group discussions that might be a *barrier* to perform this main action. Thus, respondents were required to indicate the extent to which each of the 12 factors would be a barrier to them if they were to engage in talking about the risk of the sexual transmission of HIV. The options for response were on a four-point scale with end points “not at all” and “to a large extent” dimension (not at all=1, to some extent=2, to a large extent=3, don't know=4) (Ajzen & Fishbein, in Glanz *et al* 2002).

Using a measure of 13 *behavioural outcomes* identified from the elicitation focus group discussions, respondents were then required to evaluate each outcome on an unlikely/likely scale (1=unlikely, 2=likely, 3=don't know) regarding talking about the risk of the sexual transmission of HIV.

Based on the ten *behavioural consequences* identified from the elicitation focus group discussions, respondents were again required to evaluate each consequence on an unlikely/likely dimension (1=unlikely, 2=likely, 3=don't know) if they *do not talk* to parishioners and the clergy about the risk of the sexual transmission of HIV.

(b) Providing advice on HIV prevention

For the second main action, “providing advice on HIV prevention to parishioners and the clergy” and based on the 6 possible outcomes listed from the elicitation focus group discussions, respondents were required to evaluate each outcome on an unlikely/likely dimension (1=unlikely,

2=likely, 3=don't know).

Based on the 9 belief consequences identified from the elicitation focus group discussions for action two, respondents were required to evaluate each consequence on an unlikely/likely dimension (1=unlikely, 2=likely, 3=don't know) if they provided advice on HIV prevention to parishioners and the clergy.

An additional belief not mentioned in the focus group discussions, but frequently cited in the literature, was included in the questionnaire. The belief refers to the idea that condom-use prevents conception as cited in studies on the church doctrine on AIDS and HIV prevention (Fisher; Allen, in Van Deutekom 2007). Condom-use is regarded by many churches, especially the Catholic Church, as a sinful and immoral artificial contraceptive that prevents God's plan to bring a new life into the world.

- **Section four** (questions 16 and 17 of the questionnaire) covered *normative beliefs regarding the influence of important others* (social referents) – people who would approve or disapprove of the church leaders' roles in HIV prevention.

This fourth part of the questionnaire covered subjective norms and consisted of a measure of the expectation of 11 social referents (people living with HIV, people affected by AIDS-related illnesses, Bishops, Pastors, Partners, the government, Matabeleland AIDS Council, National AIDS Council, Network of people living with HIV and the Lutheran Communion in Southern Africa) being or not being supportive. A measure of the expectation of 7 referents being and not being obstructive if church leaders engaged in the identified behavioural actions included individuals or people who have negative attitudes towards HIV and AIDS and see themselves as “holy”, young people, some of the pastors, sex workers, social political parties, “sugar daddies or sugar mummies” and other competing organisations.

3.3.3 Phase 3: Pilot study

3.3.3.1 Objective

The objective of piloting the questionnaire was to identify any questions that used general terms that could be open to different interpretations such as “regularly” as such terms are ambiguous. Piloting would also identify other problems related to the content of the questionnaire, layout and the operationalisation of variables, as well as how easy or difficult it was to complete the questionnaire. By doing a pilot study, the researcher aimed to ensure that all flaws were corrected, and that the questionnaire was culturally appropriate, as well as to estimate the approximate time required to complete the questionnaire. The questionnaire was available in two languages, namely, English and isiNdebele, to facilitate easy communication as some respondents might have difficulties in expressing themselves in English.

3.3.3.2 Participants and sampling procedures

The sample for the pilot study was drawn from the staff members of the Lutheran Communion in Southern Africa (LUCSA) organisation in Johannesburg in South Africa. The pilot sample was designed to meet the objectives of selecting representatives of the various subgroups of leaders that characterise the Lutheran church which include men, women, youth and the clergy. A purposive sampling technique was used to draw a small sample of eight participants from the staff compliment of twelve of the LUCSA Office through volunteer responses to telephone and word-of-mouth requests.

The researcher identified participants based on their being members of the Lutheran church and having been or were currently in a leadership position and who were representatives of the clergy, the men, women and youth groups in their congregations. The findings of the main study in Chapter 4 indicate the types of leadership positions in the church held by the respondents. The eight Lutheran church leaders who participated in the pilot study were requested to complete a questionnaire. Five were of Zimbabwean

nationality and three were South Africans, but all were based in Johannesburg in South Africa. Of these, four were males and four were females. The participants included one male bishop, three male pastors, two church elders (one male, one female) and two female project staff officers within the Lutheran Communion in Southern Africa who previously held leadership positions in their parishes. The participants were between 27 and 50 years old.

3.3.3.3 Conducting the pilot study

Before completing the questionnaire, the researcher discussed the following procedures with all eight of the church leaders involved in the pilot study:

- The researcher introduced the study to the participants and thanked them for their participation in the pilot study. Participants were informed that the questionnaire was being tested to determine if questions were understandable and easy to answer. The cover letter to the questionnaire included information on the purpose of the study, an assurance of confidentiality for participants and that participation in the study was voluntary. Instructions on how to complete the questionnaire were read out by the researcher before the administration of the questionnaire.
- The questionnaire was self-administered at the conference centre within the LUCSA office premises in Johannesburg in South Africa.
- At the end of completing the self-administered questionnaires, the researcher gave each participant a review form on which they were to provide feedback on any difficulties they had experienced in completing the questionnaire in terms of the language used, content, layout and time taken to complete it. This feedback enabled minor revision of some of the questionnaire items.
- The researcher remained in the same room to address any issue of concern while careful not to influence the responses of the respondents.

- Respondents took 20 minutes on average to complete the questionnaire and all the respondents reported that they found the questionnaire easy to complete.

Following minor revision of the questionnaire items, the completed questionnaires were given to the two research supervisors in the Department of Sociology at UNISA at the time who reviewed the completed questionnaires and expressed satisfaction with the level of consistency regarding the way in which the respondents answered the questions. The questionnaire was adopted as being suitable for the main study.

3.3.4 Phase 4: Main survey

3.3.4.1 Objective

The objective of the main survey was to gather information on the attitudes of church leaders toward their leadership roles in HIV prevention.

3.3.4.2 Research design

A cross-sectional survey research design was adopted. The researcher used a self-administered questionnaire in which the research respondents completed the questionnaire themselves. Punch (2005) states that cross-sectional research designs are used to collect data from people at a particular time. Cross-sectional study observes a phenomenon at one point in time or aims at describing a population at a given time (Babbie 2007).

3.3.4.3 Study Population

A study population describes boundaries on the study units with similar characteristics that the researcher focuses upon (De Vos *et al* 2005; Babbie 2007). The study population for the main research was all leaders of the different church groups of the Western Diocese of the Evangelical Lutheran

Church in Zimbabwe who attended the leadership seminar held in Gwanda. These leaders comprised of pastors, deacons, church elders and members of various church committees and councils, who included the Chairman of the Church Assembly and leadership from the youth, men and women's groups.

3.3.4.4 Unit of Analysis

Babbie (2007) describes the unit of analysis as the "what or whom is being studied". The unit of analysis for this study was the individual church leaders, i.e., church leaders of the Western Diocese of the Evangelical Lutheran Church in Zimbabwe. The study assessed the attitudes of church leaders toward their leadership roles in HIV prevention. The set of data manipulated were variables defined at the level of individual church leaders.

3.3.4.5 Inclusion and Exclusion Criteria

The church leaders who were currently serving as clergy, men, women and youth leaders in the Western Diocese of the Evangelical Lutheran Church in Zimbabwe were included in the study.

The church members that did not hold any leadership position in the Western Diocese of the Evangelical Lutheran Church in Zimbabwe and did not attend the seminar were excluded from the study.

Section 3.3.4.6 below elaborates further on the delimitation of the study.

3.3.4.6 Delimitation of the Study

The study population defines the limits of the sample and narrows the generalisation of findings to a larger population.

Delimitations for this study included:

- The study was restricted to the Evangelical Lutheran Church in Zimbabwe because data collection took place during the time the researcher was working in Zimbabwe.

- The sample was selected within the parishes of the Western Diocese located in Bulawayo and in the Matabeleland South Province of Zimbabwe as the Western Diocese had a scheduled leadership seminar that would bring church leaders together in one place. Therefore, the researcher would have access to a large number of respondents in a short, given time and would not have to incur additional costs related to travelling to different parishes. Administering a questionnaire to a group of respondents in one location would also eliminate the possibility of respondents from one parish discussing questions with the next parish beforehand, which could affect the next person's responses.
- Data were gathered from predominantly urban church leaders and therefore cannot be generalised to rural locations or all church leaders in Zimbabwe, whether they are Lutherans or from any other denomination. This is because the location of the scheduled gathering (seminar) was in an urban area and most church leaders from the rural areas had experienced challenges with transport and had not arrived at the seminar at the scheduled time and could therefore not participate in the data collection process.
- Participation in the survey was delimited to the church leaders who were present at the time the survey was scheduled, which was during the first session of day one of the seminar.
- Participation in survey was delimited to those who were literate, as the self-administered questionnaire requires reading and writing skills.
- Participation in the survey was delimited to those who were over 18 years of age. According to the ELCZ Constitution (2009), 18 years is the majority age for people to participate in men and women's fellowship groups.
- Church leaders, who met all other qualifications but were members of the other Dioceses, namely, the Central and Eastern Dioceses, were excluded from participating in this study.
- The study was delimited to an examination of the Evangelical Lutheran Church leaders' attitudes towards their perceived leadership roles in HIV prevention using the Theory of Reasoned Action. Church leaders' attitudes

towards other conditions was not considered.

3.3.4.7 Sampling design and procedures

The sample for the survey was drawn from the church leaders of the Western Diocese of the Evangelical Lutheran Church in Zimbabwe (ELCZ) in the Matabeleland Province of Zimbabwe who were attending a two-day annual revival seminar in Gwanda. This was the second meeting of the ELCZ church leaders that provided an opportunity to access a sample for the main study survey. The ELCZ Western Diocese consists of two Deaneries with 120 congregations that form twenty parishes. In January 2011, the Diocese register showed a figure of total general membership of 50,520, excluding children under the age of 18 years.

Given the large number of potential church leaders, the researcher acknowledged that it would not be practical to study the entire population of church leaders in all the twenty parishes. The researcher, therefore, had to decide how to sample the population as efficient as possible. To seek an appropriate sample population, the researcher asked for assistance from the Diocesan Bishop to ensure that representatives of leaders for all church subgroups (men, women, youth and the clergy) for each parish attended the seminar.

Criteria were set on what would make “good representatives” of church leaders. A list of qualifications was composed and the defined qualities included being a member of the Western Diocese of the Lutheran Church in Zimbabwe and holding a leadership position (such as representing church subgroups of men, women, youth, and clergy or committee members). In this way, the selection of the respondents was purposively done to reach church members in a leadership position. Purposive sampling is a non-probability type of sampling, which selects categories of people that needed to respond to research questions who have not been chosen in a random manner (Bryman 2012). Non-probability sampling methods rely on available categories of people as opposed to probability sampling techniques, such as

random sampling.

The theme for the Revival seminar was encouraging members to “declare their service” and “take up leadership roles in the church” (ELCZ Seminar Report 2009). This gathering gave an opportunity for the researcher to access a study population who matched the inclusion criterion of being a church leader representing various groups of church members including men, women, youth and the clergy. The chairperson of the seminar explained to all the seminar delegates that the Diocesan Bishop and the organising team granted the researcher permission to conduct the study (see Annexure B) and stressed that participation in the study was voluntary. The sample, therefore, was selected on the basis of the church leaders’ willingness to cooperate. Eighty-eight church leaders were present in the morning session of the seminar and formed the sample that participated in the main study survey. These included youth leaders, women church leaders, leaders of men’s church groups and church elders (who are congregation committee members) as well as the staff complement of the 23 all-male clergy of the Western Diocese.

3.3.4.8 Data collection method and procedure: the questionnaire

A questionnaire is a set of research questions designed to extract specific information for appropriate data analysis (Babbie 2007). The types of questions used in the questionnaire can be either open-ended or closed. Closed questions limit responses to a range of answers provided whereas open-ended questions allow respondents to provide their own views as answers. In this study, only two questions in section one (demographic information) were open-ended while the rest of the questions were closed. The two open-ended questions were used to explore the *involvement* of church leaders in HIV prevention activities and their *exposure* to training in HIV prevention. Questionnaires can allow the collection of information from large numbers of respondents simultaneously, especially self-administered questionnaires, thus cutting down on the cost of engaging research assistants in collecting data. Self-administered questionnaires further allow for anonymity

if respondents are not required to fill in their names. Allowing anonymity may increase honest answers to questions that seek personal information.

Self-administered questionnaires are generally regarded as quicker and cheaper to use than individual face-to-face interviews that require an interviewer to guide a discussion in a face-to-face encounter, do not introduce interviewer bias and are ideal to elicit responses to issues that are sensitive as they offer anonymity to the respondent (Babbie, 2007). Babbie (2007) describes interviewer bias as when the interviewer asks leading questions when interviewing respondents. The researcher employed a self-administered questionnaire because this study included questions that dealt with sensitive issues, such as attitudes about HIV prevention measures and religion. Anonymity was encouraged to harness honest responses.

The church leaders who participated in the study were selected from a group attending a revival seminar as explained in section 3.3.4.3 above. The respondents were given the first two hours, before the seminar began, to complete the questionnaire immediately upon receipt of a copy distributed by the researcher in the conference room. Delegates to the seminar who arrived half an hour after the questionnaire session had started, were excluded from the survey. Eighty-eight (88) questionnaires were handed out to men and women church leaders who attended the first morning session of day one of the two-day revival seminar, which started at eleven o'clock in the morning. The survey cover letter stated clearly that participation was voluntary. Instructions on how to complete the questionnaire were read out by the researcher to ensure all understood the requirements stipulated in the questionnaire even though each set of questions had instructions on how to respond. The researcher and her assistant coordinated the data collection process. This made it possible for the respondents to feel comfortable to complete the questionnaire since people not directly involved in their day-to-day church activities administered the data collection.

The availability of the researcher and her assistant helped to improve the response rate by clarifying questions when necessary; for example, there was

need to clarify what tertiary education included. At the end of the survey session, the respondents placed the completed questionnaire in a “return box” located at the exit of the conference room. Upon the completion of the data collection process, the researcher filed and kept the completed questionnaires in a safe and secure place at the researcher’s residence.

All of the 88 questionnaires that were handed out to the church leaders for self-administration were returned. Eighty-five (85) of the questionnaires were completed in full while three questionnaires were incomplete, giving a response rate of 96.6%. The three incomplete questionnaires had more than five unanswered items and were classified as incomplete and not suitable for inclusion in the analysis of this study.

Several factors could have contributed to this high response rate, such as prioritisation of this survey by the church leaders’ organizing committee when they allocated two hours for the completion of the questionnaires in the programme of their seminar and the inclusion in the agenda of a person living with HIV (PLHIV) to give a testimony. Other possible factors include the researcher having previously been a member of the church and was known by a good number of the respondents. Furthermore, the title of the seminar theme, namely "Time for Men to declare their service to God", could have played a role since it might have compelled the church leaders to live out the call of the theme. According to Babbie (2007), delivered and picked-up questionnaires have a higher completion rate than mailed questionnaires. Leedy and Ormond (2010) also confirm that the response rate of mailed self-administered questionnaires might be even less than 20 percent.

3.4 RELIABILITY AND VALIDITY

3.4.1 Reliability

The reliability of an instrument refers to the stability of the instrument as well as the consistency with which the instrument yields the same results when

applied repeatedly to the same object (Babbie 2007; Bryman 2012). Furthermore, a questionnaire is considered reliable if the same result is obtained repeatedly when the questionnaire is re-administered to the same sample of participants on two or more occasions (Bryman 2012).

As explained above, the researcher pre-tested the questionnaire during the pilot study by using a sample of eight church leaders who did not participate in the actual study. Comments that emerged from the pilot study led to only minor changes in the format of the questionnaire and a second round of elicitation focus group discussion was not considered to be necessary. The completed questionnaires were reviewed by the two research supervisors in the Department of Sociology at the time who confirmed that there were no inconsistencies, such as that similar questions were asked and that respondents did not skip particular questions consistently. The supervisors expressed satisfaction with the degree of consistency regarding categorisation of the data of the main study, which was similar to the categories generated for the pilot study data. Bryman (2012) highlights that inter-observer consistency is one of the “three prominent factors” that determine the reliability of a measure. This means that when more than one observer is involved in the translation of data into categories, consistency in their decision on how to categorise answers to open-ended questions indicates the reliability of a measure.

3.4.2 Validity

There are several ways of testing the validity of a measure and some of the important ones include face validity, construct validity, criterion-related validity, and content validity. Content validity is the degree to which an instrument adequately covers information on all the different components included within a concept or topic in order to succeed to measure what it is supposed to measure (Babbie 2007). Bryman (2012) emphasises that face validity is the minimum requirement that the researcher has to establish for all new measures or instruments developed to establish whether the content of the concept under study is adequately reflected. To achieve the content and face

validity of an instrument, researchers can refer to both experts in the field for comment and those they study or can refer to the literature on the research topic (Bryman 2012).

To establish the validity of this survey instrument, the researcher ensured the careful and systematic formulation of questions and statements contained in the questionnaire to include all the constructs of the theory of reasoned action to measure the attitudes and subjective norms of church leaders. For face and content validity, the researcher's supervisor assessed the questionnaire. A team of eight church leaders not included in the main study participated in the pilot testing of the questionnaire. Comments by the team of church leaders who participated in the pilot study and the supervisors were incorporated in the final questionnaire to ensure ease of administration, clarity of questions and precision in measuring attitudes and subjective norms regarding talking about HIV prevention. A follow-up interview with all of the pilot study participants over the telephone confirmed that their responses were in line with what they had given in the questionnaire.

3.5 DATA ANALYSIS OF PHASE 4: MAIN STUDY SURVEY

The researcher assigned each questionnaire an alphanumeric number. The answers were coded and captured on the computer using Epi-Info version 6 and exported into the SPSS statistical package version 19 for analysis. The survey data were first entered by the researcher and then reviewed by the research assistant for accuracy in capturing the data. The researcher's supervisor further verified the captured data and discrepancies were resolved.

Three levels of statistical analyses were performed with the coded data from the survey questionnaires, namely, descriptive statistical analysis, factor analysis and Chi-square.

These data analysis methods are described briefly in the paragraphs below.

3.5.1 Descriptive analysis

The Statistical Package for Social Sciences (SPSS) programme was used to analyse and present the data in the form of frequency distributions and percentage tables in order to describe the study population. Descriptive analysis is concerned with summarising and describing either the characteristics of a sample or the association among variables (Babbie 2007).

3.5.2 Factor analysis

Factor analysis was used to identify interrelationships between variables and to explain variables in terms of common underlying dimensions (factors). Factor analysis is a collection of statistical methods used to examine how underlying constructs influence the response on a number of measured variables. It is a statistical approach that can be used to analyse interrelationships among a large number of variables and to explain these variables in terms of their common underlying dimensions (factors). This statistical approach involves finding a way of condensing the information in a number of original variables into a smaller set of dimensions (factors) with a minimum loss of information (Hair, Jr., Black, Babin & Anderson 2010).

In this study, factor analysis was used to group together variables that were closely related. The aspects on attitudes toward leadership roles in HIV prevention and normative beliefs regarding influence of significant others were used to determine those falling in the same group, that is, those strongly correlated.

3.5.2.1 Assumptions of factor analysis

An adequate sample size will be the one where the sample size is at least five times the number of variables. Accordingly, the sample size for this study had to be at least 60. In the case of this study, the sample size was 85, which was adequate for factor analysis to be employed. A sample size of 85 requires a factor loading of 0.6 or more (Hair *et al* 2010).

3.5.2.2 Suitability of factor analysis

The suitability of factor analysis can be determined using the Kaiser-Meyer Olkin (KMO) measures of sampling adequacy and Bartlett's test of sphericity. In order for factor analysis to be suitable, the KMO value should exceed the heuristic value of 0.7. Bartlett's test of sphericity is a statistical test for the presence of correlations among variables. It provides the statistical significance with regard to the fact that the correlation matrix has found significant correlations among at least some of the variables.

3.5.3 Chi-square

The Chi-square is a statistical test commonly used to compare observed data with expected data according to a specific hypothesis (Babbie 2007: 466). It is a test used to analyse whether two variables are related or not. In this study, the chi-square test was done to determine whether attitudes of church leaders towards their leadership roles in HIV prevention had an interrelationship with the characteristics of the respondents. A log linear analysis was then performed to identify the source of the interrelationship. A log-linear model is a tool for investigating possible interactions or interrelationship among variables (Babbie 2007).

3.6 ETHICAL CONSIDERATIONS

In accordance with the standards of conducting any research, the researcher had to seek ethical clearance before conducting the study. The researcher submitted the following documents for approval by the supervisor, namely, the elicitation interview schedule and the covering letter that explained the aims of the study and requested participation in the survey. The research supervisor approved these after the University of South Africa granted ethical clearance. Since the participants in the study were members and workers in the Western Diocese of the Lutheran Church of Zimbabwe, the researcher sought further permission to conduct the study from the Bishop of the Western Diocese of

the Evangelical Lutheran Church in Zimbabwe (see attached Annexure A).

Adhering to the standards of research ethics is essential to ensure that all researchers protect the well-being of everyone who participates in any study. Babbie defines *ethical* in terms of *Webster's New World Dictionary* as "conforming to the standards of conduct of a given profession or group." The goal of research ethics is to protect participants and minimise their risk of harm because of the research procedure while at the same time supporting researchers to gain scientific knowledge (Bless *et al* 2008). To minimise the risk of harming the research participants or putting them in a position of discomfort when collecting data, researchers must observe four basic ethical principles. The researcher needs to (1) obtain informed consent from participants, (2) protect the identity of participants, (3) avoid deceptive practices when designing the research and recruiting research participants, and (4) allow participants to have the right to withdraw from the study.

The researcher considered ethical issues that pertain to informed consent, anonymity and confidentiality, the principle of no harm being done to participants, communicating results and debriefing the research participants. These principles are discussed below.

3.6.1 Informed consent

According to Babbie (2007:64), informed consent is "a norm in which subjects base their voluntary participation in research projects on a full understanding of the possible risks involved." This consent may be verbal or written. The importance of informed consent is that it assures respect for and offers the participants accurate and full information about the nature of the research to enable a voluntary decision to participate or not to participate in the research. Informed consent gives assurance to protect both the participants, whose autonomy is respected, and the researcher, should there be legal issues arising following the research.

3.6.1.1 Obtaining permission from the Bishop to do research

In order to obtain informed consent from the **focus group** participants, the researcher first approached the Bishop of the Western Diocese of the Evangelical Lutheran Church in Zimbabwe, explained the phases of the study to him in person and then wrote a formal letter to seek permission to conduct the research (see Annexure A). The Bishop granted permission to conduct both the focus group and survey (see Annexure B). The Bishop facilitated a church leaders' seminar where interested people could learn more about the study and ask questions.

3.6.1.2 Obtaining informed consent from focus group participants

Using both English and the local language, Ndebele, the researcher explained in simple terms the purpose, objectives and benefits of the study to the focus group participants. The researcher highlighted that the anticipated time for the focus group discussion would be about one and half hours. However, the researcher was careful not to talk about the topic in detail to avoid influencing the responses of the participants during the discussion. The researcher gave time for participants to seek clarity during the focus group discussion in cases where they did not understand the questions. The researcher also explained that the focus group discussion formed a critical phase of the development of questionnaires for the main study's survey. When there were no further questions, the researcher sought confirmation from the potential focus group participants if they had fully understood and asked them to give their oral consent to participate in the discussion.

3.6.1.3 Obtaining informed consent from survey respondents

To observe the principle of informed consent in the case of the survey respondents, all respondents were informed that participation in the study was voluntary and were assured that there was nothing to lose by not participating.

However, the potential respondents might have felt obligated to participate as their Bishop supported this study. To counter any feelings of coercion, the participants' rights and autonomy were recognised by announcing in the presence of the Bishop that participation was voluntary and anonymous. Each questionnaire had a covering letter stating the aims and objective of the study and requesting participation in the study (see Annexure D). The researcher informed the respondents that there was no separate consent form to complete but that the return of the completed questionnaire would be considered as having given consent to participate in the study. The covering letter attached to the questionnaire was, together with the completed questionnaire, placed in a "return box" located at the exit of the conference room by the respondents.

3.6.2 Confidentiality and anonymity

"Confidentiality" refers to when the researcher knows who would have participated but does not reveal in any way their identity in the findings of or report on the study (Babbie 2007). "Anonymity" refers to when a researcher cannot link a given response with a particular participant (Babbie 2007).

Prior to making a decision to participate, the researcher warned the potential respondents that the findings of the study would be made available to the Bishop of the Western Diocese of the Evangelical Lutheran Church in Zimbabwe. The provision that the findings of the study will be shared with church leadership might have increased the possibility of some individuals being identified based on their comments, thus, raising the issue of protecting the respondents' identity. In order to deal with this, the researcher exercised caution on how detailed the data analysis would be. For example, only a few of the church leaders from the rural-based congregations participated in the survey as the majority arrived after the survey exercise due to transport challenges. To protect the identity of these respondents, the peri-urban and rural categories were collapsed together during the interpretation and analysis of the data, resulting in the category "rural". Therefore, the individual identity of the few respondents from the rural-based congregations was protected.

To adhere to the ethical principle of confidentiality in the case of the **focus group discussion**, each participants was issued a number to uphold individual confidentiality after the focus group discussions and in the process of analysis of the data as well as when reporting the findings. The researcher emphasised to all participants at the beginning and end of each session of the two focus group discussions not to reveal or indicate who made specific comments during the discussions. To protect any information being used against a particular individual, participants of the elicitation phase agreed, verbally, upon request by the researcher, to keep information shared by other members of the focus group confidential.

The researcher further explained that any participant, who was uncomfortable to participate despite the assurance of confidentiality, should feel free to withdraw from the focus group without feeling threatened that they would be victimised or disadvantaged in any way. The potential focus group participants were also given the contact information of the researcher's supervisor should they have needed more specific information about the study.

Participation in the **survey** offered anonymity as the participants did not need to reveal their identity since no individual names were entered on the questionnaires. In addition, the researcher assured the respondents that the data collected would be treated confidentially during analysis and that their identity will not be revealed in any way in the study report.

3.6.3 Principle of no harm

Anyone involved in collecting data from people must ensure that no harm occurs to the participants and that all participants have made a voluntary decision to be involved in the study (Babbie 2007: 62-63; Punch 2005: 276-277). This means that researchers must consider the needs and concerns of the study participants, establish a basis for trust between the researcher and the participants and be responsible for the appropriate conduct of the

research, which needs to take place within the specific study protocol.

The researcher's strategy determines largely the approach to research ethics. However, all research should adhere to the basic ethical principles of "doing good" and "doing no harm" with regard to all the components of the research, namely, research designs, methods, sampling strategies and data analysis techniques (Bryman 2012).

Harm to research participants in the social sciences may be of a physical or emotional manner (Bless *et al* 2008). Research participants can be subjected to different types of harm because of being asked to reveal certain personal information that may "seem demeaning, such as a low income" or "deviant behaviours" that may cause among others loss of self-esteem, psychological distress and discomfort and social disadvantage (Babbie 2007; Bryman 2012). In order to minimise the risk of harm, researchers are expected to adhere to ethical norms by ensuring the following:

- voluntary participation of and obtaining informed consent from participants,
- protecting the identity of participants, and
- safeguarding against deceiving participants about the nature and purpose of research (Babbie 2007; Bless *et al* 2008; Bryman 2012).

In addition, all participants should be provided with the right to withdraw from research at any time.

There was no potential harm seen to be associated with the survey phase of this study.

3.6.4. Provision of debriefing, counselling and additional information

The covering letter attached to the questionnaire explained that feedback on the study findings would be provided to the Bishop. The letter stated that a summary of the findings would be made available to the respondents upon

request. The letter also included the details of the researcher for respondents to contact her should they at a later stage wish to discuss the study.

3.7 CONCLUSION

Chapter 3 described the four phases of the research design of this study, namely, the elicitation of beliefs during two focus group discussions, the development of a questionnaire, conducting a pilot study and conducting a survey that utilised this newly developed questionnaire in order to study church leaders' attitudes towards their perceived leadership roles in HIV prevention.

This chapter further explained that a non-experimental survey research design was used in this study. The sample for the survey participants consisted of Lutheran pastors and parishioners, 18 years old and older who belonged to parishes in the Western Diocese of the Evangelical Lutheran Church in the Matabeleland Province in Zimbabwe. These pastors and parishioners were recruited using a purposive sampling technique. They were recruited from a gathering of the Witnesses revival seminar of church leaders held in Gwanda, the capital and central point of the Matabeleland South Province in Zimbabwe. A questionnaire was developed, based on the Theory of Reasoned Action, a review of literature and elicitation focus group discussion to measure the church leaders' attitudes and subjective norms regarding their perceived leadership roles in HIV prevention. A 3-point Likert scale was used to elicit attitudes. Subjective norms were also measured on a 3-point Likert scale. Barriers perceived by the study participants to discussing the risk of HIV transmission were measured on a 4-point Likert scale.

The questionnaire consisted of four sections. The first section of the questionnaire covered background information, with a series of questions designed to elicit demographic information. Section 2 of the questionnaire explored the church leaders' involvement in HIV prevention activities, exposure to training in HIV and AIDS and personal knowledge of any person

living with the HI-virus. Section 3 of the questionnaire covered the key TRA constructs, and indirect measurement of attitudes. Section 4 dealt with the social referents using outcome evaluations of behavioural beliefs.

This chapter also discussed the reliability and validity of the questionnaire and the delimitation of the study. The data collection methods and procedures and the statistical analyses performed were described. The ethical issues considered in this study, which pertained to informed consent, anonymity and confidentiality, the principle of no harm and debriefing were also discussed.

Chapter 4 presents a detailed discussion of the analysis and interpretation of the data gathered and the findings of the study.

CHAPTER 4

DATA ANALYSIS AND INTERPRETATION

4.1 INTRODUCTION

A survey research design, which was based on the Theory of Reasoned Action, was adopted for this study. The data were obtained during a two-day seminar in which self-administered questionnaires, measuring attitudes, subjective norms and barriers, were used to examine the attitudes of the Lutheran church leaders towards their leadership roles in HIV prevention. These church leaders were members of the Western Diocese of the Evangelical Lutheran Church in Zimbabwe. Permission was obtained from the Bishop of the Diocese and the organisers of the seminar to conduct the research and ethical clearance was granted by UNISA.

This chapter reports on and discusses the findings of this study. The objectives of the study were to:

- determine the level of the church leaders' involvement in HIV prevention activities,
- describe the attitudes of the Lutheran church leaders toward taking leadership roles in HIV prevention and
- explore how biographic variables, location of a congregation, position in the church, length of Lutheran membership, gender, age, education, involvement in HIV prevention activities and exposure to HIV training, may influence the attitudes of the Lutheran church leaders towards taking a lead in HIV prevention.

The hypothesis to be tested in relation to research question 3 was:

- ***H₀: The variables are independent (there is no association)***
- ***H₁: The variables are dependent (there is an association)***

The statistical analyses of the gathered data were done in relation to the above objectives. Firstly, the characteristics of the respondents are presented in section 4.2. The HIV and AIDS experiences of church leaders who

participated in this study are described under section 4.3. Section 4.4 describes the attitudes of church leaders towards taking leadership roles in the prevention of HIV and their normative beliefs regarding the influence of significant others, respectively. The results from the factor analysis are presented in section 4.5. The statistical tests for association is presented under section 4.6.

4.2 CHARACTERISTICS OF THE RESPONDENTS

Descriptive statistics were generated to reflect the nature of the sample. The biographic variables include location of the congregation of the respondent, position in the church, length of membership as a Lutheran, gender, age, educational qualification, involvement in HIV prevention activities and exposure to any HIV training. The frequency tables below represent how the respondents' responses were distributed across the various specified categories. The rank column reflects the ranking of the respondents' responses in terms of frequency.

4.2.1 Geographical location of respondents' congregations

Most of the respondents (72.9%) indicated that their congregation was located in an urban area, while 18.8% came from a rural area, 5.9% from a peri-urban area and 2.4% were located in both urban and rural areas as indicated in Table 3 below.

Table 3: Location of respondents' congregation (n=85)

Area	Frequency (n)	Percentage	Rank
Urban	62	72.9%	1
Rural	16	18.8%	2
Peri-urban	5	5.9%	3
Urban and rural	2	2.4%	4
TOTAL	85	100	

One can conclude that the congregations of most leaders (72.9%) who responded to the questionnaire were based in urban areas.

4.2.2 Position held in the church

Table 4 below shows that 26.5% of the respondents belonged to the men’s fellowship group and that 22.9% were parish council members whereas 16.9% were clergy. The representation of women’s fellowship group and church elder was 13.3% and 12% respectively. The Diakonia Evangelism and Stewardship Committee and the youth group were the least represented with 4.8% and 3.6% respectively.

Table 4: Position held in the church (n = 83)

Position	Frequency (n)	Percentage	Rank
Men’s fellowship group	22	26.5%	1
Parish council member	19	22.9%	2
Clergy	14	16.9%	3
Women’s fellowship group	11	13.3%	4
Church elder	10	12.0%	5
Diakonia Evangelism and Stewardship Committee	4	4.8%	6
Youth group	3	3.6%	7
TOTAL	83	100	

The fact that the majority of the respondents were members of the men’s fellowship group (26.5%) and parish council members (22.9%) as well as the clergy (16.9%) probably reflects the dominance of male participants. The bias in male dominance was due to the fact that the respondents were recruited from a Revival Seminar which was targeting men to “declare their service” and “take up leadership roles in the church” (ELCZ Seminar report 2009). Traditionally, men remain dominant as Bishops and clergy in the Lutheran

church in Zimbabwe, hence the high representation of men in the above highlighted groups.

4.2.3 Years of being a member of the Lutheran Church

Membership in the Lutheran Church was obtained by providing three different categories from which the respondents selected their status. The majority of the respondents (75.3%) were brought up in the Lutheran faith teachings and practices (thus for most of their lives) as indicated in Table 5 below, whilst 23.5% had been a member of the Lutheran church for more than five years but were not lifelong members and only 1.2% had been a member for less than 5 years. Thus, most of the respondents had been in the Lutheran church for many years and were in a good position to reflect the attitudes of church leaders in the Evangelical Lutheran Church in Zimbabwe.

Table 5: Membership in the Lutheran church (n = 85)

Membership	Frequency (n)	Percentage	Rank
Brought up in the Lutheran faith teachings and practices	64	75.3%	1
Member for more than 5 years	20	23.56%	2
Member for less than 5 years	1	1.2%	3
TOTAL	85	100	

4.2.4 Gender

The sample was primarily comprised of men (70.6%), whilst 29.4% were women as shown in Table 6 below.

It can be observed from “*Table 4 Position held in the church*” above, that most of the church leadership positions are dominated by males. This may indicate

a stronger tendency toward a gender effect in decision making even on areas of HIV education.

Table 6: Distribution of respondents by Gender (n = 85)

Membership	Frequency (n)	Percentage	Rank
Male	60	70.6%	1
Female	25	29.4%	2
TOTAL	85	100	

4.2.5 Age

The majority of the respondents (57.7%) were aged between 41 and 60 years as indicated in Table 7 below.

Table 7: Age of respondents (n=85)

Age	Frequency (n)	Percentage	Rank
30 and below	2	2.4%	6
31-40	15	17.6%	3
41-50	19	22.4%	2
51-60	30	35.3%	1
61-70	14	16.5%	4
71 and above	5	5.9%	5
TOTAL	85	100	

One can conclude that most of the church leaders who participated in this study were middle aged and 20% were younger than 40 years.

4.2.6 Educational qualifications

Education was categorised according to the highest educational level completed. The majority of the leaders had completed secondary education (45.9%); whilst 44.8% had completed tertiary education, which includes post-school qualifications and degrees, as shown in Table 8 below.

Table 8: Highest educational qualification (n=85)

Qualification	Frequency (n)	Percentage	Rank
None	1	1.2%	5
At most up to primary level	4	4.7%	3
At most up to secondary level	39	45.9%	1
A-level	3	3.5%	4
Tertiary	38	44.8%	2
TOTAL	85	100	

The highest educational qualification among the church leaders who participated in this study was secondary education followed by tertiary education. Thus, one can conclude that the majority of church leaders who participated in this study were literate.

4.3 HIV AND AIDS EXPERIENCE

The responses regarding church leaders' involvement in HIV and AIDS activities are presented in Table 9 below. This study found that less than half (45.6%) of the church leaders' involvement in HIV and AIDS church activities were targeted at prevention of HIV infection.

Table 9: Involvement in HIV and AIDS activities (n=79)

Activity	Frequency (n)	Percentage	Rank
Prevention education	36	45.6%	1
Pastoral care and counselling	13	16.5%	2
Counselling vulnerable groups/PLHIV/Widows	11	13.9%	3
Orphan care	8	10.1%	4
Promotion of VCT	6	7.6%	5
Home-based care	3	3.8%	6
Promoting herbal gardens	1	1.3%	7
Presiding at services/elder/Christian awareness	1	1.3%	7
TOTAL	79	100	

The activities that were mentioned to target the prevention of HIV infection were related to HIV and AIDS education and awareness, promotion of abstinence, faithfulness and condom use (ABC), peer education and behaviour change communication. With more than half of church leaders (54.5%) not involved in HIV prevention in the face of a high adult HIV prevalence rate of 15% experienced in Zimbabwe, the attitudes and views of church leaders regarding their leadership roles in HIV prevention need to be reviewed critically to determine what prevents them from addressing the threats posed by the epidemic.

However, in terms of attending training in HIV prevention, 43.5% of the church leaders who participated in the main survey had attended whilst 56.5% had not attended. It can be observed that the proportion of respondents who attended training in HIV prevention is similar to that involved in HIV prevention activities including prevention education. In terms of types of training received, the most common were prevention, pastoral care and counselling as well as counselling of vulnerable groups/PLHIV/widows.

The majority of the church leaders (92.9%), had encountered a person living

with HIV whilst only six did not encounter a person living with HIV. This acknowledgement of knowing someone living with HIV clearly indicates the magnitude of the epidemic and the unimaginably large burden of the illnesses felt by the churches and communities. Therefore, it requires churches to reflect upon HIV and AIDS as a reality of life and a challenge to their calling.

4.4 DESCRIPTIVE FINDINGS

4.4.1 ATTITUDES TOWARDS LEADERSHIP ROLES IN HIV PREVENTION

An assessment of the attitudes of church leaders towards their leadership roles in HIV prevention is integral to understanding the current involvement of the church leadership and the development, by policy makers, of improved strategies to increase the response to the epidemic, especially in rural and remote areas. In this regard, the conceptual model of the Theory of Reasoned Action (TRA) guided this study. According to this model, the concepts of “belief”, “attitudes”, “subjective norms”, “intentions” and “behaviour” are the major components that affect the likelihood of performing a particular behaviour (Terry *et al* 1993:8, citing Fishbein and Ajzen 1991).

To elicit beliefs underlying their attitudes, the respondents were given statements on leadership roles in HIV prevention to which they had to respond. These statements were divided in the following five categories:

- Barriers when discussing the sexual risk of HIV transmission with parishioners and the clergy.
- Advantages of talking to parishioners and the clergy about the sexual risk of HIV transmission.
- Consequences of not talking to parishioners and clergy about the sexual risk of HIV transmission.
- Advantages of providing advice on HIV prevention to parishioners and the clergy.

- Consequences of providing advice on HIV prevention to parishioners and the clergy.

The five above-mentioned categories will be discussed below.

4.4.1.1 Barriers

The respondents were asked to indicate the degree to which they felt certain issues could be regarded as barriers by utilising four response options, which were:

- To a large extent
- To some extent
- Not at all
- Don't know

The response options “to some extent” and “to a large extent” were grouped together to rank the issues in terms of level of degree of extent as indicated in Table 10 below.

The three main issues with regard to which respondents felt that no barriers existed were:

- Church is not the place to discuss HIV (55.3%)
- When the people you have to talk to are younger than you (54.1%)
- Past risky sexual behaviour on your part (54.1%)

Table 10 below shows that more than half (55.3%; 54.1%; 54.1% respectively) of the respondents indicated that the last three statements, (Church is not the place to discuss HIV; When the people you have to talk to are younger than you; Past risky sexual behaviour on your part), would not deter them from discussing sexual issues with parishioners and clergy. These findings suggest that the Evangelical Lutheran Church in Zimbabwe has made some achievements in breaking the silence around HIV prevention as mandated by the LWF Action Plan 2002 and the LUCSA Strategic Plans 2008 – 2012 and

2013 -2017. Thus, one can pose the question whether the persistent high level of HIV prevalence with its resulting impact of AIDS-related illness and death may have propelled church leaders into discussing HIV and AIDS-related issues.

However, a third of the respondents (31.7 %, 30.6%, 29.4% respectively) have found the above-mentioned issues as barriers “to some extent” / “to a large extent.” This is worrying as this may suggest that there could still be a strong feeling within the church that HIV affects only those outside the church if church leaders continue to view the church as an inappropriate venue to discuss HIV issues.

The fact that 29.4% showed concern over their “past risky sexual behaviour” as indicated in the above paragraph, suggests the need to deal with personal factors and unknown fears that may negatively influence the behaviour and affect the confidence of the respondents in terms of taking up leadership roles in HIV prevention. Fear of “past risky behaviours” may result in fear of being stigmatised by both congregants and the church hierarchy if there are no supportive policies (Eriksson *et al* 2010). The measurement of self-efficacy may help gain some insights into further factors influencing the decision-making process regarding leadership positions in HIV prevention.

Scholars indicate that a sizable number of church leaders still battle with cultural issues regarding HIV prevention strategies that require people to talk about sex and sexuality - topics that many find uncomfortable to engage in, in public discussions (Paterson 2009). In the case of this study, when those who said “to a large extent and to some extent” are combined, more than one third (41.2%) of the respondents agreed with the following statement: “Cultural belief that talking about sex is taboo”. However, 45.9% indicated that “talking about sex is taboo”, was not a barrier, while 12.9% failed to take a position on this statement. The issues pertaining to sex and sexuality remain a challenge for many to the extent that if not addressed, they may compromise the meaningful involvement of church leaders in HIV prevention.

Table 10: Degree to which issues are barriers

Barriers	Level of extent					Rank
	To a large extent	To some extent	Not at all	Don't know	Total	
When traditionally respected persons, such as in-laws, are part of the group you address	20.0% (17)	36.5% (31)	23.5% (20)	20.0% (17)	100% (85)	1
Lack of confidence	15.3% (13)	37.7% (32)	34.1% (29)	12.9% (11)	100% (85)	2
People are bored of HIV/AIDS because everybody now knows about it	14.1% (12)	35.3% (30)	31.8% (27)	18.8% (16)	100% (85)	3
Lack of HIV prevention knowledge on your part	16.5% (14)	30.6% (26)	37.6% (32)	15.3% (13)	100% (85)	4
When the person you speak to has higher status than you	17.7% (15)	28.2% (24)	34.1% (29)	20.0% (17)	100% (85)	5
Not knowing your own HIV status	21.2% (18)	23.5% (20)	31.8% (27)	23.5% (20)	100% (85)	6
When the people you have to talk to are older than you	20.0% (17)	22.4% (19)	43.5% (37)	14.1% (12)	100% (85)	7
Cultural belief that "talking about sex is taboo"	14.1% (12)	27.1% (23)	45.9% (39)	12.9% (11)	100% (85)	8
Not having first-hand experience of a person living with HIV	14.1% (12)	24.7% (21)	41.2% (35)	20.0% (17)	100% (85)	9
Church is not the place to discuss HIV	14.1% (12)	17.7% (15)	55.3% (47)	12.9% (11)	100% (85)	10
When the people you have to talk to are younger than you	15.3% (13)	15.3% (13)	54.1% (46)	15.3% (13)	100% (85)	11
Past risky sexual behaviour on your part	9.4% (8)	20.0% (17)	54.1% (46)	16.5% (14)	100% (85)	12

By grouping together the responses of “to some extent” and “to a large extent,” the key barriers to the successful performance of leadership roles in HIV prevention seem to be:

- When traditionally respected persons, such as in-laws are part of the group one is addressing (56.5%).
- Lack of confidence (52.9%).
- People are bored of HIV and AIDS because everybody now knows about it (49.4%).

With regard to the aspect of “in-laws,” one can conclude that due to the close connection between HIV prevention messages and topics regarded as culturally sensitive or taboo, such as sex and sexuality, more than half of the respondents would have a problem discussing these topics in the presence of their in-laws. This raises the issue of finding an “appropriate language” for discussing HIV prevention without offending those holding certain cultural beliefs, yet, taking care not to under-deliver the message as one might end up avoiding the real issues around the sexual transmission of HIV.

With more than half (52.9%) of the respondents indicating that a “lack of confidence” is a barrier to taking up leadership roles in HIV prevention, it suggests the need to identify further personal factors that influence their decisions to engage in HIV prevention. These factors need to be addressed to improve the confidence of church leaders. Policy makers need to recognise such constraints faced by church-based responses to HIV prevention and develop appropriate strategies that encourage sensitivity to the church leaders’ perspectives of HIV and AIDS and improve their confidence and greater involvement in the response to the epidemic.

Almost half (49.4%) of the respondents viewed “People are bored of HIV and AIDS because everybody now knows about it,” as a barrier. This may point towards a demotivational factor regarding the church leaders’ involvement in HIV prevention, as they may not see the benefit of being at the forefront of HIV prevention activities due to the perceived widespread knowledge of HIV

and AIDS.

Another aspect had almost the same proportion of respondents rating it as a barrier and not a barrier, namely, “talking to older people than myself”. Respect for the elderly is a practice that is highly valued in many African cultures. Traditionally, speaking about all that pertains to sexual activity is normally a cultural taboo (Chitando 2007; Paterson 2009) including talking about sex openly with respected and significant others. This indicates the difficulties in communicating HIV prevention measures specifically because of topics that are regarded as taboos, such as sex and sexuality.

One can conclude that the Lutheran church could be a potential source for information on HIV prevention in Zimbabwe if the barriers relating to talking to in-laws on sexual issues, lack of confidence and the perceived wide spread knowledge of HIV and AIDS are addressed.

All of the 12 factors, combining “to some extent” and “to a large extent”, had between 29.4% and 56.5% of the respondents rating them as barriers as shown in Table 10 above and these can be grouped as follows:

- **Self-efficacy constraints:** confidence, experience, social status, knowledge; e.g. “people are bored of HIV and AIDS because everybody now knows about it”; “not having first-hand experience of a person living with HIV”; “status of the person I speak to higher than own”; “lack of HIV prevention knowledge”; “lack of confidence”; “own past risky sexual behaviour”.
- **Institutional constraints:** “church not a place to discuss HIV (approximately, a third of the respondents concurred with this statement).
- **Cultural constraints:** “presence of traditionally respected people, e.g. in-laws”; “when the person you speak to has higher status than you”; “talking about sex is taboo.”

4.4.1.2 Advantages of talking to parishioners and clergy about the sexual risk of HIV transmission

The respondents were asked to rate the likelihood of certain outcomes of talking about the sexual risk for HIV transmission with parishioners and the clergy (see Table 11 below). The outcomes were ranked according to responses indicated that the outcome is likely to happen.

The top outcomes that are likely to occur with a high frequency of at least 75% according to the respondents were:

- This will encourage positive living by PLHIV (85.9%).
- It will reduce stigma and discrimination, making people talk about HIV prevention freely (82.4%).
- There will be better management of HIV and AIDS as a disease (77.4%).
- Such talks will lead to positive attitudes and sexual behavioural change (77.4%).
- Persons living with HIV and those affected will not feel discriminated by the church (75.3%).

These findings indicate that the majority of the respondents were optimistic about the positive effects of them talking about the sexual risk of HIV transmission as leaders of the church. These expected positive effects encourage promotion of churches as stigma-free social environments that will allow open discourse on HIV prevention and education on positive living for PLHIV to enhance risk reduction behaviours.

A high proportion (74%) of church leaders also acknowledge that more open discussion about HIV prevention with parishioners and the clergy will lead to a decline in the number of people being infected by HIV. With the majority acknowledging the benefits of their involvement in this way, this can serve as a starting point to engage the church leaders further to overcome the barriers identified in Table 11 and to get a stronger commitment on the part of

everybody involved to give their support.

In addition, a large proportion of the respondents (71.8%) felt that taking a leadership role in HIV prevention would reduce the loss of its members. This may suggest that the church may well be experiencing a loss of church's members due to AIDS-related deaths and the church now sees the need to be fully involved in HIV prevention.

However, on the outcome statement "such talks will lead to positive attitudes and sexual behaviour change", the respondents who felt that it would be either "unlikely to happen (8.3%)" or "don't know what will happen (14.3%)", give an impression that there is need for an understanding of the parishioners' and the clergy's attitude concerning behaviour change.

The response to HIV prevention by the church leaders, therefore, needs to be informed by the underlying attitudes of the parishioners towards adoption of HIV prevention measures if such outcomes are to be realised.

Twenty-five percent (25.9%) of the respondents believed that their talking about the sexual risk of HIV transmission was "unlikely" to motivate people to go for an HIV-test and 16.5% were ambivalent. This is worrying as it suggests that as much as church leaders may engage in HIV prevention talks, parishioners in the church leaders' opinion may not view themselves as to be at risk of acquiring HIV infection; therefore, HIV testing is not meant for them as the church-goers, but only for those (outsiders) who indulge in risky behaviours.

By grouping together the responses of "unlikely" and "don't know," 40.5% of the respondents believe HIV cannot be regarded like other chronic diseases, such as high blood pressure and diabetes mellitus. It therefore seems that HIV cannot be regarded as a chronic disease possibly because of its link or association with sexual transmission, sexual immorality and stigma. It therefore appears that more work still has to be done on education and destigmatisation of HIV and AIDS.

Table 11: Extent of likelihood of outcomes in talking to Parishioners and the clergy about sexual risk of HIV transmission

Outcome	Likelihood				Rank
	Likely to happen	Unlikely to happen	Don't know	Total	
This will encourage positive living by PLHIV	85.9% (73)	5.9% (5)	8.2% (7)	100% (85)	1
It will reduce stigma and discrimination, making people talk about HIV prevention freely	82.4% (70)	7.0% (6)	10.6% (9)	100% (85)	2
There will be better management of HIV and AIDS as a disease	77.4% (65)	4.8% (4)	17.9% (15)	100% (84)	3
Such talks will lead to positive attitudes and sexual behaviour change	77.4% (65)	8.3% (7)	14.3% (12)	100% (84)	3
Those infected and affected will not feel discriminated against by the church	75.3% (64)	7.1% (6)	17.6% (15)	100% (85)	5
More open discussions about HIV prevention among parishioners will lead to a decline in the number of people being infected by HIV	74.1% (63)	10.6% (9)	15.3% (13)	100% (85)	6
The church will not lose members due to death and leaving the church to seek faith healing elsewhere	71.8% (61)	16.4% (14)	11.8% (10)	100% (85)	7
The youth will be able to deal with fear and feel free to get tested for HIV	68.2% (58)	14.1% (12)	17.7% (15)	100% (85)	8
People I talk to will have more knowledge of HIV prevention	65.9% (56)	21.2% (18)	12.9% (11)	100% (85)	9
There will be increased condom use	61.9% (52)	10.7% (9)	27.4% (23)	100% (84)	10
AIDS will be regarded as a chronic disease normalising it, like high blood pressure, diabetes mellitus etc.	59.5% (50)	25.0% (21)	15.5% (13)	100% (84)	11
More people will go for an HIV-test if I talk to my parishioners and clergy	57.6% (49)	25.9% (22)	16.5% (14)	100% (85)	12
Sex education for young people will encourage early onset of sexual activity	44.7% (38)	32.9% (28)	22.4% (19)	100% (85)	13

Only one aspect, “sex education for young people will encourage early onset of sexual activity”, had less than half of the respondents (44.7%) stating that it was “likely” to happen. In this case, only 32.9% of the respondents indicated

that it was unlikely to occur whilst 22.4% did not know what would happen. One can say that almost 45% of the church leaders seem to think that sex education to youth will encourage them to be sexually active. This is quite a large proportion, considering that almost half of the church leaders had this perception. The question to be asked in this regard is: Are the church leaders with this kind of thinking likely to discuss sex education with youths? Considering the youth are the ones at highest risk of being infected with HIV, it is essential that church leaders should be re-oriented to be able to facilitate sex education without fearing that young people will prematurely engage in sexual activities. Such dialogue would close the current gaps and missed opportunities for empowering young people to understand issues around HIV prevention and taking leadership in protecting themselves.

4.4.1.3 Consequences of not talking to parishioners and clergy about the sexual risk of HIV transmission.

In this case, the respondents were asked to rate the likelihood of certain consequences, as set out in Table 12, of not talking about issues with regard to the sexual transmission of HIV. The consequences were ranked according to the responses of those who indicated it was likely to occur.

The top consequences that are likely to happen with a high frequency of at least 75% indicated by the respondents included:

- People will remain in the dark and the number of people who are infected and affected will increase (84.7%)
- Denial will persist and those infected will keep infecting others (80.0%)
- There will be an increase in the number of orphans (80.0%)
- The loss of church members to AIDS-related deaths will increase (75.3%)
- There will be no sharing of information and ideas on how to help persons living with HIV and those affected by HIV (75.3%)

All the consequences had more than 60% of respondents regarding them as

“likely to happen”. One can conclude on this basis that the church leaders are agreeing that there is a need to talk to parishioners and clergy about the sexual transmission of HIV.

Table 12: Extent of likelihood of the consequences of not talking to parishioners and clergy about the sexual risk of HIV transmission

Consequences	Likelihood			Total	Rank
	Likely to happen	Unlikely to happen	Don't know what will happen		
People will remain in the dark and the number of people who are infected and affected will increase	84.7% (72)	9.4% (8)	5.9% (5)	100% (85)	1
There will be an increase in the number of orphans	80.0% (68)	10.6% (9)	9.4% (8)	100% (85)	2
Denial will persist and those infected will keep infecting others	80.0% (68)	11.8% (10)	8.2% (7)	100% (85)	2
The loss of church members to AIDS-related deaths will increase	75.3% (64)	17.6% (15)	7.1% (6)	100% (85)	4
There will be no sharing of information and ideas on how to help those living with HIV and those affected by AIDS	75.3% (64)	21.2% (18)	3.5% (3)	100% (85)	4
People may believe that there is no persons living with HIV in the church	74.1% (63)	18.8% (16)	7.1% (6)	100% (85)	6
There will be denial that AIDS is a problem	72.94% (62)	18.82% (16)	8.24% (7)	100% (85)	7
There will be increased stigma of Persons living with HIV	70.2% (59)	17.9% (15)	11.9% (10)	100% (84)	8
There will be a reduction in church attendance	64.7% (55)	25.9% (22)	9.4% (8)	100% (85)	9
Church leaders may disassociate themselves from HIV and AIDS and will not be able to assist those in need	62.4% (53)	23.5% (20)	14.1% (12)	100% (85)	10

The church leaders thus should be responsible and ensure that denial regarding the existence of HIV among parishioners as well as the assumption that churchgoers could be immune to infection are addressed to enhance prevention efforts.

4.4.1.4 Advantages of providing advice on HIV prevention to parishioners and clergy

The respondents were asked to indicate the likelihood of advantages as listed in Table 13 below likely to occur if they provided advice to the parishioners and clergy on HIV prevention. The frequency related to the option “likely” was used to rank the responses.

Table 13: Extent of likelihood of outcome in providing advice

Advantages	Likelihood			Total	Rank
	Likely	Unlikely	Don't Know		
People will be better informed about the disease	94.1% (80)	2.4% (2)	3.5% (3)	100% (85)	1
More lives will be saved	91.8% (78)	5.9% (5)	2.3% (2)	100% (85)	2
More people will participate in health programmes such as Prevention of Parent-to-Child Transmission (PPTCT) of HIV infection	90.6% (77)	3.5% (3)	5.9% (5)	100% (85)	3
It will reduce the number of new HIV infections	89.4% (76)	7.1% (6)	3.5% (3)	100% (85)	4
More people will take up HIV-testing	85.7% (72)	3.6% (3)	10.7% (9)	100% (84)	5
Those infected with HIV will live longer	84.7% (72)	9.4% (8)	5.9% (5)	100% (85)	6

All the listed advantages in Table 13 above had a likelihood of at least 84%, according to the respondents, of occurring. The three top advantages that had over 90% of the respondents indicating that they were “likely” to happen, were:

- People will be better informed about the disease (94.1%)
- More lives will be saved (91.8%)
- More people will participate in health programmes such as the Prevention of Parent-to-Child Transmission (PPTCT) of HIV infection (90.6%)

The above findings indicate that the respondents agreed that there was a need to provide advice on HIV prevention. Nearly all the respondents (94.1%) were convinced that if church leaders provided advice on HIV prevention people would be better informed about the disease. This response was similar to the results presented in Table 11 on the outcomes of talking about the sexual risk of HIV transmission where the majority supported the statement that people would be knowledgeable (65.9%) and better able to manage the disease (77.4%) if church leaders took a leading role engaging parishioners and clergy on HIV prevention.

4.4.1.5 Consequences of providing advice on HIV prevention to parishioners and clergy

The respondents were asked to indicate the likelihood of the consequences materialising, as listed in Table 14 below, when providing advice on sexual transmission of HIV to parishioners and clergy. The frequency with regard to the “likelihood” option was used to rank the responses.

When considering the responses in this regard, only one aspect, “the promotion of condom use will encourage early sexual experimentation amongst young people”, had slightly more than half of the respondents (52.9%) stating that it was “likely” to happen. The statement “the promotion of condom use will encourage promiscuity” was ranked second with 44.7%

indicating that it was “likely” to happen. The high ranking of the two consequences mentioned above reflect a perception that might lead to unwillingness on the part of the church leaders to promote condom use as a preventive measure, thus limiting the promotion of options for effective safe practices against HIV infection, especially for young people. However, as pointed out in Vatican (2011), the Catholic Archbishop Tomas of the Holy See rather recommends a “completely meaningful lifestyle for the person” that includes teachings on dignity of the human person, the sanctity of marriage and sexual abstinence outside marriage and mutual fidelity within marriage as opposed to condom promotion.

In the case of five items, the “unlikelihood” of the consequences occurring was above 50%, namely:

- People may think you are falsely accusing them of promiscuity (55.3%)
- Providing advice on HIV prevention might lead to a shortage of resources especially when people take positive action, for example, an increased demand of condoms may result in reduced condom supply (52.9%)
- Your advice may result in family quarrels (57.6%)
- Pastors will become suspicious and think you belittle them (64.7%)
- It may lead others to risky behaviour (64.7%)

The implications of the declining likelihood of these consequences to occur suggest that people understand the problem of HIV to be a more serious health issue, so it warrants strengthening community systems including churches and other religious organisations to be instrumental in implementing HIV prevention programmes.

Table 14: Extent of likelihood of consequences of providing advice on HIV prevention

Consequence	Likelihood			Total	Rank
	Likely	Unlikely	Don't Know		
The promotion of condom use will encourage early sexual experimentation amongst young people	52.9% (45)	35.3% (30)	11.8% (10)	100% (85)	1
The promotion of condom use will encourage promiscuity	44.7% (38)	40.0% (34)	15.3% (13)	100% (85)	2
Advice on HIV prevention may lead to increased health-seeking behaviours for care, resulting in decreased access to services	44.7% (38)	42.4% (36)	12.9% (11)	100% (85)	2
The promotion of condom use will prevent conception which is a God-given gift for humanity	34.1% (29)	42.4% (36)	23.5% (20)	100% (85)	4
People may think you are falsely accusing them of promiscuity	32.9% (28)	55.3% (47)	11.8% (10)	100% (85)	5
Advice on HIV prevention may lead to a shortage of resources especially when people take up positive action, for example, an increased demand of condoms may result in reduced supply	30.6% (26)	52.9% (45)	16.5% (14)	100% (85)	6
Your advice may result in family quarrels	28.2% (24)	57.7% (49)	14.1% (12)	100% (85)	7
Pastors will become suspicious and think you belittle them	22.3% (19)	61.2% (52)	16.5% (14)	100% (85)	8
Advice on HIV prevention may lead others to risky behaviour	22.4% (19)	64.7% (55)	12.9% (11)	100% (85)	8

4.4.2 NORMATIVE BELIEFS REGARDING THE INFLUENCE OF SIGNIFICANT OTHERS

In order to describe the extent to which the respondents thought that significant others wanted them to engage in leadership roles in HIV prevention, the respondents were asked to indicate whether certain groups of people or organisations would be supportive or not to the church leaders talking about the sexual risk of HIV transmission or providing advice on HIV prevention to the parishioners and clergy, using the responses stated below:

- Will support
- Will not support
- Don't know

The church leaders' responses with regard to the level of obstruction to be expected from persons, groups or organisations in talking about the sexual risk of HIV transmission or providing advice on HIV prevention are discussed in detail and presented in Tables 15 and 16 below.

4.4.2.1 Level of support of various groups

The respondents were asked to indicate the likelihood that various groups or organizations will assist and support them by engaging in talking about the sexual risk of HIV transmission or providing advice on HIV prevention to the parishioners and the clergy. The frequency of responses that indicated expectations of support was used to rank the groups.

With regard to each of these groups/organisations listed in Table 15 below, 80% or more of the respondents indicated that they expect that the various groups/organisations will support them. Thus, the level of expected support was high. However, one can ask, to what extent are the services of these groups/organisation utilised by the church leaders to enhance their own leadership roles in HIV prevention? This aspect needs to be explored in more depth.

Table 15: Groups or Organisations likely to support

Groups or organisations	Level of support				Rank
	Will support	Will not support	Don't Know	Total	
Pastors	88.2% (75)	1.2% (1)	10.6% (9)	100% (85)	1
Bishops	87.0% (74)	1.2% (1)	11.8% (10)	100% (85)	2
National AIDS Council (NAC)	87.0% (74)	1.2% (1)	11.8% (10)	100% (85)	2
Non-governmental organisations	87.1% (74)	3.5% (3)	9.4% (8)	100% (85)	2
Zimbabwe National Network of People Living with HIV (ZNNP+)	86.9% (73)	2.4% (2)	10.7% (9)	100% (84)	5
Matabeleland AIDS Council (MAC) organisation	85.9% (73)	2.3% (2)	11.8% (10)	100% (85)	6
The government	85.9% (73)	4.7% (4)	9.4% (8)	100% (85)	6
People living with HIV	84.7% (72)	3.5% (3)	11.8% (10)	100% (85)	8
Lutheran Communion in Southern Africa (LUCSA)	84.7% (72)	3.5% (3)	11.8% (10)	100% (85)	8
Partners	83.5% (71)	2.4% (2)	14.1% (12)	100% (85)	10
Those who have lost relatives to AIDS-related illnesses	81.2% (69)	10.6% (9)	8.2% (7)	100% (85)	11

4.4.2.2 Likelihood of obstruction by various groups/organisations/persons

The respondents were asked to indicate the level of obstruction to be expected from persons, groups or organisations in talking about the sexual risk of HIV transmission or providing advice on HIV prevention. The frequency of the responses to “will obstruct”, was used to rank the groups.

Table 16: Level of obstruction

Persons/groups/organisations	Likelihood			Total	Rank
	Will obstruct	Will not obstruct	Don't know		
“Sugar daddies or sugar mummies”	54.1% (46)	28.2% (24)	17.7% (15)	100% (85)	1
Individuals or people who have negative attitudes towards HIV/AIDS and see themselves as “holy”	50.6% (43)	30.6% (26)	18.8% (16)	100% (85)	2
Sex workers	48.24% (41)	32.94% (28)	18.82% (16)	100% (85)	3
Other organisations who may feel that there is duplication of programmes and fear competition	30.6% (26)	40.0% (34)	29.4% (25)	100% (85)	4
Some political parties	30.6% (26)	48.2% (41)	21.2% (18)	100% (85)	4
Young people	28.2% (24)	56.5% (48)	15.3% (13)	100% (85)	6
Some of the pastors	24.7% (21)	58.8% (50)	16.5% (14)	100% (85)	7

The significant others whose opinion respondents expected to be supportive of them taking leadership roles in HIV prevention were “some of the pastors” (58.8%) and “young people” (56.5%). Almost half of the respondents (48.2%) expressed the opinion that some political parties will be supportive. One can

conclude that church leaders were less concerned about what pastors and young people and to some extent some political parties thought of their leadership roles in HIV prevention as they indicated that these groups of people were likely not to obstruct their behaviour.

The most important others who church leaders expected would obstruct their leadership roles in HIV prevention included:

- “Sugar daddies or sugar mummies” (54.1%),
- Individuals or people who have negative attitudes towards HIV and AIDS and see themselves as “holy” (50.6%)
- Sex workers (48.2%)

Such views might lead some church leaders to distance themselves from those who are to take a lead in HIV prevention as they associate HIV transmission with “immoral people” who are believed to be outside the church circle. In this regard, church leaders with such views may not be motivated to take up leadership roles in HIV prevention. “Sugar daddies or sugar mummies” refer to people who engage in trans-generational sex for financial benefits.

4.5 FACTOR ANALYSIS

Factor analysis is a collection of statistical methods used to examine how underlying constructs influence the response on a number of measured variables. It is a statistical approach that can be used to analyse interrelationships among a large number of variables and to explain these variables in terms of their common underlying dimensions (factors). This statistical approach involves finding a way of condensing the information in a number of original variables into a smaller set of dimensions (factors) with a minimum loss of information (Hair *et al* 2010).

An adequate sample size is usually regarded as one where the sample size is at least 5 times the number of variables. Therefore, the size of the sample of

this study should be at least 60. In the case of this study the sample size is 85, which is adequate for factor analysis to be employed. A sample size of 85 requires factor loadings of 0.6 or more (Hair *et al* 2010).

The suitability of data for factor analysis can be determined by using the Kaiser-Meyer Olkin (KMO) measures of sampling adequacy and Bartlett's test of sphericity. The KMO and Bartlett's test measure the strength of the relationships among variables. In order for factor analysis to be suitable, the KMO value should exceed the heuristic value of 0.7. Bartlett's test of sphericity is a statistical test for measuring the presence of correlations among variables. It measures the statistical significance of correlations among at least some of the variables.

4.5.1 Attitudes Toward Leadership Roles in HIV Prevention

Factor analysis was used to group together variables that were closely related into categories on the attitude items that were tested for reliability - these included Q11 to Q17 of the questionnaire. Determining unique dimensions in the data helped to gain insight into the attitudes held by church leaders towards their leadership roles in HIV prevention.

The results that give a description of the highest loading variables on each of the rotated factors are presented below. The variables specifically identified attitudes regarding (a) barriers in personally discussing the sexual risk for HIV transmission, (b) advantages of talking about the risk of the sexual transmission of HIV, (c) consequences of not talking about the risk of sexual transmission of HIV and (d) normative beliefs regarding the level of support of and obstruction by the significant others.

4.5.1.1 Issues that are barriers when discussing the sexual risk of HIV transmission with parishioners and the clergy

The Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy was 0.717,

indicating that the correlations were adequate for factor analysis. Secondly, Bartlett's test was used to test for lack of sufficient correlation between variables. The null hypothesis states that there is lack of sufficient correlation between variables. The **p-value = 0.000**, in other words, it was less than 0.05, thus, the null hypothesis was rejected and the researcher concluded that there was a sufficient correlation between the variables. Thus, the results from both tests were deemed adequate to allow for the meaningful interpretation of the analysis of the variables.

The communalities indicate the degree to which each variable is participating or contributing to the component solution. All communalities were above 0.5. The number of factors was determined by taking those eigenvalues that were more than 1. In this case, four factors were retained as indicated below. The first factor accounted for 34.16%, the second factor for 12.26%, the third factor for 10.85% and the fourth factor for 10.12% of the variance. All in all, the factors accounted for 67.39% of the variance. In practice a robust solution should account for at least 50% of the variance. The factor analysis grouped the items into four factors but only three factors had more than one item and these were used to name factors 1 to 3 as presented in Table 17 and in the discussion below:

Factor 1: Barriers due to difference between communicator and audience

The question items that constituted the first factor reflect barriers due to differences between communicator and audience when discussing the sexual risk of HIV transmission with the parishioners and the clergy. Four items loaded on this factor with two of these loading at a value of 0.818 and greater while the other two loaded at a value of 0.575 and greater as indicated below:

- When the people you have to talk to are older than you **(0.830)**
- When the people you have to talk to are younger than you **(0.818)**
- When traditionally-respected persons, such as in laws are part of the group you address **(0.593)**

- Cultural belief that 'Talking about Sex' is taboo (**0.575**)

Table 17: Issues that are barriers

Consequence	Component			
	1	2	3	4
When the people you have to talk to are older than you	.830	.119	.157	.226
When the people you have to talk to are younger than you	.818	.153	.035	.159
When traditionally-respected persons, such as in laws are part of the group you address	.593	.215	.377	-.089
Cultural belief that 'Talking about Sex' is taboo	.575	.208	.317	-.191
People are bored of HIV/AIDS because everybody now knows about it	.055	.845	.117	.015
Past risky sexual behaviour on your part	.188	.766	.267	.135
Church is not the place to discuss HIV	.305	.712	-.116	.010
When the person you speak to has more status than you	.221	.041	.822	.075
Not having first-hand experience of a person living with HIV	.250	.065	.720	-.100
Lack of confidence	-.107	.227	.569	.538
Lack of HIV prevention knowledge on your part	.166	.032	-.060	.874

One question item, “when traditionally-respected persons, such as in-laws are part of the group you address”, supports the descriptive findings reflected in Table 10. The nature of these items identified as barriers due to difference between communicator and audience could be interpreted as reflecting attitudes that express the church leaders’ underlying beliefs, values and cultural conceptions. These beliefs, values and cultural conceptions reflect perceptions about what is acceptable within one’s community and these, in turn, shape the identity of an individual and facilitate interpersonal relations. For example, the fourth factor item “cultural belief that ‘talking about sex’ is taboo” could indicate that people are still firmly rooted in cultural beliefs which stipulate that talking about sex is taboo.

The main mode of HIV transmission in Southern Africa is through sexual contact. Generally, public discussion of sex and sexuality in the African society

and especially in some churches, remains taboo. These personal beliefs that are influenced by the person's culture may have contributed to these responses. This, therefore, makes talking about sexual transmission of HIV difficult for many, especially in public.

Identifying how socio-cultural and personal values interact with and determine the boundaries of communication between people and about certain topics, is important as it provides relevant information for the development of interventions that will influence the specific attitudes that church leaders hold toward taking leadership roles in HIV prevention

Factor 2: Barriers due to experiences and perceptions of the communicator

The question items that constituted the second factor reflect barriers due to the experiences and perceptions of the communicator when discussing the sexual risk of HIV transmission with the parishioners and the clergy. Three items loaded on this factor at a value of 0.712 and greater as indicated below:

- People are bored of HIV and AIDS because everybody now knows about it **(0.845)**
- Past risky sexual behaviour on your part **(0.766)**
- Church is not the place to discuss HIV **(0.712)**

The fact that two items loaded on this factor (“People are bored of HIV/AIDS because everybody now knows about it”; “Church is not the place to discuss HIV”) could be interpreted as reflecting defeatist attitudes in which the communicator feels defeated before he/she even starts. This could be because church leaders may have felt that their contributions would not add new information on HIV prevention as they assume the public has already received adequate knowledge. The second item “Church is not the place to discuss HIV” could be interpreted as revealing perceptions pertaining to moralisation of HIV (or that associate HIV with immoral behaviour”). One item, “past risky sexual behaviour on your part”, could be interpreted as reflecting self-protection from anxiety and attacks on self-esteem. This displays an

attitude that protects the self should people not be supportive of the church leaders' roles in HIV prevention as they might be viewed as not having been good role models due to their past risky sexual behaviours.

Factor 3: Barriers due to lack of self-efficacy

The question items that constituted the third factor reflected barriers related to a lack of self-efficacy when discussing the sexual risk of HIV transmission with parishioners and the clergy. Two items loaded on this factor at a value of 0.720 and greater as indicated below. A third item ("lack of confidence") loaded on two factors at values of 0.569 and 0.538, and therefore, was excluded. Consequently, the following two items were considered for Factor 3 as indicated below:

- When the person you speak to has more status than you **(0.822)**
- Not having first-hand experience of a person living with HIV **(0.720)**

The nature of the two items that loaded on this factor (i.e. barriers due to lack of self-efficacy) could be interpreted as reflecting defensive attitudes. The church leaders seem to reflect perceptions that express protection of self in a perceived environment that might condemn them for failing to deliver in their leadership roles in HIV prevention. In other words, they might be defending themselves from taking responsibility as a way of protecting their self-esteem.

The last item in this group of factors that related to barriers was not named since there was only one item, "Lack of HIV prevention knowledge on your part - **(0.874)**". Therefore, it was removed from the factor analysis. One item factor "Not knowing your own HIV status" loaded on both factors.

4.5.1.2. Advantages of talking to parishioners and clergy about the risk of the sexual transmission of HIV

The church leaders were asked to indicate the extent that various outcomes were likely to happen if they talked to parishioners and the clergy about the

sexual risk of HIV transmission. The KMO measure of sampling adequacy was 0.823 indicating that the correlations were adequate for factor analysis. Bartlett's test had a **p-value = 0.000**. Since the p-value was less than 0.05, the null hypothesis was rejected and the researcher concluded that there was sufficient correlation between variables. Thus, the results from both tests were deemed acceptable to allow the researcher to proceed with the analysis.

Table 18: Outcomes of talking to parishioners and the clergy about sexual risk of HIV transmission

Consequence	Component		
	1	2	3
More open discussions about HIV prevention among parishioners will lead to a decline in the number of people being infected with HIV.	.818	.228	-.039
Those infected and affected will not feel discriminated against by the church.	.790	.224	-.031
This will encourage positive living by people living with HIV.	.759	.322	.318
Such talks will lead to positive attitudes and sexual behaviour change.	.736	.027	.310
The people I talk to will have more knowledge of HIV prevention.	.716	.130	.240
It will reduce stigma and discrimination, making people talk about HIV prevention freely.	.709	.070	.503
There will be better management of HIV and AIDS as a disease.	.681	.324	-.271
Sex education for young people will encourage early onset of sexual activity.	.026	.815	.133
HIV and AIDS will be regarded as a chronic diseases normalizing it like high blood pressure, diabetes mellitus, etc.	.207	.737	.030
The church will not lose members due to death and leaving the church to seek faith healing elsewhere.	.405	.691	.118
There will be increased condom use.	.105	.179	.892

All communalities were above 0.5. The number of factors retained was three as indicated below. The first factor accounted for 46.74%, the second factor for 11.76% and the third factor 10.32% of the variance. All in all, the factors accounted for 68.81% of the variance. In practice, a robust solution should account for at least 50% of the variance.

The factor analysis grouped the questionnaire items into three factors as shown in Table 18 above. However, only two factors had more than one variable and these variables were used to name factors 4 and 5 as discussed below.

Factor 4: Perceived impact of HIV communication

The question items that constituted the fourth factor reflect the perceived impact of HIV communication about the sexual risk of HIV transmission that generates positive results. Seven items loaded on this factor at a value of 0.712 and greater as indicated below:

- More open discussions about HIV prevention among parishioners will lead to a decline in the number of people being infected with HIV **(0.818)**
- Those infected and affected will not feel discriminated against by the church **(0.790)**
- This will encourage positive living by people living with HIV **(0.759)**
- Such talks will lead to positive attitudes and sexual behaviour change **(0.736)**
- The people I talk to will have more knowledge of HIV prevention **(0.716)**
- It will reduce stigma and discrimination making people talk about HIV prevention freely **(0.709)**
- There will be better management of HIV and AIDS as a disease **(0.681)**

The items were related to the agreement with the fact that “talking to parishioners and the clergy about the sexual risk of HIV transmission” will benefit church members. The items express the value of talking to parishioners and the clergy about the sexual risk of HIV transmission which will result in increased knowledge on prevention, reduced stigmatisation and discrimination of PLHIV and improved management of the disease. The insight gained from this grouping of items suggests that some church leaders have positive attitudes towards their leadership roles in HIV prevention. On the basis of this result, one might argue that the benefits of talking to

parishioners and the clergy about the sexual risk of HIV transmission might be an important starting point for designing interventions that target the increased involvement of church leaders in HIV prevention.

Factor 5: Behaviour change results

The question items that constituted the fifth factor reflect a combination of positive and negative behaviour change outcomes perceived to result from talking about the sexual risk of HIV transmission. Three items loaded on this factor at a value of 0.691 and greater as indicated below:

- Sex education for young people will encourage early onset of sexual activity **(0.815)**
- HIV/AIDS will be regarded as a chronic disease normalising it like High Blood Pressure, Diabetes Mellitus etc. **(0.737)**
- The church will not lose members to death and leaving the church to seek healing elsewhere **(0.691)**

One questionnaire item, “sex education for young people will encourage early onset of sexual activity”, can be interpreted as expressing a concern about the fate of young people who are classified as vulnerable to HIV infection. This concern can also be interpreted as being related to perceptions pertaining to issues that are acceptable within the norms and values of a community. Promoting anything contrary to acceptable norms may result in being accused of promoting “immoral standards” and secluded from the social group. The belief that *sex education for young people will encourage early onset of sexual activity*, then becomes problematic for church leaders to engage in delivering comprehensive HIV prevention messages that are promoted by UNAIDS (2010) to include a combination of behavioural, biomedical and structural responses discussed under section 2.3 in chapter 2.

The items that constituted the last two groups of factors that relate to advantages were removed because the first factor had two questionnaire items, “more people will go for an HIV-test if I talk to my parishioners and

clergy” and “the youth will be able to deal with fear and feel free to get tested for HIV”, that had cross loadings even after rotating. The second factor was not named since there was only one variable, “there will be increased condom use” (0.892).

4.5.1.3 Factor analysis of consequences of not talking to parishioners and clergy about the sexual risk of HIV transmission

The church leaders were asked to indicate the extent that various consequences were likely to happen if they did not talk to parishioners and the clergy about the sexual risk of HIV transmission. The KMO measure of sampling adequacy was 0.795 indicating that the correlations were adequate for factor analysis. Bartlett’s test gave a p-value = 0.000, enabling the researcher to reject the null hypothesis that there is a lack of sufficient correlation between variables since the p-value = 0.000 (less than 0.05). Thus, the results from both tests were acceptable for one to proceed with the analysis.

All communalities were above 0.5 except for two with 0.498 and 0.450. The factor analysis grouped the question items related to consequences into two groups or factors, namely, “Adverse effects on church and society from withholding HIV communication” (factor 6) and “negative reactions in the church due to lack of leadership involvement” (factor 7). Factor 6 (concerning adverse effects on church and society) accounted for 48.32% of the variance. Factor 7 (that relates to negative reactions in the church due to lack of leadership involvement) accounted for 12.01% of the variance. All in all, the factors accounted for 60.33% of the variance. Thus, it is a robust solution since in practice, a robust solution should account for at least 50% of the variance. The factor analysis grouped the variables into the following two factors:

Table 19: Consequences of not talking to parishioners and clergy about sexual risk of HIV transmission

Consequence	Component	
	1	2
There will be no sharing of information and ideas on how to help persons living with HIV and those affected by HIV and AIDS.	.815	.144
The loss of church members to AIDS-related deaths will increase.	.797	.169
There will be an increase in the number of orphans.	.757	.217
People may believe that there is no HIV in the church.	.722	.336
There will be increased stigma of people living with HIV.	.711	.268
Denial will persist and those infected will keep infecting others.	.532	.463
Church leaders may disassociate themselves from HIV/AIDS...to assist those in need.	.097	.880
There will be denial that HIV-AIDS is a problem.	.180	.809
People will remain in the dark and the number of people...affected will increase.	.360	.554
There will be a reduction in church attendance.	.412	.529

Factor 6: Adverse effects on church and society from withholding HIV communication

The question items that constituted the sixth factor related to adverse effects on the church and society that might result if HIV and AIDS education information is not shared. Six items loaded on this factor at a value of 0.532 and greater as indicated below:

- There will be no sharing of information and ideas on how to help those infected and affected by HIV. **(0.815)**
- The loss of church members to AIDS-related deaths will increase. **(0.797)**
- There will be an increase in the number of orphans. **(0.757)**

- People may believe that there are no persons living with HIV in the church. **(0.722)**
- There will be increased stigma of people living with HIV. **(0.711)**
- Denial will persist and those infected will keep infecting others. **(0.532)**

The items expressed attitudes of concern that relate to perceived consequences of the spread of HIV and its resultant negative impact on the church and society. One could argue that church leaders understood the problem of HIV and AIDS to be a very serious health issue that is characterised by the burden of illness and suffering of the affected. These attitudes of concern are important and could influence willingness among church leaders to take a lead in talking about the sexual risk of HIV transmission.

Factor 7: The value of church leadership in HIV communication

The question items that constituted the seventh factor reflected negative reactions in the church due to lack of involvement of church leaders in talking to parishioners and the clergy about the sexual risk of HIV transmission. Four items loaded on this factor at a value of 0.529 and greater as indicated below:

- Church leaders may disassociate themselves from HIV and AIDS and will not be able to assist those in need. **(0.880)**.
- There will be denial that HIV and AIDS is a problem. **(0.809)**
- People will remain in the dark and the number of people who are infected and affected will increase. **(0.554)**
- There will be a reduction in church attendance. **(0.529)**

These findings highlight the necessity and value of church leadership in communicating about the sexual risk of HIV transmission as a lack of church leaders' involvement may result in missed opportunities to change attitudes and behaviour. The unique dimensions that could be determined in the Factor 7 items gravitate towards two areas: denial that HIV is a problem and high HIV

prevalence rates due to a lack of knowledge on HIV transmission. These outcomes are perceived to subsequently have a negative impact on the church in that the church will not become a place of refuge but rather a place of “refusal” as it will not assist those in need. Furthermore, there could be reduction in church attendance should church leaders fail to speak openly about the sexual risk of HIV transmission. One could argue that these results show concern by respondents that involvement of church leaders is critical to the control of the HIV epidemic and mitigation of its impact.

4.5.1.4 Factor analysis of advantages of providing advice on HIV prevention to parishioners and clergy

The church leaders were asked to indicate the extent to which various outcomes were likely to happen if they provided advice to parishioners and the clergy on HIV prevention. The KMO measure of sampling adequacy was 0.707 indicating that the correlations were adequate for factor analysis. Bartlett’s test had a p-value = 0.000 (which is less than 0.05) which enabled the researcher to reject the null hypothesis of a lack of sufficient correlation between variables. Thus, the results from both tests were acceptable and allowed the researcher to proceed with the analysis. All communalities are approximately above 0.5. Two factors were retained.

Table 20: Advantages of providing advice

Advantage	Component	
	1	2
The persons living with HIV will live longer	.784	.061
More lives will be saved	.760	.310
More people will take up HIV-testing	.728	.089
It will reduce the number of new HIV infections	.700	.308
People will be better informed about the disease	.050	.949
More people will participate in health programmes such as Prevention of Parent-to-Child Transmission (PPTCT) of HIV infection	.412	.822

The first factor accounted for 51.34% and the second factor for 18.07%. All in all, the factors accounted for 69.40% of the variance. Thus, it is a robust solution. The factor analysis grouped the variables into two groups, factor 8 and 9 as described below.

Factor 8: Positive effects for health outcomes

The first factor was named “positive effects for health outcomes” and it had loaded on four items, namely:

- Those infected with HIV will live longer **(0.784)**
- More lives will be saved **(0.760)**
- More people will take up HIV-testing **(0.728)**
- It will reduce the number of new HIV infections **(0.700)**

These results indicate that church leaders were in agreement that their involvement in HIV prevention could help in having a positive effect on the lives of their parishioners and the clergy. The items in this factor suggest that the church has a potential to controlling the spread of HIV infection, in this way, serve a “therapeutic” function that could complement health management of the epidemic. With such positive attitudes, one could argue that church leaders’ roles in HIV prevention, once enhanced, could create opportunities for their members to discuss ways of reducing susceptibility and vulnerability to HIV infection in their communities.

Factor 9: General positive outcomes

Factor 9 consisted of two items which loaded at values of 0.822 and greater as indicated below:

- People will be better informed about the disease **(0.949)**
- More people will participate in health programmes such as Prevention of Parent-to-Child Transmission (PPTCT) of HIV infection **(0.822)**

The items that loaded on this factor were related to church leaders’ agreement

with the fact that if people are better informed about HIV prevention, more people will participate in health programmes. These items appear to reflect the potential of church leaders' contribution to HIV prevention using their influence and dominant role in the society, thus, realising positive outcomes for the general population.

4.5.1.5 Factor analysis of consequences of providing advice on HIV prevention to parishioners and clergy

The church leaders were asked to indicate the extent that various consequences were likely to happen if they provided advice to parishioners and the clergy on HIV prevention. The KMO measure of sampling adequacy was 0.770 indicating that the correlations were adequate for factor analysis. Bartlett's test had a p-value = 0.000 (which is less than 0.05) which enables us to reject the null hypothesis of lack of sufficient correlation between the variables. Thus, the results from both tests were good and the researcher could proceed with the analysis.

All communalities are above 0.5 except one that had 0.399. Two factors were retained. The first factor accounted for 45.79% and the second factor for 14.09% of the variance. All in all, the factors accounted for 59.88% of the variance. Thus, it is a robust solution. The factor analysis as shown in Table 21 below, grouped the variables into two groups identified as factors 10 and 11 as set out below.

Factor 10: Anticipated negative outcomes of leadership engagement

The question items that constituted factor 10 related to anticipated negative outcomes if church leaders gave advice on HIV prevention. Four items loaded on this factor at a value of 0.640 and greater as indicated below:

- The promotion of condom use will encourage promiscuity **(0.869)**
- The promotion of condom use will prevent conception which is a God-given gift for humanity **(0.753)**

- The promotion of condom use will encourage early sexual experimentation amongst young people **(0.714)**
- It may lead to a shortage of resources especially when people take positive action, for example, an increased demand of condoms may result in reduced supply **(0.640)**

Table 21: Consequences of providing advice on HIV prevention

Consequence	Component	
	1	2
The promotion of condom use will encourage promiscuity	.869	.197
The promotion of condom use will prevent conception which is a God-given gift for humanity	.753	.138
The promotion of condom use will encourage early sexual experimentation amongst young people	.714	.188
It may lead to a shortage of resources especially when people take up positive action, for example, an increased demand of condoms may result in reduced supply	.640	.382
People may think you are falsely accusing them of promiscuity	.190	.828
Your advice may result in family quarrels	.195	.783
Pastors will become suspicious and think you belittle them	.355	.643
It may lead others to risky behaviour.	.120	.620
The promotion of condom use will encourage promiscuity.	.869	.197
The promotion of condom use will prevent conception, which is a God-given gift for humanity.	.753	.138

The items for factor 10 express church leaders' attitudes, values and perceptions of moral consequences of giving advice on HIV prevention. The first item ("condom use will encourage promiscuity") had the highest loading on this factor. This suggests misuse and effects of condom-use on the Christian moral values. These findings suggest that it is important to highlight the history of condom use that dates back to the 16th century when condoms were used to prevent the spread of syphilis in Europe. Later on in the 20th

century, Sweden used condoms to fight against poverty by bringing down the number of children and encouraging child-spacing measure to promote women's SRHR. Condoms were not intended to encourage promiscuity. However, through the long-standing history of condom use people may have experienced abuse of condom use that may have led to the experience of seeing some people having many sexual partners.

Factor 11: Presumed negative responses/ reactions from the community

The question items that constituted factor 11 related to presumed negative response or reactions from the community if church leaders gave advice on HIV prevention. Four items loaded on this factor at a value of 0.620 and greater as indicated below:

- People may think you are falsely accusing them of promiscuity **(0.828)**
- Your advice may result in family quarrels **(0.783)**
- Pastors will become suspicious and think you belittle them **(0.643)**
- It may lead others to risky behaviour **(0.620)**

All four of the above items are related to the reactions of others. One interpretation of these results could be that the church leaders felt that providing advice will have consequences such as that they could be labelled as demeaning people's status or undermining their integrity. Such views of undermining one's integrity could be due to the fact that HIV infection is closely associated with behaviours that are socially sensitive, such as sexual immorality and promiscuity, which automatically lead to the shame-related stigmatisation of persons living with HIV. Given the traditional perspective of the church on sexually related infections, such as HIV, it is, therefore, likely that church leaders were concerned about the presumed negative impact on families and communities.

The questionnaire item, "It may lead to increased health-seeking behaviours for care, resulting in decreased access to service" loaded high on two factors even after factor rotation and thus was not used in the analysis.

4.5.2 FACTOR ANALYSIS ON NORMATIVE BELIEFS REGARDING INFLUENCE OF SIGNIFICANT OTHERS

The respondents were asked to indicate whether important referent individuals or significant others would support or not support, obstruct or not obstruct the engagement of church leaders in talking about the sexual risk of HIV transmission or giving advice on HIV prevention to parishioners and clergy. The factor analysis results are presented below.

4.5.2.1 Factor analysis on level of support from various groups

The respondents were asked to indicate whether important referent individuals or significant others would support or not support the church leaders' engagement in talking about sexual risk of HIV transmission or giving advice on HIV prevention to parishioners and clergy. The KMO measure of sampling adequacy was 0.834 indicating that the correlations were adequate for factor analysis. Secondly, Bartlett's test enabled the researcher to reject the null hypothesis of a lack of sufficient correlation between variables since the p-value = 0.000 (which is less than 0.05) which leads to the rejection of the null hypothesis. Thus, the results from both tests were acceptable for the researcher to proceed with the analysis.

The communalities indicate the degree to which each variable is participating or contributing to the component solution. Nine (9) out of eleven (11) communalities were above 0.5. The number of factors were determined by taking those eigenvalues more than one. In this case one factor was retained. The one factor retained accounted for 69.04% of the variance. In practice a robust solution should account for at least 50% of the variance. Only one component was extracted which explained all the variance in the data, thus the solution could not be further rotated. Thus, all the groups were supported. The factor analysis grouped the variables into one group, namely, factor 12.

Factor 12: Support anticipated from key stakeholders

All items were classified as one factor, factor 12, and were named “**support anticipated from key stakeholders**” as they related to anticipated support from groups or organisations if church leaders talked about sexual risk of HIV transmission or gave advice on HIV prevention. All the eleven items loaded on this factor at a value of 0.612 and greater as indicated below:

- Matabeleland AIDS Council (MAC) organisation **(0.914)**
- The Government **(0.912)**
- National AIDS Council (NAC) **(0.912)**
- Zimbabwe National network of People Living with HIV (ZNNP+) **(0.904)**
- Pastors **(0.876)**
- Lutheran Communion in Southern Africa (LUCSA) **(0.865)**
- Bishops **(0.856)**
- Non-governmental Organisations (NGOs) **(0.841)**
- Partners **(0.751)**
- Those who have lost relatives to AIDS-related illnesses **(0.621)**
- People living with HIV (PLHIV) **(0.612)**

When asked if there were individuals, groups or organisations who would support their leadership roles in HIV prevention, items that had the highest loadings, that is, 0.80 and above, included both specific AIDS-service organisations and government departments as well as the clergy. It is of interest to note that life partners, such as wives/husbands, of the respondents were ranked in the middle (0.751) while individuals affected (“those who have lost relatives to AIDS-related illnesses”) and those living with HIV had mediocre rankings of 0.621 and 0.612. Based on the above results, one could argue that the church and FBOs can play a positive role in HIV prevention if they aggressively garner support from the significant others (individuals, groups or organisations) in their areas of operation.

4.5.2.2 Factor analysis on level of obstruction by various groups / Organisations / persons

The respondents were asked to indicate whether important referent individuals or significant others would obstruct or not obstruct the church leaders' engagement in talking about sexual risk of HIV transmission or giving advice on HIV prevention to parishioners and clergy.

The KMO measure of sampling adequacy was 0.787 indicating that the correlations were adequate for factor analysis. Secondly, Bartlett's test enabled the researcher to reject the null hypothesis of a lack of sufficient correlation between variables since the p-value = 0.000 (which is less than 0.05) which leads to the rejection of the null hypothesis. Thus, the results from both tests were acceptable for the researcher to proceed with the analysis.

The communalities indicate the degree to which each variable is participating or contributing to the component solution. All communalities were all above 0.5. The number of factors were determined by taking those eigenvalues more than one. In this case two factors were retained. The first factor accounted for 49.66% and the second factor for 14.95% of the variance. All in all the factors accounted for 64.61% of the variance. In practice a robust solution should account for at least 50% of the variance. Table 22 below shows that the factor analysis grouped the variables into two groups, namely, factors 13 and 14.

Factor 13: Specific group-resistance anticipated

The question items that constituted factor 13 were named "specific group-resistance anticipated" as they related to presumed obstruction from some community members if church leaders talked about the sexual risk of HIV transmission or gave advice on HIV prevention. Five items loaded on this factor at a value of 0.649 and greater as indicated below:

- "Sugar daddies or sugar mummies" **(0.869)**

- Sex workers **(0.841)**
- Individuals or people who have negative attitudes towards HIV/AIDS and see themselves as "holy" **(0.712)**
- Other organisations who may feel that there is duplication of programmes and fear competition **(0.691)**
- Some political parties **(0.649)**

All these items related to the anticipated resistance of either individuals or certain groups or organisations. Thus, on one hand, the church leaders may feel that some groups of people, such as sex workers, will hinder their leadership roles in HIV prevention because respondents may be thinking that sex workers would lose their clients and therefore would resist anything that oppose their business. On the other hand, resistance is anticipated from those, such as congregation members, who associate HIV infection with “sinners” while they might tend to regard themselves as “holy”. Resistance is also anticipated from some of the political parties who may fear that church leaders may pursue different agendas that might interfere with political stability. However, it appears as if the church leaders were concerned about resistance from groups of individuals both outside and within the church.

Table 22: Groups or Organisations likely to support

Consequence	Component	
	1	2
“Sugar daddies or Sugar mummies”	.869	.108
Sex workers	.841	.091
Individuals or people who have negative attitudes towards HIV and AIDS and might see themselves as "holy"	.712	.227
Other organisations who may feel that there is duplication of programmes and fear competition	.691	.219
Some political parties	.649	.356
Some of the pastors	.130	.847
Young people	.235	.787

Factor 14: Resistance anticipated from pastors and youth

The question items that constituted factor 14 were named “resistance anticipated from pastors and youth”. Two items loaded on this factor at a value of 0.787 and 0.847 as indicated below:

- Some of the pastors **(0.847)**
- Young people **(0.787)**

The two items related to presumed obstruction by some clergy and the young people if church leaders talked about the sexual risk of HIV transmission or gave advice on HIV prevention. In this regard, it seems one can therefore conclude that church leaders felt that greater obstruction will come from some pastors as the group loaded higher than that of the young people. Much remains to be learnt about the factors that would influence pastors to oppose engagement of church leaders in taking a lead in HIV prevention. This will be against the backdrop that the member churches of the Lutheran World Federation that included ELCZ, committed themselves to breaking the silence and speaking openly about human sexuality and HIV and AIDS.

4.6 CHI-SQUARE TESTS OF ASSOCIATIONS

Chi-square tests were done to determine whether respondents’ views on the attitudes of church leaders towards their leadership roles in HIV prevention were dependent on:

- Area congregation is located,
- Position in the church,
- Length of a member in being a Lutheran,
- Gender,
- Age group,
- Level of education,
- Involvement in HIV Prevention activities, and
- Whether a person attended any training in HIV prevention.

The main questions to be answered in this instance were:

- Do the attitudes of church leaders towards their leadership roles in HIV prevention depend on the biographical variables in order to answer the research question 3? **How do the biographical variables location of a congregation, position in the church, length of Lutheran membership, gender, age, education, involvement in HIV prevention activities and exposure to HIV training, influence the attitudes of the Lutheran church leaders towards their leadership roles in HIV prevention?**
- If so, where is the possible interaction?

The hypothesis to be tested was:

H₀: The variables are independent (there is no association)

H₁: The variables are dependent (there is an association)

The analysis was done at the 5% level of significance. The p-value approach was used to determine whether or not the null hypothesis should be rejected. A p-value less than 0.05 will lead to the rejection of the null hypothesis of no association. Thus, the researcher will be concluding that there is an association if the p-value <0.05.

According to Diamantopoulos and Schlegelmilch (2000), in applying the chi-square test, one should ensure that no more than 20% of the cells have expected values less than 5 and no cells should have an expected frequency of less than 1. They also state that if all this has been achieved the researcher can try to combine categories to reduce the number of cells in the contingency table (Diamantopoulos & Schlegelmilch, 2000). Thus, in some cases, *to some extent*, and, *to a large extent* were combined to form the category *to an extent*. In this case only valid chi-square values that were significant were presented, that is, those indicating an association and have less than 20% of the cells with expected values less than 5 and no cells with expected value

less than one.

Where an association exists, the log linear analysis was used to determine which effects were significant. In the case of the log-linear analysis, the z-value will be significant if it is greater than 1.96 or less than -1.96. Thus, the **z-value** will be significant if less than -1.96 or greater than 1.96 or the **p-value** which will be compared to **$\alpha=0.05$** . The log-linear analysis was done to identify the source of the interaction. The log-linear analysis is a tool for investigating possible interactions between respondents' attitudes and biographical variables.

The variables *position in the church, length of being a member of a Lutheran church, gender, age group, level of education, and training in HIV prevention*, resulted in the null hypothesis of independence not being rejected. Thus, the way the respondents answered the questions was not related to their position in the church, whether there were male or female, were brought up in the Lutheran faith teaching and practices ("born Lutheran") or not, were of a particular age group, had a particular level of education and whether or not they attended a training in HIV prevention. The variables, *age group, gender, level of education and whether a person attended any HIV training* reflected in some cases a significant association but could not be analysed further since more than 20% of the cells had expected value of less than 5.

However, in some aspects the biographical variables; *area where congregation is located and involvement in HIV prevention activities* had shown a relationship with the way the respondents answered the questions – these cases will be discussed below.

4.6.1 TESTING FOR ASSOCIATION BETWEEN AREA IN WHICH CONGREGATION IS LOCATED AND ATTITUDES TOWARDS LEADERSHIP ROLES IN THE PREVENTION OF HIV

The peri-urban and rural categories were collapsed together resulting in the category "rural". Thus, the researcher ended up having two categories in this

regard, *urban* and *rural*. The categories “to a large extent” and “some extent” were collapsed into “*to an extent*”. The variables that showed an association were the following:

In relation to barriers when discussing the sexual risk of HIV transmission with parishioners and the clergy:

- Lack of confidence.
- When the person you speak to has higher status than you.
- People are bored of HIV and AIDS because everybody now knows about it.
- When the people you have to talk to are older than you.

In relation to consequences of not talking to parishioners and clergy about the sexual risk of HIV transmission:

- There will be a reduction in church attendance.

In relation to consequences of providing advice on HIV prevention to parishioners and clergy:

- People may think you are falsely accusing them of promiscuity.
- It may lead to increased health-seeking behaviours for care resulting in decreased access to services.
- The promotion of condom use will encourage promiscuity.

The above-mentioned associations will be discussed in more detail below.

4.6.1.1 Testing for association between location of congregation and issues that were barriers when discussing the sexual risk of HIV transmission with parishioners and the clergy

The chi-square test of independence was rejected in the case of the following variables: *when traditionally respected persons, such as in-laws are part of the*

group you address and different age groups: talking to people older than myself. However, these associations could not be evaluated further since the cells with expected values less than 5 were 33.3% of the total cells and thus the chi-square test was not applicable to these parameters. It could not be analysed further because more than 20% of the cells had values less than 5.

There was no association between any of the other variables related to barriers when discussing the sexual risk of HIV transmission with parishioners and the clergy and the area in which the congregation was located, except in the case of the variables listed below, which showed an association with area in which the congregation was located:

In relation to barriers when discussing the sexual risk of HIV transmission with parishioners and the clergy:

- Lack of confidence.
- When the person you speak to has higher status than you.
- People are bored of HIV and AIDS because everybody now knows about it.
- When the people you have to talk to are older than you.

In testing for association between location of congregation and issues that were barriers when discussing the sexual risk of HIV transmission with parishioners and the clergy, the main effects were *to an extent, not at all, don't know, urban and rural*. The interaction effects were *urban*to an extent, urban*not at all, urban*don't know, rural*to an extent, rural*not at all and rural*don't know*.

The null hypothesis of independence was therefore rejected for the variables *lack of confidence ($X^2 = 6.888$ and $p - value = 0.032$), when person you speak to has a greater social status/class ($X^2 = 10.403$ and $p - value = 0.006$), people are bored of HIV and AIDS because everybody now knows about it ($X^2 = 7.440$ and $p - value = 0.006$), and when the people you have to talk to are older than you ($X^2 = 6.232$ and $p - value = 0.044$) at the 5% level of*

significance. In the first order of effects, Table 23 below shows that the effects *to an extent* had a high significant association with the aspect *lack of confidence*. In terms of the interaction effect, *urban*to an extent* was significant with regard to the *people are bored of HIV and AIDS because everybody now knows about it* whilst the interaction effect *urban*not at all* was significant with regard to all four variables.

Table 23: Chi-square test: area in which congregation is located and issues that were barriers when discussing the sexual risk of HIV transmission with parishioners and the clergy

Aspect	Chi-square	p-value	Effects	Z-value for Effect
Lack of confidence	6.888	0.032	To an extent	2.088 [*]
			Urban*Not at all	2.288 [*]
When person you speak to has a greater social status/class than you.	9.233	0.010	Urban*Not at all	2.528 [*]
People are bored of HIV/AIDS because everybody now knows about it	10.403	0.006	Urban*To an extent	2.081 [*]
			Urban*Not at all	2.903 ^{**}
When the people you have to talk to are older than you.	6.232	0.044	Urban*Not at all	2.018 [*]

Note: The statistical significance of the z-values is ** for p<0.01 and * for p<0.05

There is an association between each of the following variables :(a) *lack of confidence*, (b) *when one is speaking to someone of higher social status/class*, the view that (c) *people are bored of HIV and AIDS because everybody now knows about it*, (d) *when the people you have to talk to are older than you*, and *area where the congregation is located*. The association is more noticeable in the case of those who stay in urban areas and who indicated “not at all”. Based on these findings one can conclude that the above-mentioned variables act to a lesser degree as barriers in the case of urban church leaders, suggesting that it is easier for urban church leaders to

talk about the risk of sexual transmission of HIV than those in the rural setting in the case of these four variables. Thus, for rural church leaders, talking about issues of sexual transmission of HIV in public could create barriers in the case of these four variables.

4.6.1.2 Testing for association between area in which congregation is located and advantages of talking to parishioners and clergy about the risk of the sexual transmission of HIV

There was no association between any of the variables (attitudes) related to advantages of talking to parishioners and clergy about the sexual risk of HIV transmission and the area in which the congregation was located. However, the attitude *the church will not lose members due to death and leaving the church to seek faith healing elsewhere* was significant but had 33.3% of the cells with expected value less than 5. This might be valid if the sample size is increased.

4.6.1.3 Testing for association between area in which congregation is located and consequences of not talking to parishioners and clergy about the risk of the sexual transmission of HIV

In testing for association between area in which congregation is located and consequences of not talking to parishioners and clergy about the sexual risk of HIV transmission, the main effects were *urban, rural, likely, unlikely and don't know*. The interaction effects were *urban*likely, urban*unlikely, urban*don't know, rural*likely, rural*unlikely and rural*don't know*.

There was no association between any of the variables (attitudes) related to consequences of not talking to parishioners and clergy about the risk of the sexual transmission of HIV and location of congregation, except in the case of the attitude *“there will be a reduction in church attendance”* as illustrated in Table 24 below.

Table 24: Chi-square test: area in which congregation is located and consequences of not talking to parishioners and clergy about the sexual risk of HIV transmission

Aspect	Chi-square	p-value	Effects	Z-value for Effect
There will be a reduction in church attendance	8.678	0.013	Likely	2.690**
			Urban*Unlikely	2.475*

Note: The statistical significance of the z-values is ** for $p < 0.01$ and * for $p < 0.05$

The null hypothesis of independence was rejected with regard to the variable, *there will be a reduction in church attendance* ($X^2 = 8.678$ and $p - value = 0.013$) at the 5% level of significance. In the first order effects, the effects *likely* had a high significance and the interaction effect *Urban*Unlikely* was significant.

The results show that there is an association between the attitude *there will be a reduction in church attendance* and the area in which congregation is located. The association is more noticeable in the case of those church leaders who stay in urban areas and indicated that it was unlikely.

This finding indicates that urban church leaders tend to feel more strongly that it is unlikely that there will be a reduction in church attendance as compared to rural church leaders. The urban church leaders indicated that there would be no reduction in church attendance even if they do not talk about HIV transmission. The implication is that parishioners in urban areas will get and are already getting information about HIV from other sources and attend church services to hear about the Word of God and not necessarily to learn about HIV and AIDS from church leaders.

However, four perceived consequences were significant but had more than 20% of the cells with expected value less than 5 and, therefore, could not be

analysed further since the Chi-square test was not applicable. The items for the four consequences were *denial will persist and those infected will keep infecting others, there will be no sharing of information on how to help PLHIV and the affected, the loss of church members to AIDS will increase, and increased number of orphans.*

4.6.1.4 Testing for association between area in which congregation is located and advantages of providing advice on HIV prevention to parishioners and clergy

In testing for association between area in which congregation is located and the advantages of providing advice on HIV prevention, the main effects were *urban, rural, likely, unlikely and don't know. The interaction effects were urban*likely, urban*unlikely, urban*don't know, rural*likely, rural*unlikely and rural*don't know.*

The aspect *more lives will be saved* was significant but had more than 30% of the cells with expected count less than 5 and therefore could not be tested because there were more than 20% of the cells with value less than 5.

4.6.1.5 Testing for association between area in which congregation is located and consequences of providing advice on HIV prevention to parishioners and clergy

In testing for association between area in which congregation is located and the consequences of providing advice on HIV prevention, the main effects were *urban, rural, likely, unlikely and don't know. The interaction effects were urban*likely, urban*unlikely, urban*don't know, rural*likely, rural*unlikely and rural*don't know.*

The null hypothesis of no association was not rejected in the case of all the attitudes except with regard to three attitudes. These attitudes were: *people may think you are falsely accusing them of promiscuity ($X^2 = 6.129$ and $p - value = 0.047$); it may lead to increased health-seeking behaviours for care*

resulting in decreased access to services ($X^2 = 8.089$ and $p - \text{value} = 0.018$) and the promotion of condom use will encourage promiscuity ($X^2 = 7.416$ and $p - \text{value} = 0.025$). The log-linear analysis revealed that the following effects were significant.

Inspecting the *z-values*, Table 25 below revealed that with respect to the interaction terms (response categories), the term *urban*unlikely* provided the biggest contribution towards making the interaction significant for the attitudes/perceived consequences “*people may think you are falsely accusing them of promiscuity*” and “*the promotion of condom use will encourage promiscuity*”. In the first order effects, the effect *likely* had a high significant effect on the attitude “*it may lead to increased health-seeking behaviours for care, resulting in decreased access to services*”.

Table 25: Chi-square test between area in which congregation is located and consequences of providing advice on HIV prevention to parishioners and clergy

Aspect	Chi-square	p-value	Effects	Z-value for Effect
People may think you are falsely accusing them of promiscuity	6.129	0.047	Urban*Unlikely	2.158*
It may lead to increased health-seeking behaviours for care, resulting in decreased access to services	8.089	0.018	Likely	2.310*
The promotion of condom use will encourage promiscuity	7.416	0.025	Urban*Unlikely	2.405*

Note: The statistical significance of the z-values is ** for $p < 0.01$ and * for $p < 0.05$

The association is more noticeable in the case of those who reside in the urban areas and who indicated that it was unlikely in terms of the attitudes on

promiscuity and condom use. This means that urban church leaders feel more strongly that it is unlikely that “people may think that they are being falsely accused of promiscuity” and that “the promotion of condom use encourages promiscuity” than rural church leaders. These findings may imply that urban church leaders as opposed to rural church leaders have a greater understanding that condom use does not necessarily promote promiscuity. Their understanding of condom use may be because of multiple sources of information in urban settings, which reduce and remove bias on indications and use of condoms. The findings may also imply that there are still negative perceptions about condom use among rural church leaders.

4.6.2 TESTING FOR ASSOCIATION BETWEEN AREA IN WHICH CONGREGATION IS LOCATED AND NORMATIVE BELIEFS REGARDING THE INFLUENCE OF SIGNIFICANT OTHERS

There was no association between area of congregation and all the variables related to normative beliefs regarding the influence of significant others.

4.6.3 TESTING FOR ASSOCIATION BETWEEN INVOLVEMENT IN HIV ACTIVITIES AND ATTITUDES TOWARDS LEADERSHIP ROLES IN THE PREVENTION OF HIV

The variables that showed an association with involvement in HIV activities were:

In relation to barriers:

- *When the person you speak to has more status than you.*

In relation to advantages of talking about the sexual risk of HIV transmission:

- *Sex education for young people will encourage early onset of sexual activity.*

4.6.3.1 Testing for association between involvement in HIV activities and degree of issues as barriers when discussing the sexual risk of HIV transmission with parishioners and clergy

The main effects for this analysis were *to a large extent/some extent, not at all, don't know, yes and no*. The interaction effects were *yes*to an extent, yes*not at all, yes*don't know, no*to an extent, no*not at all and no*don't know*.

Table 26: Chi-square test between involvement in HIV activities and issues that are barriers when discussing the sexual risk of HIV transmission with parishioners and clergy

Aspect	Chi-square	p-value	Effects	Z-value for Effect
When person you speak to has a higher social status/class than you.	9.310	0.010	To an extent	2.673**
			Not at all	2.901**
			Yes*Not at all	-2.807**

Note: The statistical significance of the z-values is ** for $p < 0.01$ and * for $p < 0.05$

There was no association between those involved in HIV activities and any of the variables related to barriers when discussing the sexual risk of HIV transmission with parishioners and the clergy except in the case of the variable *when the person you speak to have a higher social status/class and involvement in HIV activities*

The null hypothesis of independence was rejected with regard to the attitude *when person you speak to has a higher social status/class* ($X^2 = 9.310$ and $p - value = 0.010$) at the 5% level of significance. The log-linear analysis revealed that the main effects were *to an extent* and *not at all* and the interaction effect *yes*not at all* provided the biggest contribution towards the

interaction with regard to this attitude.

This means that social status is less of a barrier in talking about the sexual risk of HIV transmission in the case of church leaders involved in HIV activities as compared to those not involved. The implication of this finding is that exposure to HIV activities can overcome social barriers related to talking about the risk of sexual transmission of HIV if church leaders are correctly informed that HIV can affect anyone, including those with a higher social status. People of high social status such as actors, politicians and clergy, have also died from AIDS.

4.6.3.2 Testing for association between involvement of HIV activities and advantages of talking to parishioners and clergy about the sexual risk of HIV transmission

In testing for association between involvement in HIV activities and advantages of talking to parishioners and clergy about the sexual risk of HIV transmission, the main effects were *yes, no, likely, unlikely and don't know*. The interaction effects were *yes*likely, yes*unlikely, yes*don't know, no*likely, no*unlikely and no*don't know*.

There was no association between any of the variables (attitudes) related to advantages of talking to parishioners and clergy about the sexual risk of HIV transmission except in the case of the attitude *sex education for young people will encourage early onset of sexual activity*. The log-linear analysis revealed that the following effects were significant:

The null hypothesis of independence was rejected for the attitude *sex education for young people will encourage early onset of sexual activity* ($X^2 = 6.635$ and $p - \text{value} = 0.036$) at the 5% level of significance as shown in Table 27 below. The main effect *yes* had a high significant association with this attitude, whilst the interaction effect *yes*likely* was significant.

Table 27: Chi-square test between involvement in HIV activities and advantages of talking to parishioners and clergy about the sexual risk of HIV transmission

Aspect	Chi-square	p-value	Effects	Z-value for Effect
Sex education for young people will encourage early onset of sexual activity	6.635	0.036	Yes	-2.310*
			Yes*Likely	2.309*

Note: The statistical significance of the z-values is ** for $p < 0.01$ and * for $p < 0.05$

One can conclude on the basis of this finding that church leaders involved in HIV activities feel more strongly that it is likely that *sex education for young people will encourage early onset of sexual activity* than church leaders not involved in HIV activities. Interestingly, while social status was not a barrier to church leaders involved in HIV activities, in this regard, it appears, according to the perceptions of church leaders involved in HIV activities, that sex education seems to equal promotion of early onset of sexual activities for young people. The implication of this finding is that church leaders involved in HIV activities may still be upholding beliefs that set limitations on who one can talk to about the sexual risk of HIV transmission. This is worth noting, as some church leaders might not be willing to promote sex education among the young people, as they perceive them to be not sexually active and fear the promotion of early sexual debut among this age group. There is therefore a need to empower the church leaders to address these fears.

4.6.3.3 Testing for association between involvement in HIV activities and consequences of not talking to parishioners and clergy about the sexual risk of HIV transmission

There was no association between any of the variables (attitudes) related to consequences of not talking to parishioners and clergy about the risk of the sexual transmission of HIV.

4.6.3.4 Testing for association between involvement in HIV activities and advantages of providing advice on HIV prevention to parishioners and clergy

The null hypothesis of no association was not rejected in the case of all the variables (attitudes) related to advantages of providing advice on HIV prevention to parishioners and clergy. The non-rejection of the null hypothesis means that whether or not church leaders had been involved in HIV activities had no effect on their attitudes in this regard. One can conclude that the responses with regard to the advantages of providing advice on HIV prevention to parishioners and clergy are not statistically associated with whether or not church leaders were involved in HIV activities.

These findings may imply that church leaders who participated in this study understand the effects of HIV in society and therefore attach importance to educating people about HIV prevention measures.

4.6.3.5 Testing for association between involvement in HIV activities and consequences of providing advice on HIV prevention to parishioners and clergy

The null hypothesis of no association was not rejected with regard to all the variables related to consequences of providing advice on HIV prevention to parishioners and clergy. Thus, whether or not church leaders had been involved in HIV activities had no effect on their attitudes in this regard.

These findings may imply that church leaders who participated in this study understand the need for sharing information on HIV prevention in order to control the spread of HIV and mitigate the impacts of AIDS.

4.6.4 TESTING FOR ASSOCIATION BETWEEN INVOLVEMENT IN HIV ACTIVITIES AND NORMATIVE BELIEFS REGARDING THE INFLUENCE OF SIGNIFICANT OTHERS

The variables that showed an association with involvement in HIV activities were:

- Young people
- “Sugar daddies or sugar mummies”

4.6.4.1 Testing for association between involvement in HIV activities and level of support of various groups

There was no association between church leaders' involvement in HIV activities and their normative beliefs regarding the influence of significant others in terms of level of support of various groups.

4.6.4.2 Testing for association between involvement in HIV activities and level of obstruction by various groups/organisations/persons

In testing for an association between involvement in HIV activities and level of obstruction by various groups of people or organisations, the main effects were *yes*, *no*, *will obstruct*, *will not obstruct* and *don't know*. The interaction effects were *yes*will obstruct*, *yes*will not obstruct*, *yes*don't know*, *no*will obstruct*, *no*will not obstruct* and *no*don't know*.

The chi-square test of association was rejected with regard to all the variables in this regard except the variables *young people* ($X^2 = 7.133$ and $p - value = 0.028$) and *sugar daddies or sugar mummies* ($X^2 = 6.574$ and $p - value = 0.037$) at the 5% level of significance.

Table 28: Chi-square test between involvement in HIV activities and level of obstruction by various groups/organisations/persons

Group	Chi-square	p-value	Effects	Z-value for Effect
Young people	7.133	0.028	Yes	-2.454*
			Will not obstruct	2.065*
			Yes*will obstruct	2.057*
			Yes*will not obstruct	2.240*
Sugar daddies and sugar mummies	6.574	0.037	Yes	-2.450*
			Will obstruct	2.017*
			Yes*will not obstruct	2.318*

Note: The statistical significance of the z-values is ** for $p < 0.01$ and * for $p < 0.05$

The log-linear analysis revealed that the following effects were significant: Inspecting the *z-values* revealed that with respect to the interaction terms, *yes*will not obstruct* provided the biggest contribution towards making the interaction significant for both aspects as shown in Table 28 above. In the first order effects, one can see that the effect *yes* had a high significant effect with regard to both groups. The researcher can conclude that there is an association between *church leaders' involvement in HIV activities and level of obstruction by young people, and level of obstruction by sugar daddies and sugar mummies*. The main effect *will not obstruct* and the interaction effect

*yes*will not obstruct* was significant for both groups. This means that church leaders involved in HIV activities feel more strongly than those not involved that it is unlikely that young people and "sugar daddies and mummies" will obstruct them. It is worth noting that anticipated support from young people points towards an opportunity for church leaders to ensure access to correct information within and outside the church. Therefore, church leaders should be encouraged to take a lead in HIV prevention without fear of being antagonized by these groups.

4.7 CONCLUSION

In this chapter, the researcher presented the analysis of the findings of this study.

There were three objectives for this study. Firstly, to determine the level of the church leaders' involvement in HIV prevention activities. Secondly to describe the attitudes of the Lutheran church leaders toward taking leadership roles in HIV prevention. Thirdly, to explore how biographic variables, location of a congregation, position in the church, length of Lutheran membership, gender, age, education, involvement in HIV prevention activities and exposure to HIV training may influence the attitudes of the Lutheran church leaders towards taking a lead in HIV prevention. The statistical analyses presented in this chapter were done in relation to these objectives.

The majority of the participants who completed the questionnaire for the main study were male with a secondary or tertiary level of education. Firstly, the biographical characteristics of the respondents were presented. Most of the church leaders who participated in this study indicated that there were "born Lutherans", that is, raised under the Lutheran teachings and belong to congregations located in an urban setting.

Secondly, the findings from this study show that the Lutheran church is a potential source for information on HIV prevention in Zimbabwe. However,

there are certain barriers that can limit the utility of this institution as vehicle for HIV prevention. Based on the descriptive analysis, the researcher grouped these barriers under three thematic areas. The first theme was *self-efficacy constraints* that include church leaders reporting lack of confidence, ability and adequate knowledge to address people of higher status than themselves. The second theme was *institutional constraints* which had a third of respondents concurring with the statement that the 'church is not a place to discuss HIV. The third theme was *cultural constraints* as respondents regarded talking about sex to be taboo especially in the presence of traditionally respected people, such as the in-laws and the elderly. In addition, almost half of the church leaders have a perception that sex education to young people and promotion of condom use will encourage young people to be sexually active prematurely. Church leaders with such a perception are likely not to discuss sex education with youth and thus missing the opportunity for empowering the young people for effective protection against HIV infection.

Based on the factor analysis, the researcher grouped the barriers under three different thematic areas. The first theme was *difference between communicator and audience* that included church leaders' underlying beliefs, values and cultural conceptions, which reflect perceptions about what is acceptable within one's community in terms of taboos and facilitates interpersonal relations. The second theme was *experience and perceptions of the communicator*, which reflected defeatist attitudes on the part of the communicator. The communicator reflects the perception that his/her contribution in HIV prevention would not add value because the public has already received adequate knowledge about HIV and the church is not the place to talk about HIV, presumably associating HIV with immorality. Furthermore, the communicator displays an attitude that protects the self should people discredit their leadership roles in HIV prevention due to his/her past risky sexual behaviours that might be viewed as not reflecting good role models. The third theme was *self-efficacy* as respondents reflected defensive attitudes that express protection of self-esteem in an environment that might condemn them for failing to deliver. In this regard, the communicator found the higher status than theirs of the people they speak to about HIV prevention and not having first-hand experience of a person living with HIV on their part, a

barrier to their leadership roles in HIV prevention.

While this study's findings indicated that majority of the church leaders were not involved in HIV prevention activities but rather in care and support interventions, more than 60 percent of the church leaders who participated in this study are agreeing that there is need to talk to parishioners and clergy about the sexual transmission of HIV. Based on the descriptive analysis, their involvement would avert new HIV infections, reduce stigma and discrimination and promote better management of the disease. The factor analysis highlighted promotion of churches as stigma-free social environments, open discourse on HIV prevention and education on positive living for PLHIV to enhance risk reduction behaviours, as positive results of their involvement in HIV prevention. The church leaders were confident that if they were to provide leadership roles in HIV prevention various groups of people and organisations would render high level of support to them and these included Bishops, pastors, NGOs and government institutions. Whereas this positive outlook creates an opportunity for networking and collaborating with the above-mentioned groups of people and organisations viewed as supportive, the extent of the utilisation of this support was not established, as it was not part of this study. However, more than half of the church leaders viewed certain people such as 'sugar daddies and mummies' and sex workers, as individuals that would obstruct them from taking a lead in HIV prevention activities.

While it is well acknowledged that the Lutheran church leaders in the Southern African countries including Zimbabwe committed themselves to breaking the silence around HIV, this study showed that their level of involvement in HIV prevention is minimal.

The AIDS epidemic is not yet over as Southern Africa continues to shoulder disproportionately the burden of HIV and AIDS in spite of the reported decrease in HIV prevalence rate in the region as 9 out of 10 countries still report HIV infection rates of above 10 percent. The multi-sectoral approach urges individuals to take ownership and reduce their risky behaviours. However, on the other hand, church leaders are encouraged to exercise their

faith practices that call them, through baptism, to promote life and in this case by empowering their congregants to prevent HIV through sharing of skills and knowledge on HIV and AIDS. In this regard, church leaders could hold each other accountable to be good stewards charged with well-being of the congregation and strive for an effective and concerted effort to educate and take leadership roles in HIV prevention.

Chapter 5 will conclude the discussion and presentation of this. A summary of the findings of this study is presented in chapter 5, as well as recommendations for future research. The limitations of the study and possible action and implementation plans are also discussed in chapter 5.

CHAPTER 5

CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS

5.1 INTRODUCTION

The Zimbabwe National Behavioural Change Strategy (NBCS) aimed to reduce the HIV prevalence rate to less than 10% by 2010 and the subsequent National HIV and AIDS Strategic Plan II 2011 – 2015, lists faith-based organisations as part of the multi-sectoral response and key behavioural change agents in HIV prevention (NAC 2006; UNGASS 2012). The ZNASP 2011-2015 emphasises the importance of HIV prevention as a national priority to reduce the yearly new adult and children HIV infections by 50% by 2015.

Furthermore, the Lutheran World Federation Action Plan 2002-2012 and the LUCSA HIV and AIDS Policy 2010 encourage a quantitative increase in church leadership that supports effective HIV preventive measures in their communities (LWF 2003; LUCSA 2010). The central role of churches in communities places them at a comparative advantage to secular organisations in terms of their ability to engage fully in HIV prevention among their constituencies (Eriksson *et al* 2010; Gregson *et al* 1999; Nhamo 2011; Trinitapoli 2006). However, the fact that HIV infection mainly occurs through sexual transmission poses a challenge in Southern Africa in terms of the traditional views of many churches that regard speaking about sexual matters in public as a taboo (De Gruchy in Haddad 2011; Eriksson *et al* 2010; Paterson 2009). Church leaders are in a unique position to influence behaviour change in both rural and urban settings given their wide following.

Therefore, this study aimed to examine the attitudes of church leaders in Zimbabwe regarding their leadership roles in HIV prevention since this could facilitate the development of new strategies to motivate church leaders to take a lead in HIV prevention, which was the focus of this study.

This study specifically focused on the attitudes of the Lutheran church leaders

towards their perceived leadership roles in HIV prevention. Application of the Theory of Reasoned Action (TRA) model has provided a conceptual framework to identify critical beliefs that could have a potential influence on the attitudes of church leaders to take a lead in HIV prevention. This model has also enabled this study to identify intervention targets for strengthening commitment of Lutheran church leaders in promoting open dialogue and addressing sexual risky behaviours, as well as negative social and cultural factors that fuel HIV infection. HIV prevention is an important strategy to control the HIV epidemic. In the context of Zimbabwe, there is need for all stakeholders, including the religious leaders, to work together in a multi-sectoral approach for the achievement of the ZNASP II 2011-2015 goal to reduce the yearly new adult and children HIV infections by 50% by 2015.

When seeking to influence behaviour, such as, increased involvement of church leaders in HIV response as is the case in this study, insights have been gained into the underlying beliefs that can be a barrier or a facilitator to church leaders' engagement in HIV prevention. Literature by Chitando (2007), Evangelical Church in Germany (2007) and Nürnberger (2005) have highlighted the need to review currently held beliefs and practices that act as obstacles for theologians to respond effectively to the epidemic. This study is significant because it employed a scientifically proven behavioural theory-driven approach, the TRA, in providing some insights into the beliefs that potentially influence church leaders' attitude to take a lead in HIV prevention. The findings related to these individual beliefs and the extent of their involvement in HIV prevention, are summarised below.

This study report provided an overview of the HIV epidemic in Southern Africa and in Zimbabwe, in particular, in chapter 1 and 2. In chapter 2, the literature was examined on the role of churches in HIV prevention, and a background into the Lutheran Church in Southern Africa and particularly in Zimbabwe was provided. The methodology utilised in this study and the methods of data collection and analyses were discussed in chapter 3. It was pointed out in chapter 3 that a quantitative research methodology was used for the main study. Using the Theory of Reasoned Action (TRA) model, the main study

utilised a questionnaire as a quantitative data collection technique.

The findings of this study were presented and discussed in chapter 4. This chapter, chapter 5, presents a summary of the findings of this study, highlights the limitations of the study, draws conclusions and makes recommendations.

The purpose of this study was to describe the attitudes of church leaders that could potentially explain both the barriers and attitudes regarding taking a lead in HIV prevention in the Matabeleland Province of Zimbabwe.

The main objectives of this study were to:

- Determine the extent of involvement of Lutheran church leaders in HIV prevention activities.
- Describe the attitudes of Lutheran church leaders towards taking a leadership role in HIV prevention.
- Explore how biographical variables such as location of a congregation, position in the church, length of Lutheran membership, gender, age, education, involvement in HIV prevention activities and exposure to HIV training, may influence the attitudes of the Lutheran church leaders towards their leadership roles in HIV prevention.

5.2 SUMMARY OF RESEARCH FINDINGS

5.2.1 Research objective 1: The extent of the involvement of Lutheran church leaders in HIV prevention activities.

The Lutheran church leaders' attitude towards their leadership roles in HIV prevention were analysed to identify entry points for interventions to scale up their response to the epidemic.

The study has shown that in the case of the church leaders that responded to the questionnaire, despite the majority (92.9%) of them having encountered a

person living with HIV, the level of their involvement in HIV prevention is low (45.6%). This finding confirms the findings of research by Chin *et al* (2005); LUCSA 2008 and Masika (2008) who concluded that religious leaders' involvement in HIV and AIDS was weak, erratic and fragmented or inconsistent.

The study has identified a gap that more than half (54.4%) of church leaders were not involved in HIV prevention. This should be a cause for concern to policy makers in that the church is not fully participating in HIV prevention, as non-participation cannot contribute towards strengthening of community systems and infrastructures for effective response to the epidemic as recommended in the ZNASP 2011-2015 (NAC 2011).

5.2.2 Research objective 2: The attitudes of Lutheran church leaders towards taking leadership roles in HIV prevention

Constructs of the Theory of Reasoned Action (TRA) have been applied in this study to examine behavioural intentions regarding attitudes that people hold about the use of condoms and communication about HIV and AIDS among others (Glanz *et al* 2008; Henning 2009; Tlou 2012). Of the reviewed literature, none had utilised the theory of reasoned action to examine the factors that are associated with the church leaders' attitude towards their leadership roles in HIV prevention.

An assessment of the attitudes of church leaders towards their leadership roles in HIV prevention is integral to understanding the current involvement of the church leadership in and the development by policy makers, of improved strategies to increase the response to the epidemic, especially in rural and remote areas. In this regard, the conceptual model of the Theory of Reasoned Action (TRA) guided this study. According to this model, the concepts of "belief", "attitudes", "subjective norms", "intentions" and "behaviour" are the major components that affect the likelihood of performing a particular behaviour (Terry *et al* (1993:8), citing Fishbein and Ajzen 1991). To elicit the beliefs underlying the attitudes and the normative component of the TRA

model, focus group discussions with 24 parish leaders as key informants were conducted as a first step towards the assessment of the attitudes of church leaders regarding their leadership roles in HIV prevention.

To elicit beliefs underlying their attitudes, the respondents were given statements on leadership roles in HIV prevention to which they had to respond. These statements were divided in the following five categories:

- Barriers when discussing the sexual risk of HIV transmission with parishioners and the clergy.
- Advantages of talking to parishioners and the clergy about the sexual risk of HIV transmission.
- Consequences of not talking to parishioners and clergy about the sexual risk of HIV transmission.
- Advantages of providing advice on HIV prevention to parishioners and the clergy.
- Consequences of providing advice on HIV prevention to parishioners and the clergy.

In order to provide an overview of section 5.2.2, the main sub-sections and the main factors identified under each of these sections are presented in Table 29a to Table 29g below.

Table 29a: Section 5.2.2.1: Barriers when discussing the sexual risk of HIV transmission with parishioners and the clergy

Barriers per type of analysis	Main factors identified per section per type of analysis
Barriers on the basis of descriptive analysis	<ul style="list-style-type: none"> • Self-efficacy constraints. • Cultural constraints. • Institutional constraints.
Barriers on the basis of factor analysis	<ul style="list-style-type: none"> • Barriers due to difference between communicator and audience • Barriers due to experience and perception of the communicator. • Barriers due to lack of self-efficacy.

TABLE 29b: Section 5.2.2.2: Advantages of talking to parishioners and clergy about the sexual risk of HIV transmission

Advantages per type of analysis	Main factors identified per section per type of analysis
Perceived advantages/benefits on the basis of descriptive analysis	<ul style="list-style-type: none"> • Promotion of churches as stigma-free social environments • More open discourse on HIV prevention • Education on positive living for PLHIV to enhance risk reduction behaviours
Perceived advantages/benefits on the basis of factor analysis	<ul style="list-style-type: none"> • Perceived impact of HIV communication • Behaviour change results

Table 29c: Section 5.2.2.3: Consequences of not talking about the sexual risk of HIV transmission

Consequences per type of analysis	Main factors identified per section per type of analysis
Perceived consequences on the basis of descriptive analysis	<ul style="list-style-type: none"> • People will be less knowledgeable about HIV and infection will increase. • Denial about HIV will persist <p>Increase in the number of orphans due to AIDS</p> <ul style="list-style-type: none"> • Churches will lose members due to AIDS-related deaths • There will be limited strategies on the mitigation of the HIV and AIDS impact and care of PLHIV and the affected.
Perceived consequences on the basis of factor analysis	<ul style="list-style-type: none"> • Adverse effects on church and society from withholding HIV communication. • The value of church leadership in HIV communication.

Table 29d: Section 5.2.2.4: Advantages of providing advice on HIV prevention

Advantages per type of analysis	Main factors identified per section per type of analysis
Perceived advantages on the basis of descriptive analysis	<ul style="list-style-type: none"> • People will be knowledgeable • There will be better management of the disease
Perceived advantages on the basis of factor analysis	<ul style="list-style-type: none"> • Positive effects for health outcome • General positive outcomes

Table 29e: Section 5.2.2.5: Consequences of providing advice on HIV prevention

Consequences per type of analysis	Main factors identified per section per type of analysis
Anticipated consequences on the basis of descriptive analysis	<ul style="list-style-type: none"> • The promotion of condom use will encourage early sexual experimentation amongst young people
Anticipated consequences on the basis of factor analysis	<ul style="list-style-type: none"> • Anticipated negative outcomes of church leadership engagement. • Presumed negative responses/reactions from the community

Table 29f: Section 5.2.2.6: Support from significant others

Support per type of analysis	Main factors identified per section per type of analysis
Significant others who will be supportive on the basis of descriptive analysis	<ul style="list-style-type: none"> • High level of support expected from all the listed individuals, groups or organisations (Pastors; Bishops; NAC; NGOs; ZNNP+; MAC; the government; PLHIV; LUCSA; Partners; relatives of those lost to AIDS-related illnesses)
Significant others that will be supportive on the basis of factor analysis	<ul style="list-style-type: none"> • AIDS-Service organisations • Governments • Clergy

Table 29g: Section 5.2.2.7: Obstruction by significant others

Obstruction per type of analysis	Main factors identified per section per type of analysis
Significant others who will be obstructive on the basis of descriptive analysis	<ul style="list-style-type: none"> • “Sugar daddies or sugar mummies” • “Holier than thou” individuals
Significant others that will be obstructive on the basis of factor analysis	<ul style="list-style-type: none"> • Specific group-resistance anticipated (i.e. “sugar daddies or sugar mummies”; sex workers; individuals who regard themselves as holier than thou; organisations who fear competition; some political parties) • Resistance anticipated from pastors and youth

5.2.2.1 Barriers when discussing the sexual risk of HIV transmission with parishioners and clergy:

The descriptive statistical analysis and factor analysis revealed that the beliefs of individual church leaders display a combination of factors that include personal, environmental and societal influence that determine their attitudes and can affect the likelihood of them talking or not talking and providing advice or not about HIV prevention to their parishioners and the clergy.

The findings of the study based on the descriptive statistical analysis indicate that the Lutheran church is a potential source for HIV prevention in Zimbabwe. However, according to descriptive analysis, key barriers grouped as, **self-efficacy constraints** (*“lack of confidence”- 52.9%, “everybody knows about HIV and AIDS and now bored – 49.4 %”*), **Cultural constraints** (*“presence of traditionally respected people, e.g. in-laws”-(56.5%) and institutional constraints* (*“church not a place to discuss HIV - a third concurred with this statement–31.8%*), could limit the utility of this institution as a channel for HIV prevention.

According to factor analysis, the barrier items that had a high loading fell under three factors. The three factors were labelled as **“Barriers due to difference between communicator and audience”** (*“when people you have to talk to are older than you” (0.830), “when people you have to talk to are younger than you” (0.818), “when traditionally-respected persons, such as in-laws are part of the group you address” (0.593) and “cultural beliefs that ‘Talking about Sex’ is taboo” (0.575); “Barriers due to experience and perceptions of the communicator” (*“people are bored of HIV and AIDS because everybody now knows about it” – (0.845); “past risky sexual behaviour on your part” – (0.766); “church is not the place to discuss HIV” – (0.712) and “Barriers due to lack of self-efficacy”: *“when the person you speak to has more status than you” – (0.822); “not having first-hand experience of a person living with HIV”- (0.720).***

Cultural constraints and barriers due to difference between communicator and

audience appear to indicate the difficulties in communicating HIV prevention measures, specifically because some of these topics are regarded as taboos, such as sex and sexuality. The findings of this study are in accord with the previous research done in South Africa, Tanzania and Zimbabwe (Chitando 2007, Nürnberger 2005, Patterson 2009; Zou *et al* 2009). Traditionally, speaking about all that pertains to sexual activity is the normal cultural taboo of many people not talking about sex openly to respected and significant others (Chitando 2007; Paterson 2009).

However, of interest is that the descriptive statistical analysis shows that with regard to the cultural belief that “Talking about sex is taboo”, nearly half (45.9%) of the respondents indicated that it was not an issue at all whilst well over one third of the respondents (41.2%) indicated that, to some/large extent, it was an issue. This difference in the views of church leaders regarding the degree to which talking about sex is a taboo when communicating HIV prevention to their audiences reflects that they are not a homogeneous group of people who hold the same beliefs and values. It is, therefore, important to consider other theoretical models that could possibly provide different types of attitude measurements such as function theory, to explore the underlying individual beliefs and values of church leaders in determining the motivations that underlie their attitudes towards their leadership roles in HIV prevention. A study by Visser (2006) in which she integrated the Theory of Planned Behaviour (TPB) and Attitude Functions, concluded that the use of attitude functions provided greater insights into reasons (specific psychological functions) for the different attitudes held by teachers regarding talking about sexuality and condoms to students. These findings suggested the need to tailor training campaigns to address those specific reasons why teachers may decide not to talk to students about HIV and AIDS (Visser 2006).

In the descriptive analysis, another aspect, “when people you talk to are older than you”, had 42.4% indicating that it was a barrier, whilst 43.5% indicating that it was not. However, this aspect was reflected as a barrier in the factor analysis as it loaded high (0.830).

These findings indicate that the church leaders regard talking about the sexual transmission of HIV as an issue that might be influenced by both individual and social-cultural values as there were mixed reactions on the descriptive and factor analysis aspects stated above. Attitudes that express values reflect perceptions of moral judgement and consequences of talking about HIV prevention and these attitudes can negatively influence the church leaders' willingness to take a leadership role in HIV prevention (De Gruchy in Haddard 2011; Ericksson *et al* 2010; Paterson 2009; Zou *et al* 2009). Thus, one can conclude that there is still a great deal of silence about HIV prevention among the church leaders. Research suggest that cultural taboos and silence around communicating about HIV perpetuates HIV-related stigma which in turn hinders development of creative action plans to respond to HIV and AIDS including failure to effectively address HIV prevention (Genrich & Brathwaite 2005, Nhamo 2011).

However, these findings are contrary to those reported in studies among church leaders in Malawi by Trinitapoli 2006. Trinitapoli found that church leaders in Malawi are open to engage their rural congregations in HIV and AIDS discussions, as well as in some other churches such as Pentecostal churches who have teachings against alcohol consumption and extra-marital affairs (Gregson *et al* 1999, Addai in Nhamo 2011, Garner 2000, Parsitau in Nhamo 2011).

5.2.2.2 Advantages of talking to parishioners and clergy about the risk of the sexual transmission of HIV:

The findings based on the descriptive analysis revealed that the majority of the respondents were optimistic about the effects of taking a leadership role and talking about the sexual risk of HIV transmission and the majority acknowledged the possible benefits of such involvement. The perceived benefits of talking about the sexual risk of HIV transmission include the promotion of churches as stigma-free social environments that allow for open discourse on HIV prevention and education on positive living for PLHIV to enhance risk reduction behaviours. With the majority of church leaders

acknowledging the benefits of their involvement in HIV prevention, this can serve as a starting point to engage them further to overcome the barriers identified above and to elicit a stronger commitment on the part of church leaders to give their support.

Based on the factor analysis, the attitudes of the church leaders towards talking about the sexual risk of HIV transmission were categorised into two groups, namely, '**perceived impact of HIV communication**' and '**behaviour change results**'. The perceived impact of HIV communication indicated that the church leaders had positive attitudes towards their leadership roles in HIV prevention. The items that loaded high on this factor expressed the value of talking to parishioners and the clergy about the sexual risk of HIV transmission, which will result in increased knowledge on prevention, reduced stigmatisation and discrimination of PLHIV and improved management of the disease. The findings of this study in this regard concur with the findings of previous studies undertaken in Uganda and South Africa (Muturi 2008; Van Deutekom 2007). These studies indicate that regardless of the continued perception by the public of the churches and FBO to be in opposition to the condom use and sexuality education, the church leaders themselves do acknowledge the importance of their involvement because of their social influence as trusted and credible sources of information (Muturi 2008; Van Deutekom 2007). From this result, one can conclude that the benefits of talking to parishioners and the clergy about the sexual risk of HIV transmission may be an important starting point for designing interventions that target the increasing involvement of church leaders in HIV prevention.

However, there is one negative outcome from the 'behaviour change results'. The perceived negative outcome relates to 'sex education for young people will encourage early onset of sexual activity'. Forty five percent (45%) of the church leaders were in agreement with this statement, and in the factor analysis, the statement had a high loading of 0.815. Such views suggest attitudes of concern as it represents fear about the fate of young people regarded as vulnerable to HIV infection. This attitude of concern further suggests perceptions about issues that are acceptable within the norms and

values of a community – church leaders may fear that promoting anything contrary to the norm may result in them being accused and excluded from the social group.

The aspect “sex education for young people will encourage early onset of sexual activity” highlights possible beliefs and values inherent within the context of the church leaders’ communities. The church leaders’ concerns that educating young people about HIV prevention might influence them to be sexually active has been reported elsewhere by Eriksson *et al* (2010) as discussed in Chapter 2 of this study. Some of the ambivalent HIV prevention messages known to have positive and negative consequences include promotion of condoms and sex education.

The aspect “HIV and AIDS will be regarded as a chronic disease, thus, normalising it like high blood pressure, diabetes mellitus etc.” (59.5%) supports the need for churches to hold regular educational meetings for parishioners to dialogue on issues of HIV and AIDS in order to prevent new infections and reduce stigma associated with HIV as observed by (Nhamo 2011). If church leaders continue to be silent about HIV, it becomes difficult for persons living with HIV to find refuge in churches as silence perpetuates stigma. If church leaders commit themselves to frequent educational meetings on HIV issues, it may help to place HIV in the chronic disease category. By bringing it into the chronic disease category, there should be no complacency (let down) in the prevention strategies, otherwise the epidemic may continue to spread in the background.

Regarding the aspect “the church will not lose members due to death and leaving the church to seek faith healing elsewhere”, the findings (71.8%) indicate that there is a general understanding that although the church leaders are a vital source of HIV information, similar information can be obtained from other stakeholders. In addition, whereas the church may be the only resource centre for HIV and AIDS, particularly in the hard-to-reach areas, the prime objective to go to church is not to hear about HIV but rather to hear the Word of God.

Overall, the aspects related to the two factors, “perceived impact of HIV communication” and “behaviour change results”, are an indication that church leaders can play a positive role in HIV prevention since they have knowledge on the aspects that can assist in prevention of HIV transmission.

5.2.2.3 Consequences of not talking about the sexual risk of HIV transmission

All the consequences (Table 12) had more than 60% of respondents regarding them as “likely to happen”. The church leaders mostly agreed that there is need to talk to parishioners and clergy about the sexual transmission of HIV in order to prevent denial that HIV is a problem, avert new HIV infections, reduce loss of church members to AIDS-related deaths and minimise number of orphans. In this regard, church leaders thus should be empowered to take responsibility and ensure that denial regarding the existence of HIV among parishioners as well as the assumption that churchgoers could be immune to infection is addressed to enhance prevention efforts as noted by Campbell *et al* 2011; Zou *et al* 2009.

According to the factor analysis, two factors regarding the consequences were identified, namely, **‘adverse effects on church and society from withholding HIV communication’** and **‘the value of church leadership in HIV communication’**.

The first factor expresses attitudes of concern that relate to perceived consequences of the spread of HIV and its resultant negative impact on church and society. The factor analysis results correspond with the results of the descriptive statistical analysis that indicated that the church leaders support the provision of educational talks about the sexual risk of HIV transmission to their parishioners and clergy. This may indicate that church leaders have an understanding of the problem of HIV and AIDS to be a more serious health issue that is characterised by the burden of illness and suffering of the affected. These results are in line with the findings of the LWF

HIV and AIDS Impact Assessment in 2013. LWF (2013) concluded that member churches of LWF, ELCZ included, have honoured their commitments to breaking the silence on HIV and AIDS by establishing AIDS desks that have heightened awareness and intensified involvement in major HIV and AIDS programmes. In the case of ELCZ, the church established the Thusanang project in the Matabeleland South province of Zimbabwe, which provides peer education on HIV prevention for the youth, home-based care for PLHIV and for orphans. Furthermore, these findings support the views of Myaka (2011) who sees the need to contemplate a Lutheran theological principle of one's response to HIV epidemic. Referring to Luther's treatise, "whether one may flee from a deadly plague or not" (Luther 1527), Myaka encouraged the Lutheran church leaders to review the theological principle undergirding Luther's response of not fleeing from the bubonic plague. In like manner, the Lutheran leadership should not "flee" from their responsibility of educating parishioners and the clergy about HIV transmission and prevention. Despite the fact that 54.5% are not involved in HIV prevention, an overwhelming number of church leaders (70 % to 80%) realise the consequences of their inaction of not being involved in HIV prevention. The consequences to this factor relate to lack of knowledge on HIV prevention and management of the impact of AIDS, denial that church members are also vulnerable to HIV infection and stigmatisation of PLHIV. These attitudes of concern are important as they could influence the willingness of church leaders to take a lead in talking about the sexual risk of HIV transmission. By virtue of the fact that the church members constitute 80% of the Zimbabwean population, whatever affects church members should indirectly have an impact on the general population, for example, deaths among church members may increase the number of orphans and the burden of their care in both church and society.

The second factor highlights the necessity and value of the church leadership to communicate about the sexual risk of HIV transmission. Lack of church leaders' involvement may result in missed opportunities to change attitudes and behaviour, denial that HIV is not a problem and high prevalence of HIV rates that will subsequently affect church members should church leaders fail

to speak openly about the sexual risk of HIV transmission. These findings are in support of the conclusions of the study by the Evangelical Lutheran Church in Germany who recommended that church leaders should go beyond general preventive information to initiate programmes that would enable each individual to translate various elements of ABC prevention principles into a change of behaviour (Evangelical Lutheran Church in Germany 2007). One could argue that these results show that the involvement of church leaders is critical to the control of the epidemic and mitigation of its impact. The essence of these findings is that if church leaders do not talk about HIV, they minimise their ability to assist those in need. What the church leaders cannot do for their church members they cannot do for the society. Though they are meant to be the light of the world, and demonstrate a pastoral role of attending to the needs of the parishioners, this role will not be complete if church leaders disengage from talking about HIV transmission, that is, they will be feeding the spiritual wellbeing but neglecting the physical wellbeing of the vulnerable groups.

It is important to strengthen the capacity of church leaders also to address the physical needs of the people by openly discussing HIV preventative methods and employing strategies proven effective in reducing the HIV-related stigma.

5.2.2.4 Advantages of giving advice on HIV prevention

With regard to the descriptive analysis, the results show that nearly all the church leaders (94.1%), who took part in the survey, were convinced that if church leaders provided advice on HIV prevention, people would be better informed about the disease.

According to the factor analysis, two factors regarding the consequences were identified, namely, '**positive effects for health outcomes**' and '**general positive outcomes**'. The results of the factor analysis in this regard indicate that church leaders were in agreement that their involvement in HIV prevention will result in more people taking up HIV testing, reduction of new HIV infections, more lives will be saved, prolonged life for PLHIV. This implies

that church leaders not only place a value in HIV prevention education but also that their involvement may save lives. However, though church leaders have indicated the importance of talking about the sexual risk of HIV transmission and giving advice on HIV prevention to their parishioners and clergy, they are currently less involved as more than half (54.5%) are not involved in the education on sexual matters of HIV transmission as shown in Table 9. A more enhanced or active role played by church leaders in HIV prevention may create a platform for members to share and benefit from ways that reduce susceptibility and vulnerability to HIV infection in their communities as observed by Campbell *et al* (2011) and Van Deutekom (2007). The importance or significance of these results is that quality of life will be improved and not so many people will succumb to the impact of HIV and AIDS if church leaders take a lead in HIV prevention.

With regard to 'General positive outcomes' the items that loaded on this factor were related to an agreement with the fact that increased awareness and better education about HIV prevention may possibly lead to an increased number of people participating in health-care programmes. These results appear to reflect the potential of church leaders' contribution to HIV prevention using their influence in the society, thus, realising positive outcomes on the general population. Given the above, there is great potential for church leaders to contribute to HIV prevention using their influence and this presents great opportunity for church leaders to use their influential position to reduce the effects of HIV infection in society.

The results indicate that while church leaders express positive attitudes about HIV prevention education, they are not comfortable to talk openly about the sexual risk of HIV transmission and to give advice on HIV prevention. This was particularly the case with regard to barriers highlighted in section 5.2.2.1, which were grouped as self-efficacy constraints, cultural constraints, institutional constraints, barriers due to difference between communicator and audience, barriers due to experience and perception of the communicator and barriers due to lack of self-efficacy. The findings are in agreement with the studies by Muturi (2008) and Van Deutekom (2007) who indicated the benefits

of the positive influence churches have on sexual behaviour. The influence on behaviour change points to a paradigm shift of moving away from blaming churches for failures in controlling the spread of HIV. Muturi (2008) and Van Deutekom (2007) argue that rather the focus should be on strengthening collaboration of the secular world and religious circles in maximising their comparative advantages to control the epidemic competently. The Lutheran Communion in Southern Africa, as the coordinating body for strengthening the capacity of her member churches to respond effectively to the epidemic, need to develop strategies that will boost the confidence of church leaders to overcome their barriers.

5.2.2.5 Consequences of giving advice

With regard to the descriptive analysis, the results show that more than half (52.9%) of the respondents were convinced that if church leaders provided advice on HIV prevention – through the promotion of condom use - it will encourage early sexual experimentation amongst young people. Such a perception might lead to unwillingness on the part of the church leaders to promote condom use as a preventive measure, thus limiting the options for effective safe practices against HIV infection especially for young people.

On the basis of the factor analysis two factors regarding the consequences of giving advice were identified, namely, **‘anticipated negative outcomes of leadership engagement’** and **‘presumed negative responses/reactions from the community’**.

With regard to anticipated negative outcomes of leadership engagement, the items express attitudes of value that reflect perceptions of moral consequences of giving advice on HIV prevention. The first item (condom use will encourage promiscuity) had the highest load on this factor. This is in support of the views that some religious leaders in Africa preach that use of condoms encourages promiscuity, an approach that works against their efforts as observed by Agadjanian 2007; Zou et al 2009. On the other hand, one can argue that church leaders with such attitudes, as depicted by the items for

factor 10, are seen as rather advocating for promotion of a “completely meaningful life style for the person” that depicts a more responsible sexual relationship approach through pre-marital sexual abstinence and marital sexual fidelity (Vatican 2011). The more responsible sexual relationship approach is opposed to the distribution of condoms that is regarded as an incomplete “quick-fix” HIV prevention approach (Vatican 2011). The views of such church leaders who call for abstinence and faithfulness have been proven to be effective as shown by the decline of HIV rates in some countries (Kenya, Zimbabwe) that have been attributed to a decrease in the number of sexual partners (UNAIDS 2010; 2012).

The essence is that some people believe that certain preventive measures are counter-intuitive; instead of reducing infections, they may encourage more risky behaviours, which will result in more infections. This is in support of the findings by Kwitonda (2010) who notes that the societal expectation of religious leaders to promote comprehensive methods of HIV prevention becomes at odds with the leaders’ religious beliefs. In this regard, Kwatindo highlights that being uncertain of the outcome of an action makes it difficult for church leaders to commit themselves to promoting comprehensive HIV prevention methods, as they believed that condom use would lead to committing adultery. This negative outcome would then be difficult for church leaders to reverse, hence their feeling unease in promoting comprehensive HIV prevention methods. This finding suggests that some church leaders believe that the use of condoms is counter to reduction of new infections instead it increases infections as it gives false protection and encourages risky behaviours that will lead to exposure to HIV.

With regard to presumed negative responses/reactions from the community, all items related to the reactions of others, namely, falsely accusing parishioners and clergy of promiscuity, family quarrels, risky behaviour, and belittling pastors. One can conclude that the church leaders were concerned about the presumed negative impact on their members, the clergy, families and communities as shown in a study by Campbell et al 2011.

In many communities, there is a general view that use of condoms is linked to promiscuity and risky sexual behaviours. Some church leaders may not advocate for condom use as an HIV prevention method because they may be viewed as falsely accusing members of promiscuity. In addition, they may have also experienced cases where there has been misuse of condoms resulting in promiscuity and risky behaviours. If parishioners and clergy feel that the church leaders are underestimating their integrity, they may not listen to what they say and therefore church leaders would lose their influential role.

5.2.2.6 Support from significant others

With regard to the descriptive analysis, each of the groups/organisations listed in Table 15 (in chapter 4), had 80% or more of the respondents indicating that the various groups/organisations will support them. Pertaining to the ranking of these groups/organisations in the descriptive analysis, the first group had four items that had 87% to 88.2% of respondents indicating would be supportive, namely, Pastors, Bishops, National AIDS Council and Non-governmental organisations. The second group had five items that had 84.7% to 85.9% of the respondents indicating that they would be supportive, namely, Zimbabwe National Network of People Living with HIV, Matabeleland AIDS Council organisation, the Government, People living with HIV and the Lutheran Communion in Southern Africa. The third group had two items that had 81.2% and 83.5% of the respondents stating that they would be supportive, namely, Partners and those who have lost relatives to AIDS-related illness.

Interestingly, the church leaders are presenting a dilemma in this study. On one hand they are not featuring in HIV prevention education activities as more than half (54.5%) were not involved in HIV prevention activities and on the other hand they are excelling as supporters - pastors and bishops ranked the highest (88.2% and 87%). If church leaders say that they are going to be supporting HIV prevention activities, their support might encourage greater involvement of the whole leadership to take a lead in HIV prevention. This in turn, might contribute to the reduction of new HIV infections and the related

negative outcomes including stigmatisation of PLHIV – might help Zimbabwe to realise their goal of reducing new HIV infection among the adults and children by 50% by 2015.

According to factor analysis, one factor regarding supportive groups/organisation, was identified, namely, **strategic partners/stakeholders**. Within this factor, the researcher further categorised the items into three groups. The first group had four aspects loaded at 0.90 and above, namely, the MAC, the Government, NAC and ZNNP+ with the second group that had five aspects loading between 0.751 and 0.876, namely, Pastors, LUCSA, Bishops, NGOs and partners of the church leaders while the third group had two items loading between 0.612 and 0.621. The first group, the government agents and national organisations, are policy makers that drive the response to the epidemic in Zimbabwe and render support to multi-sectoral programme implementers that include church groups. The second group included programme implementers that operate at varying levels. For example, the clergy have a direct responsibility of establishing programmes in their parishes. While LUCSA, as a regional coordinating body, has the mandate to strengthen the capacity of member churches for a relevant and effective response to HIV and AIDS, ‘partners’ of the church leaders, that is, husbands or wives, assist the clergy in establishing programmes. The third group comprises people who need current HIV and AIDS information for their meaningful participation in the response to the epidemic, namely persons living with HIV and those who have lost relatives to AIDS-related illnesses.

The results of the factor analysis in this regard indicate that the level of expected support of church leaders’ involvement in HIV prevention is high. Based on the above rankings of the variables, one can argue that the church and their FBOs can play a positive role in HIV prevention if they aggressively garner support from the significant others in their areas of operation. Parry (2008) supports the church’s involvement in HIV response sighting the significant advances achieved as a result of strong and committed leadership.

However, one can ask, to what extent are the services of these

groups/organisation utilised by the church leaders to enhance their own leadership roles in HIV prevention? Addressing this question would be relevant in further identifying factors that make church leaders' involvement in HIV response weak. A study in America by Chin et al (2005) concluded that in some exceptions religious leaders' involvement in HIV and AIDS was weak, erratic, and fragmented. Assisting church leaders garner support from local stakeholders, would be critical in addressing their weak involvement in HIV prevention.

5.2.2.7 Obstruction by significant others

With regard to the descriptive analysis, more than half (50.6% and 54.1% respectively) of the respondents indicated that two groups of individuals or people might obstruct the church leaders' involvement in HIV prevention. These groups include, the “sugar daddies or sugar mummies” and “certain Christian individuals who have negative attitudes towards HIV and AIDS and see themselves as holy”, as shown in Table 16 (in chapter 4).

Based on the factor analysis, two factors regarding obstruction of significant others were identified, namely, **‘specific group-resistance anticipated’** and **‘resistance anticipated from pastors and youths’**.

With regard to **‘specific group-resistance anticipated’**, the items related to the anticipated resistance of either individuals or groups of competitors. In this regard, the results indicate that the anticipated specific group-resistance is from “sugar daddies or sugar mummies”, sex workers, and certain Christian individuals with negative attitudes towards HIV and AIDS and see themselves as “holy” as well as organisations who may feel that there is duplication of work that might result in competition and some political parties.

Attitudes of being “holy” might create wider gaps between church members and those who are to take a lead in HIV prevention as the ones who regard themselves as “holy” associate HIV transmission with ‘immoral people’. In this regard, church leaders with views of being “holy” may not be motivated to take

up leadership roles in HIV prevention. The findings of this study are in contrast to the findings of a study by Hartwig et al (cited in Van Dyk & Van Dyk 2007), who found that many persons living with HIV instead perceive the church to be the one opposed to those working in the field of HIV and AIDS. This is because churches are perceived as associating HIV and AIDS with taboo topics namely sex and sexuality, immorality, promiscuity and therefore, would not be comfortable in participating in the field of HIV and AIDS.

Sex workers and “sugar daddies or sugar mummies” are associated with immorality. It is assumed that the obstruction from the “sugar daddies and mummies” and sex workers would be out of fear of being exposed for their behaviours regarded as inappropriate by the society. The findings further suggest that the church construes that sex workers would obstruct them as they may think that they would lose their clients whose sexual risky behaviours may be changed. In this regard some church leaders may not be motivated to take up leadership roles in HIV prevention beyond their churches to the communities.

With regard to **resistance anticipated from pastors and youths**, the two items identified related to presumed obstruction from some clergy and the youth if church leaders talked about the sexual risk of HIV transmission or gave advice on HIV prevention. It may be that they view themselves as being “holy” and regard issues of HIV transmission with immoral behaviour such as promiscuity, hence opposed to involvement in HIV prevention. These findings are in line with the findings of a study by Hartwig et al (cited in Van Dyk & Van Dyk 2007), who stated that many persons living with HIV perceive the church to be opposed to those working in the field of HIV and AIDS.

The foundation of ELCZ, “the faith and doctrine”, is buildt on the love of the Lord Jesus Christ that is unconditional. From the findings of this study, ELCZ pastors and youth anticipated to oppose HIV prevention will have deviated from unconditional love of Jesus Christ by imposing conditions on HIV prevention i.e. in that they are not willing to share knowledge with people who are immoral, promiscuous and/or ungodly). Pastors and youth who are

opposed to HIV prevention would be violating / not fulfilling the constitution of ELCZ that promotes healing, which talks about healing of body and of soul.

Engaging the ELCZ church leaders on the foundation of their church as stated in their constitution could be an important entry point in influencing them to see their roles and responsibilities in HIV and AIDS response.

5.2.3 Research objective 3: To explore how biographical variables location of a congregation, position in the church, length of Lutheran membership, gender, age, education, involvement in HIV prevention activities and exposure to HIV training may influence the attitudes of the Lutheran church leaders towards their leadership roles in HIV prevention.

The exploration of the way respondents answered the questions did not reveal an association or significant differences in relation to *position held in the church, length of being a Lutheran member, gender, age, level of education and exposure to HIV and AIDS training.*

However, the exploration detected, in some aspects, significant differences across two biographical variables, namely, *area where congregation is located* and *involvement in HIV prevention activities* in relation to four items under barriers, with the urban church leaders stating that these were not a barrier.

Firstly, the attitudes that showed an association with *area in which congregation was located* were in relation to four aspects under barriers, one aspect under consequences of not talking about the sexual risk of HIV transmission and three aspects under consequences of providing advice on HIV prevention to parishioners and the clergy.

The findings showed that location of a congregation is associated with attitudes towards leadership concerning barriers when discussing the sexual risk of HIV transmission with parishioners and clergy. The findings showed

that lack of confidence, when speaking to someone of a higher social status, people are bored of HIV and AIDS because everybody now knows about it and talking to older people were less of a barrier for urban church leaders than the rural-based ones. The difference should be interpreted in the light of both exposure to AIDS information and socio-cultural contexts of congregations. Thus, the researcher attributes this difference to the assumption that people in the urban area may not have 'stage fright' as they are used to seeing people talking in public, therefore, do not have much inhibition. In the rural areas, people have fewer opportunities for public speaking. The urban church leaders have more sources of information on HIV prevention than the rural-based church leaders.

The researcher attributes the findings that urban church leaders were significantly more favourable with regard to taking up leadership roles in HIV prevention perhaps since access to HIV and AIDS information is readily available in urban settings. Many of the respondents are in an urban setting where information about HIV and AIDS is easily accessible through various media, such as newspapers, television, radio and internet, over and above different gatherings. In the rural areas that are remote, few people may access information through radio and television. The majority of people may access HIV information by word of mouth or in some settings through traditional initiation schools for boys and girls. HIV information can also be shared in general terms at social and church gatherings. Some of the traditional ways of sharing information include cultural initiation schools for boys and girls – where an aunt or an uncle has the responsibility to educate young people about issues of sexual reproductive health and adulthood. However, this varies from family to family. Unfortunately, the effects of urbanisation and migration as well as the impact of HIV and AIDS has broken down these traditional structures, making it difficult to sustain this form of sex education for young people (Nganda cited by Amanze in Chitando & Nickles 2010).

Cultural norms are more enforced and observed in the rural setting. Culture often prescribes respect for people older than the subject and for those of a

higher status – it might therefore be difficult to discuss sexual matters with those one has to show respect according to cultural prescriptions. These findings reinforce the challenges in talking to different age groups about issues regarded as taboo, such as the sexual transmission of HIV especially to those whose congregations were located in rural areas.

The findings reveal that location of a congregation is also associated with attitudes towards leadership concerning consequences of providing advice on HIV prevention to parishioners and clergy. The association is more noticeable in those from the urban areas who indicated that it was unlikely *people may think you are falsely accusing them of promiscuity, the promotion of condom use will encourage promiscuity and it may lead to increased health-seeking behaviours for care, resulting in decreased access to services*. These findings point towards attitudes of urban church leaders that are flexible to embrace comprehensive strategies for HIV prevention. The researcher attributes these findings to church leaders in urban areas having greater connection with other AIDS Service Organisations through attending workshops on HIV prevention and exposure to information on HIV and AIDS through various media, as well as personal encounter with a PLHIV and the demand for care for orphans due to AIDS-related deaths. UNAIDS (2009) attributes the decrease in HIV prevalence in Zimbabwe to reduction of sexual partners, high deaths due to AIDS and condom use with casual partners. In regards to high number of AIDS related deaths, one would expect both urban and rural areas to have witnessed similar experiences as many PLHIV return to their rural homes for terminal care. The urban-rural differences observed in this study are contrary to the findings of Agadjanian and Menjivar (2008) who found rural and semi-rural congregations in Malawi more open to HIV and AIDS-related conversations than among urban ones. The finding that urban congregations had no issues with the above-stated consequences may be an entry point for increasing support to urban church leaders for their greater involvement in HIV prevention and to influence their counterparts in rural areas.

The exploration of the consequences of providing advice on HIV prevention to parishioners & clergy detected significant differences across the urban and

rural congregations with respect to *people may think you are falsely accusing them of promiscuity, the promotion of condom use will encourage promiscuity and it may lead to increased health-seeking behaviours for care, resulting in decreased access to services*. The association is more noticeable in the case of those church leaders whose congregations are in urban areas and who indicated that it was unlikely in terms of the aspects on falsely accusing people of promiscuity and condom use resulting in promiscuity.

Another association detected was in relation to one item under consequences of not talking about the sexual risk of HIV transmission and the variable *location of congregation*. The association was more noticeable in those who stay in the urban areas and indicated that it was unlikely that there would be a *reduction in church attendance* if church leaders did not talk about sexual risk of HIV transmission to parishioners and clergy. It is likely that the position taken by the urban church leaders is because many stakeholders are involved in the response to the epidemic, and therefore, many people in general receive information from different sources including different media such as radio, TV as well as in their workplaces and communities. It is also likely that the urban church leaders realise that the prime objective of attending church services is to hear the Word of God and therefore have no fear that people will not attend services if they talk about HIV. However, stigmatization and discrimination result in the destruction of the will power and social standing for the persons living with HIV and these will not be addressed if there is no sharing of information on how to help PLHIV and the affected as PLHIV will keep on blaming themselves, which does not promote healing.

Secondly, the attitudes that showed an association with *involvement in HIV activities* were in relation to barriers, consequence of talking about sexual risk of HIV transmission and level of obstruction by various significant others.

There is a difference in opinion, in terms of addressing people of higher status, between those who were involved in HIV activities and those not involved, in relation to location of congregation. Those in urban areas were not likely to be deterred by status, as they had no fear speaking to someone

of higher social status than them. This finding may be related to greater interaction with other players in the field of HIV and AIDS, such as government agents, NGOs and other ASOs and may point to urban congregations as a state of readiness to taking their leadership roles in HIV prevention beyond the church members to even advocate and lobby governments for support. This finding aligns with the support pledged by the global network of churches to strengthen the churches' advocacy efforts in HIV and AIDS response (EAA 2011).

Another association was between *involvement in HIV activities* and the variable *sex education for young people will encourage early onset of sexual activity*. The association was more noticeable in those who said they were involved in HIV activities and indicated that it was likely. The interpretation of this association seem to be closely aligned to cultural and religious beliefs that regard discussing sex matters in the presence of children as taboo and not appropriate for young people, in particular those who were not ready for their passage to adulthood (Amanze in Chitando & Nickles 2010; Khathide in Dube 2003). The above-mentioned authors state that talking openly about sexual matters arises from the fear that young people may experiment with sex with their playmates. However, other scholars believe that this need not be the case. The benefits of sex education and talking about sexual matters to young people include “addressing biological, social-cultural, psychological and spiritual dimensions of sexuality from the cognitive domain (Information), affective domain (feelings, values and attitudes), and behavioural domain (communication and decision-making skills)” as stated by Nganda cited by Amanze in Chitando & Nickles 2010). As a vulnerability group to various sexual reproductive health illnesses, including HIV infections, church leaders are encouraged to review the importance of and provide sex education to young people. Kirby *et al* and Underhill cited in Eriksson *et al* (2010) observed in their studies that sexuality and HIV education were not associated with more risky sexual behaviours among young people. The findings of these studies may address the concerns of those church leaders who perceive HIV prevention to be associated with promiscuity, and help in motivating them to provide sex education to young people.

Finally, the exploration of *involvement in HIV activities* detected an association with the level of obstruction by young people and “sugar daddies and sugar mummies”. A possible interpretation of this association may be in relation to religious beliefs and a socio-economic perspective. In terms of young people, the obstruction may be due to ideological issues that pertain to viewing the church to be an improper venue to discuss the sexual risk of HIV transmission and prevention as these are, in many religious settings, associated with immoral people, believed to be outside the church circle.

In terms of “sugar daddies and sugar mummies”, church leaders may be fearing obstruction from these groups based on the assumption that some people engage in sex work or “survival sex” due to poverty. HIV prevention activities aim to influence people who become vulnerable to HIV infection due to risky behaviours including those who are vulnerable to patrons who offer them incentives to engage in sexual risky behaviours. Therefore, this implies that the business of those patrons might slow down due to a positive change of sexual risky behaviours. In this regard, the church leaders may assume that sugar daddies or sugar mummies, who engage in sex work, might oppose or obstruct the church leaders who would take up leadership roles in HIV prevention.

However, the studies reviewed indicate that church leaders were the ones viewed to be unsupportive towards PLHIV and the work in response to HIV and AIDS (Hartwig *et al* in Van Dyke & Van Dyke 2007).

5.3 LIMITATIONS OF THE STUDY

The findings of this study are limited by several factors including the inherent difficulties associated with survey as a cross-sectional research design. Cross-sectional research designs do not allow measurement of change over time as all data are collected at once. The present study aimed at describing the attitudes of church leaders toward their leadership roles in HIV prevention

at the time the study was conducted. It is possible that attitudes may change as time progresses.

Another limitation of the study concerns the belief elicitation phase. Ajzen and Fishbein in Glanz et al (2007) recommend the use of a small convenience sample for the elicitation phase. Concerns over how representative the beliefs elicited from such a small sample may be of the larger population, can be raised. However, this study addressed this concern by reaching “saturation” points during focus group discussions. In addition, the focus group participants had a socio-demographic profile that matched the main study population, making their ideas relevant to the target behaviour – talking or not talking about sexual risk of HIV transmission and providing or not providing advice on HIV prevention - as they also were active members of the church in leadership positions. However, due to the delimitation of the study to the church leaders of the Western Diocese parishes in Bulawayo and Matabeleland South provinces of Zimbabwe, caution should be exercised in generalising the findings of this study to other contexts in Zimbabwe.

A weakness of surveys is that they can only collect self-reported data based on the recall of past action or hypothetical action. Studying attitudes could be problematic, for example, the respondent may have given no thought to the issue under study and may at that point form an opinion on the matter which may reflect artificiality, and thus putting a strain on validity (Babbie 2007). In the case of this study, the data was not compromised by using self-reported data as the beliefs elicited to develop a questionnaire for the main study were collected from a sample of the target population that were part of the decision-making context of the Lutheran church leadership but were not included in the main survey. The aim of the elicitation phase was to identify relevant target beliefs that best described the population studied.

Furthermore, given the sensitivity surrounding HIV prevention topics that invariably usher in issues of sex and sexuality, the self-reported nature of the questionnaires could have resulted in respondents expressing values, attitudes and socially desirable responses (Marsh & Julka 2000). It is

therefore possible that respondents were biased in their responses in this regard.

Given that all the people attending the seminar had been informed through the activity schedule prior to the event about the topics on HIV and AIDS including a testimony that was to be given by a person living with HIV, conducting the study at the seminar venue may have resulted in selection bias. It is possible that people attending this seminar already had interest on issues of HIV and AIDS, making generalizability of the findings of this study limited to mostly the Lutheran church leaders who attended this seminar.

The researcher originally planned to select a sample size of 100 church leaders, but due to the late arrival of some of the delegates, only those who were present at the time allocated for the administration of the questionnaire were included in the survey. The survey was done during the first two hours of the seminar and therefore delegates that arrived towards the end of the time allocated and those who arrived later in the day were excluded from the survey. Time therefore became a constraint and contributed to a reduced sample of 88 church leaders instead of 100.

However, the researcher does not anticipate that any of these limitations resulted in systematic errors in data collection. In addition, the theoretical or conceptual framework employed in this study can still be generalised to other settings, and to different behaviours and populations.

5.4 SUGGESTIONS FOR FURTHER RESEARCH

The researcher recommends that further research be conducted using other theoretical or conceptual frameworks to investigate the motivations that underlie attitudes that people hold, such as the functional theory (Katz 1960 cited in Visser 2006). The main assumption of the functional theory is that people hold attitudes for a reason, i.e. that they serve a specific psychological function. Understanding different “attitude functions” may offer essential

information for the design of programmes that engage church leaders in HIV prevention to influence specific attitudes for their greater involvement.

The sample of this study was drawn from church leaders that were attending a seminar organised by one of the three Dioceses of the Evangelical Lutheran Church in Zimbabwe. Consequently, the findings of this study may not be representative of the entire population of the Lutheran Church leaders in Zimbabwe. The researcher recommends a nationwide study of the attitudes of Lutheran church leaders on involvement in HIV prevention.

Most of the church leaders who participated in this study were male. Further research with a sample that will be more representative of the sex and age distribution of Lutheran church leaders, could increase confidence levels with regard to the generalizability of the findings of the study.

Lastly, further research that could address how different attitudes impact on the content of HIV prevention that church leaders discuss with their parishioners and clergy to help elucidate underlying causes of attitudes towards taking a lead in HIV prevention.

5.5 RECOMMENDATIONS FOR POLICY AND PRACTICE

Recommendations are made based on three sets of themes and these are discussed below:

5.5.1 Maximising the involvement of churches or faith-based organisations in HIV prevention.

HIV prevention remains fundamental for the significant control of the spread of HIV infection, but the challenge is to bring about significant change of sexual risky behaviours. HIV prevention can be enhanced by multi-sectoral response and strengthening of community systems including the church structures. The strategies that engage churches should consider the attitudes of church

leaders towards taking a lead in HIV prevention.

Specific barriers exist among some church leaders that would compromise their leadership roles in HIV prevention. Weak involvement of church leaders will continue to result in missed opportunities to reach a wider audience commanded by churches for effective HIV prevention. The use of a model such as the theory of reasoned action's principles and procedures can identify the salient beliefs in a structured manner that can inform effective strategies when seeking to influence behaviour.

In the Zimbabwe situation, in which HIV prevalence has increased from 14.3% in 2013 to 15% in 2014 in the adult population, there is need to adopt the (TRA) model to a broader population. This is demonstrated by the findings of this study, which indicate that almost half of the respondents still battle with issues of lack of self-efficacy, difference between experience and perceptions of the communicator, institutional and cultural constraints as barriers to their leadership roles in HIV prevention.

The researcher recommends the following:

- i. ELCZ church leaders should adhere to the policies that they recommend, e.g. they committed themselves to breaking the silence on HIV and yet 54.4% of the Lutheran church leaders who responded to the questionnaire are not involved in HIV prevention.
- ii. The LUCSA Council should utilise its annual general meetings as a forum to hold all church members accountable for their response to the epidemic, in particular on HIV prevention, through sharing of clear milestones achieved towards their intended results and conducting exposure visit to learn from each other's programmes.
- iii. Research should be conducted on a wider scale among various groups of church leaders to identify barriers and ascertain the attitudes towards taking leadership roles in HIV prevention in order to influence their greater involvement.
- iv. ELCZ Church leaders should be assisted to develop, for in-service pastors and lay leaders, an annual refresher course on HIV and AIDS

issues to help them address taboo topics and uncertainties related to communicating issues of sex, sexuality and condom use.

- v. The annual refresher courses should be a platform to involve a wider circle of church leadership in designing strategies and messages that are sensitive to religious beliefs concerning communicating HIV prevention messages to help address barriers identified in this study.

5.5.2 Capitalising on missed opportunities for increased leadership roles in HIV prevention

The Evangelical Lutheran Church in Zimbabwe prides itself in teaching, preaching and healing. Under their arm of education, they have regular schools - primary and secondary. Under healing, they have clinics, hospitals, nursing training colleges and pastoral training colleges. All these should have a curriculum that incorporates HIV and AIDS education.

The researcher further recommends that:

- a) ELCZ church leaders should be encouraged to include HIV topics in syllabi of their institutions of learning, namely, primary and secondary education, academic, nursing education and pastoral training.
- b) Church activities involving gatherings of members as different groups or leagues should develop a structured learning programme for their weekly meetings that mainstreams issues of HIV and AIDS with a particular focus on HIV prevention which was shown in this study to be the less implemented activity compared to care and support activities.
- c) The church HIV prevention programmes should utilise innovative strategies that are informed by research that identifies gaps in knowledge and needs. Information should cascade to all levels or situations of the church, that is, top, down and urban, rural.

5.5.3 Walking together to reach far: engaging community systems for collaboration

Regarding cultural issues that were identified as barriers, ELCZ leadership should liaise with the community elders in their locality to address cultural issues that could be health or educational related.

Furthermore, the church leaders should liaise with local elders to find ways on how they could deal with taboo issues when talking about the sexual risk of HIV transmission and providing advice on HIV prevention. In the case of this study, barriers such as “when in-laws are part of the group that I address” and other cultural issues, such as “when the person I talk to is older than me”, could be overcome through partnership with the custodians of traditional norms and belief systems, namely, elders in the community.

5.6 CONCLUSION

This study reveals that the application of the principles and procedures of the theory of reasoned action provide a framework to identify behavioural and normative beliefs influencing the church leaders’ attitudes towards taking leadership roles in HIV prevention. The elicitation focus group discussion which formed the first phase of this study, was found to be an essential first step in identifying the salient beliefs relevant to church leaders’ attitudes towards taking leadership roles in HIV prevention and provided the basis for the development of the questionnaire for the main study. Analyses of survey data identified specific key beliefs that should inform development of programmes to influence greater involvement of church leaders in HIV prevention.

This study showed that the involvement in HIV prevention by the church leaders in the Western Diocese of the Evangelical Lutheran Church in Zimbabwe was low.

The church leaders assume that because people know much about HIV and

AIDS they are not going to be effective if they take leadership roles in HIV prevention.

There is need to boost the self-efficacy of church leaders if they are to play a leading role in changing the sexual risk behaviours of people.

The results of this study show that the majority of the church leaders, in rural and urban areas, believe that there is need to talk to parishioners and clergy about the sexual risk of HIV transmission and provide advice on HIV prevention. The church leaders were in agreement that awareness about HIV prevention will help in having a positive effect on the lives of the people as people become better informed about HIV and AIDS and participate in health programmes.

However, talking about the sexual risk of HIV transmission and HIV prevention is less of a barrier among church leaders in urban areas as compared to those in rural areas. The issues that were of a barrier to the urban church leaders relate to a lack of confidence when speaking to someone of greater social status/class, people are bored with HIV and AIDS because everybody now knows about it and when talking to older people.

There is an indication that the church and FBOs can play a positive role in HIV prevention since they have knowledge on the aspect that could assist in HIV prevention.

Church leaders should take responsibility in preventing HIV infection. It is understood that individuals have to take ownership and reduce their risky behaviours. However, on the other hand, church leaders should exercise their faith that calls them, through baptism, to promote life and in this case by empowering their congregants to prevent HIV through sharing of skills and knowledge on HIV and AIDS. In this regard, church leaders should hold each other accountable to be good stewards charged with the well-being of the congregation and strive for an effective and concerted effort to educate and take leadership roles in HIV prevention.

LIST OF SOURCES

Agadjanian, V. 2005. *Gender, religious involvement, and HIV/AIDS prevention in Mozambique*. *Social Science & Medicine* 61: 1529-1539

Agadjanian V. & Menjivar C. 2008. Talking about the “Epidemic of the Millennium”: Religion, Informal Communication, and HIV/AIDS in Sub-Saharan Africa. Society for the Study of Social Problems, Inc. Available at: <http://socpro.oxfordjournals.org/content/socpro/55/3/301.full.pdf>. (Accessed on 31 December 2013).

Agadjanian V. & Sen S. 2007. Promises and challenges of faith-based AIDS care and support in Sub-Saharan Africa. *American Journal of Public Health*. 97 (2):262–66.

Ajzen, I. 2006. Constructing a TpB questionnaire: Conceptual and methodological considerations. Available at: <http://www.umass.edu/aizen/tpb.html>. (Accessed on 22 March 2007).

Anozie, IE, 2011. The responses of a faith-based organisation to the challenges of HIV/AIDS“ A Case study of maseru United Church in Lesotho. [SI] (online publication): Available at: http://scholar.sun.ac.za/bitstream/handle/10019.1/6548/anozie_responses_2011.pdf. (Accessed on 20 February 2012)

Babbie, E. 2007. *The practice of social research*. 11th edition. Belmont, Thomson Learning Inc.

Ballard, S. 2014. Responding to the HIV/AIDS Epidemic in Africa: Churches United Against HIV and AIDS. Undergraduate Honours Theses. Paper 38. University of Colorado Boulder. Available at: http://scholar.colorado.edu/cgi/viewcontent.cgi?article=1037&context=honr_theses. (Accessed on 31 August 2014).

Barnett T & Whiteside A. (2002) *AIDS in the 21st Century: Disease and Globalisation*. New York, NY: Palgrave Macmillan.

Barnett, T & Whiteside, A. 2006. *AIDS in the twenty-first century: Disease and globalization*. Eastbourne: Palgrave McMillan.

Bless, C, Higson-Smith, C & Kagee, A. 2008. 4th edition. *Fundamentals of social research methods: An African perspective*. Juta and Company Ltd.

Bohner, G & Wänke, M. 2002. *Attitudes and attitude change*. East Sussex: Psychology Press.

Brown, JM, Wald, A, Hubbard, A, Rungruengthanakit, K, Chipato, T, Rugpao, S, Mmiro, F, Celentano, DD, Salata, RS, Morrison, CS, Richardson BA, and Padian, N. 2007. *Incident and prevalent herpes simplex virus type 2 infection increases risk of HIV acquisition among women in Uganda and Zimbabwe*. *AIDS* 21 (12): 1515-1523

Bryman, A. 2012. *Social research methods. 4th edition*. Oxford: Oxford University Press.

Campbell, C., Skovdal, M. and Gibbs, A. 2011. *Creating Social Spaces to Tackle AIDS-Related Stigma: Reviewing the Role of Church Groups in Sub-Saharan Africa*. *AIDS and Behavior*, 15, 1204-1219.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3514979/> (Accessed on 10 September 2012).

Central Statistics of Zimbabwe. 2002. *Population of Zimbabwe*. Government Printers, Harare.

CHGA (Commission on HIV/AIDS and Governance in Africa) 2008. *Securing our Future*. Addis Ababa.

Chin, JJ., Mantell, J, Weiss, L, Bhagavan, M, Luo, X. 2005. *Chinese and South*

Asian religious institutions and HIV prevention in New York City. *AIDS Education and Prevention* 17 (5), 484-502.

Chitando, E. 2007. *Acting in Hope: African Churches and HIV and AIDS 2*. Geneva: WCC publications.

Chitando, E. & Nickles, P. (eds). 2010. What's faith got to do with it? A global multifaith discussion on HIV response. INERELA. Available at: [http://www.inerela.org/wp-content/downloads/what'sfaithgottodowithit\(finall-res\).pdf](http://www.inerela.org/wp-content/downloads/what'sfaithgottodowithit(finall-res).pdf). (Accessed on 20 October 2014).

Church of Sweden, 2007. A pastoral letter from the Bishops of the church of Sweden about HIV from a global perspective. Uppsala: Church of Sweden.

Denis, P, & Becker, C. (eds) 2006. The HIV/AIDS epidemic in sub-Saharan Africa in a historical perspective. [SI] (online publication): Available at: http://www.refer.sn/rds/article.php3?id_article=245 (Accessed on 20 November 2008)

De Vos, AS, Strydom, H, Fouché, CB, & Delpont, CSL. 2005. *Research at Grassroots for the Social Sciences and human service professions* 3rd Edition. Pretoria: Van Schaik Publishers.

Diamantopoulos, A. & Schlegelmilch, BB. 2000. *Taking the Fear Out of data Analysis. A Step-by-Step Approach*. SOUTH-WESTERN Cengage Learning EMEA. Seng Lee Press, Singapore.

Dillard, JP. & Pfau, M. 2000. *The persuasion handbook: developments in theory and practice*. [SI] (online book): (pp 259-286).

Dube, M. 2003 (ed), *HIV/AIDS and the Curriculum: Methods of Integrating HIV/AIDS in Theological Programmes*. Geneva: World Council of Churches, 1-9; 59-75.

Duri K, Stray-Pedersen B & Muller F, 2013. HIV/AIDS: The Zimbabwean Situation and Trends. *American Journal of Clinical Medicine Research*, 2013, Vol. 1, No. 1, 15-22. Available at: pubs.sciepub.com/ajcmr/1/1/5 (accessed on 25 September 2014).

Ecumenical Advocacy Alliance, 2009. *Live the Promise: HIV and AIDS campaign. Framework for Action 2009-2012*. Geneva: EAA.

Ecumenical Advocacy Alliance, 2011. UN Review of AIDS: Is the world moving away from HIV? Available at: <http://www.e-alliance.ch/en/s/news/single/print/article/2011/04/11/un-review-on-aids-is-the-world-moving-away-from-hiv/> (Accessed on 15 May 2012).

Eriksson E, Lindmark G, Axemo P, Haddad B, & Ahlberg B.M. 2010. Ambivalence, silence and gender differences in church leaders' HIV-prevention messages to young people in KwaZulu-Natal, South Africa. *Culture, Health & Sexuality* 2010; 12(1):103-14

Eriksson E. 2011. *Christian communities and prevention of HIV among youth in KwaZulu-Natal: PhD thesis*, Uppsala University.

Evangelical Lutheran Church in Germany. 2007. *For a life with dignity. The global threat of HIV/AIDS: possible courses of action for the church*. Hannover: Church office of the Evangelical Church in Germany.

Evangelical Lutheran Church in Zimbabwe. 2008. *Church profile: Evangelical Lutheran Church in Zimbabwe*. Bulawayo: ELCZ.

Evangelical Lutheran Church in Zimbabwe. 2009. *HIV/AIDS Programme Evaluation Report*. Bulawayo: ELCZ.

Evangelical Lutheran Church in Zimbabwe. 2009. *Constitution of the Evangelical Lutheran Church in Zimbabwe*. Bulawayo: ELCZ.

Evangelical Lutheran Church in Zimbabwe. 2011. Revised version. *Constitution of the Evangelical Lutheran Church in Zimbabwe*. Bulawayo: ELCZ.

Fortunato, L. 2008. "Predicting condom use from adolescence to emergent adulthood: a comprehensive health behavior model". *Masters Theses and Doctoral Dissertations*. Paper 212. Eastern Michigan University.

<http://commons.emich.edu/theses/212>

Francis, JJ., Eccles, MP., Johnston, M., Walker, A., Grimshaw, J., Foy, R., Kaner, EFS., Smith, L. and Bonetti, D. 2004. Constructing questionnaires based on the theory of planned behaviour: A manual for health services researchers. Centre for Health Services Research; Newcastle upon Tyne, United Kingdom. Available at: <http://www.rebeqi.org/ViewFile.aspx?itemID=212>. (Accessed on 25 January 2007).

Garner, RC. 2000. Safe sects? Dynamic religion and AIDS in South Africa. *J Mod Afr Stud* 2000, 38:41-69. Cambridge University Press.

Genrich, GL & Brathwaite, BA. 2005. Response of religious groups to HIV/AIDS as a sexually transmitted infection in Trinidad. *BMC Public Health* 2005, 5:121

Geweke, D. 2009. Woven whole: weaving spirituality through a Lutheran epistemology and a liturgical hermeneutic. Available at [http://www.thefreelibrary.com/Woven whole: weaving spirituality through a Lutheran Epistemology and...-a0206058524](http://www.thefreelibrary.com/Woven+whole:+weaving+spirituality+through+a+Lutheran+Epistemology+and...-a0206058524) (Accessed on 21 October 2009).

Glanz, K, Rimer, BK & Lewis, FM (eds). 2002. *Health behaviour and health education: theory, research and practice*. 3rd edition. San Francisco: Jossey-Bass.

Glanz, K, Rimer, BK & Viswanath, W (eds). 2008. *Health behaviour and health*

education: theory, research and practice. 4th edition. San Francisco: Jossey-Bass.

Green, EC. 2003. *Faith-based organisations: contributions to HIV prevention*. The Synergy project report, Washington DC, United States Agency for International Development (USAID). Available at: <http://www.docstoc.com/doc7395/Faith-Based-Organizations-Contributions-to-HIV-prevention-USAID-Health-HIVAIDS-Partnerships-Faith-Based-Organization> (Accessed on 17 January 2009).

Green, EC, Halperin, DT, Nantulya, V, & Hogle, AJ. 2006. Uganda's HIV prevention Success: the role of sexual behaviour change and the national response. Available at: <http://www.pubmedcentral.nhi.gov/articlerender...1668> (Accessed on 17 January 2009)

Gregson, S, Zhuwau, T, Anderson, RM & Chandiwana, SK. 1999. Apostles and Zionists: the influence of religion on demographic change in rural Zimbabwe. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/11623883> (Accessed on 9 September 2009)

Gregson, S, Terceira N, Mushati P, Nyamukapa C, & Campbell C. 2004. *Community group participation: can it help young women to avoid HIV? An exploratory study of social capital and school education in rural Zimbabwe*. Soc Sci Med 2004; 58: 2119 – 32.

Haddad, B. 2006. 'We pray but we cannot heal: Theological challenges posed by the HIV/AIDS crisis'. Journal of Theology for Southern Africa: 125 (July): 80-90.

Haddad, B. (ed). 2011. Religion and HIV and AIDS: charting the terrain. Pietermaritzburg: University of KwaZulu Natal Press

Hair, JF. Jr., Black, WC., Babin, BJ. & Anderson, RE. 2010. Multivariate Data Analysis. 7th edition. Upper Saddle River, NJ: Pearson Education.

- Henning, M.J. 2009. Factors Associated with School Teachers' Attitudes toward HIV Prevention Education in Lusaka, Zambia. PhD Thesis /Dissertation, Oregon State University.
- Hood, LJ. 2006. Contextual factors that promote the success of church-based HIV/AIDS programmes in South Africa. M.S thesis. Eastern University School of Leadership and Development, South Africa.
- Isaksen, J, Songstad, NG & Spissøy, A. 2002. Socio-economic effects of HIV/AIDS in African countries. A study commissioned by NORAD. Available at: www.cmi.no/public/pub2002 (Accessed on 29 October 2008)
- Kwitonda, JC. 2010. Communication, HIV Prevention and Faith-Health Intersection: An Exploration of Perspectives among Christian Leaders in Rwanda. MA thesis, Ohio University. Available at: https://etd.ohiolink.edu/!etd.send_file?accession=ohiou1276805962&disposition=inline (Accessed on 15 September 2014).
- Leedy, PD & Ormrod, JE. 2010. Practical Research: Planning and Design (9th ed.). Merrill, Upper Saddle River, New Jersey.
- Leshota, PL. 2011. A deconstruction of disability discourse amongst Christians in Lesotho. PhD thesis, University of South Africa.
- Life Application Study Bible, New Living Translation. South Korea: Tyndale House.
- Lutheran Communion in Southern Africa. 2004. *LUCSA HIV and AIDS Policy*. Johannesburg: LUCSA.
- Lutheran Communion in Southern Africa. 2005. *LUCSA Midterm review report*. Johannesburg: LUCSA.
- Lutheran Communion in Southern Africa. 2007. Revised version. *Constitution*

of the Lutheran Communion in Southern Africa. Johannesburg: LUCSA.

Lutheran Communion in Southern Africa. 2008. *LUCSA End of five-year programme evaluation of member churches' response to HIV and AIDS.* Johannesburg: LUCSA.

Lutheran Communion in Southern Africa. 2013. Revised version. *Constitution of the Lutheran Communion in Southern Africa.* Johannesburg: LUCSA.

Lutheran Communion in Southern Africa. 2010. Revised version. *LUCSA HIV and AIDS Policy.* Johannesburg: LUCSA.

Lutheran Communion in Southern Africa. 2012. *Evaluation of Phase 3: LUCSA AIDS Action Programme (2009-2011).* Johannesburg: LUCSA.

Lutheran World Federation. 2003. *Compassion, conversation, care: responding as churches to the HIV/AIDS pandemic.* LWF 10th Assembly, Winnipeg

Lutheran World Federation. 2005. *Lutheran World Information: POSITIVE CHURCH.* HIV/AIDS Resource Material: No 11/2005. Geneva, Switzerland.

Lutheran World Federation. 2013. Impact Assessment of the LWF HIV and AIDS global campaign (2002-2013). Geneva, LWF. (Unpublished).

Marsh, K. L. & Julka, D. L. (2000). A Motivational Approach to Experimental Tests of Attitude Functions Theory. In Maio, G. R., and Olson, J. M. (Eds.), *why we evaluate: Functions of attitudes* (pp. 271-294). Mahwah, NJ: Erlbaum.

Masika, E.M. 2008. An assessment of the HIV and AIDS Education Information in the Baptist Church in Mchinji District. Malawi, MPH Dissertation, University of Malawi.

McFarland, W, Gwanzura, L, Bassett, MT, Machezano, R, Latif, AS, Ley, C, Parsonnet, J, Burke, RL & Katzenstein, D. 1999. Prevalence and incidence of

herpes simplex type 2 infection among male Zimbabwean factory workers. *Journal of Infectious Diseases* 180 (5): 1459-65

Ministry of Health & Child Welfare & National AIDS Council. 2004. The AIDS epidemic in Zimbabwe: where are we? Where are we going? Background, projections, impacts and strategic response. Harare: Government Printers

Ministry of Health and Child Welfare. 2007. *Zimbabwe Demographic and Health Survey (2005/06)*. Harare: Government Printers.

Ministry of Health and Child Welfare. 2009. *Zimbabwe National HIV Estimates 2009*. Harare: Government Printers

Mukuka L & Slonim-Nevo V. 2006. The role of the Church in the fight against HIV/AIDS infection in Zambia. Available at: <http://isw.sagepub.com> at UNISA Univ of South Africa (Accessed on 6 June 2008)

Munjoma MW,, Kurewa, EN, Mapingure, PM, Mashavave, GV, Chirenje, MZ, Rusakaniko, S, Hussain, A & Stray-Pedersen, B. 2010. *The prevalence, incidence and risk factors of herpes simplex virus 2 infection among pregnant Zimbabwean women followed up nine months after childbirth*. BMC Women's Health. Available at: <http://www.biomedcentral.com/1472-6874/10/2> (Accessed on 10 January 2011).

Murimba, S. 2010. Teacher management in a context of HIV and AIDS: Zimbabwe report. Unpublished manuscript. Paris, UNESCO-IIEP. Available at: <http://www.iiep.unesco.org/research/highlights/hivaids/research.html> (Accessed on 10 January 2011).

Muturi N. 2008. Faith-Based initiatives in Response to HIV/AIDS in Jamaica. *International Journal of Communication* 2: 108 -131

Myaka, NM. 2011. "Luther's response to the bubonic plague and its implications to: LUCSA's HIV and aids response an address to the LWF and

LUCSA consultation on HIV and AIDS and gender". Johannesburg. Unpublished.

National AIDS Council, Zimbabwe. 2006. *Zimbabwe National HIV and AIDS Strategic Plan (ZNASP) for 2006-2010*. Harare: NAC

National AIDS Council, Zimbabwe. 2011. *Zimbabwe National HIV and AIDS Strategic Plan (ZNASP) for 2011-2015*. Harare: NAC

Nhamo, MN. 2011. The role of churches in tackling HIV stigma in eastern Zimbabwe. PhD thesis, The London School of Economics and Political Science (LSE). Available at: http://etheses.lse.ac.uk/222/1/Nhamo_The_role_of_churches_in_tackling_HIV-stigma_in_eastern.pdf (Accessed on 20 May 2013)

Nürnberg, K. 2005. *Martin Luther's message for us today. South African perspectives*. Pietermaritzburg: Cluster Publications.

Nyoni, C. 2008. Socio-cultural factors and practices that impede upon behavioural change of Zimbabwean women in an era of HIV/AIDS: PhD thesis, University of South Africa.

Olivier J, Cochrane, JR & Schmidt, B. 2006. ARHAP Literature Review: Working in a Bounded Field of Unknowing. Cape Town: African Religious Health Assets Programme. Available at: http://www.arhap.uct.ac.za/research_who.php (Accessed on 8 August 2008)

Parker, W. & Birdsall, K. 2005. HIV/AIDS, Stigma and Faith-based Organisations A review. The Futures Group.

Parry, S. 2003. Responses of the faith-based organisations to HIV/AIDS in Sub-Saharan Africa. Ecumenical HIV/AIDS Initiative in Africa (EHAIA), Geneva: World Council of Churches. Available at: <http://www.wcc-coe.org/wcc/what/mission/fba-hiv-aids.pdf> (Accessed on 10 June 2008)

Parry, S. 2008. *Beacons of hope HIV competent churches: a framework for action*. World Council of Churches, Ecumenical HIV/AIDS Initiative in Africa (EHAIA). Geneva: World Council of Churches

Paterson, G (ed). 2009. *HIV Prevention: A Global Theological Conversion*. Geneva: Ecumenical Advocacy Alliance.

Paulson, S. 2004. *Luther for Armchair Theologians*. Louisville: Westminster John Knox Press.

Pfeiffer, J. 2004. *Condom Social Marketing, Pentecostalism, and Structural adjustment in Mozambique: a clash of AIDS prevention messages*. *Medical Anthropology Quarterly* 18 (1): 77-103. American Anthropological Association

Powers, KA, Poole, C, Pettifor, AE, & Cohen, MS. 2008. Rethinking the heterosexual infectivity of HIV-1: a systematic review and meta-analysis. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2744983/> (Accessed 20 November 2010).

Punch, KF. 2005. *Introduction to Social Research: Quantitative and Qualitative Approaches*. London: Sage Publications

Schramm, WE. 1946. *What Lutherans Believe*. Mineapolis, Augsburg Publishing House

Shisana, O & Letlape, L. 2004. The impact of HIV/AIDS on the sub-Saharan African economy. Paper commissioned by Commission for Africa.

Smetzer, J & Navarra, BM. 2007. Measuring Change: A Key Component of Building a Culture of Safety. *Nurs Econ*. 25 (1): 49-51. Jannetti Publications, Inc

Statement of Religious Leaders at the XV International AIDS Conference.

Bangkok, July 2004.

Strasser, A. 1999. Luther's Ecclesiology and Today: the contributions of the Latin American Church. B Sc essay, University of Pietermaritzburg, South Africa

Terry, DJ, Gallois, C & McCamish, M. [ed.] 1993. *The theory of reasoned action: its application to AIDS-preventive behaviour*. Oxford: Pergamon Press Ltd.

The Random House college dictionary: revised edition. 1988. 6th edition. Sv "religion". New York: Random House

Tlou, E.R. 2012. The application of the theories of reasoned action and planned behaviour to a workplace HIV/AIDS health promotion programme. PhD Thesis. University of South Africa

Trinitapoli, J. 2006. Religious responses to AIDS in Sub-Saharan Africa: An examination of religious congregations in rural Malawi. *Review of Religious Research*, 47, 253-270.

Trinitapoli, J. 2009. Religious teachings and influences on the ABCs of HIV prevention in Malawi. *Soc.Sci Med.* 2009:69 (2): 199-209. [PubMed: 19447536].

Ukah, A. 2007. African Christianities: Features, Promises and Problems. Working Papers. Nr: 79. Department of Anthropology and African Studies, Gutenberg. Available at: <http://www.ifeas.uni-mainz.de/Dateien/AP79.pdf> (Accessed on 17 November 2011).

UNAIDS/WHO, 2004. AIDS epidemic update December 2004. Geneva: Joint United Nations Programme on HIV/AIDS.

UNAIDS. 2005. Intensifying HIV prevention: UNAIDS Policy Position Paper.

Available at:
[http://www.unaids.org/en/KnowledgeCentre/Resources/PolicyGuidance/Umbr
ellaPolicies](http://www.unaids.org/en/KnowledgeCentre/Resources/PolicyGuidance/Umbr
ellaPolicies) (Accessed on 10 August 2008).

UNAIDS. 2006. *Report on the global AIDS epidemic*. Geneva: Joint United Nations Programme on HIV/AIDS.

UNAIDS/WHO. 2007. *AIDS epidemic update*. Geneva: Joint United Nations Programme on HIV/AIDS.

UNAIDS. 2008. *2008 Report on the global AIDS epidemic*. Geneva: Joint United Nations Programme on HIV/AIDS.

UNAIDS/WHO. 2009. *AIDS epidemic update*. Geneva: Joint United Nations Programme on HIV/AIDS.

UNAIDS. 2010. *Global report: UNAIDS report on the global AIDS epidemic 2010*. Geneva: Joint United Nations Programme on HIV/AIDS.

UNAIDS, 2010. *United Nations General Assembly Special Session Report on HIV and AIDS: Follow-up to the Declaration of Commitment on HIV and AIDS. Zimbabwe Country Report 2008-2009*. Available at:
[http://data.unaids.org/pub/Report/2010/zimbabwe_2010_country_progress_re
port_en.pdf](http://data.unaids.org/pub/Report/2010/zimbabwe_2010_country_progress_re
port_en.pdf). (Accessed on 20 June 2010).

UNAIDS. 2011. UNAIDS Terminology Guidelines. Revised version 2011.
[http://www.unaids.org/sites/default/files/media_asset/JC2118_terminology-
guidelines_en_0.pdf](http://www.unaids.org/sites/default/files/media_asset/JC2118_terminology-
guidelines_en_0.pdf). (Accessed on 5 April 2011).

UNAIDS. 2012. Global AIDS response progress report. Follow-up to the 2011 political declaration on HIV/AIDS: Intensifying our efforts to eliminate HIV/AIDS. Zimbabwe country report 2010-2011. Available at
[www.unaids.org/sites/default/files/en/dataanalysis/knowyourresponse/country
progressreports/2012countries/ce_ZW_Narrative_Report.pdf](http://www.unaids.org/sites/default/files/en/dataanalysis/knowyourresponse/country
progressreports/2012countries/ce_ZW_Narrative_Report.pdf). (Accessed on

9 November 2013).

UNAIDS. 2013. Regional report: Getting to Zero: HIV in Eastern & Southern Africa. Geneva: Joint United Nations Programme on HIV/AIDS.

UNAIDS. 2013. Global report: UNAIDS report on the global AIDS epidemic 2013. Geneva: Joint United Nations Programme on HIV/AIDS.

UNAIDS. 2014. The Gap report. Geneva: Joint United Nations Programme on HIV/AIDS. Available at www.unaids.org/sites/default/files/media_asset/UNAIDS_Gap_report_en.pdf. (Accessed on 3 October 2014)

Van Deutekom, H. (2007). And the Lord said: Abstinence, faithfulness...condom use?! A comparative case study of the impact of the Catholic Church and the Church of Pentecost on HIV prevention in Nandom, Ghana. Msc thesis. University of Amsterdam.

Van Dyk, PJ & van Dyk, AC. 2007. Does the church deliver? Pretoria: University of South Africa.

Vatican City, 2011. "The Internal Role of the Catholic Church in the Prevention and Treatment of HIV/AIDS". A paper presented at the U.N. offices in Geneva at a May 27-28 Vatican meeting on "The Centrality of care for the Person in Prevention and Treatment of illnesses caused by HIV/AIDS. Available at: <http://www.zenit.org/en/articles/the-church-s-response-to-aids>. (Accessed on 15 May 2012).

Visser, M.R. 2006. Communicating about HIV/AIDS – how attitude functions impact on teachers' willingness to talk about condoms and sexuality. Paper approved by the Intercultural and Developmental Communication Division for presentation at the Annual Conference of the International Communication Association on Networking Communication Research held at the International Congress Centre in Dresden, Germany, June 19-23, 2006.

World Council of Churches. 2004. *Facing AIDS: the challenges, the churches' response*. Geneva: WCC Publications.

World Council of Churches. 2011. *Minute on strengthening the Ecumenical response to HIV/AIDS*. Available at: <http://www.oikoumene.org/en/resources/documents/central-committee/2011/report-on-public-issues/minute-on-strengthening-the-ecumenical-response-to-hiv-aids>. Accessed on 16 April 2012.

WHO/UNAIDS. 2007. *Male Circumcision and HIV Prevention: Research Implications for Policy and Programming*. Available at: www.unaids.org/sites/default/files/media_asset/mc_recommendations_en_0.pdf.

WHO/UNAIDS/UNICEF. 2009. *Towards universal access: scaling up priority HIV/AIDS interventions in the health sector. Progress report 2009*. WHO Press, Geneva.

Yeatman, SE, & Trinitapoli, J. 2008. Beyond denomination: the relationship between religion and family planning in rural Malawi. *Demographic Research* 19 (55): 1851-1882. Available at: <http://www.demographic-research.org/Volumes/Vol19/55/> (Accessed on 9 January 2009).

Zimbabwe Demographic and Health Survey 2010-11. Calverton, Maryland: ZIMSTAT and ICF International Inc. Available at: <http://dhsprogram.com/pubs/pdf/FR254/FR254.pdf>. Accessed on 16 November 2012.

Zimbabwe Ministry of Health & Child Welfare & National AIDS Council. 2004. *The HIV and AIDS epidemic in Zimbabwe: where are we? Where are we going? Background, projections, impacts and strategic response*. Harare: Government Printers

Zimbabwe Ministry of Health and Child Welfare. 2007. *Zimbabwe Demographic and Health Survey (2005/06)*. Harare: Government Printers.

Zimbabwe Ministry of Health and Child Welfare. 2009. *Zimbabwe National HIV Estimates 2009*. Harare: Government Printers.

Zimbabwe National Statistics Agency (ZIMSTAT) and ICF International. 2012. Zou, J., Yamanaka, Y., John, M., Watt, M., Ostermann, J. and Thielman, N. 2009. *Religion and HIV in Tanzania: influence of religious beliefs on HIV stigma, disclosure, and treatment attitudes*. BMC Public Health 2009, 9:75

ANNEXURE A

REQUEST TO CONDUCT A STUDY ON 'ATTITUDES OF CHURCH LEADERS TOWARDS THEIR POTENTIAL LEADERSHIP ROLES IN HIV PREVENTION IN THE EVANGELICAL LUTHERAN CHURCH, WESTERN DIOCESE PARISHES IN BULAWAYO

By
Venah Mzezewa
UNISA

Bishop Dr SM Dube
Evangelical Lutheran Church in Zimbabwe
Western Diocese, P.O Box 1244
Bulawayo

January 13, 2009

Dear Bishop Dube

I greet you in the name of our Lord and Saviour, Jesus Christ!

I hereby request your permission to conduct a study with the Congregational church leaders of the Bulawayo Parishes in April/May 2009.

The focus of my research is to ascertain church leaders' attitudes related to what they believe they should be doing as leaders in their communities as far as HIV prevention is concerned in order to control the spread of HIV infection among their parishioners, clergymen and communities.

As you are aware, church leaders command great respect among people and can influence policymaking. They can offer inspired leadership in HIV prevention. Thus my study intends to include all leaders of the church hierarchy in order to uncover a wide array of perceptions about perceived leadership roles in HIV prevention.

It is hoped that findings from this study might increase understanding of where the strengths and opportunities lie for strengthening the church leadership's response to HIV prevention from the church leaders' perspective.

I will make the necessary appointments to see the church leaders and to conduct my study. Two rounds of data gathering are envisaged. The first round is a qualitative round in which I conduct interviews with 20 selected church leaders and ask them to describe typical leadership scenarios. This first round is used to obtain items for a structured questionnaire, which will be the second round of the study. In all of these endeavours, your kind support, in the form of a letter approving this study and offering suggestions, will be highly valued.

I would greatly appreciate your response at your earliest convenience. Thank you for treating this request with the importance it deserves.

Yours in the Lord's service

Venah Mzezewa
LUCSA HIV/AIDS Programme Coordinator

Annexure B

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P. 1

Evangelical Lutheran Church in Zimbabwe



Western diocese

P.O. Box 1317
Bulawayo Tel:263-09 884211



The Bishop's Office

To: Mrs V. Mzezewa
From: Bishop Dr S.M Dube
Date: 13th January 2009
RE: **REQUEST TO CONDUCT A STUDY**

I acknowledge your request to conduct a study in the ELCZ Western Diocese concerning HIV/AIDS in some of our parishes.

I want as Bishop of the ELCZ Western Diocese accept your request and offer you the privilege to feel free to do your study. Your research will in another way motivate our Christians to be engaged in the process of the HIV/AIDS programme within their congregations and community and see its importance. I welcome your research and request wholeheartedly.

You are welcome to do your study at Tshabalala Congregation where the Bulawayo East Parish will be gathered in 6 -9 February 2009. Another opportunity might also be at the Witnesses Annual General meeting at Cwanda Parish Centre on 15 -17 May 2009. You are welcome to participate in these programmes.

May the good Lord be with you always.

I beg to remain

Yours sincerely

The Rt Rev Dr S.M. Dube
BISHOP

BISHOP: The Right Rev. Dr. Stephen Mupfema Dube. Diploma Theology BA(Hons)(UZ; MAI(UNISA) D.Min(Luther Seminary)

ANNEXURE C

GUIDE FOR THE ELICITATION INTERVIEW

A STUDY ON 'ATTITUDES OF CHURCH LEADERS TO THEIR LEADERSHIP ROLES IN HIV PREVENTION'

Purpose: Elicitation phase is crucial to ensure that the behavioural beliefs and evaluation of outcomes (Attitudes toward behaviour) as well as the normative beliefs and motivation to comply (Subjective Norms) are extensively identified to adequately cover a wide spectrum of factors to be measured.

Objective: To elicit from church leaders the factors that may affect what they believe they should be doing in varying forms of leadership roles in HIV prevention.

Open-ended Interview Guide:

A: Actions:

- For our first question. I would like you to think about a typical scenario in which you might discuss the risk of the sexual transmission of the HI-virus with your parishioners and/or clergy. With such a scenario in mind, please tell me whether, how and under what circumstances you as church leaders will talk to your parishioners and clergy about sexual risk for HIV and offer prevention advice to them.
- In your own opinion, what should church leaders do as far as HIV prevention is concerned?

B: To elicit behavioural beliefs about each action above

1. I am now going to read to you three possible actions which church leaders can take. The first one is: Talking to parishioners and clergy about HIV and AIDS. In your opinion, what are the merits (in terms of advantages and possible positive outcomes of taking this action? Now tell me about the possible demerits (in terms of disadvantages and possible negative outcomes) of taking this action?
2. The second one is: Providing advice on HIV prevention to parishioners and clergy; in your opinion, what are the merits (in terms of advantages and possible positive outcomes) of taking this action? Now tell me about the possible demerits (in terms of disadvantages and possible negative outcomes) of taking this action?
3. The third one is: Taking or providing the kind of leadership roles which we have spoken about earlier; in your opinion, what are the merits (in terms of advantages and possible positive outcomes) of taking this action? Now tell me about the possible demerits (in terms of disadvantages and possible negative outcomes) of taking this action?

C: To elicit normative beliefs for each action:

For our final question, I would like us to again consider the four possible actions which we have discussed, but this time, instead of considering the merits and demerits of each, I would like us to discuss the people, groups or organizations that in the case of each action would be supportive or obstructive, so:

In the action "Talking to parishioners and clergy about HIV and AIDS". In your opinion, which persons, groups or organizations would be supportive to you in taking this action? Now tell me which persons, groups or organizations would be obstructive should you take this action?

The second one is: Providing advice on HIV prevention to parishioners and clergy; in your opinion, which persons, groups or organizations would be supportive to you in taking this action? Now tell me which persons, groups or organizations would be obstructive should you take this action?

The third one is; Taking or providing the kind of leadership roles which we have spoken about earlier. In your opinion, which persons, groups or organizations would be supportive to you in taking this action? Now tell me which persons, groups or organizations would be obstructive should you take this action?

Thank you very much for your time and invaluable contributions to my study!

ANNEXURE D

AN ANALYSIS OF THE ATTITUDES AND PERCEPTIONS OF CHURCH LEADERS TOWARDS THEIR PERCEIVED LEADERSHIP ROLES IN HIV PREVENTION IN THE MATABELELAND PROVINCE OF ZIMBABWE

Dear Sir/Madam

I hereby request your participation in this study. If you accept, please complete the following questionnaire which will take about 20 to 30 minutes. Kindly return the completed questionnaire personally to the researcher or by putting the questionnaire in the 'return box' placed near the exit.

Please also note that:

The study is undertaken towards the degree of Masters in Social Behaviour Studies in HIV/AIDS at the University of South Africa (UNISA).

Your participation to the study is voluntary and there is no remuneration for participating in this study.

Selection of your participation in this study was purely on the basis that you are currently holding a leadership position in your parish.

The questionnaire is anonymous. All information acquired from this study will be handled confidentially and professionally.

The results will be presented in such a way that information cannot be traced back to the individual participants. It is hoped that this information might be useful in the HIV prevention strategies.

- A summary of the findings will be made available to the participants upon request. If you have any questions concerning the questionnaire or need additional information regarding this study, please contact me at +27 (0) 11 973 1086 or email: verna@lucsa.org

Thank you for showing interest in this study.

Yours sincerely

Mrs. Venah Mzezewa

SECTION ONE: GENERAL INFORMATION

Please answer all the questions by ticking (✓) the box next to the option that best applies to you. At some questions, you will be asked to write down the information required.

SECTION I: BACKGROUND INFORMATION

Q1. In which area is your congregation located?

Urban	1
Peri-urban	2
Rural	3

Q2. What is your position in the church?

Clergy (Bishop, Dean, Pastor, Deacon(ness))	1
Parish Council member	2
Church elder member	3
Diakonia, Evangelism & Stewardship Committee (DESC)	4
Lutheran League Service Fellowship	5
Women's fellowship group (Omanyano/Vashandiri)	6
Men's fellowship group (Zvapupu)	7
Youth group	8
Sunday school teacher/superintendent	9
Other (please specify)_____	10

Q3. How long have you been a member of the Lutheran church?

Born Lutheran (thus all my life)	1
1-5 years	2
More than 5 years, but not lifelong	3

Q4. Sex: [Please indicate your sex by ticking (✓) the box next to the option that applies to you]

Female	1
Male	2

Q5. How old are you? [In complete years].

_____ years

Q6. What is the highest level of education that you have completed?

None	1
Some Primary	2
Primary Completed	3
Some Secondary	4
Secondary Completed	5
A Level	6
Tertiary	7
Other (specify).....	8

SECTION 2 HIV AND AIDS EXPERIENCE

Q7. What HIV and AIDS activities are you personally involved in?

HIV prevention education	1
Pastoral care and counselling	2
Home-based care activities	3
Orphan Care activities	4
Treatment Literacy	5
Promotion of Voluntary Testing and Counselling	6
Other (specify) _____	7

Q8a. Are you involved specifically in HIV prevention activities? If No, skip to Question 9

Yes	1
No	2

Q8b. If Yes at Question 8, please describe what HIV prevention activities you do.

Q9a. Have you had any training in HIV prevention? If No, skip to Question 10

Yes	1
No	2

Q9b. If yes, at Question 9, please describe the type of training you have received.

TYPE OF TRAINING	Duration of training in days (actual contact time)	When (month and year)

Q10. Have you ever personally known anyone living with HIV?

Yes	1
No	2

SECTION 3: ATTITUDES TOWARD LEADERSHIP ROLE IN HIV PREVENTION

Q11. Degree of issues as barriers when discussing the sexual risk of HIV transmission with parishioners & the clergy

Please read the statements in the box below. For each statement, indicate to what extent /degree the issues would be a problem for you personally when discussing the sexual risk for HIV transmission with parishioners and the clergy. Answer this question by ticking (√) the box next to the option that best applies to you, whether the outcome is: **To a large extent; To some extent; Not at all or Don't know**

To what degree are these issues a barrier when discussing the sexual risk of HIV transmission with parishioners and the clergy?	To a large extent	To some extent	Not at all	Don't know
a. Lack of HIV prevention knowledge on your part	1	2	3	4
b. Lack of confidence	1	2	3	4
c. When the person you speak to has higher status than you	1	2	3	4
d. Not having first-hand experience of a person living with HIV	1	2	3	4
e. People are bored of HIV and AIDS because everybody now knows about it	1	2	3	4
f. Church is not the place to discuss HIV	1	2	3	4
g. When traditionally respected persons, such as in-laws are part of the group you address	1	2	3	4
h. Past risky sexual behaviour on your part	1	2	3	4
i. Not knowing your own HIV status	1	2	3	4
j. When the people you have to talk to are younger than you	1	2	3	4
k. When the people you have to talk to are older than you	1	2	3	4
l. Cultural belief that 'talking about sex' is taboo	1	2	3	4

Q12. Advantages of talking to parishioners & clergy about the risk of sexual transmission of HIV

Please indicate to what extent the following outcomes are likely if you talk about the sexual risk of the HIV transmission with parishioners and the clergy. Answer this question by reading each statement and ticking (√) the box next to the option that best applies to you, whether the outcome is: **likely; unlikely or don't know**

To what extent are the following outcomes likely to happen if you talk to parishioners and the clergy about the sexual risk of HIV-transmission?	This is likely to happen	This is unlikely to happen	I don't know what will happen
a. The people I talk to will have more knowledge of HIV prevention	1	2	3
b. More people will go for an HIV-test if I talk to my parishioners and clergy	1	2	3
c. There will be better management of HIV-related disease	1	2	3
d. More open discussions about HIV prevention among parishioners will lead to a decline in the number of people being infected with HIV	1	2	3
e. Such talks will lead to positive attitudes and sexual behaviour change	1	2	3
f. HIV and AIDS will be regarded as a chronic disease normalizing it like high blood pressure, high blood sugar (diabetes mellitus), etc.	1	2	3
g. It will reduce stigma and discrimination, making people talk about HIV prevention freely	1	2	3
h. The youth will be able to deal with fear and feel free to get tested for HIV	1	2	3
i. There will be increased condom use	1	2	3
j. People living with HIV (PLHIV) and those affected will not feel discriminated against by the church	1	2	3
k. The church will not lose members due to death and leaving the church to seek faith healing elsewhere	1	2	3
l. This will encourage positive living by people living with HIV	1	2	3
m. Sex education for young people will encourage early onset of sexual activity	1	2	3

Q13. Consequences of NOT talking to parishioners & clergy about the risk of the sexual transmission of HIV

To what extent are the following consequences likely to happen if you do not talk to parishioners and the clergy (clergy includes Bishops, Deans, pastors, deacons/deaconesses) about the sexual transmission of HIV?

Answer this question by reading each statement and ticking (✓) the box next to the option that best applies to you, whether the outcome is: **unlikely; likely or don't know**

	If I <u>do not</u> talk to parishioners and clergy about the sexual transmission of HIV, then...	Unlikely	Likely	Don't know
a.	People will remain in the dark and the number of people living with HIV and those affected by AIDS will increase	1	2	3
b.	Denial will persist and those infected will keep infecting others	1	2	3
c.	Church leaders may disassociate themselves from HIV and AIDS and will not be able to assist those in need	1	2	3
d.	There will be no sharing of information and ideas on how to help people living with HIV and those affected by AIDS	1	2	3
e.	There will be denial that HIV and AIDS is a problem	1	2	3
f.	There will be increased stigma of people living with HIV	1	2	3
g.	The loss of church members to AIDS-related deaths will increase	1	2	3
h.	There will be an increase in the number of orphans	1	2	3
h.	People may believe that there is no person living with HIV in the church	1	2	3
j.	There will be a reduction in church attendance	1	2	3

Q14. Advantages of providing advice on HIV prevention to parishioners & clergy

To what extent are the following outcomes likely to happen if you provide advice on HIV prevention to parishioners and clergy (clergy includes Bishops, Deans, pastors, deacons/deaconesses)? Answer this question by reading each statement and ticking (✓) the box next to the option that best applies to you, whether the outcome is: **likely; unlikely or don't know**

	If you provide advice to parishioners and clergy, to what extent is it likely that...	Likely	Unlikely	Don't know
a.	People will be better informed about the disease	1	2	3
b.	More lives will be saved	1	2	3
c.	It will reduce the number of new HIV infections	1	2	3
d.	People living with HIV will live longer	1	2	3
e.	More people will take up HIV-testing	1	2	3
F	More people will participate in health programmes such as Prevention of Parent-to-Child Transmission (PPTCT) of HIV infection	1	2	3

Q15. Consequences of providing advice on HIV prevention to parishioners & clergy

To what extent are the following consequences likely to happen if you provide advice on HIV prevention to parishioners and the clergy (clergy includes Bishops, Deans, pastors, deacons/deaconesses)? Answer this question by reading each statement below and ticking (✓) the box next to the option that best applies to you, whether the outcome is: **unlikely; likely or don't know.**

If you provide advice about the sexual transmission of HIV to parishioners and clergy, how likely are the following consequences?	Unlikely	Likely	Don't know
a. Pastors will become suspicious and think you belittle them	1	2	3
b. People may think you are falsely accusing them of promiscuity	1	2	3
c. Your advice may result in family quarrels	1	2	3
d. It may lead others to risky sexual behaviour	1	2	3
e. It may lead to a shortage of resources especially when people take up positive action, for example, an increased demand of condoms may result in reduced supply	1	2	3
f. It may lead to increased health-seeking behaviours for care, resulting in decreased access to services	1	2	3
g. The promotion of condom use will encourage promiscuity	1	2	3
h. The promotion of condom use will encourage early sexual experimentation amongst young people	1	2	3
i. The promotion of condom use will prevent conception which is a God-given gift for humanity	1	2	3

SECTION 4: NORMATIVE BELIEFS REGARDING INFLUENCE OF SIGNIFICANT OTHERS

Q16. Level of support of various groups

To what extent are the following persons, groups or organisations likely to support you in **talking to parishioners and clergy about the risk of the sexual transmission of HIV-virus** or in **providing advice on HIV prevention to parishioners and clergy?**

Answer this question by ticking (✓) the box next to the option that best applies to you:

Groups or Organisations	Will support me	Will NOT support me	Don't know
a. People living with HIV	1	2	3
b. Those who have lost relatives to AIDS-related illnesses	1	2	3
c. Bishops	1	2	3
d. Pastors	1	2	3
e. Partners	1	2	3
f. The government	1	2	3
g. Non-Governmental Organisations	1	2	3
h. Matabeleland AIDS Council (MAC) organisation	1	2	3
i. National AIDS Council (NAC)	1	2	3
j. Zimbabwe National Network of People Living with HIV (ZNNP+)	1	2	3
k. Lutheran Communion in Southern Africa (LUCSA)	1	2	3
l Other (specify)			

Q17. Level of obstruction by various groups/organisations/person

To what extent are the following persons, groups or organisations likely to obstruct you in **talking to parishioners and clergy about the risk of the sexual transmission of HIV-virus or on providing advice on HIV prevention to parishioners and clergy?** Answer this question by ticking (✓) the box next to the option that best applies to you:

Persons/Groups or Organisations	Will obstruct me	Will NOT obstruct me	Don't know
a. Individuals or people who have negative attitudes towards HIV and AIDS and see themselves as “holy”	1	2	3
b. Young people	1	2	3
c. Some of the pastors	1	2	3
d. Sex workers	1	2	3
e. Some political parties	1	2	3
f. ‘Sugar daddies or Sugar mummies’	1	2	3
g. Other organisations who may feel that there is duplication of programmes and fear competition	1	2	3
h. Other (specify)			

THANK YOU VERY MUCH FOR YOUR TIME!