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# Catherine Campbell, Morten Skovdal and Andy Gibbs

# Creating social spaces to tackle AIDS-related stigma: reviewing the role of church groups in Sub-Saharan Africa

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# Creating social spaces to tackle AIDS-related stigma: Reviewing the role of Church groups in sub-Saharan Africa

**Abstract**

An expanding body of literature explores the role of African church groups in facilitating or hindering the support of people living with AIDS and challenging or contributing to AIDS-related stigma. Treating church groups as social spaces in which AIDS-related stigma may potentially be challenged, we systematically review this literature, identifying five themes that highlight the complex and contradictory role of the church as a potential agent of health-enhancing social change. In many ways the church perpetuates AIDS stigma through i) moralistic attitudes and ii) its reinforcement of conservative gender ideologies, often leading to the denial of AIDS in public church settings. However some churches have managed move towards action that makes a more positive contribution to HIV/AIDS management through iii) promoting various forms of social control for HIV prevention, iv) contributing to the care and support of the AIDS-affected and v) providing social spaces for challenging stigmatising ideas and practices. We conclude that church groups, including church leadership, can play a key role in facilitating or hindering the creation of supportive social spaces to challenge stigma. Much work remains to be done in developing deeper understandings of the multi-layered factors that enable some churches, but not others, to respond effectively to HIV/AIDS.

**Key words**: Community responses; church groups; religion; stigma; AIDS; Africa

**Suggested running head:** *Creating social spaces to tackle AIDS-related stigma*

**Introduction**

Religion is a significant social force in Africa, where traditional and more mainstream religions have long had a stronghold. Numerous Christian church groups and sects have emerged and developed since Christianity was first introduced. In the year 2000 there were an estimated 390 million Christians in Africa, a number which is estimated to increase to 640 million by 2025 as Africa becomes the continent of most Christians and of as many Muslims as Asia (1). As religion shapes the beliefs and activities of many people, it is vital, in the context of HIV/AIDS, that we understand how religions and their growing number of adherents either facilitate or undermine stigma. Defining churches as any body of worshippers in the Christian faith, our literature review seeks to generate examples and lessons for 'best practice' in the interests of informing the increasingly frequent calls for churches to play a greater role in empowering communities to deal more effectively with HIV/AIDS. Such calls are made on the grounds that (a) churches are often the most well established community networks in AIDS vulnerable communities, and thus potentially have wide influence; and (b) that church teachings of love and care open up many potential spaces for an increased positive role in supporting people living with HIV/AIDS (PLWHA). By bringing together research findings on church groups from different sub-Saharan African countries we hope to advance understandings of how churches can respond positively to the AIDS epidemic and highlight some of the existing challenges. A better understanding of the potential of church groups to provide supportive social spaces for tackling HIV-related stigma could be an important first step in informing those church leaders seeking to construct a theology which supports greater church involvement in supporting PLWHA (2, 3), one which challenges the church's historically very conservative views on sexuality, youth and female empowerment which may sometimes unintentionally undermine the fight against HIV/AIDS (4).

HIV/AIDS-related stigma is increasingly regarded as one of the key drivers of the epidemic in sub-Saharan Africa, primarily through the role stigma plays in undermining the ability of individuals, families and societies to protect themselves from HIV, to provide assistance to those affected, and to access services and adhere to treatment if they become infected (5, 6). This, coupled with the growing emphasis on the need to facilitate local community responses to HIV/AIDS through participation (7, 8), suggest there is an

urgent need to uncover what kind of participation community members can engage in to minimise AIDS-related stigma and through what networks this participation should take place.

Two tentative bodies of research point to this as a productive area for future research. Firstly, Low-Beer & Stoneburner (9) and Epstein (10) argue that relatively high levels of social communication about HIV/AIDS in informal grassroots networks may have served as one key catalyst for the behaviour change documented in Uganda in the 1990s. They argue that communication in face-to-face local networks reduces levels of stigma – making it more likely that people will make optimal use of HIV-prevention and AIDS-care information and services. The second group of studies are framed within the context of on-going debates about the impact of social capital on health (11). These studies provide preliminary evidence that membership of certain grassroots social groupings can play a role in shaping how members respond to the HIV/AIDS epidemic. Three separate studies in South Africa and Zimbabwe have suggested that participation in certain (but not all) types of local community groupings might create social spaces that are protective of group members' sexual health. In South Africa, Camlin and Snow (12) have identified participation in clubs and community groups to be associated with safer HIV-related behaviours. Elsewhere in South Africa, Campbell, Williams et al. (13) have pointed towards the complex impacts of group membership on peoples' responses to HIV/AIDS. They found that young women who belonged to youth groups and sports clubs were less likely to be HIV positive and less likely to have casual partners than non-members, but that members of savings groups, with meetings accompanied by social events including alcohol consumption, put savings group members at higher risk than non-members. A study in Zimbabwe found that it was not so much group membership *per se* that facilitated health-enabling behaviours. It was belonging to what members perceived to be an effective group, that was associated with reduced HIV infection (14).

Against this background, this paper seeks to further our understandings of the role that indigenous community group memberships might play in reducing stigma and facilitate support – with particular emphasis on the role of the church. As already stated, in  many sub-Saharan African settings, the church is the most well-established social network (15), and as such could potentially serve as a vital community

resource, especially in settings with limited access to health and welfare support and services. Furthermore religious teachings specifically emphasise the importance of supporting the sick and the needy – which would point to the potential for this group to make a valuable contribution to strengthening local responses to AIDS. Agadjanian (16) argues that church groups in Africa are key to creating social spaces that nurture social interaction and exposure to social issues. However, the extent to which these social spaces facilitate or hinder support for PLWHA, and promote or challenge stigmatising attitudes remains unexplored. Creating communities where those with HIV/AIDS are treated with love, care and compassion is seen as a key element of stigma reduction, and to this extent the church would seem like a strong potential player in HIV/AIDS management. However, as will be highlighted below, the church has played a complex and contradictory role in responding to HIV/AIDS, due to its traditionally conservative and judgemental views of 'sexual transgressors' and the historical disapproval of many churches to condoms. Against this background the church is often seen as a driver of stigma rather than a solution. Our review of the existing literature on church responses to HIVAIDS in sub-Saharan Africa tackles the following questions:

1. What role do the churches currently play in contributing to HIV/AIDS-related stigma?
2. What role do the churches currently play in tackling HIV/AIDS-related stigma?

## Conceptual Framework

The starting point of our paper is that community groups (in this case church groups) can serve as social spaces in which people can formulate local responses to HIV/AIDS. We use a 'social space' perspective to shed light on some of the resources and processes within church groups (understood as potential social spaces for debate, discussion and the negotiation of new social norms) that can challenge AIDS-related stigma and facilitate supportive attitudes towards PLWHA. According to Buttimer (17), the concept of social space was first used by Durkheim in the 1890s where he referred to social space as the social environment, or group framework, in which one is located. Within psychology, 'social space' has been used to refer to the symbolic and interactional sites in which social representations, shared knowledge and meaning, social identifications as well as 'recipes for living' (socially negotiated behavioural possibilities

and options) are constructed and reconstructed through the process of communication as social actors go about their daily lives (18, 19).

Building on these perspectives, we view churches as potential interactional contexts in which people negotiate their collective responses to social challenges (in this case HIV/AIDS), offering the potential for interactants to challenge social representations that encourage harmful and disempowering behaviours (e.g. stigmatising representations of HIV/AIDS), and construct social representations that are more positive and enabling. To explore this further, we draw on our evolving concept of an 'AIDS-competent community context', defined as a social space in which local community members are most likely to work collectively to change their behaviour, support people with HIV/AIDS and their carers, and challenge stigma (20-22). Campbell and colleagues point to six features of a supportive social space:

- The presence of HIV/AIDS-related knowledge and skills;
- Opportunities for critical dialogue and debate about HIV/AIDS;
- A sense of individual and collective ownership of the problem and responsibility for contributing to its solution;
- Confidence in the existence of individual, group and community strengths which could be mobilised to fight the epidemic;
- A sense of solidarity amongst group members around tackling HIV/AIDS; and
- Strong links with potential support agencies in the public and private sector outside of the community (bridging or linking social capital).

Ideally social spaces facilitate opportunities for people to discuss and challenge negative representations of HIV/AIDS and those affected by it – through developing new and less stigmatising understandings (20, 22). Viewing churches and church-groups as social spaces that can potentially play a key role in HIV/AIDS management and stigma-reduction campaigns, we will use the concept of 'AIDS-competent community' as a framework for this paper's discussion of the two questions outlined above.

**Identifying and organising the literature**

In this review we draw on peer-reviewed articles only. We used electronic databases (Medline, Pubmed, Popline, PsychInfo, African Journals Online (AJOL), Google Scholar and Web of Knowledge/Science) to identify studies by drawing on a combination of the key words 'AIDS', 'HIV', 'treatment', 'care', 'prevention', 'stigma', 'church', 'faith groups', 'religion', 'sub-Saharan Africa' and 'Africa'. We also drew on 'The Cartography of HIV and AIDS, Religion and Theology' (23), a recently completed bibliography which has identified 1,779 resources related to AIDS and religion. Reference lists from key articles, books and review articles were scanned to identify further peer-reviewed studies for possible inclusion. To limit the number of articles included for this discussion, as well as to identify studies relevant to our objective, included only peer-reviewed studies presenting empirical evidence, or reviews of empirical studies, that discussed ways in which Christian congregations and denominational organisations (henceforth church groups) in sub-Saharan Africa responded to HIV/AIDS.

As we worked our way through the many potential sources, we began by focusing carefully on article titles and abstracts. This was followed by an intensive reading of the full texts of articles of interest and relevance to our research questions. A total of 37 articles were identified for the inclusion of this review (see Table 1 for characteristics of included studies). As each author independently read the articles each of us made notes of what we perceived to be the core themes emerging from the studies. A comparison of our notes, and discussion of emerging themes led us to identify five core questions which best framed the discussion of these issues in the reviewed studies. These questions constitute the five headings under which we present the findings of our literature review below.

**Table 1**: Summary of 37 included studies

**What representations held within church groups hinder their responses to AIDS and contribute to stigma?**

The devastating impact of AIDS has led many people to seek answers and meaning from various sources, including Christianity. Peoples' understandings of, and responses to, HIV/AIDS are therefore often filtered through religious beliefs in a process that seeks to "make the unfamiliar familiar" by anchoring understandings of the new phenomenon of HIV/AIDS into peoples' pre-existing understandings of the social world (24, p.235). One particular framework through which HIV/AIDS has often been interpreted is that of a conservative church morality which typically includes the stigmatisation of sexuality, particularly the sexuality of women and young people (4). As HIV-infection is primarily transmitted through sex, which churches emphasise should only occur in the marriage of a sexually monogamous man and woman, people come to understand and associate HIV/AIDS with immoral behaviours, linked to the underlying assumption that HIV/AIDS should not be a risk for those who adhere to the teachings of the church.

Whilst this process of 'making the unfamiliar familiar' serves to assist those trying to make sense of their everyday lives in a context of AHIV/IDS, the anchoring of understandings of AIDS within such a framework leads to church members framing HIV/AIDS in images of sin and punishment, perpetuating AIDS-related stigma. A number of recent studies identify this relationship. In a quantitative study amongst Catholic, Lutheran, and Pentecostal church-goers in Tanzania for example, Zou, Yamanaka et al. (25) found shame-related HIV/AIDS stigma to be closely associated with religious beliefs. Just over half (53.2%) of their respondents believed HIV/AIDS was a punishment from God, even more so amongst rural participants. Similarly, a third of respondents argued that PLWHA had not followed the word of God through engaging in sinful actions (immoral behaviour).

Our literature review also highlighted ways in which PLWHA internalised a sense of shame, voluntarily excluding themselves from church groups. In Tanzania for example, Watt, Maman et al. (26) found that self-stigmatisation, linked to the notion of 'sinful' sexual behaviour, led PLWHA to avoid involvement in church groups – particularly if they were visibly ill. HIV positive church members feared disclosing their HIV status, particularly in churches where nobody else had disclosed. They feared that other church members would regard them as having sinned, leading to what they feared would be unbearably hurtful and humiliating responses of blame and judgement. Similarly, a Ugandan study reported how the

moralistic attitudes preached by church groups led both to self-stigma, withdrawal from religious activities and feelings of anger for the way in which some ministers spoke demeaningly of PLWHA (27).

There was an associated tendency for churches to speak more of HIV prevention, and less of the challenges of living with HIV/AIDS and undergoing treatment, or of the potential role of church members in supporting PLWHA (26). HIV prevention messages preached in churches were often limited to abstinence and fidelity (reinforcing dominant church moralities and understandings of sexuality), which sometimes clashed with 'mainstream' HIV prevention campaigns. Pfeiffer (28), reporting on the *Jeito* campaign in Mozambique – a condom social marketing campaign – found church leaders regarded pro-condom health messages as sinful, based on their belief that those who adhered to church teachings would not need condoms. This implicitly stigmatised anyone wishing to use a condom. More widely it has been suggested that, within church groups, condoms have come to represent 'a tool for unfaithful wives' (29) or for those who have premarital sex. The Mozambican example highlights how mainstream messaging about condoms may contradict the positions adopted by powerful churches, highlighting the need to involve church leaders in discussions about the design of health campaigns.

Many churches draw a link between HIV/AIDS, condom use and immorality in a way that risks undermining HIV prevention efforts through suggesting that only non-believers are at risk, with church members less likely to feel at risk of contracting HIV or to think they need to use condoms. Church members distance themselves from the 'immoral people' that HIV prevention messages target. Lagarde, Enel et al. (30) observed that people who self-identified as religious were less likely to display HIV-preventive behaviours than those who attached less importance to religion. Similarly, findings in Zambia (31) suggested that whilst membership of a church was likely to lead to first sexual experience at a later age, members were less likely to use condoms once they started to have sex. Focusing specifically on migrant youth in Nigeria, Smith (32) found popular religious teachings about HIV led church-going youth to perceive themselves as at little or no risk, leading to inconsistent protective practices. The positive effect of religious teachings in delaying sexual debut were countered by the subsequent reduced likelihood of people using condoms through a false sense of security.

An additional issue linked to the close association between HIV/AIDS, sexuality and shame was the extent to which this limited open discussion of HIV/AIDS by church leaders, thereby reinforcing HIV/AIDS-related stigma. Exploring the extent to which church groups fuelled  stigma, Haddad (3) found that whilst many southern African church leaders did not condemn HIV/AIDS management strategies, their self-identification  as 'holy' people prevented them from developing new and creative ways of talking about sex and HIV transmission, in the light of the taboo nature of discussions of sexuality within church settings.

Similar struggles have been identified in Burkina Faso in a project that sought to educate pastors of the Assemblies of God about HIV/AIDS and mother-to-children transmission (MTCT). Although pre-test-post test examination, as well as a later follow-up, showed pastors had understood and had retained the knowledge, only a fraction had discussed MTCT in their churches (33). One contributing factor could be the challenges of discussing new problems and solutions using old speech and traditional theology. In Tanzania, many church leaders lacked the vocabulary and confidence to talk about HIV/AIDS-related stigma and were reluctant even to try to do this because of continued opposition of senior pastors (32).

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

**How does the linking of AIDS and sin relate to representations of gender in ways that intensify AIDS-related stigma?**

Several papers in our literature review highlighted how the link between HIV/AIDS and 'immoral' sexual behaviour had been interpreted and extended to reinforce patriarchal social relations, often undermining the likelihood that women would take control of their sexual health and protect themselves from HIV-infection, or that PLWHA will receive the love, care and support that church members frequently offered the sick in the case of less controversial diseases.

Preaching around HIV/AIDS often involved selected emphases on the more conservative aspects of the Bible; in the process disregarding those aspects that would be more supportive of women's right to health and respect, accepting of female and youth sexuality and lay greater emphasis on the forgiveness of sinners. Looking at Evangelical churches in three sub-Saharan Africa countries, Marshall and Taylor (29) found churches to reinforce traditional values of female subservience and male dominance, including the submission of women to male desires, putting young women under strong pressure to be sexually active – and in so doing contributing to escalating HIV infection rates.

Conservative gender ideologies bolstered through the teachings of most African churches have been observed to negatively impact on women's knowledge about HIV/AIDS, and in turn their sexual behaviour. In a study of religious involvement and HIV/AIDS prevention in Mozambique, Agadjanian (34) found that women involved in some religious congregations, particularly Pentecostal-type churches, had less knowledge about HIV preventative measures than  women in more mainstream churches, such as the Roman Catholic and Protestant churches. Yet Takyi,  (35) in a study in Ghana, found female church members to be better informed about HIV/AIDS than women who were not church members.

Churches also tend to emphasise the sacredness of heterosexual marriage, reinforcing patriarchal social relations, undermining married people's perceived sense of risk of HIV as well as intensifying the stigmatisation of homosexuals. According to Marshall and Taylor (29) and Otolok-Tanga, Atuyambe et al. (27) married women are at particular risk of contracting HIV in many sub-Saharan Africa countries. Many women enter a marriage, either feeling a false sense of security about their sexual health, or unable to negotiate condom use for fear that this would be associated with distrust or promiscuity. In a study of

Ugandan church groups, Otolok-Tanga, Atuyambe et al. (27), found that their emphasis on fidelity within marriage, and members' belief that the sexual health of married people was not at risk, hindered people from developing a realistic sense of the possibility of contracting HIV from their marriage partner.

Furthermore the emphasis of many religions on the desirability of heterosexual marriage can lead to the ostracising of those engaging in same-sex activities (36). A study of the experiences of men who have sex with men in Nigeria (36) found that their churches and pastors openly condemned homosexuality. This served to distance them from the church, increased the stigma associated with this high risk group, and reinforced the conviction that 'good' people within the church were not at risk from contracting HIV. Such distancing and 'othering' can lead to the reinforcement of personal or internalised stigma by homosexual church members, or people living with HIV/AIDS, making them believe that they are to blame for their sexuality and contracting of HIV (37).

In short, the studies above suggest that in many settings church teachings are actively contributing to the perpetuation of gendered inequalities and the perpetuation of traditional values, through promoting conservative gender ideologies and emphasising heterosexual marriage, limiting people's (especially women's) knowledge of HIV/AIDS. They serve to represent HIV/AIDS as a problem that is located outside of the church, as well as undermining women's ability to take control of their sexual health. In this sense HIV-related stigma can be understood as a form of psychological policing of the sexuality of young people, women and homosexuals, serving as a form of 'symbolic punishment' those who have challenged or breached social hierarchies and conservative systems of social control (4). Within such contexts the emergence of social spaces in which HIV-related stigma can be challenged are highly constrained.

The preceding two sections have highlighted how many church groups perpetuate representations of sex, morality and gender that continue to limit the fight against HIV/AIDS in many African settings. Representations of HIV/AIDS as a disease of sin, shame and deviating sexuality, in the language of conservative traditional values, continue to marginalise the groups of people at high risk of HIV/AIDS, such as women and homosexuals. However, the impact of any social institution will always be too

complex to summarise in one-dimensional stereotypes. Our review also provided some evidence for positive impacts of church membership in relation to HIV/AIDS management in certain settings. We turn to examine these in the following three sections.

**What is the impact of churches' role in forms of social control that facilitate HIV prevention?**

Whilst many of the representations examined in the two preceding sections limit church response to PLWHA and contribute to stigma, they may also paradoxically contribute to a level of social control that may contribute to HIV prevention in some situations. On the one hand, the social control demonstrated by many church groups goes against the spirit of standard international criteria for HIV/AIDS control (e.g. 38), through perpetuating stigmatising links between HIV/AIDS and sin, and through supporting unequal gender relations that undermine women's ability to negotiate safer sexual encounters. On the other hand, some commentators argue that western-dominated conceptualisations of 'sexual empowerment' may not be appropriate, or effective, in all settings, and that the social control imposed by many churches may sometimes, *de facto*, help curb the spread of AIDS.

Some studies suggest that the social and sexual control of church members can lead to a reduction of high risk sexual behaviours. In South Africa for example, Garner (39) found some churches influenced their members to reduce extra- and pre-marital sexual activity in order to minimise their risks for AIDS. Similarly, in Ghana, the preaching of various Pentecostal and Evangelical churches against 'immoral sexual behaviours' has served to encourage early and faithful marriages and reduce polygamous unions (40). In Kenya, the Deliverance church promotes abstinence before marriage, fidelity within marriage and mandatory HIV testing for those getting married – highlighting which Parsitau (41) refers to as the social and sexual discipline of church members. In some contexts such efforts may have been successful in reducing risk behaviours. In Malawi, Trinitapoli and Regnerus (42) found that married men belonging to a Pentecostal church reported lower levels of HIV risk behaviour than men of other faith groups, and that regular church attendance, regardless of denomination, was associated with fewer extramarital partners which served as an important factor in reducing HIV-related risk behaviours.

However, different church groups have varying levels of influence on members' sexual behaviours (41). In Zimbabwe Gregson, Zhuwau et al. (43) found Spirit-type churches more likely to control members' alcohol consumption and extra-marital affairs than Mission churches. Garner (39), looking at different Christian denominations in South Africa, found that only Pentecostal churches had any significant impact on reducing extra- and pre-marital sex. He identified four key variables to explain this level of social control: indoctrination, religious experience, exclusion and socialisation. The Pentecostal churches had tighter control over members' behaviour, backed up by their authority to expel or exclude those who chose to reject this control (39). Such disciplining was also observed by Trinitapoli (44) in a more recent study in Malawi. However, she found that the monitoring of church members' sexual behaviour was only one effort of several strategies by church leaders to curb the spread of HIV/AIDS. Members of congregations where pastors monitored their sexual behaviour, spoke openly about HIV/AIDS and delivered HIV prevention messages as well as privately encouraging condom use and were most likely to be abstain, be faithful and use condoms (the so-called ABC of HIV prevention).

However, the situation is more complex than this, with some studies suggesting that church discipline can lead to negative HIV risk outcomes. Work in Zambia by Agha, Hutchinson et al. (2006) found little difference in HIV-prevalence levels between religious groups that excommunicate members for engaging in premarital sex and oppose condom use, and those who do not. Young women affiliated with conservative and more controlling groups are more likely to delay sexual initiation but less likely to use condoms during first sex (perhaps due to some church members not viewing themselves at risk, as discussed above) - cancelling out the potential HIV prevention benefits of delayed first sex. These findings are also reflected in a similar Zimbabwean study (44). Overall, the potential for discipline and social control to lead to reduced risk behaviours remains unclear.

**In what ways can church groups and faith provide support to people living with AIDS?**
Even amidst much evidence for their role in perpetuating stigma and undermining prevention efforts, there is also much evidence for church groupings contributing to the care and support of those infected and

affected by HIV/AIDS. According to Becker and Geissler (45) church groups are ideally placed to do this through their commitment to traditional values of solidarity as well as the fact that they are truly community-based. Looking at the Redeemed Christian Church of God in Nigeria, Adogame (46) argues that Pentecostal churches, whose conceptualisation of disease and healing is central to their responses to HIV/AIDS, need to be acknowledged for their efforts to combat the epidemic and provide care and support for those infected. Drawing on qualitative data from Malawi, Trinitapoli (47) found that many church groups in rural Malawi are  involved in caring for the sick, sponsoring HIV/AIDS education programs for youth, and emphasizing the care of orphans as a religious responsibility. A study in Botswana observed that – in the context of modernity and changes to traditional values and customs – Christian values may provide a framework that enables poor communities to cope with the care and support of children affected by AIDS (48). Looking at Church members in Ghana, Bazant and Boulay (49) found that the greatest contributing factor to the care and support of PLWHA by church group members was whether respondents had heard their leader publicly speak about HIV/AIDS.

Having said this, Agadjanian and Sen (50) in their study in Mozambique found the involvement of church groups in the provision of assistance to be limited to psychological support and personal care, neglecting many of the material and financial needs of those affected. This probably partly reflects the poverty of many churches and church members, but could also be an indicator of resource-based stigma (namely the belief that PLWHA are not deserving of material support or services). They also found financial constraints and institutional rivalry to be a hindrance to the cooperation of religious organizations in the provision of assistance to PLWHA (ibid.).

The lack of resources, coupled with HIV-related stigma, could perhaps explain why Watt, Maman, et al. (26) in Tanzania found personal faith to be important for PLWHA, with formal church membership having no influence, or a negative influence, on their experiences of living with HIV/AIDS. So whilst formal institutionalised religious spaces might contribute to the stigmatisation of PLWHA, at a personal level PLWHA derived great comfort from their ability to confide in God and have an open relationship with God – a level of social support they were not getting elsewhere. In a Namibian study, Plattner and Meiring (37)

found religion to be an important framework used by PLWHA to make sense of their illness and to come to terms with it. The self-blame resulting from the church's teachings even helped some to make sense of their status in a way that increased their sense of control over their predicament. Almost all participants reported that since being diagnosed with HIV/AIDS, religion had become very important to them – giving them a sense of meaning and purpose to life.

The contrasting findings of these studies highlight the complex and often contradictory impacts of social networks and their associated representations. Many church groups have the potential to provide supportive social spaces for PLWHA (51), yet also hold oppressive views of PLWHA. Haddad (52) highlights such contradictions, arguing that despite many positive moves by individual church leaders to get involved in HIV/AIDS management, church groups as a whole are struggling to formulate a coherent theology that enables them to acknowledge and support PLWHA in a loving Christian way, in the context of what they interpret as religiously informed imperatives to condemn the behaviours they believe have led to PLWHA's predicament. In the next section we discuss the movement within some church groups towards the creation of more supportive social spaces even against the background of this complexity and ambiguity.

**How can church groups create 'supportive social spaces'?**

One of the key drivers of HIV-related stigma is the lack of social spaces to talk about HIV/AIDS and related concerns (5). Although, as already touched on above, many church pastors initially approached the AIDS epidemic with silence and condemnation (52), a study of church leaders in Tanzania highlights that they now include AIDS in their teachings, influencing the attitudes of church members and creating opportunities for social spaces characterised by reflection and compassion (53). Similar observations have been made in some settings in neighbouring Kenya (52) and Uganda (27) where church groups have been reported as open to engaging with HIV/AIDS health education and actively encouraging discussions about the subject of HIV/AIDS with their parishioners. Trinitapoli (47) highlights that in rural Malawi religious leaders discussed HIV/AIDS with their congregations.

In some settings, churches may also provide important spaces for congregants to disclose their HIV-positive status to church leaders. A study in Nairobi, Kenya, by Miller and Rubin (54) found that many people disclosed their HIV-positive status to church pastors. Similar observations have been made in the Republic of Congo where Maman, Cathcart et al. (55) found women to see church leaders as important targets for disclosing their HIV status as well as supporting them through their decisions to disclose their status to others, including their husbands. If church leaders are understanding and accepting of people living with HIV/AIDS, and encourage more people to live positively, this may, as observed in Tanzania, have wider positive impacts. Here it was found that if church members, or people affiliated to a church group, were open about their HIV status, non-disclosed members would find it easier to be open about their HIV status in turn (26).

Studies also highlight how in certain settings church groups have been able to renegotiate understandings of HIV/AIDS in more positive, less morally charged ways that also encourage social action to tackle HIV/AIDS. Although the Catholic church condemned the use of condoms in 1993, and Protestant churches often condemn premarital sex, a study has found that church groups, youth groups affiliated to churches and religious schools in Kenya have resisted the moral doctrines of church leaders and actively engaged in HIV management and condom distribution programmes – creating important social spaces for the prevention of HIV (56). Similarly, a number of studies have emphasised how the church has allowed people to reconstruct their ideas about HIV/AIDS in a way that is meaningful to them. In the context of HIV/AIDS in Uganda, the concept of 'Salvation' of the Pentecostal church has assumed renewed meanings, encouraging young people to get involved in religious campaigns against AIDS (57). Dilger (58) focusing on a neo-Pentecostal church in Tanzania, shows that in contexts characterised by high levels of HIV/AIDS, poverty and economic insecurity, this church offers practices of healing and social support for those living with HIV/AIDS. It has provided a social space in which new understandings of HIV/AIDS can emerge, after being interpreted through local understandings. It also offers a basis for action, as the church in Dilger's (58) study provided dense networks of economic and social support for all its members.

In addition the Pentecostal church in Uganda has been observed to provide a social space where sexual behaviour can be renegotiated. Looking at the relationship between materialism and sexual behaviours amongst university students, Sadgrove (59) reports that student members of the Pentecostal church created 'born again' peer groups who sought to abstain from some of the high risk sexual practices found on campus (particularly around transactional sex for material gains). Whilst the groups promoted sexual abstinence and anti-materialist rhetoric, however, broader socio-economic dynamics were found to influence the ways in which theologies were received and acted upon by church members – highlighting the challenge of renegotiating identities and social spaces in economically deprived settings.

We have highlighted a range of studies across Africa that highlight how some church groups have provided social spaces for challenging HIV-related stigma, through enabling open discussion of HIV/AIDS, disclosure of congregants' HIV-positive status and providing the impetus and starting point for social action. However, as will be discussed below, these important studies tend to be descriptive in nature, pointing to outcomes of church efforts, rather than reporting on the processes through which some churches have managed to respond positively to PLWHA. We will argue for the need for more in-depth analysis of the processes through which some, but not other, churches or church leaders have managed to resist dominant stigmatising understandings of HIV/AIDS and those affected by it.

**What next? What is the potential of church groups in tackling HIV/AIDS-related stigma?**

Before we discuss the potential of church groups in tackling HIV/AIDS-related stigma, a few limitations of this study deserve mention. As already stated, most papers were descriptive and cross-sectional in their design, making it hard for us to say anything about the processes through which some churches and church members have been able to resist, subvert or work creatively with the AIDS-shame-sin representation, or to make space for a more supportive acknowledgement of the humanity and dignity of HIV/AIDS sufferers. We have sought to provide an overall picture of church groups, without seeking to draw more fine-grained distinctions between different religious denominations (e.g. Catholic vs Pentecostal churches) or their contextual locations (e.g. rural vs urban; country-specific features). Furthermore, as with any review, publication bias may have encouraged us to report disproportionately on

churches that have faced problems in building supportive and empowering responses to HIV/AIDS, given that problematic or fraught social situations often come to the attention of researchers more frequently than more successful or harmonious ones.

As we limited ourselves to the peer-reviewed literature, we may have missed out on important findings identified by non-academic frontline health and welfare practitioners which are often published in the non-academic 'grey' literature. Nevertheless, despite these limitations we believe that our review of the published literature on HIV/AIDS and the church in Africa provides a useful overview of the complex and contradictory role of the church as a whole in perpetuating and challenging HIV-related stigma in Africa. Aside from potentially problematic teachings communicated by churches, there may be other aspects of church existence that deter church groups from contributing effectively to HIV/AIDS management, such as lack of resources for example, which featured in relatively few of our reviewed articles given our interest in representational and symbolic factors rather than on material ones. There is a need to develop wider understandings of the social, economic and political contexts in which churches operate, that goes beyond a focus on the potential impacts of religious teachings on the experiences and behaviours of their congregants and PLWHA in the wider communities in which they are located.

We have focused on the complex and contradictory ways in which HIV/AIDS has been interpreted or anchored in pre-existing frameworks of knowledge and representation in various settings and highlighted the way in which dominant notions of HIV/AIDS have been refracted through conservative approaches to sex, sexuality and morality, often limiting the extent to which church groups can develop as social spaces which challenge HIV-related stigma. We now turn to reflect on the implications of our findings in the light of the dimensions of an AIDS-competent community, outlined in our conceptual framework section above.

The possibility that church groups might emerge as *spaces for dialogue and critical thinking* about HIV/AIDS is severely curtailed by their anchoring of the condition in representations of immorality and sin, often rendering HIV/AIDS almost literally 'unspeakable' in ways that are not associated with blame and shame. Where church leaders have managed to develop a language to talk about HIV/AIDS openly, there

is some evidence of the positive effect that this can have in challenging HIV-related stigma. This negative framing of HIV/AIDS also serves to discourage critical thinking and dialogue regarding the social roots of HIV/AIDS and HIV-related behaviour (in social conditions such as poverty, gender and/or migrant labour in various contexts). The church's reinforcement of gender hierarchies is closely linked to the policing of young people's and women's sexuality and, as has been argued elsewhere (4), in such contexts HIV-related stigma serves as a symbolic punishment for those who have failed to respect socially prescribed notions of morality. Thus, the potential for church groups to emerge as social spaces for dialogue and critical thinking are severely curtailed in ways that actually often make the perpetuation of HIV-related stigma more likely.

Church groups also offer the potential to provide *spaces to identify group strengths* available for responding to HIV/AIDS, another key feature of an AIDS competent community. Our review highlights the extent to which the church's more general representation of its role in the provision of care and support for the sick potentially provides a vital tool to frame supportive attitudes to the sick and dying. Yet the extent to which church groups can make use of this representation as a framework for responding compassionately and lovingly to people with HIV/AIDS remains limited. Alongside widespread poverty amongst many church groups, which limits the resources available to support the sick, this additional symbolic constraint on church involvement limits its potential role in the struggle against HIV/AIDS.

Our review also suggests that the capacity for church groups to serve as spaces for the emergence of an enhanced sense of *community ownership of HIV/AIDS management*, is limited. Framing HIV/AIDS as a problem of 'sinners', locates those affected outside of the boundaries of 'moral, respectable and well-behaved congregants' which forms such an important part of the self-presentation strategies and social identities of so many church members. In such a context, PLWHA become the symbolic 'other' (60), against whom church members most explicitly seek to define themselves. This is particularly the case in relation to many churches' extremely negative representations of non-heterosexual relationships and sex outside of marriage.

Finally the literature on church responses to HIV/AIDS provides relatively little evidence for the forging of *church links with potential support agencies outside of the church community* in developing or strengthening such responses. With notable exceptions, in many cases churches are not optimally integrated in wider community or regional prevention or care activities. Given that many African communities and church groups operate in contexts of various forms of poverty and social marginalisation, links to outside agencies with the material and political power to support the development of effective responses to tackling HIV/AIDS and stigma remains very important.

We conclude by echoing Haddad's (2) argument that there is a strong need for churches to develop new theologies – systems of representation and understanding that can assist church leaders in developing a more explicit and confident role for the church to play in supporting people with HIV/AIDS. Such theologies could, for example, challenge stigma through emphasising those aspects of the Christian message that potentially advocate the forgiveness of sinners; the empowerment of women; a compassionate understanding of the impacts of poverty and other social inequalities on behaviour; and recognition of the inherent dignity of all human beings. While there may be resistance to such a move in some church circles, our review has highlighted evidence that some churches have been able to transform their values and attitudes to provide non-stigmatising care and support for people affected by HIV/AIDS. Furthermore some religious leaders and scholars have explicitly argued that churches should not only contribute to care and treatment (e.g. 61), but also explicitly examine the role they can play in combating HIV/AIDS-related stigma, opening up further spaces for the development of less stigmatising responses.

**Future research directions**

There is a pressing need for two forms of research to further actionable understandings in this area. The first relates to the need for more detailed naturalistic case studies of the processes through which some churches, but not others, have organically developed creative and non-stigmatising responses to the challenges of HIV/AIDS. Our interest in naturalistic case studies of organic community responses to HIV/AIDS is driven by our belief that indigenous and bottom up responses developed by local groupings themselves are often more likely to be more feasible and sustainable vehicles of social change than

actions imposed on communities by outside professionals and experts (e.g. NGOs, health promotion bodies, overseas development agencies and so on). Where possible, research should be longitudinal, tracking changes in church understandings and responses to HIV/AIDS over time in order to understand the processes through which stigmatising representations are reproduced or transformed in response to wider social changes – such as the growing availability of antiretroviral treatment in many settings, or progressive or conservative developments in international church doctrines, for example.

Such studies need to be explanatory rather than descriptive in nature, underpinned by a theory of change, which identifies the processes through which negative social representations of HIV/AIDS, and those affected by it, are sometimes resisted and transformed in a ways that lead to greater 'AIDS competence' by church groups (21, 22). We have sought to provide a starting point for such a theory of change in our own work on stigma reduction (5, 62). Here we draw on Paulo Freire's (63-65) accounts of the role that participatory dialogue and critical thinking can play in creating social spaces in which community groups (in this case church groups) can work to identify, challenge and reformulate disempowering social representations (66, 67). We also emphasise the important role of supportive alliances between and across the social and health sectors (including faith-based organisations, the NGO sector, the HIV/AIDS sector and so on) in enabling community groups to translate new representations of social problems into feasible and locally appropriate action strategies through which church groups might best support people living with HIV/AIDS.

The most useful lessons come from documenting organic changes rather than externally imposed ones. However, growing attention is being paid to the role externally generated approaches such as 'action research' (68) or 'community-based participatory research' (69) can play in can play in opening opportunities for marginalised communities to  debate ways in which their existing social representations may perpetuate stigma and social exclusion, and undermine the likelihood of positive community action. Such debates open the potential for developing new and more empowering understandings of HIV/AIDS and how to tackle it (70). One particularly promising approach is Photovoice (71-74), where community members engage in facilitated discussions of photographs they themselves have taken, and which ideally

serves as a springboard for positive social action in favour of socially excluded groups. We are currently

engaged in an action research study using another such approach, that of 'community conversations' (75,

76), with church groups in rural Zimbabwe. Our Zimbabwean study explores the potential for community

conversations to provide opportunities for church members to renegotiate existing social identities (often

based on the 'othering' of those affected by HIV/AIDS), generating less harmful understandings of the

problem, a greater sense of individual and group ownership of HIV/AIDS-related problems as well as a

sense of responsibility for tackling them, an enhanced sense of solidarity in addressing this challenge, and

mobilising greater stocks of supportive social capital for doing so – all with the intention of building greater

AIDS competence in churches.

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