Knowledge and attitudes of religious leaders towards HIV/AIDS

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Declaration

I, the undersigned, hereby declare that the work contained in this thesis is my own original work and that I have not previously in its entirety or in part submitted it at any university for a degree.

Signature:

Date:

Abstract

Religion plays a significant role in the structuring of people's identities and perceptions and also has the potential to play a fundamental role to determine how communities respond to HIV/AIDS. Faith-based organisations are respected in their communities and have existing resources, structures and systems in place. People who are diagnosed with HIV often turn to the church where they receive emotional and spiritual support.

The primary objective of this study was to determine the knowledge of religious leaders about HIV/AIDS and their attitudes towards people living with it. A non-experimental quantitative research design was used in this study and the data was gathered through a structured questionnaire.

The respondents were not exceptionally informed about the transmission of the HI-virus, but their knowledge around the risk of specific sexual behaviour was high and their attitudes towards PLHA generally positive.

Opsomming

Geloof speel 'n belangrike rol in die vorming van 'n mens se identiteit en persepsies en het ook die potensiaal om gemeenskappe se reaksie rakende MIV/Vigs te bepaal. Geloofsorganisasies word in hul gemeenskappe gerespekteer en het bestaande hulpbronne en stelsels in plek. Mense wat MIV postitef gediagnoseer word, wend hul dikwels na hierdie organisasies waar hul emosionele en geestelike ondersteuning ontvang.

Die doel van hierdie navorsing was om die kennis en houdings van geloofsleiers rondom MIV/Vigs en die mense wat daarmee leef te bepaal. 'n Nie-eksperimenteel kwantitatiewe navorsingsontwerp is gebruik, en die data is deur middel van 'n gestruktureerde vraelys ingesamel.

Hoewel die respondente se kennis omtrent die oordrag van die MI-virus nie voldoende was nie, het hul die nodige kennis rondom die risiko van spesifieke seksuele gedrag gehad. Hul houdings rondom MIV/Vigs en mense wat daarmee leef was positief.

1. Introduction

The latest UNAIDS/WHO AIDS epidemic update stated that HIV/AIDS is on its highest level ever, with an estimated 39.4 million people globally living with the virus at the end of 2004 (UNAIDS/WHO, 2004). Sub-Saharan Africa remains the worst affected region with 25.4 million people living with HIV/AIDS. This accounts for 60% of all people that is globally living with HIV/AIDS. Although it is found that adult HIV prevalence has stabilised, this does not mean that the epidemic is decelerating, but that an equal amount of people that are newly infected are also dying because of AIDS. South Africa is the country with the highest number of people living with HIV/AIDS (PLHA) in the world with an estimated 5.3 million people that were infected at the end of 2003.

"*HIV/AIDS is a state of emergency which threatens development, social cohesion, political stability, food security, life expectancy and imposes a devastating economic burden. This dramatic situation on the African continent needs urgent and exceptional national, regional and international action*" (UN Declaration of Commitment as cited in Malinga, 2002). In his opening address at the South African National Interfaith AIDS Conference in 2002, Bishop Purity Malinga mentioned that this state of emergency poses a challenge to all sectors of society, especially the religious sector. He said that religious communities have always been places of anchor and refuge in times of trouble and it should be the same in the time of HIV and AIDS. He believes that religious leaders must play an active role in the de-stigmatising of the epidemic.

Religion has been an important resource in the promotion of health and well-being, especially in Africa, where it plays a significant role in the structuring of people's identities, thoughts and perceptions (Byamugisha, Steinitz, Williams & Zondi, 2002). Religious leaders therefore have the potential to play a fundamental role to determine how communities respond to HIV/AIDS.

Churches are found in almost all communities and have a significant level of influence – culturally, politically, socially and educationally (Calderón, 1997). They are respected in their communities and have existing resources, structures and systems. They are the largest, most stable and most extensively dispersed non-governmental organisation in any country that have human, physical, technical and financial resources. People who are diagnosed with HIV often turn to the church where they receive emotional and spiritual support.

Given the importance of religious leaders and their potential in the fight against HIV/AIDS the question can be asked as to how prepared they are for fighting the disease. It is important to determine what they know about the disease and how they feel about people living with it.

2. Research objective

The primary objective of this study is to determine the knowledge of religious leaders about HIV/AIDS and their attitudes towards people living with it. The second objective is to determine if there is a significant relationship between the respondents' knowledge of HIV/AIDS and their level of education and personal involvement with PLHA. The results of this study will create an understanding of the current situation in faith-based organisations (FBOs) and will be useful in the development and implementation of future training and education programmes as well as further research.

3. Literature study

3.1 Definition of concepts

For the purpose of this study the term *faith-based organisation* is "an institution, association or group formed by people of the same religious affiliation. This can include – but are not limited to – churches, church-affiliated organisations, youth groups, Sunday school, social welfare bodies, and both national and international church organisations and networks" (Byamugisha *et al*, 2002). The term *church* refers to all places of worship

where faith-based organisations congregate, including chapels, mosques, cathedral, pagodas, synagogues, tabernacles and temples. The term *religious leader* also refers to all faith leaders, irrespective of their religious conviction.

3.2 How religious leaders reacted in the early stages of HIV/AIDS

In the early stages of the epidemic religious leaders reacted with fear and confusion to the disease, some kept quiet, not knowing how to confront the issue. The silence deepened the discrimination, sigmatisation and rejection of PLHA. Only few of them have been willing to take responsibility in the prevention of HIV/AIDS or to declare themselves HIV positive since they fear that this would weaken their spiritual legitimacy (Liebowitz, 2002; UNICEF, 2003). The church was not a safe or welcome place for people living with or affected by HIV/AIDS. Most religious leaders have been unwilling to engage in anything that could imply the diminution of moral standards. Some felt that if they admit that homosexuality or marital betrayal exists within the congregation it may appear that the church has failed in its mission to lay down Christian principles (Calderón, 1997). This moralistic approach has hindered the spread of accurate information as well as open discussions around HIV/AIDS (Campbell & Rader, 2001; Parry, 2003; World Council of Churches, 1996; Malinga, 2002).

Some FBOs had a judgmental approach and believed that HIV/AIDS was Gods' punishment for the sin of sexual transgression and the responsibility of the offender and not of the church (Michigan HIV News, 2003; Tan, 2000; Byamugisha *et al*, 2002; Liebowitz, 2002; Pillay, 2003). Anglican Archbishop of Cape Town, Njogonkulu Ndungane, said that the church is to blame for the stigma around HIV/AIDS because of a destructive theology that linked sex with sin, guilt and punishment (Clifford, 2004). It is this association between HIV/AIDS and sin that lead to fear, stigmatisation, discrimination and the exclusion of PLHA.

Today many religious leaders are involved in grassroot advocacy and HIV campaigns. They receive HIV-related training and raise awareness in their

places of worship, encouraging their followers to change their attitudes towards PLHA and to end discrimination and stigmatisation.

3.3 The importance of FBOs in the fight against HIV/AIDS

The church as pioneer

As early as 1987 the executive committee of the World Council of Churches (WCC) called the churches to address the urgent challenges caused by the spread of HIV/AIDS throughout the world (WCC, 1996). FBOs have been the pioneers in the field of home-based care, palliative care and the care of orphans (Christian Aid, 2001; Parry, 2003; Paterson, 2001; WCC, 1996; Steinitz, 2002; Green, 2003; Pick, 2002). Paterson (2001) states that the home-based care programme of the Catholic Church and the Salvation Army are amongst the oldest and most effective in Africa. While many government hospitals turned people with HIV/AIDS away, it was the Anglican, Lutheran, Presbyterian and other church hospitals that took them in during the mid-1980's.

Channels of communication and network coverage

FBOs have the widest network coverage and reach out to virtually every community, even to the most remote villages where few other institutions exist (Green, 2003; Southern Africa AIDS Action, 2001; Myeza, undated; Parry, 2003; Steinitz, 2002). Reaching more than 80% of the world's population (Michigan HIV News, 2003; WCC Press Release, 2001), it is the most community-oriented institution that has an intimate involvement with people's lives (Paterson, 2001). FBOs have access to people of diverse backgrounds and are in an excellent position to mobilise communities at grassroot level to respond to the HIV/AIDS crisis and to change social norms (Sayed, 2004; Woldehanna, Ringheim, Murphy, Clerisme, Uttekar, Nyamongo, Savosnick, Keikelame, Im-em, Okolok-Tango, Atuyambe, & Perry, 2004). The church is the strongest and most influential non-governmental organisation in South Africa that reaches an average of 63% of the Christian population on a weekly basis (Hendriks, Erasmus & Mans, 2004).

Infrastructure

FBOs have an enviable infrastructure in place that can deliver a variety of health care, educational and social welfare support services (Michigan HIV News, 2003; Parry, 2003; Pillay, 2003; Woldehanna *et al*, 2004; Calderón, 1997). They can undertake these actions in a cost-effective way due to their reservoir of volunteers and wide spectrum of human resources (Green, 2003; Steinitz, 2002; Parry, 2001). Churches have a strong and motivated volunteer force in a community that works out of conviction with no expectation of pay or advancement. On average 10% of a church's followers may become actively involved as volunteers (Calderón, 1997).

Trust and respect

FBOs are amongst the most established community institutions. They have proven their sustainability through their continuous presence in communities, they have withstood conflict, natural disaster, political oppression and plagues (Michigan HIV News, 2003). As trusted and highly respected members of society, religious leaders are listened to and their actions set an example to their followers (UNICEF, 2003). People turn to them in times of crisis and need, and discuss issues with them that they cannot deal with alone. According to research of the Human Sciences Research Council (HSRC) to rate South African social institutions in 2000, the church received the highest percentage (74%) of trust (Hendriks *et al*, 2004).

Credibility and authority

FBOs have legitimacy, credibility and authority (Michigan HIV News, 2003) that they provide to millions of people worldwide. This platform of authority can be constructively used to affect cultural norms and social structures (Michigan HIV News, 2003; Calderón, 1997) as people turn to their religious leaders for spiritual and moral guidance (WCC, 1996; Policy Project, 2002; Michigan HIV News, 2003; Malinga, 2002). FBOs are powerful institutions with the potential to influence the attitudes and behaviour of their followers (Policy Project, 2002; Plan of action, 2001).

3.4 The importance of a partnership with FBOs

The UNAIDS Global Strategy Framework (UNAIDS, 2001) suggested a partnership between social groups, government, non-governmental organisations, PLHA, community-based groups and religious organisations at community level. Partnerships avoid duplication, allow parties to exchange information, learn from one another and share resources, like financial resources, working models, human expertise and infrastructure (King, 2004).

Dramatic changes in the course of the epidemic can be seen in countries such as Uganda, Senegal and Thailand, where FBOs were involved in the planning and implementation of national AIDS strategies from the early stages of the epidemic (Christian Aid, 2001; WCC, 2001; Green, 2003). FBOs in Uganda, for example, have played a major role in delivering information, encouraging open discussion, providing services and changing sexual behaviour (Liebowitz, 2002). This cooperation between government and religious leaders led to a dramatic decrease in infection rates and increased levels of abstinence and condom use (WCC Press Release, 2001).

3.5 Knowledge and attitudes of religious leaders

According to the WCC (2001) the capacity of FBOs has remained under-utilised because they have not received adequate levels of training or resources to address the impact of the disease. Most FBOs are not well informed around the extent and impact of HIV/AIDS (Pick, 2002) and lack knowledge, attitudes and skills (Byamugisha *et al* 2002). They feel ill prepared to deal with HIV/AIDS counselling as they have insufficient knowledge around it and have ambiguous feelings about the disease and the people living with it (Parry, 2001).

Campbell & Rader (2001) states that religious leaders have a reputation to respond negatively to HIV/AIDS. They often compartmentalise PLHA as either "innocent victims" – babies and people who received contaminated blood transfusion – or as "promiscuous" – people who were infected because of unsafe sexual practices (Huggins, Baggaley & Nunn, 2004). Some feel that there should be no compassion for those infected with the virus as they are

sinners (Mas'udi, 2000) and that HIV/AIDS is a way of cleansing society of such undesirables (Tan, 2000). Secrecy and denial about HIV status are common in all sectors of society, but particularly among religious leaders. If they can be open about their status they can be influential advocates for compassion and acceptance.

Many religious leaders find it difficult to incorporate HIV issues in their sermons. Clifford (2004) states that this can be due to a lack of knowledge about the subject or fear of not wanting to talk about a forbidden topic. Talking about sex and sexuality is a difficult issue for many religious leaders (Liebowitz, 2002). The fact that the main mode of HIV transmission is sexual, intensifies the tension that are present around sexuality (Tan, 2000). Religious leaders see themselves as authority figures who only offer 'true' messages, some think that talking about it may result in the increase of promiscuous behaviour, condom use, sex outside marriage and early sexual activity under youth (Southern Africa AIDS Action, 2001). Counselling people about HIV prevention is difficult without addressing sex and without exploring people's attitudes and behaviour in a non-judgemental way. This can be exceptionally challenging for religious leaders working in a strict moral framework (Huggins *et al* 2004). This problem can be addressed through the necessary training – HIV/AIDS should be part of the training syllabus for clergy and lay training.

The HSRC study, that was mentioned earlier, indicated that factors such as education, socio-economic status, place of residence (rural of urban) and race affect the flow of information and the spread of knowledge about HIV/AIDS (HSRC, 2002). The results of that study showed that high education levels, high economic status, employment, urban living and personal involvement with HIV/AIDS were linked with higher HIV/AIDS knowledge. Abera (2003) also stated that education is a key variable in determining the level of knowledge. This study will therefore investigate if education levels and personal involvement with HIV/AIDS have a significant relationship with the respondents' knowledge of HIV/AIDS.

4. Research problem

The primary objective of this study is to determine the knowledge of religious leaders towards HIV/AIDS and their attitudes towards people living with it. The research question can thus be stated as **"What is the knowledge and attitudes of religious leaders towards HIV/AIDS and people living with it?"**

5. Research methodology

5.1 Research design

A non-experimental quantitative research design was used in this study. This type of research provides an accurate description of a particular situation and also identifies the variables that exist in that situation as well as the relationship that exists between these variables (Christensen, 2001).

5.2 Sampling

The sample comprised of a group of 105 religious leaders that attended a HIV/AIDS mobilising workshop within the religious community. The aim of this interfaith workshop was to strengthen the capacity of the religious community to enable religious leaders to facilitate and support HIV/AIDS prevention and care programmes within their communities.

5.3 Data collection

Data was gathered through a structured anonymous questionnaire. The questionnaire, with only closed ended questions, consisted of three parts, namely biographic details, knowledge of HIV/AIDS and attitudes towards PLHA. The questionnaire was only in English because of the practical difficulty to issue each respondent with a questionnaire in his/her own mother tongue.

5.4 Ethical consideration

The respondents voluntarily participated in this study and were asked not to place their names or other personal identifier on the questionnaires to ensure confidentiality.

5.5 Statistical analysis

The data was analysed with the Statistical Package for Social Sciences (SPSS). Frequencies and percentages were computed to describe the knowledge and attitudes of the respondents towards HIV/AIDS. This descriptive statistical analysis fulfilled the descriptive objective of the study. In order to fulfill the second objective of the study, the chi-square for independence with a significance level of 0.05 was used.

6. Results

6.1 Biographic information

In this study (61%) of the respondents were female and 39% were male. This is in contradiction with theory that the church still follows a patriarchal approach (Camba, 1996; Paterson, 2001).

The respondents were mainly in their twenties (35.2%), from the African/Black population group (67.6%), with Afrikaans (20%) and Xhosa (18.1%) as the most predominant languages. Almost half of the respondents (44.8%) had a senior certificate, followed by 21.9% with a college or technicon diploma.

The majority (90.5%) of the participants were part of the Christian religion with the Catholic and Pentecostal (each 18.1%) as the best represented Christian faith groups. They were mainly involved as religious leaders, with 67 full-time and 33 part-time religious leaders. There were three respondents that were working in the church (other than being a religious leader) and two youth leaders.

6.2 Knowledge of HIV/AIDS

6.2.1 Knowledge regarding the transmission of the HI-virus

The questionnaire contained four questions regarding the transmission of the HI-virus.

Question 1. Do you think that a person can get infected with the HI-virus from a mosquito when the mosquito has bitten someone with the HI-virus just before biting you?

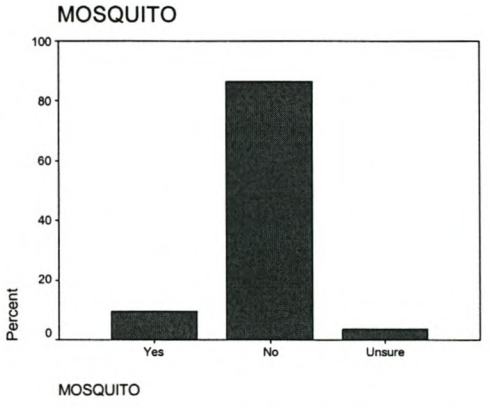

Fig. 1: Do you think that a person can get infected with the HI-virus from a mosquito when the mosquito has bitten someone with the HI-virus just before biting you?

The respondents were well informed regarding the transmission of the HI-virus from a mosquito to a human as 85.7% indicated that the virus cannot be transmitted through a mosquito.

Question 2: Do you think that a person can get infected with the HI-virus by eating food which might contain blood of an HIV positive person?

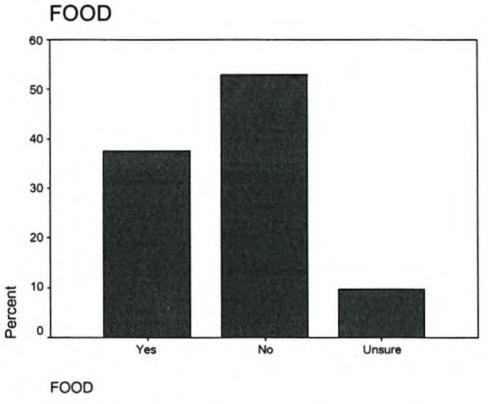

Fig.2: Do you think that a person can get infected with the HI-virus by eating food which might contain blood of an HIV positive person?

The respondents' answers to this question indicated that there is a lack of knowledge around the transmission of the HI-virus through food that might contain blood from an HIV positive person. Only 52.4% gave the correct answer (that it is not possible), 37.1% said it is possible and 9.5% were unsure.

Question 3: Do you think that a person can get infected with the HI-virus if blood from an HIV positive person spills on your skin where there are no cuts or sores?

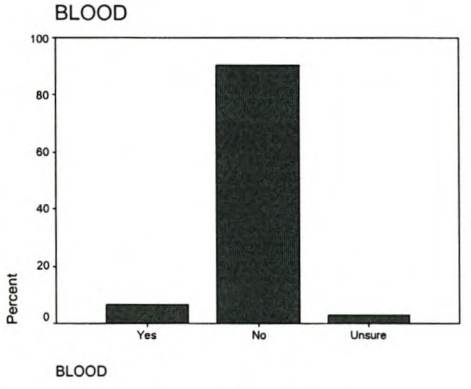

Fig.3: Do you think that a person can get infected with the HI-virus if blood from an HIV positive person spills on your skin where there are no cuts or sores?

The respondents were well informed regarding this issue as the majority (90.5%) said that a person cannot get infected with the HI-virus if blood from an HIV positive person spills on your skin where there are no cuts or sores.

Question 4: What is a HIV positive mother's risk of transmitting the HI-virus to her baby?

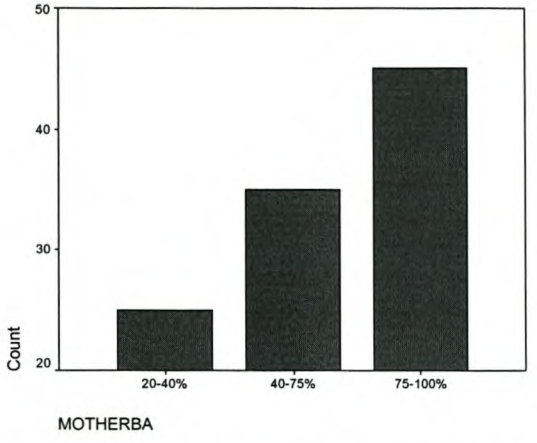

Fig.4: What is a HIV positive mother's risk of transmitting the HI-virus to her baby?

There is a concern around this question as only 23.8% of the respondents gave the correct answer. This means that 76.2% of the respondents did not know the transmission risk of an HIV positive mother to her baby.

6.2.2 Knowledge regarding the risk of sexual behaviour

The questionnaire contained six questions regarding the possible risk of different sexual behaviours.

Question *1: How safe/risky is kissing on the lips?*

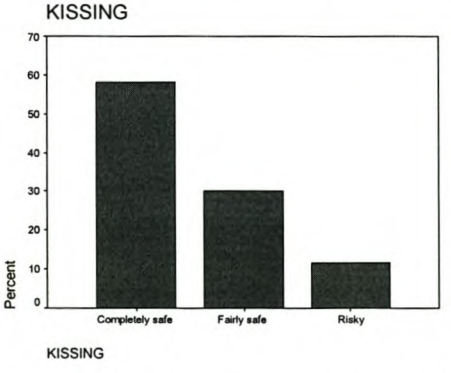

Fig. 5: How safe/risky is kissing on the lips?

88.3% of the respondents indicated that kissing on the lips is safe (57.1% completely safe; 29.5% fairly safe). The reason for the uncertainty between completely safe and fairly safe can be attributed to vagueness of the question. The respondents could have taken the possibility of sores on the lips into account when answering this question. It is suggested that this question should be re-phrased in future research to be more specific.

Question 2: How safe/risky is oral sex?

Question 3: How safe/risky is anal sex?

Question 4: How safe/risky is vaginal sex?

		Frequency	Percent
Valid	Completely safe	5	4.8
	Fairly safe	15	14.3
	Risky	85	**81.0**
	Total	105	100.0

Table 1: Risk of oral sex

		Frequency	Percent
Valid	Completely safe	3	2.9
	Fairly safe	7	6.7
	Risky	94	**89.5**
	Total	104	99.0
Missing	System	1	1.0
Total		105	100.0

Table 2: Risk of anal sex

		Frequency	Percent
Valid	Completely safe	2	1.9
	Fairly safe	5	4.8
	Risky	97	**92.4**
	Total	104	99.0
Missing	System	1	1.0
Total		105	100.0

Table 3: Risk of vaginal sex

The respondents had remarkable knowledge regarding questions 2, 3 and 4 as the majority indicated these three sexual behaviours as risky. 81% indicated that oral sex is risky, 89.5% said that anal sex and 92.4% that vaginal sex is risky sexual behaviour.

Question 5: How safe/risky is sex using a condom?

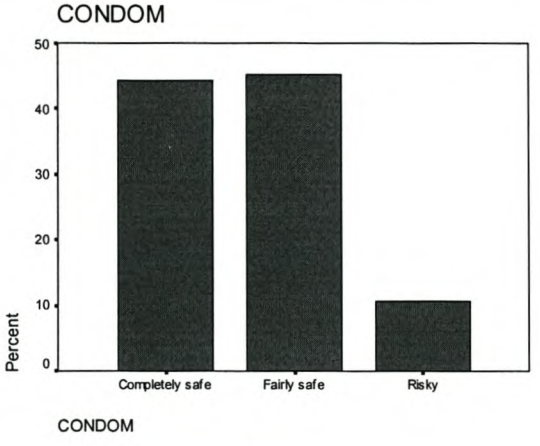

Fig 6: Risk of sex with a condom

The majority of the respondents indicated that sex with a condom is safe (43.8% completely safe; 44.8% fairly safe).

Question 6: How safe/risky is masturbating your partner?

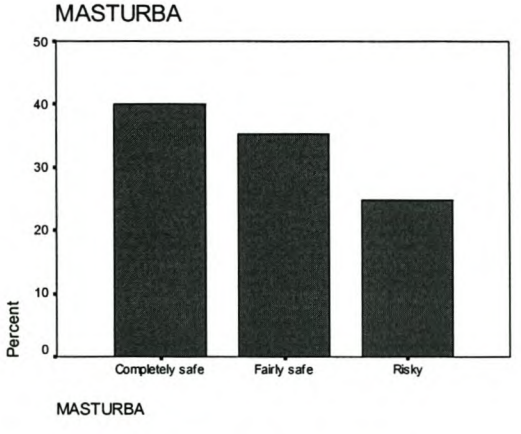

Fig 7: Risk of masturbating your partner

The respondents' answers to this question indicated that there is a lack of knowledge about the risk of masturbating a partner. 40% of the respondents

indicated masturbating a partner to be completely safe, 35.2% fairly safe and 24.8% was unsure. These percentages illustrate that the respondents do not have the necessary knowledge regarding this issue.

6.3 Attitudes towards HIV/AIDS and PLHA

There were seven questions to determine the respondents' attitudes towards HIV/AIDS and people living with it.

With three of the questions the respondents were given a statement where they had to either *agree* or *disagree.* It can be concluded that the respondents have a strong belief in the prevention of further spread of the disease. This is illustrated by the fact that 57.1% agreed that HIV positive people should abstain from sexual activity and 45.7% agreed that HIV positive women should be sterilised. The majority of the respondents (70.5%) felt that HIV positive people are not entitled to keep their HIV status a secret from their community.

For the remaining four questions a five-point Likert scale was used. This technique measures the extent to which a person agrees or disagrees with a particular statement. The items were rated on a 1 to 5 response scale with 1 = strongly agree; 2 = agree; 3 = unsure; 4 = disagree and 5 = strongly disagree.

Question 1: People with AIDS deserve it.

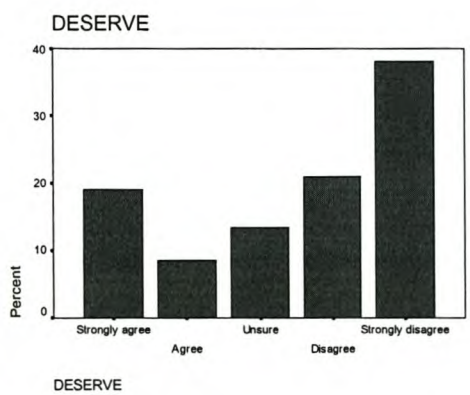

Fig 8: People with AIDS deserve it

A total of 59.1% of the respondents disagreed with the statement that people with AIDS deserve it (21% disagreed; 38.1% strongly disagreed). There were 14 respondents (13.3%) that were unsure about their attitude towards this statement.

Question 2: The AIDS problem does not really affect me.

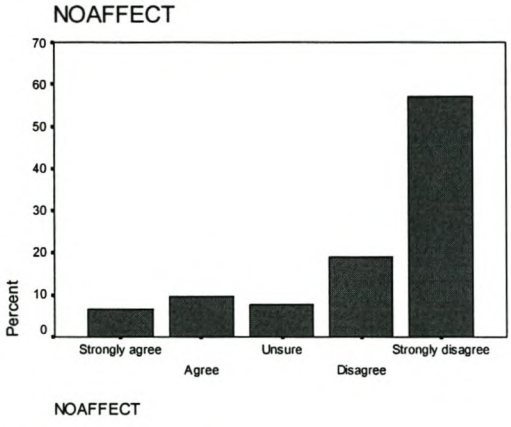

Fig 9: The AIDS problem does not really affect me

Figure 9 illustrates that the majority of the respondents disagreed with the above-mentioned statement and that they do realise the affect that AIDS can have on them.

Question 3: The AIDS problem will not have a severe impact on my faith group.

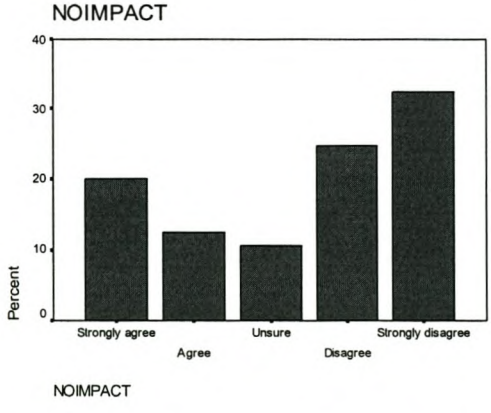

Fig. 10: The AIDS problem will not have a severe impact on my faith group

The majority of the respondents (57.2%) disagreed with this statement, 32.4% agreed with it and 10.5% was unsure. Although the majority realised the impact that AIDS can have on their faith group, there is a concern about the large percentage that still believe that it will not have a severe impact and also of the 10.5% that was unsure about the impact.

Question 4: I feel AIDS is a punishment for having many sexual partners.

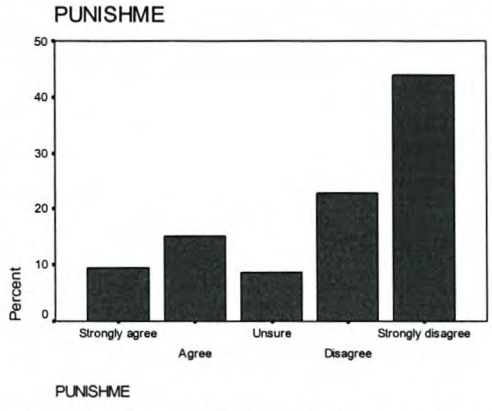

Fig 11: AIDS is a punishment for having many sexual partners

A total of 66.7% of the respondents disagreed with the statement that AIDS is a punishment for having many sexual partners (22.9% disagreed; 43.8% strongly disagreed).

6.4 Personal involvement with PLHA

There were 61% of the respondents that knew someone who is living with HIV/AIDS of which only 33.3% indicated that they knew someone infected or affected with HIV within their congregation. 39% of the respondents indicated that they ever counseled someone infected or affected by HIV/AIDS.

6.5 The focus of FBOs in Southern Africa

The respondents were positive about the future contribution that FBOs can make in the fight against HIV/AIDS. The majority of the respondents (89.5%) believed that FBOs can help to lower the spread of HIV in Southern Africa. They feel FBOs should focus more on support for HIV infected and affected people, the provision of counselling services, programmes for youth and

orphans, care centres for the terminally ill and HIV/AIDS awareness programmes.

6.6 The relationship between the respondents' level of education and personal involvement with PLHA and their knowledge of HIV/AIDS

The chi-square test for independence was used to test the following research postulates.

Research postulate 1: There is not a significant relationship between the respondents' level of education and their knowledge regarding HIV/AIDS.

Null hypothesis 1.1: There is not a significant relationship between the respondents' level of education and their knowledge regarding the transmission of the HI-virus.

At two of the three questions regarding the transmission of the HI-virus a significance level of more than 0.05 was found. It was only at the question '*if blood from an HIV positive person can infect another person that does not have any cuts or sores'* that a significant chi-square (χ^2= 26.272, p=0.05) has been found. This means that there is a significant relationship between the level of education and the respondents' knowledge regarding the risk of blood from an HIV positive person to infect another person that does not have any cuts or sores on the skin.

Null hypothesis 1.2: There is not a significant relationship between the respondents' level of education and their knowledge regarding unsafe sexual behaviour.

A significance level of more than 0.05 has been found in all the questions regarding unsafe sexual behaviour. This means that there is not a significant relationship between the respondents' level of education and their knowledge regarding unsafe sexual behaviour.

Research postulate 2: There is not a significant relationship between the respondents' personal involvement with PLHA and their knowledge regarding HIV/AIDS.

Null hypothesis 2.1: There is not a significant relationship between the respondents' personal involvement with PLHA and their knowledge regarding the transmission of the HI-virus.

A significance level of more than 0.05 has been found in all the questions regarding the transmission of the HI-virus. This means that there is not a significant relationship between the respondents' personal involvement with PLHA and their knowledge regarding the transmission of the virus.

Null hypothesis 2.2: There is not a significant relationship between the respondents' personal involvement with PLHA and their knowledge regarding unsafe sexual behaviour.

A significance level of more than 0.05 has been found in all the questions regarding unsafe sexual behaviour. This means that there is not a significant relationship between the respondents' personal involvement with PLHA and their knowledge regarding unsafe sexual behaviour.

7. Discussion of the results

The respondents were not exceptionally informed about the transmission of the HI-virus. They were well informed regarding the fact that a mosquito and blood from an HIV positive person, that is in contact with skin that has no cuts or sores, cannot transmit the HI-virus. A significant relationship was found between the level of education and the respondents' knowledge regarding the risk of blood from an HIV positive person to infect another person that does not have any cuts or sores on the skin. They however lacked knowledge about the risk of food that contains blood of an HIV positive person and an HIV positive mothers' risk of transmitting the HI-virus to her baby.

Their knowledge around the risk of specific sexual behaviour was generally high. They knew that oral, anal and vaginal sex are risky sexual behaviours, but were not sure about the risk of kissing on the lips and masturbating their partner.

The respondents' attitudes towards PLHA were generally positive. They did not feel that AIDS is a punishment for having many sexual partners or that people with AIDS deserve it. They are aware of the affect of HIV/AIDS on them, but there is a concern about the number of respondents that feel that AIDS will not have a severe impact on their faith group.

The respondents were positive about the future contribution FBOs can make in the fight against HIV/AIDS. They feel FBOs should focus more on support for HIV infected and affected people, the provision of counselling services, programmes for the youth and orphans, care centres for the terminally ill and HIV/AIDS awareness programmes.

8. Limitation to this study

A limitation that is common in studies of knowledge and attitudes towards HIV/AIDS, is the respondents' self-declaration. Respondent's answers might be affected by social desirability as they tend to give the most socially acceptable answer. To prevent this it is advisable to use questions that have been previously validated in similar scientific studies (HSRC, 2002).

9. Recommendations for FBOs in the fight of HIV/AIDS

Religious leaders need to be sufficiently equipped

Religious leaders should understand their roles and responsibilities in HIV prevention and care (Huggins *et al*, 2004). They should prepare themselves to provide appropriate pastoral care and counselling to persons living with and affected with HIV/AIDS. They need a better understanding of the epidemic and its implications (Parry, 2001), and need to empower people to take responsibility and make responsible and informed choices (Rassool, 2002).

HIV/AIDS education and training needs to be integrated into the curricula of religious training institutions (Myeza, undated) and should receive adequate financial support. Faith specific liturgies and sermon guides can be developed and distributed to religious leaders to use in the church. In this way church members will be more informed and will understand the role of the religious community in fighting this epidemic.

Information sharing

FBOs need to create a safe environment where people living with HIV/AIDS can share their story with others (Pick, 2002). They need to promote the sharing of accurate information about HIV/AIDS and work against the spread of misinformation and fear (WCC, 1997). They can establish an HIV/AIDS resource centre or display to share information and resources with other sectors (Malinga, 2002). That can include HIV/AIDS related articles, books, news stories, bulletin announcements, community bulletin boards, local radio and television community service programs (Michigan HIV News, 2003).

Care for those infected and affected by HIV/AIDS

FBOs need to use their available resources to ensure that PLHA receive the highest possible level of care, respect, love and solidarity (WCC, 2001). PLHA need to be included in the prevention and care, spiritual outreach and theological debates as a way of enhancing their dignity. Prevention programmes are more effective where PLHA participate (Pick, 2002) as people react more positive if they see someone who already experienced the implications of being infected. It is not only people that are infected with the virus that need care, but also those affected by it. This group includes orphans, widows, widowers and the elderly left with children (Calderón, 1997).

Care for carers

The care of the carers, who also need spiritual and emotional support, is often neglected and taken for granted (Slattery, 2002). Religious leaders will experience stress and burnout due to grief, mourning and lower moral taking their toll as their followers die or are affected by HIV/AIDS (Myeza, undated).

The demands exceed those they are trained for. They were, for example, trained to deal with dying among the older age groups, but now it is primarily younger people – often the largest groups in religious bodies – youth, young couples and professionals. To combat stress and burnout, FBOs can develop internal support systems for those involved with HIV/AIDS work, provide training in stress management and offer opportunities for open discussion and support.

Openness

Openness around HIV/AIDS promotes effective change and support to the infected and affected (Pick, 2002). The church should work to overcome attitude and behavioural barriers that prohibit the acceptance of PLHA. FBOs need to be free of judgement and accepting the HIV positive individual as a person. It is necessary for them to create an environment of openness and support within the church (Michigan HIV News, 2003), to invite and welcome PLHA and their families to bible study groups or other church activities.

Although most religious leaders remained silent and few acknowledged their HIV positive status, they play a significant role in changing their followers' attitudes towards HIV and PLHA (Huggings *et al*, 2004). Personal testimonies by religious leaders can shift beliefs and prejudices around the epidemic. When they are open about their status they can be powerful advocates for compassion and acceptance.

Empowerment of women

FBOs need to put programmes in place that eliminate traditional and cultural inequalities that exacerbate the vulnerability of women (WCC, 2001) and promote their rights. Women can be assigned to various commissions within the community to help build their self-esteem (Calderón, 1997). The UNDP recommended that at least one-third of training budgets should be spent on women – women should play their full part in policy-making, leadership and training to get away from the patriarchal approach (Paterson, 2001).

Women can play a significant role in HIV prevention education because of their triple roles as nurturers, carers and educators in the family and community (Huggins *et al*, 2004). They are therefore in a unique position to influence the beliefs, attitudes and behaviour of friends, relatives, community and religious leaders.

10. Conclusion

The importance of religious leaders and their potential to make a difference to HIV/AIDS have been emphasised in this study. Although the respondents proved to have exceptional knowledge regarding the risk of specific sexual behaviour, they lacked knowledge in terms of the transmission of the HI-virus. Their attitudes towards HIV/AIDS and PLHA were generally postive and they were also positive about the future contribution of FBOs in the fight against HIV/AIDS.

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