

## ORIGINAL ARTICLE

# Can interfaith research partnerships develop new paradigms for condom use and HIV prevention? The implementation of *conceptual events* in Malawi results in a 'spiritualised condom'

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Accepted 11 September 2011

Published Online First  
8 October 2011

## ABSTRACT

**Objectives** The aim of this intervention research study was to engage senior leaders of faith-based organisations (FBOs) in Malawi in a participatory process to construct an interfaith theology of HIV/AIDS. This process was designed to enhance the capacity of faith leaders to respond more effectively to the HIV/AIDS pandemic.

**Methods** An evidence-driven combination of ethnographic and participatory action research methodologies was utilised. *Conceptual events*—innovative participatory action research processes—were held over the 4-year project and brought together health service providers, policy makers and a non-governmental organisation in partnership with FBOs and grassroots faith-based communities.

**Results** Through facilitated dialogue, an interfaith theology of HIV/AIDS emerged, resulting in the proposition that a 'spiritualised condom' endorses a 'theology of protecting life'. This proposition was based on the following convictions: (1) life is sacred and to be protected, (2) to kill or murder is a 'greater sin' than the 'lesser sin of infidelity', (3) protection of the innocent is a moral and religious requirement, (4) condoms have the potential to prevent the death of an innocent person and (5) condoms need to be encouraged, even in the context of marriage.

**Conclusions** Clinicians, non-governmental organisations, health service providers and policy makers, assisted by health social scientists, can successfully partner with FBOs and their leaders to (1) modify and transform faith-based understandings of HIV risk and (2) bring about attitudinal and behaviour changes that help to address the challenges associated with HIV/AIDS.

## INTRODUCTION

The Republic of Malawi is a country in south-central Africa, with a population of 12 million and around 200 000 HIV-infected people in need of antiretroviral therapy,<sup>1</sup> and almost 90 000 new HIV infections per year.<sup>2</sup> The national adult HIV prevalence rate is 12%,<sup>2</sup> one of the highest in the world, and the number of individuals aged 0–49 years living with HIV/AIDS is between 0.7 and 1.1 million.<sup>3</sup> More than half a million children in Malawi have been orphaned by AIDS.<sup>4</sup>

Most HIV-infected Malawians are unaware of their HIV infection and do not use condoms.<sup>5</sup> Many Malawians are not convinced that condoms are safe or capable of preventing HIV transmission, and many distrust condom marketing campaigns,

believing them to be population control efforts by the Malawian government and the international community.<sup>6–7</sup> While there is some discussion among Malawians of condom use in the context of extramarital relationships, condom use within marriage relationships is very limited.<sup>8</sup>

It is widely acknowledged that there is potential for faith-based organisations (FBOs) to play an important role in HIV/AIDS prevention.<sup>9–15</sup> However, FBOs can be hampered in this role by sociocultural and theological factors.<sup>14–18</sup> In many cultural settings, including Malawi, faith leaders actively discourage condom use.<sup>17–19</sup>

Malawi's FBOs are well positioned to fight the HIV/AIDS epidemic,<sup>20</sup> but their effectiveness is limited by cultural and theological factors that inhibit dialogue on the disease and its prevention.<sup>18</sup> Faith persuasions in Malawi have traditionally been isolated from each other. In addition, many faith leaders continue to promote a theology replete with sin, blame and immorality, which contributes to experiences of stigma and discrimination. These faith leaders have generally discouraged condom use because they believe that it inadvertently encourages infidelity and adultery and creates an unnatural reproductive barrier.<sup>18</sup> In Malawi, where procreation is linked in African Traditional Religions to fertility, sexuality, bodily fluids and the land, any reproductive barrier is thought to be disruptive and inconsistent with the demands of the ancestors.<sup>18–21</sup>

## OBJECTIVES

Changing the ways in which Malawians address the problem of HIV/AIDS requires that the senior leaders of FBOs in Malawi be engaged as *enabling resources* to promote attitudinal and behavioural change. The aim of our research was to construct an interfaith theology of HIV/AIDS that would enhance the capacity of these faith leaders to respond effectively to the HIV/AIDS epidemic.

Our findings in year one of this project revealed that while faith leaders in Malawi were committed to constructive dialogue about HIV/AIDS, they had profoundly different perspectives on the issue, and these differences were contributing to their inability to communicate and work together to promote the attitudinal and behavioural changes necessary to stop the spread of HIV.<sup>18</sup> They required a new, practical, interfaith theological argument to guide their response to the epidemic.



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Because the beliefs of faith-based groups in Malawi do not easily integrate scientific perspectives, innovative processes were required to ensure that this new theology would be infused with the latest scientific knowledge about HIV/AIDS.<sup>21</sup>

Using the *conceptual event* (CE), an innovative participatory action research (PAR) process,<sup>18</sup> our 4-year project (beginning in 2002) set out to determine whether health service providers, health policy makers and a non-governmental organisation could partner with FBOs and grassroots faith-based communities (FBCs) in Malawi to construct a theology of HIV/AIDS. The goal was to construct a theology that modifies faith-based understandings of HIV/AIDS risk, facilitates dialogue and behaviour change, de-stigmatises the disease and encourages condom use as a method of preventing the spread of HIV. While transformed, ecumenical theologies do not automatically lead to behaviour change, they can facilitate behaviour change when they are practical; in turn, the development of more compassionate behaviours can lead to revised theological thinking.<sup>22</sup>

## METHODS

At the core of this project's achievements were the unique, collaborative research partnerships developed among health service providers and scientists, 24 Christian and Muslim FBOs (see online appendix 1), FBCs, the Department of Theology and Religious Studies and College of Medicine at the University of Malawi, the National AIDS Commission of the Republic of Malawi and the *Salama* SHIELD Foundation (SSF). SSF is an international non-governmental organisation promoting partnerships in developing countries; it draws on indigenous wisdom, scientific knowledge and spiritual values to construct sustainable solutions in response to development concerns (<http://www.salamashield.org>).

We utilised an evidence-driven combination of ethnographic and PAR methodologies, described in a report on our preliminary findings (year one)<sup>18</sup> and in other publications<sup>23–30</sup> (see box 1). CEs were the principal method used to meet the objectives of this project. A CE, an innovative iteration of the PAR process, is a facilitated, creative problem-based forum that intentionally nudges individuals with different perspectives towards the

### Box 1 Participatory action research (PAR) and *conceptual events* (CEs)

PAR involves cycles of dialogue, reflection and practice that bring people to a critical consciousness of their situation; from this consciousness, they generate new knowledge and social action aimed to transform their circumstances. PAR engages significant leaders (*key communicators*) and stakeholders in a process of (a) consensually identifying the problem; (b) analysing the problem contextually and culturally; (c) representing the problem in quantitative and qualitative terms; (d) proposing responses to the problem; (e) implementing the responses conceptually and behaviourally and (f) evaluating the impact of the proposed response or solution to the problem. We used CEs to advance this research.

The CE, an innovative PAR process, is a facilitated, creative problem-based forum that intentionally nudges individuals with different perspectives towards the construction of a shared ethically compelling framework for understanding a problem and devising solutions (see online appendix 2).

construction of a shared ethically compelling framework for understanding a problem and devising solutions<sup>18</sup> (see online appendix 2).

As the implementing partner in this project, *Salama* SHIELD Foundation-Malawi (SSF-M) introduced the CE to Malawi's FBOs and FBCs as a PAR process,<sup>30</sup> deliberately designed to bring together faith leaders who are affected by HIV/AIDS and who share the goal of finding life-sustaining solutions to the problems caused by this disease, but who nonetheless have profoundly different understandings of the fundamental truths governing their lives, the determinants of health and illness in the context of HIV/AIDS and how they should respond to evidence of risk.

Three Lilongwe-area CEs were held in 2004 to bring these faith leaders together to engage in critical reflective dialogue on the contentious issues that divide them in the areas of HIV/AIDS prevention, supportive care and education and on what they should say and do about the epidemic. At the first CE, the Nantipwiri Colloquium, papers were presented by faith leaders<sup>31</sup> who contributed valuable theological expertise to the dialogue. Physicians provided clinical and scientific information on the characteristics of HIV transmission and the safety of condom use. Other participants presented grassroots views on HIV/AIDS (gathered in meetings of FBCs and other community groups) through the use of oral reports, drama, dance, songs and poetry, encouraging the faith leaders to rethink their theologies in terms of practical problems on the ground (see online appendix 3 for a list of participants and their contributions). In two follow-up CEs at the Ryalls Hotel and Superior Hotel in Blantyre, co-facilitated by the first author (medical anthropologist) and heads of FBOs, senior leaders of the mainline churches met for further discussion and decision making. These deliberations led to three key CEs in 2005 and 2006 and many other CEs throughout the period of the project, including meetings within faith groups and monthly interfaith meetings with Lilongwe faith leaders. Decisions were made on the basis of consensus—after strenuous discussion. Our methodologies for analysis and interpretation of these CEs have been previously described in a report on this project's preliminary findings in year 1<sup>18</sup> (see online appendix 4).

## RESULTS

The CEs organised by this project were historic events for Malawi's FBOs and FBCs and their leadership. While these faith leaders live and work in close proximity to each other in Blantyre, Lilongwe and Zomba, most had not worked together or even interacted in any meaningful way for many years (James Tengtenga, Co-Chair, Nantipwiri Colloquium, personal communication, 24 July 2004). Yet remarkably, all the leaders of the umbrella bodies of faith communities, the mainline churches and the independent and smaller churches of Malawi came to be highly committed to this project and its objectives. All actively participated in our Lilongwe-area interventions and some pastors were trained as field workers and assisted with research throughout the project period.

The CEs challenged these faith leaders to examine their theological stances, bridge diverse perspectives, construct shared solutions, change the ways in which they discussed HIV/AIDS issues with their communities and modify their approaches to HIV/AIDS prevention, supportive care and education.

There were surprising changes during this process in the ways in which Malawi's faith leaders approached faith and its relationship to HIV/AIDS. Over the course of the many CEs that took place in 4 years (see online appendix 5), a new theology of HIV/AIDS began to emerge. On 28 September 2004, all heads of

the mainline Christian churches and Muslim FBOs in Malawi signed a statement that they named *The Ryalls Declaration* (online appendix 6), committing themselves to ongoing dialogue on contentious issues surrounding HIV/AIDS, the continued development of an interfaith theology of HIV/AIDS, the support of programmes and practices that contribute to the prevention of HIV/AIDS and to the reduction of the stigma and discrimination associated with it. To help implement the declaration's pioneering objectives, these faith leaders established a *Forum for theological dialogue and research on HIV/AIDS*. At a meeting of this Forum in January 2006, the participating faith leaders issued a landmark statement to the press, promoting the use of condoms to protect innocent life (see box 2).

Over time, the dialogue at the CEs shifted and changed as the FBO and FBC leaders exchanged ideas and theological arguments on the subjects of HIV/AIDS prevention and condom use. Eventually, these leaders developed an effective way to graft prevention messages onto a moral imperative and committed themselves to implementing within their communities a systematic and practical *theology of protecting life*, based on the following convictions.

1. Life is sacred and to be protected.
2. To kill or murder is a 'greater sin' than the 'lesser sin' of infidelity.
3. Protection of the innocent is a moral and religious requirement.
4. Condoms have the potential to prevent the death of an innocent person (the unsuspecting spouse or partner of a person with multiple sexual partners).
5. Therefore, condom use needs to be encouraged, even in the context of marriage.

While Pope Benedict XVI's recent comments<sup>32</sup> acknowledged that the use of condoms to prevent the spread of HIV is a lesser evil than putting the life of another human being at risk (and this is significant for his followers around the world), the Vatican still holds that condom use is immoral,<sup>33</sup> even in the context of a marriage in which the condom has the 'double effect' of preventing HIV transmission in addition to pregnancy.

In contrast, the diverse group of Malawian faith leaders involved in this research project came to the surprising conclusion that under the circumstances in which their faith communities find themselves, a *theology of protecting life*, based on scripture, makes condom use a moral and religious *imperative*.

**Box 2 Forum for theological dialogue and research on HIV/AIDS, Press Release Excerpt Victoria Hotel, Blantyre, Malawi 27 January 2006**

*[We] do realize that in certain circumstances, if properly used, [the condom] does contribute to the saving of innocent life. [We] emphasize the responsibility of the unfaithful to at least reduce the effects of their actions on their unsuspecting partners by the use of condoms. The same God who says, "Do not commit adultery" equally says, "Do not kill."*

In view of the serious effects of the pandemic on our communities, we emphasise the need for increased integration of counselling in our pastoral work and in the training of religious leaders. In order to protect life, we emphasise the need for a dramatic increase in voluntary counselling and testing. We also see that declaring one's status may help to save life and decrease stigma.

They concluded that this theology, emerging from their reflections in the CEs, had yielded a new concept they called 'the spiritualised condom'<sup>34</sup> (see online appendix 7).

The spiritualised condom refers to a profound linkage between the technology of HIV prevention and a shared moral purpose—to protect life. Among individuals whose behavioural choices are driven by ancestral authorities and whose epistemological references are more spiritual and indigenous than secular or biomedical, the spiritualised condom legitimises public health strategies for HIV prevention. With the concept of the spiritualised condom, the public health requirement of condom use is given spiritual authority, which in this instance transcends a variety of faith traditions.

The development of the idea of the spiritualised condom reflected the realisation among these faith leaders that condom use is an ethical act, *required* by their own moral beliefs and by a theology that sanctifies life. The spiritualised condom endorses prevention in a novel and positive way.

One of the Malawian co-facilitators of the CEs put it this way:

Can the faith community in Malawi justify its moral stance on condoms in the face of this pandemic? I am persuaded to say that it cannot. There is a good at stake, and that good for me is life. The question then is shall we save life or let it die? ... The choice is on the side of life.

## DISCUSSION

This project demonstrated that the participatory process of CEs can translate the intellectual and experiential capacity of multiple stakeholders, including faith leaders, into effective strategies and solutions for HIV prevention.

This research focused on faith leaders, challenging them to radically transform their theologies and communicative behaviours in ways that could potentially lead to behaviour change among their followers and encourage condom use. Though many questions remain for future research (online appendix 8), we observed significant changes over the course of our CEs in the ways in which faith leaders communicated with each other and their followers about HIV/AIDS.

While unique and innovative research partnerships were created between health scientists, health service providers and diverse FBOs and FBCs, our methodology has a number of limitations with regard to its ability to achieve intervention effectiveness for individuals at risk for HIV/AIDS. The effectiveness of these partnerships was hampered to some degree by the cultural and epistemological divide that existed between researchers with scientific and faith-based backgrounds and by the ongoing challenge of involving more Malawians in this research. While our research partners were representative of the mainline FBOs in Malawi, they did not include, for example, the leaders of the African Traditional Religion sector in Malawian society—though some traditional views were reflected in the information gathered from meetings of FBCs. Furthermore, qualitative studies, such as this one, are complex and costly and can require a long time period before hoped-for results can be demonstrated at the clinical level. Follow-up studies are in the works and will incorporate qualitative and quantitative methodologies to measure the impact and behaviour outcomes of this intervention within Malawi's FBOs. Although the merit of our CE process in other African settings is uncertain, its application in settings outside Malawi could test its generalisability and potentially lead to the development of practices that could be utilised effectively by other faith communities in the region.

## Key messages

- ▶ *Conceptual events*—innovative participatory processes—can translate the intellectual and experiential capacity of multiple stakeholders into effective strategies for HIV prevention.
- ▶ Healthcare stakeholders (clinicians, policy makers, researchers), in partnership with faith-based organisations, can bring about attitudinal and behavioural changes with respect to HIV risk.
- ▶ The implementation of *conceptual events* has produced an interfaith consensus on condom use as a moral imperative despite initial resistance and disagreement.
- ▶ Interfaith research partnerships have led to the concept of a 'spiritualised condom', which legitimises public health strategies for HIV prevention among Malawi's indigenous communities.

By entering respectfully into the cultural and epistemological divides that exist between researchers, governments and faith communities, we believe that research partnerships such as those described here can modify faith-based understandings of HIV/AIDS and build on common ground, leading to long-term health solutions.

**Acknowledgements** We thank the Department of Theology and Religious Studies, Chancellor College, University of Malawi for partnering with the *Salama SHIELD* Foundation-Malawi (SSF-M) to organise CEs. The authors are indebted to: Dr Dixie Maluwa Banda, Professor of Education and Psychology, University of Malawi, for his expertise in the area of behaviour change; Dr John Kumwenda, Department of Medicine, College of Medicine, University of Malawi, for his expertise in the areas of HIV/AIDS treatment and management; and Dr Nelson Sewankambo, Professor of Medicine and Principal at the College of Health Sciences, Makerere University, Uganda, for his expert contributions to this project's CEs. Special appreciation goes to the leaders of FBOs who attended all of the CEs and who established the *Forum for theological dialogue and research on HIV/AIDS*; among them were the following (in alphabetical order): Reverend (Rev) Mezuwa Banda, Father Dr Joseph C Chakanza, Right Rev Dr Felix Chingota, Rev Dr Macford Chipuliko, Dr Klaus Fiedler, Rev Fletcher Kaiya, Right Rev Bishop Patrick Kallilombe, Sheik Dr Imran Shereef Mahomed, Archbishop Bernard Malango, Rev Dr Geoffrey Matoga, Dr Sostain Mfune, Bishop Musikuwa, Pastor Canaan Phiri, Sheik Sanudi, Monsignor Montfort Sitima and Right Rev Bishop James Tengeatenga. Sincere thanks to Professor Deborah Cook, Department of Clinical Epidemiology and Biostatistics, McMaster University, Hamilton, ON, Canada, for her support and constructive comments on the paper. We also recognise and are grateful for the excellent editorial direction and assistance of Ms Jane Willms. Finally, we thank the editors for their constructive, helpful and supportive comments.

**Funding** Canadian Institute of Health Research (CIHR) grant (No. HHP-53379), National AIDS Commission (NAC) grants (Ref. No. NAC/10/05/59 and NAC/FMA/C/0005) and the Salama SHIELD Foundation (SSF). DGW was supported by McMaster University as a faculty member and a Career Scientist Award from the Ontario HIV Treatment Network (OHTN – ROGC101), M-IA was supported by a CIHR grant (No. HHP-53379), and PM was supported by a CIHR grant (No. 53379).

**Competing interests** All authors have completed the Unified Competing Interest form (available on request from the corresponding author) and declare that (1) this work was supported by a Canadian Institute of Health Research (CIHR) grant (No. HHP-53379), National AIDS Commission (NAC) grants (Ref. No. NAC/10/05/59 and NAC/FMA/C/0005) and the Salama SHIELD Foundation (which is a not-for-profit organisation, registered in Canada, Malawi and Uganda, that secures its funding primarily through individuals and corporate donors), that DGW was supported by McMaster University as a faculty member and a Career Scientist Award from the Ontario HIV Treatment Network (OHTN—ROGC101), M-IA was supported by a CIHR grant (No. HHP-53379), and PM was supported by a CIHR grant (No. 53379) for the submitted work; (2) the authors have no relationships with companies that might have an interest in the submitted work in the previous 3 years; (3) their spouses, partners or children have no financial relationships that may be relevant to the submitted work and (4) the authors have no non-financial interests that may be relevant to the submitted work. The researchers worked independently from the funders and fulfilled all of the grant requirements for reporting to the CIHR and the NAC. SSF Malawi

functioned as the implementing non-governmental organisation (NGO) partner in the research; because it is respected in Malawi, it had easier access to stakeholders and key communicators among faith-based organisations (FBOs) and faith-based communities than an academic team from McMaster University with no direct affiliation to either the University of Malawi or the FBO administrative bodies would have had.

**Ethical approval** Ethical approval provided by the McMaster University Research Ethics Board (REB File No. 2002 023), which ensured compliance with the Tri-Council Policy Statement and the McMaster University Policies and Guidelines for Research Involving Human Participants. Participants gave informed consent before taking part.

**Contributors** This research was conceived and designed by DGW, who wrote the grant proposal to the Canadian Institute of Health Research, hired PM and M-IA and co-facilitated all the conceptual events. PM oversaw data gathering and, with research assistants (RAs), conducted interviews and focus groups. M-IA managed the project, conducted interfaith and intercultural workshops and co-wrote with DGW the grant proposal to the National AIDS Commission. DGW, PM, M-IA and RAs participated in the analysis and interpretation of data. All three authors co-wrote reports to the donors, participated in drafting or critically revising this article and gave final approval of the version to be published. All authors had full access to all of the data in the study and can take responsibility for the integrity of the data and the accuracy of the data analysis. Jane Willms provided editorial direction and helped to draft and revise this article. DGW is guarantor.

**Provenance and peer review** Not commissioned; externally peer reviewed.

**Data sharing statement** Transcripts of the conceptual events are available upon request to researchers for review, interpretation and analysis.

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# Malawi faith communities responding to HIV/AIDS: preliminary findings of a knowledge translation and Participatory-Action Research (PAR) project

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This paper reports on the preliminary findings (year one) of a four-year intervention and Participatory-Action Research (PAR) project in Malawi. Project goals are to enhance the response capacity and effectiveness of Faith Community (FC) leaders to the problem of HIV/AIDS. Ethnographic interviews with FC leaders were conducted. Intercultural training sessions and theological events were also held using a participatory method called conceptual events. Preliminary results indicate a commitment on the part of faith community leaders to enter into a dialogue with other sectors and faith traditions in addressing the common, critical concern of HIV/AIDS. All FC leaders share a common feeling that they are a small moral voice in this fight against HIV/AIDS, drowned out by a 'big voice' promoting condom use by donors and government. FC leaders are expected to present themselves as having an authoritative voice with respect to protecting the soul, but at the same time are sincerely searching for ways to speak about HIV/AIDS in more practical ways. Condoms become a metaphor for resistance. For example, FC leaders wish to know how the message of condom promotion (a behavioural and technical argument) might be grafted onto what they would posit as a moral message of care, prevention and support. This challenge is made even more complex by the quiet assumption to incorporate the truths of African traditional religion (ATR) in the construction of an ecumenical theology of faith, hope and compassion.

**Keywords:** compassion, conceptual events, condoms, constructions of God, theology

## Introduction

Histories have been exchanged for gossamer hopes of freedom untethered to tradition (Schroeder, 2001, p. xiii).

In March 2003 in Malawi, conservative estimates put the HIV prevalence in the 15–49 age group at around 14% nationally. The HIV infection in people aged 15–49 is concentrated in younger age groups, particularly women. There is evidence as well that the infection rate in younger females aged 15–24 is about four to six times higher than in their male counterparts. Malawi has one of the highest infection rates in the region and in the world (National AIDS Commission, 2003).

Tragically, current intervention programmes, which primarily focus on information, education and counselling (IEC), have had limited success at creating significant, sustained behaviour change among Malawians, as evidenced in increasing HIV prevalence rates, data on condom acceptance and condom use and non-reduction of sexual partners.

In this social and cultural context, population and community-based efforts directed at prevention, social and behaviour change, counselling and care need to re-consider *who* are the most effective and culturally compelling agents of change. While clinicians, government-funded health educators and Non-Government Organisation (NGO) project officers are critically important purveyors of messages of HIV/AIDS risk and prevention, in the African setting, other

influential agents and spokespersons may be even more effective communicators of these critical health concerns. Father Emmanuel Agundo has argued that African Christians should be encouraged to access traditional healers in addressing the problem of HIV/AIDS since they promote health and healing, and accommodate the fundamental imperatives expressed in ATR (Makondesa, 2003). We recognise the legitimate role of traditional healers in addressing the problem of HIV/AIDS (Green, 1999a; 1999b; Willms, Johnson, Chingono & Wellington, 2001), but in this instance concentrate on the particular role of FC leaders and their use of theological languages<sup>1</sup> in addressing issues of stigma and discrimination with respect to HIV/AIDS.

Throughout sub-Saharan Africa, FC leaders are particularly well positioned to become central agents of change in this work. They are persuasive, influential and provide a constant source of inspiration and influence in matters of life and death. They are also expected to speak with authority. As such, they provide an enabling resource during the critical events experienced in the lives of their adherents, for example, rites of passage, illness, healing and sickness. Yet structurally and experientially, there is a particular reluctance within some FCs to be more engaged in this work. Based on our findings, we suggest that this attitude reflects the dilemma of having to speak with certainty and authority, yet also admitting that they do know how best to talk about the difficult sub-

ject of HIV/AIDS (how it occurs, why it has happened and how it can be prevented in faith-based settings where condoms are not condoned).

FC leaders admit that they are not comfortable talking about sexuality. Furthermore, while FC leaders are intimately involved in comforting and caring for those in their midst who have lost family members to HIV/AIDS, this component of caring is often not reflected in the theological languages used. Languages of guilt, fault and sin continue to dominate the discourse on why and who is infected with HIV, resulting in adherents experiencing the concomitant blame, stigma and shame. FC leaders talk about the need to break the silence surrounding AIDS, but continue to struggle with how to open this discourse safely and comfortably, for themselves as well as for their adherents.

This research acknowledges an ethos of stigma and discrimination surrounding HIV/AIDS within FCs. Where does this discrimination and blame come from? Based on our interviews, it emerged that these expressions of blame may be symptomatic of deep, core cultural values — understandings of what is considered to be true, and which cause persons to marginalise, separate from and shun those that are perceived to have broken the moral requirements of life within an FC.

In this context, this research seeks to find ways for FCs to embrace and support those infected and affected.

The central questions are two: (1) how can FCs be approached and enjoined in an HIV/AIDS intervention process that would result in the generation of theologies of faith, hope and compassion with respect to HIV/AIDS, and in the construction of an ecumenical theology of HIV/AIDS, and (2) how would social and behavioural prevention, supportive care and counselling programmes be designed and implemented within FCs that meet the felt needs of their adherents? An ecumenical (or shared) understanding of these concerns is the preferred end result. The question is how to construct and develop a shared, theological perspective on HIV/AIDS.

This paper reports on this complex and challenging research, and provides some preliminary findings on the process itself, and importantly, the anthropological experience and theological perspectives of FC leaders who are struggling with notions of God in the midst of HIV/AIDS. At this preliminary stage in our research, we report on findings reflecting the first objective: the methodological process utilised, the present dilemma with condoms and how condoms emerge as a metaphor for resistance, and an advancing conceptual framework for a theology of HIV/AIDS.<sup>2</sup>

## Literature review

A bruised reed he will not break,  
a smouldering wick He will not snuff out.  
In faithfulness he will bring forth justice ...  
(Isaiah 42:3–4)

### **Constructing a theology of HIV/AIDS**

In light of the gravity of HIV/AIDS, especially in places hardest hit by the pandemic (sub-saharan Africa), some are wondering about the nature of God in all of this, and reflecting on a

theology of HIV/AIDS for our time. Systematically, theologians have written about the nature of God in a number of ways. For this time, there is a need to understand God in the midst of threats of nuclear war or an environmental crisis (Kaufman, 1985; McFague, 1987), a God that is appreciated in a post-modern world of individuation and the demise of any singular truth paradigm (Kaufman, 1972), or a God that is not simply male but reflects and expresses female qualities and characteristics (Gilligan, 1982). These and numerous other theological scholars appear to agree that a theology for our time (McFague, 1987, p. x) requires a process of deconstructing notions of a God that suited a previous tribal and patriarchal culture. The work required, they suggest, is one that enters a process of 're-mythologising the relationship between God and the world' (McFague, 1987, p. xi).<sup>3</sup> These process requirements are particularly poignant during this time of HIV/AIDS.

### **Theologies of care and compassion with respect to HIV/AIDS**

Not surprisingly, significant theological reflections on the subject of a theology of HIV/AIDS are being constructed in Africa. FCs are faced with the challenge of caring for their adherents infected and/or affected by HIV/AIDS, and to start the caring process, they must be more receptive to hearing the stories of these persons (Van Deventer, 2002). Much of the stories reported on in grey literatures speak of those who suffer as persons who share Christ's suffering; as such, they are seen to embody authentic human suffering (Rassool, 2002). During our conceptual events, these sentiments were shared by Christians and Muslims alike. This present and immediate suffering is compared to an incarnational faith demonstrating God's *presence* in this suffering (Dowling, 2002, p. 96; Lauber, 2002; Ott, 2000). There is even a call to revitalise traditional, ritual healing processes to accommodate persons infected and/or affected with HIV/AIDS in the church, as a means to provide more culturally compelling systems of care, compassion and support (Makondesa, 2003). In this context, arguments are made that through spiritual re-birth and transformation, the persons infected and/or affected will be healed, and in this healing, find more positive ways to live (Christian Science Sentinel Staff, 2003). By attending to these very practical concerns, suggests Reverend Gideon Byamugisha, there is the opportunity to create a culturally acceptable theology of HIV/AIDS (Byamugisha, 2000).

All of this, however, will emerge if and when FC leaders 'break the silence' and discover processes for openly discussing issues of sexuality, gender and HIV/AIDS (Ndungane, 2002, p. 93). Some of the more progressive FCs are seeking to 'change the fatalistic language' (Buku, 2003) in which AIDS is usually described, in an effort to create settings and 'stories which provide hope instead of despair' (Jones, 2001).

### **Condoms and a theology of HIV/AIDS**

The Reverend Gideon Byamugisha from the Diocese of Namirembe (Kampala, Uganda) is a fresh, provocative and encouraging voice in this work. As a person living with HIV/AIDS, he continues to be an outspoken proponent for FCs being and becoming caring communities for those

infected and/or affected by HIV/AIDS (Jones, 2001, p. 36). He has addressed the issue of condom use and is a strong advocate for consistent 'condom use by those who, against ... teachings on abstinence, choose to be sexually active in marriage or outside it when they are either HIV serostatus blind, or outright positive' (Byamugisha, 2000, p. 51). As our preliminary findings support, he recognises the conflict in prevention paradigms (condoms vs abstinence), but as an FC leader, is religious in his resolve to reason through the arguments in a manner that will not compromise the teachings of his church, but rather, will transform and strengthen them.

The discussion on condoms persists as a contentious issue in this debate. It has divided FCs and created rifts in what could be a partnership of purpose. In our work, Roman Catholic FC leaders usually sided with Muslim sheiks, both of whom strenuously argued with faith leaders from other Christian traditions who are open to condoning condom use in some circumstances. To date, there does not appear to be an ecumenical perspective or agreement on the subject of condom use within FCs. The challenge to produce a shared theological perspective is central to our research.

### Study justification

If we [in the church] stay silent, we're killing people.  
Silence with HIV/AIDS means death!  
(Naomi Fuentes. In Lauber, 2002)

In 1999, the government of Malawi tabled a National HIV/AIDS Strategic Framework for 2000–2004 that included a more deliberate partnership with FCs in an effort to promote debate and advocacy among communities on sex-related values and beliefs (Government of Malawi, 1999a, pp. 11–13). Within this plan, the National AIDS Commission (NAC) Technical Working Group designated a Faith Communities Technical Working Group (TWG) as well as a sub-theme group with representatives from committed FC stakeholders. This latter group was organised to provide a grounded and pragmatic opportunity for reflection on what were the expectations of FC adherents in addressing HIV/AIDS concerns. Furthermore, a newly-created Behavioural Change Intervention Unit, in consultation with diverse stakeholders, developed a Behaviour Change Intervention Strategy where many of the cultural problems that contribute to the spread of the epidemic were identified (National AIDS Commission, 2002). This document stressed the need for a holistic, inter-faith approach to behaviour change, which could best be implemented through participatory development approaches.

Among the five key strategic actions delineated to mitigate the impact of the epidemic, two objectives support the research being reported on here, and are: in the context of the HIV/AIDS epidemic, support religious leaders in the re-working and development of their theology which builds hope, faith and spiritual support for people living with AIDS, and those affected by the epidemic; develop and disseminate Information, Education and Counselling (IEC) messages which underline new theological understandings of hope, targeting religious leaders, traditional leaders, counsellors, community support groups and the general public.

Supporting these initial government-driven policies, the recent submission of the government of Malawi to the Global Fund to Fight AIDS, TB and Malaria (2002) identified FCs as key participants in a necessary collaboration to ameliorate HIV/AIDS (Government of Malawi, 2002, pp. 18, 53–54). At present, the NAC continues to emphasize the fact that the government of Malawi will need the collaboration of NGOs and religious-based organisations to motivate and guide behavioural change.

While earlier inter-faith discussions set the stage for this kind of collaboration, there has been no sustained follow-up. In fact, inter-faith activities have been limited to specific events. This research honours the policy statements and support for an inter-faith and inter-sectoral partnership to address HIV/AIDS concerns.

As already documented in other contexts (Green, 2003), faith-based communities play a central role in various societies. Likewise, a pre-occupation with spiritual matters and the moral requirements of living within an FC is central to the lives of the majority of Malawians. What persons of faith receive is a moral, ideological and social template for living. And it is the FC leader who is called on, because of trust and faith in their calling, to provide the instruction and advice on how to address critical life concerns. Most of this occurs during normal worship and is experienced face-to-face, in mosques, churches and informal places of worship, but also during calendrical and critical rites and events (religious holidays, funerals, initiations, weddings). Yet some of these communicated truths occur in a more public way (radio, newspaper). For example, in the weekend *Religion*, the supplement to the best-selling daily (the *Nation*), leaders of various faith groups have an opportunity to voice their views (and interpretations) on a number of issues and situations (e.g. HIV/AIDS), providing direction to their followers. It remains to be seen whether they can effectively address the troubling and thorny issues intimately imbedded in the discourse on HIV/AIDS; that is, issues on gender relations, sex and sexuality, sin-fault-guilt, discrimination, stigma and blame.

The FC (as research context and setting) and the FC leader (as agent of behavioural and social change) provide a necessary yet challenging *entree* into the world of HIV/AIDS interventions. As posited by the NAC, FCs are well placed to be a part of this work, for the following reasons: (1) they have a long history of presence, proclamation and persuasion, (2) they have well-developed institutions and structures, (3) they are self-sustaining, (4) they have a captive and loyal audience which often meets more than once a week, (5) they have predictable leadership, (6) they cut across geographical, tribal, national, gender, age, ethnicity and other barriers, and (7) they have grass-roots support.

While faith-based work is rationalised on these grounds, we recognise the fact that the barriers to change are daunting and difficult. Most of the resistance derives from fundamental differences at the level of epistemology, culture and philosophy. The truth paradigms reflected in faith-based and religious communities do not easily incorporate the truths of science, and as such, require innovative processes for transformation and change in the construction of third-order conceptual systems (Willms *et al.*, 2001). Why might this be important?

In previous research with traditional healers in

Zimbabwe (see Willms *et al.*, 2001), we came to recognise the significance of how differences in understanding shape behaviour. Public health officers in Zimbabwe previously brought traditional healers (*ngangas*) together to talk about HIV and HIV transmission. They would speak to them about using clean razor blades with new patients. The recommendations and statements were based on scientific assumptions and truths. We learned that the traditional healers would often leave these educational workshops saying to themselves: we are protected by our spirits ... this does not apply to us. In short, their own spiritual interpretations were considered to be true, overriding anything that public health officers would offer as an alternative, scientific argument.

In this project, we are faced with a similar dilemma: how to reconcile scientific truths which recommend behavioural change (e.g. the use of a condom with a new sexual partner), with the strong and enduring principles of ATR, truths predicated on the authority of ancestral spirits, and, on living a 'worthy life' which come from the teachings of the Sacred Books (The Bible and the Qur'an, by those converted). Constructing a shared understanding of these concerns is critically needed to provide culturally compelling interventions for minimising high-risk behaviours.

This leads us to a final justification for this research. A collaborative research partnership with FCs offers an unprecedented opportunity for the development of new knowledge and its subsequent translation into effective programmes and policies, both locally and regionally. The commitment of the Malawi government to give the HIV/AIDS epidemic top priority provides the political will and focuses on resources critical to fighting the problem. With the willing collaboration of religious-based NGOs and faith-based groups, whose members provide much of the care and services to women, men and children in local communities, there is the opportunity for this research to produce a feedback effect for policymakers inside and outside of the church.<sup>4</sup> These organisations become both the consumers and producers of the research. Second, HIV/AIDS interventions with FCs could lead to the creation of best practices utilised by other FCs in the region. Our intent, therefore, has been to systematically interpret, represent and document every stage of this FC HIV/AIDS intervention — a participatory process where conceptual events (defined below) are organised within and between FC leaders, theological understandings are shared and critically discussed in a manner which does not compromise individual theological positions, yet where a shared perspective is made possible and ultimately viewed as beneficial in all FC settings. Finally, we argue that if successful in this translational and intervention work, this project could emerge as a signature piece for how it is that NGOs and government, assisted by health social science researchers, can successfully partner with FCs in addressing the many challenges of the HIV/AIDS epidemic.

### Method (data gathering)

Authentic human relationship creates the possibility of communication, and truth is in the shape of authentic communication.

(C Norman Kraus, *The Authentic Witness*, 1979)

The methodologies adopted in this research are mixed. They combine ethnographic with translational research methodologies, all of which are accomplished in the context of PAR. Ethnography seeks to uncover the truths that govern people's lives, and normally elicits these understandings through in-depth interviews, focus groups and participant observation. Key communicators (Willms & Johnson, 1996) express their view of events in the world through stories. The texts are then interpreted and content analysed, where emergent issues and themes are identified (Willms, Best, Taylor, Gilbert, Wilson, Lindsay & Singer, 1990). In the process of interpretation of the transcribed texts, the first two authors triangulated their findings (agreeing on emergent issues and themes) and corroborated these with the Malawian researchers whose first language knowledge of Chichewa was critical for working with metaphor and nuances of meaning.

Translational research, on the other hand, is a developing health social science discipline that attempts to bridge different disciplines, diverse realities and epistemologies, so that varieties of research evidence can be translated, and then applied to policy and action (Lavis, Woodside, Robertson, MacLeod & Adelson, 2003; Willms, 2000). We assume that there is *not* a seamless transfer of evidence or knowledge to persons living the reality of HIV/AIDS; for example, that if persons learn about HIV and HIV transmission, they will automatically change their behaviour. Rather, we assume a certain resistance to accepting beliefs (e.g. the scientific truths of HIV) that might challenge or compromise dominantly held beliefs (e.g. If I get AIDS, it is God's will and is not a result of my personal lifestyle or behaviours). Translational research, therefore, incorporates the methodology of conceptual events to bring discordant perspectives together, in an understanding of what can be shared as theologically true with respect to HIV/AIDS.

PAR is both a methodology and a philosophy based on the work of Paulo Freire (1970 and 1973). PAR works to change the experience and social conditions of vulnerable, marginal and oppressed peoples through a process of collective inquiry into their social reality (in this instance, the social reality is that as experienced within a particular FC). Participatory processes involve cycles of dialogue, reflection and action or praxis, which bring people to a critical consciousness about their situation, from which they generate new knowledge and social action aimed to transform their circumstances (see Smith, Willms & Johnson, 1997).

We combined the abovementioned methods through an intervention methodology which we call conceptual events. Conceptual events are trans-disciplinary, trans-contextual and trans-experiential fora that *intentionally* nudge persons with different truth perspectives (or paradigms) to construct a shared, ethically compelling framework for understanding the problem and the behavioural and social solution. They are usually one- to two-day meetings of persons (in this instance, FC leaders representing different faith traditions) who come together in a supportive environment for an intense period of facilitated discussion to talk about their particular understandings and experience with HIV/AIDS. Utilising PAR methods, these conceptual events enable the synthesizing of HIV/AIDS narratives and stories (scientific,

social-cultural, FC narratives and other evidence of ethical and moral reasoning).

Conceptual events are designed to involve an active, participatory, problem-solving process which not only draws on people's stories, but as FC leaders listen to each other's stories, they come to see new possibilities for change, develop merged understandings and negotiate solutions to a shared problem. It is an experience of transformation and shared learning, which affects both the outside researcher and participant-as-researcher. As FC leaders (representing diverse faith traditions) are brought together through these conceptual events, the intent is to generate shared understandings and an ecumenical theology of HIV/AIDS which does not compromise their individual faith perspective. The conceptual events organised in this research brought together leaders from a variety of faith traditions — principally Christian and Muslim. The more hard-to-reach independent, animist and prophet-led FC leaders are currently being recruited as this research continues.

In all instances, the conceptual events were facilitated by one of the authors. In an attempt to remain as objective as possible, the facilitator would not take sides or even express his/her particular viewpoint on a subject (e.g. for or against the use of condoms). Rather, he/she would use open-ended questions to begin the discussion, and once viewpoints were raised, would guide the conversation in ways that promoted an acceptance of different perspectives, but also, would eventually lead to a consensus of viewpoints and perspectives.

For example, the senior author asked a group of FC leaders during one of the conceptual events this question: 'How do you explain a God who permits the suffering experienced by HIV-affected or -infected women and children?'. Interestingly, the answer to this question underscored the divide between Western thought and African thought, more than it did any disagreement between the FC leaders assembled. It emerged in our interpretation that such a question does not easily compute with African thought — where life experience is about suffering and where God is seen to 'come alongside'. With respect to theodicy, Western thought might tend to separate God from human sufferers, rather than bring God and human sufferers closer together.

### Analysis and interpretation

All the conceptual events, in-depth interviews, theological events and intercultural training sessions were audio-taped and transcribed. The person taping the conceptual events also transcribed the tapes. As a Chichewa-speaking Malawian, she took notes during the sessions, and referred to them during the transcription process. The third author, also Chichewa-speaking, then went through all the audio-tapes one more time to ensure that the transcription authentically and accurately reflected what FC leaders said during the conceptual events. All the sessions were conducted in English, yet from time to time, an FC leader might use Chichewa to explain a thought or notion more clearly to the rest of the participants. This was translated as accurately as possible into English by both the transcriptionist and the third author. However, when this occurred during the sessions (i.e. an FC leader would need to explain something in

Chichewa and not English), the facilitator would ask someone to immediately translate, and agreement as to the meaning of the text would be achieved through a process of consensus.

All texts were interpreted and analysed using a nine-step process of ethnographic interpretation created by the senior author and colleague (see Willms & Johnson, 1996). The nine-step process involves (in condensed form): (1) reading the narrative text twice, focusing on categorising what has been said, and finding a word or phrase from the text to describe the content; (2) on a blank sheet of paper, listing these words and phrases — in short, generating a preliminary list of topics; (3) rewriting the list grouping related topics, then setting the list aside; (4) re-reading the narrative text — this time, underlining key quotations, jotting questions, interpretations and insights in the margins; (5) repeating step 2 with the new material written in the margin — this is the preliminary list of emergent issues and themes; (6) combining the lists created in steps 3 and 5 to produce a first draft for a coding scheme; (7) taking another narrative text and with this preliminary coding scheme, coding the text — at the same time, continuing to underline key quotations and jotting questions and insights in the margins, as well as making note of any new topics in the margins; (8) making revisions to the preliminary coding scheme because some codes may be too broad while others may need to be collapsed into a single code and new codes may need to be added; (9) coding all data and re-coding data that was coded using earlier drafts. Two persons independently do this task. Periodically, a small subset of the data is compared and inter-coder reliability assessed.

These were the interpretive process steps used in this research.

### Design/sampling justification

We must enter into dialogue with other sectors of society, to learn and to share information and resources.

(Archbishop Harry Kaitano, African Independent Church)

Twenty FC leaders were interviewed using a semi-structured interview format. Eight conceptual events — in this instance labelled theological events — were held that brought together FC leaders from the following faith traditions: the Quadria Muslim Association, Assemblies of God, Baptist, African Baptist Assembly, Victory and Jordan Pentecostal, Roman Catholic, Seventh Day Adventist and Evangelical Lutheran. Finally, twelve intercultural training events were held with selected grass-roots workers of the participating FCs. The training included a re-thinking and discussion of the terms community, change, vulnerability, care and prevention (World Council of Churches, 1999), followed by explanations of how to work with people in a participatory manner, how to elicit reliable information, how to choose informants, how to interview and conduct focus groups — in short, how to utilise research in generating 'best practices' in the work the 'trainees' are conducting under their respective FCs. The overarching question was: how do we put our beliefs and our understandings into practice? This, of course, entailed considering the following: how do the teachings of the Sacred Books inform who we are as

grass-roots workers; what are the values that inform what we do; how we do it? And further, how do we know that we are doing the work of God? In this process, Christians from different denominations and Muslims would cite passages of their respective Books and compare notes in terms of their understandings and approaches. The group also learned to be more needs-oriented and to focus on the people they were serving.

These interviews, intercultural training sessions and theological events were held in the Lilongwe catchment area. Lilongwe is the capital city of Malawi and as such, is the geographical setting for government offices. It also provides the address and site for a large number of NGOs, international donors and FC headquarters for the country.

Present funding restrictions have not permitted us to work in all three areas of the country. Our intention, however, is to begin in the Lilongwe catchment area, and then gradually move outwards.

## Results

'AIDS = American Ideas to Discourage Sex' (participant)

### **Conceptual events and the creation of a culture of dialogue within and between faith communities**

Our preliminary results indicate a sincere and highly committed interest on the part of FC leaders in entering into a systematic and sustained dialogue with other FC leaders on the question of HIV/AIDS. As one CCAP (Church of Central Africa Presbyterian) key communicator stated: 'we are very, very interested in working with other FCs in forums'. This suggests both a sympathetic appreciation of the recommended participatory process (through conceptual events) but also a shared sense of the urgency of the HIV/AIDS crisis. Everyone seems to agree that concerted efforts are required in overcoming disagreements in faith perspectives in addressing the problem of HIV/AIDS. While there are distinct theological differences between the FCs who are participating in this applied research project (e.g. Muslim and Christian), there is a desire and interest in creating an ecumenical theology of HIV/AIDS. Interestingly, the tenor of statements made by the majority of FC leaders suggested that this collaborative effort would strengthen individual FCs in challenging government and donor interventions, which they seem to feel are undermining faith-based and spiritual understandings of how to effectively come to terms with this issue.

### **Constraints to implementing an FC position on HIV/AIDS**

These are the perceived constraints and experiences of resistance collectively expressed by FC leaders on how best to address the problem of HIV/AIDS in spiritual and faith-based terms. First, there is the problem of *outside* (i.e. government and donor) resistance to their *inside* stance — messages dominated by reference to abstinence, fidelity and, in some instances, the non-use of condoms. It is not the case that the government disagrees with the message of faithfulness and abstinence; it is just that the condom message seems to drown out these other, moral options. As such,

there is palpable evidence in the discussions held with FC leaders that it is *us* against *them*. As one leader said, 'we need to defeat this campaign'. These sentiments were reflected during numerous interviews and conceptual events. These statements also express a deeper concern, that being their relative powerlessness *vis-a-vis* government, external donors, business (the pharmaceutical companies) and the research community. These others preach condom use. This reflects a shared sentiment that they (the other) are strong, have a voice and are monied. Compared to these loud voices, FC leaders feel weak, poor and vulnerable. In this environment of suspicion and concern, conspiracy theories abound.

During these conceptual events, FC leaders were surprisingly vulnerable as they reflected on the issue of what is wrong *within* their FCs. Some leaders said that there continues to be cultural practices that enhance the risk for HIV transmission; for example, extra-marital sex culturally sanctioned at weddings and funerals. Also, they said, there remain strict taboos about talking about sex within the church and FC, and even talking about HIV/AIDS. While progress has been made, there remains a culture of silence on the subject. Additionally, there is the problem of FC leaders being unapproachable: they do not understand the issues, are judgmental and continue to use a language of blame that marginalises their people. For persons (especially women in their community) infected or affected by HIV/AIDS, it causes them to remain silent and to go elsewhere for assistance and support. Many reported on the fact that these persons go to leaders outside of their FC for supportive counselling and care. In short, the church and mosque was still seen to be a place lacking in love, compassion, understanding and care. All of these were sentiments expressed by FC leaders themselves.

A final concern discussed is that of the role of ATR in addressing the problem of HIV/AIDS. The few women leaders represented in the conceptual events countered male arguments on the issue of the role of ATR in these matters. The men said: 'we are new creatures in Christ — the old [namely ATR] has passed away!'. The women said: 'ATR still influences our lives in the present, in spite of the fact that we are Christian or Muslim'. One woman leader drew a picture of a tree in three parts. There was an elaborate and extensive root system (which she labelled ATR), a trunk which stood alone and appeared to be separated from the root system (which she labelled Christianity) and the leaves and branches (which she called the fruits and product of our lives). Interestingly, in her diagram, the trunk was separated — if not severed — from the rest of the tree (the roots and the fruits). She went on to tell a number of stories on how dreams (the product of ATR) continue to influence her life, in spite of her Christian faith, and implied that Christianity and Islam needed to accommodate ATR in addressing HIV/AIDS concerns. An important principle for ATR, of course, is that of procreation, fertility and fecundity — arcane principles which are threatened by the marketing of condoms.

All of this reinforces the difficult challenge of coming to terms with competing epistemologies and truth paradigms. We concur that there are at least four truth paradigms that could potentially compromise the effectiveness of FCs in

addressing the problem of HIV/AIDS. These are: (1) a Western/secular paradigm — promoted by Western governments and international agencies and which use the language of empowerment, economic development, capacity-building and structural adjustment, (2) a bio-medical paradigm — promoted by the Western-trained scientific and health research community, which uses the languages of risk, HIV/AIDS, ARVs, VCT (Volunteer Counselling and Testing), epidemiological trends (incidence, prevalence), bio-statistics and transmission routes, (3) a missionary/church, religious and FC paradigm — promoted by churches and mosques and which uses moral and spiritual languages, which in the era of HIV/AIDS is often expressed as sin and guilt, but also in more redemptive terms such as love, forgiveness and salvation, and finally, (4) an African-indigenous paradigm, which defers to traditional values and clan-based accountabilities and sentiments: the role of ancestors and spirits, the importance of fecundity, land, sexuality and fertility.

All four paradigms co-exist in the Malawian FC, and are voices that affect how effective interventions should be introduced to minimise the risk of HIV transmission. We could argue that most of these paradigmatic approaches are distinctive, bounded and not easily receptive to change and transformation. What we are searching for are culturally compelling HIV/AIDS interventions that respect the truths that govern peoples lives (e.g. a particular faith stance that is built on moral principles) but which also incorporate what is known to be an effective (technical, behavioural) means of protection (e.g. condom use where there is unknown risk).

### **Constructions of God**

What are the notions of God that emerge through these conceptual events?

First of all, God is seen to be 'in this with us'. As one leader paraphrased from Scripture, 'in trouble He is with us'. Leaders reinforced this belief by speaking of the 'whence-ness of God ...'. God is seen to be incarnationally present, grounded and available for His people to 'cling to' — a God metaphorically likened to the root system of the tree mentioned above. The *axis mundi* of their faith (an anchoring and rooted strength), this God is viewed in personalistic and relational terms.

Yet this is also a God of active control, agency and intervention. Many spoke of the fact that 'He is angry with us and has allowed this to happen'. Interestingly, most FC leaders were reticent to talk about God as a punishing God (though some did), but rather suggested that 'God has *allowed* this to happen ... [HIV/AIDS] is a *consequence* of our sin'. In short, while God is seen to be this soulful comfort and strength (the deep roots that require persons to cling to Him for support during a time of suffering), He is also viewed as the Someone who 'actively acts' out of 'anger' — the Someone who 'allows and permits this to happen' because His people have not been faithful.

### **Considering the experience of HIV/AIDS-infected or -affected persons**

Persons of faith who are infected or affected by HIV/AIDS suffer greatly. Women are frequently impoverished in the

process and say that they look to their FC for practical support and care. What is of interest here is that the explanation given for their suffering is not so much linked to the disease in their body but rather to the separation that occurs in community — with people and with their God. As one leader stated, 'both kill!' Whether considered a punishment from God, or more mildly, the consequence of someone's (not necessarily their own) moral indiscretion, real suffering occurs at the level of emotion and experience within or without the community of faith.

This suffering is only exacerbated by the inability within FCs to 'break the silence'. To date, many churches, mosques and FCs do not have a structure (or process) in place for dealing with Persons Living with HIV/AIDS (PLWA).<sup>5</sup>

### **Faith community interventions, the discourse on condoms and preferred faith community strategies**

What about the issue of condoms? It would seem that is a kind of shared confusion amongst FC leaders as to the place of condoms in this discussion. Leaders would say, 'God is not in the condom'. What they do agree on is a feeling that recommending condom use is not the primary strategy for HIV/AIDS control. Rather, they suggest that a moral argument is fundamentally required in HIV/AIDS interventions. When interpreting these remarks, it became clear that it is not so much an issue of deliberately speaking against the use of condoms, but rather finding a way to legitimately talk about condom use in certain circumstances. If a moral argument (that of protecting the soul) becomes the major intervention strategy, grafting onto this a technical argument (using a condom) may eventually be seen as credible and necessary.<sup>6</sup> What remains is the challenge as to how this can be accomplished in a way that is unique to FC situations, and where they do not feel co-opted by government and donors, but rather fulfill a special and authoritative voice.

### **Discussion and conclusion**

'[What] we know is a very little thing, but there is hope against hope'  
(study participant)

### **Required change and the challenges faced by faith communities**

Given the above report on preliminary results and findings, there are some significant challenges still to be faced in the process of constructing an ecumenical theology of HIV/AIDS.

First, it would seem that there is critical need for both a systematic and practical theological argument with respect to the response of FCs in addressing the problem of HIV/AIDS. To date, there are numerous anecdotal references to HIV/AIDS experiences but few publications in the literature which provide a foundation for thinking through these complex and difficult issues. Systematically, there is a need for the theological reasoning on notions of God in the context of HIV/AIDS. Practically, there is a need for theological reasoning on appropriate systems of care in the context of FCs. For

example, if a woman's husband has died of HIV/AIDS and she is subsequently impoverished, how can she avoid sex-for-exchange (Spittal, 1995) as the only available means to feed herself and her children? What is the practical role for the FC in this instance? How does the discussion of condom use or non-use enter this discussion? What about AIDS orphans? How do we morally reason through emerging constructs of family, marriage and community in the context of communities devastated by this disease? These are present and anticipated moral concerns and require the combined thinking of ethicists, theologians, social scientists and numerous other stakeholders and influential people at the level of government, non-government organisation, business and community.

Second, condoms emerge in these discussions as a metaphor for resistance, a symbol of what separates FCs and their distinctive notions of truth from that of government, donors and the scientific community. And yet, there appears to be a commitment on the part of FC leaders to engage the condom discourse, but only in a manner that does not threaten or compromise a moral algorithm for HIV/AIDS prevention.<sup>7</sup> The challenge therefore is to create a faith-specific process for grafting condom messages onto this moral narrative. This will require the same urgent attention as that of systematic and practical theological reasoning on the matter of HIV/AIDS.

Third and finally, PAR and intervention research must continue in the Malawi setting, using conceptual events. These conceptual events should engage FC leaders in a process of discussion and debate that does not compromise their individual faith stance, but rather causes them to move towards an ecumenical theology of HIV/AIDS. These conceptual events should also be expanded to include and involve of committed, non-judgmental stakeholders and influential agents from government, NGO, business and broad community sectors. Without these voices coming together as equals, it will be difficult to transcend and transform the truth paradigms which separate and divide (whether faith-based, scientific, donor or even that of ATR). At present, the languages we use are evocative of 'us and them', men and women, Western and traditional, weak and strong, loud and quiet. This too can change! The discourse on HIV/AIDS prevention must change, if we are to find a language of love, compassion and care for those infected with and affected by HIV/AIDS.

## Notes

- <sup>1</sup> A satellite symposium was recently held at the International Conference on AIDS and STIs in Africa (ICASA, Nairobi, Kenya, 21–26 September 2003) called The Role of Religious Leaders in Reducing Stigma and Discrimination Related to HIV/AIDS. Chaired by Ambassador Stephen Lewis (United Nations Secretary General Special Envoy for HIV/AIDS in Africa), panel members spoke to the impact of theological languages with reference to HIV/AIDS within FCs and asked: 'how do we construct a theology of HIV/AIDS that reduces stigma and discrimination?' This question underscores the complex challenges we are facing in the research reported on here.
- <sup>2</sup> There is a burgeoning literature on a theology of HIV/AIDS in Africa. We are cognisant of this work (see References) and have been influenced by these writers, FC leaders and theologians.

Our view, however, is that more theological thinking is required that is both systematic and practical in nature. Once this occurs, FC leaders can adopt these theological policies and translate them into practical programmes for HIV/AIDS care for their communities. Yet they also recognise that transformed beliefs are not automatically reflected in behaviour change. More compassionate behaviours on the part of FC members can result in theological growth and change (see Byamugisha, 2000).

- <sup>3</sup> This theological tradition is supported by previous advances in the sociology of knowledge, a perspective that posits that all knowledge (as well as notions of truth and of God) is socially constructed (Berger & Luckmann, 1967). Many persons of faith do not agree with this position: for them, statements of truth are theistically-given and -driven, and not socially-made, -derived, or -constructed (Kaufman, 1972). African cultures are particularly prone to a theistic truth paradigm, which makes the work of *constructing* a theology of HIV/AIDS enormously difficult.
- <sup>4</sup> One prominent spokesperson in the Malawian FC, a Reverend Dr Augustine Musopole of the Malawi Council of Churches (MCC), suggested that this research might have another important impact — *how we do church!* By that he implied that women and youth will emerge as having a prominent voice in the affairs of the church, and not be simply usurped by their male leaders. As such, working towards a theology of HIV/AIDS could alter organisational dynamics within FCs, particularly as the hidden voices of a structurally silenced leadership (women and youth) become increasingly heard, acknowledged, and legitimised.
- <sup>5</sup> At a recently held symposium on the role of religious leaders in reducing stigma and discrimination related to HIV/AIDS at the 13<sup>th</sup> International Conference on AIDS and STIs in Africa held in Nairobi, Kenya from 21–26 September 2003, an Anglican priest from South Africa spoke of the self-stigmatisation, fear and self-blame that occurred in learning about his HIV status. There was the 'stress of being hidden', in the context of recognising that the church has no system in place to deal with persons like him.
- <sup>6</sup> Fathers Bernard Joinet and Wilhelm Nkini (1996), in *The Fleet of Hope*, posit a practical algorithm for sexual experiences — the choice of abstinence, fidelity and technology (condoms). Their approach skilfully navigates the resistance of his church to condom promotion.
- <sup>7</sup> Paul Farmer (1992) posits what he calls a moral calculus for understanding the discrimination, stigma and blame associated with persons infected with or affected by HIV. His argument refers to the understanding of the social experience of those affected — experiences of poverty, gender inequities and power imbalance. Our argument builds on this calculus, and seeks to advance a moral algorithm for HIV/AIDS prevention, counselling and care through FCs and their leadership. By moral algorithm, we search for a means and process for theologically reasoning risk and vulnerability (i.e. advancing an HIV theology of faith, hope and compassion) and the behavioural consequences of embodied truths so prescribed (i.e. how to act and be more compassionate and caring within a faith community).

*Acknowledgements* — We gratefully acknowledge the financial support of the Canadian Institutes for Health Research (CIHR), project number HHP 53379. Additional funding has come from the Salama SHIELD Foundation (SSF), the implementing NGO partner in Malawi and the National AIDS Commission (NAC) of Malawi (ref. no. NAC/10/05/59). Initial support for developing the project proposal was generously provided by World Vision Canada (WV-C). Dennis Willms is personally funded through the Ontario HIV Treatment Network (OHTN) as a Career Scientist, which has made this research possible. We also sincerely thank AJAR reviewers who provided constructive comments, as well as Ann Conroy, Gunnar Bjune, Rosalee Karefa-Smart and Susan Walker.

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## APPENDICES

### Appendix 1

#### Partnerships

Throughout the project period, Salama SHIELD Foundation Malawi (SSF-M, a non-governmental organization/NGO registered in Malawi in 2002) engaged in a wide variety of partnerships with faith-based organizations (FBOs) and faith-based communities (FBCs) in Malawi. Initially, SSF-M partnered with leaders *within* representative FBOs and FBCs. Participant observation, in-depth interviews, focus groups, and intercultural training sessions were used to elicit the theological perspectives of these leaders and their communities, to document, over time, their emerging and more inclusive theological stance as they addressed HIV/AIDS issues, and to train selected community workers to conduct participatory research in their respective faith communities that would elicit grassroots views on how to put religious beliefs into practice in the context of HIV/AIDS.<sup>1</sup> SSF-M also partnered with leaders *across* different Christian and Muslim FBOs and FBCs, conducting *conceptual events* to advance a shared theological perspective on HIV/AIDS issues.

In addition, SSF-M worked with governmental and educational organisations involved in addressing HIV/AIDS issues and with experts in the fields of psychology, epidemiology, and medicine.

The following faith-based organisations (FBOs) participated in this research:

Seven umbrella or “mother” bodies of Christian and Muslim faith communities:

- Anglican Council of Malawi (ACM)
- Charismatic and Pentecostal Association of Malawi (CHAPEL)
- Episcopal Conference of Malawi (ECM)
- Evangelical Association of Malawi (EAM)
- Malawi Council of Churches (MCC)
- Muslim Association of Malawi (MAM)
- Quadria Muslim Association of Malawi (QMAM)

Eleven mainline Christian churches:

- African Baptist Assembly Malawi Inc.
- Archdiocese of Blantyre (Catholic)
- Assemblies of God Church
- Baptist Convention of Malawi
- Church of Central African Presbyterian - Blantyre Synod
- Church of Central African Presbyterian - Livingstonia Synod
- Church of Central African Presbyterian - Nkhoma Synod
- Diocese of Chikwawa (Catholic)

- Anglican Church - Upper Shire Diocese
- Mangochi Diocese (Catholic)
- Seventh-day Adventist Church

Six smaller churches:

- Faith of God Church
- Free Methodist Church
- Independent African International Church
- Jordan Pentecostal Church
- Mt Hermon Pentecostal Church
- Victory Pentecostal Church

## Appendix 2

### The Methodology of *Conceptual Events (CEs)*

The senior author (DW) developed the methodology of *conceptual events* (CEs) as a participatory action research process (PAR) that would transition from (1) ethnographic understandings of critical health and development issues to (2) programmes and interventions that provide practical solutions. Focus groups, in-depth interviews, and participant observation (the usual, triangulated methods of ethnography) elicit relevant information. In this instance, the health-service and health-policy challenge was to build on ethnographic understandings of the *risk reality* of HIV/AIDS and then provide compelling and appropriate interventions and programmes for faith adherents who are at risk from and affected by HIV/AIDS.

In the development of this intervention methodology, we were informed and influenced by the scientific writings of Lev S. Vygotsky. His intent was to “establish dialogues across disciplines” such as “pedagogy, special education, aesthetics, linguistics, history, neuropathology, and neuropsychology.”<sup>2</sup> To establish such dialogues, he posited, requires that one is willing to become “unbalanced”<sup>3</sup>; these dialogues need to be established “across time, across space, across theories, across praxis, and across cultures.”<sup>4</sup> Within a “community of praxis,”<sup>5</sup> one is permitted to investigate how “cultural artifacts” (in this instance, the condom) are mediated, reconstructed, and transformed within cultural-historical time. As posited by Holland and Cole, “cultural artifacts are mediating devices that demand the bringing together of schema and the social and material peculiarities of historically specific situations.”<sup>6</sup>

Methodologically, the active ingredients of the *conceptual event* (CE) process are as follows:

1. One brings together stakeholders who share a common concern. (In this instance, the problem/concern is that faith leaders acknowledge the fact that HIV is present within their faith communities.)

2. Once assembled, they confirm and underscore the common concern as a shared experience within their respective communities.
3. The group, once assembled, identifies a possible solution to the common problem (such as the use of condoms).
4. The group – co-facilitated by a member of the research team and a respected leader chosen by the participants – poses a question. (In this instance, the question was: “*Should we, or should we not, promote the use of condoms to prevent HIV transmission?*”)
5. A discussion of possible answers to the question occurs (in this instance, the idea and construct of the condom as a preventive solution).
6. Arguments are made on all sides of the issue (in this case, arguments promoting the use of condoms, or rationalizing non-use of condoms, are predicated on theological interpretations).
7. The group identifies the differences in opinion, argument, and rationale (for and against the use of condoms for preventing HIV).
8. The group reasons, argues, and speaks to the issue (in the context of extant theological arguments, current science, and preventive dilemmas).
9. The group, recognizing the critical nature of the problem, finds “common ground” and reaches a consensus of understanding.
10. The group realizes a common humanity of concern and purpose (in this case, rationalising/theologising a moral imperative – “to save lives”!).
11. The participants formalize their agreement and construct an argument (by spiritualizing the condom, they protect innocent lives and thereby prevent the taking of a life, which is a “greater evil” than infidelity).

These are the active ingredients of a *conceptual event (CE)*. The organizers and facilitators do not know what the outcome will be in these CEs. Their purpose is to bring together individuals who are affected by a shared problem (eg., HIV/AIDS), and who are seeking to secure solutions and responses to this shared problem. The group may have determined, together, that condoms were not the solution. This, in itself, would have been an interesting outcome.

In this research, the CEs began with a big question: “What are we to do with the issue of condoms as a preventive measure for HIV transmission?” Then they dove deep into the domain of being “unbalanced” in this search for understanding (bridging the domains of health science, theology, culture, and context). The aim was to co-construct a solution to the problem and, in this instance, to determine an effective and morally reasoned response.

The only given in a CE is that stakeholders come to the same table, agree that they have a problem in common (in this case, that HIV/AIDS has affected them as faith communities), and agree that they are vulnerable, “not knowing,” and determined to find solutions to the problem.

## Appendix 3

### Nantipwiri Colloquium: participants and contributions

The Nantipwiri Colloquium was held at the Nantipwiri Pastoral Centre in Limbe, July 24-27, 2004. This colloquium brought together approximately forty participants: the most senior leaders of FBOs in Malawi; leaders of FBOs and FBCs in the Lilongwe area; leaders of grassroots community groups in the Lilongwe area; faculty members from the Department of Theology and Religious Studies (TRS) at Chancellor College, University of Malawi; representatives of the National AIDS Commission of the Republic of Malawi (NAC); and physicians and multidisciplinary researchers in the medical and social sciences from the University of Malawi, Makerere University in Uganda and McMaster University in Canada. (The latter group included: Dr John Kumwenda, a specialist in HIV/AIDS treatment and management from the Department of Medicine, College of Medicine, University of Malawi; Dr Nelson Sewankambo, a clinical epidemiologist, HIV/AIDS specialist, and Professor of Medicine and Principal at the Makerere University College of Health Sciences; Dr Dixie Maluwa Banda, a specialist on behavioural change (education and psychology) from the University of Malawi; and Dr Dennis Willms, a medical anthropologist, and Dr Marie-Ines Arratia, a social anthropologist, both from McMaster University.) The grassroots leaders had participated in intercultural training sessions in advance of the Nantipwiri Colloquium; their participation at Nantipwiri demonstrated their commitment to the dialogue.<sup>1</sup>

Dr Sewankambo spoke of the need to graft moral messages onto a scientific understanding of HIV transmission. Dr Kumwenda, at this CE and others, provided technical, scientific information on the characteristics of HIV transmission and the safety of condom use through the use of PowerPoint presentations; these presentations helped to clear up misconceptions, so that faith leaders could discuss HIV/AIDS issues with the support of up-to-date, scientific knowledge.

Bishop Andrew Kaitano of the Independent African International Church presented the views on HIV/AIDS gathered in Lilongwe-area meetings of FBCs and other community groups. Bringing these views to the senior faith leaders of Malawi was a crucial part of the process of developing a theology that would result in behaviour change at the grassroots.

The learning process was facilitated by the oral presentation of papers by participating faith leaders, question-and-answer sessions, small group discussions, and visual presentations. A “popular education team,” organized by SSF-M to communicate HIV/AIDS messages in peer education programmes, brought a grassroots understanding of HIV/AIDS issues to the faith leaders through the use of drama, song, dance, poetry, and videos, encouraging these leaders to rethink their theologies in terms of practical problems on the ground, instead of limiting their discussions, as they often do, to their traditional doctrines.

## Appendix 4

### Methodologies for text analysis and interpretation

Our methodologies for analysis and interpretation of the CEs have been previously described in a report on our findings in year one of this project.<sup>1</sup> They are summarized below.

All of the CEs were audio-taped and transcribed into text by a Chichewa-speaking Malawian assistant who was fluent in both English and Chichewa; she took notes during the sessions and referred to them during the transcription process. The second author, also fluent in both English and Chichewa, then reviewed the audio-tapes and transcription to ensure that the transcription authentically and accurately reflected the comments made by faith leaders during the CEs.

The sessions were conducted primarily in English, but participants used Chichewa at times to explain their thoughts more clearly to other participants. When this occurred, the facilitator asked someone to interpret, and agreement on the English meaning of the Chichewa comments was achieved through a process of consensus. Based on these discussions of interpretation, the Chichewa comments were later translated into English by the transcriptionist and the second author.

The transcription was interpreted and analyzed using a nine-step process of ethnographic interpretation created by the senior author and colleagues.<sup>7 8</sup>

The nine-step process involves (in condensed form): (1) reading a narrative text twice, focusing on categorizing what has been said, and finding words or phrases from the text to describe the content; (2) creating lists of these words and phrases to generate a preliminary list of topics; (3) rewriting the list, grouping related topics, and then setting the list aside; (4) re-reading the text, this time underlining key comments and jotting questions, interpretations, and insights in the margins; (5) repeating step 2 with the new material written in the margins to create a preliminary list of emergent issues and themes; (6) combining the lists created in steps 3 and 5 to produce a first draft for a coding scheme; (7) taking another narrative text, and, with this preliminary coding scheme, coding the text – at the same time, continuing to underline key quotations and jotting questions and insights in the margins, and making note of any new topics in the margins; (8) making revisions to the preliminary coding scheme – some codes may be too broad, some may need to be collapsed into a single code, new codes may need to be added; and (9) coding all data and recoding data that was coded using earlier drafts of coding schemes. Two analysts complete these tasks independently. Periodically, small sub-sets of the data are compared, and inter-coder reliability assessed.

Each CE participant's comments were coded separately, and then compared to the others, as explained in steps (7) and (8) above; this generated a comprehensive coding system, which was then applied to all of the narrative texts, as explained in step (9) above.

The content of the new theology described in this paper emerged through the facilitated discussions in the CEs and the statements of participating faith leaders. The interpretive methodologies outlined above were used to corroborate these new theological understandings.

## Appendix 5

### ***Conceptual events in Malawi leading to the development of a new theology on HIV/AIDS that promotes preventive practices***

In year one of this project, members of different faith traditions participated in eight *conceptual events*, and grassroots workers in participating FBCs attended twelve intercultural training workshops.<sup>1</sup> The first *conceptual event* organized in 2004 was the Nantipwiri Colloquium, held at the Nantipwiri Pastoral Centre in Limbe, July 24-27.

At the Nantipwiri Colloquium, FBO and FBC leaders struggled with issues related to condom use or non-use. Leaders from the Catholic and Muslim FBOs formed an alliance and argued forcefully that: condoms should not be used under any circumstances; condoms are flawed and frequently break; condoms may have the virus embedded within them; and condoms promote infidelity and immorality and discourage natural creation and procreation. Muslims and Catholics were aligned against more “open” faith-based leaders, such as Anglicans, who advanced the condom option; in other words, Muslims and some Christians came together in partnership against the perceived liberal views of those who promoted or accepted condom use in preventing HIV/AIDS.

The medical clinicians participating in this colloquium responded in the following way: while acknowledging the importance of engaging faith leaders in the HIV/AIDS prevention discourse through their communications in churches and mosques, they pointed out that any moral debate in a public health context must incorporate accurate and up-to-date scientific information.

Participating FBC leaders (grassroots spiritual leaders engaged daily with people living with HIV/AIDS) expressed concern that while they were dealing with the hard realities of sexual practice and suffering and death, the senior leaders of FBOs were engaged in talking about the theology of sexuality and lacked understanding of the problems being addressed at the grassroots level. The colloquium attempted to build bridges between these two “realities” and resulted in the tabling of a declaration entitled, *Our faiths and HIV: expressions of hope and compassion for the people of Malawi*.

Faith leaders discussed, revised, and ratified this declaration at the Ryalls Hotel Colloquium, held in Blantyre, September 27-28, naming it *The Ryalls Declaration* (Appendix 6). All heads of the mainline Christian churches and Muslim FBOs in Malawi signed the declaration and consensually agreed they would continue an interfaith dialogue and work toward advancing an ecumenical theology of HIV/AIDS. They selected a small group of senior faith

leaders to determine how best to proceed; this group met at the Superior Hotel in Blantyre, December 12-13, 2004.

At this meeting, the participants proposed the establishment of a *Forum for theological dialogue and research on HIV/AIDS* as a way of implementing the landmark objectives articulated in the *The Ryalls Declaration*. They believed this forum would facilitate the shaping of a common theological voice as research partners continued to engage in PAR on HIV/AIDS.

At a January 2005 CE attended by representatives of faith leaders at the Superior Hotel meeting and the Malawian Interfaith AIDS Association (MIAA), it was suggested that the *Forum for theological dialogue and research on HIV/AIDS* be integrated as a research focus into the Kachere Institute for Research on Religion, Culture and Society of the Department of Theology and Religious Studies, Chancellor College, University of Malawi, in partnership with SSF-M as of May 2005. This proposal was supported by representatives of five mainline churches, the umbrella bodies of FBOs, and other FBOs and FBCs.

At the first *Forum for theological dialogue and research on HIV/AIDS* in August 2005 at Victoria Hotel in Blantyre, forum participants were challenged to consider how theological reflection could help to free and unite them in their efforts to address HIV/AIDS issues. At the second *Forum for theological dialogue and research on HIV/AIDS* in January 2006 at Victoria Hotel, the participants acknowledged that the truth is “messy,” especially with respect to HIV/AIDS, and that they should resolve to meet the “mess” head on and find life-giving ways to communicate their messages. By the end of this three-day forum, the faith leaders agreed to a landmark statement concerning their views on HIV/AIDS and gave it to the press on January 27, 2006 (see text box in paper).

## **Appendix 6**

### **THE RYALLS DECLARATION**

*Blantyre, Malawi  
September 28, 2004*

Acknowledging the grass-roots colloquium that occurred July 27-30, 2004 at Nantipwiri Pastoral Centre (Limbe, Malawi), where members of various faith communities issued a declaration entitled, *Our Faiths and HIV/AIDS: Expressions of Hope and Compassion for the People of Malawi*, we, the leaders of Christian and Muslim faith communities, sign this declaration, and thereby endorse the fact that we are committed to strengthening our efforts in ameliorating the problem of HIV/AIDS:

We, the undersigned:

1. commit to sustaining a *dialogue* within and amongst faith communities through colloquiums, events, and forums that challenge theological perspectives and practices, which, if not transformed, will continue to compromise the health and well-being of individuals who suffer, are victimized, or are affected by HIV/AIDS within our respective faith communities;
2. commit to strengthening our partnership and work with the government of Malawi, which, by virtue of the fact that HIV/AIDS is an extraordinary public health concern, bears the primary responsibility for addressing the complex issues and consequences associated with HIV/AIDS;
3. commit to dialoguing with government about the way in which the message of abstinence and mutual faithfulness is communicated, and about how this message and other messages of prevention are designed and disseminated;
4. commit to upholding the rights and dignity of the infected and affected against stigmatisation and discrimination;
5. commit to assisting those who have the clinical need to attain their right to fair and equal access to ARVs and other medical services, in keeping with the principle of solidarity and our experience as persons of faith of “being one body”;
6. commit to continuing to support and encourage Home-Based Care (HBC) initiatives, and in the process, to lobbying for means (enabling resources both human and financial) to provide equal support for volunteers, the majority of whom are presently women, and also to working to ensure that HBC workers are properly trained;
7. commit to strengthening and creating programmes within faith communities that address the specific and practical needs of persons infected by HIV/AIDS and their families, children in particular, who are affected and frequently orphaned;
8. commit to recommending that faith-based organizations establish and support an AIDS Desk in settings where this is not yet the case, and that HIV/AIDS intervention and prevention initiatives are mainstreamed within all programmes;
9. commit to working towards the re-shaping and re-constructing of notions of gender and sexual relations through a dialogical process, conducted within faith communities, which upholds principles of equity, justice, and respect, so as to confront gender disparity as a major determinant of risk for HIV;
10. commit to supporting the special needs of infected and affected families, while recognizing that faithful spouses, who may have become infected in the context of marriage and stigmatised as a result, require special supportive services within their faith community;
11. commit to critically re-evaluating traditional cultural practices, as well as contemporary or modern practices, that enhance the risk for HIV transmission, but also to recognize that in some instances, traditional, as well as contemporary or modern systems, can be made to be effective sociocultural vehicles for communicating matters of faith and the risk for HIV transmission;
12. endorse the Nantipwiri Youth Declaration (July 27, 2004), which says:  
As youth, we declare to live as role models as we follow your footprints [i.e., that of respected faith community leaders]. We promise to work together with you and to use available resources for the intended purpose

- in fighting HIV/AIDS and in providing home-based care services, as well as to engage in many other areas that would require our participation;
13. commit to continuing to articulate faith, hope and love in ways that will mitigate against HIV/AIDS in our society;
  14. commit to focusing on children, in addition to youth, who are also extremely vulnerable to HIV/AIDS and a neglected and overlooked age group;
  15. commit to seeking ways to share resources amongst faith communities;
  16. commit to promoting behaviour change and accessing VCT services; and,
  17. commit to praying for our nation in this time of HIV/AIDS.

## Appendix 7

### Constructing the idea of a “spiritualized condom”

How did the construction of the idea of a “spiritualized condom” occur?

During the CEs, one of the most contentious issues faced by interfaith leaders was the use/non-use of condoms to prevent HIV. Initially, Roman Catholic leaders sided with Muslim faith leaders in opposing condom use – in a strenuous rebuke of faith leaders who were condom-friendly. In the context of the HIV/AIDS prevention debate, condoms were controversial and contentious; and yet, this group of interfaith leaders was committed to finding *common ground*. The CEs provided the opportunity to take the problem of condoms to another level of moral and theological reasoning.

Initially, the discussion amongst these interfaith leaders underscored their differences and the effect of the moral dilemma of HIV/AIDS on their preaching and teaching.

*Pastoral theology which is worth this name is one that is informed by ethics and biblical theology. Emotional, uninformed, opinionated pronouncements are unbecoming to leaders and are unhelpful to society as a whole. The position that the faith community takes has to be one that is moral and pastoral and thus defensible. Moral resolutions are not made on simplistic assumptions, opinions, or feelings. The common problem of all moralities is how to apply universal precepts to particular circumstances (an Anglican Bishop and co-facilitator of CEs).*

The particular circumstance in question was that of HIV/AIDS and the use/non-use of condoms. Extending his argument during the CE, this Anglican faith leader said:

*For me, the matter is life and not necessarily liberty. Because when you look at the debate that is going on over the condom, it seems to be we are against the sexual liberty that it is going to bring, not so much the life that it is going to save.*

A Baptist lay minister stressed the need to “*theologize at the grassroots – to see how the condom can still achieve traditional (sexual) purposes.*” Most of these preliminary discussions on the controversial aspects of condom use occurred in the context of traditional African notions of sexual relations:

*Sex has to do with sexual fluids, and if these fluids are interfered with, are you still having sex? If it is ritual sex, are the mystical powers of the fluids operative? (Anglican Bishop).*

Constructing the idea of a “spiritualized condom” was, therefore, accomplished through a process of moral reasoning in the context of culture and sexuality, but also marriage.

*When you begin to think about sex and marriage ... is sex natural ... is marriage natural? What comes first – sexual relations in the natural state or marriage? Because marriage becomes a construct of society as it develops, we therefore construct a morality around an institution we have created called marriage. (Anglican Bishop)*

Interestingly, the process of constructing the idea of a “spiritualized condom” was articulated with a re-construction of theological positions, and especially positions on “lesser and greater sins.”

One of the faith leaders initially most resistant to the promotion of condoms (inside and outside of marriage) was a Pentecostal preacher and faith leader:

*Anybody who takes advantage of a condom is already confused in the mind and is already sinful in his mind. It is not the condom that makes him sinful.*

When agreement was reached among the disparate faith leaders on the “spiritualized condom,” this Pentecostal preacher said:

*When I talk about condoms, I am not defending a weakness at all. I am simply trying to portray a picture of a God who is looking to the suffering of his people.*

A Muslim faith leader weighed in his support:

*The intention for those who invented the condom was, I think, for preventive measures – that can be spiritualized.*

An Anglican Bishop, one of the CE co-facilitators, was reasoned and articulate in his arguments to spiritualize the condom:

*Can the faith community in Malawi justify its moral stance on condoms in the face of this pandemic? I am persuaded to say that it cannot. There is a good at stake, and that good for me is life. The question then is, shall we save life or let it die? It is evil to let people die but it is less so to allow them to live with the help of condoms. The choice is on the side of life. As an act of faith, and with fear and trembling, the faith community should take the leap of faith in the dark, trusting in the mercy of the Lord, and see condoms as a moral choice in this situation of HIV/AIDS. This position takes seriously the sinfulness of mankind and goes on*

*to suggest that God, in his infinite mercy, will understand well-meaning, well-intentioned actions taken by finite beings.*

As participants in an interfaith group, discussing these contentious issues within the safe domain of a *conceptual event* (CE), these faith leaders were able to work out the controversial aspects of condom use – culturally, morally, scientifically, and theologically. What emerged was a refining of not only the common ground, but a theological response that they could then use in their own faith settings: i.e., a language they could use for their preaching on the “spiritualized condom.”

One participant posited:

*We cannot afford, as a community of faith, to overemphasize one (education) at the expense of the other ( condom promotion). Our teaching must focus on a holistic approach; there is no one, quick fix to the epidemic.*

A Muslim faith leader began to work with what he would say to his faith adherents in the mosque:

*Knowing the fact that not all people adhere to these strict religious requirements, we need to tell them that ... in such situations where you feel you cannot manage, do not give (the virus) to others because spreading it to others is even more dangerous because then you are going to kill innocent people.*

One of the more charismatic of faith leaders said that he would say to Malawians and the world:

*Whosoever knows that he (sic) is diseased with the virus HIV and cannot abstain, they must use a condom to prevent transmission. **It is spiritual.** It is right, because you prevent the suffering of others. (emphasis added).*

Other leaders in this interfaith group confirmed this consensus of emergent thought:

*We preach to the living. You would not be preaching to a dead person; you would be preaching to a live one, and so first of all you need to save life, and then talk about these other issues later – so I think “spiritualizing the condom” is a good thing.*

*The hardcore will always condemn condoms. Remember the saying in Chichewa: life cannot be entrusted to somebody else – you are responsible for it. And so if you think you are in a situation where a condom might help you, use it, regardless of what anybody else says.*

## Appendix 8

### Unanswered questions and future research

The barriers to change at the level of individual behaviour in the context of HIV/AIDS are formidable. Though researchers in the field of HIV/AIDS acknowledge that there is potential for FBOs and FBCs to play an important role in prevention, few studies have examined the role of faith leaders in the tasks of breaking down stigma and encouraging prevention strategies. Research in Tanzania has found that faith leaders involved in HIV education activities can help break down stigma, but may face opposition from senior pastors.<sup>9</sup> Interviews in Malawi have revealed that faith leaders are critical of government and media messages that promote condom use; they say these messages undermine the teachings of faith communities on abstinence and fidelity.<sup>10</sup>

Our research challenged faith leaders to radically change their theologies and communicative behaviours in ways that would lead to behavioural change among their followers and encourage condom use. Further intervention work needs to be done to “script” theological messages on the “spiritualized condom” to parishioners and faith adherents. Our research should be followed by translation research that would permit the formation of faith messages, sermons, and HIV prevention statements that could readily be used by faith leaders “at the grassroots.” Further research, therefore, is required to translate these deliberations and conclusions on the “spiritualized condom” into popular messages that can easily be used by faith leaders at every level of Malawian society. We are in the process of evaluating: (1) the ways in which the *conceptual events* held during this research project have influenced the sermons given by faith leaders (e.g., are their messages more compassionate, caring and hopeful?); and (2) the ways in which behaviours have changed amongst the adherents of FBOs with regard to HIV/AIDS.

We need to understand better the relationships between theologies and behaviours in FBOs and FBCs. How, for example, do emerging theological understandings of HIV/AIDS affect the behaviours of persons vulnerable to HIV transmission? And how do changes in the responses of FBOs and FBCs to HIV/AIDS concerns lead to theological and cultural understandings that are more accepting, supportive, and hopeful with regard to people living with HIV/AIDS?

Further research is needed on how condom use – if generally spiritualized – can be negotiated in the context of marriage. Making condom use a moral and religious requirement for all sexually active persons, whether married or not, raised new ethical questions with theological implications. Would this moral/religious requirement of condom use make it easier for men to rationalize sexual relationships outside of marriage, because the need to discuss issues of infidelity or condom use with their spouses would be weakened? Would faith leaders, by arguing that condom use is a moral and religious obligation, actually be helping to silence honest discussions of fidelity in marriage? Such questions, embedded as they are in the cultural context of Malawi, highlight the profound importance of appropriating the intellectual and experiential capacity of stakeholders in HIV/AIDS research.

Future CEs should address the question of how the theological reflections reported here apply to the female condom. This has not been discussed during any of the CEs to date. It was already a “big issue” to discuss the male condom.

The roles that faith leaders might play in preventing the spread of HIV need further study and elaboration. How can faith leaders be most effective in their contributions to HIV/AIDS prevention, support, and education? What are the steps they must take to help ensure behaviour change among individuals in their communities? And what kinds of working relationships among faith leaders, medical and scientific specialists, policy makers, and community workers best contribute to behaviour change among individual actors?

There is also a need for more transdisciplinary and translational studies that bridge the different epistemological worlds and “truth paradigms” of biomedicine and theology; such studies are needed in order to create culturally compelling health interventions. The translation of scientific truths into truths that are meaningful for grassroots communities creates enhanced opportunities for behavioural change among people who are vulnerable and at risk.

All these questions need further study in the global effort to combat the HIV/AIDS epidemic.

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