

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.¹ 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.”² To establish such dialogues, he posited, requires that one is willing to become “unbalanced”³; these dialogues need to be established “across time, across space, across theories, across praxis, and across cultures.”⁴ Within a “community of praxis,”⁵ 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.”⁶

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.¹

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.¹ 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.^{7 8}

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.¹ 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.⁹ 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.¹⁰

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.

References

¹ Willms, DG, Arratia, M-I, Makondes, P. Malawi faith communities responding to HIV/AIDS: preliminary findings of a knowledge translation and participatory-action research (PAR) project. *African Journal of AIDS Research* 2004;3:23-32. <http://ajol.info/index.php/ajar/article/view/7140>.

² Lima, ES, Vygotsky in the international scene: a brief overview. *Anthropology & Education Quarterly* 1995;26:490-499. <http://onlinelibrary.wiley.com/doi/10.1525/aeq.1995.26.4.05x1066z/abstract>

³ Ibid., 496.

⁴ Ibid., 497.

⁵ Lave, J, Wenger, E. *Situated learning: legitimate peripheral participation*. Cambridge: Cambridge University Press, 1991.

⁶ Hill, DH, Cole, M. Between discourse and schema: reformulating a cultural-historical approach to culture and mind. *Anthropology & Education Quarterly* 1995;26:475-489. <http://onlinelibrary.wiley.com/doi/10.1525/aeq.1995.26.4.05x1065y/abstract>

⁷ Willms, DG, Best, JA, Taylor, DW et al. A systematic approach for using qualitative methods in primary prevention research. *Med Anthropol Q* 1990;4:391-409. <http://www.jstor.org/pss/649223>.

⁸ Willms, DG, Johnson, NA. Essentials in qualitative research: A notebook for the field. Hamilton, Canada: Department of Anthropology, McMaster University, 1996.

⁹ Hartwig, KA, Kissioki, S, Hartwig, CD. Church leaders confront HIV/AIDS and stigma: a case study from Tanzania. *Journal of Community & Applied Social Psychology* 2006;16:492-97. <http://www3.interscience.wiley.com/journal/113440477/abstract>.

¹⁰ Rankin, SH, Lindgren, T, Kools, SM, Schell, E. The condom divide: disenfranchisement of Malawi women by church and state. *J Obstet Gynecol Neonatal Nurs* 2008;37:596-606. <http://www.ncbi.nlm.nih.gov>.