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Christian Communities and Prevention of HIV among Youth in KwaZulu-Natal, South Africa

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Abstract

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Young people in South Africa, particularly females, are at great risk of acquiring HIV, and heterosexual sex is the predominant mode of HIV transmission. In order to curb the epidemic the Department of Health encourages all sectors in the society, including religious institutions, to respond effectively.

The present thesis seeks to increase the understanding of the role of Christian communities in prevention of HIV for young people. Three denominations in KwaZulu-Natal were selected to reflect the diversity of Christian churches in South Africa: the Roman Catholic Church, the Evangelical Lutheran Church in Southern Africa, and the Assemblies of God.

Using qualitative interviews the first paper explores how religious leaders (n=16) deal with the conflict between the values of the church and young people's sexuality. Study II reports on attitudes to HIV prevention for young people among religious leaders (n=215) using questionnaire survey data. Study III investigates how young people (n=62) reflect on messages received from their churches regarding premarital sex by analysing nine focus group discussions. In the fourth paper, based on questionnaire survey data, we report on young people's (n=811) experiences of relationships with the opposite sex and their perceived risk of HIV infection.

The view that young people in churches are sexually active before marriage was common among religious leadership. The majority of religious leaders also reported that they are responsible for educating young people about HIV prevention. Religious leaders who had received training on HIV were more likely to run a life skills programme for young people, however they were ambivalent about prevention messages. Young people reported premarital sexual abstinence as the main HIV prevention message from their churches. The majority responded that they had received information about HIV in church. To be in a relationship was common, more so for males for whom multiple relationships also were viewed more acceptable. To perceive themselves at risk of HIV infection was common.

Further training for religious leaders is needed to enable them to manage the conflict between the doctrine of the church and their willingness to assist young people in the transition into adulthood.

Keywords: HIV prevention, Young people, Religion, Religious leaders, Sexuality, HIV risk, South Africa

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To Patrik

List of Publications

This thesis is based on the following papers, which are referred to in the text by their Roman numerals.

I Eriksson E, Lindmark G, Axemo P, Haddad B, and Ahlberg BM. Ambivalence, silence and gender differences in church leaders' HIV-prevention messages to young people in KwaZulu-Natal, South Africa. *Culture, Health & Sexuality, 2010;12(1): 103-114.*

II Eriksson E, Lindmark G, Haddad B, and Axemo P. Involvement of religious leaders in HIV prevention, South Africa. *Swedish Missiological Themes,2011;99(2): 119-135*

III Eriksson E, Lindmark G, Axemo P, Haddad B, and Ahlberg BM. Faith, premarital sex and relationships: Are church messages in accordance with the perceived realities of the youth? A qualitative study in KwaZulu-Natal, South Africa. *Accepted for publication in the Journal of Religion & Health,* 2011; DOI: 10.1007/s10943-011-9491-7

IV Eriksson E, Lindmark G, Haddad B, and Axemo P. Sexuality and HIV prevention: concerns of young people within faith communities in KwaZulu-Natal, South Africa. *Manuscript*

Content

Abbreviations

ABC	abstinence, faithfulness, condom use
AICs	African Independent Churches
AIDS	acquired immunodeficiency syndrome
ANERELA+	African Network of Religious Leaders Living with or Personally Affected by HIV
AOG	Assemblies of God
ARHAP	African Religious Health Asset Programme
CI	(95%) confidence interval
EAA	Ecumenical Advocacy Alliance
ELCSA	Evangelical Lutheran Church in Southern Africa
FBO	faith-based organization
FGD	focus group discussion
HIV	human immunodeficiency virus
IMCH	International Maternal and Child Health
INERELA+	International Network of Religious Leaders Living with or Personally Affected by HIV
MAP	Medical Assistance Programme
NGO	non-governmental organization
OR	odds ratio
PACSA	Pietermaritzburg Agency for Christian Social Awareness
PMU InterLife	(Swedish) Pentecostal International Relief and Development Co-operation Agency
SACBC	Southern African Catholic Bishops' Conference
SANAC	South African National AIDS Council
SAREC	Swedish Agency for Research Cooperation with Developing Countries
SAVE	safer practices, available medications, voluntary counselling and testing, and empowerment
Sida	Swedish International Development Agency
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization

Foreword

My interest in this thesis topic can be traced back to 1996 when I became a nurse. Already during my training I was one of a few students who showed an interest in international health by becoming an exchange student at Wrexham Hospital, Wales. My working experience is from two hospitals in Oslo, Norway, and the Uppsala University Hospital Akademiska sjukhuset, in Uppsala, Sweden.

I started to work with HIV prevention in faith communities during an internship at Medical Assistance Programme (MAP) International in Nairobi, Kenya, in 2000. During my 4 months in the country, I was exposed to the difficulties this non-governmental organization (NGO) faced when trying to educate religious leadership about HIV and AIDS.

These experiences motivated me to pursue further studies, and I completed a Master in International Health at Uppsala University, Sweden. For my Master report, I had the privilege of visiting South Africa for the first time. During my 2 months' stay I established contacts with religious leaders within the Assemblies of God (AOG) and interviewed young people about their knowledge on HIV and AIDS.

I was thereafter employed by PMU InterLife, the Swedish Pentecostal International Relief and Development Co-operation Agency, and in 2001 wrote their policy on HIV and AIDS. During this work I extensively studied the faith communities' response to the HIV epidemic and visited UK-based faith-based organizations (FBOs) working in low-income countries. It became clear to me that young people in faith communities wanted information about HIV from their churches, but issues on sexuality and HIV prevention appeared to be very sensitive topics in these communities. This finding raised new questions, such as: "What do religious leaders teach young people about HIV prevention?" and "How do young people in faith communities perceive these messages?" I have since then had the opportunity to visit South Africa several times to deepen my understanding related to these questions, which are the point of departure of my thesis.

This thesis has a multidisciplinary approach and the research team have contributed with their expertise from the disciplines of international health, sociology and theology. It is my hope that this thesis may facilitate collaboration between public health professionals and faith communities in order for them to work together in addressing issues related to HIV prevention for young people.

Introduction

The year 2011 marks 30 years of response to the human immunodeficiency virus (HIV) epidemic. In 2009, 33.3 million people worldwide were living with HIV (1). Of the estimated 15 million people living with HIV in low and middle-income countries and needing treatment, only 5.2 million have access to such treatment (1). Globally, 23% of all individuals living with HIV are younger than 24 years, and young people aged 15–24 years account for 35% of all people becoming newly infected (2). Although knowledge about HIV among youth is increasing, only 34% had accurate and comprehensive knowledge of HIV in 2009 (1). Sub-Saharan Africa is the most affected region, accounting for 68% of all people living with HIV (1).

The HIV epidemic among young people in South Africa

South Africa's epidemic is the largest in the world, with an estimated 5.6 million people living with HIV (1). Acquired immunodeficiency syndrome (AIDS) is the main cause of maternal mortality in the country and also accounts for 35% of deaths in children under 5 years (3). Hopefully this will change as South Africa has achieved almost 90% coverage of treatment to prevent mother-to-child transmission of HIV (1). In 2010, life expectancy at birth was estimated to be 53.3 years for males and 55.2 years for females (4). Social factors, such as poverty, unemployment, migration and gender inequalities, increase vulnerability to HIV infection.

Most people are infected during unprotected heterosexual intercourse, and this is also the most common mode of transmission among young people (3). The median age of first sexual contact for youth currently aged 15–24 is 17 years (5). The HIV prevalence in the same age group is 8.7% (3) and the gender difference in HIV prevalence is of major concern. Among young people aged 15–24 years the HIV prevalence is three times higher among females (13.6%) than among males (4.5%) (3). One reason for this can be that young women often have older male sexual partners, who are more likely than younger men to be infected with HIV. As a result, HIV prevalence among women rises sharply at a young age, peaking when women are in their late twenties, while levels of HIV infection among men rise slowly, with higher prevalence when men are in their early thirties (3).

In an attempt to increase young people's knowledge about HIV transmission, life skills education has been implemented in secondary schools (6). Young people are also targets of messages on HIV prevention through television, radio, magazines and youth events organized by Lovelife, a non-governmental organization (NGO) with support from the government (7). Despite these efforts, the majority of youth in South Africa believe that they are at low risk of HIV infection (8-10), even though especially young men are engaged in high-risk partnering (11). In KwaZulu-Natal, premarital and extramarital sexual activity is highly stigmatized, particularly for young teenage women, and their relationships with a male partner are therefore often hidden (12).

Young people's sexuality in a South African context

From a historical perspective, young people's sexuality can be described as the interplay between two discourses. The first is rooted in an African culture in which sex is seen as healthy and as a normal part of the life cycle (13). In most South African cultures some sort of sex play or "external sexual intercourse" was permitted among young people, but was not supposed to lead to pregnancy (14). The practices were controlled by strong youth structures where peer groups monitored adolescent sexuality (13, 14).

The second discourse is rooted in Christianity, with a perception of sex as shameful and restricted to married couples. The introduction of these Christian attitudes brought silence about sexual issues as sexuality could no longer be discussed in public or within families (13). Furthermore, missionaries removed many cultural institutions, for example initiation schools that taught young men and women about sexuality, and how to relate to the opposite sex (15). A problem emerged when the teaching about sexuality was not replaced by the missionaries.

In the 20th century, sexual socialization through the youth structures also fell apart as a result of urbanization, migrant labour, Western education and Christian teachings (13). As a consequence, pre-marital pregnancies increased. The peer pressure that had previously controlled young people's sexuality now pushed youth to greater levels of sexual experimentation and violence. Young urban men who grew up in the 1940s and 1950s faced unemployment and secondary schooling was not common. For these male adolescents, the urban gangs provided some companionship, income (though often from criminal activity) and protection from other gangs. In the gang culture, affirmation of manhood was expressed by showing physical strength. Violence became the norm, including violence towards women (13).

In contemporary South Africa it is difficult to distinguish between what has been described as the African culture and the influences of Western Christian teachings. In a recent survey (n=1,504) on religion in South Africa,

80% of those surveyed were affiliated to Christianity (16). Among these, 73% believed that the Bible is the word of God and is to be taken literally. However, 47% of the Christian respondents also consulted traditional religious leaders and 50% participated in traditional African ceremonies to honour ancestors.

Rationale for including faith communities in HIV prevention

Christian faith communities exert a powerful influence in the communities where they operate and have credibility in the society, which is perhaps one of their major assets. Local churches are also present in both urban and rural areas and their extensive networks can be valuable in delivering health services (17). Since the mid-1980s, faith communities have provided care, treatment and support to those infected and affected by HIV, including orphans and vulnerable children (18). A World Health Organization (WHO) report from Zambia and Lesotho estimated that 30–70% of health care services in Africa are run by churches and faith-based organizations (FBOs) (19). Religious leaders have also provided pastoral and spiritual care to people living with HIV, and they may also influence political decision-making processes through their advocacy (20). However, some challenges for the faith communities in their response to the HIV epidemic have been noted. For example, many faith communities face problems with administration and financial resources, and documentation of good practices is limited (20, 21).
The contribution of the faith communities to the HIV epidemic has been acknowledged by the Joint United Nations Programme on HIV/AIDS (UNAIDS), but so has also the need to mobilize faith communities that are not yet responding to the epidemic (20). Research in this field is increasing (22), but it is important to identify examples of good practice within faith communities to deepen our understanding of the factors that enable some faith communities, but not others, to respond effectively to the epidemic.

In this thesis the term "faith communities" is used to refer only to the local churches which often have national and international links or networks. This definition differs from the term "faith-based organizations" (or "FBOs"), as used by UNAIDS to refer to both local churches and NGOs that are faith-based. As some churches also run development projects, we sometimes make use of both terms.

The role of religion for young people

In countries where religion is influential in local communities, religion and relationships – including sexual relationships – comprise two important

components of social life for young people. By providing individuals with education, rules, rituals, and social networks among peers as well as across generations, the local faith communities create a structural social environment where young people can be socialized (23). The churches may serve as a social entity for those youth who attend religious services, and may provide them with a sense of belonging, which is important during adolescence (23).

The relationship between religious factors and health outcomes among young people has been studied for decades. In general, religion is described as a protective factor for young people regarding sexual behaviour, and can be associated with behaviours such as delayed sexual debut (24), lower likelihood of voluntary sexual activity (25), and fewer sexual partners outside romantic relationships (26). In research on religion and health, scholars differentiate between distal and proximal domains of religion (27). The distal domains of religion mainly measure the individual's behaviour, such as religious affiliation, service attendance, and frequency of prayer. The proximal domains, on the other hand, measure the functions of religion for the individual, for example spiritual meaning, religious decision making and spiritual coping during an illness. Some authors argue that research on religion and health outcomes should include both distal and proximal aspects of religion to allow for a deeper understanding of specific aspects of religion that may or may not influence health (28).

HIV prevention messages

Since the discovery of HIV it has been considered vital to increase the knowledge about the virus so that young people may reduce their risk behaviours and avoid contracting the disease (29). However, because of the relation between HIV and sexuality, and because sexuality is a sensitive topic, there have been many public debates concerning the content of education programmes (30-32).

Initially the abstinence, faithfulness, condom use (ABC) approach was common in HIV education programmes. However, this approach has been criticized for a number of reasons. From a gender perspective it has been argued that women may abstain until marriage, and be faithful to their partner but still lack control over condom use. The approach is therefore less applicable to them. Furthermore, those with negative attitudes towards condom use have only supported the messages of abstinence until marriage and fidelity within marriage, sometimes called "abstinence-only programmes". The debate regarding the abstinence-only versus the abstinence-plus programmes (the latter including information about condoms) has been especially intense in the United States (33). Contrary to what some may fear, sex and HIV education programmes aimed at reaching young people, including

information on contraceptives and condom use, do not increase sexual activities among youth (34, 35).

A review of HIV education programmes for young people concluded that there are many similarities between programmes. The central differences between approaches are related to the way the purpose of HIV education is conceptualized (36). Three approaches were identified, namely "scientifically" informed programmes that aim to change risky behaviour, programmes that draw on notions of "rights", and "moralistic" programmes that promote conservative values. The last category often draws on traditional interpretations of religious values regarding sexuality.

However, within the faith-based communities an extensive range of views exist concerning HIV prevention. For example, the African network of religious leaders living with or personally affected by HIV (ANERELA+) have developed a comprehensive HIV prevention model known as "SAVE": Safer practices (covering all the different modes of transmission), Available medications, Voluntary counselling and testing, and Empowerment (education) (37). This model could be categorized as a "scientifically" informed programme, and illustrates the complexity when trying to categorize HIV education programmes.

The role of religious leadership in HIV prevention

It is recognized that religious leaders have a unique authority that plays a central role in providing moral and ethical guidance within their communities (20). However, religious leaders have faced difficulties in talking about HIV prevention in their congregations (38, 39). In the early years of the epidemic, many religious leaders thought that AIDS did not affect them or the members of their churches. When people living with HIV were found to be members of their own churches, many religious leaders reacted with denial. As a result, many people living with HIV experienced stigma in various forms from their churches (18).

Religious leaders can play both a facilitating and a hindering role in the creation of supportive social spaces to challenge stigma (40). Religious leaders who have contributed to addressing stigma within their own communities are those who personally live with HIV. Before 2003, very few religious leaders in Africa lived openly with HIV, fearing stigma and discrimination. In 2003, African religious leaders who were positively living with HIV founded a network and sought to address these issues. Partners to the network outside Africa proposed a global expansion, and in 2008 the International Network of Religious Leaders Living with or Personally Affected by HIV (INERELA+) was launched at the International AIDS Conference in Mexico City (37). The network aims to empower its members to use their positions within their faith communities to challenge stigma and provide

delivery of evidenced-based prevention, care and treatment services. In spite of the initial denial of AIDS, African religious leaders have been involved in HIV education in Trinidad (41), Senegal (42), Malawi (43), Mozambique (44) and South Africa (45).

Theology and the HIV epidemic

Internationally, theologians and practitioners have worked together to develop theological responses to the HIV epidemic. One important dialogue among religious leaders was initiated by UNAIDS in Namibia in 2003, focusing especially on stigma (46). The international dialogue among theologians has continued, exemplified in the ecumenical conferences at the international AIDS conferences in Bangkok (2004), Toronto (2006), Mexico City (2008) and Vienna (2010). Scholars in theology have addressed a range of topics related to the HIV epidemic, such as gender and violence (47), treatment (48), sexuality and condom use (49), sickness and suffering (50), sermon guidelines and liturgy (51) and theological education (52).

The Ecumenical Advocacy Alliance (EAA), an international network of churches and Christian organizations, has initiated a global theological dialogue on HIV prevention, which has resulted in a publication (18) presenting some theological difficulties regarding HIV prevention. One of the fundamental differences among theologians is between those who read the Bible as literal truth, and those who take a more historical or contextualized view. The different interpretations have differing views about how the scriptures should be applied to contemporary issues. Another difference lies in the understanding of the HIV epidemic. For some Christians, HIV prevention is understood as a moral issue, while for others, it is a public health problem, a gender issue or a social justice problem. Perhaps the main problem for the theological discussion on HIV prevention is that topics which have been taboo within the Christian tradition have to be addressed. These include sex and sexuality, gender inequality, violence, drugs, homosexuality and promiscuous lifestyles.

The examples mentioned above illustrate that theologians have responded to the HIV epidemic, and the ongoing conversation and publications are crucial to the educational institutions in the training of new religious leaders. Although theology is developing in relation to HIV, religious leaders in KwaZulu-Natal struggle when relating theology to their daily work in their local churches (53). This has limited open discussions on HIV by religious leaders and contributed to stigma towards people living with the disease.

Gender and the HIV epidemic

The HIV epidemic is recognized to be gendered as the epidemic disproportionately affects women. Today 50% of people living with HIV are women and girls (1), and in sub-Saharan Africa, for every ten men, 13 women become infected (1). Women are also disproportionately affected in terms of sexual violence, the lack of women-initiated prevention methods, stigmatization faced by those who are living with HIV, as well as women being the primary caretakers for HIV-infected relatives and family members (2).

The relationship between gender, and especially gender inequalities, and HIV prevention has become a major concern in addressing the epidemic. The WHO defines "gender" as referring to "the socially constructed roles, behaviours, activities and attributes that a given society considers appropriate for men and women" (54). Gender is consequently created by actions and social interactions, and is often defined as "doing gender" (55).

Social factors such as power imbalances and harmful social gender norms increase the vulnerability of both women and men to HIV infection. However, the consequences of gender inequalities in terms of low socioeconomic status and unequal access to education add to the greater biological vulnerability of women and girls being infected with HIV (1). Women also have little capacity to negotiate safer sex and access the health services they need (1). The social factors mentioned here are examples of structural gender inequalities in the society, as well as gender inequalities in intimate relationships.

In South Africa, violence and injuries are the second leading cause of death (56). Violence is deeply gendered, with men aged 15–49 years disproportionately engaged in violence both as victims and perpetrators. Furthermore, findings from South Africa have confirmed the association between violence and HIV infection. Women in South Africa who have experienced physical or sexual intimate partner violence, or who are in relationships with low equality, are at greater risk of HIV infection than women who do not experience these situations (57).

Explanations for violent behaviours among men could be found in the way boys are socialized within the context of contemporary South Africa. Although since the ending of apartheid in 1994 male adolescents have grown up within a democracy, the new politics have not removed notions of patriarchy and men's dominant role in public life (58). During apartheid and the fight for liberation in the 1980s violent behaviour among men increased, and violence is reinforced in the post-apartheid system. Male adolescents are socialized in this context. Employment is a key component of male identity; however, as many of these adolescents lack working opportunities their male identity is therefore also lost (59).

When men who had raped women were asked about their motives for rape, the researchers found that socialization from early childhood into social norms that legitimate the exercise of gendered sexual power was the main explanation (60). Furthermore, these men claimed that punishment of women was legitimate, and punishment was expressed though sexual violence. Moreover, social factors such as poverty, unemployment, access to firearms, alcohol, drug misuse and patriarchal notions of masculinity are driving forces of violence (56, 61).

Prevention of HIV in South Africa must take into account and address gender inequalities and ideals of masculinity. The dominant ideals of masculinity include demonstrations of toughness, defence of honour, and gaining high status when fighting, which may lead to risk-taking behaviour (62). Different power values in men and women as well as culturally based expectations of men to demonstrate their "manhood" in relation to women are gender norms that increase both men's and women's risk of HIV (63). Furthermore, the notion of sex being commonly viewed as a male domain where women are expected to be submissive, legitimates men to control women in intimate relationships (64).

Gender, religion and the HIV epidemic

Religion is one factor influencing the construction of gender roles, and perhaps it is especially important in countries where the majority of the population identify themselves as religious. Religion is often described as a factor that legitimizes gender inequalities and therefore, as outlined above, especially increases women's vulnerability to HIV infection. However, within Christianity the extent of gender inequalities varies between denominations. In Mozambique, Agadjanian (44) found that gender differences were less pronounced among members in mainline churches (churches established through Western missionaries) than in Pentecostal churches. For instance, women in the Pentecostal churches had less knowledge about HIV preventive measures than women in the Roman Catholic and other Protestant churches.

Within Christianity, gender inequalities are often mentioned in relation to patriarchal structures in the churches, and the dominance of men in leadership positions. Patriarchy within Christianity has a long tradition and can be traced back to the background culture that informs the Bible, which was patriarchal (65). Through history, theology has taken patriarchy to be the ordered structure of humans, and in that way legitimized patriarchy (66). The overall patriarchal context has also shaped attitudes towards human sexuality, and men have been socialized to be dominant in sexual relationships (65).

In Africa, African women theologians have raised their voices against the oppression of patriarchy that women experience in the wider society as well as within the faith communities (67). In 1989, the Circle of Concerned African Women Theologians (also "the Circle") was launched as a community of African women theologians who came together to encourage research on women's experiences of religion, culture, politics and socio-economic structures in Africa. Members of the Circle have promoted the teaching of gender issues in theological curriculums, encouraged research on HIV and AIDS in relation to religion (68) and invited African male theologians to address ideals of masculinity that can be harmful in relation to HIV (67).

Responses of the Christian communities to the HIV epidemic in South Africa

The South African government has acknowledged the involvement of churches in issues related to HIV, and in 1995 the Department of Health invited religious bodies to collaborate in addressing the epidemic. Later on, religious organizations were invited to become members of the South African National AIDS Council (SANAC), in order to increase the provision of care for people living with HIV (69).

It is difficult to generalize about the "Christian response" to the HIV epidemic in South Africa, since different Christian denominations provide a diversity of services to different client groups. A mapping study in the South African national HIV database found 162 FBOs working in HIV prevention and care related to AIDS, 96% of which had a Christian orientation (70). These faith communities and FBOs have diverse institutional profiles, ranging from small-scale projects run by religious groups at community level to national religious structures. Although policies on HIV are formulated within many FBOs these may not translate into plans of action and implementation. Poor documentation of existing programmes contributes to poor monitoring and evaluation of implemented programmes (71).

The Roman Catholic Church has taken numerous initiatives to respond to people infected and affected by HIV (72). The AIDS office of the Southern African Catholic Bishops' Conference (SACBC) collaborates with the government's Department of Health and FBOs, and leads the response to the HIV epidemic in a five-country region. The "Choose to Care" initiative has supported 140 projects with a focus on HIV education in Catholic schools, home-based care, services for orphans and vulnerable children, and treatment. An evaluation in 2003 concluded that the Catholic Church runs a comprehensive response to the HIV epidemic through its established network among congregations (73, 74). Between 2000 and 2005, the Catholic Church intensified its care and treatment activities and became the largest

care provider to people living with HIV, next to the government (69). Although in the early stages of the epidemic, local faith communities in KwaZulu-Natal were slow to respond, they have gradually increased their engagement on the epidemic (75).

Christian norms of sexuality

This thesis includes three Christian denominations that represent Roman Catholicism and Protestantism. Within the Protestant churches one Lutheran denomination and one Pentecostal denomination have been included. This section briefly outlines Christian norms of sexuality, as well as denominational differences regarding sexuality.

Throughout church history there has been a tendency to think of the body as "bad" and the spirit as "good" (76). The separation of sexuality and spirituality can be traced back to theologians active during the 3rd and 4th century. For example, St. Augustine (354–430), the most important medieval Christian theologian, viewed human sexuality in a negative way when he referred to sex in terms of the "shame, which attends all sexual intercourse" (77). This may be one reason why faith communities have difficulty in talking about issues related to sexuality (15). The difficulty for faith communities to address human sexuality is recognized as one of the major obstacles to their involvement in HIV prevention (38, 49, 78).

In general, Christianity in its various forms adopts the stance that sexual intercourse is reserved for the context of heterosexual marriage. Married partners are expected to be faithful to one other in a life-long commitment, and young people are taught that sexual abstinence prior to marriage is a Christian virtue.

Denominational variations in teachings on sexuality

According to the teachings of the Catholic Church, marriage is a sacrament ordained by God. Sexual intercourse is primarily meant for procreation and is only acceptable within marriage (79).

The Catholic Church considers human life as sacred, and as a consequence "husband and wife, through that mutual gift to themselves, which is specific and exclusive to them alone, develop that union of two persons in which they perfect one another, cooperating with God in the generation and rearing of new lives" (80). As a result of the teaching of "Natural Law", any artificial birth control methods will "deprive the nature" of man and woman, and is therefore not allowed. However, the church recognizes "the weakness of men" and has compassion for those who find adherence to the teaching of the church on sexuality difficult or even impossible. Nevertheless, it is the

duty of the priests and leadership in the Catholic Church to ensure that members know these teachings on marriage and contraception (80).

From a contemporary Lutheran Christian perspective, the goal should be to save all human life. Therefore, members should strive for abstinence before and faithfulness in marriage, but individuals must also be practical and protect life with available appropriate methods, including condoms (76). In 2002 the member churches of the Lutheran World Federation in Africa acknowledged that their churches had contributed to stigmatization of people living with HIV. Furthermore, the leadership committed themselves to breaking the silence and speaking openly about human sexuality and HIV and AIDS (81).

As described later in this thesis, Pentecostal churches and their leadership are more independent compared with both Lutheran and Catholic churches. Therefore the teachings in these churches may be more dependent on the individual religious leader. Furthermore, these churches as a social organization are different from the so-called "mainline" (Catholic and Lutheran) churches. According to Garner (82), four aspects of a social organization will determine its power to affect the behaviour of its members, in our case church members. These aspects are indoctrination (Biblical teaching), the religious/subjective experience (emotional involvement and level of participation in church activities), exclusion (the boundary that members experience between themselves and the wider society) and socialization (the involvement of members in the life of the church and the level of control over these activities). These aspects are important to the teachings on sexuality. Some Pentecostal churches strongly emphasize the importance of "being born again" and expect their members to follow the teaching of the church, including messages of premarital sexual abstinence. The Pentecostal church in Garner's study in KwaZulu-Natal possessed high levels on each of these aspects, and only members of the Pentecostal church had reduced extra- and premarital sex compared with members from mainline and African independent churches (AICs). Similar findings have been reported among Pentecostal university students in KwaZulu-Natal, who feared sanctions from their local church if they engaged in premarital sex (83).

Description of three denominations in South Africa

Although this thesis does not aim to represent the Christian churches in general in South Africa, the selection principle was to choose denominations that reflect some of the diversity of Christianity in South Africa. Therefore three denominations were purposely selected to capture the multiple responses of faith communities to HIV prevention among young people: the Roman Catholic Church, the Evangelical Lutheran Church in Southern Africa (ELCSA) and Assemblies of God (AOG). These were selected within

the major categories that can be distinguished in South African Christianity: "mainline", AICs and Pentecostal churches. It was not feasible to include the AICs, as English may be less spoken among members in many of these churches. Furthermore, as a researcher I was welcomed by the leadership in the selected denominations, which was necessary in order to gain access to study participants. Descriptions of the denominations in relation to structure and policies on HIV and gender are outlined below.

Organization and leadership structures

These denominations represent two of Christianity's major divisions: Roman Catholicism and Protestantism (Lutheran churches and AOG). The Roman Catholic Church is the world's largest Christian denomination (84), and the most hierarchal denomination in this study. At the national level, the bishops at the Bishops' Conference set the priorities for social work within the church. At regional level, parishes are grouped into dioceses. The bishop has to ensure that the teaching in the dioceses conforms to the doctrines of the Catholic Church. At a local level, the ordained priests head one or more congregations, defined as a parish. The Pope in Rome has the ultimate authority on matters of theology, and bishops are responsible to the Pope for their actions.

Protestant denominations can be divided into three organizational structures: synodical (Lutheran), congregational and connectional (AOG) denominations. The Lutheran churches elect bishops as head of the church in a region, called a diocese. As in the Catholic Church the ordained priest is head of the parish, and lay ministers lead the congregation in the parish when the priest is absent. The dean is head of the body of parish priests.

In the AOG, churches are accountable to each other through an official body of rules. In the churches, decisions are made by the congregation, usually by their board. The AOG is structured into three main sections according to population group: The Movement (Africans), The Group (whites) and The Association ("Coloureds", people of mixed race). During the apartheid years the AOG showed their criticism of the apartheid system by creating a collective board at national level, the General Executive. The sections work independently, but in the General Executive the sections collaborate on special issues important to them. There are also churches within the AOG that are not affiliated to any of the main three sections, the so-called "autonomous section". In the AOG, the pastor usually leads the congregation although elders (lay leaders) may play an important role in the church.

In general, protestant clergy have more autonomy than Catholic leadership in carrying out work in the community. However, the organizational structure of the denominations may not necessarily correspond to the influence the religious leaders have on their members. For example, the AOG has a looser organizational structure compared with the other denominations, but

their pastors may have a stronger influence on their congregation members due to mechanisms of social control, as described previously (82).

Policies on HIV and AIDS

The three denominations strongly emphasize premarital sexual abstinence for young people in order to avoid HIV infection. The Lutheran Church promotes the ABC approach, suggesting that the church recognizes that some young people are sexually active, and that they can use condoms to prevent HIV infection (85).

Regarding prevention, in 2003 the Catholic Church approved a life skills manual entitled, *Education for Life*, as a manual for a national youth programme (86). Life skills programmes are commonly used to prepare young people not only for sexual life but also for family life. In South Africa life skills programmes have become mandatory in secondary schools with the goal to increase knowledge about HIV transmission, develop skills to handle pressures for sexual intercourse and unprotected sex, and promote positive and responsible attitudes as well as strategies for coping with loss and grieving (6). The manual of the Catholic Church deals with issues such as sex outside marriage, peer pressure, substance abuse, as well as decision-making choices regarding health (86). The Catholic Church in South Africa does not encourage condom use except in the case of married couples with discordant HIV status, as it is recognized that this is necessary to prolong life. Regarding these situations, the South African bishops have stated that –

> The Church accepts that everyone has the right to defend one's life against mortal danger. This would include using the appropriate means and course of action (87).

Individual bishops have also promoted condoms in other circumstances. For example, Bishop Kevin Dowling of Rustenburg argues that especially women may demand that their partner use condoms in order to protect themselves from HIV infection (88).

Like the Catholic Church, the AOG only encourages condom use in the case of married couples with discordant HIV status (89).

Policies on gender

There is limited research on gender issues in the selected denominations and it is therefore problematic to describe how they differ in this field. The Pietermaritzburg Agency for Christian Social Awareness (PACSA) have tried to evaluate gender-related policies within South African churches, but only five denominations had available documents to be included in their study (90). The AOG was not included and it may therefore be assumed that

this denomination has less documentation on gender policies than the Roman Catholic Church and ELCSA, which were included in the study.

Nevertheless, the report confirms that patriarchy is established through different mechanisms in the local churches, for example through the socialization process where dominant attitudes, behaviours and moral perspectives are reproduced through the teachings of the church in various activities (sermons, Sunday school, etc). Furthermore, women are marginalized or excluded from decision-making structures at higher levels of the institutional churches. Although some churches include women in their decision-making structures, the number of ordained women is very low. Within the Lutheran Church (ELCSA) women are eligible for election but may not be elected by church members. Only one of the five denominations had an active gender structure, also called "the women's desk". Findings from a PhD thesis in two churches within the AOG in Durban revealed that women were seen as weak, vulnerable and too emotional to be in leadership positions, although there are no constitutional reasons why a woman cannot be ordained as a pastor (91). However, women in these churches were actively involved in the life of the church through women's work, and functions such as youth leaders and Sunday school leaders. This may illustrate the limited capacity of these denominations to lead and evaluate policy work on gender issues within a formal approach.

Theoretical framework

This section starts with an introduction to theories and models that have been used in relation to HIV prevention. As this thesis has a multidisciplinary approach, where prevention of a disease is studied in the context of religion (in this case, young people in faith communities) we found two frameworks particularly important. Both the African Religious Health Asset Framework (92) and the Social Ecological Model (93) offer the possibility to study the individual in the context of the broader community. These frameworks are described below.

Initially HIV prevention was dominated by theories that focused on individual behaviour change, for example the Health Belief Model (94) and the AIDS Risk Reduction Model (95). Within these theories there is an assumption that decisions about HIV prevention are based on rational thinking with less regard to more "true-to-life" emotional responses in engaging in sexual behaviour (96).

More recently there has been a shift towards social theories and models, for example the Diffusion of Innovations theory (97). According to these theories or models, an individual's behaviour is rooted in the social and cultural context. Therefore, the core concepts within sociology – norms, values,

networks, structures and institutions – are understood to influence and shape human behaviour (98). This understanding has contributed to the more recent concept of social drivers in the HIV prevention context. UNAIDS defines social drivers as "the structural and social factors, such as poverty, gender, and human rights abuses, that can increase people's vulnerability to exposure to HIV", adding that the term "is often reserved to describe underlying determinants" (99). There is now a growing interest in the public health community to develop interventions that can be effective at a social or structural level (100).

One example of a structural framework is the Social Ecological Model which can be described as a variation of Bronfenbrenner's model (101). The ecological model for health promotion acknowledges both individual and social environmental factors as targets for health interventions. The model assumes that changes in the social environment can bring about changes in individuals, but also that support to individuals is essential for changes at the environmental level (93). Patterns of behaviour are the outcome of interest, and behaviour is understood as being determined by five factors, namely labelled, intrapersonal factors (characteristics of the individual, such as knowledge and attitudes), interpersonal processes (social networks such as family and friends), institutional factors (organizational characteristics, for example the characteristics of schools, workplaces and churches), community factors (interactions among organizations) and public policy (such as national laws) (93). The Social Ecological Model has been used in violence prevention (102) and church-based health promotion interventions (103). We found the model useful for studying HIV prevention for young people in faith communities, and identifying different levels of interventions, such as the individual, social network, or organizational level.

Faith-based organizations are among those institutions in the South African society that may have a real impact on the social factors underpinning the epidemic. Choices regarding health and ill health depend on the norms, values and world views that people have, and the resources that are available to them in the given context. In South Africa where the large majority affiliate themselves to Christianity, people may turn to biomedical, African traditional healing, and faith healing remedies simultaneously for their health condition (104), thus mixing these resources without much concern that these services may be seen as contradictive by others.

The framework developed by the African Religious Health Asset Programme (ARHAP, referred to in (92)) is useful for understanding the relationship between public health and religion. This framework is inspired by the asset-based community development process that uses an asset language which is different from the standard discourse of needs or deficits, which focuses on what is lacking (105). According to Kretzmann and McKnight, the assets of a community comprise three main categories: individuals, asso-

ciations and institutions. The capacity of the individuals in a community, and the associations between them, formal and informal, form the base for community development. Associations can also include the network of religious, cultural, athletic and other associations in a community. The formal institutions, public and private, located in the community are perhaps the most visible assets of communities, and include schools, hospitals and libraries, to mention a few. Altogether these main categories contain much of the assets base in every community (105). What people and communities do to protect, increase and maintain health often has deep religious motives. Religion may therefore operate in various ways defined as both tangible and intangible "religious health assets" (22). Hospitals, clinics and home-based care may be termed direct or tangible religious health assets. However, religion can also have more indirect effects on health or health-seeking behaviour. Education, volunteerism, the individual sense of meaning, and the building of social capital are some examples of less visible religious health assets. In this thesis we used the framework to identify tangible as well as intangible assets important for HIV prevention programmes for young people in faith communities.

Aim of the thesis

The overall aim of this thesis was to study the role of Christian faith communities and to identify assets within Christian communities useful in HIV prevention among young people. Furthermore, the aim was to explore the possibility to strengthen the impact of the faith communities in the HIV prevention strategies**.**

Specific objectives were:

- To explore how individual church leaders deal with the conflict between the core values of the church and the context where people make decisions concerning sexuality (Paper I)
- To examine attitudes to and involvement in HIV prevention for young people among religious leaders (Paper II)
- To explore how young people perceive and reflect on messages received from their churches regarding premarital sex in the context of their own lived experiences (Paper III)
- To assess HIV prevention messages reported by young people in faith communities, their experience of relationships and their perceived risk of HIV infection (Paper IV)

Methods

Study setting

KwaZulu-Natal is the second largest province in South Africa, with a population of 10 million people (4). Durban on the Indian Ocean coast is the third largest city in the country, with one of Africa's most important harbours. According to the 2001 census (106), population groups in Durban are, in descending order: Africans, Indians/Asians, Whites, and Coloureds. The province has consistently reported the highest HIV prevalence in the country among antenatal clinic attendees, 37.4% (107). Further, the HIV prevalence in the age group 15–24 years is higher in KwaZulu-Natal (15.3%) compared with the overall HIV prevalence (8.7%) in the same age group in South Africa (3).

In South Africa, the largest group within Christian churches is the AIC (32%), followed by the Roman Catholic churches (7%), Pentecostal churches (7%) and Lutheran churches (2.5%) (106). However, in Durban district council, affiliation to the main religions and churches differs from the national affiliation and is, in descending order: the Roman Catholic Church, Hinduism, Zion Christian churches, other Christian churches, Apostolic churches and Pentecostal/Charismatic churches (106).

Study design

A mixed methods design was used, described by Creswell (108) as an explorative design, where qualitative data collection was followed by quantitative data collection. An integration of both types of data offers the possibility to assess phenomena identified in qualitative studies in larger quantitative surveys. An overview of the studies is presented in Table 1.

Table 1. Design, methods and participants of the studies included in the thesis.

Study	Study design	Data collection method	Sample size	Data analysis
I.	Qualitative study design	Interviews	n=16 religious leaders	Interpretive descriptive analysis
II.	Cross-sectional study design	Questionnaire survey	n=215 religious leaders recruited at regional meetings	Descriptive statistics; Binary logistic regression analysis
III.	Qualitative study design	Focus group discussions	Nine focus group discussions n=62 youth aged 13–20 years	Interpretive descriptive analysis
IV.	Cross-sectional study design	Questionnaire survey	n=811 young people recruited at youth conferences/ meetings	Descriptive statistics; Binary logistic regression analysis

Study participants

Religious leaders and young people for all studies were recruited from the three selected denominations: the Roman Catholic Church, the ELCSA and the AOG.

Religious leaders

In Study I, religious leaders were defined as local clergy with pastoral and liturgical responsibilities. The religious leaders were contacted with the help of two regional leaders and one national leader from the three denominations. The religious leaders represented the denominations equally: Catholic Church (n=5), Lutheran Church (n=6) and AOG (n=5). The interviewees represented the population groups African, Indian/Asian, White and Coloured; 15 were male and one female.

In Study II, all participants served as priest, deacon or lay minister in one of the three denominations. Religious leaders (n=215) were approached at regional meetings within the Roman Catholic Church and the Lutheran Church. There are no regional meetings within the AOG, and religious leaders were therefore reached at regional meetings within the three different sections (The Movement, The Group and The Association).

Young people

In Study III, young people in local churches were introduced to the study by their pastor or youth leader during ordinary youth gatherings about 1 week prior to the study. However, in two churches the leadership introduced the study just before they asked the young people to participate. Sixty-two young people (31 female and 31 male) aged 13–20 years participated. The participants represented the population groups African (n=14), White (n=5) and Coloured (n=43), and the focus group discussions (FGDs) were conducted in both high and low-income areas.

In Study IV, young people (n=811) were recruited from the three denominations in the Durban and Pietermaritzburg area. Participants were approached at regional youth conferences arranged by the archdiocese of the Durban Catholic Church, and the Durban Circuit Lutheran church. The AOG do not arrange regional youth conferences that include all sections within the AOG in the Durban area. Young people were therefore asked to participate at youth meetings in local churches within The Association and The Group, and during a regional conference within The Movement.

Data collection methods

Different data collection methods were used to explore and analyse HIV prevention for young people within faith communities. Because of limited research in this field in South Africa, at the time of study an explorative approach was applied with both qualitative and quantitative research methods.

A variety of techniques were used, including interviews, FGDs, observations, and analysis of relevant documents (109). By using a range of techniques the researcher can explore different perspectives of what people think and do concerning a phenomenon in a given context. In this way the research is naturalistic (110), as it is grounded in how a group of people give meaning to a phenomenon in a local context.

In qualitative research the sampling procedure differs from the random sampling used in quantitative studies. In qualitative research the goal is to include information-rich respondents who can share their experiences about the topic being studied, and participants are therefore selected purposely. By recruiting participants who represent a range of variation among individuals in the study setting, the sample is considered theoretically representative (109). Furthermore, the sample size is not determined beforehand; rather, the researcher judges when no more new information will be gained by adding further respondents to the sample, and saturation is reached (110, 111).

After conducting two qualitative studies, we decided to follow up issues on HIV prevention that were important for both the religious leaders and the young people in two questionnaire surveys. In these surveys we could assess

how prevalent some of the previous findings were, but also frame the questions based on our results.

The position of the researcher

Interdisciplinary research within health and religion may raise controversial issues, which introduces challenges to the researcher. This is also true when the researcher is from a different country to where the data are being collected. In this regard I, a White Swedish female researcher, was an outsider. Coming from a different background and trained as a nurse, I had entered a new field when studying the intersection of religion and health. To overcome some of the challenges I spent some time in South Africa, or prolonged engagement in the field, as described in qualitative research. During data collection I participated in Sunday services in all three denominations included in the study, in low as well as high-income areas in the Durban and Pietermaritzburg area. I was also an observer at youth meetings in some churches, and visited FBOs working with HIV and AIDS, as well as an HIV clinic. These visits and informal conversations with professionals and theologians at the University of KwaZulu-Natal and the University of Cape Town have added to my understanding of the HIV epidemic in South Africa.

Interviews

In Study I, we considered interviews to be appropriate to deepen our understanding of religious leaders' thoughts, attitudes, and experiences of HIV prevention for young people. In total, 16 face-to-face interviews were conducted with religious leaders, five in 2004 and eleven in 2005. A semi-structured question guide was used covering questions about attitudes towards HIV prevention messages, HIV testing, gender issues, and HIV-related church activities. Based on the findings in 2004, two more questions were added to the question guide in 2005, which concerned the personal experiences of religious leaders in work related to HIV and AIDS. The interviews were conducted in English by the first author (E.E.) and were held at locations convenient for the interviewees, usually in their church. Interviews were conducted in both high and low-income areas. Privacy was ensured as only the interviewee and the interviewer were present in the room during all interviews. Each interview lasted between 40 and 90 minutes.

In qualitative research, the term "semi-structured interview" is used to describe interviews that aim to access the individual's own experiences, and the interview is preferably carried out in the life world of the interviewee (109, 111). Interviews can vary in their degree of structure, but open-ended questions are used to ensure that the interviewee's own perceptions of a topic are obtained. Although a question guide can be thematic or consist of predefined questions, the interviewer can probe for further explanation

where necessary. In the interview situation, a feeling of trust between the interviewer and interviewee is essential to enable the interviewee to speak freely.

Focus group discussions

In Study III, nine FGDs were conducted in November 2006 to study the perceptions of young people on HIV prevention in their churches. Three groups in each denomination were considered sufficient to allow for variation. Each group consisted of four to twelve participants, and seven of the groups were mixed, consisting of both young men and women. One group consisted of young men and met in a Lutheran church, and one group of young women had their FGD take place in a Catholic church. Two exercises were used to encourage discussion before more sensitive questions about HIV prevention were raised. These exercises concerned the importance, for young people, of the church in the community. During the discussions, a semi-structured topic guide covered the young people's attitudes towards relationships and HIV prevention. Other questions related to sexual education in the church, and reasons why young people are sexually active. The group discussions were conducted in English by the first author (E.E.), and in some groups, a female Zulu interpreter was present to ensure all participants could take an active part in the discussions. Local churches were the most convenient location for the group discussions, since the participants met there regularly. Each session lasted between 30 and 70 minutes.

Holding FGDs is a common method for collecting data on perceptions, attitudes and beliefs (112). Focus groups are a form of group interview where the group process is believed to help explore views of the participants, which would be more difficult to access in individual interviews (113). Furthermore, group work can facilitate the discussion of sensitive topics when more open speaking members of the group break the ice for more reticent participants. Groups may be "natural occurring", for example at the workplace, or members of a group may be called together for a research project. The advantage of using already existing groups may be that friends can relate to each other's daily lives and challenge each other on contradicting views (113). The group size is recommended to consist of seven to ten participants, but the size may range from four to twelve participants (112). The moderator is responsible for facilitating the discussion and encouraging all members to speak, as well as for preventing participants from revealing more sensitive information than they had initially anticipated.

Cross-sectional surveys

Two cross-sectional, self-administered questionnaire surveys were conducted, one with religious leaders (August – October 2008) and one among young people (May and July 2009). In both surveys, the results from the qualitative studies (studies I and III) were used when developing the survey instruments.

Findings from the interview study among religious leaders identified issues important to them for their involvement in HIV prevention for young people. These topics related to previous education on HIV, HIV-related stigma, HIV prevention messages to young people, policies on HIV, and learning opportunities on HIV and AIDS for religious leadership, and were included in the questionnaire.

To ensure that the questionnaire was relevant to religious leaders in South Africa, we sent it out for review. Firstly, it was sent to three HIV co-ordinators in Sweden with experience of working with churches in sub-Saharan Africa. Two co-ordinators responded, and their comments were taken into consideration. Secondly, the three denominations in the survey in South Africa were asked to comment on the questionnaire. Only the Catholic Church responded and asked for clarification of one question, which was given. Finally, the questionnaire was piloted among ordained ministers (n=10) who were students at the School of Theology, University of KwaZulu-Natal, Pietermaritzburg.

Results from Study III highlighted the conflicting context for young people with regard to the teaching of the churches on sexuality, on the one hand, and their own lived experiences, on the other. Matters that were discussed concerned messages on sexuality and HIV prevention, experiences of relationships, the perceived risk of HIV infection, and the influence of the church on their decisions regarding sexual behaviour. These topics were included in the questionnaire, as well as two open-ended questions. The first question asked what churches can do to help young people to wait until they are married, before having sex. In a second question, we asked the participants to write down questions that they might have about sexuality, HIV and AIDS. The leadership in the three denominations were asked to comment on the questionnaire, and they suggested no changes. The questionnaire was finally piloted among young people (n=12) from four denominations in Durban.

In all settings, the participants received a short verbal introduction about the research, provided in English and/or Zulu, and were given instructions to read the information letter and fill in the questionnaire if they were willing to participate. The two questionnaires were in English, with the information letters being in both English and Zulu.

Analysis of qualitative data

Interpretive description guided the analyses in the two qualitative studies (studies I and III). Interpretive description was developed as a non-categorical methodological approach to developing clinical understanding, especially within nursing science (114). Researchers in nursing science often seek to generate general knowledge that can be applied in clinical practice. Although interpretive description is closely linked to traditional qualitative methodologies, such as grounded theory, the aim is not to develop new theories (115). Even though interpretive description was originally developed for nursing science, the orientation toward research questions in the health disciplines was also considered applicable to the interdisciplinary approach in this thesis.

The interviews and FGDs were audio-taped and transcribed verbatim. The transcripts were read repeatedly to obtain a holistic sense of the data before the coding procedure began. Line-by-line analysis was applied to identify codes reflecting the content of the text, and similarly codes were compared and merged (116). Through reading and constantly comparing, the open codes were grouped into categories. The authors discussed the identification of the categories and redefinitions were made to minimize overlapping between categories. Finally, similar categories were sorted into themes. An example of the analytical process is illustrated in Figure 1.

Two qualitative software programmes were used to manage the large amount of data. In Study I, transcripts were imported into the Swedish program OpenCode, version 2.0 developed by Umeå University (109), and in Study III the program NVivo8 (QSR International, Melbourne, Australia) was used. To ensure anonymity, transcripts and audio files were kept safe and were only accessible to the research team.

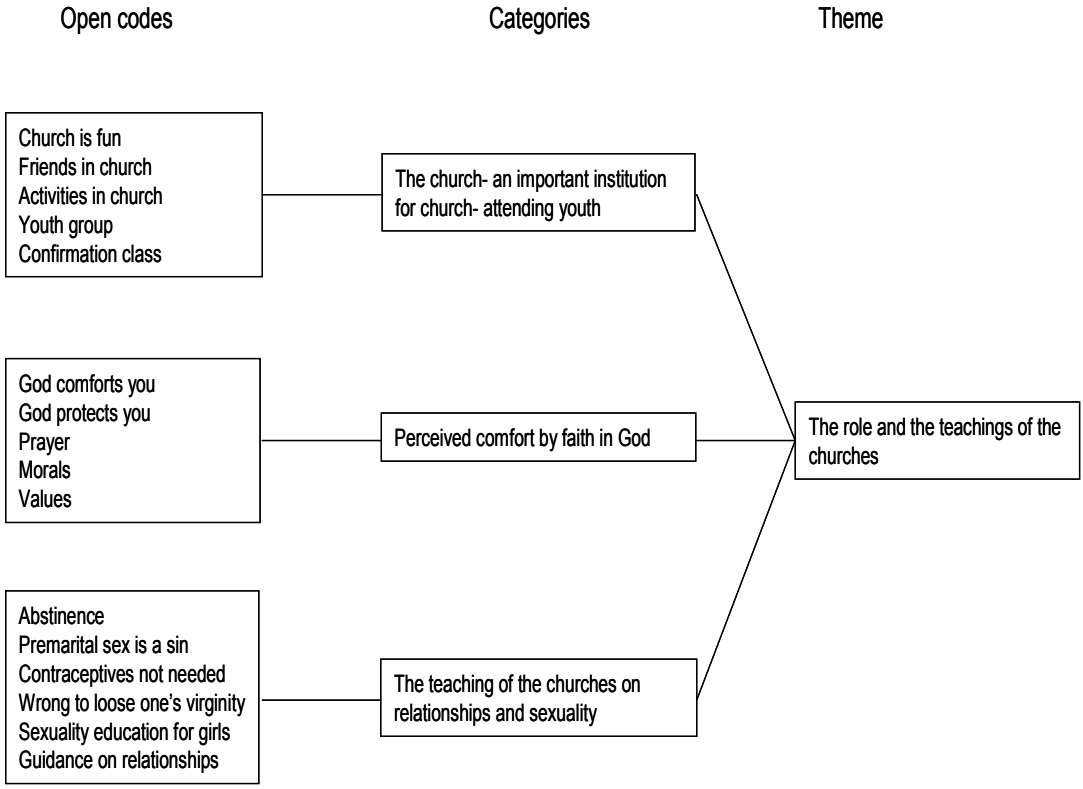

Figure 1. The analytic process.

Analysis of quantitative data

Differences between groups were tested using Kruskal-Wallis and Mann-Whitney tests in Study II, the survey among religious leaders. To assess whether religious leaders presented the same HIV prevention messages to both young men and young women, McNemar's test was used. In Study IV, the survey among youth, differences between groups were tested using Pearson's chi-square test.

In Study II, logistic regression models were developed to determine the extent to which previous HIV education of the religious leaders was associated with factors important for HIV prevention. The models were adjusted for age, gender, marital status, education, denominational affiliation, leadership position and time in the current position.

In Study IV, logistic regression models were developed to evaluate the relationship between religious affiliation, age and gender (independent variables) and young people's perceived risk of HIV infection, experiences of and attitudes towards relationships, and sexuality and HIV education in local churches (dependent variables).

Responses to the two open-ended questions in the questionnaire in Study IV were grouped into content areas by the first author (E.E.) and double-checked by the last author (P.A.). A *p*-value of <0.05 was considered statistically significant for all tests. Statistical analyses were performed in SPSS 17.0 (Study II) and SPSS 18.0 (Study IV) (SPSS Inc, Chicago, IL, USA).

Ethical considerations

Research focusing on sexuality within faith communities and especially young people's sexuality may be sensitive. All participants received written and/or verbal information about the research project before taking part in any of the four studies. In the information letters it was emphasized that participation was voluntary and that collected data would only be accessible to the research group. For practical reasons, we were unable to obtain written informed consent from all participants in studies II and IV.

The four individual studies were approved by the regional or national leadership within the three denominations in South Africa. Ethical clearance was obtained from the Research Office, University of KwaZulu-Natal, for the whole project. Additionally, advisory statements were obtained from the Regional Ethics Committee in Uppsala, Sweden, for studies II–IV.

Results

The findings from the four studies call attention to the complexity of HIV prevention in faith communities. Findings are presented in two major themes: HIV prevention from the perspective of religious leaders and HIV prevention from the perspective of young people.

HIV prevention from the perspective of religious leaders (studies I and II)

Breaking the silence on HIV

Religious leaders faced various problems in trying to break the silence on HIV prevention, such as conflicts with their congregation and/or the church hierarchy. Furthermore, they expressed feelings of isolation when addressing issues on HIV. In addition, they struggled when dealing with their own value systems in relation to sexuality and HIV prevention. To break the silence on HIV in the churches, religious leaders emphasized Christian values to their congregation members and used citations from the Bible in their sermons (Study I).

In the questionnaire survey, items measuring stigma revealed that the large majority (88%) of the religious leaders were positive about letting a colleague who is living with HIV continue to work as a minister. The majority (65%) of the religious leaders knew a church member who was HIV-positive. More Catholic (77%) and Lutheran (70%) leaders than AOG (46%) leaders knew a church member who was HIV-positive. Concerning HIV testing, more than half (58%) of those surveyed had taken an HIV test, and among those who had not been tested 63% answered that they were willing to go for an HIV test (Study II).

Ambivalence about HIV prevention

Regarding whose responsibility it is to inform youth about HIV prevention, some variation was found in the responses of the religious leaders. In Study I, religious leaders reasoned that it was primarily the responsibility of parents to talk to their children about sexuality and HIV prevention, while in

Study II, the large majority (94%) of them agreed that ministers are responsible for educating young people about HIV prevention. However, those who considered this to be parents' responsibility also acknowledged that it is difficult for parents to talk to their children about sexuality, and that some children lack good role models. Some respondents therefore encouraged parents to break the cultural taboo to talk about sexuality with their children and to take greater responsibility for their children's health.

Religious leaders were ambivalent about HIV prevention messages as sexuality is rarely mentioned from the pulpit in church (Study I). The main preventive message to young people from religious leaders was abstinence from premarital sex (studies I and II). Biblical teachings were the reason for promoting premarital sexual abstinence, and for some religious leaders, abstinence and faithfulness to one partner was the only message they supported (Study I). There was also ambivalence about condom use among religious leaders. Some religious leaders expressed negative attitudes towards condom use, such as –

> *Condoms are not the teaching of God.*

or

> *Condoms are not 100% safe.* (Study I)

Others who knew that some of the youths in their church were sexually active would encourage condom use to them in individual talks. The view was expressed that young people can handle different messages, as well as that talking about condoms would encourage young people to become sexually active (Study I). While 69% of the respondents in the questionnaire survey agreed to include messages on condom use as an HIV prevention message, some denominational differences were found. More Catholic (63%) and Lutheran (84%) compared with AOG (56%) leaders supported giving messages on condom use.

Regardless of the ambivalence about HIV prevention, the majority (78%) of religious leaders believed that youth aged 15–24 years in their congregations were sexually active before marriage (Study II). However, only 39% of the religious leaders in the same study reported that their church had run a life skills education programme for young people in the previous 6 months. Though respondents mentioned different activities for creating awareness among young people, for example in youth groups, lack of funds and trained human resources were the major barriers to increased involvement in HIV prevention (Study I).

Concerning gender differences, the qualitative study indicated a discrepancy between religious leaders' belief in gender equality and the HIV prevention

messages they verbalized. Though the respondents said they adhered to government gender policy their messages appeared to be shaped by patriarchal norms that tended to burden girls. For example, concerning the ability of young women to negotiate about sex, the religious leaders stated that –

Girls can be taught not to expose themselves.,

suggesting that it was the girls' fault if they found themselves in situations where they would need to negotiate about sex. On the other hand, according to the religious leaders, the reason why boys were violent was that they had nothing to do and needed activities such as sports. However, in the quantitative study, no significant difference in religious leaders' messages to young men and women was found.

Education and policies on HIV prevention

Over half (60%) of the religious leaders in study II had received some training on HIV prevention, most commonly from their own denominational institution (47%), or from health institutions (33%) or other FBOs (33%). Only 21% of the respondents had received training on HIV during their theological training. The majority (73%) expressed interest in further training if they were offered a course on "pastoral training in HIV/AIDS". Also, the majority (>97%) of the religious leaders were interested in topics in such a training course that are important for HIV prevention, for example education for youth on sexuality, HIV prevention and life skills, and counselling for people living with HIV. However, condom use as an HIV prevention topic was of interest to only 65% of respondents.

Religious leaders who had received training on HIV and AIDS were more likely to report that their church had run a life skills programme for young people in the previous 6 months (odds ratio (OR) 3.9, 95% confidence interval (CI) 1.9–8.2). Also, these religious leaders were more likely to have taken an HIV test themselves (OR 2.3, CI 1.2–4.4) (see Table 4, Study II).

Regarding policies, only 46% of the religious leaders in the survey answered that their denomination had a policy on HIV, and 42% responded that their local church had one. However, committees working on HIV issues in the local churches were more common, as reported by 54% of the religious leaders. Concerning denominational variations, more Catholic (57%; p=0.001) and Lutheran (43%; p=0.033) leaders reported that their local church had a policy on HIV compared with AOG (25%) leaders. Similarly, more Catholic (56%; p=0.002) and Lutheran (74%; p<0.001) compared with AOG (27%) leaders reported that their local church had a committee working with HIV-related issues.

HIV prevention from the perspective of young people (studies III and IV)

The role and the teachings of the churches

Church-attending youth in Study III viewed the church as the third most important institution in the community. Church was valuable to young people as a meeting place and for counselling from the pastor if they needed counselling. Furthermore, faith in God was described as a foundation for the individual's values and morals, as one Catholic girl said,

> *Belief, at least for me, is the base for your morals, who you are.*

Also, faith in God was said to be helpful for young people, especially when life was difficult.

According to the youth, abstinence from premarital sex was the main HIV prevention message from the churches to young people. Other HIV prevention messages such as faithfulness to one partner, HIV testing and condom use were less common (see Table 3, Study IV). However, while participants in Study III said that discussion on sexuality in the church was not common, the large majority (73%) of respondents in Study IV reported that they had received information about sexuality in youth groups (see Table 1, Study IV). In Study IV, the majority (83%) of respondents participated in youth groups and described themselves as religious (80%). For further characteristics about the respondents in Study IV, see Table 1.

Similarly, the majority (75%) of respondents in Study IV reported that they had received information about HIV and AIDS in youth groups. Concerning denominational variations, Lutheran (OR 5.99, CI 3.7–9.8) and Catholic (OR 1.78, CI 1.1–2.8) youth were more likely to report information on HIV and AIDS than AOG youth.

The majority (84%) of respondents in Study IV rated the quality of the sexual education as "fair" or "good", and youth leaders were viewed as the most trusted educators on sexuality in the churches (see Table 3, Study IV). Although 61% of the youth in the same study thought that the teaching of the church influenced their choices regarding sex, no significant associations with age, gender or denomination were found.

Regarding gender, young people expressed the view that young women were exposed to more information about sexual issues in the churches than men were (Study III).

When respondents in the questionnaire survey were asked about what the churches can do to help young people abstain from premarital sex, they sug-

gested further education on sexuality and HIV, as illustrated by the comment:

> *It is important for us as the youth to know about sex and HIV. We need to be taught about it.*

They also suggested more education on relationships and more activities for young people: "… keep them occupied with interesting events". In the same study, the large majority of respondents (88%) expressed interest in participating in a life skills education programme if their church would organize one (see Table 1, Study IV).

Although young people reported that they received information about sexuality and HIV/AIDS, they had basic questions about the transmission of HIV, as illustrated here by an 18-year-old man:

> *Is it possible to get HIV through kissing?*

Young people also had questions about their sexuality, as expressed by a 16-year-old boy:

> *Do we need to have sex to be accepted by our friends? Must we have sex to please ourselves or to have fun?*

and a 19-year-old woman:

> *Is it true that boys cannot live without sex because they will get sick?*

It was obvious from the questions young people asked that some of them experienced a conflict between religion and sexuality, as illustrated by the following questions:

> *I would like to know if God forgives you if you ask for forgiveness even though you knew it [sex] was wrong?* (woman, 18 years old)

and

> *What if I am not blessed with marriage, do I remain a virgin forever? How can I use the knowledge of the Bible to help me make wise decisions about sex now?* (woman, 17 years)

Finally, issues of trust within relationships concerned young people, as expressed by this 21-year-old woman:

Should it be a choice or an agreement to have sex? Can you be with someone without having sex?

The social context and relationships

Several reasons were mentioned by participants in Study III about why young people became sexually active before it was socially accepted. Peer pressure was discussed as the main reason why people did not follow the church's message on abstinence. The young men especially thought that it was difficult to abstain from sex, as one male respondent said,

... honestly speaking, the truth is, it's hard to abstain.

Furthermore, consumption of alcohol and drugs was mentioned as common reasons for individual sexual risk taking, as were negative influences from the media. Also, a fatalistic view of the future among peers in the community was said to increase sexual risk taking, as one girl described:

They say… how are you going to know if you are going to die today, and ... they influence you, no you must go and do it, it's a good thing.

Young people in Study III had conflicting views about relationships. Although many expressed a desire to be in a relationship, the view that relationships could be a distraction from school or work was also discussed. They also explained that their parents did not allow them to have a boy or a girlfriend until a certain age or until they were financially independent.

Concerning sexual relationships, the young people reasoned that it was a question of time before sex was introduced into a relationship, as one female participant said:

... that's when, like, your boyfriend is, like, he won't touch you ... then he goes like he needs the sex and then eventually that is how it happens.

According to the participants, their parents shared the same view, and therefore it was difficult for young men and women to meet alone as friends. The opinion that girls experienced stricter rules from their parents regarding relationships was also expressed. One girl said,

They leave the guys and overprotect the girls, because girls get raped at a young age.

In Study IV, the large majority (84%) of respondents had experience of having a boy or a girlfriend. Catholic (OR 2.5, CI 1.5–4.1) and Lutheran (OR 2.4, CI 1.5–3.8) youth were more likely to report ever having had a relationship than AOG youth. Furthermore, male respondents were more likely to report ever having been in a relationship than female respondents (see Table 5, Study IV). At the time of data collection in the same study, 58% reported that they were in a relationship. Among these, 75% reported that they had talked to their partner about sex, and 25% thought that their partner had other sexual partners.

Regarding gender difference in relationships, participants in Study III expressed the view that it was considered more acceptable for boys and men to have multiple sexual partners than for girls/women. Furthermore, the consequences of premarital sex were described as being different for young men and women. While young men would be considered "heroes" among peers after having had sex, young women faced social stigma if they were sexually active. Because these young women risked having "a bad reputation", the view was expressed that women did not talk in public about their sexual desires and behaviour. To illustrate, one female participant said:

> *... so it is like if you are sexually active, the girls seem to be a little bit quieter about it than the guys.*

Perceived risk of HIV infection

Over half (53%) of the respondents in the questionnaire survey perceived themselves to be at risk of HIV infection and 29% had been tested for HIV. The likelihood of having been tested was associated with increased age, being female and being Lutheran (see Table 4, Study IV). In Study III, participants discussed HIV testing as a way to detect unfaithfulness in a relationship, rather than a strategy to prevent HIV infection. Furthermore, they perceived the risk of HIV infection less important than the risk of an unplanned pregnancy, as illustrated by one male participant:

> *... they focus on one if there is pregnancy or not, they are not focusing on do I have AIDS, am I infected, no. So I think many of them focus on pregnancy.*

In the same study, negative attitudes towards condom use were expressed, but in relation to the high prevalence of HIV in their communities, positive attitudes were also expressed:

> *... there are condoms, and you must use it because [of] the times; most of the people living here are having HIV.*

Discussion

In this thesis we studied the role of the Christian communities regarding HIV prevention for young people in South Africa. Religious leaders acknowledged that young people in their churches are sexually active and that they, as religious leaders, are responsible for educating youth about HIV prevention. Young people reported that information on HIV was given in church youth groups, and that youth leaders were trusted as educators on sexuality. However, premarital sexual abstinence was the main HIV prevention message from the church, which appears to be in line with already existing traditional Christian messages about sexuality, and may not reflect the lived experiences of young people. Strategies are suggested to further strengthen the impact of the faith communities in HIV prevention for young people at the individual, intrapersonal, and denominational level.

Methodological considerations

Interviews were considered an appropriate method of data collection on attitudes of religious leaders on HIV prevention for young people as interviews allow participants to speak openly. Although FGDs could have been used it would have been difficult to get groups of religious leaders to meet owing to their scattered locations and the nature of their work. We were moreover concerned that in a group setting, religious leaders would talk from the perspective of their denomination rather than from the perspective of their own lived experiences.

In Study III we used FGDs to generate data on perspectives of young people on HIV prevention in faith communities. Our decision to carry out the FGDs in local churches rather than in more neutral places enabled us to reach youth who regularly attend church. However, it is possible that the participants were uncomfortable when speaking about sensitive issues such as sexuality in their own churches. The local pastor or youth leader helped in the selection of participants and introduced the study to the participants. It is possible that the leadership, who approved the study, mostly selected participants who supported the church doctrine. However, as young people expressed views not officially supported, we believe that the potential bias in selection of participants has not affected the data presented in this study.

In Study I we found that religious leaders had different attitudes towards HIV prevention messages directed to young men and messages directed to women, but this could not be confirmed in the questionnaire survey in Study II. As the quantitative study was conducted 3 years after the qualitative study, the mixed results could possibly be explained by changes in attitudes over time. Furthermore, differences in messages for men and women may be more easily uncovered during an interview than through a questionnaire survey. For example, personal views may be more pronounced in a conversation, and people may be more likely to report what is perceived as the "correct" answer in a questionnaire.

In studies II and IV, the cross-sectional surveys, the instruments had been developed by the authors and were non-standardized. Efforts were made to find standardized survey instruments that had been used among religious leadership regarding issues of sexuality in Africa, but at the time of the study, such instruments could not be found. The same efforts were made concerning the survey instrument for young people. Although survey instruments on young people's sexuality are available we found they were difficult to use in our research setting, as the study needed permission from the regional and local church leadership. Therefore we did not ask questions about the participants' sexual behaviour, which would have been of interest for comparison of our findings with other studies.

Trustworthiness

A qualitative approach was used in studies I and III, and trustworthiness, the qualitative criterion used in qualitative research, was ensured as follows: the first author spent several months in the field, during repeated visits from 2004 to 2009, to establish contacts with local and regional church leadership. The prolonged engagement in the field helped the author to understand the local context of both religious leaders and the young people in their churches.

The research team represented different disciplines as well as the perspectives of insiders and outsiders (Swedish and South African members). All contributed to the planning of the four studies, interpretation of findings and reviewing drafts of the different papers.

To increase the credibility of the presented data, discussions on preliminary findings were held within the research team and at seminars with researchers at International Maternal and Child Health (IMCH) to obtain peer evaluation and critical reflections from researchers not involved in the project.

During field visits, the author collected information about relevant topics that were locally based, for example local reports, and books and journals published in South Africa. This information was integrated in the papers

together with a detailed description of the methods used, to allow the reader to judge whether our findings may be transferable to other contexts.

Finally, the first author kept different types of personal notes. During field visits, reflective notes were taken and topics of interest that were brought up during an interview or FGD were asked about in the next session, allowing for an emergent design. This provided flexibility in the interaction with participants while ensuring that the question guide was followed, and that all questions were discussed in all the sessions. Furthermore, the first author kept notes on important decisions regarding the research process.

Studies II and IV were based on cross-sectional survey data and the inclusion criteria allowed only members of three denominations to participate. Furthermore, it was difficult to estimate the total number of possible eligible participants in these studies, as these data were not available to the researcher. We therefore included all religious leaders and young people who met the inclusion criteria at the time of data collection.

The questionnaires were non-standardized. Though based in part on previous studies in Africa ([117, 118], see below) they were specific to the study and had been developed by the authors. In Study II some questions were taken from a survey among church leaders in Kenya (117), and in Study IV some questions were obtained from an instrument used among Anglican youth in Cape Town (118). Furthermore, the instruments were sent out for review to denominational leadership and pre-tested to increase the reliability of the presented data.

The province of KwaZulu-Natal has the highest HIV prevalence among young people in South Africa (3), and is therefore not representative of the whole country. One should consequently be cautious in generalizing our findings to populations with different HIV prevalence and religious patterns. The perceived risk of HIV infection among church-attending youth is likely to be different in settings with lower HIV prevalence.

Identifying assets in HIV prevention for young people

We started this project from the premise that the choices people make regarding their health and ill health depend on the norms and values that people have, and the resources available to them; further, that religion may present what has been described as both a tangible and an intangible health asset. Inspired by the African Religious Health Assets Framework we discuss the identified assets important to HIV prevention for young people in the following section.

Firstly, the local church in its own right is a tangible asset, as young people described the church as an important meeting place for them in their com-

munity. Furthermore, we found that many young people had obtained some information about sexuality and HIV in church youth groups. Premarital sexual abstinence was the main prevention message and similar findings are reported from KwaZulu-Natal (82, 119, 120), Malawi (121) and Nigeria (122). Although the effect of premarital sexual abstinence as an HIV message can be debated, abstinence does prevent HIV infection. Information about HIV in youth groups was more often reported by Lutheran and Catholic youths than by AOG youth. A possible explanation for the denominational differences is that these denominations have different policies on HIV. To our knowledge the Catholic Church is the only denomination that has adopted a national life skills programme for young people (86), and the Lutheran Church emphasizes the importance of starting education about HIV at a young age, already in Sunday school (85). It appears that the policies of these denominations have some impact on informing young people in their churches about HIV.

In this study, young people reported high motivation to participate in life skills education offered by their local church. As the South African government aims to target young people to hinder further spread of the HIV epidemic, it is important to take advantage of such motivation among church-attending youth (123).

Another observed intangible asset was the trust young people had in youth leaders in church to educate them on sexuality. The role of youth leaders in HIV prevention in local churches among young people therefore needs further investigation.

Young people in our study thought that the teaching of the church influenced their decisions concerning sexuality. The trust young people have in their church is therefore valuable, and should be utilized for organizing and implementing comprehensive HIV education.

When exploring the role of religious leaders in HIV prevention, several assets were identified. Although our study showed some mixed results about whose responsibility it is to educate young people about HIV, the large majority of religious leaders in Study III thought that this was their responsibility. Our findings are in agreement with the literature among religious leaders in Nigeria (124) and the United States (125).

More than half of religious leaders in Study III had received some training about HIV, most of them from their own denominational institution. Thereby the faith communities show that they value educated leadership on these issues, although we did not ask about the content or the length of the training the leaders had received. Moreover, religious leaders were positive about further education defined as “pastoral training in HIV/AIDS”, and about topics important for HIV prevention. This is essential as our results indicate that religious leaders who were trained about HIV were also more likely to report that their church had run life skills programmes for young

people. Also, these religious leaders were more likely to have been tested for HIV. As HIV testing is a vital component in the overall prevention strategy in South Africa, religious leaders could become role models and encourage young people to go for HIV testing.

Challenges for HIV prevention in Christian communities

Although we used an asset approach as a point of departure for this study our findings also highlight some of the dilemmas for faith communities in effectively responding to the HIV epidemic. As the African Religious Health Assets Framework mainly looks at resources already existing in the community (92), this framework is less useful when discussing problems in HIV prevention for young people. In the following section we therefore move beyond the asset framework and draw attention to the challenges for faith communities on the topic of HIV prevention.

Regarding HIV prevention messages and young people's sexuality, the strong emphasis on premarital sexual abstinence may not reflect the lived experiences of young people. Rather, the focus on abstinence appears to be based on the traditional Christian values about sexuality. The view that sexual intercourse is primarily meant for procreation and only acceptable within marriage forms the basis of the HIV prevention messages of most faith communities. However, to delay sexual debut until marriage may be difficult for South African youth due to the increased age at marriage. With a median age of first marriage of 25 years in women and 31 years in men in rural KwaZulu-Natal (126), the period between sexual debut and formal marriage has been extended. Furthermore, the notion of the body as "bad" and human sexuality as shameful has become a hindrance for faith communities to talk about sexuality. Our findings are supported in the literature from KwaZulu-Natal where lack of a positive and life-affirming discourse on sexuality has been observed in Christian churches (90). Furthermore, the literature suggests that the HIV prevention messages or abstinence messages are inappropriate for young people who may be sexually active (127).

We found diverse attitudes towards condom use among religious leaders, which has previously been reported by international agencies (21) and from Zambia (128) and Malawi (43). Furthermore, the support observed among some of the Catholic leaders for condom use, given to young people whom they knew were sexually active, indicates that these leaders did not adhere to the policy of their denomination. Similar findings have been reported among Catholic priests in the UK (129). In Mozambique, Catholic leadership allowed more discussions on controversial topics, including condoms, in their churches than did leaders from Pentecostal churches (44). The recent state-

ment by Pope Benedict XVI suggests that condoms can be used in some cases as "a first step in the direction of moralization, a first assumption of responsibility, on the way toward recovering an awareness that not everything is allowed and that one cannot do whatever one wants" (130). This indicates that the Catholic Church recognizes the need to prevent diseases such as HIV. Young people's attitudes towards condom use in our study appear to reflect the attitudes of their church leadership, suggesting that those with negative attitudes may be less likely to practise safe sex. Findings from women in Zambia affiliated to more conservative denominations concluded that although the women delayed sexual debut, the likelihood of condom use after sexual initiation was reduced (128). The view that condoms should be used because of the high prevalence of HIV in the community was also expressed by young people in our study. However, despite this view it is difficult to know whether the young people actually use condoms in sexual relationships, as we did not specifically ask about condom use (see above).

To summarize the discussion on prevention messages, young people in faith communities need messages that correspond to their current life situation. Young people who are in relationships and want to live in line with the core values of their church may need encouragement and support to do so. However, the faith communities also have to acknowledge that not all young people choose (for whatever reason) to follow their church's traditional values regarding sexuality. Different messages are therefore needed to protect the health of young people.

Another concern was young people's lack of knowledge on HIV transmission, which was obvious from the questions they asked about their sexuality and HIV. Although young people are exposed to information about HIV prevention in school and through the media (6, 7) and in church as our study illustrates, young people in South Africa appear to have insufficient knowledge to make informed choices about their sexual health. This may reflect the dilemma with messages focusing mainly on the individual with the assumption that once information is given the individual will change negative behaviours. The lack of knowledge on HIV among young people in South Africa, especially among young females, has been reported elsewhere (3).

Regarding relationships, we found that young people considered sex as part of a relationship. Similar findings have been reported in another study from KwaZulu-Natal where young people associated primary partnerships with love, romance, trust and intimacy (131). According to the youth in our study, their parents feared that their sons and daughters would not abstain from premarital sex if they were in a relationship. As a result, it was difficult for young men and women to meet alone as friends. As the church-attending youth of South Africa are sexually active, for example with 30.5% of Anglican youth aged 12–19 years in Cape Town having had vaginal, oral or anal

sex (118), we argue that young people's perception of relationships renders them vulnerable to HIV infection.

A quarter of the young people who were in a relationship at the time of data collection in Study IV thought their partner had another sexual partner. This is in line with findings from Mozambique which concluded that religion had a limited effect on multiple relationships (132). Regarding denominational variations, Catholic and Lutheran youth in our study were more likely to report having had a boy or a girlfriend than AOG youth. Similar denominational variations have been reported from Zambia (128) and in another South African study (82). Practices of social control over young people in Pentecostal churches are reported as one reason for these differences (82, 133). The position of the leadership in the Pentecostal churches is strong and the pastor also has the right to discipline members who do not live according to the values of the church, for example through counselling. This is one way in which relationships among young people may be controlled in these churches (91).

Another concern is that young people in our survey perceived themselves at risk of HIV infection. This finding disagrees with studies from Nigeria where young migrants affiliated to evangelical and Pentecostal Christianity imagined themselves to have little or no risk of HIV infection (134). Furthermore, young people in our study viewed HIV testing as a way to detect unfaithfulness in a relationship rather than as a strategy to prevent HIV infection.

Differences according to gender and HIV prevention appear to be neglected within the faith communities. Our results indicate that young women are given more information on sexuality than young men in the same churches. Males were also more likely to have experiences of a relationship than females. Moreover, young people suggested that it was more acceptable for men to have multiple partners than for women. Finally, young women feared social stigma if they had premarital sex and talked about their experiences, while young men did not appear to face similar stigma. These findings suggest that the teaching of the churches is part of the construction of the sexual norms and roles of young people, which appears to be biased towards the control of women. Within Christian patriarchal structures the teachings and practices of the churches have contributed to the reinforcement of gender inequalities between men and women (135, 136). For example, within the AOG churches, men are described as holding the position as "the head of the home" and men are therefore expected to have the final say in the family. Since the feeling of belonging is very central to church members, some women accept the position of males, and may not even perceive themselves as submissive (91). A resistance to changing gender norms has also been observed outside the faith communities of South Africa. A study aimed to develop an HIV prevention intervention for men in the Western Cape confirmed that hostile resistance to changes in gender power relations

was one of the major challenges for curbing the HIV epidemic (137). As the faith communities are part of the wider society, addressing stereotyped views of men and women remains a critical challenge also for the local churches.

Stigma related to HIV was a problem for religious leadership who had to handle stigma in their churches before they could talk openly about HIV prevention. Stigma in relation to HIV in faith communities in KwaZulu-Natal is a known obstacle for religious leaders becoming involved in HIV prevention work (53, 120, 138).

Few religious leaders reported that their church had run a life skills programme in the previous 6 months, even though they believed that young people in their churches were sexually active before marriage. Although church policies on HIV may influence the actions of the individual leader, knowledge about denominational policies among religious leadership was limited. Unfamiliarity with denominational policies has been reported in literature from Kenya (117) and Nigeria (124).

Strategies to prevent HIV infection among youth in faith communities

We have identified assets as well as challenges for the faith communities regarding HIV prevention for young people. We will now focus on strategies that could strengthen the impact of Christian communities on the same topic. Based on the Social Ecological Model, we started with the assumption that interventions addressing more macro levels of change, such as social networks and institutional levels, will be more effective than interventions aimed at the individual level only. The local church is an example of an institution in the community, which, unlike most other institutions, holds the possibility to exert multiple levels of influence on health behaviours. Inspired by the Social Ecological Model, in the next section we discuss multiple levels of interventions for the faith communities on HIV prevention.

At the intrapersonal level our study has demonstrated that young people obtain clear individual messages about sexual conduct. However, more comprehensive HIV education is needed to address the lack of knowledge about HIV transmission. Furthermore, as most young people in faith communities have experiences of relationships they need to know how to protect themselves from HIV infection, if their relationship turns into a sexual relationship. The church leadership may also consider adapting their message for young people who already are sexually active. As sexuality and HIV education programmes are not associated with more risky sexual behaviours among young people (34, 35), comprehensive HIV education such as the SAVE model is recommended (37). The SAVE framework has helped reli-

gious leaders in talking more openly about HIV prevention, including condom use and HIV testing (139).

At the interpersonal level, religious leaders may influence both formal and informal networks existing in their churches. For example, attitudes about relationships including issues of trust and how to relate to the opposite sex can be addressed in formal youth groups. Furthermore, social norms about peer pressure, alcohol and drugs can be talked about to support healthy behaviours, as well as negotiation skills. The format may be a life skills programme integrated in ordinary activities for youth or special events addressing young people. In a church setting, religious leaders also have the possibility to address some of the parents of young people, perhaps in a woman's or a man's group or in a support group.

The denomination as an institution has a profound responsibility to address HIV prevention, not only for young people. As our study reveals that religious leaders are unaware of the HIV policy of their own denomination, leadership at the denominational level should ensure that policies about HIV are known to local church leadership. Also, they should ensure that learning opportunities about HIV are offered to local clergy, and also to youth leaders who are most trusted by young people to educate them about sexuality. This education is needed at two levels. Firstly, local church leadership should be offered training on HIV and AIDS from a health perspective. Secondly, local leadership needs support and guidance on how to address issues of sexuality with congregation members and especially among youth. To address gender inequalities and discourage gender norms from negatively affecting HIV prevention should be a concern for denominational leadership. They may provide local religious leaders with training and resources to be used in local churches to challenge stereotyped views of men and women. Training manuals addressing gender inequality have been developed by local agencies in KwaZulu-Natal (140), and by international FBOs (141). A recent manual promoting gender equality focuses especially on deconstructing harmful masculinities in local churches (142). These and similar resources need to be available for local churches and their leadership.

When looking at community factors, networking with other institutions in the neighbourhood is essential for faith communities that do not run their own health facilities. Faith communities may advocate, through various activities, to improve the health options for their own members as well as for the whole community. Finally, the faith communities have been invited to collaborate with the Department of Health on HIV-related issues. This collaboration is important in developing joint plans of action to curb the HIV epidemic among young people.

Recommendations for future research

From a theological perspective our findings have contributed to the understanding of the faith community's response to HIV prevention among young people, by mapping the work of three denominations in South Africa. Future research within faith communities should also examine the role of youth leaders as educators about sexuality and HIV prevention, both in local churches and at regional and national youth camps, which gather large numbers of young people. Future research should also focus on the experiences of young people who are living with HIV and who attend church; we need to understand how HIV prevention messages can be adapted to their special needs. The role of female religious leadership in HIV prevention for young people likewise needs further investigation.

The frequency of published articles in the field of religion and reproductive health has increased, leading Gaydos et al. (143) to suggest that a new discipline is evolving. This thesis has contributed to this field of research by recognizing the complexities of research in studying religion and HIV prevention for young people.

As our findings are based on cross-sectional data, future research could benefit from longitudinal studies in understanding the relationship between religion and HIV prevention for young people in faith communities.

Conclusion

Information about HIV prevention in church youth groups was common within the Roman Catholic Church, the Lutheran Church and the AOG in KwaZulu-Natal. However, premarital sexual abstinence was the main prevention message to young people. Lutheran and Catholic youth had more learning opportunities about HIV in their youth groups than did young people affiliated to the AOG. Despite the information provided, young people had profound questions about sexuality and relationships. The large majority of young people in the studied denominations had experiences of having a boy or a girlfriend, and young people perceived themselves at risk of HIV infection.

Religious leaders in the same denominations acknowledged that the young people in their churches were sexually active and that they as religious leaders were responsible for educating young people about HIV prevention. Life skills education programmes were more common in churches where the church leader had been trained about HIV. Young people expressed an interest in participating in life skills programmes if their church would run one, which suggests that further education efforts are feasible from a youth perspective. However, by concentrating on premarital sexual abstinence, Christian communities appear to focus on moral aspects of sexuality when young people would benefit from learning opportunities about different HIV prevention methods as well as from discussions about a life-affirming sexuality, trust in relationships, and how to change negative gender roles.

Support and further training for local religious leaders is needed to enable them to manage the conflict between the doctrine of the church and their willingness to assist young people in the transition into adulthood.

Summary in Swedish/ Sammanfattning på Svenska

Förebyggande av HIV bland ungdomar i kristna församlingar i KwaZulu-Natal, Sydafrika

Hiv och följdsyndromet AIDS beskrevs för första gången 1981 och tre decennier senare lever ca 33 miljoner människor med hiv. Södra Afrika är den värst drabbade regionen med nästan två tredjedelar av alla smittade. Hiv-epidemin i Sydafrika där ca 5.6 miljoner människor lever med hiv är den största i ett enskilt land. Förväntad livslängd för kvinnor var 2010, 53 år och 55 år för män. Sociala faktorer så som fattigdom, arbetslöshet, migration och brist på jämställdhet mellan män och kvinnor bidrar till smittspridningen.
Hiv-prevalensen bland ungdomar i åldersgruppen 15-24 år är hög (8.7%) och utgör ett växande hälsoproblem. Heterosexuell smitta är vanligast och de flesta ungdomar smittas genom oskyddat sex. Risken för att bli smittad av hiv är tre gånger högre för flickor och unga kvinnor än för pojkar och unga män i samma åldersgrupp. Trots satsningar på undervisning om hiv i skolorna och genom radio och TV, så finns det fortfarande bristande kunskap hos unga människor om hiv och om hur man skyddar sig.

För att förhindra spridningen av hiv uppmanas alla samhällssektorer att delta i det hälsofrämjande arbetet, inklusive kyrkor och kyrkliga organisationer. Kyrkliga hälsoinstitutioner har länge erbjudigt vård och behandling av hivsmittade och barn, och svarar för en stor andel av det arbete som utförs vid sjukhus, hemsjukvård och i sociala insatser. I Sydafrika räknar sig ca 80 % som kristna och kyrkorna utgör en potentiell resurs även i det preventiva arbetet. Historiskt sett har kyrkorna även varit en del av problemet pga. kyrkornas oförmåga att hantera frågor kring sexualitet. Kyrkornas tystnad om hiv och sexualitet har också bidragit till stigmatisering av människor som lever med hiv.

Den här avhandlingen avser att öka kunskapen om hur kyrkorna i Sydafrika arbetar med förebyggande insatser bland ungdomar för att minska spridningen av hiv. För att få en samlad bild av kyrkornas arbete inkluderades både kyrkoledare och ungdomar i fyra delstudier i Durban i provinsen KwaZulu-Natal. Tre samfund valdes ut för att återspegla mångfalden av de kristna kyrkorna i Sydafrika, den Romersk Katolska kyrkan, Lutherska kyrkan, och Assemblies of God (AOG), motsvarande Pingstkyrkan.

Att känna till kyrkoledares attityder till hiv-prevention för ungdomar i sina lokala församlingar är ett av de första stegen för att nå ungdomar i kyrkorna med undervisning om hiv. Den första delstudien i denna avhandling har därför undersökt hur enskilda kyrkoledare hanterar konflikten mellan kyrkans underliggande värdegrundsfrågor och ungdomars sexualitet. Sammanlagt genomfördes 16 intervjuer med präster/ pastorer inom de tre samfunden i Durban. Resultatet visade en komplex bild där kyrkoledare försökte överbrygga sin teologiska värdegrund med det arbete som de utför, till exempel. begravningar av unga människor som dött i AIDS. Kyrkoledarna ställdes också inför olika problem när de ville bryta tystnaden kring hiv, bland annat uppstod konflikter med församlingsmedlemmar eller med deras egen närmsta chef inom samfundet. Det framkom även en ambivalens angående budskapen för att påverka unga människor och göra dem medvetna om risken för hiv. Resultatet visade också en diskrepans angående de preventiva budskap som gavs till unga män respektive unga kvinnor. Trots att ledarskapet uppgav att jämställdhet var viktigt så framstod budskapen vara formade av traditionella patriarkala normer.

I det andra delarbetet i denna avhandling följde vi upp resultaten från intervjustudien i en större enkätstudie bland kyrkoledare (n=215) som även inkluderade lekmän i ledande positioner. Ett frågeformulär delades ut vid regionala möten i de tre samfunden under perioden augusti till oktober 2008. Frågorna berörde tidigare utbildning om hiv, attityder till preventionsprogram för ungdomar, genusfrågor, hiv-relaterat stigma, samt önskan om deltagande i ytterliggare utbildning om hiv. Resultatet visade att ledare som hade deltagit i utbildning om hiv hade i större omfattning ordnat preventionsprogram för ungdomar i sina kyrkor, även om dessa totalt sett var få. Ledare från den katolska och lutherska kyrkan hade oftare deltagit i utbildning om hiv än ledare från Pingstkyrkan. De som hade deltagit i utbildning var också i högre grad själva testade för hiv. En stor majoritet av kyrkoledarna trodde att ungdomarna i deras församlingar var sexuellt aktiva innan äktenskapet, och de ansåg också att de som ledare var ansvariga för utbilda ungdomarna om hiv.

Kunskap om ungdomars föreställning om sexualitet och hiv är viktigt för att kunna bedöma hur eventuella preventiva insatser för ungdomar i kyrkorna bör utformas. I delstudie tre undersöktes därför hur unga människor uppfattar och reflekterar över informationen om sexualitet och hiv från sina kyrkor. Nio fokusgruppintervjuer bland ungdomar (n=62) mellan 13-20 år gamla genomfördes 2006, tre grupper i varje samfund. Resultatet visade att kyrkan var en viktig institution i samhället och fungerade som en mötesplats för dessa ungdomar. Vidare att ungdomarna var ambivalenta till nära relationer som att ha en pojk- eller flickvän eftersom man förväntades ha en sexuell relation till sin partner, medan detta stred mot kyrkans värdegrund. Ungdo-

marna ansåg att det var mer acceptabelt för unga män att ha flera sexuella partners än för unga kvinnor. Dessutom skiljde sig konsekvenserna av sex före äktenskapet åt mellan könen. Medan unga män kunde kallas för "hjältar" bland sina kompisar efter att ha berättat om sina sexuella erfarenheter, mötte unga kvinnor ofta socialt stigma om de var sexuellt aktiva före äktenskapet. Ungdomarna uppgav också att flickor/ unga kvinnor fick mer information om sexualitet, relationer och hiv än vad pojkar/ unga män fick i samma kyrkor.

I den sista delstudien i avhandlingen följde vi upp resultaten från fokusgruppintervjuerna i en enkätstudie bland ungdomar (n=811) i åldersgruppen 15-24 år. Frågeformulären delades ut på regionala ungdomskonferenser eller ungdomsmöten inom samma samfund. Frågorna täckte in sociodemografisk data, vilken information de fick om hiv och sexualitet från sina kyrkor, om de hade erfarenhet av att ha en pojk- eller flickvän, om de själva tror att de riskerar att få hiv, samt om kyrkan påverkar deras sexuella beteenden. Deltagarna fick också möjlighet att skriva egna frågor som de hade angående sexualitet och hiv. Resultatet visade att avhållsamhet från sex före äktenskapet var det främsta preventiva budskapet från kyrkorna till ungdomar angående hiv. Relativt få angav att de fick information om trohet till en partner, vikten av att testa sig för hiv, eller om kondomer. I en jämförelse mellan samfunden framkom att lutherska och katolska ungdomar hade erhålligt mer information om hiv i kyrkliga ungdomsgrupper än ungdomar från pingstkyrkan. De flesta hade erfarenhet av en relation och ansåg att de möjligen kunde drabbas av hiv. Av dem som var i en relation vid studietillfället trodde en fjärdedel att deras partner hade en annan sexuell partner. Ungdomarna var också positiva till att delta i framtida preventionsprogram i deras kyrkor. Frågorna från ungdomarna visade på bristande kunskap om hiv och om hur man kan bli smittad. Vidare framkom osäkerhet kring ämnen som berörde relationer, hur det är att leva med hiv, samt en upplevd konflikt mellan kyrkans värdegrund och deras egen sexualitet.

Hiv-epidemin är ett växande hälsoproblem i Sydafrika, också inom kyrkorna, där dess ledarskap möter många människor som lever med hiv. Kyrkorna utgör en potentiell resurs i det preventiva arbetet, men kanske har de ännu inte helt och hållet insett hur viktig deras roll är. Informationen till ungdomar ger intrycket av att fokusera på moraliska aspekter av sexualitet när ungdomar bör ha mer nytta av information om olika hiv-förebyggande metoder. Vidare bör ungdomar i kyrkorna ges möjlighet att diskutera en positiv syn på sexualitet, tillit till en partner i en relation samt hur negativa könsroller kan förändras. Samtidigt behövs stöd och fortbildning till lokala kyrkoledare för att de ska kunna hantera konflikten mellan kyrkans värdegrundsfrågor och deras vilja att hjälpa ungdomar som påbörjar en sexuell relation.

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