Faith-based organisations and HIV prevention in Africa: A review

Authors:
Rachel Mash[1]
Robert Mash[1]

Affiliations:
[1]Division of Family Medicine and Primary Care, Stellenbosch University, South Africa

Correspondence to:
Rachel Mash

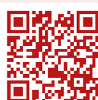
Email:
rmash@mweb.co.za

Postal address:
PO Box 1932, Cape Town, 8000

Dates:
Received: 16 June 2013
Accepted: 26 Jan. 2013
Published: 30 May 2013

How to cite this article:
Mash R, Mash R. Faith-based organisations and HIV prevention in Africa: A review. Afr J Prm Health Care Fam Med. 2013;5(1), Art. #464, 6 pages. http://dx.doi.org/10.4102/phcfm.v5i1.464

Copyright:
© 2013. The Authors. Licensee: AOSIS OpenJournals. This work is licensed under the Creative Commons Attribution License.

Read online:

Scan this QR code with your smart phone or mobile device to read online.

Background: Faith-based organisations (FBOs) are potentially an important role-player in HIV prevention, but there has been little systematic study of their potential strengths and weaknesses in this area.

Objectives: To identify the strengths and weaknesses of FBOs in terms of HIV prevention. The questions posed were, (1) 'What is the influence of religion on sexual behaviour in Africa?', and (2) 'What are the factors that enable religion to have an influence on sexual behaviour?'.

Method: A literature search of Medline, SABINET, Africa Wide NIPAD and Google Scholar was conducted.

Results: The potential for Faith-based organisations to be important role-players in HIV prevention is undermined by the church's difficulties with discussing sexuality, avoiding stigma, gender issues and acceptance of condoms. It appears that, in contrast with high-income countries, religiosity does not have an overall positive impact on risky sexual behaviour in Africa. Churches may, however, have a positive impact on alcohol use and its associated risky behaviour, as well as self-efficacy. The influence of the church on sexual behaviour may also be associated with the degree of social engagement and control within the church culture.

Conclusion: Faith-based organisations have the potential to be an important role player in terms of HIV prevention. However, in order to be more effective, the church needs to take up the challenge of empowering young women, recognising the need for their sexually-active youth to use protection, reducing judgemental attitudes and changing the didactical methods used.

Les organisations religieuses et la prévention du VIH en Afrique : Étude

Présentation: Les organisations religieuses pourraient jouer un rôle important dans la prévention du VIH, mais peu d'études systématiques sont réalisées sur les forces et faiblesses observées dans ce domaine.

Objectifs: Identifier les forces et faiblesses des organisations religieuses en termes de prévention du VIH. Les questions posées étaient les suivantes : (1) «Quelle est l'influence de la religion sur les comportements sexuels en Afrique», et (2) «Quels sont les facteurs permettant à la religion d'influencer le comportement sexuel?»

Méthode: Une recherche documentaire a été réalisée dans Medline, SABINET, Africa Wide NIPAD et Google Scholar.

Résultats: Le potentiel des organisations religieuses à jouer un rôle important dans la prévention du VIH est sapé par les difficultés rencontrées par l'église pour parler de sexualité, éviter la stigmatisation, intégrer les questions liées au genre et accepter les préservatifs. Par opposition avec les pays à revenu élevé, il semblerait que la religiosité n'ait pas d'impact positif général sur les comportements sexuels à risque en Afrique. Les églises peuvent cependant avoir un impact positif sur la consommation d'alcool et les comportements à risque qui y sont associés, ainsi que l'efficacité personnelle. L'influence de l'église sur le comportement sexuel pourrait également être associée au degré d'engagement social et de contrôle au sein de la culture de l'église.

Conclusion: Les organisations religieuses pourraient jouer un rôle important en matière de prévention du VIH. Cependant, pour que celles-ci gagnent en efficacité, elles doivent s'attaquer au défi que représente l'autonomisation des jeunes femmes, reconnaître la nécessité que les jeunes sexuellement actifs se protègent, réduire les attitudes critiques et changer la didactique adoptée.

Introduction

Significance

This review highlights the important role of religion in terms of its impact on sexuality. Given the reach of Faith-based organisations (FBOs) in Africa, this review has some important findings with regard to HIV prevention:

> Religion is so overwhelmingly significant in… African values, attitudes, perspectives and decision-making frameworks that the inability to understand religion leads to an inability to understand people's lives.[1]

Aim of the article

Although African Faith-based organisations are recognised as being important role players in the provision of HIV care, there is less evidence of their engagement with HIV prevention programmes or in reducing risky sexual behaviour.[1,2,3] The aim of this article is to review the literature in relation to the following three questions:

- What are the strengths and weaknesses of FBOs in terms of HIV prevention?
- What is the influence of FBOs on sexual behaviour in Africa?
- What are the factors that enable FBOs to have an influence on sexual behaviour?

Key word search

A search of Medline, SABINET, Africa Wide NIPAD and Google Scholar was conducted using the following key words: religion, faith-based, Christian, Islam, Muslim, HIV prevention, sexual activity, sexual behaviour, condoms, abstinence, Africa and Sub-Saharan Africa. The review included both medical and religious journals, but was limited to literature in English from 1990 onward. FBOs were defined as local religious congregations or religious non-profit organisations.[6]

The strengths of Faith-based organisations in HIV prevention work

Faith-based organisations are accessible throughout Africa and extend into the poorest informal settlements and the most remote villages.[3,4,5,6,7] Interventions via FBOs are affordable since churches have existing infrastructure and personnel, and church members are often motivated by their faith and are willing to volunteer.[1,6] FBOs also have a high level of acceptability, sometimes higher than government or foreign organisations, since they are part of the local culture.[1,3] They are also known for their positive values such as justice, compassion and respect for human dignity.[3] FBOs can have a positive role in facilitating behaviour change with a large constituency on a weekly basis, affording opportunities for information-sharing and teaching. Religions uphold the principles surrounding family, marriage and sexuality; promoting abstinence outside of marriage; and fidelity within marriage.[6,7] FBOs, therefore, have the potential strength to be key role players in combating the HIV pandemic, but this potential is limited by several weaknesses.

The weaknesses of Faith-based organisations in HIV prevention work

In the early days of HIV in Africa, the Church added to the stigma of those diagnosed with HIV. Many church leaders are not comfortable with speaking openly about sex and give inadequate attention to issues such as domestic violence or sexual coercion.[3,8] The church has often ignored the needs of sexually-active adolescents and has enormous issues with the topics of gender and homosexuality.[6] FBOs contributed to this stigma since many churches viewed HIV infection as being the consequence of immoral actions. Although the position of the church has changed slowly over the past twenty years, stigmatising attitudes continue at the local level.[3,6] Churches have been criticised for patriarchal and hierarchical structures that promote gender inequality.[4,6,7] The most highly-publicised negative role of the church is its attitude toward condoms; especially the Roman Catholic and Pentecostal Churches. As a Catholic priest in Kenya said:

> There is no place in our religion for the use of condoms, whether in the regulation of fertility or in the control of the diseases. And that is the teaching of Christ.[8]

Many Protestant churches also believe that teaching about condoms would encourage promiscuity. The condom debate tends to focus almost entirely on individual morality, sidelining issues such as socio-economic status, culture and gender relations.[8]

The influence of Faith-based organisations on sexual behaviour

Research conducted in high-income countries shows that religious faith plays a role in protecting young people from early sexual activity.[9,10,11,12,13,14,15] Religious youths were likely to have fewer sexual partners and to delay sexual initiation.[11,12,15,16,17] However, studies also indicate that sexually-active religious youths were less likely to use protection due to the linking of condoms with sin.[13,14,15,16,18] Thus studies from high-income countries indicate that although religiosity may protect against initiating sexual activity, it may fail to protect against unsafe sex once youths are sexually active. There are a few studies on religiosity and sexual activity from Africa,[19,20,21,22] and the eleven studies found are summarised in Table 1.

Sexual activity

Two studies reported a later age of sexual debut for religious youth, whereas three others showed no impact.[20,22,23,24,27] Studies from South Africa and Nigeria found that sexual activity amongst church youth did not appear to differ substantially from that of the local community.[22,23,25,26] As these studies are based in different cultural and theological groups, they suggest that the effect of religiosity on sexual behaviour might be less in Africa than in high-income countries. Only one study showed an impact of religiosity on numbers of partners whereas all the others showed no impact.[24] Most of the studies showed a reduction in condom use and one study showed no impact.[27]

Non-vaginal sex

In South Africa, church youth engage in oral and anal sex in order to maintain a technical virginity.[23,25] Because the

TABLE 1: Studies linking religion and sexual behaviour in Africa.

Study	Location	Sample size	Age (Years)	Results†
Survey of Anglican Youth[23]	Cape Town, South Africa	1306	12–19	• 30% were sexually active (40% of males, 21% of females) • Only 35% used condoms at sexual debut • 6% were forced to have sex at sexual debut • 33% of sexually active youth had more than four partners • Rates of sexual activity were similar to the general population
Survey of youth in Pentecostal and Mainline churches[22]	Nigeria	341	12–35	• By the age of 19, 42% of girls and 44% of boys were sexually active • Rates of sexual activity were similar to the general population (65% vs. 63%) • No significant difference in number of partners or abstinence between Pentecostals and Mainline churches • Pentecostals more likely to use a condom than Mainline (p = 0.007)
National survey of women[19]	Ghana	4843	15–49	• Self-reported low risk of AIDS: More Christians reported a low risk (56%) than non-Christians (49%) ($p < 0.001$) • AIDS knowledge: Christians had highest level (Roman Catholic 76%, Protestant 87%, no religion 54%) ($p < 0.05$) • Higher levels of religiosity linked to lower levels of condom use ($p < 0.05$) • The effect of religion on avoidance of multiple partners was not significant
Survey of first year university students[24]	Western Cape, South Africa	1817	18–21	Students with high levels of religiosity were: • More likely to have a later age of sexual debut ($p < 0.01$) • Less likely to intend to be sexually active in the year ahead ($p < 0.01$) • Less likely to use safer sex practices ($p < 0.01$) • Reporting fewer sexual partners in high school ($p < 0.01$)
Survey of rural community[21]	Senegal	858	15–59	Men who cited religion as very important were: • Less likely to intend to change risky sexual behaviour (OR 0.8 (CI** 0.4–1.0) Women who cited religion as very important were: • More likely to agree that condoms are forbidden by religion (OR 2.7 (CI 1.1–6.5)
National Health Survey[20]	Nigeria	2070	15–19	Males and females: • A higher importance of religion had no significant effect on sexual activity • Frequent religious attendance had a close to significant difference on sexual activity (males p = 0.05, females p = 0.08)
Survey of Anglican Youth[25]	South Africa, Namibia, Lesotho, Swaziland	164	14–17	Anglican youth: • 92% considered themselves religious • 24% were sexually active • Types of sex: oral 12%, vaginal 28%, anal 2% • 12% had been forced to have sex • Agree 'people should wait until they are married to have sex' – 80% • Are willing to wait if they haven't yet had sex – 79%
Survey of Anglican Youth[25]	South Africa, Namibia, Lesotho, Swaziland	174	18–24	Anglican youth: • 45% currently sexually active • 61% have been sexually active • 84% think sex is only okay when you are married
Survey of religious congre-gations[26]	Mozambique	731	Adults	• Pentecostals used condoms less at the last sexual encounter (28%) than people from Mainline churches (37%) (OR 0.35 (CI 0.18-0.69))
National Health Survey[27]	Zambia	5534	13–24	• Conservative church groupings (e.g. Jehovah's Witnesses) more likely to delay sexual initiation ($p < 0.01$) • Conservative church groups less likely to use condoms ($p < 0.01$)
Survey of blood donors[28]	Ghana	348	Adults	• No significant difference in HIV levels between those who believed that extramarital sex was a sin or believed that religion helps you to abstain • HIV levels were lower amongst those who were leaders in their church (OR 0.4 (CI 0.2-0.8))
Survey of high schools[29]	Nigeria	2 schools	High school	• Sexually-active students at religious school used condoms less (4%) than at public schools (37%) ($p < 0.01$)

Source: Literature review. Sources cited individually in Study column can be obtained from http://dx.doi.org/10.4102/phcfm.v5i1.464
CI, Confidence interval; OR, Odds ratio.
†, Odds ratio (OR) or p-value were not recorded in all cases

church often views these subjects as 'taboo' they are possibly exposing youth to risk through a lack of information.

Gender

One study showed higher levels of sexual activity amongst religious girls, as compared with non-religious girls.[22] Religious girls may also be at higher risk of HIV infection because they are more likely to see condoms as forbidden by their religion.[21] They may also conform to religious teaching to be submissive, finding it harder to either refuse sex or negotiate for condom use. This finding contrasts with studies from high-income countries that show that religiosity can aid in reducing sexual activity amongst girls and could point to lower levels of self-efficacy amongst African women.[21]

Sexual coercion

Rates of sexual coercion are high amongst church youth in some of these studies and this is an area of concern since few religious organisations deal with this issue openly.[23,25]

These findings suggest that religious people may be at higher risk of contracting HIV, since the protective effect of a raised age of sexual debut may be cancelled out by the negative impact of reduced condom use. The positive effect of religion which was noted in high-income countries appears to be weaker in Africa.

How Faith-based organisations influence sexual behaviour

Several factors determine the extent to which an individual's behaviour is influenced by their religiosity. These include moral and religious teaching, socialisation within the group, level of attendance and commitment to the group.[27,30,31]

Teaching on extramarital sex

Most religious groups are opposed to premarital and extramarital sex, but messaging varies between groups.[30,32] In Zionist and Mainline Churches, the 'approach seems to

be that promiscuity is bad, but that abstinence is unrealistic, and that pre-marital sex with one partner is admissible'.[30] In contrast, the Pentecostal churches give very clear directives against pre-marital sex:

> 'The abasindiswa (Pentecostals) don't have sex at all before marriage. But we amakholwa (Mainline) are more realistic, we know that we are human. So we do have our boyfriends, but just one at a time. Non-church goers have as many relationships as they want'. [30]

Teaching on condoms

Although Pentecostal and Catholic churches take a stronger stance against condom usage than others, it appears that the official teaching of the Catholic Church is not always adhered to at grassroots level and some priests discuss condom use privately with parisioners.[31] In contrast, the Pentecostal church appears to be strictly against condoms, at both official and grassroots levels. Some Pentecostal leaders described condoms as 'satanic' and 'promoters of sin'.[32] Amongst Mainline churches there is often more openness to the promotion of condoms through the ABC (Abstain, Be faithful, Condomise) message. However, many leaders feel that these are conflicting messages:

> I find it difficult to tell my members to use Chishango (condoms) should they fail to abstain. I tell someone that doing this is sinning. I have disseminated two different messages at once. [31]

Methods of teaching

Current moral teaching does not appear to be effective in leading to behaviour change and churches often address issues of sexuality in didactic and judgemental ways.[6] Young people are told to stay away from sex, but are not empowered with the skills to be able to do so. Changing values and behaviour requires interaction, discussion and clarification.[33] In order to adopt and internalise new values, interactive dialogical methods of teaching are likely to be more effective. Through participatory educational methods, young people can apply their spiritual values to the area of sexuality as well as develop a critical consciousness around their gender roles that protects them better from unsafe sex.[34]

Attitudes to alcohol

Religious groups tend to have more conservative attitudes to alcohol, which may lead to a reduction in levels of unsafe sexual behaviour (as this is often seen to occur under the influence of alcohol).[9,35]

Building self-efficacy

Religion helps people in their search for meaning and associations have been found between self-efficacy and religiosity.[9,12] Self-efficacy can be increased as young people are affirmed and given opportunities for leadership.[36]

Social groups

The more deeply involved religion is in daily life, the greater its ability to influence behaviour.[3,30] In South Africa, Pentecostal youth meet about five times a week and this group has a strong influence on their attitudes and behaviour, helping them to abide by stricter rules. In contrast, few of the Mainline churches have youth meetings more than once a week:

> Given the muted religious experience of Mainline Christianity, the absence of youth groups or choirs (socialisation) and the lack of specific teaching on sex-related matters (indoctrination) the influence of these churches on sexual praxis is limited.[30]

Social capital can be increased as young people become more involved in the church through positive peer pressure and by building relationships with adults who are positive role models.[31,37,38]

Social control

Conservative denominations also exercise control over young people's sexual behaviour. In Zambia, the 'New Mission' churches (e.g. Jehovah's Witness, Seventh Day Adventist) had a greater degree of social control than other denominations as those found guilty of premarital sex were removed from membership. Other denominations are more flexible, with doctrines based on repentance and forgiveness.[27,32]

Level of commitment

Sexual behaviour is also impacted by a person's level of commitment to their religion.[27,31,39] With greater levels of commitment, an individual will receive more frequent religious messages and will socialise with peers with similar attitudes.[40] Fatusi's study in Nigeria found that increased attendance at church increased sexual activity, whereas those who attached a higher level of importance to religion had lower rates of sexual activity.[20] This could indicate that, in certain communities, attending church is one of the ways to meet sexual partners. Myint's study[41] also indicated that HIV-positive people may attend church more frequently as a source of support.

Limitations of the review

This was an extensive review of the literature as part of a doctoral thesis, however the methodological rigour of a systematic review on one specific research question was not followed. The literature found was very limited and, as a result of its paucity, it was necessary to include studies which were not methodologically of a high standard. For example, details of the methods and outcome measures were often not well defined. Although the literature is reviewed in terms of an African perspective, the huge variety of contexts, cultures and religions within Africa make it difficult to generalise. The findings of this review should therefore be seen as preliminary and tentative. Nevertheless, the review summarises the available literature in an aspect of HIV prevention that is often overlooked from a health perspective. There is a need for further research to explore the suggested trends and associations. The majority of the literature was from the Christian tradition and very little was found from other religious traditions.

Conclusions

In Sub-Saharan Africa, given the church's accessibility, affordability and acceptability, FBOs are potentially-important role players in HIV prevention. However, this potential is undermined by the church's difficulties with discussing sexuality, avoiding the stigma of HIV, promoting gender equality and accepting the use of condoms.

In contrast with high-income countries, preliminary findings suggest that religiosity does not have a positive impact on sexual behaviour in Africa, apart from on the most committed members. In general, church-based youth may be at higher risk than the general population since sexual activity is similar, but they are less likely to use protection. Young women in particular appear to be at risk. The church needs to take up the challenge of empowering young women as well as recognising the need for protection of their sexually-active youth.

Faith-based organisations influence sexual behaviour through their moral and religious teaching, but differ significantly between denominations in the content of the teaching and usually do not engage with effective teaching methods. They may, however, have a positive impact on alcohol use, self-efficacy and peer pressure through social engagement and control. The level of an individual's commitment is also associated with the effect on sexual behaviour.

Acknowledgments

Prof. D. Nel from the Centre for Statistical Consultation at Stellenbosch University provided statistical support and analysed the data. Prof. C. Kapp, recently retired from the Faculty of Education at Stellenbosch University, and Prof. P.J.T. de Villiers, previously Head of Family Medicine and Primary Care at Stellenbosch University, provided supervision during the research process, but did not feel a need to be involved as authors in any resultant publications.

Competing interests

The authors declare that they have no financial or personal relationship(s) that may have inappropriately influenced them in writing this article.

Authors' contributions

R.M. (Stellenbosch University) conducted this review as part of her PhD. R.M. (Stellenbosch University) made significant intellectual contributions.

References

1. ARHAP (African Religious Health Assets Programme). Appreciating assets: the contribution of religion to universal access in Africa. Cape Town: World Health Organization; 2006.
2. UNAIDS. UNAIDS religion and faith based organizations (FBO) working group strategy development meeting. Geneva: UNAIDS; 2008.
3. Keough L, Marshall K. Faith communities engage the HIV/AIDS crisis: Lessons learned and paths forward. Georgetown: Berkley Center for Religion, Peace and World Affairs; 2007.
4. Chikwendu E. Faith-based organisations in anti-HIV/AIDS work among African youth and women. Dialect Anthropol. 2004;28(3–4):307–327. http://dx.doi.org/10.1007/s10624-004-3589-1
5. Schmid B, Thomas E, Olivier J, et al. The contribution of religious entities to health in Sub-Saharan Africa. University of Cape Town: ARHAP (African Religious Health Assets Programme); 2008.
6. Taylor N. Working together? Challenges and opportunities for international development agencies and the church in the response to AIDS in Africa. Teddington, Middlesex: TEARFUND; 2006. Report No. 7.
7. Haddad B, Olivier J, De Gruchy S. The potential and perils of partnership: Christian religious entities and collaborative stakeholders responding to HIV and AIDS in Kenya, Malawi and the DRC. University of Cape Town: ARHAP (African Religious Health Assets Programme); 2008.
8. Kelly M. The role of religions in the HIV/AIDS epidemic (with special reference to Christianity and Islam). UNAIDS; 2003.
9. Aukst-Margetić B, Margetić B. Religiosity and health outcomes: review of literature. Coll Antropol. 2005;29(1):365–371.
10. National Campaign to Prevent Teenage Pregnancy. Bridging the divide: involving the faith community in teen pregnancy prevention. [document on the Internet] c2004. [cited 2012 May 1]. Available from: http://www.thenationalcampaign.org/resources/pdf/Bridging_FINAL.pdf
11. Thornton A, Camburn D. Religious participation and adolescent sexual behavior and attitudes. J Marriage Fam. 1989;51(3):641–653. http://dx.doi.org/10.2307/352164
12. Hubbard D, Wingood G, DiClemente R, et al. Religiosity and risky sexual behaviour in African-American adolescent females. J Adolesc Health. 2003;33(1):2–8. http://dx.doi.org/10.1016/S1054-139X(02)00460-3
13. Rostosky S, Wilcox B, Comer M, et al. The impact of religiosity on adolescent sexual behaviour: a review of the evidence. J Adolesc Res. 2004;19(6):677–697. http://dx.doi.org/10.1177/0743558403260019
14. Brewster K, Cooksey E, Guilkey D, et al. The changing impact of religion on the sexual and contraceptive behaviour of adolescent women in the United States. J Marriage Fam. 1998;60(2):493–504. http://dx.doi.org/10.2307/353864
15. Zaleski E, Schiaffino K. Religiosity and sexual risk-taking behavior during the transition to college. J Adolesc. 2000;23(2):223–227. http://dx.doi.org/10.1006/jado.2000.0309, PMid:10831144
16. Jones R, Darroch J, Singh S. Religious differentials in the sexual and reproductive behavior of young women in the United States. J Adolesc Health. 2005;36(4):279–288. http://dx.doi.org/10.1016/j.jadohealth.2004.02.036, PMid:15780783
17. Whitbeck L, Yoder K, Hoyt D, et al. Early adolescent sexual activity: a developmental study. J Marriage Fam. 1999;61(4):934–946. http://dx.doi.org/10.2307/354014
18. Cooksey E, Rindfuss R, Guilkey D. The initiation of adolescent sexual and contraceptive behaviour during changing times. J Health Soc Behav. 1996;37(1):59–73. http://dx.doi.org/10.2307/2137231, PMid:8820311
19. Takyi B. Religion and women's health in Ghana: insights into HIV/AIDS preventive and protective behaviour. Soc Sci Med. 2003;56(6):1221–1234. http://dx.doi.org/10.1016/S0277-9536(02)00122-3
20. Fatusi A, Blum R. Predictors of early sexual initiation among a nationally representative sample of Nigerian adolescents. BMC Public Health. 2008;8:136–150. http://dx.doi.org/10.1186/1471-2458-8-136, PMid:18439236, PMCid:2390536
21. Lagarde E, Enel C, Seck K, et al. Religion and protective behaviours towards AIDS in rural Senegal. AIDS. 2000;14(13):2027–2033. http://dx.doi.org/10.1097/00002030-200009080-00019, PMid:10997408
22. Nweneka C. Sexual practices of church youth in the era of HIV/AIDS: Playing the ostrich. AIDS Care. 2007;19(8):966–969. http://dx.doi.org/10.1080/09540120701249512, PMid:17851991
23. Mash R, Kareithi R, Mash B. Survey of sexual behaviour among Anglican youth in the Western Cape. S Afr Med J. 2006;96(2):124–127.
24. Nicholas L, Durrheim K. Religiosity, AIDS and sexual knowledge, attitudes, beliefs and practices of black South African first year university students. Psychol Rep. 1995;77(3 Pt 2):1328–1330. http://dx.doi.org/10.2466/pr0.1995.77.3f.1328, PMid:8643798
25. Erasmus J, Le Roux M. Baseline study about sexuality and AIDS among 10 to 24 year old members in the 19 selected dioceses. University of Stellenbosch: Unit for Religion and Development Research; 2008.
26. Agadjanian V. Gender, religious involvement and HIV/AIDS prevention in Mozambique. Soc Sci Med. 2005;61(7):1529–1539. http://dx.doi.org/10.1016/j.socscimed.2005.03.012, PMid:8643798
27. Agha S, Hutchinson P, Kusanthan T. The effects of religious affiliation on sexual initiation and condom use in Zambia. J Adolesc Health. 2006;38(5):550–555. http://dx.doi.org/10.1016/j.jadohealth.2005.04.012, PMid:16635766
28. Allain J, Anokwa M, Casbard A, et al. Sociology and behaviour of West African blood donors: the impact of religion on human immunodeficiency virus infection. Vox Sang. 2004;87(4):233–240. http://dx.doi.org/10.1111/j.1423-0410.2004.00578.x, PMid:15585018
29. Borire A, Oyekunle O, Izekor T, et al. Comparing the knowledge and attitude about HIV/AIDS and the sexual behaviour of secondary school students of a missionary school and a public school. Nig Q J Hosp Med. 2008;18(4):206–210.
30. Garner R. Safe sects? dynamic religion and AIDS in South Africa. JMAS. 2000;38(1):41–69.
31. Trinitapoli J. The role of religious organizations in the HIV crisis of Sub-Saharan Africa [Doctoral dissertation]. Austin: University of Texas; 2007.

32. Van Deutekom H. And the Lord said: abstinence, be faithful ... condom use?!: A comparative case study of the impact of the Catholic Church and the Church of Pentecost on HIV prevention in Nandom, Ghana [Masters dissertation]. Amsterdam: University of Amsterdam; 2007.
33. Lawlor W, Morris R, McKay A, et al. Human sexuality education and the search for values. SIECUS Report. 1990;18(6):4–14.
34. Campbell C, MacPhail C. Peer education, gender and the development of critical consciousness; participatory HIV prevention in South African youth. Soc Sci Med. 2002;55(2):331–345. http://dx.doi.org/10.1016/S0277-9536(01)00289-1,
35. Poulson R, Eppler M, Satterwhite T, et al. Alcohol consumption, strength of religious beliefs, and risky sexual behaviour in college students. J Am Coll Health. 1998;46(5):227–232. http://dx.doi.org/10.1080/07448489809600227, PMid:9558822
36. Bandura A. Social cognitive theory and exercise of control over HIV infection. In: DiClemente R, Peterson J, editors. Preventing AIDS: theories and methods of behavioural interventions. New York: Plenum Press; 1994. p. 25–53.
37. Campbell C, Nair Y, Maimane S. Building contexts that support effective community responses to HIV/AIDS: a South African case study. Am J Community Psychol. 2007;39(3–4):347–363. http://dx.doi.org/10.1007/s10464-007-9116-1, PMid:17447133
38. Campbell C, Williams B, Gilgen D. Is social capital a useful conceptual tool for exploring community level influences on HIV infection? An exploratory case study from South Africa. AIDS Care. 2002;14(1):41–54. http://dx.doi.org/10.1080/09540120220097928, PMid:17447133
39. Odimegwu C. Influence of religion on adolescent sexual attitudes and behaviour among Nigerian university students: affiliation or commitment? Afr J Reprod Health. 2005;9(2):125–140. http://dx.doi.org/10.2307/3583469, PMid:16485593
40. Beal K. Religiosity and HIV risk among adolescents in Accra: a qualitative analysis. Sexuality in Africa Magazine. 2005;2(2):11–14.
41. Myint T, Mash B. Coping strategies and social support after receiving HIV-positive results at a South African district hospital. S Afr Med J. 2008;98(4):276–278.