

**An Investigation into the Knowledge Levels, Attitudes, Beliefs and  
Practices of Evangelical and Pentecostal Christians in Zimbabwe  
Regarding HIV and AIDS prevention Strategies**

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**A Case of Glenview, Harare Urban**

**11 October 2011**

*Compiled by Jonathan Chikumbu*

*Masters in Population Studies-University of Zimbabwe (UZ)*

## **Acknowledgements**

I would like to thank the University of Zimbabwe (UZ) for allowing me to be their student. I would also like to thank my classmates for the support which they gave me. Above all, I would also like to appreciate the support and help that I got from the Glenview Community, Harare City Council, National Aids Council of Zimbabwe, Evangelical Fellowship of Zimbabwe and last but not least, Professor Mhloyi, my project supervisor.

**Dedication**

To my beloved wife Melody, son Elroy and the Christians in Zimbabwe, and the world over. HIV is not fiction, it is reality and it kills but at the same time one can live positively with it. May you take the necessary steps to protect yourselves from it, and may you go out into the world and make a positive impact. Combined HIV free families form a community, and combined HIV free communities form a nation. May you make the world a better place for the young, the elderly, the pregnant, the orphans and everyone.

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## **Acronyms**

AIDS	Acquired Immune-Deficiency Syndrome
ART	Anti-retroviral Therapy
ARV	Antiretroviral Drugs
BC	Behaviour Change
CSO	Central Statistics Office
CSW	Commercial Sex Workers
FBO	Faith Based Organisation
HBC	Home Based Care
HIV	Human Immuno Virus
MC	Male Circumcision
MIMS	Multiple Indicator Monitoring Survey
MoHCW	Ministry of Health and Child Welfare
MoLSS	Ministry of Labour and Social Services
NAC	National AIDS Council
NGO	Non-Governmental Organisation
OVC	Orphans and Vulnerable Children
PLWHA	People Living with HIV and AIDS
PPTCT	Prevention of Parent to Child Transmission
PSI	Population Services International
SAfAIDS	Southern Africa HIV and AIDS Information Dissemination Service
STI	Sexually Transmitted Infections
UNAIDS	Joint United Nations Program on HIV and AIDS
UNICEF	United Nations International Children's Education Fund
VCT	Voluntary Counseling and Testing
WHO	World Health Organisation

## **Chapter 1: Introduction**

### **1.1 Introduction**

This study is an investigation into the knowledge, attitudes, beliefs and practices of Pentecostal Christians regarding HIV prevention strategies. This chapter presents and explains the background, justification, problem statement, objectives, theoretical and conceptual framework, definition of terms and the order of presentation of the study.

### **1.2 Background**

Human Immuno Virus (HIV) is an incurable viral infection which destroys the immunity system of a person thus exposing it to diseases (UNAIDS 2010). In Zimbabwe and other countries, HIV has emerged as a deadly disease which is caused by high prevalence of STDs, multiple sexual relationships and traditionally low use of condoms (Ministry of Labour and Social Services (MoLSS) 2010). According to the same source, poverty and the relatively low health status of much of the population including low nutrition, low status of women and unequal gender relations, settlement patterns and worker migration, aversive cultural practices and low levels of male circumcision are other factors which contribute to the HIV infections. There is a need to therefore design and implement comprehensive HIV polices so as to reduce the effects of the pandemic.

In the past 22 years from the year 1987, HIV infected 40 million people who are now living with the virus, and it also orphaned 4 million children (Southern Africa HIV and AIDS Information Dissemination Service (SAFAIDS) 2009). The infection levels are still high for many developing nations; Botswana (24.8 percent), Lesotho (23.6 percent), and Swaziland (25.9 percent), and there is need for increased joint efforts to further reduce the rates (Joint United Nations Program on HIV and AIDS (UNAIDS) 2010). However, the HIV prevalence rates are decreasing at varying rates in many nations. A good example is Zimbabwe whose HIV infection rate decreased from 23.7 percent in 2001 to 13.7% percent in 2010 (Ministry of Labour and Social Services (MoLSS) 2010). There is also need to have increased joint efforts to reduce the infection rates in Zimbabwe (United Nation Development Program (UNDP) 2010). The epidemic has since

stopped being regarded as an individual health issue to a social issue which affects all aspects of life. It thrives where there is poverty, human rights violations, child abuse, racism, ageism, gender inequality, classism, HIV stigma, international injustice and violence thus making the most vulnerable groups to be vulnerable to it. Moreso, the epidemic affects the social, economic, political, psychological and spiritual lives of people (Dube 2004). Amongst the Christians, it raises questions like: Does God care, does God hear prayers or heal, and is God punishing us? The damaging effects of HIV therefore call for a multisectoral approach which sees to it that every individual and institution plays a role in mitigating the pandemic. HIV was generally referred to as a public health issue, however, the church finally joined the struggle to ensure that there is a holistic approach in fighting the pandemic

### **1.3 Statement of the Problem**

There is no cure for HIV yet, and anti-retroviral drugs available can only stop the multiplication of the virus thus making HIV a threat to human life (Tearfund 2006). Donors are increasingly interested in HIV and AIDS work carried out by local churches and Christian grassroots organisations. Their reasons are that local churches are close to the community, the church is often well-respected, people listen to religious leaders, and serving marginalised people fits in well with the Christian faith. Also, some churches have experience of social action within their communities and some churches are already effectively addressing HIV and AIDS in their communities (Tearfund 2006). One in five organisations dealing with HIV is Faith Based (United Nations International Children's Education Fund (UNICEF) 2010). However, some churches are unwilling to become involved in work with those affected by HIV and AIDS. Usually this is because HIV is wrongly viewed as a punishment from God on individual people who engage in ungodly behaviour. In some places, people who are known to be living with HIV are not welcome in churches (World Council of Churches (WCC) 2007). For many years, HIV and AIDS was seen as the problem of people outside the church. However, churches now have to accept that HIV and AIDS are present among church members. As more and more people are dying from AIDS, it is becoming a subject that communities are talking about more openly (Tearfund 2006). This may make it easier for church members to be open about their HIV status. However, the challenge is that there is little literature available to inform the planning of church

programs especially on the knowledge levels, attitudes and beliefs of Pentecostal Christians regarding HIV.

It is worth mentioning that not many studies have been done on the influence of the Pentecostal Christian Religion in Zimbabwe with regards to HIV prevention knowledge levels, attitudes, beliefs and practices. Mention can be made of the study done by Central Statistics Office (CSO (2005, 2006)) and another one which was conducted by PSI in 2003. Both studies focused on knowledge levels, attitudes and beliefs and practices of people regarding HIV. The studies were not exclusively for Pentecostal Christians although they factored in the religion aspect in data analysis. However, about six to seven years have passed and a lot of changes have occurred in Zimbabwe resulting in the massive decline of HIV infections from 24.6% in 2003 to 13.7% in 2010 but no study has been done to inform Christian HIV Programming of HIV (MoLSS 2010). HIV affects all aspects of life and the church is even more affected since it is usually a place of refuge for the afflicted in society, thus the need for a thorough analysis of the knowledge, attitudes, beliefs and practices of people (Tearfund 2006).

#### **1.4 Justification of the Study**

Zimbabwe is one of the countries with the highest infection rates. The trends have been going down from high levels of 21.6% in 2001 to 13.7% in 2010 (MoHCW 2010). Also, 25% of the children are orphaned (Central Statistics Office (CSO) and UNICEF 2009). However, the levels are still high even if there has been a tremendous fall and there is need to reduce them. Zimbabwe declared HIV and AIDS an emergency thus calling for a multisectoral approach in mitigating it (NAC 2007). As such, this calls for a special recognition and support of the church which has over 80 million people in Africa (Association of Evangelicals in Africa 2009). The Christian religion also has between 75% and 85% of the Zimbabwe population (World Council of Churches 2007). At the community level, religious organizations are influential social networks that have the power to support or stigmatize people living with HIV and AIDS (PLWHA), promote or impede HIV education and endorse or reject medical treatment of HIV. Churches can give people support for both spiritual matters and daily material needs. They can provide PLWHA with spiritual counseling, prayers for healing, hope for personal spiritual

salvation, social and material support, personalized care when they are sick, and assurances of burial after they die. On a regulatory level, some churches require or heavily encourage couples to be tested for HIV before getting married (Association of Evangelicals in Africa 2009). However, the challenge is that the church does not have adequate information to inform its policies and programs. Of importance to note is that there is no data regarding Pentecostal Christians HIV KABP (EFZ 2009). In general, well informed HIV programs and policies in church will help to reduce stigma, HIV prevalence, pressure on health services, deaths, etc. There is need to therefore support the church's services through researches. The study on Pentecostal Christian knowledge levels, attitudes, beliefs and practices regarding HIV prevention will also help to provide empirical data about HIV to the church.

## **1.5 Objectives**

The goal of the project was as follows:

- To provide information which may be used to reduce the spread of HIV and AIDS in Zimbabwe.

The objectives of the study were as follows:

1. To identify the HIV and AIDS prevention practices among Pentecostal Christians.
2. To assess the knowledge levels of Pentecostal Christians regarding HIV and AIDS prevention
3. To assess the beliefs and attitudes of Pentecostal Christians regarding HIV and AIDS prevention strategies..

## **1.6 Order of Presentation**

### *Chapter One*

This chapter presents the introduction, background of the study, statement of the problem, justification of the study and the research objectives.

### ***Chapter Two***

The chapter presents the literature review from other relevant studies on HIV and AIDS prevention projects. It focuses on world trends, African Trends, Zimbabwean trends, root causes of the rise and downfall of HIV, Zimbabwean policies to mitigate HIV and the role of the church in mitigating the spread and effects of HIV and AIDS.

### ***Chapter Three***

This chapter presents the qualitative and quantitative methods that were used in the study and how the respondents of the survey were selected

### ***Chapter Four***

The findings of the study are presented in the fourth chapter. A thematic approach was adopted.

### ***Chapter Five***

The discussion of the research findings as well as the recommendations and conclusion were presented in chapter 5. Some statistics from other empirical studies and qualitative and quantitative data from the survey were used. A thematic approach was used in discussing the findings

## **1.8 Summary**

The objectives of the study were to identify the HIV and AIDS prevention practices among Pentecostal Christians, to assess the knowledge levels of Pentecostal Christians regarding HIV and AIDS prevention and to assess the beliefs and attitudes of Pentecostal Christians regarding HIV and AIDS prevention strategies. This was against a background that there is no cure for HIV and AIDS yet and the epidemic has killed and infected many people. Also, the churches are better placed to deal with HIV mitigation but the challenge is however that not many studies have been done on the Pentecostal Christians' knowledge, attitudes and beliefs to inform the church on its responses to the pandemic. People's knowledge can influence their actions towards adopting risk-reduction behaviors such as abstinence and condom use. On the other hand, the attitudes that people have towards HIV prevention methods also influence their behavior. Also, the beliefs that people have influence their reactions towards health related issues. The Health

beliefs Model helps in explaining people response to health programs and it was adopted for the development of the conceptual framework.

## **Chapter 2: Literature Review**

### **2.1 Introduction**

This section presents a review of available information on knowledge levels, attitudes, beliefs and practices of Pentecostal Christians regarding HIV prevention strategies. Special focus shall be put on world, regional, Zimbabwean and Glenview levels and trends on HIV knowledge, attitudes, beliefs and practices. Furthermore, this section will present the theoretical and logical frameworks for the study

### **2.2 World HIV Trends**

The number of people newly infected with HIV globally fell from 3.5 million in 1996 to 2.7 million in 2005 (UNDP 2010). According to the same source, the number of AIDS-related deaths has declined from 2 million in 1990 to 1.7 million in 2007. However, two thirds of new infections and a similar rate of those currently infected live in sub-Saharan Africa. Infection rates are also rapidly increasing in Eastern Europe and Central Asia. For instance, prevalence of HIV infection in Kyrgyzstan increased from 10.2% in 2008 to 12.8% in 2009 (UNDP 2010). One of the major causes identified is the rapid growth in injecting drug users. Targeted interventions have been successful in many cases. A survey of sex workers in Cambodia indicated that condom use more than doubled after the introduction of the 100% Condom Use Programme that was introduced in the country (UNDP 2010). However, the rates of adherence to condom use vary across the globe depending on the culture, religion, knowledge levels and sex of people in different countries.

### **2.3 Sub Saharan Africa HIV Levels and Trends**

Sub-Saharan Africa bears an inordinate share of the global HIV burden and a total of 23 million people living with HIV and AIDS (PLWHA) reside in the region (USAID 2011). The number of new infections on the continent seems to have peaked in the mid-1990s and the epidemic continues to be a major challenge to the health and development of many African nations. The epidemic varies considerably from country to country across the continent with prevalence estimates ranging from 0.1 percent in Madagascar to more than 15 percent in some of the

countries in southern Africa. Deaths from HIV and AIDS continue to decline as antiretroviral therapy (ART) coverage and prevention of mother-to-child transmission of HIV (PMTCT) coverage increase (USAID 2011)

The impact of HIV and AIDS varies considerably in the countries of the region, depending on the size and duration of the outbreak. Most countries have generalized epidemics. Adult prevalence exceeds 20 percent in some countries, including Botswana (24.8 percent), Lesotho (23.6 percent), and Swaziland (25.9 percent) (UNAIDS 2010). Others have concentrated epidemics with disease hotspots, such as Burundi, where the prevalence of 38 percent among sex workers is 16 times higher than that of the general adult population. In West Africa, general prevalence is markedly lower than in East and Southern Africa, but epidemics among most-at-risk populations (MARPs) are common (USAID 2011). Due to this variation, the strategic approaches to combat this disease must be designed to respond to the epidemiology of the disease in individual countries and sub-regions.

Sub-Saharan Africa has a heterogeneous epidemic with differing patterns in the three regions. In Southern Africa, prevalence has stabilized at high levels in most countries while prevalence in East Africa has declined since 2000 and stabilized at lower levels than in Southern Africa. In West Africa, prevalence rates are markedly lower than on the rest of the subcontinent at under 2 percent across the region except in Cameroon (5.3 percent), Côte d'Ivoire (3.4 percent), Gabon (5.2 percent), and Nigeria (3.6 percent) (USAID 2011). Within countries, the impact of HIV AND AIDS also varies a great deal, with urban centers often being the most affected. Across all three regions, heterosexual sex is the primary form of transmission, though in countries with more concentrated epidemics, other forms of transmission can play a significant role including sex work, migration, men having sex with men and mother-to-child transmission (USAID 2011).

#### **2.4 Southern Africa.**

Southern Africa had a total of 11.3 million PLWHA in 2009 (UNAIDS 2010). Southern Africa continues to be the most severely affected region in the world, accounting for nearly one-half of all PLWHA on the subcontinent. Also, 40 percent of all HIV-positive women in the world live in

the sub-region (UNAIDS 2010). According to the same source, more than one in five PLWHA live in Botswana, and Swaziland. Also, 5.6 million PLWHA live in South Africa alone globally. Swaziland has the highest prevalence than any country in the world and approximately one in every four citizens is HIV positive (UNAIDS 2010). Further decreasing the number of new HIV infections in Southern Africa is a continuing challenge. Compared to other countries in the sub-region, Angola has a remarkably low HIV prevalence (2 percent), in part due to the limited cross-country travel during its protracted civil war (1975–2002), which impeded the spread of the virus (USAID 2011).

In Southern Africa, the epidemic affects individuals at all levels of society, education, income, and migration strata. Scale-up of prevention programs is necessary to generate continued declines in HIV prevalence and incidence. Unfortunately, current programs often fail to address key drivers of national epidemics such as the paucity of prevention initiatives among people in stable relationships and adults over 25 years of age (USAID 2011).

## **2.5 Zimbabwe HIV Trends**

Like in other African countries, the HIV and AIDS pandemic has been showing a downward trend in Zimbabwe in the past 5 years. The HIV prevalence among adults (15-49) declined from 24,6 in 2003 to 20,1 in 2005, 18,6 percent in 2005/6 to 15,6 percent in 2007 then it finally dropped down to 13.7 percent in 2010 (MoHCW 2010). Zimbabwe was the only country which experienced such a drastic decline in Southern Africa. The prevalence rate for women aged 15-24 also declined from 29,6 percent in 2002 to 17,1 percent in 2004, 12.5 percent in 2006 and it finally dropped down to 11.6 percent in 2009. The HIV incidence in Zimbabwe was estimated to have peaked at 4.6 in 1993 and thereafter, it declined to 17 percent in 2005 and currently 0.96 percent in 2009 (MoLSS 2010).

Zimbabwe is still among the four countries with the highest HIV prevalence rates in the world despite the decline. In short, the decline in HIV and AIDS has been attributed to behaviour change through good project programming. Mortality also contributed to the decline in prevalence since access to life saving antiretroviral (ARV) drugs remained limited to women, children and the general population (MoHCW 2010).

The government and civil society worked hand in hand in implementing programs to reduce the prevalence rate. It is also important to note that religion played an important role in Zimbabwe and the world over. Hospitals, clinics, hospices and home-based care institutions serve to alleviate suffering and pain and they also act as important centres for testing and counseling. Much more should and could be done by religious organizations in these areas, but without this religious contribution, the struggle against HIV and AIDS would be much more difficult.

## **2.6 The Church and HIV and AIDS in Zimbabwe**

At first, the church in Zimbabwe was reluctant to be involved in HIV issues (EFZ 2009). Rather, the church lambasted and stigmatized the HIV infected calling it an irrevocable punishment from God for their immorality (Tearfund 2006). There was a silence with regards to HIV prevention for quite some time. Belatedly, there was recognition on both the public health sector and the religious groups that there is need for a multisectoral approach in order to fight HIV and the church was as well recognized as a missing link that needed to be taken on board in all efforts to mitigate the HIV and AIDS pandemic. Later, the church began to be involved however in a rudimentary manner and was expending much of its energy on care and support which was remedial and curative in nature (Tearfund 2006). In the National Community and Home Based Care Guidelines of 2009, the church was still somehow involved in the home based care primarily targeting the religious leaders where the role of the church was to provide guidance, counseling and spiritual support. The Zimbabwe National HIV and AIDS Strategic Plan (ZNASP, 2006-2010) corroborates the same sentiments. In general, religious leaders and faith-based communities are increasingly taking a positive pro-active role in the struggle against HIV and AIDS (World Evangelicals Alliance 2006).

It is worth mentioning that about 80 million people in Africa are Christians (Alliance of Evangelicals in Africa 2009). Also, 75-80% of the people in Zimbabwe are Christians (Evangelical Fellowship of Zimbabwe 2008). About 240, Evangelical denominations and Para-church organisations in Zimbabwe have a coordinating body called the Evangelical Fellowship of Zimbabwe, the non-aligned churches are represented by the Zimbabwe Council of Churches (ZCC) and the Catholics are represented by the Zimbabwe Catholic Bishops Conference (ZCBC). At the apex level is the Heads of Christian denomination and it is headed by the

General Secretaries and Presidents of the three umbrella bodies. The Heads of Christian Denominations formed National Faith Based Council of Zimbabwe an arm which coordinates HIV and AIDS as well as gender programmes. All the three bodies have their HIV policies. Furthermore, in 1997, Christian churches in Zimbabwe formed a coalition body called the Head of Denominations AIDS Committee, whose mandate was to ensure that the churches' ideas were included in relevant government policies (Africa News Network 1997).

In 2005, the Evangelical Fellowship of Zimbabwe in partnership with Futures Groups conducted a series of consultative meetings with representatives of its national structures in the ten provinces of the country. These consultative workshops were a culmination of several efforts and thoughts on how to come up with a comprehensive and effective policy which meaningfully addresses head on the HIV and AIDS pandemic in a period of 25 to 30 years. An HIV and AIDS policy for the network body was produced and streamlined its focus on prevention, intervention and relief. This was a milestone achievement in as far as mobilizing the church's effort in addressing HIV and AIDS issues which were formerly envisaged as a Godly punishment.

In the year 2010, the Evangelical Fellowship of Zimbabwe produced a communiqué which urged its church members to be actively involved in HIV mitigation issues however after a protracted struggle as some members were flaunting very strong resistance ([www.efzimbabwe.org](http://www.efzimbabwe.org)). Such efforts to unite show the determination of the church to organise, plan and eliminate the social ills of the people through their local assemblies (grassroots). Through the efforts of both the church and public health, HIV has declined to 13.7% in 2010 from a high level of 26.5% in 1997 (MoHCW 2009). However, the figure is still high to mention and there is need for further joint efforts between the church and public health to reduce the infection prevalence rate.

The ZCBC, through its HIV and AIDS desk, has since the early 1990s been involved in HIV and AIDS programmes where they focus on prevention, care and support, life skills training, behaviour change and HIV and AIDS education. More so, Caritas, a humanitarian arm of the network body, is involved in a copious number of HIV and AIDS programmes but the most salient ones are for Behaviour Change ([www.zcbc.org](http://www.zcbc.org)).

The ABC model of HIV and AIDS proved difficult for the church to accept especially on the condom use aspect among the unmarried people. The church was pushed to the periphery in terms of intervention (Tearfund 2006). However, with the advent of the Behaviour Change Strategy the church began to play a more salient and proactive role. The National AIDS Council of Zimbabwe in 2008 engaged the National Faith Based Council of Zimbabwe (NFBCZ), an arm of the Heads of Christian Denominations in Zimbabwe to implement the behaviour change programme in Harare and Bulawayo (Evangelical Fellowship of Zimbabwe 2010). It is also important to mention that the coming in of the church was also influenced the converging of network bodies for a workshop on Safe Practices, Available Medication, Voluntary Counseling and Testing (VCT) and Empowerment through Education (SAVE). The S.A.V.E model of HIV and AIDS was popularized by the African Network of Religious Leaders Living with or Personally Affected by HIV and AIDS (INERELA) Zimbabwe and they formed a steering committee to advance the idea of the adoption of the model by the churches (National Faith Based Council of Zimbabwe 2009).

Over the years, a number of documents that seek to address HIV and AIDS programming have been crafted without the involvement of the church but the situation has since changed. The church in Zimbabwe is currently playing a pivotal role in HIV programming through its structures. The Faith Based Organisations (FBOs) and churches have a role to sensitise the people on HIV and AIDS in the Behaviour Change strategy for Zimbabwe (NAC 2006). To date, some representatives of the church sit on the National Aids Council Board. However, some gaps in relation to the necessary required skills and the resources remain a challenge but the church is readily available to save lives (Evangelical Fellowship of Zimbabwe 2009)

## **2.7 Underlying Causes to HIV Transmission**

The high prevalence of STIs is one contributing factor to the high levels of HIV infection. The probability of transmitting HIV during unprotected sex rises dramatically if either partner is infected with another STD, such as syphilis or chancroid. These infections form ulcers and sores which facilitate the transmission of HIV (World Council of Churches (WCC) 2006). Africa has the highest level of STDs in the world and the types most common in Southern Africa are syphilis and chancroid and they are also likely to contribute to high HIV prevalence (Mars 2003).

Due to poverty and weak health systems, these STDs often go untreated and uncured, further contributing to the spread of HIV. Women can be more vulnerable than men because STDs that bring an identifiable system in men are often asymptomatic in women and therefore remain untreated.

A second factor that contributes to the heterosexual spread of HIV is multiple sexual relationships (Tearfund 2006). This is especially true when these partnerships are concurrent. Many Southern Africans have relationships with older persons (the sugar daddy and mummy phenomenon) other than their regular partners and this contributes to the spread of HIV.

When condoms are used consistently and correctly, they are a highly effective means of preventing the transmission of HIV and other STDs. Traditionally condoms were shunned as a method of family planning or disease prevention mainly because they were associated with sexual promiscuity (Tearfund 2006). However, the use of condoms has increased considerably in Southern Africa in recent years in response to the HIV and AIDS but it is still inadequate given the extent of the HIV in the population. Zimbabwean urban women who use condoms are 23.7% and males who use condoms are 57% (ZIMDAT 2009).

Widespread poverty, high rates of unemployment and generally low returns from the informal sector income generating activities have been associated with high-risk sexual behavior and the spread of HIV (UNDP 2010). The differential rates of economic growth between the first and third world also account for the differentials in HIV prevalence rates. First world countries, have high gross domestic product and per capita income, thus the majority of the population has access to the decentralized and cheaper health facilities and services than in the third world. Low rates of economic growth and low per capita incomes for the third world population have posed a great health challenge to the poor majority who lack access to the expensive and decentralized health facilities and services (UNAIDS 2009).

The low social and marginal economic status of women is an important contributor to high-risk sexual behavior and vulnerability to HIV infection. The low level of educational attainment for women reduces their access to jobs, even when jobs are available. Therefore a common coping

strategy for survival is for poor women and adolescent girls to exchange sex for money or gifts. Children and young people can be vulnerable to sexual exploitation by adults (UNDP 2010).

Settlement patterns and worker migration is another contributing factor to high HIV infection. Some of the Southern African countries are relatively highly urbanized and or the populations live in concentrated parts of the country. In Botswana for example, most of the population lives in a narrow corridor between Francistown and Gaborone, well connected by road and rail. High levels of movement back and forth between town, countryside and mining areas influence the spread of the virus throughout the region (Zimunya and Tovera 2002).

Some cultural and religious values expose people to HIV infection. Some white garment churches in Zimbabwe do not believe in visiting the hospital. At the same time some cultural values like polygamy and wife inheritance also contribute highly to HIV infection (UNICEF 2007).

Also, evidence is mounting that HIV is transmitted at a much higher rate in populations where a low proportion of males are circumcised. In Central African countries, it has been argued that if male circumcision is done with sterilized utensils, it will go a long way in improving the biological capacity of men in preventing STDs and HIV (PSI 2009).

## **2.8. Knowledge, Attitudes, Beliefs and Practices Regarding HIV Prevention**

There is scarcity of information regarding Pentecostal Christians KABP. This makes it difficult to allow for trend analysis since the study was specific to the Pentecostal Christians. This section discusses the knowledge levels, attitudes, beliefs and practices of Pentecostal Christians regarding HIV prevention.

### **2.8.1. Knowledge and Risk Perception**

There is scarcity of data regarding the knowledge levels, attitudes, beliefs and practices of Pentecostal Christians regarding HIV prevention in Zimbabwe. This therefore makes it difficult to have a trend analysis of the knowledge, attitudes, beliefs and practices of Pentecostal Christians regarding HIV prevention in Zimbabwe (Tearfund 2006). The perceptions of

vulnerability and basic knowledge about population-level risks of HIV and AIDS as well as methods of prevention have been well-established since the middle 1990s (NAC 2006). A total of 55 percent of women aged 15-49 years had comprehensive knowledge of HIV amongst the general population of Zimbabwe with the Christians included. Also, 66 percent of the women were in urban areas while 48 percent were in rural areas (ZIMDAT 2009). However, the levels of adequacy of practical knowledge related to prevention practices are questionable. This knowledge gap includes lack of understanding of interventions such as Voluntary Counseling and Testing (VCT), Prevention of Parent-to-Child Transmission (PPTCT), Anti-Retroviral Therapy (ART) and Post-Exposure Prophylaxis (PEP) and the accessibility of such services (NAC 2006). Females appear to consistently lag behind males in most areas of HIV and AIDS-related knowledge. While it is a common perception of Zimbabweans that the population is at risk, this is not consistently translated into personalized risk perception (NAC 2006).

In one study done by the Evangelical Fellowship of Zimbabwe with Pentecostal Christians aged 15-24 years in 1998 in Muzarabani, Chitungwiza and Harare, HIV Prevention knowledge was high. The majority of the youth had high knowledge levels of HIV prevention. The majority (94 percent) managed to identify abstinence as a prevention method. Also, myths were very low and the minority (18 percent) suggested that a balanced diet can prevent a person from getting HIV. Table 2.1 shows the statistics from the study.

**Table 2.1: Percentage Distribution of HIV Prevention among Youths (15-24 years)**

Protection Method	Percentage
Good Diet	17.50
Avoiding Touching	23.50
Abstinence	94.00
Condom Use	73.90
Faithful Tested Partner	86.6
Sterile Injection	85.20

*Evangelical Fellowship of Zimbabwe 1998, p14.*

## **2.8.2 Practices**

### **2.7.2.1 Age at First Sexual Exposure**

There is no clear trend in age of sexual debut in Zimbabwe since the beginning of the HIV epidemic. However, premarital sex is prohibited among Christians and people of other religions in Zimbabwe and this is likely to affect the age at first sexual exposure (Tearfund 2006). The median age at first sex (the age when half of the young people already have had sex) is 19 years for both men and women for the general population of Zimbabwe with the Christians included (MoHWC et al 2009). The age at first sex in Zimbabwe is among the highest in Africa. It is therefore unlikely that early sexual debut has been and continues to be the major driving force of the epidemic in Zimbabwe. Nevertheless, the minority of the young people, particularly the Orphans and Vulnerable Children (OVC) and out-of-school adolescents engage in early sexual activity and require attention through the implementation of HIV prevention programmes (SAfAIDS 2008). Furthermore, age differences between women and men at first sex and in subsequent sexual experience are particularly high in Zimbabwe. The majority of young women (63 percent) have sexual experience with partners five and more years older, which exposes them to a group of men with high HIV prevalence (Central Statistics Office (CSO) and UNICEF 2009). This must be seen as a major factor contributing to the relatively high HIV prevalence in young women.

### **2.8.2.2 Number of Sexual Partners and Faithfulness**

There is a decrease in number of non-regular partners in Zimbabwe and this is assumed to have contributed to the declining HIV incidence (NAC 2006). Premarital sex and extramarital affairs are prohibited by Pentecostal Christianity and this is likely to also contribute to the decrease in sexual partners in Zimbabwe (Evangelical Fellowship of Zimbabwe 2005). However, other factors like fear of HIV infection, cultural value systems which prohibit sex outside marriage and economic hardships among other factors might have also contributed to the decrease in number of sexual partners (Biomedical Research and Training Institute (BRTI) 2006). The total mean number of sexual partners in Zimbabwe with Christians included is 1.6 partners (ZDHS 2009). Concurrent partnerships (more than one partner in parallel) in adult and marriage relationships

are a special risk which exposes sex partners to particularly high levels of infection. The largely urban 'small house' phenomenon and the cultural background of polygamy provide a supportive context for multiple partnering which must be seen as a very important driver of the epidemic in Zimbabwe (NAC 2006). Partner reduction is a key requirement for successful HIV prevention in the Zimbabwean context. Despite declines in non-regular partnerships, overall levels of multiple partnering are still assumed to be high (NAC 2006). Regular partnerships and marriage are a major source of infection to women and cannot be considered protective factors. In the past, programmes have not really focused on faithfulness, parallel relations and the so-called “small houses”. In an advanced HIV epidemic which affects all population groups like in Zimbabwe, behavioural prevention aimed at partner reduction particularly concurrent partners is key to the overall success of prevention efforts (SAfAIDS 2009)

### **2.8.2.3 Condom Use**

Condom use at last sex with a non-cohabiting partner in Zimbabwe is higher than in most countries in the African region. It increased during the 1990s but it still needs to be increased given the high infection risk (NAC 2006). Condom use at last risky sexual encounter for the 15-25 year olds was 42 percent, 55 percent for urban women and 83 percent for urban men of Zimbabwe with Christians included (ZIMDAT 2009). Condom use in regular and marriage relationships remains low despite the fact that being in long-term relationships is not necessarily a protective factor (SAfAIDS 2009). Condom distribution and social marketing programmes, which led to increased uptake and use in casual sexual relationships were successful elements of the Zimbabwean HIV and AIDS response. These promotion and distribution strategies have worked and need to be sustained. However, condom use is recommended for the married only among the Christians (Evangelical Fellowship of Zimbabwe 2009). More emphasis needs to be placed on correct and consistent use of male and female condoms, including in regular relationships. The female condom has a market and its increased distribution and social marketing will give couples and sexually active women an additional choice for preventing HIV infection

#### **2.8.2.4. Other Practices that Increase Vulnerability to Infection**

Local value systems allow for a number of practices that make Zimbabwean men and women vulnerable to HIV. These include polygamy, widow inheritance, girl pledging and forced marriage, intra-vaginal practices (“dry sex”), chiramvu (a husband having sex with the younger sister of his wife) and post menopausal abstinence for women (during which the husband may have sex with other partners) (UNICEF 2008). There are several other harmful cultural practices based on notions of masculinity which drive men’s sexual behaviour and that put women and girls at the risk of contracting HIV (UNAIDS and NAC 2010). According to the same source, 65% of the women who ever had sex reported that their first sexual encounter was forced against their will with 65% reporting their current or former husband, partner or boyfriend as the perpetrator. Also, six in 10 women reported having experienced some form of violence (UNAIDS and NAC 2011). Above all, 36% of the women in Zimbabwe experienced physical violence (ZDHS 2005-06).

#### **2.8.3 Attitude towards HIV Prevention**

The Zimbabwean church views HIV prevention methods with different lenses. When they all agree on faithful monogamy and abstinence, they do not all agree on condom use. In some churches, condom use is recommended for the married only while other churches completely do not recommend its use by any group (Africa Evangelical Alliance 2009). In Uganda, 72% of women and 82% of men feel that a wife is justified in refusing sex with her husband if she knows he has a sexually transmitted infection. Similarly, 71% of women and 83% of men believe that a wife is justified in asking her husband to use a condom if she knows that he has a sexually transmitted infection (Ministry of Health (MoH)-Uganda 2007).

Six in ten adults believe that children aged 12 - 14 years should be taught about condom use to avoid AIDS (MoH- Uganda, 2007). The same study also shows that men are more likely than women to believe that children should be taught about condom use. There are few differences in this belief by background characteristics. Older respondents (those in their 40s) are less likely to support condom education for youth, as are those with no education, and those in the lowest wealth quintile (MoH- Uganda, 2007). In Zimbabwe, educating the youths about condom use is a

controversial issue largely due to cultural and religious factors (MoHCW et al 2009). According to the same source, condom use for the youth is associated with early sexual experimentation and promiscuity. However, 42 percent females and 51 percent males aged 15-24 years supported the idea of educating the youths about condom use.

## **2.9 Zimbabwe's HIV Policies Frameworks and Programs**

### **2.9.1 HIV Policy Frameworks**

Since the discovery of the first case of HIV and AIDS in 1985, the national response to HIV and AIDS have been guided by the following policies and strategic plans,

- ***Emergency Short Term Plan (ESTP) – 1987:*** It was an emergency one year plan which was formulated to create public awareness of HIV and AIDS
- ***Mid Term Plan (MTP1) – 1993:*** It focused on expanding interventions to promote behavior change, prevention and treatment of Sexually Transmitted Infections (STI), Care and Support for People Living with HIV and AIDS (PLWHA)
- ***Mid Term Plan (MTP2) – 1994-99:*** It was developed to focus on mobilisation of non-health sectors to integrate HIV and AIDS issues.
- ***National Policy on HIV and AIDS – 1999:*** A multisectoral consultative process was employed to develop the National Policy on HIV and AIDS. The process started in 1997 and ended in 1999. The policy was developed in order to promote and guide the present and future responses to AIDS in Zimbabwe.
- ***National HIV and AIDS Strategic Framework – 2000-2004:*** To operationalise the National AIDS Policy, the National HIV and AIDS Strategic Framework (2000-2004) was developed and launched in the year 2000. It is important to note that the Government of Zimbabwe had introduced the National AIDS Trust Fund in 1999 and the fund is generally known as the AIDS levy. Its purpose was to support HIV and AIDS prevention efforts and care for those with AIDS. The fund was managed by the National AIDS Council whose mandate was to coordinate the national HIV and AIDS responses
- ***Zimbabwe National HIV and AIDS Strategic Plan – 2006-2010:*** The key components of the policy were as shown on Table 2.2

**Table 2.2 : Components of ZNASP I (2006-2010)**

Prevention	Treatment and Care	Mitigation and Support	Coordination and Management
<ul style="list-style-type: none"> <li>• Prevention of mother to child transmission (PMTCT)</li> <li>• HIV counselling and Testing (HCT)</li> <li>• Condoms</li> <li>• Most at risk populations (MARPS)</li> <li>• Behaviour Change</li> <li>• Communication (BCC)</li> <li>• Youth</li> <li>• Male Circumcision (MC)</li> <li>• Sexually transmitted infections (STI)</li> <li>• Blood safety</li> <li>• Workplace</li> <li>• Gender</li> <li>• Advocacy</li> </ul>	<ul style="list-style-type: none"> <li>• Antiretroviral therapy (ART)</li> <li>• Opportunistic Infections (OI)</li> <li>• Laboratory services</li> <li>• Home based care (HBC)</li> </ul>	<ul style="list-style-type: none"> <li>• Orphans and Vulnerable</li> <li>• Children (OVC)</li> <li>• Meaningful involvement of PLHIV (MIPA)</li> <li>• Nutrition</li> <li>• Water and sanitation</li> </ul>	<ul style="list-style-type: none"> <li>• Strengthening leadership role of NAC</li> <li>• Strengthening coordination role of NAC</li> <li>• Strengthening planning and management role of NAC</li> <li>• Strengthening M&amp;E capacity at national, provincial and district level</li> </ul>

*Source: National AIDS Council and the Ministry of Health and Child Welfare (2011) p21*

- **Zimbabwe National HIV and AIDS Strategic Plan – 2011-2015:** It is a multi-sectoral framework which was developed to inform and guide the national response towards achieving zero new infections, zero discrimination and zero AIDS related deaths by the year 2015. (NAC and MoHCW 2011). The development of the plan is premised on a human rights based planning approach that is complemented by evidence and results based management approaches. The strategic plan has mainstreamed gender dimensions in the response strategies, anticipated results and indicators that will be used to measure performance. The plan provides meaningful opportunities for man and diverse stakeholders' participation in the implementation of the national response (NAC and MoHCW 2011).

In general, Zimbabwe has developed and implemented a number of policy frameworks

and this has contributed to the decline of the HIV infection rate. However, the challenge was however that the nation delayed the beginning of its intervention when the first HIV infection case was recorded in the year 1985 and this might have contributed to the increase in the infection rate

### **2.9.2. HIV Prevention, Treatment and Care in Zimbabwe**

Zimbabwe prioritises the following intervention strategies as stipulated in the Zimbabwe National AID Strategic Plan 2 (ZNASP 2).

Abstinence is one method of HIV prevention. It involves taking a positive step not to be involved in sexual intercourse up until marriage although secondary abstinence entails making a decision not to be involved in sexual intercourse even when one would have lost his/her virginity (CDC 2011). Two studies suggest that for some young people making pledges to abstain from sexual intercourse until marriage does lead to delay in the timing of their first sexual intercourse. But these young people tend to hold strong religious beliefs and enjoy being an exclusive group among peers who do not take abstinence pledges (Chitando 2008). This means that pledging abstinence is not appropriate for young people who do not hold strong religious views and, moreover, if lots of young people are involved in making pledges (as using abstinence education as a method of sex education requires) the sense of being special will be dissipated. In addition, the majority of young people who take abstinence pledges still have sex before they are married and when they do they report using condoms less often than 'non-pledgers' and are more likely to substitute anal or oral sex for vaginal sexual intercourse.

While abstinence is the safest method of HIV prevention, faithfulness to one uninfected partner is also important in preventing HIV infection. The method ensures that both partners are tested for HIV and they both know each other's status. The method advocates for partner reduction and it can be practiced by married couples. However, the marriage setting is the most affected by HIV because of the false sense of faithfulness in relationships ( Chitando 2008)

Consistent and correct use of male latex condoms can reduce (though not eliminate) the risk of HIV infection. To achieve the maximum protective effect, condoms must be used both consistently and correctly. Inconsistent use can lead to HIV infection because transmission can occur with a single act of intercourse with an infected partner. Similarly, if condoms are not used correctly, the protective effect may be diminished even when they are used consistently. The most reliable ways to avoid transmission of HIV and other sexually transmitted infections (STIs) are to abstain from sexual activity or to be in a long-term mutually monogamous relationship with an uninfected partner. (Center for Disease Control 2012)

Mother-to-child transmission (MTCT) is when an HIV-infected woman passes the virus to her baby. This can occur during pregnancy, labour and delivery, or breastfeeding. Without treatment, around 15-30 percent of babies born to HIV-infected women will become infected with HIV during pregnancy and delivery. A further 5-20 percent will become infected through breastfeeding (Avert 2011). In 2011, UNAIDS produced 'The Global Plan Towards the Elimination of New Infections Among Children and Keeping Their Mothers Alive'. The plan recognises the need to consider different ways of preventing MTCT, and to integrate HIV interventions into other family planning, maternal health and child health services. Meanwhile, Prevention of Parent to Child Transmission can only be done through the use of nevirapin drug

Knowledge of HIV status through Voluntary Counseling and Testing (VCT) or Provider Initiated Counselling (PITC) can be empowering. When people test negative, they are in a better position to assess and modify their risk behaviors to help them stay uninfected. When people learn they are infected, research shows that they take steps to protect their own health and prevent HIV transmission to others. In addition, linkage to care following a positive test helps ensure people living with HIV receive life-saving medical care and treatment, and helps reduce their risk of transmitting HIV (MoHCW et al 2011).

Male circumcision involves the removal of the foreskin, a loose fold of skin that covers the head of the penis. The procedure can be carried out at any stage; during infancy, childhood,

adolescence or adulthood (Avert 2011). Many societies have been practicing male circumcision for hundreds of years, and circumcision is often seen as a mark of belonging to a particular tribal or religious group (PSI 2009). Scientific trials have shown that male circumcision can reduce a man's risk of becoming infected with HIV during heterosexual intercourse by up to 60 percent (Avert 2011). These findings have led to the decision by UNAIDS and the World Health Organization (WHO) to recommend circumcision as an important new element of HIV prevention. Mathematical models have predicted that one new HIV infection could be averted for every 5 to 15 men who are newly circumcised. It has also been suggested that six million new HIV infections and three million deaths could be prevented in twenty years if all men in sub-Saharan Africa became circumcised (Avert 2011).

There is no cure for HIV yet and Anti-retroviral Therapy is widely used in Zimbabwe and in many parts of the world to improve the health of the infected patient and thus prolong life. The method involves the use of drugs which should be adhered to in their right conditions, quality and quantity so as to stop the multiplication of the virus. In the same vein of thinking, HIV infected patients should take the right nutrients and this entails the eating of balanced diets (MoHCW et al 2011).

Another method which is commonly used at work places and for rape victims is Post-exposure prophylaxis (PEP). It is short-term antiretroviral treatment to reduce the likelihood of HIV infection after potential exposure, either occupationally or through sexual intercourse. Within the health sector, PEP should be provided as part of a comprehensive universal precautions package that reduces staff exposure to infectious hazards at work. It is important to mention that as part of treatment and care, a Community Home Based Care program in which patients are cared for from home by trained care givers who will ensure that they will adhere to their treatment as well as live positively.

## **2.10 Theoretical and Conceptual Frameworks**

The theoretical framework which was used to assess the knowledge levels, attitudes, beliefs and practices of Pentecostal Christians with regards to HIV and AIDS prevention was the adopted

Health Beliefs Model. This section will explain the major components of the framework and how it applies to HIV KABP. The framework also provided some guidance to the formation of a conceptual framework.

### **2.10.1 Theoretical Framework -Health Belief Model (HBM)**

The Health Belief Model (HBM) is a psychological model that attempts to explain and predict health behaviours by focusing on the attitudes and beliefs of individuals (Denison 1950). According to the Christians, beliefs and practices are equated to faith and works as expressed in the Bible which says “Even so faith, if it hath not works, is dead...” (James 2 verse 17). As such, the people’s beliefs and attitudes about HIV and AIDS issues are expressed in their HIV and AIDS prevention practices.

The HBM was developed in the 1950s as part of an effort by social psychologists in the United States Public Health Service to explain the lack of public participation in health screening and prevention programs (e.g. a free and conveniently located tuberculosis screening project). Since then, the HBM has been adapted to explore a variety of long- and short-term health behaviours, including sexual risk behaviours and the transmission of HIV and AIDS (Denison 1994).

More recently, the HBM has been appended to include the notion of self-efficacy as another predictor of health behaviors – especially more complex ones in which lifestyle changes must be maintained over time (Strecher & Rosenstock, 1997). A wide variety of demographic, social, psychological and structural variables may also impact an individual’s perceptions and, indirectly, their health-related behaviors. Some of the more important ones include educational attainment, age, gender, socioeconomic status and prior knowledge.

The HBM has been one of the more empirically studied theoretical models. A 1984 review of this research (Janz & Becker 1984), conducted across numerous health and screening behaviors, found not only substantial support for the model, but that the “perceived barriers” component was the strongest predictor across studies and behaviors. Among studies that looked at sick-role behaviors (such as compliance with medication regimens, self-help behaviors among people with

diabetes), “perceived benefits” proved to be the strongest predictor of engaging in health behaviors. As social marketers make choices about the theoretical models they use in their program, this finding of different predictors of different types of behaviors needs to be heeded so that a particular theory or model is not misapplied.

### **Core Assumptions and Statements**

The HBM is based on the understanding that a person will take a health-related action if that person:

- Feels that a negative health condition can be avoided;
- Has a positive expectation that by taking a recommended action, he/she will avoid a negative health condition;
- Believes that he/she can successfully take a recommended health action.

The key variables of the HBM according to Rosenstock et al (1994) are as follows:

***Perceived Threat:*** Consists of two parts: perceived susceptibility and perceived severity of a health condition (Fig 2.1).

***Perceived Susceptibility:*** One's subjective perception of the risk of contracting HIV. In general, when one believes he/she is susceptible to HIV then the higher the chances of behaviour change.

***Perceived Severity:*** Feelings concerning the seriousness of contracting an illness or of leaving it untreated (including evaluations of both medical and clinical consequences and possible social consequences). In general, if HIV is perceived to be severe then the higher the chances of behaviour change

***Perceived Benefits:*** The believed effectiveness of strategies designed to reduce the threat of illness. Once the HIV prevention methods are perceived to be difficult to adhere to then the lesser the chances of behavior change

***Perceived Barriers:*** The potential negative consequences that may result from taking particular health actions including physical, psychological, and financial demands. Once perceived barriers are found then the lesser the chances of behavior change with regards to HIV and AIDS

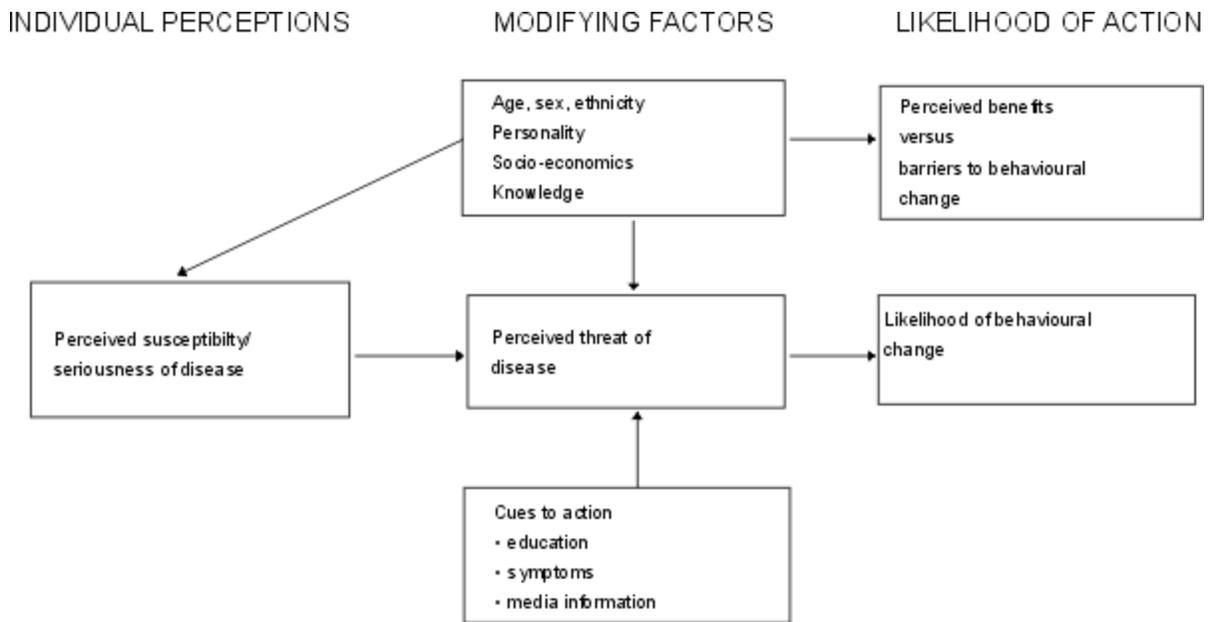
***Cues to Action:*** Events, either bodily (e.g., physical symptoms of a health condition) or environmental (e.g., media publicity) that motivate people to take action. Cues to actions are an

aspect of the HBM that has not been systematically studied. The more the cues to action then the lesser the chances of behavior change

**Other Variables:** Diverse demographic, socio-psychological, and structural variables that affect an individual's perceptions and thus indirectly influence health-related behavior.

**Self-Efficacy:** The belief in being able to successfully execute the behaviour required to produce the desired outcomes. The greater the ability of a person to make independent decisions with regards to HIV prevention issues and to implement them without hindrances, the greater the chances of behaviour change (Bandura 1977.) Figure 1.1 below shows the HBM framework

**Figure 2.1: Health belief model framework**



Source: Glanz et al, 2002, p. 52

The HBM was therefore used to assess the influence of religion in preventing HIV and AIDS. In general, Pentecostal Christians were assessed on their perceived susceptibility to HIV, perceived benefits of practicing HIV prevention, perceived barriers in adopting HIV prevention strategies, cues to action in relation to seeking the right corrective measures and self-efficacy

in relation to HIV prevention and this was reflected in their HIV prevention knowledge levels, attitudes, beliefs and practices regarding HIV prevention

## 2.10.2 Conceptual Framework

This section will explain the framework adopted to assess the knowledge, attitudes, beliefs and practices of Pentecostal Christians regarding HIV prevention.

### 2.10.2.1 Knowledge of HIV Prevention

People's knowledge can influence their actions towards adopting risk-reduction behaviours such as abstinence, reduction in premarital sex, reduction in number of sexual partners, avoidance of non-spousal sex, and condom use during non-spousal sex. Knowledge is also an important prerequisite for health-seeking behaviours, utilization of HIV prevention, care and support services as well as fighting stigma and discrimination against people living with HIV (MoH- Uganda, 2007). Above all, the knowledge of modes of HIV transmission influences the knowledge of HIV prevention. The root causes of HIV transmission as well as the myths/misconceptions were used to assess the knowledge levels of the people. The same was also done for the prevention methods. Table 1 shows the root causes and the myths.

**Table 2:3 HIV Prevention and Transmission Methods**

	<b>Transmission Method</b>	<b>Myths</b>
HIV Transmission Methods	Unprotected Sex	Shaking Hands
	Use of Infected Needles	Mosquito Bite
	Vertical Transmission	Sharing food with an Infected Person
	Oral Sex	Sharing a Public Swimming Pool
	Receiving Infected Blood	Sharing Food and Utensils
	<b>HIV Prevention Method</b>	<b>Myth</b>
HIV Prevention	Abstinence from Sex	Having Sex with Healthy Looking People
	Condom Use	Avoiding use of Public Toilets
	Faithful Monogamy	Eating a Balanced Diet
	Circumcision	
	Prevention from Mother to Child Transmission	
	Use of Sterilised Needle	

### **2.10.2.2 Attitude to HIV and AIDS Prevention**

Stigma and discrimination associated with HIV and AIDS influence how people living with and affected by HIV and AIDS are treated in society. As stated aptly, 'A stigmatizing social environment poses barriers to HIV prevention and care at many different levels by virtue of being, by definition, a non-supportive environment' (Wood and Aggelton 1999:7). Stigma and discrimination can arise from community-level responses to HIV and AIDS. The harassing of individuals suspected of being infected or of belonging to a particular group has been widely reported. It is often motivated by the need to blame and punish and in extreme circumstances can extend to acts of violence and murder. Attacks on men who are assumed gay have increased in many parts of the world, and HIV and AIDS related murders have been reported in countries as diverse as Brazil, Colombia, Ethiopia, India, South Africa and Thailand (UNAIDS 2006).

People's ability to negotiate for safer sex practices with their partners is a vital link in the prevention of HIV transmission (Priscilla et al 2005). People's attitudes towards cross generational sex, VCT, multiple sexual partnerships, condom use and the discussion of sexuality issues in church were assessed for the purposes of this study.

### **2.10.2.3 Beliefs and HIV and AIDS Prevention**

The beliefs that people carry are generally influence by their culture, religious affiliation and other socio demographic characteristics (Chitando 2007). Some of the beliefs act as an impediments or accelerating factors to health seeking behavior and HIV prevention in particular. Pentecostal Christians believe in faith healing and the purity of sex (Muturi 2007). In general condoms are not allowed for the unmarried and the sick can be healed of their illnesses if they believe that God will heal them. The beliefs of the Christians about HIV spiritual healing, sexuality issues, effectiveness of condom use and VCT shall be assessed for the purposes of this study.

### **2.10.2.4 HIV and AIDS Related Behaviour/Practice**

The relationship between perception of risk and sexual behaviour is complex and poorly understood. Several studies conducted in different cultures have associated HIV risk perception

with a wide range of variables: number of sexual partners, knowledge of sexual partner's past sexual behaviour, fear of AIDS, shame associated with having AIDS, community perception of AIDS risk, knowing someone with AIDS, discussing AIDS at home, closeness of parent-child relationships and religious affiliation (Macintyre et al 2004). In Sub-Saharan Africa, socio-cultural norms and practices are major determinants of sexual risk-taking behaviour (Chitando 2007). Cross generational sex, number of sexual partners, age at first sexual intercourse, condom use, abstinence, circumcision status, whether one is tested for HIV or not and disclosure of results were generally considered as the practices in this study

## **Chapter 3: Methodology**

### **3.1 Introduction**

This chapter discusses the methodology used to gather the data. The targeted population and the geographical location of the study area were also discussed. Above all, the research methods, sampling methods and the data collection tools used to gather the data were also explained in detail.

### **3.2 Geographic Location**

The study was carried out in Glenview, Harare. Glenview is a high density suburb of Harare, with 8 sections some of which are newly developed areas. The area has an approximate number of households of 4,000. According to the Evangelical Fellowship of Zimbabwe (2009), the area has 20 Pentecostal church assemblies and 8 Pentecostal denominations which have different numbers of assemblies in the area. The major denominations were ZAOGA which has three assemblies and AFM which also has three assemblies. The EFZ database indicated the number of assemblies and the names of the pastors and their contact details.

The area has some well-developed road networks which make it easy and possible for anyone to reach any part of the suburb. Another most important thing is that it has a well-structured and actively operating EFZ zonal structure which makes it easy for anyone to enter the area and collect some information without challenges, only if that is done through the coordination of the mother body, the Evangelical Fellowship of Zimbabwe (EFZ). In general, the Pentecostal members who subscribe to the mother body, EFZ, meets every Monday of the week for prayers and other updates and as such, it was easy to penetrate the area and meet with the Pastors.

There is no literature concerning the knowledge levels, attitudes, beliefs and practices of Pentecostal Christians regarding HIV prevention in Glenview. This study shall help to generate some information to inform Christian HIV programming in the area.

### **3.3 Target Population**

The research targeted Pentecostal Christians aged 15-49 years. Both males and females were proportionally considered, whilst special attention was also given to balancing the number of youths from 15-24 years and that of adults from 25 -49. Also, the study targeted the pastors as the major key informants who influence the behaviour of the people.

### **3.4. Study Design**

A triangulation of both quantitative and qualitative methods was used to gather the data. The quantitative method which was used was a survey. A survey questionnaire was used to gather the information. The qualitative method of data gathering was in the form of focus group discussions and a discussion guide was used to give direction to the discussions

### ***3.5. Data Collection Methods and Tools***

#### ***3.5.1 Survey***

The survey method was used and it was cross sectional. The use of a survey was to quantify the results of the survey so as to have a clear picture of the knowledge, attitudes, beliefs and practices of Pentecostal Christians regarding HIV prevention. The data gathering tool was a questionnaire and it was self-administered to avoid false responses since the questionnaire had some sexuality issues which are regarded as sensitive in church. However, the illiterate were assisted to fill the questionnaires. The survey targeted 198 Pentecostal Christians from 5 churches.

#### **3.5.1.1 Sampling**

The study participants were proportionally sampled from 5 churches and there was a proportional number of males and females. The 5 churches were selected by simple random sampling from the list of 20 assemblies which were recorded on the EFZ database of assemblies in Glenview. The Evangelical Fellowship of Zimbabwe is the umbrella body for the Pentecostal Churches in Zimbabwe. It has a total of 248 denominations and para-church organisations and it

has a database of its members and their assemblies throughout the country. However, a few other Pentecostal churches are not yet registered with the organisation.

### 3.5.1.2 Sample Size Determination

#### Sample Size Determination Formulae

$$n = \frac{z^2 \cdot \alpha/2 \cdot p \cdot q}{e^2}$$

$z^2$ =confidence interval (1.96)

$\alpha$ =Level of Significance (0.05/2)

$p$ =Proportion of Christians between 15 and 49 years. They were 2800 out of a total population of 3300

$q=1-p$

$n$ =Sample Size

$$n = \frac{1.96^2 \cdot (0.848485)(0.151515)}{0.05 \cdot 0.05}$$

$$n = 197.5478$$

Sample size = 198 people

A total of 198 respondents were proportionately selected from the 5 assemblies which were randomly selected from the 20 assemblies. The formula to select the 198 respondents was as follows

$$\frac{\text{(Total Number of People aged 15-49 years in the Respective Assembly)}}{\text{Total Number of People aged 15-49 years in the Selected 5 Assemblies}} \times 100$$

*Total Number of People aged 15-49 years in the Selected 5 Assemblies*

Table 3.1 shows the number of the proportionately selected respondents and the names of their assemblies. Survey questionnaires were distributed to proportionately selected 198 willing church members aged 15-49 years at each of the 5 church assemblies in Glenview. A total of 167

questionnaires were returned and 17 of them were either spoiled or not fully completed. A total of 150 questionnaires were adopted for the study.

**Table 3.1: Names of the Selected Churches and the Numbers of the Proportionally Selected Respondents**

Name of Church	Number of People Selected
Assemblies of God Glenview Assembly	56
Zimbabwe Assemblies of God Africa	30
Family of God	45
United Assemblies in Africa	28
Full Gospel Church of God	39
<b>Total</b>	<b>198</b>

### 3.5.1.3 Questionnaire Design

A questionnaire was designed by the student and a thematic approach was used. The questionnaire collected socio-demographic information, HIV knowledge information, information on attitudes towards HIV prevention strategies, information on beliefs regarding HIV prevention and information on HIV prevention. The questionnaire was discussed with the student and other classmates and also with the project supervisor.

### 3.5.1.4 Questionnaire Pretesting

The questionnaire was pretested with 10 Pentecostal Christians in Arcadia to avoid sensitising the people of Glenview on the questions to be asked. A few challenges were noted in completing the questionnaire and they were corrected before it was finally adopted for use in the study area, Glenview.

### **3.5.2 Focus Group Discussions**

A total of 6 Focus group discussions with not more than 12 members each were used to explore qualitative data about the beliefs, attitudes and practices of Christians regarding HIV and AIDS prevention. The discussions were held with boys and girls (15-24 years old) separately and they were brought together at last. The same strategy was used for the men and women (25-49 years old). This allowed the researchers to see how the Pentecostal Christians interact on the topic of HIV and AIDS. The assumption was that more information will be gathered from different people in a short space of time. Interacting with the people in focus group discussions helped to identify attitudes and behaviour patterns that are not considered to be socially acceptable. In general, the targeted population was Pentecostal Christian males and females aged 15-49. Probing was used to get a deeper and better understanding of issues raised. The members were randomly selected from 3 other assemblies which were selected by simple random sampling from the EFZ database of assemblies in Glenview.

#### **3.5.2.1 Selection of Participants**

A total of 6 new assemblies which were not selected during the survey were selected by simple random sampling from the data base of the 15 remaining assemblies in Glenview. A maximum of 12 members aged 15-49 years were randomly selected from each of the 3 assemblies taking note to proportionately balance the number of males and females, and also ensuring that there was equal representation of each age group.

#### **3.5.2.2 Focus Group Discussions Facilitation**

The focus group discussions were moderated by the student himself. The people set in the form of a semi-circle and the facilitator could see everyone in as much as they were also seeing each other. The facilitator started introducing himself and he gave the respondents some numbers which he used to identify them by and not their actual names. After explaining the purpose of the research and building the necessary rapport, the researcher started the discussion. The questioning was as open ended as possible to allow the respondents to speak spontaneously about

their attitudes, beliefs and practices regarding HIV prevention. A note taker recorded the findings from the discussions.

### **3.6 Data Analysis**

The student made use of the Statistical Package for Social Scientists (SPSS) to capture the data and analyse it so as to produce the results which were in the form of graphs and statistics. Also, a thematic approach was adopted in analyzing the data so as to ensure that all the objectives of the study were covered. Frequencies were used for the description of data while relationships and association were illustrated by cross tabulations. Subgroups were comparatively analysed by age, sex, marital status and education level depending on the issue at hand. Focus group discussions were qualitatively analysed to complement the quantitative data done through SPSS. The focus group discussion data was thematically recorded during the discussions. A summary of each session was written soon after the session for easy reference during the writing of the report.

## **Chapter 4: Findings**

### **4.1 Introduction**

This chapter describes the results obtained from the analysis of data collected from the survey and focus group discussions, which sought to provide data on the knowledge levels, attitudes, beliefs and attitudes of Pentecostal Christian Religion regarding HIV prevention. The data are presented in different methods which include frequency tables and graphs. A thematic approach was used and a triangulation of both qualitative and quantitative methods was also used. The findings therefore present information on demographic and socio-economic characteristics of the respondents, HIV prevention knowledge, attitudes towards HIV prevention, beliefs regarding HIV prevention and the practices of Pentecostal Christians regarding HIV prevention.

### **4.2 Demographic and Socioeconomic Characteristics of respondents**

Table 4.1 shows the socio demographic characteristics of the respondents. Close to a quarter of respondents (26%) were aged 25-29 years age group and the minority age group (5%), were aged 45-49. The greater proportion (57%) of the respondents was women. Also, more than half (57 percent) of the respondents were married while the minority group (1%) were separated. However, divorce was high and it was 17%. Most of the respondents (97%) had attained a minimum of primary education and only 3% had never been to school. Close to a third of the respondents (34%) were in positions of leadership in church and the majority did not have any positions.

**Table 4.1: Percentage Distribution of Demographic and socioeconomic characteristics of respondents**

<b>Demographic Characteristic</b>	<b>Category</b>	<b>Percentage</b>
<b>Age Group</b>	15-19	18.0
	20-24	16.7
	25-29	26.0
	30-34	14.0
	35-39	11.3
	40-44	8.7
	45-49	5.3
	<b>Total</b>	<b>100</b>
<b>Sex</b>	Male	42.7
	Female	57.3
	<b>Total</b>	<b>100</b>
<b>Marital Status</b>	Married	43.3
	Divorced	17.3
	Never Married	38.0
	Separated	1.3
	<b>Total</b>	<b>100</b>
<b>Education level</b>	Never been to School	3.3
	Primary	14.0
	Secondary	57.3
	Tertiary	25.3
	<b>Total</b>	<b>100</b>
<b>Position in Church</b>	Respondents with Positions	34.2
	<b>Total</b>	<b>100</b>

N=150

### **4.3. KNOWLEDGE LEVELS OF HIV and AIDS**

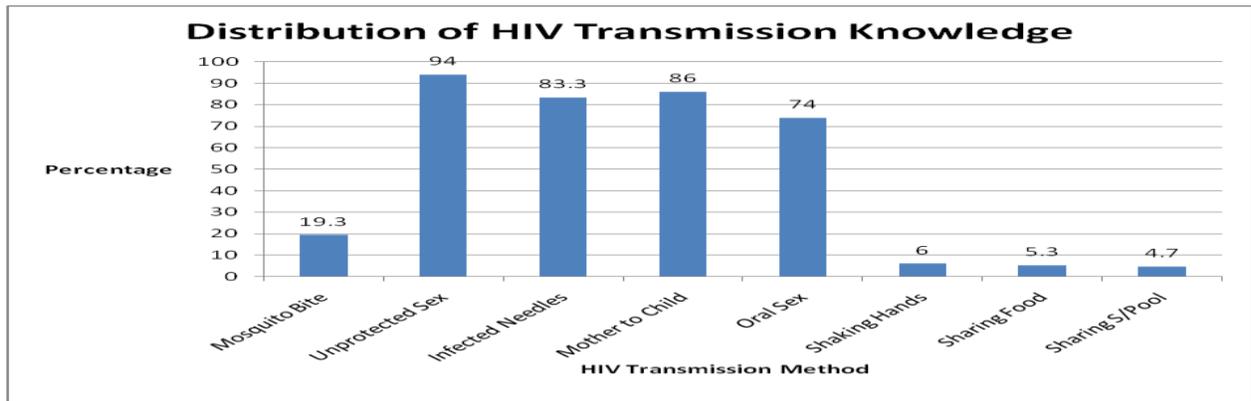
#### **4.3.1 Introduction**

Knowledge of HIV and AIDS influences people's perceived susceptibility to it and thus influences the behaviour regarding its prevention. This section describes the study findings on Pentecostal Christians regarding HIV

### 4.3.2 HIV Transmission Knowledge

In general, the respondents were knowledgeable of the HIV and AIDS transmission modes. Figure 4.1 shows the results obtained from the survey. The findings from the survey showed that the HIV and AIDS modes of transmission were identified as unprotected sex (94%), oral sex (74%), vertical transmission (86%) and the use of HIV infected needles (83%). Also, the myths or misconceptions about the modes of the transmission of HIV were low (19% maximum and 5% minimum). The myths or misconceptions of the modes of HIV transmission were low and identified as shaking hands with an HIV infected person (6%), sharing food with an HIV infected person (5%), mosquito bite (19%), and sharing a swimming pool with an HIV infected person (5%). Qualitative information from the focus group discussions also supported the fact that Pentecostal Christians are knowledgeable about modes of HIV transmission and these were identified as unprotected sex, oral sex, vertical transmission, and infected needles (Fig 4.1)

**Figure 4.1: Percentage Distribution of Knowledge of HIV Modes of Transmission**



**N=150**

### 4.3.2 HIV Transmission by Socio-Demographic Characteristics

The majority of both the male and female respondents (over 70%) managed to identify unprotected sex, infected needles, infected blood, oral sex, and vertical transmission as transmission modes of HIV. Also, less than a quarter of the male and female respondents (25%) had some misconception about the HIV prevention methods. The misconceived modes of HIV transmission were shaking hands with an infected person, sharing a swimming pool with an

infected person, mosquito bites, sharing food with an infected person and sharing tools with an infected person (Table 4.2)

It also followed that the greater proportion of the respondents of all marital categories (over 67%) managed to identify the HIV modes of transmission. Less than a fifth of the respondents of all marital categories (20%) had some misconceptions about the modes of HIV prevention (Table 4.2)

Over two thirds of the respondents of all education levels (67%) managed to identify the modes of HIV transmission. Furthermore, less than a quarter of the respondents who had reached primary, secondary or tertiary levels of education had some misconceptions about HIV modes of prevention. However, the respondents who had never been to school had a higher level of misconceptions compared to the other categories (sharing swimming pool with an infected person (60%), sharing food with an infected person (60%), and shaking hands with an infected person (20%) (Table 4.2)).

The majority of the respondents aged 25-29 years, 30-34 years, 35-39 years, 40-44 years and 44-49 years (over 70%) managed to identify the modes of HIV transmission. However, a higher percentage of the respondents aged 15-19 years and 20-24 years managed to identify the other transmission modes (over 75%), but only 48% of those aged 15-19 years managed to identify oral sex as a transmission mode. Also, only 40% of the respondents aged 20-24 years identified oral sex as a transmission mode. Above all, only 45% of the respondents aged 15-19 years identified vertical transmission as a transmission mode. It is important to mention that less than a third of respondents of all education levels (30%) had some misconceptions about the transmission modes of HIV. However, 38% and 37% of those aged 40-44 years and 45-49 years respectively suggested mosquito bites as a mode of HIV transmission

It was generally accepted during the focus group discussions that HIV prevention is high. One man in Glenview 2 stood up and said

*“HIV is now a song in schools, churches, hospitals and even in beerhalls. There is a likelihood that many people now know about it.”*

However, some group participants appealed for more knowledge on vertical transmission and oral sex since they indicated that they did not know much about those issues.

**Table 4.2: Percentage Distribution of HIV Transmission Knowledge levels by Socio-Demographic Characteristics**

<b>Demographic Characteristic</b>	<b>Category</b>	<b>Unprotected Sex</b>	<b>Infected Needles</b>	<b>Infected Blood</b>	<b>Oral Sex</b>	<b>PPTCT</b>	<b>Sharing Swimming Pool</b>	<b>Shaking Hands</b>	<b>Mosquito Bite</b>	<b>Sharing Food</b>	<b>Sharing Tools</b>
<b>Sex</b>	<b>Male</b>	92.2	85.9	95.3	75	84.4	3.1	9.4	21.9	7.8	6.3
	<b>Female</b>	95.3	81.4	98.8	73.3	87.2	5.8	3.5	17.4	3.5	7
<b>Marital Status</b>	<b>Married</b>	95.4	86.2	96.9	81.5	95.4	4.6	9.2	24.6	4.6	10.8
	<b>Divorced</b>	96.2	65.4	92.3	65.4	80.8	11.5	7.7	8.9	11.5	3.8
	<b>Never Married</b>	91.2	89.5	100	68.4	77.2	1.8	1	14	3.5	3.5
	<b>Seperated</b>	100	50	100	100	100	0	0	0	0	0
<b>Education level</b>	<b>Never</b>	80	80	80	66.7	100	60	20	40	60	0
	<b>Primary</b>	100	66.7	90.5	66.7	76.2	4.8	14.3	38.1	9.5	9.5
	<b>Secondary</b>	90.7	82.6	98.8	68.6	82.6	3.5	2.3	22.1	3.5	7
	<b>Tertiary</b>	100	94.7	100	94.7	97.4	0	7.9	0	2.6	5.3
<b>Age Group</b>	<b>15-19</b>	81.5	85.2	100	48.1	45.9	3.7	3.7	25.9	7.4	0
	<b>20-24</b>	96	96	100	40	88	4	4	4	4	4
	<b>25-29</b>	97.4	76.9	100	82.1	94.9	2.6	2.6	5.1	3.2	2.6
	<b>30-34</b>	95.2	71.4	90.5	85.7	90.5	14.3	9.5	28.6	4.8	9.5
	<b>35-39</b>	100	100	94.1	64.7	88.2	0	0	29.4	5.9	5.9
	<b>40-44</b>	92.3	76.9	92.9	84.6	92.3	0	7.7	38.5	7.7	23.1
	<b>45-49</b>	100	75	100	75	87.5	12.5	37.5	37.5	12.5	25

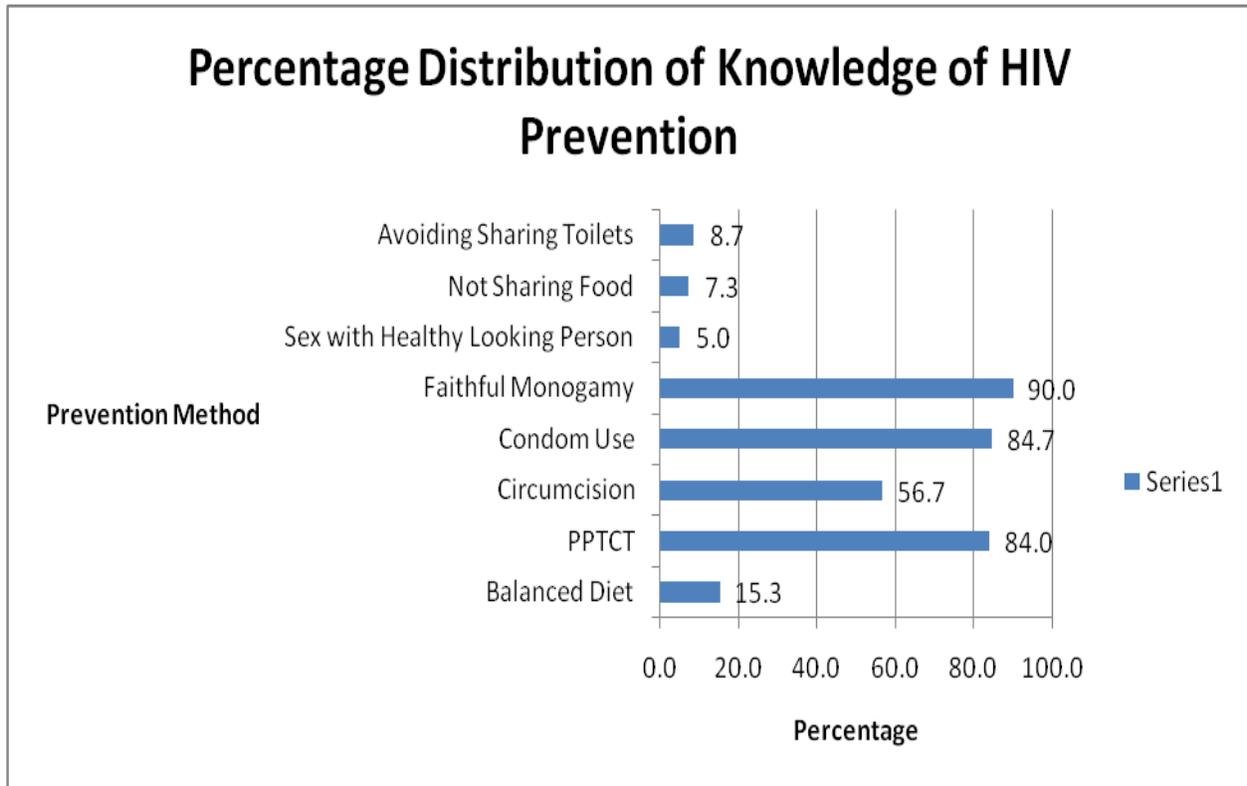
N=150

### 4.3.3 HIV Prevention Knowledge

Figure 4.2 shows the percentage distribution of HIV prevention knowledge among Pentecostal Christians. In general, Pentecostal Christians are also generally knowledgeable of HIV prevention methods and some misconceptions were low. The HIV prevention methods were identified as condom use (85%), faithful monogamy with an uninfected partner (90%), PPTCT (84%) and male circumcision (57%). There was however an indication that the respondents were not quite familiar with male circumcision (57%) as a prevention method compared to the high percentages of over 80% for the other methods like condom use, prevention of parent to child transmission and faithfulness to one uninfected partner. The focus group discussion revealed that some people think that male circumcision in Africa is just an experiment by Western countries to see if it works. The suggestion was that if Western countries would want to end HIV and AIDS in Zimbabwe and in Africa, then they should address poverty, the root cause. This generally showed that some men were still skeptical about the benefit of male circumcision although some of them agreed to the notion that it reduces the chances of being infected by 60-65%.

Also, some misconceptions about the prevention of HIV were low. There were low responses in favour of eating a balanced diet (15%), having sex with health looking people (5%), not sharing food with HIV infected people (7%) and not sharing toilets with HIV infected people (9%) as HIV prevention methods (Figure 4.2). Through the focus group discussion, it was pointed out that the churches, NGOs government and the media have done a great job in raising people's awareness about HIV prevention.

**Figure 4.2: Percentage Distribution of HIV Prevention Knowledge Levels**



**N=150**

#### **4.3.4 HIV Prevention Knowledge by Socio-demographic Characteristics**

Both male and female respondents (58% and 56% respectively) understood male circumcision as a method of HIV prevention compared to their higher knowledge of other HIV prevention methods (over 78). The other HIV prevention methods that were identified were abstinence, faithfulness to one HIV negative person, condom use, sterilization of injection needles and PPTCT. It also followed that a fifth of both male and female respondents (20% and less) had some misconceptions about HIV preventions. The misconceived methods that were identified were having sex with a health looking person, eating balanced diets, avoiding sharing toilets with the infected, avoiding sharing food with the infected and avoiding sharing tools with the infected as methods of HIV prevention (Table 4.3).

The never married (47% and the separated (0%) identified male circumcision as a method of HIV prevention compared to the married (67%) and the divorced (58%). However, over two thirds of the respondents of all marital categories (68% and more) managed to identify the other HIV prevention methods. Less than a fifth of the respondents of all marital categories (20% and less) had some misconceptions about HIV prevention. However, 30% of the divorced suggested that eating a balanced diet prevents a person from HIV infection (Table 4.3)

The knowledge of male circumcision as a prevention method increased with education level from 20% for the respondents who had never been to school to 61% for those who reached tertiary level. However, the greater proportion of the respondents of all marital categories (60% and above) managed to identify the prevention methods of HIV. Less than a quarter of the respondents of all education levels (25% and less) had some misconceptions about HIV prevention although 60% of the respondents who had never been to school suggested that not sharing food with an infected person prevents one from being infected (Table 4.3).

Also, the respondents' knowledge of male circumcision was low for ages 15-19 years (44%), 20-24 years (44%) and 25-29 years (56%). A total of 60% and more of the respondents of the other age groups managed to identify the methods of HIV prevention. In general, a quarter and less of the respondents of all age groups had some misconceptions about HIV prevention. It is important to however note that 31% of respondents aged 40-44 years and 50% of those aged 45-49 years believed that eating a balanced diet prevents one from getting HIV infections (Table 4.3).

The focus group discussions alluded to the fact that the knowledge of people regarding HIV prevention is generally dependant on certain socio demographic characteristics. The suggestions were that the respondents at tertiary level are supposed to know HIV prevention better than the respondents of any other category and likewise, the males are supposed to know more about male circumcision compared to women. However, it was agreed that the levels of knowledge sometimes do not always follow that thinking since variations of knowledge levels are bound to occur even among people of the same sex, gender or place of residence.

**Table 4.3: Percentage Distribution of HIV Prevention Knowledge by Demographic Characteristics**

<b>Demographic Characteristic</b>	<b>Category</b>	<b>Sterilised Injection Needles</b>	<b>Male Circumcision</b>	<b>PPTCT</b>	<b>Abstaining from Sex</b>	<b>Faithful Monogamy</b>	<b>Condom Use</b>	<b>Sex With Healthy Looking People</b>	<b>Avoiding Sharing Toilets</b>	<b>Balance Diet</b>	<b>Not Sharing Food</b>
<b>Sex</b>	<b>Male</b>	81.3	57.8	79.7	95.3	93.8	90.6	3.1	10.9	18.8	6.3
	<b>Female</b>	82.6	55.8	87.2	91.7	87.2	80.2	5.8	7.0	12.8	8.1
<b>Marital Status</b>	<b>Married</b>	64.3	68.6	90.8	96.9	92.3	90.8	1.5	7.7	16.4	4.6
	<b>Divorced</b>	88.5	57.7	80.8	92.3	92.3	69.2	11.5	20.8	30.8	6.1
	<b>Never Married</b>	82.5	47.4	77.2	87.5	86.0	84.2	5.3	5.3	10.5	7.0
	<b>Separated</b>	100.0	0.0	100.0	100.0	100.0	100.0	0.0	0.0	0.0	0.0
<b>Education level</b>	<b>Never</b>	100.0	20.0	100.0	60.0	80.0	40.0	0.0	20.0	20.0	60.0
	<b>Primary</b>	85.7	52.4	71.4	95.2	95.2	71.4	14.3	23.8	23.8	14.3
	<b>Secondary</b>	80.2	58.1	83.7	91.9	88.4	87.5	3.5	4.7	16.3	6.2
	<b>Tertiary</b>	81.6	60.5	89.5	97.3	92.1	86.8	2.6	8.1	7.9	0.0
<b>Age Group</b>	<b>15-19</b>	85.2	44.4	70.4	88.9	92.6	96.3	7.4	7.4	14.8	7.4
	<b>20-24</b>	72.0	44.0	92.0	83.3	88.0	76.0	4.0	0.0	8.0	8.0
	<b>25-29</b>	79.5	56.4	89.7	100.0	84.6	79.5	0.0	2.7	5.1	5.1
	<b>30-34</b>	85.7	76.2	76.2	90.5	81.0	90.5	9.5	9.5	14.3	4.8
	<b>35-39</b>	94.1	76.5	94.1	94.1	100.0	94.1	0.0	23.5	23.5	5.9
	<b>40-44</b>	76.9	85.7	76.9	100.0	100.0	76.9	0.0	15.4	30.8	15.4
	<b>45-49</b>	87.5	62.5	87.5	87.5	100.0	75.0	25.0	25.0	50.0	12.5

N=150

#### 4.3.5 Knowledge of Other HIV Issues which Contribute to Effective Prevention of HIV

Also, the respondents aged 15-49 were knowledgeable of other factors which contribute to HIV prevention, 70 percent accepted that HIV can be asymptomatic and 81 percent accepted that STIs increase the chances of HIV infection. However, some of the respondents were not quite clear of whether babies born to HIV positive parents carry the infection too resulting in the low percentages of 49% reporting vertical transmission as a mode of transmission (Table 4.4). Information from the focus group discussion held proved that people were not quite clear on whether HIV transmission from the mother to the child happens in the womb, at birth or during breast feeding. Table 4.4 shows the variations in knowledge levels of HIV

**Table 4.4: Percentage Distribution of HIV Knowledge Levels**

HIV Prevention Issues	Percentage
Babies born to HIV Positive Mothers are born HIV positive	49.3
Condoms are 100% safe	19.0
Can STI be Asymptomatic	70.4
STIs increase HIV infection	81.1
Can HIV be healed Spiritually	45.0
Can be Visually Detected	15.2
Is there a Cure for HIV	14.3

N=150

#### 4.4 ATTITUDES AND BELIEFS REGARDING HIV AND AIDS PREVENTION STRATEGIES

The attitudes of Pentecostal Christians regarding HIV and AIDS were very mixed and they ranged from extreme negative to extreme positive. The variations generally depended on whether the issues in questions were in line with their Christian values or not.

The attitudes of the Pentecostal Christians towards cross generational sex, multiple sexual partners for males, condom use and voluntary counseling and testing as methods of HIV prevention and practices which contribute to its transmission showed that their beliefs contribute

to HIV prevention. The majority of the respondents (77%) did not believe in cross generational sex, 69% believed that it is not natural for men to have multiple sexual partners, 95% believed that VCT is necessary for HIV prevention and 68% of the respondents believed that condoms do not nullify the objective of sex (Table 4.5). Focus group discussions supported the fact that VCT is necessary even if people fear to be tested for HIV. Moreso, cross generational sex and multiple sexual partners for men were taken as practices of people who do not know God, although some few Christians were believed to be doing so.

A higher percentage of the male respondents (95%) compared to the female respondents (94%) believed that it is necessary to go for VCT for HIV prevention. Also, a higher percentage of the female respondents (78%) compared to the male respondents (77%) did not believe that people should be involved in cross generational sex (Table 4.5).

The influence of education levels on the beliefs of the respondents regarding HIV prevention were also investigated. It was noted that 100% of those who had reached tertiary level, 100% of those who had never been to school, 91% of those who had reached primary level and 93% of those at secondary level reported VCT as necessary for HIV prevention. The respondents who believed that condom use overrides the objective of sex were few for the respondents of other education levels who were 34% and less although 60% of those who had never been to school suggested the same. Also, 33% of the respondents of primary level, 30% of those of secondary level and 32% of those of tertiary level accepted that condom use overrides the objective of sex. It is also important to note that the majority of the respondents who had never been to school (60%), accepted that multiple sexual partnerships are acceptable. However, 38% of the respondents of primary level, 30% of secondary level and 36% of those at tertiary level believed that multiple partnerships are acceptable. Moreso, the majority of those who have never been to school (60%), accepted that cross generational sex is acceptable. However, only 33% of the respondents of primary level, 23% of those of secondary level and 21% of those of tertiary level suggested that cross generational sex is acceptable (Table 4.5).

An assessment of the attitudes of the respondents towards VCT, condom use, multiple partnerships and cross generational sex against the marital status of the respondents was done. It was noticed that the majority of people of all marital statuses view VCT as a necessary part of

prevention with 100% of the respondents who were separated from their partners, 91% of those who were never married viewed VCT, 98% of the married respondents and 92% of those who were divorced suggesting the same reason (Table 4.7) Also, 29% of the married, 39% of the divorced, 30% of the never married and 100% of the separated believed that condom use overrides the objective of sex. Not many respondents accepted having multiple sexual partners as a good practice. The findings from the survey revealed that only 30% of the married, 42% of the divorced 32% and the never married cited that they did not see any problem with having multiple sexual partnerships. The responses of the respondents of all marital statuses who suggested that cross generational sex is acceptable were also low. The findings from the survey indicated that 20% of the married, 42% of the divorced, 50% of the separated and 15% of the separated respondents felt that they did not see anything wrong with cross generational sex. (Table 4.5)

The attitude of the respondents towards VCT, condom use, multiple sexual partnerships and cross generational sex against their age group were also assessed. The survey findings indicated that 100% of the respondents of age groups 20-24 years 35-39 years and 40-44 years reported that VCT is necessary for HIV prevention. The lowest number of respondents of 85% was for the age group 15-19 years. Moreover, half of the respondents (50%), aged 45-49 years believed that condom use overrides the objective of sex. All the other age groups had fewer respondents of 39% and less who viewed the use of condoms as overriding the objective of sex. The minority of the respondents of all age groups cited that multiple sexual partnerships are acceptable. Also, 38% of the respondents aged 45-49 years had the highest response while those aged 35-39 years had the least number (19%). It is also important to note that 60% of the respondents aged 45-49 years believed that cross generational sex is acceptable. However, some lower percentages of 22% for the 15-19 year age group, 24% for the 20-24 age group, 21% for the 25-29 age group, 33% for the 30-34 age group, 12% for the 35-39 age group and 15% for the 40-44 years age group cited that cross generational sex is acceptable

**Table 4.5: Percentage Distribution of Attitudes and Beliefs Towards HIV Prevention**

<b>Demographic Characteristic</b>	<b>Category</b>	<b>Importance of VCT</b>	<b>Condom Use Acceptability</b>	<b>Multiple Sexual Partners</b>	<b>Cross Generational Sex</b>
<b>Sex</b>	<b>Male</b>	95.3	29.7	28.1	23.4
	<b>Female</b>	94.2	33.7	33.7	22.1
<b>Marital Status</b>	<b>Married</b>	98.5	29.2	30.4	20.0
	<b>Divorced</b>	92.3	38.5	42.3	42.3
	<b>Never Married</b>	91.2	29.8	31.6	15.5
	<b>Seperated</b>	100.0	100.0	50.0	50.0
<b>Education level</b>	<b>Never</b>	100.0	60.0	60.0	60.0
	<b>Primary</b>	90.5	33.3	38.1	33.3
	<b>Secondary</b>	93.0	30.2	30.2	23.3
	<b>Tertiary</b>	100.0	31.6	35.7	21.1
<b>Age Group</b>	<b>15-19</b>	85.2	25.9	33.3	22.2
	<b>20-24</b>	100.0	32.0	20.0	24.0
	<b>25-29</b>	97.4	34.5	35.9	20.5
	<b>30-34</b>	95.2	38.1	33.3	33.3
	<b>35-39</b>	100.0	25.9	18.5	11.8
	<b>40-44</b>	100.0	30.8	30.8	15.4
	<b>45-49</b>	75.0	50.0	37.5	60.0

N=150

Pentecostal Pastors have negative attitudes on sexuality. Only 13% of the youth leaders and 12% of the pastors often talk about sexuality in church. It was also alluded to during the focus group discussions that sexuality in church is not usually talked about. Also, the church is not quite supportive in dealing with HIV infected patients although some felt that the church is doing a lot of work with the infected in the community. Information from the survey shows that only 22% of the respondents sometimes heard of confessions on HIV in their churches and only 5% of them often heard confessions of the same being made (Table 4.6). Focus group discussions also revealed that there are many people who are HIV positive in church but they do not reveal their status because of the stigma which they will face after revealing their status. Table 4.6 shows the percentage distribution of attitudes towards sexuality.

**Table 4.6: Percentage Distribution of Attitudes Towards Sexuality**

	Testimonies	HIV/Deaths	Sexuality & Pastor	Sexuality & Y/Leader
Never	32.7	30.9	10.7	9.3
Rarely	40.0	40.3	34.7	36.0
Sometimes	22.0	20.1	42.7	42.0
Often	5.3	8.7	12.0	12.7

**N=150**

## **4.5 PREVENTION PRACTICES**

### **4.5.1 HIV Testing**

Slightly above half of the respondents (56%), were tested for HIV (Table 4.7). Findings from the focus group discussions held suggested that HIV testing among Christians should be high since many of the people should not be sexually promiscuous and should have nothing to fear in relation to HIV testing. However, this was in line with Christian teachings against per-marital sex, fornication and adultery although people may not necessarily live as commanded by the Bible.

Also, a lower percentage of 46% of the male respondents compared to 63% of female respondents had been tested for HIV (Table 4.7). In general, it was suggested during the focus group discussion that men do not usually go HIV testing unless they are coerced to do so. One man from Glenview 3 said,

*“Men do not go for VCT unless they are put under pressure by their employers, doctors, and spouses”*

The assessment of VCT among the respondents against their education level was also done. The percentage of the respondents who were tested for HIV increased at every education level, from as low as 20% for those who had never been to school to 76% for those at tertiary level.

It was also important to assess the levels of MTCT experiences across marital statuses of the respondents who were tested for HIV. Interestingly all (100%) of the separated and 69% of the married were tested for HIV compared to 50% of the divorced and 41% of those who were never married were also tested for HIV (Table 4.7)

VCT experience increased with education. About 76% of those with tertiary education reported that they had been tested. This compares to 53% and 20% of those at secondary and the never been to school respectively (Table 4.7). Some suggestions during focus group discussions suggested that education influences health seeking behavior since they the educated are more likely to perceive the benefits of visiting a clinic or seeking information when ill.

**Table 4.7: Percentage Distribution of HIV Testing by Socio-demographic Characteristics**

<b>Demographic Characteristic</b>	<b>Category</b>	<b>Percentage</b>
<b>Sex</b>	<b>Male</b>	45.9
	<b>Female</b>	62.7
<b>Marital Status</b>	<b>Married</b>	69.4
	<b>Divorced</b>	50.0
	<b>Never Married</b>	41.1
	<b>Separated</b>	100.0
	<b>Education level</b>	<b>Never</b>
	<b>Primary</b>	36.8
	<b>Secondary</b>	53.0
	<b>Tertiary</b>	75.7
<b>Age Group</b>	<b>15-19</b>	7.4
	<b>20-24</b>	70.8
	<b>25-29</b>	74.4
	<b>30-34</b>	60.0
	<b>35-39</b>	62.5
	<b>40-44</b>	45.5
	<b>45-49</b>	71.4
	<b>Total</b>	

N=144

## **Disclosure of Results, Reasons for Testing and Willingness to be Tested for HIV**

The majority of the respondents (87%), went for VCT and collected their results (Table 4.8). Findings from the focus group discussions hinted that it is however difficult to tell whether the disclosed results will be correct or not since the New Start Centres in Zimbabwe do not allow people to carry the slip of their results home. However, some exceptions were made for those who visited hospital facilities and those who took their relatives or other close people to the New Start Center so that they would see the results for themselves. Of special reference were pregnant women who undergo mandatory HIV testing and counseling. It was mentioned that the HIV test results are written on their anti-natal care visit cards and some can also be given the result slips.

Almost three quarters (74%), of the respondents who had never gone for VCT indicated that they were willing to disclose their results if they got tested. However, some suggestions from a focus group discussion were that the disclosure of the HIV test results may be dependent on whether one would be HIV positive or not. There was a general agreement among the focus group members that many people would prefer to disclose an HIV negative result than an HIV positive result for fear of stigmatization in their societies.

The suggested reasons for going for VCT by those who had been tested revealed that the majority (57%) of them just wanted to know their HIV status compared to 26% who did it in preparation for marriage, 19% who were asked by their doctors to do so and 2% of them who had other reasons for doing so (Table 4.8 ). Information gathered from a focus group discussion showed that those who frequent VCT Centres do so because they already know their status through their sexual behaviour or previous tests. Other than that, many of the men are coerced to do so by other people.

The reasons why some of the respondents had never gone for VCT showed that fear of being found HIV positive was the major reason for not doing so and 65% of respondents feared being found HIV positive compared to 22% who suggested they had never had sex, 9% feared being stigmatized if found HIV positive and 4% of them had other reasons for doing that (Table 4.8) Information from the focus group discussion in Glenview 4 showed that people view HIV and AIDS as a death penalty. They would rather choose to die without knowing they were HIV

positive that to know. However, it was also suggested that some people are now willing to know their HIV status because of the improved availability of anti-retroviral drugs which are believed to be useful in prolonging life after being infected by HIV.

**Table 4.8: Percentage Distribution of HIV Status Knowledge, Disclosure, Reasons for Testing and Reasons for not being Tested**

<b>Issue in Question</b>	<b>Response</b>	<b>Percentage</b>
<b>Knowledge of Status</b>	<b>Yes</b>	86.7
	<b>No</b>	13.3
<b>Disclosure of Status</b>	<b>Yes</b>	74.4
	<b>No</b>	25.6
<b>Willingness to Be Tested</b>	<b>Yes</b>	60.0
	<b>No</b>	40.0
<b>Reason for Being Tested</b>	<b>Provider Initiated</b>	18.5
	<b>Just to Know</b>	53.1
	<b>Marriage Requirement</b>	25.9
	<b>Any other</b>	2.5
<b>Reason for Not Willingness to be Tested</b>	<b>Fear of HIV</b>	65.2
	<b>Never Had Sex</b>	21.7
	<b>Fear of Stigmatisation</b>	8.7
	<b>Any Other</b>	4.3

N=150

#### **4.5.2 Male Circumcision**

The greater proportion of all the male respondents (84%), was not circumcised (Table 4.9). The focus group discussion held in Glenview 2 revealed that very few men are circumcised because they fear the circumcision process and that those who were circumcised might have been circumcised as a cultural practice which they could not escape and not as a health practice. However, it was agreed that some men are beginning to do so for HIV prevention since a number of organisations and the government are campaigning for male circumcision.

The influence of education levels on the preferences of men to be circumcised was assessed. The finding revealed that 11% of the respondents of primary level, 19% of secondary level and 13% of the respondents who had reached tertiary level were circumcised (Table 4.9).

The influence of marital status on male circumcision preference was also assessed. The findings for the survey indicated that 100% of the married, 13% of the divorced, 24% of the never married and none of the separated were circumcised (Table 4.9).

**Table 4.9: Percentage Distribution of Male circumcision by Socio-demographic Characteristics**

Demographic Characteristic	Category	Percentage
<b>Education</b>	<b>Primary</b>	11.1
	<b>Secondary</b>	18.8
	<b>Tertiary</b>	13.6
<b>Marital Status</b>	<b>Married</b>	10.0
	<b>Divorced</b>	12.5
	<b>Never Married</b>	24.0
<b>Age Group</b>	<b>15-19</b>	23.1
	<b>20-24</b>	0.0
	<b>25-29</b>	16.7
	<b>30-34</b>	42.9
	<b>35-39</b>	0.0
	<b>40-44</b>	12.5
	<b>45-49</b>	0.0
	<b>Total</b>	<b>15.9</b>

N=63

Of the male respondents who were not circumcised, the majority (70%) suggested that they would not want to be circumcised even if the service was made available to them for free.

The findings from the survey pertaining to the reasons why the circumcised male respondents chose to do so revealed that HIV prevention was the major reason and almost half (52%), wanted to protect themselves from HIV, 12% were circumcised at birth, 12% copied others and 18% were circumcised as a religious exercise (Table 4.10)

Also, the results about the reasons why the male respondents chose not to be circumcised showed that fear of the circumcision process is the major reason for low uptake of circumcision and 52% of the respondents feared the circumcision process, 18.2% thought their religion does not permit circumcision, 12% did not know about circumcision and 6% of them had other reasons (Table 4.10). Moreso, the male respondents who attended the focus group discussion in Glenview 2 shared the same sentiments that the process is fearsome and that some men trust their wives hence they had no reason to be circumcised. Also, circumcision is dominantly done as a cultural practice in Zimbabwe and 60% of the circumcised men were circumcised at birth. However, 40% of the circumcised males were circumcised one year ago. Table 4.10 shows the percentage distribution of Pentecostal Christians regarding male circumcision.

**Table 10: Percentage Distribution of Reasons, Willingness, Date of Circumcision and Reasons for not Wanting to be Circumcised**

<b>Issue in Question</b>	<b>Response</b>	<b>Percentage</b>
<b>Reason for Being Circumcised</b>	<b>Religious Exercise</b>	27.3
	<b>HIV Prevention</b>	20.3
	<b>To be Like Others</b>	9.1
	<b>Circumcised when Young</b>	54.6
	<b>Other Reasons</b>	0
<b>Date of Circumcision</b>	<b>At Birth</b>	60
	<b>One Year Ago</b>	40
	<b>2 Year Ago</b>	0
	<b>3 Years ago and more</b>	0
<b>Willingness to be Circumcision</b>	<b>Yes</b>	30
	<b>No</b>	70
<b>Reason for Unwillingness to be Tested</b>	<b>Religion Prohibitions</b>	18.2
	<b>Fear of Pain</b>	51.5
	<b>Circumcision has no Benefit</b>	12.1
	<b>Do not Know about Circumcision</b>	12.1
	<b>Other Reasons</b>	6.1

N=64

### 4.5.3 Women and Abortion

Good reproductive health practices like condom use and safe abortions contribute to HIV mitigation. An investigation into the number of female respondents who practice unsafe abortions was done. The majority of the Pentecostal Christian women (72%), had never had an unsafe abortion (Table 4.11). However, the focus group discussion in Glenview 3 proved that unsafe abortions in church should be very high and one man remarked:

*“Many girls and women in church are bound to abort pregnancies because of the restrictive laws which prohibit sex out of marriage and before marriage.”*

As reasonable as it was, the issue was debatable since some felt that not many Christian women are bound to do so since they are born again. Table 4.11 shows the abortion status of women

**Table 4.11: Percentage Distribution of Women Practicing Unsafe Abortions**

<b>Response</b>	<b>Frequency (%)</b>
Practiced Unsafe Abortion	28
Never Practiced Unsafe Abortion	72

N=83

### 4.5.4 Condom Use

Condom use is not generally accepted among Pentecostal Christians although some Christians use them. Results from the study revealed that 66% of the respondents who had had sex in their lives were not using condoms (Table 12). It was suggested during the focus group discussion in Glenview 2 that condoms are prohibited since the gospel prohibits people from fornication and adultery and thus condoms will enhance deviant behaviour. One man from the focus group discussion noted:

*“Condoms should never be considered as a solution to HIV prevention since they promote promiscuity in sexual relationships”*

In general, some Christian values are a barrier to effective HIV prevention among Christians.

Condoms among Pentecostal Christians are generally used for family planning and STI prevention purposes. Statistics obtained from the survey showed that 51% of the Pentecostal Christians used condoms for STI prevention and 68% used condoms for pregnancy prevention.

In general, pregnancies are feared more than STIs. However, focus group discussions showed that married men and women do not usually use condoms because they trust each other. One woman in a focus group held in Glenview 3 noted:

*“We have never used a condom since we got married and I trust my husband. It is difficult to introduce it now because he will suspect that I am cheating on him or that I do not trust him. I am afraid that this condom issue will destroy my marriage”*

Also, the unmarried are not allowed to use condoms because it promotes fornication. Condoms can only be used for family planning and STI prevention among those who are married only. The church is generally not a centre for condom distribution. Almost half (54%) of the respondents cited the peers as of information about condom use while 58% of them cited the media as influencing the same. The church is generally silent about condom use and only 22% of the respondents received advice on condom use from the church. Table 4.12 shows the percentage distribution of condom use among Pentecostal Christians.

**Table 4.12: Percentage Distribution of Condom use**

Issue in Question	Response	Percentage
<b>Ever Used a Condom</b>	Yes	34.0
	No	66.0
<b>Reason for Condom Use</b>	Partner Requested	18.7
	HIV Prevention	48.2
	Other STI Prevention	51.3
	Pregnancy Prevention	68.4
	Sex During Menstrual Periods	4.5
	Other Reasons	1.1
	Never Used a Condom	31.3
<b>Source of Advice to Use a Condom</b>	Media	57.6
	Friends	53.8
	Health Clinic Counseling	39.6
	Church	21.8
	Other	8.9

N=106

It was revealed that 38% of the Christian women compared to 29% of the Christian men used condoms although both males and females have low use of condoms (Table 4.13). Focus group discussion hinted that the condom is unpopular even when it is one of the ways to prevent pregnancies and HIV at the same time. The reasons given were that churches do not allow the unmarried to use of condoms, they can break thus making them unsafe and some people generally trust their partners and do not see the reason to protect themselves from HIV.

The investigation into the marital status of the males who used condoms made it clear that condom use is influenced by marital status and the never married women had the highest percentage (67%) of condom use and the married had the lowest percentage (19%). Information from the focus group discussions revealed that Christian marriages uphold the purity of sex and thus there is no need for condom use for the married unless it is used for pregnancy prevention (contraception). However, it was also suggested that the low use of condoms in marriage makes the marriage institution dangerous in relation to the transmission of HIV since some people are trustworthy in marriages.

Furthermore, an assessment of the influence of the education level of the respondents on their use of condoms was assessed. The findings from the survey showed that 67% of those who had never been to school, 21% of those at primary level, 38% of those at secondary level and 36% of those at tertiary level used condoms (Table 4.13). It was suggested during the focus group discussions that the youth and the unmarried have high levels of condom use for the prevention of unwanted pregnancies since fornication is against Christian values and pregnancy can be one visible sign of failure to abide by the Christian values. Table 4.13 shows the percentage distribution of condom use by socio demographic characteristics

**Table 4.13: Percentage Distribution of Condom Use by Socio-demographic Characteristics**

Demographic Characteristic	Category	Percentage
<b>Sex</b>	<b>Male</b>	29.2
	<b>Female</b>	37.9
<b>Marital Status</b>	<b>Married</b>	19.7
	<b>Divorced</b>	44.0
	<b>Never Married</b>	66.7
	<b>Separated</b>	50.0
<b>Education level</b>	<b>Never been to School</b>	66.7
	<b>Primary</b>	21.1
	<b>Secondary</b>	37.5
	<b>Tertiary</b>	35.7
<b>Age Group</b>	<b>15-19</b>	50.0
	<b>20-24</b>	60.0
	<b>25-29</b>	34.3
	<b>30-34</b>	42.9
	<b>35-39</b>	11.8
	<b>40-44</b>	20.0
	<b>45-49</b>	28.6
	<b>Total</b>	<b>34.0</b>

N=106

**4.5.5 Behaviour Change**

An assessment of whether the respondents felt they had changed their behaviour for the positive with regards to HIV prevention in the past 6 months was done. The results suggested that 57% of the respondents reported that they had changed their behavior so that they would prevent HIV (Table 4:14). Some similar sentiments were shared during the focus group discussion in Glenview 3 and the participants generally agreed that though difficult, people in their community were beginning to use condoms, have sexual intercourse with one HIV negative partner and some were abstaining. It was however debatable as some members of the same group argued that not many people were doing so.

Furthermore, an assessment of the influence of sex on behaviour change was done. The findings revealed that 64% of the females compared to 52% men reported that they had changed their behavior (Table 4:14).

Also, an assessment of the influence of education level on behavior change revealed that 50% of those who had never been to school, 42% of those at primary level, 60% of those at secondary level and 61% of those at tertiary level had changed their behavior. The lowest behavior change of 42% was for the respondents at primary level and the highest behavior change of 61% was for those at tertiary level (Table 4.14).

An investigation into the marital status of the respondents showed that 56% of the married, 68% of the divorced, 43% of the never married and 100% of the separated had changed their behavior to protect themselves from HIV in the past 6 months. Only 43% of never married had changed their behavior to protect themselves from HIV while 100% of the separated had also changed their behavior. It is important to mention that behaviour change varied with age and those aged 38% of those aged 30-34 years had the least behaviour change. All the other age groups had high percentages of over 50% (Table 4.14). Some suggestions from the focus group discussion revealed that a greater proportion of the people might have changed their behaviour because of fear of HIV infection and improved knowledge of HIV.

**Table 4.14: Percentage Distribution of Behaviour Change**

<b>Demographic Characteristic</b>	<b>Category</b>	<b>Percentage</b>
<b>Sex</b>	<b>Male</b>	63.8
	<b>Female</b>	51.6
<b>Education level</b>	<b>Never</b>	50
	<b>Primary</b>	42.1
	<b>Secondary</b>	60
	<b>Tertiary</b>	60.7
<b>Age Group</b>	<b>15-19</b>	71.4
	<b>20-24</b>	50
	<b>25-29</b>	64.7
	<b>30-34</b>	38.1
	<b>35-39</b>	50
	<b>40-44</b>	53.8
	<b>45-49</b>	100
<b>Marital Status</b>	<b>Married</b>	56.45
	<b>Divorced</b>	66.7
	<b>Never Married</b>	42.9
	<b>Seperated</b>	100
	<b>Total</b>	<b>56.9</b>

N=109

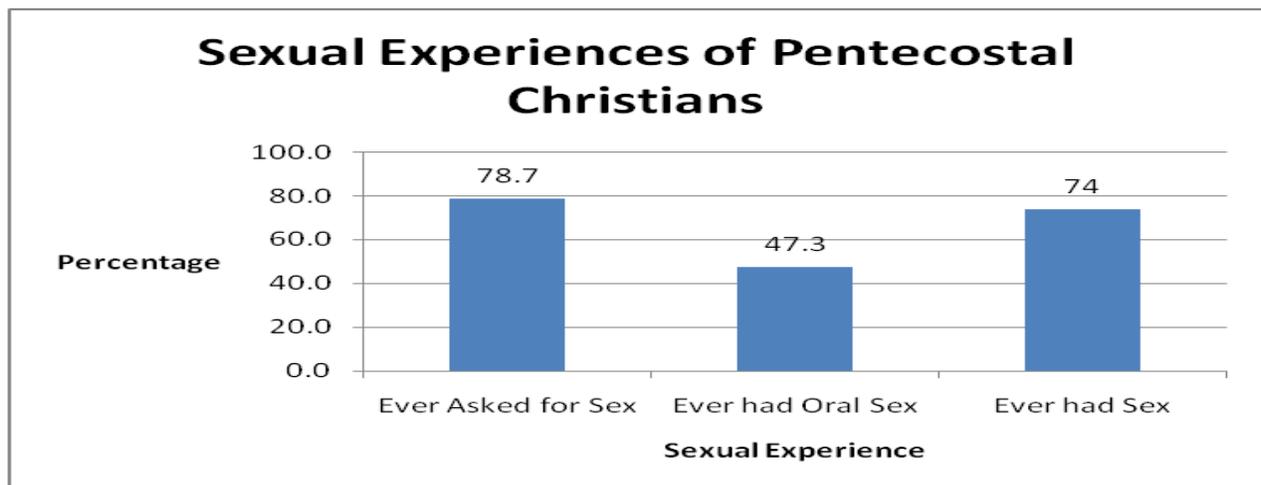
#### **4.5.6 Sexual Intercourse Experiences of Pentecostal Christians**

An assessment of the sexual behaviour of the respondents and HIV prevention practices was done. The findings from the survey revealed that 79% of the respondents had been requested for sexual intercourse by someone (Figure 4.3). Almost half of the respondents (47%) had had oral sex and almost three quarters (74%), had had sexual intercourse (Fig 4). The focus group discussions also showed that people are prone to sexual temptations. One woman from the focus group discussions remarked:

*‘Many heroes in the Bible like David, Gidion and Ahab failed the Lord because of their weakness to women. Credit can be given to Joseph who fled away from Portipher’s wife’.*

It was pathetic to note that many adolescents were reported to be practicing oral sex for fear of losing their virginity. Fig 4.3 shows the percentage distribution of sexual intercourse experiences of Pentecostal Christians.

**Figure 4.3: Percentage Distribution of Sexual Intercourse Experiences**



**N=150**

#### **4.5.7 Number of Sexual Partners in One’s Life**

Of the sexually active respondents, an account of the number of sexual partners in one’s entire life was taken. The maximum number of sexual partners that was recorded was 30, the minimum number was 1 and the mean number of sexual partners per individual was 3. The males had a higher number of sexual partners of 4 compared to their female counterparts who had 3 (Table 4.15). Information from one focus group discussion in Glenview 4 however hinted that Pentecostal Christians are supposed to have lower numbers of sexual partners since the church preaches faithful monogamy and abstinence. However, it was generally agreed that people were failing to live according to the stipulations of the Bible.

Furthermore, the marital category of the sexually active respondents was assessed. The mean number of sexual partners per individual was used. It was shown that the divorced had about 5 partners in their life time and the separated had about 4. Those two marital categories had the

highest numbers of sexual partners. The never married and the married had the least number of about 3 sexual partners each

The assessment of age of the respondents and the number of their sexual partners revealed that those aged 40-44 and 45-49 years had 4 and 5 partners respectively. Also, those aged 25-29 had 4 partners and those aged 30-34 years had about 3 partners (Table 4.15).

**Table 4.15: Distribution of Mean Number of Sexual Partners in Whole Life by Socio Demographic Characteristics**

<b>Demographic Characteristic</b>	<b>Category</b>	<b>Mean</b>
<b>Sex</b>	<b>Male</b>	3.8
	<b>Female</b>	3.1
<b>Marital Status</b>	<b>Married</b>	2.9
	<b>Divorced</b>	4.7
	<b>Never Married</b>	3.3
	<b>Separated</b>	4.0
<b>Education Level</b>	<b>Never</b>	1.0
	<b>Primary</b>	4.0
	<b>Secondary</b>	3.2
	<b>Tertiary</b>	3.5
<b>Age Group</b>	<b>15-19</b>	3.0
	<b>20-24</b>	2.1
	<b>25-29</b>	4.0
	<b>30-34</b>	2.8
	<b>35-39</b>	2.4
	<b>40-44</b>	4.2
	<b>45-49</b>	5.0
	<b>Total</b>	<b>3.4</b>

N=108

#### **4.5.8 Number of Sexual Partners in the Past Six Months**

An investigation into the mean number of the number sexual partners of the sexually active group in the past 6 months was also done. The overall mean number was 1.1 and it generally

made it clear that sexual activities with multiple sexual partners was minimum. However, the highest mean number of sexual partners was for the females who had 1.2 partners while the males had a lower number of 1 (Table 4.16). To the contrary, qualitative information from the focus group discussions revealed that women generally have lower numbers of sexual partners than men thus suggesting that at some point societal and religious values do not yield the expected results.

An assessment of the influence of marital status and the mean number of sexual partners in the past six months revealed that the number of sexual partners is controlled by marital status and divorced had the highest mean number of sexual partners of 1.7 while the married had a mean number of 1. All the other categories had a mean number of less than one. From the focus group discussions in Glenview 3, it was suggested that some divorced women are generally cheated by men in relationships thus resulting in them having many relationships. Moreso, some of them seek for survival through risky sexual behaviours

The education levels of the respondents were assessed and it was shown that the number of sexual partners gradually increased from 1.3 for those who have never been to school to 3.0 for those at primary level. The number for those at secondary level was at 1.1 and it finally decreased to 0.9 for those at tertiary level. However, qualitative data suggested that education level has nothing to do with virtues. They gave examples of some doctors and nurses who contract HIV through risky sexual behaviours when they are the ones who teach about HIV. Table 4.16 shows the distribution of the mean number of sexual partners in the past 6 months by demographic characteristics

**Table 4.16: Distribution of the Mean Number of Sexual Partners in the Past 6 months by Socio Demographic Characteristics**

Demographic Characteristic	Category	Mean Number of Sexual Partners
<b>Sex</b>	<b>Male</b>	1.0
	<b>Female</b>	1.2
<b>Marital Status</b>	<b>Married</b>	1.0
	<b>Divorced</b>	1.7
	<b>Never Married</b>	0.8
	<b>Separated</b>	0.0
	<b>Never Been to School</b>	3.0
<b>Education Level</b>	<b>Primary</b>	1.3
	<b>Secondary</b>	1.1
	<b>Tertiary</b>	0.9
	<b>15-19</b>	1.1
<b>Age</b>	<b>20-24</b>	0.7
	<b>25-29</b>	1.4
	<b>30-34</b>	0.8
	<b>35-39</b>	1.3
	<b>40-44</b>	1.2
	<b>45-49</b>	1.3
	<b>Total</b>	

N=106

#### **4.5.9 Cross Generational Sex**

The overall age difference between sexual partners was 4.5 years. The mean age difference for the male respondents and their sexual partners was 4.8 years and was higher than that for the female respondents and their partners which was 4.2 years. It was also agreed upon during focus group discussions that men usually prefer younger women than them because they want to have control over them. However, it was also suggested that some women prefer older men than them because they are usually financially stable.

However, age difference with sexual partner was noted to be controlled by education level with respondents who had never been to school having the highest age difference (6 years) as compared to the respondents of the other education levels who had around 4 years difference (Table 4.17). Also, the divorced had the highest age difference with their sexual partners (5.1 years) as compared to the married (4.3 years) and the never married (4.8 years). Table 4.17 shows the percentage distribution of age differences by socio demographic characteristics.

**Table 4.17: Distribution of Age Difference Between Sexual Partners**

Demographic Characteristic	Category	Mean Number of Sexual Partners Per Individual
<b>Sex</b>	<b>Male</b>	4.8
	<b>Female</b>	4.2
<b>Marital Status</b>	<b>Married</b>	4.3
	<b>Divorced</b>	5.1
	<b>Never Married</b>	4.8
<b>Education Level</b>	<b>Never</b>	4.0
	<b>Primary</b>	6.0
	<b>Secondary</b>	4.1
	<b>Tertiary</b>	4.4
	<b>Total</b>	4.5
<b>Age Group</b>	<b>15-19</b>	1.3
	<b>20-24</b>	4.7
	<b>25-29</b>	4.4
	<b>30-34</b>	4.1
	<b>35-39</b>	4.6
	<b>40-44</b>	4.6
	<b>45-49</b>	6.6
<b>Total</b>		<b>4.5</b>

N=88

#### **4.4.10 Age at First Sexual Encounter**

Generally, the mean age at first sexual encounter for both males and females was high (20.1 years). It was suggested during the focus group discussions in Glenview 5 that it is generally

expected of Christian people to delay sex because of the restrictive laws of the Bible regarding sexual matters.

It was however identified that age at first sexual encounter was controlled by sex and male respondents who participated in the survey started sexual encounters at an average age of 20.1 years compared to their female counterparts who started at the age of 19.8 years (Table 4.18). From the focus group discussions done in Glenview 4, it was suggested that girls mature earlier than boys and it thus exposes them to sexual issues earlier than they can handle the consequences of such issues.

Also, an investigation into the influence of education level on age at first sexual encounter of the respondents was done. Age at first sexual encounter was controlled by education level with respondents who reached tertiary level engaging into sexual encounters at a later age of about 21 years compared to about 20 years for those at secondary level, 20 years for those at primary level and about 18 years for those who had never been to school (Table 4.18). Some suggestions from the focus group discussion revealed that education commitments delay marriages amongst the youths since they may choose to first finish school then get married after that.

Furthermore, an investigation of the marital status of the respondents and their age at first sexual encounter was done. Findings from the survey showed that the highest age at first sexual encounter of 20.4 years was for the married and the lowest age of 18 years was for the separated (Table 4.18). It was explained during the focus group discussions that some men generally prefer marrying younger girls than them thus exposing the girls to sexual issues at an early age.

**Table 4.18: Distribution of the Mean Age at First Sexual Encounter**

Demographic Characteristic	Category	Mean Age at First Sex Encounter
<b>Sex</b>	<b>Male</b>	20.6
	<b>Female</b>	19.8
<b>Marital Status</b>	<b>Married</b>	20.4
	<b>Divorced</b>	20.1
	<b>Never Married</b>	19.5
	<b>Separated</b>	18.0
<b>Education Level</b>	<b>Never</b>	18.3
	<b>Primary</b>	20.0
	<b>Secondary</b>	19.7
	<b>Tertiary</b>	21.4
<b>Total for Males and Females</b>		<b>20.1</b>

N=110

**4.5.11 Future Sexual Plans for the Abstaining Pentecostal Christians**

The plans of the abstaining respondents regarding sexual matters were looked into. Those who were satisfied with their decision to abstain were 97%. About 68% of the respondents who were satisfied with their decision to abstain reported their reason for their satisfaction as their wish to abstain until they got marriage, 10% wanted to wait for the right partner, 72% wanted to be obedient to God, 43% wanted to avoid pregnancy and 67% wanted to prevent themselves from HIV infection. None of the respondents suggested that he/she wanted to have sexual intercourse as much as he/she wanted (Table 4.19). During the focus group discussions, it was suggested that sexual issues are a difficult topic to discuss and people usually give some false response in some cases. Also, 100% the respondents suggested that they wanted to abstain until they got married. It was generally agreed during the focus group discussions that many people would want to abstain until marriage although this may not be practical in many people's lives.

**Table 4.19: Percentage Distribution of Future Sexual Plans for the Abstaining Christians.**

<b>Issue in Question</b>	<b>Response</b>	<b>Percentage</b>
<b>Satisfaction with the Decision to Abstain</b>	<b>Yes</b>	97.2
	<b>No</b>	2.8
<b>Reason For Abstaining</b>	<b>Wait till Marriage</b>	72.2
	<b>Be Obedient to God</b>	68.4
	<b>Wait for Right Partner</b>	10.0
	<b>Have Sex as often as I like</b>	0.0
	<b>Avoid Pregnancy</b>	43.2
	<b>Avoid HIV infection</b>	66.7
	<b>Other</b>	2.8
<b>Future Plans About Sex</b>	<b>Wait till Marriage</b>	100.0
	<b>Have One Sexual Partner Only</b>	0.0
	<b>Have No Plan</b>	0.0
	<b>Other</b>	0.0

N=36

## **Chapter 5: Discussion**

### **5.1 Discussion**

This chapter discusses the findings of the study. A thematic approach is adopted and the knowledge, attitudes, beliefs and practices regarding HIV prevention are discussed separately. The findings of the survey and focus group discussion were compared with the findings from other studies including ZIMDAT 2009 and the other studies which are mentioned in the literature review of the study. The position of the Pentecostal Christians regarding HIV prevention was established and some possible recommendations to inform future church programs were made

In general, the Pentecostal Christians have high knowledge of HIV prevention. This was characterised by the ability of the respondents to identify the modes of HIV transmission and the prevention methods. Findings from the survey revealed that the respondents who managed to identify the HIV transmission mode of unprotected sex were 94% use of infected blood (83%), oral sex (74%), and vertical transmission (86%). Some misconceptions were low. The respondents who suggested that's sharing a swimming pool with an infected person, sharing food with an infected person and mosquito bites are modes of HIV transmission were less than 20% for every method. Also, the respondents who identified condom use as a prevention method were 84%, male circumcision (57%), and faithful monogamy with an uninfected partner (90%). The misconceptions/myths were having sex with a healthy looking person, eating a balanced diet, not sharing food with an infected person and not sharing a swimming pool with an infected person. Less than 16% of the respondents suggested the above mentioned misconception of HIV prevention methods. The Zimbabwean urban women who had comprehensive knowledge of HIV were 51% and the urban men who were knowledgeable of HIV were 47% (ZIMDAT 2009). It is important to note that the effectiveness of the fight against HIV should be backed by knowledge of the pandemic so that efforts are directed towards workable solutions.

Socio demographic characteristics determine people's knowledge of HIV. The findings from the survey showed that the majority (97%) of the people had reached primary level and an even higher level of education. Also, qualitative information from the focus group discussions revealed that HIV was included on the schools education curriculum starting from primary

school. The school enrolment rate of Zimbabwe is 91% (MoLSS 2010). Also, HIV is a common pandemic which has caused death in almost every family in Zimbabwe (NAC 2007). Many people got the information about HIV through many institutions like hospitals, schools, churches and Non Governmental Organisations. The media also played an important role and information about HIV is always on the television, radio, newspapers, bill boards, and many other forms of communication. Moreover, Zimbabwe declared HIV as a national disaster as long back as 2002 and this could have ensured that almost every institution got to do something about HIV (NAC 2007). The challenge is however that not everyone is able to prevent himself/herself even when the message about HIV is written everywhere. The reasons may be peer pressure, and other cultural barriers like wife inheritance (UNICEF 2010)

It is important to mention that the attitudes of Pentecostal Christians were generally in support of the HIV prevention methods. Only 32% of the Pentecostal Christians suggested that condom use overrides the objective of sex and 95% believed that VCT should be done for HIV prevention. On average, the attitudes of Pentecostal Christians towards HIV prevention were in favour of HIV prevention. Interpersonal contacts and communication is a critical component in health and behaviour change communication (Muturi 2007). According to the same source, by actively communicating about the AIDS epidemic, leaders reinforce HIV and AIDS media messages. However, such communications are hindered or made possible by the attitudes and beliefs of people within any society (Chitando 2007). In general, if the beliefs and attitudes of a person are positive towards HIV prevention then the higher the chances of behaviour change. It is logical therefore to continue encouraging the people through the provision of relevant knowledge about HIV and the role of the church. This will help the people to reduce stigma, build a supportive environment for the HIV infected and also help to prevent HIV transmission.

In general, Pentecostal Christians understand the severity of HIV infection, thus making it clear that there is high HIV prevention among Christians. A total of 86% of the respondents believed that HIV has no cure. However, it was a bit confusing to note that 45% of the same group of Christians also believed that HIV can be cured spiritually. There was an indication that there are challenges in balancing scientific knowledge of HIV and what people believed about the viral

infection. In general, God is portrayed as the healer of all diseases and people are healed by faith. As such, many Pentecostal Christians believe that God is a forgiving God who will heal them of their illnesses if they sincerely beg for forgiveness and believe in faith that God will heal them. Some pastors claim to heal HIV and some people were reported to have stopped taking their anti-retroviral drugs believing in faith that God had healed them and yet it was not so (Smith 2004). According to the same source, some were reported to have been truly healed and they tested negative after that. As debatable as it can be, the truth is difficult to understand but during the focus group discussions, some people suggested that when antiretroviral drugs are taken correctly, the virus can get suppressed to levels where it cannot be detected by some testing machines and people who notice such a thing call it a miracle. The church should come up with clear policies that state its position in relation to issues of spiritual healing and adherence to antiretroviral drugs so that it will serve people's lives.

In as much as the church finally joined the government and civil society in the fight against HIV and AIDS, some Pastors and church leaders are unwilling to openly address HIV and AIDS and make it a priority in their mission and ministry. Maureen (1997) postulated untreated sexually transmitted diseases are likely to destabilize families because of sexual dysfunctions. While new infections are likely to be high, the study findings indicated that 42% of the pastors sometimes talk about sexuality in church, 41% of the youth leaders sometimes talk about sexuality in church and only 22% of the people reported some confessions about HIV. In the study, the word sometimes meant that they talked about an issues only once after 2 months. HIV remains a low priority issue despite that it is killings and crippling many people. (Muturi 2007). According to the same source, many religious leaders, particularly at grassroots level, lack education about HIV transmission and prevention. Their theology is sometimes dysfunctional to life. They are ill-equipped to teach others about this subject. This silence has meant that many people, even within a particular church community, have been left with no helpful messages or information about how to protect themselves and their families. Life-saving and health-protecting information and preventive commodities, have been denied not only to the broader community and those most impoverished and marginalized, but to the young and others in a particular religious family (Muturi 2007). It was also mentioned during the focus group discussions that many Pastors deal

with HIV like a pandemic which is mainly caused by adultery and fornication and as such they emphasise on living a holy life without actually looking at issues of vertical transmission and other issues to do with the issue of the use of unsterilized needles.

The findings from the survey indicated that only 22% of the survey respondents heard some people in their churches making some confessions about their HIV status in church. Zimbabwe has many people who are living with the infection (13.7%) more confessions should generally be heard in church since it the place of refuge for the afflicted (MoLSS 2010). In general, people do not disclose their HIV status for fear of being stigmatized. Information from one focus group discussion suggested that religious teachings and practices have intensified this stigma by labelling persons infected as sinners and treating persons as second or third class citizens. What makes HIV and AIDS prevention particularly difficult is the stigma that has been attached to this disease. Few if any other disease, suffers this degree of stigmatization and discrimination (UNAIDS and NACC 2010). Whether it is the teaching that “you reap what you sow,” or saying “people get what they deserve” or suggesting it is a result of karma or previous life behaviour, religious beliefs combined with other negative cultural customs ostracizing and shunning infected people and their families. In general, the commitment to deal with HIV issues is low since it is believed to affect the social misfits who fail to abide by the Christian values and principles. In most cases, the stigmatization was associated with lack of knowledge since people quite so often ignore the fact that there are many innocent children, women and men who are unfortunately infected by their parents and spouses. The church should generally seek to ensure that it converts its high knowledge levels of HIV into tangible positive action which can be exhibited through action towards the infected and not simply through talking. HIV and stigma awareness campaigns are key to the achievement this objective.

The Pentecostal Christian religion proved to be one religion with values which can be an answer to the fight against HIV and AIDS. Such values included the promotion of abstinence, faithful monogamy and circumcision. A total adherence and commitment to live as the Bible says will save the whole world without doubt (WCC 2007). However, some Pentecostal Christian leaders either cannot see or are unwilling to recognize the realities of human behaviour, especially in connection to sexual activity and lifestyles. They attempt to adhere to moral principles deemed

divine regardless of the human consequences (Rodgers 2008). According to the same source, it appears they are more eager to preserve the purity or correctness of their theological perspective than to protect human lives. In general, denial of reality means not recognizing what people actually do in a particular culture, society, or religious group (Rodgers 2008). This may mean pretending that young people regularly abstain from becoming sexually active until they are married or pretending that married couples are always mutually monogamous.

The majority of the respondents (66%) shun condom use. The minority of the males (29%) and 38% of the females use condoms. Some suggested reasons for the low use of condoms which were made during the focus group discussions were; trust between sexual partners and the fact that condom use over rides the objective of sex. In general, Zimbabwe still needs to ensure that people will use condoms for HIV prevention since only 24% of the urban women and 57% of the males use condoms (ZIMDAT 2009). In general, the church does not approve of condom use (WCC 2009). However, the Zimbabwean church is reported to have accepted condom use as a method of HIV prevention. However, the method was restricted to the married only since the church does not encourage fornication among the unmarried (EFZ 2009). One of the reasons for the high levels of HIV infection in Sub-Saharan Africa is low condom use (Smith 2004). Condom use in church is a sticky issue in general and it may not be easy to engage the church in a dialogue to promote condom use for the unmarried. During the focus group discussions, it was echoed by some believers that condom use for the unmarried is a difficult subject in church since it compromises the values of the religion

Also, the number of Pentecostal Christian aged 15-49 years who went for VCT is above half (56%). It is also important to note that 63% of the females compared to 46% of the males were tested for HIV. Information from the focus group discussion alluded to the fact that some people are not tested because they do not have access to the ARVs. However, it was suggested that the access to the drugs is improving although the nation still needs to improve its services. The national statistics of Zimbabwe also reveal that the percentage of people who go for VCT is still low (58%). However, the percentage of Pentecostal Christians who have been tested was lower (56%) compared to that of the general population of Zimbabweans with Christians included (58%) (ZIMDAT 2009). Moreso, the majority of the women (71%) had been tested for HIV

compared to Pentecostal Christians (63%). Focus group discussions revealed that people are not forced to go for VCT and they usually seek for the service at a point when they cannot do without the results. Some Pentecostal youths were reported to be taking the bold step to go for VCT at the point of marriage when they introduce themselves to the pastor. The effectiveness of such an approach is difficult to tell since some youths would have already started having sexual intercourse. However, the church usually teaches about abstinence and the results of this approach should not be underestimated. The challenge is however that many people are not able to realistically do so. Moreso, the majority (65%) of the Pentecostal Christians fear HIV and that is why they do not go for VCT.

Age at first sexual encounter was high (20.1 years) for Pentecostal Christians. However, mean age at first sexual encounter was higher for males (20.6 years) than for females (19.8 years). Some reasons suggested during the focus group discussions held in Glenivew 3 and 2 revealed that females are bound to be married earlier than males because men have got to be financially stable before getting married and it usually takes long for many males to get financially stable. The males have to pay for the bride price and they are also regarded as the providers in many homes. On the other hand, females mature earlier than males and puberty is usually earlier for females than for males in Zimbabwe and other countries. The age at first sexual encounter for other Zimbabweans was lower (19 years) than that of Pentecostal Christians (20.1 years) (MoHCW et al 2009). The reasons suggested from focus group discussions were generally that more Christian youths are bound to abstain for longer because of the gospel of abstinence which the church usually preaches.

Sexual networking is high among Pentecostal Christians. Findings from the survey showed that the total mean number of sexual partners for ages 15-49 was 3.4 partners per individual of which the mean number for males was about 4 partners and that for females was 3 partners. The mean number of sexual partners during a lifetime for males aged 15-49 for Zimbabwe's urban females was 1.7 and that for urban males was 6.2 partners (ZIMDAT 2009). In general, Pentecostal Christian women had more sexual partners than other women although Pentecostal men had a lower mean number of sexual partners than other men. The mean number of sexual partners among Christians is expected to be low since the church promotes abstinence and faithful

monogamy. Also, African culture promotes virginity among girls (Burchadt 2009). However, the challenge was that high numbers of sexual partners for a few women were recorded thus increasing the overall total number of sexual partners per individual. Also, the church is open to everyone and the history of some people before they were converted to be Christians can also be a contributing factor to the high mean number of sexual partners per individual.

When the church promotes circumcision as a health practice, the majority of the male respondents (84%) shun it. In general, low levels of male circumcision are another cause for high HIV infections in Sub-Saharan Africa (PSI 2010). According to the same source, low male circumcision levels of 10% in Zimbabwe were also noticed (PSI 2010). World statistics show that male circumcision is as low as 30% of which 68% of the men are Muslims, 0.8% are Jewish and 13% are United States men (PSI 2010). Male circumcision can reduce HIV infection by 60-65%. However, it should be used synergistically with other HIV prevention methods like condoms and abstinence. It is important to note that HIV incidence could be reduced by 25% to 35% if 50% of men are circumcised in Zimbabwe (PSI 2010).

The involvement of people in church programs other than the Sunday service is low, thus reducing the impact of the church in communities. Only 60% of the respondents attended other church programs and the rest did not. This means that some people are not found where HIV and other important issues in life are discussed. The church draws its power from such meetings like the cell groups, youth fellowship, men's fellowship and women's fellowship (Chitando 2007). In the same vein of thinking, some Christians who attend services on Sunday only generally benefit very little from being Christians. In general, this may be another reason why some people fail to practise their Christian values like abstinence and faithful monogamy because they lack encouragement from other church programs.

Focus group discussions hinted out that women are more disadvantaged because of their biological make up and their inability to negotiate for safe sex culturally. Women and girls are the most affected by the HIV virus (UNAIDS and NAC 2010). According to the same source, gender roles and sexual norms as well as economic and legal factors compel some women to engage in risky sexual behaviours. Statistics on whether it is acceptable for a woman to request for condom use with a husband with an STI revealed that 82% the Zimbabwe would encourage

that (ZIMDAT 2009). However, not all STIs show signs. Some of them may be asymptomatic for some time and many women are infected by their sexual partners during that stage. Also, patriarchal thinking among the some Christian leaders have proved insensitive to the dilemmas women face in the contemporary world (Muturi 2007). The focus group discussions revealed that the Pentecostal religion has very few female pastors. The “ABC’s” of prevention are inadequate unless gender equality is underscored and women are accorded autonomy over their own bodies and destinies (UNAIDS and NAC 2010). Religious teachings and customs often increase the vulnerability of women to HIV infection as they are told to obey their husbands, even if those same men have been unfaithful to them. More often, men ignore that the same Bible commands them to love their wives as Christ loved the Church (Chitando 2007). There is need therefore to continue encouraging couples to go for couples’ meetings and seminars so that they will be enlightened on biblical gender roles since some couples get into marriage without receiving any marriage counselling.

Unequal yoking and double standards in church negatively impact on the usefulness of the church as a behaviour change agent. Some members in Focus group discussions alluded to the fact that men and women from the church marry and have sexual relationships with people who do not go along with their beliefs and principles as Christians. Many innocent Pentecostal Christian men and women are therefore infected by their partners, or it is no longer clear who infects who. According to Dube 2002, poverty is a driving factor for unequal yoking and since some people are married to non-Christians for financial reasons. However, there is an obsession in people to be identified as Christians when in actual fact they may be traditionalists or even non religious. When Zimbabwe is believed to be over 80% Christian, actual Christians may only be 40% or less (Evangelical Fellowship of Zimbabwe 2009). Findings from the survey suggest that 40% of the respondents were those Christians who go to church on Sunday only and do not attend any other services. The church has to rise against the tide and keep its principles as Christians. The pastors have to know their people and walk along with them as their shepherds. However, qualitative data from the focus group discussions alluded to the fact that the ratio of pastor to church members in some churches grow to such an extent that the pastor may not even know his/her sheep. As such, some mechanisms have to be adopted to ensure that pastors will lead some manageable congregations.

## 5.2 Conclusion

In general, Pentecostal Christians have high knowledge levels of HIV prevention and their beliefs and attitudes to HIV prevention vary from issue to issue. In some cases, the behavior of some Pentecostal Christians does not reflect that they have high knowledge levels of HIV prevention and that their attitudes and beliefs also favour the prevention of HIV. This generally shows that what is thought to be ideal in some cases is not what is practically happening among the Pentecostal Christians. Christianity is a religion with sound values and principles which can be considered as major weapons against HIV and AIDS. Their power is in the ability of people to practice them. However, in as much as more are the perceived benefits from the values, people are generally overwhelmed by the perceived barriers of failure to abstain and to practice faithful monogamy in marriage settings. Since the church itself is made up of people with different levels of understanding and willingness to practise what the Bible says, the church is getting affected by HIV quickly and greater are the challenges. Christians have got to be encouraged to use condoms, go for male circumcision, go for VCT, get married to equally serious Christian partners, talk more often about HIV and AIDS in church, train pastors on HIV and AIDS, encourage the youths to delay sexual debut, encourage church members to attend other church programs other than the Sunday service and to shun cross generational sex. Some misconceptions concerning the prevention of HIV like having sex with a healthy looking person and mosquito bites were low but they should be completely eliminated among the Pentecostal Christians. Moreso, the positive behaviours of delayed sexual debut, sanctity of marriage, purity of sex and voluntary counselling and testing has got to be continuously emphasized and reinforced. As long as the church avoids double standards and sticks to its business, the Christians would need no other intervention other than abstinence, faithful monogamy, male circumcision and voluntary counseling and testing, but condom use especially for married couples with STI's may be recommended for the sake of the weaker brethren. Finally, the church has to continue building working networks with other stakeholders in ameliorating the challenge of HIV and AIDS. There is however no doubt that the church is one institution which has the will and the resources to help reduce HIV and AIDS and that a further improvement of its approaches to HIV mitigation will build a better world for tomorrow.

### 5.3 Recommendations

The following recommendations were made

- The church should encourage the pastor's wives or husbands and other people in positions of leadership in church to go for pastoral training so that they will be better placed to lead the people in the fight against HIV and other church issues.
- The church should put HIV and AIDS as a course for Pastors' training. The pastors who had already graduated should go for short courses on HIV and AIDS so as to equip them with knowledge and information to talk about sexuality and HIV and AIDS in church.
- The church should scale up its activities on gender equity and equality through training female pastors, electing female leaders and initiating many other programs which allow the women to also participate.
- The church should scale up programs which deal with couples. Examples can be couples meetings. The church should ensure that some of the women or men who may not be part of their congregations will attend these sessions for the benefit of their spouses so as to reduce the effects of unequal yoking. However, the church must encourage its people to be married to other Christians so as to reduce the problems of unequal yoking again.
- The church has to come up with HIV policies which will guide the operations of the church and also ensure that an HIV desk is established at every church, if possible, so as to ensure that HIV issues are not left out in the programming of the activities of the church.
- Some manuals or training tools on HIV programming and mitigation, which are specific for the church, have got to be developed to further complement what has been developed by the circular world. This makes the programs more acceptable.
- When the church is controlled by the four umbrella bodies, there are problems in terms of who speaks on behalf of who, since there are some denominations which have not

registered with any of the 4 bodies and are operating autonomously. The church should therefore unite and speak with one voice.

- The church must strengthen its operation systems and ensure that everyone attends other church services like youth fellowship, men's fellowship and women's fellowship so as to allow them to benefit from being members of the church. In general, some considerations can be done in terms of looking at the ratio of members to pastor so as to ensure that the pastor will reach out to every member of his church.
- The church must act as a role model in preventing HIV and AIDS and fighting stigma. The opening up of one popular pastor, Pastor Kapachawo about his HIV status generally shows that everyone is susceptible to HIV, a thing which therefore promotes behaviour change.
- The youth, the never married, the divorced and the widowed should be targeted for HIV prevention since they are exposed to sexual temptations and abuses more than any other group.
- The church must continue to encourage the youths to abstain. Some ways to reward those who abstain till marriage have got to be revived so as to encourage the youths to abstain. The abstaining youths and the married should continuously be encouraged to be faithful to God and to follow their Christian principles.
- The scaling up of male circumcision awareness campaigns should be done. The women should be involved in the process and the mutual benefit of male circumcision should be explained so that they will encourage their spouses to go for circumcision. Also, the church leadership should be targeted for trainings on male circumcision.
- All the stakeholders working towards the mitigation of HIV including the government should work closely with the church since it has the people, the infrastructure, the respect and the voice to influence people's attitudes, behaviors and practices towards HIV prevention

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**Annexes**

**Annex 1. Survey Questionnaire**

**Knowledge Levels, Attitudes, Beliefs and Practices of Pentecostal Christians Regarding  
HIV Prevention Strategies Assessment Questionnaire**

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**Questionnaire Identification Number** \_\_\_\_\_

This is a self administered survey questionnaire which seeks to gather information on people's

**Purpose of Study and Consent**

Knowledge levels, Attitudes, Beliefs and Practices (KABPs) regarding HIV and AIDS prevention so as to inform the Church's HIV and AIDS policy formulation. The questionnaire does not involve any identification by name or any other particulars and your participation is voluntary. Your information will be kept private and confidential and it shall not be used for any other purpose other than the above mentioned.

**Risks and Benefits**

This study does not have any direct benefits to you. Your answers will help in improving the HIV and AIDS interventions of the Church and it may not directly affect you.

**Demographic Information**

*Please tick in the appropriate box or fill in the correct answer in the space provided*

- 1. How old are you
- 2. Sex  Male  Female
- 3. Marital Status  Married  Divorced  Never Married  Separated
- 4. Education level  Illiterate  Primary  Secondary  Tertiary
- 5. Place of Residence

GV 1	GV 2	GV 3	GV4	GV 7	GV8
------	------	------	-----	------	-----

6. What is your religion?  1. Pentecostal  2. Protestant  3. Catholic  4. Traditional  
 5. None
7. If you go to church, do you hold a position of leadership?  1. Yes  2. No
8. Do you attend any meetings besides the Sunday Service?  1. Yes  2. No
9. If yes to question 8, what meetings do you attend?
1. Youth Fellowship  2. Men's Fellowship  3. Women's Fellowship
4. Praise & Worship
5. Any other. Specify \_\_\_\_\_

### Knowledge Levels of Root causes of HIV Transmission

*Please CIRCLE the correct answer*

<b>10. People get HIV from:</b>	<b>Yes (1)</b>	<b>No (2)</b>
a. 1. Sexual intercourse without a condom	1	2
b. 2. Sharing needles among drug users	1	2
c. 3. Receiving blood from an HIV infected person	1	2
d. 4. Mother to child transmission	1	2
e. 5. Having oral sex with an HIV infected person	1	2
f. 6. Shaking hands with an infected person	1	2
g. 7. Mosquito bite with an infected person	1	2
h. 8. Sharing food together with an infected person	1	2
i. 9. Sharing tools and official utensils with an infected person	1	2
j. 10. Sharing public swimming pools with an infected person	1	2

**Total correct answers about transmission routes**

### Knowledge Levels of HIV AND AIDS Prevention Strategies

**Tick CIRCLE all the answers that apply**

11. People can protect themselves from getting HIV and AIDS by (*please circle All answers that apply*)

**Yes (1)                      No (2)**

- |  |   |   |
|--|---|---|
| a. Not sharing food with a person with HIV and AIDS.           | 1 | 2 |
| b. . Abstaining from sexual intercourse (including oral sex).  | 1 | 2 |
| c. Having only one sexual partner who has been tested for HIV. | 1 | 2 |
| d. Always using a condom.                                      | 1 | 2 |
| e. Always having sex with healthy-looking people.              | 1 | 2 |
| f. Avoiding the use of public toilets.                         | 1 | 2 |
| g. Ensuring that injections are done with sterile needles.     | 1 | 2 |
| h. Be tested for HIV and remain faithful to one sex partner.   | 1 | 2 |
| i. Circumcision  | 1 | 2 |
| j. Eating a balanced diet every day                            | 1 | 2 |
| k. Prevention of Parent to Child Transmission (PPCT)           | 1 | 2 |
| l. Other means   |   |   |

**Total of Correct Answers**

12. Do babies born to HIV positive mothers carry the infection too

- 1.Yes       2.No       3.Dont Know

13. Can you tell just by looking whether a person has HIV infection?

- 1.Yes       2.No       3.Dont Know

14. Is there a cure for HIV and AIDS

- 1.Yes       2.No       3.Dont Know

15. Can Spiritual healing cure HIV and AIDS

- 1.Yes       2.No       3.Dont Know

16. Are condoms 100% safe in preventing HIV and AIDS?

- 1.Yes       2.No       3.Dont Know

17. Can an infection with other STIs increase a person's chances of being infected by HIV and AIDS?

1. Yes       2. No       3. Dont Know.

18. Can a person have an STI without showing any signs or symptoms

1. Yes       2. No       3. Dont Know

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### Attitude of Pentecostal Christians Towards HIV and AIDS Prevention

**In answering questions 19-27, please tick only ONE response on the scale:**

**Rarely = 2-3 times a year; Sometimes = once in every 2 months; Often = 1-2 times a month.**

*19. Sexuality is talked about in my church by a pastor:*

1. Never       2. Rarely       3. Sometimes       4. Often

*20. Sexuality is talked about in my church by a youth leader*

1. Never       2. Rarely       3. Sometimes       4. Often

*21. HIV AND AIDS is talked about in my church by either a pastor or youth leader:*

1. Never       2. Rarely       3. Sometimes       4. Often

*22. Someone in your church has told the congregation that he or she has AIDS:*

1. Never       2. Rarely       3. Sometimes       4. Often

*23. I keep hearing of persons from my church who have died of AIDS:*

1. Never       2. Rarely       3. Sometimes       4. Often

**Please tick either "YES" or "NO"**

24. Cross generational sex is acceptable       1. Yes       2. No

25. It is natural for men to have multiple partners       1. Yes       2. No

26. It is necessary for people to be tested  1.Yes  2.No
27. Condoms defeat the objective of sex  1.Yes  2.No

### HIV AND AIDS Prevention Practices

The following questions are very personal. It is **CRITICAL** that you answer them **VERY** truthfully.

28. Have you ever been asked to have sexual intercourse?  Yes1  No2
29. Have you ever had oral sex?  Yes1  No2
30. Have you ever had sexual intercourse?  Yes1  No2. (If **your answer is no to question 28 and 29, please skip to question 50**)

**Please answer the next 5 questions with a NUMBER. If not applicable, write “0”**

31. \_\_\_\_\_ At what age did you first have sexual intercourse? (*Please be specific*).
32. \_\_\_\_\_ At what age did you first have oral sex? (*Please be specific*)
33. \_\_\_\_\_ How many sexual partners (including intercourse, oral and digital sex) have you had in \_\_\_\_\_ your entire lifetime? (*Please state a NUMBER*).
34. \_\_\_\_\_ In the past 6 months, how many sexual partners have you had?
35. \_\_\_\_\_ In the past month, how many times have you had sexual intercourse?
36. Have your sexual behaviors changed for the better in the past 6 months?  Yes1  No2
37. If “Yes” why have your sexual behaviors changed? (*Please tick as many answers as can apply*)
- 1.My commitment to Jes  2.Fear of HIV and AIDS

3 Any other, Specify \_\_\_\_\_

38. If “Yes” to **question 36**, please explain in what way your sexual behaviour has changed?

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39. If “No” to **question 36**, please explain why your sexual behaviour has not changed

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40. When you first had sexual intercourse, was it... ***Please tick only ONE answer.***

- 1 Your choice to start  4 Someone else’s choice to start  
 2 You and the other person agreed that you wanted to  5 You were pressured  
 3 You were forced by another person  
 6 Other \_\_\_\_\_

41. Who was your first sexual partner? ***No names, please. Please tick only ONE answer.***

- 1 Spouse  7 Prostitute  
 2 Boyfriend/Girlfriend  8 Family friend  
 3 Classmate  9 Neighbour  
 4 New acquaintance  10 Teacher  
 5 Extended family member  11 Other \_\_\_\_\_  
 6 Someone (not a family member) who gave me a gift or other help

42. Why did you have sexual intercourse when you first had it? ***Please tick ALL answers that apply.***

- 1 I felt I was old enough  6 I was forced/pressured  
 2 To gain experience  7 Curiosity

- 3 To demonstrate my love for the person
- 4 It was my wedding night
- 5 Other \_\_\_\_\_
- 8 It just happened
- 9 I was being sexually abused

43. With whom do you **now** have sexual intercourse most frequently? *Please tick only ONE answer.*

- 1. Spouse
- 2. Boyfriend/Girlfriend
- 3. Classmate
- 4. New acquaintance
- 5. Extended family member
- 6. Someone (not a family member) who gives me gifts or other help
- 7. Prostitute
- 8. Family friend
- 9. Neighbour
- 10. Teacher
- 11. I am no longer having sex

44. How old is your sexual partner

45. What is the age difference between you and your sexual partner?

46. Did you and your partner use a condom the last time you had sex?  Yes1  No2

47. The last time you used a condom, was it because... (*Please tick ALL answers that apply.*)

- 1. Your partner requested it.
- 2. You wanted protection against AIDS.
- 3. You wanted protection against other sexually transmitted infections.
- 4. You wanted to avoid pregnancy or to avoid getting the other person pregnant.
- 5. You were having sex during monthly menstruation.
- 6. Other \_\_\_\_\_
- 7. You have started to have sex, but you have never used a condom.

48. Who or what encouraged you to use a condom? *Please tick ALL answers that apply.*

- 1. Media (Radio, TV, Newspapers, Pamphlets, etc.)
- 2. Friends

- 3.Counseling from health clinic
- 4.Church
- 5.Other \_\_\_\_\_

49. Have you ever had an abortion? (*To be answered by females only*)  Yes1  No2.

50. Have you ever been tested for HIV and AIDS?

- 1.Yes
- 2.No

51. Do you know your HIV status?

- 1.Yes
- 2.No

52. If tested, did you disclose/share your results with your partner?

- 1.Yes
- 2.No

53. If “Yes” why were you tested?

- 1.My Doctor asked me to be tested.
- 2.Just wanted to know my status
- 3.Wanted to marry
- 4. Any other. Specify \_\_\_\_\_

54. If not tested, would you want to be tested if testing was made available?  1.Yes  2.No.

55. If “No” why do you not want to be tested

- 1.Fear of HIV.
- 2.Have never had sex
- 3.Fear of being stigmatised
- 4.Any other. Specify \_\_\_\_\_

**Questions 56 to 60 to be answered by men only**

56. Are you circumcised

- 1.Yes
- 2.No

57. If “Yes” to question 56, why did you get circumcised? (*tick all the correct answers*)

- 1.Its a religious exercise
- 2.To prevent myself from HIV and AIDS
- 3.To be like my colleagues
- 4.Circumcised when I was young
- 5.Any other reason. Specify \_\_\_\_\_

58. When were you circumcised?

1. At birth     2. One Year ago     2. Two years ago     3. More than 2 years ago

59. If not circumcised, would you want to be circumcised?  1. Yes  2. No

60. If “NO” to question 58, why are you not circumcised (Tick all the answers that apply)

1. Our religion/culture does not allow us to be circumcised  
 2. Fear of pain during the circumcision process  
 3. Circumcision does not protect me from HIV in any way  
 4. I do not know about circumcision  
 5. Any other. Specify \_\_\_\_\_

***Questions 61 to 63 should be answered by those who are abstaining from sex only.***

61. If you have abstained so far, are you satisfied with your decision not to have sexual intercourse?

- Yes1     No2

62. Why did you decide to wait to have sexual intercourse? (***Please tick ALL answers that apply***).

1. To wait until marriage.  
 2. To be obedient to God and the Bible.  
 3. To wait for the right boyfriend/girlfriend.  
 4. To avoid pregnancy.  
 5. To avoid AIDS and other sexually transmitted infections.  
 6. Other \_\_\_\_\_

63. What do you plan to do in the future about having sexual intercourse? ***Please tick only one answer.***

1. Abstain until marriage.  
 2. Have sex with only one partner  
 3. Have sex as often as I like

4. I really do not have a plan

5. Other \_\_\_\_\_

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**Identified Gaps**

64. Would you want more information about HIV and AIDS prevention

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65. What do you think the church should do to prevent HIV and AIDS?

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66. For Data Capturer's Purpose Only-Status of Questionnaire

1. Fully Completed.     2. Not fully Completed     3. Not Completed

**End of Questionnaire**

*Thank you for your participation*