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The Condom Divide: Disenfranchisement of Malawi Women by Church and State

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Abstract

Objective—To examine the impact of two mitigating social institutions, religious organizations and the state, on Malawi women's vulnerability to HIV.

Design—In-depth interviews with a purposive sample of 40 central leaders from 5 faith based organizations (FBOs) in Malawi were recorded and transcribed as part of an on-going larger study. Qualitative description was used to identify themes and categories.

Setting—Primarily urban and peri-urban areas of south-central Malawi.

Participants—A minimum of 6 leaders from each FBO were interviewed; the mean age of the primarily male (68%) participants was 44 years (range 26–74).

Results—Analysis of religious leaders' messages about HIV produced an overarching theme, the condom divide, which conceptualized the divergence between FBOs and the state's prevention messages related to HIV prevention strategies.

Conclusion—Faith based organizations have “demonized” state messages about condoms as promoting sin. The FBOs' insistence on abstinence and faithfulness leaves women with few options to protect themselves. As socially conscious citizens of the world, nurses can increase the responsiveness to the disparate levels of suffering and death in countries like Malawi.

Keywords

HIV/AIDS; prevention; women; sub-Saharan Africa; religions; government Accepted April 2008

Girls or women in sub-Saharan Africa are often described in reference to their disempowered social and cultural status, their vulnerability to violence, including rape, their

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1. While religious organizations have typically taken on roles protecting the health and well-being of Malawians, their suspicion of government authority regarding HIV/AIDS may disadvantage women.

2. The condom divide highlights the oppositional stances of the government and faith based organizations' messages about how to effectively prevent the spread of HIV.

3. The plight of women in Malawi is complicated by the overwhelming poverty, regional migration, and global economic changes common across sub-Saharan Africa.

nearly total economic dependence upon men, and the convergence of these factors resulting in increased susceptibility to HIV/AIDS (Gregson et al., 2005; Lindgren, Rankin, & Rankin, 2005; Swidler & Watkins, 2007). Limited information exists on women in Malawi, a central African country, and there is no evidence that Malawi women are less susceptible than their African sisters elsewhere to the threats listed above. The purpose of this paper is to examine the influence of institutions such as religious organizations and the state that might serve to reduce or exacerbate the vulnerability to HIV infection of Malawi women.

Background

Malawi and HIV/AIDS

The Republic of Malawi is a country of 12.8 million people in south central Africa, which has a 14% HIV prevalence rate. Close to a million people live with HIV/AIDS (PLWHA), which is about the same as PLWHAs in the US. In light of the AIDS pandemic, life expectancy has been reduced to 41 years and the median population age is now 15.5 years (UNAIDS, 2006).

Despite recent efforts to address long-standing socio-economic inequalities and poverty, Malawi remains one of the world's least developed countries, ranked 162 out of 175 countries (United Nations Development Programme, 2004). The World Food Programme (2004) estimated that 60% of the mostly rural population lives below the poverty line, and 33% are malnourished.

Unlike neighboring countries of Tanzania and Zimbabwe, Malawi is less westernized and developed. Life is centered in rural areas, where 87% of the population lives, and even the most urbanized Malawians tend to return to their villages for important family events such as weddings, childbirth, and funerals. Villages are organized around tribes, which have unique and overlapping cultural values and practices (Msiska, 1995; Rangeley, 2000). Thus Malawi village culture continues to shape the nature of the response to HIV/AIDS (Lwanda, 2005).

As elsewhere in Africa, poverty contributes to the spread of HIV/AIDS by decreasing people's educational and economic capacities (Kaponda, Norr, & Norr, 2000; Niekerk, 2001; Norr, Norr, McElmurry, Tlou & Moeti, 2004). Lack of education limits understanding and access to knowledge about the disease, and economic deprivation limits the ability of many to afford condoms thus placing adolescent girls at particular risk for HIV as they may engage in transactional sexual relationships for basic survival (Feldman, O'Hara, Baboo, Chitalu, & Lu, 1997; UNFPA & Population Council, 2006; Rankin, Lindgren, N'goma, & Rankin, 2005).

Women have been disproportionately affected by HIV/AIDS. Females become infected at earlier ages than males and this difference is most marked in rural areas where 13% of females are infected compared to 9% of males (National Statistics Office, Malawi & ORC Macro., 2005). The status of African women is traditionally lower than men and this gendered power imbalance contributes to the higher prevalence in young women. Evidence supports that first sexual experiences are often not by choice with many girls being forced or coerced into having sex (Jejeebhoy & Bott, 2003; Monasch & Mahy, 2006; UNICEF, 2006). Young women often have older partners who are likely to have multiple partners, thus increasing HIV exposure. This age differential contributes to young women being less able to refuse sex or negotiate condom use (Dancy, 1999; MacPhail & Campbell, 2001; UNFPA, 2003). Further, girls have less access to even minimal education and may be pressured into early marriage or transactional sex to reduce family economic burden (MacPhail & Campbell, 2001; Feldman et al., 1997; Rankin, Lindgren, N'goma, & Rankin, 2005;

UNFPA, 2003; UNICEF, 2006). Additionally, young women report difficulties with using condoms, including becoming the target for community gossip and negative interactions with clinic staff when requesting condoms (MacPhail & Campbell, 2001).

Although the Malawi government is now actively engaged in a campaign to intervene in the spread of HIV/AIDS, historically it was considered taboo to publicly discuss sexual behavior (Mhone, 1996). It is only recently that the silence about sexual behaviors and their contributions to HIV transmission has been broken. The government's national health planners recognized the impact of HIV/AIDS on Malawians and proposed a plan to implement not only HIV prevention and AIDS care, but also for reducing infectious and other diseases (Department of Planning, Ministry of Health, 2004). The government, through the Health Ministry, supports the distribution of condoms to be used both for birth control and for HIV prevention (Meekers, Van Rossem, Silva, & Koleros, 2007). However, for men from all levels of society, condoms are generally considered unacceptable either for birth control or HIV/AIDS prevention (Muula, 2006; Kalipeni & Ghosh, 2007).

The Influence of Faith-Based Organizations

The importance of religious organizations in Malawi cannot be understated. They are largely responsible for providing the infrastructure of village, urban, and peri-urban life. Approximately 55% of Malawians are Protestant, 20% are Catholic, 15% or fewer are Muslim, and the remaining 10% or so practice African traditional religions (Malawi Profile, 2005). Religious organizations play a central role in the African HIV/AIDS context. In a positive vein, in a country where most of the population lives in rural areas, they provide the only reliable infrastructures reaching the villages. Religious leaders are frequently accorded respect as opinion-leaders and moral authorities in their communities. In religious services and ceremonies, leaders have a public platform from which to educate about caring for the sick or orphans and appropriate sexual behavior and convey other important information concerning HIV prevention and care.

However, religious organizations have not been without blame in the HIV/AIDS epidemic. With some notable exceptions, religious leaders have promulgated inaccurate information and unhealthy attitudes and behaviors impacting children and adults infected or affected by HIV. One of the most damaging attitudes is HIV-related stigma, which has been fueled by punitive preaching or ignoring the problem of HIV/AIDS in their community. These messages have helped to create a barrier to success in prevention, diagnosis, and treatment of HIV infection among young people (Alubo, Zwandor, Jolayemi, & Omundu, 2002; Brown, Macintyre, & Trujillo, 2003; Goldin, 1994; Moyo, 1998; Muyinda, Seeley, Pickering, & Barton, 1997; Rankin, Brennan, Schell, Laviwa, & Rankin, 2005; Smith, 2003; Spira et al., 2000).

Important for understanding the interface between the government and religious organizations is the historic role that religious organizations have played in Malawi's political life. Christian and Muslim leaders have effectively collaborated over the past 20 years to intervene in political situations where the government's power was becoming excessive and diminishing civil freedoms (Newell, 1995; Englund, 2006). While religious organizations have typically taken on roles protecting the health and well-being of Malawians, their suspicion of government authority regarding the HIV/AIDS epidemic, especially concerning prevention, may disadvantage women while adding to their vulnerability to HIV infection.

Methods

Background of the Malawi Christians and Muslims Project

The Malawi Christians and Muslims Project has been in process since 2006 and is ongoing. It partners with and utilizes the resources of the Global AIDS Interfaith Alliance (GAIA), an international organization working primarily in Malawi to reduce stigma and enhance HIV prevention and care through churches and mosques. GAIA's long-standing ties to numerous faith-based organizations (FBOs) have allowed us to examine five religious groups to determine the extent and nature of their involvement in HIV-related activities. The five FBOs are: 3 mainstream mission-based Christian groups, 1 indigenous Pentecostal group, and a Muslim group. Study aims include: 1) describe FBO strategies to prevent HIV infection and to care for people living with HIV/AIDS (PLWHA); and, 2) describe the perceived power and influence exerted by Malawi religious groups on risk-taking and HIV mitigation behaviors of their members from the perspectives of central leadership, local level leadership, and members at local levels. The entire US team consists of 6 faculty, 2 doctoral students, and one theologian. The Malawi team includes one faculty in theological studies and 12 university and diploma educated adults who have worked on other research projects. The research team represented in this paper consists of three US and one Malawi faculty.

Sample and Setting

A purposive sample of 40 national and central level religious leaders was interviewed in 2006 by US and Malawi research team members. These leaders represented the 5 faith-based organizations (FBOs) and were characterized by our Malawi consultants as being central or national religious leaders. The mean age of the primarily male (68%) participants was 44 years (range 26–74), and 7 of Malawi's 10 tribes (Osei-Hwedi, 1998) were represented. All leaders approached for the study agreed to participate. Interviews were conducted in settings that were convenient for the respondent-- usually in an office of the religious organization, but also in the lodge where the investigators stayed, or in the local villages. The FBOs were located primarily in the Blantyre urban and peri-urban area and in Lilongwe, the capital of Malawi.

Data Collection

The purpose of the interviews with the central/national leaders was to determine their viewpoints on how their organizations have responded to the HIV/AIDS epidemic, including doctrinal positions, policies, fatwahs (decrees by an Islamic Mufti-religious leader) and basic messages, attitudes towards women and youth, and how their viewpoints have been communicated to local religious entities. Questions and probes explored religious leaders' views on issues of HIV prevention, including condom use, sexual behavior, and women's and youth roles in the church and society. Our study design did not include interviews with government officials, but we gleaned data on government positions from the religious leaders and the media.

All interviews with the national/central leaders were conducted in English, one of the two national languages in Malawi, by the US research team because the respondents were comfortable speaking English. These semi-structured interviews, which lasted at least one hour, were recorded and transcribed in Malawi by both US and Malawi research team members, with the Malawi members explaining Chichewa terms and local customs with which the US team was unfamiliar. Field notes pertaining to each interview were written.

Data Analysis

Qualitative description was used to reduce and thematically analyze the semi-structured interview data. Qualitative description is “low inference,” less interpretive analysis, not requiring a “highly conceptual or abstract rendering of data,” to obtain “unadorned” or “minimally theorized” answers to specific questions (Sandelowski, 2000, p. 335, 337). Atlas.ti, a computer software program that provides for qualitative analysis of large bodies of textual, graphical, audio and video data, was used to manage the volume of data and to aid the analytic process. The four research team members individually read the transcripts and field notes, and open coded the data without regard for relative importance of initial codes. This phase of analysis served as data expansion and allowed for an understanding of the breadth of ideas and concepts expressed in the interviews. Once a critical mass of data was coded in this manner, the analysts moved to focused coding to identify patterns across interviews and develop an understanding and description of salient themes.

Results

The “condom divide” can be conceptualized as the divergence of messages related to HIV prevention strategies that were transmitted by FBOs and the government. FBO leaders emphasized abstinence and marital fidelity, faithfulness as a female virtue, condoms promote sin, and demonization of the government's message. They also commented on government messages, including the ABCs (Abstinence, Be Faithful, use Condoms), the government's HIV prevention message, and the government's message on use and distribution of condoms. Religious and government messages regarding condom use were in opposition to each other, hence the condom divide.

Some religious leaders acknowledged that these competing messages are potentially problematic. One Christian religious leader said:

The fact [is] that when you go [to] the people out there and one is preaching this and one another one, you tend to even contradict each other. And even to say this is not right [using condoms], but don't do this.

However, it is also clear that these oppositional stances around the use of condoms for prevention can further disadvantage women and increase their vulnerability to infection.

Religious Organizations' HIV Messages

Consistent across all FBOs' prevention messages was the absolute insistence on pre-marital abstinence and marital fidelity, but it was also clear that fidelity was expected of women but not necessarily of men. Condoms were also universally condemned as a prevention strategy, which could produce a demonization of the government and its HIV programs.

Abstinence and Marital Fidelity—Leaders from all groups strongly stressed the importance of abstinence and fidelity in marriage for both men and women. These value-laden behavioral expectations were viewed as imperative to living a religiously ordered life and the primary (only) means of reducing the spread of HIV. Moreover, leaders recognized and bemoaned the high rate of adultery:

Even married people are also doing adultery. Even married people do go outside. There are other cultural beliefs and other things which are affecting us and which are affecting marriages. And we should tell them to abstain.

At the same time they blamed cultural influences for infidelity. One such cultural practice that puts women at risk for HIV is widow cleansing, in which a widow is expected to have sex with her husband's brother or other relative before his spirit and her life can move on:

That's one of our beliefs and also, when the husband dies, there is this cleansing problem. The woman has to be cleansed. She is unclean, so she needs to be cleansed from whatever the spirits are there.

Faithfulness is a Female Virtue—While leaders from all groups emphasized abstinence and fidelity, they pointed out that cultural expectations for men and women are different:

For the male side of it, there is a proverb saying that “Mwamuna ndi tonde” which means literally meaning a man is a billy-goat, who must stink, and if properly translated, he must prove himself. ...Eh, hm, if a male's faithfulness in marriage would be as high as female faithfulness, possibly half of the dangers would be gone.

Other informants confirmed that faithfulness is regarded as a female virtue:

In the families, in the married families, usually when you are talking of mutual faithfulness, usually the one who is expected to be faithful is a woman. Culturally, the man will never do something wrong. If it is promiscuity, as a man, ah, it is usual. But for a woman, it will be an issue. So the woman always tries to maintain the dignity of the family, while the husband is going away.

If you say, “You must be faithful” that means for the woman, yes. For the wife, but the man?... because faithfulness is a female virtue.

Condoms Promote Sin—Both Christian and Muslim leaders clearly expressed their fear that acceptance of condoms would promote infidelity and undermine the message of abstinence. They were particularly concerned that messages about condoms encourage youth to experiment with sex and give married people the license to sin. One Christian leader said:

And my point of view I don't agree with that point (encouraging condoms). And it was controversial that time when we said no. The bible tells us; “the wages of sin is death and the gift of God is eternal life.” So for somebody who is sinning they should die. He has decided that I am going for this (extra marital sex with a condom) and he has already made plans that I am going about this move. So we can't encourage these condoms as Christians.

Another leader articulated the fear that condoms “encourage” sinful behavior for those who are not able to abstain:

One of the people have argued to say:... “why do you say we should not use condoms? Are you saying just go do it because, yes, people who will be faithful with one wife or completely abstain [*will not put themselves at risk*]; but how about those are not able to abstain? What are you telling them? Are you telling them don't use it [*a condom*]?” Oh, if you give them a condom you are just encouraging them.

Muslim and Christian leaders were also united in their condemnation of condoms as a means of preventing the spread of HIV. One Christian leader expressed what many felt:

I was in Lilongwe (capital city) yesterday. The TV in Malawi were there, and they interviewed me and I've said the same and I still repeat, “condom is not an answer. Abstinence, saying no to casual sex. For boys and girls, let them wait until when have met a partner and they're ready, want to get married.”

Demonization of the Government's Position—Because of the conflict over messages about condoms as a means to prevent HIV, religious leaders have a tendency to paint government messages in a very negative light. One Christian leader, while explaining what

the religious organizations should not do, articulated the overall sense of the religious leaders' perspective:

As a religious community they should not frustrate the government effort; they should not look upon the condom as the devil. They understand that it's the contribution towards HIV/AIDS thought; as religious communities they can still emphasize the use of condoms among discordant couples but not anyhow [for everyone]. It's there that they realize they shouldn't demonize it, they should not talk against whatever the government is preaching about condoms.

Media and Religious Leaders' Perceptions of Government HIV Messages

The ABCs. The government position that has pervaded all of sub-Saharan Africa regarding HIV prevention is the ABC message. The position of the government agreed with the FBOs on abstinence and being faithful. However, in stark contrast, correct and consistent condom use is a key strategy in the government's tripartite prevention model: **A**bstinence, **B**e faithful, **U**se **C**ondoms. These messages were evident in billboards promoting the use of condoms (the Chishango marketing project), in TV and radio programs and in newspapers. The disparity between the FBOs' messages and the government's one related to ABC was made clear by a Christian leader:

So that is how we are sending conflicting signals, because of the nature of our society where lots people are not that educated, people tend to listen to what people say. And because of the cultural thing, all that the big man says, that's ok. So talk about what do you, I mean the famous ABCs. Abstinence, we tend to say abstinence, and faithfulness. The government tends to say we [the government] are abstinence [focused] although sometimes they say that; usually they are busy distributing condoms.

HIV prevention messages—Religious leaders' perceptions of the government's message about condoms is a source of conflict. One Muslim leader clearly articulated their fears:

The other thing, generally on this one, you see a person will go to church or mosque and he is told that he or she should not be doing sexual immorality, to do sex outside marriage. Now they go home and listen to the radio and they hear that if you can not abstain, use condoms and this and that. With those messages they start practicing that [sex]. And when they feel like doing it and there is no condom, they will say; "Anyway sex is sex. I do not have a condom and I can still do it."

When questioned about how the government and religious organizations could work together, an informant said:

Of course with the government there are organizations dealing with HIV/AIDS and these organizations work with the church. They use the church to pass messages. Like that poster up there. It's a sheik and a CCAP [Presbyterian] leader saying "I've gone for testing", so it's like encouraging church members; "as your pastor, I've gone there, why shouldn't you?"

However, this informant was alone in proclaiming that the religious organizations and the government should work together. The shared messages about abstinence and being faithful are propagated by religious leaders, but messages concerning condoms are not, as evidenced by a Muslim leader's statement:

In the Islamic circles that has not been encouraged. We have not come across that kind of program ...that message comes to us from the newspaper, umm from the radio, from the National AIDS Commission, but not from the Sheikhs or any other body.

Messages on use and distribution of condoms—The government's messages in 2001–02 regarding condoms were not sensitive to Malawi's cultural values and served to disadvantage women while at the same time offending them. In 2001, a campaign was initiated to convince the populace to use condoms. The most offensive of the posters, according to women in a focus group conducted in 2002 (Rankin, Lindgren, N'goma, & Rankin, 2005), was that of a woman with a red bra and a skirt slit up the side to the hip exposing a great deal of thigh. Women expressed their displeasure with this attempt by the government to convince people to use condoms by saying that “this is not the way of Malawi women; we are conservative in our dress and we would never dress this way.” Therefore, a campaign that was supposed to convince people to use condoms concluded by offending many women who were in a position to ask their sexual partners to use condoms.

Religious leaders in our sample were not happy with the media messages around condom use but particularly took exception to the distribution of condoms to secondary school children. One leader remarked:

Me, I have never advocated the use of the condom. But advocating that condoms should be distributed to schoolgirls and boys. That's not on! That's not on! No!

The Condom Divide

The condom divide, as an overarching theme, highlights the oppositional stances of the government and FBOs' messages about how to effectively prevent the spread of HIV. Figure 1 demonstrates the conflicting influences that produce the condom divide. The conflicting messages result in confusion around HIV prevention messages and a “demonization” of the government because 1) religious leaders do not support condoms; 2) they are suspicious of the government believing that they have no right to mandate behavior; and, 3) the long history of distrust of the government by the religious leaders leads to further distrust.

Only when it comes to discordant couples, where one partner is positive and the other negative, do the FBOs' and government's messages come together. The “official” position of all but one of the organizations we studied was, in principle, that condom use by discordant couples is acceptable. However, this position is not supported by all of our respondents, and some feel condom use is not appropriate for anyone. A level of ambivalence is evidenced in the following quote:

Those who are married they have to abstain (from) sexual intercourse, more especially if they can afford (avoid). But if they feel like they cannot afford (avoid), they have to use a condom. Yes, they have to use a condom. They can't say at all, “Oh maybe, if I am positive, my spouse is also positive,” but they have to use a condom whenever they want to sleep together as a couple.

This condom divide, with its conflicting messages about HIV prevention strategies, is enacted within a context in which the acceptance of the message is dependent on trust in the messenger. The power of religious leaders vis a vis government leaders to bring about a change in behavior was clearly articulated by one informant:

Normally most Malawians are religious and we go to church willingly; we are not forced. Our reverend [clergy] is the person who can take an active role in counseling us; we have a lot of trust in our reverends, not in our politicians who are very far from us in most cases. We always talk with our reverends. So it makes them to be the ones who should be involved to counsel people. Our religious attitudes matter a lot. Whatever people can hear from a preacher it will make more sense than if we hear it from a politician or somebody else.

It is clear that religious leaders' views and teachings carry much weight in Malawi society, but their inconsistent leadership on the issue of condoms continues to disadvantage Malawi women.

Discussion

Malawi religious leaders, both Christian and Muslim, have been slow to take up the HIV/AIDS prevention messages. Participants were clear that in Malawi, “religious attitudes matter a lot.” Religious music, especially Christian music, is heard constantly on the radio and television, and church and mosque services are well attended. Members of FBOs pay more attention and exhibit more trust in their religious leaders' messages and counseling than what is paid to political leaders and, by extension, government messages. As such, religious leaders are uniquely positioned to champion the government's complete HIV prevention program (A, B and C) and encourage women to protect themselves; yet they have largely refused or been reluctant to take on this role. Instead, suspicion of the government's message, a rigid insistence upon abstinence and faithfulness and silence, or outright “demonization” of condoms diminishes their ability to help. The unanimous message that extramarital sex is a sin and condoms encourage promiscuity has resulted in condemnation of condom use except in discordant couples.

Abstinence before and fidelity in marriage are expectations for all FBO members, but gender-based expectations are not well addressed. The statement that “faithfulness is a female virtue” indicates that the Abstinence and Be Faithful messages are directed toward women and, therefore, responsibility for preventing HIV is theirs. However, social realities highlight the problems women have in fulfilling this responsibility. Malawi women are less likely than men to have completed their education, work outside the home, own property or have access to their own resources. Thus, they lack power to impact their husband's behavior or contest his decisions about sexual activity, making them more susceptible to contracting HIV. Because their options are limited (Ghosh & Kalipeni, 2005), women are likely to remain in marriages even when they know their husbands have been consorting with other women, and their ability to negotiate condom use is constrained.

Although messages from the clergy to men and women are “be faithful” and “don't use condoms,” men are not really expected to be faithful. Previous discussions with religious leaders in Malawi have demonstrated different gender expectations and consequences of behavior. One pastor at a GAIA-sponsored conference expressed a commonly held belief that women should forgive unfaithful husbands, but men should divorce unfaithful wives.

Although government messages should offer a chance for women to protect themselves through the use of government-distributed condoms, the government's health education messages have only alienated women. Poorly executed health education campaigns to foster the use of condoms have at times produced negative results, such as resistance to condom use, adding to lack of confidence in the government's message. Even members of the Malawi National Assembly were found to have negative attitudes towards condom promotion and use and did not perceive condoms as an effective method of controlling the spread of HIV (Muula, 2006).

The history of distrust between the religious organizations and the government has been cemented for the religious organizations by their previous activity in the overthrow of the first president and their on-going challenge of elected political leaders' corrupt practices (Dugger, 2007; Englund, 2006) and attempts to change the constitution in order to remain in power. Past lack of confidence in the Ministry of Health has resulted in distrust of the quality of condoms. They also believe that the government should not intervene in matters

within the realm of religious organizations because the message across all religious groups is that sex outside marriage is sin. The plight of women in Malawi is complicated by the overwhelming poverty, regional migration, and global economic changes common across sub-Saharan Africa (Ghosh & Kalipeni, 2005).

Poverty in the US also contributes to the spread of HIV and the leading edge of new infections appears to be most heavily concentrated in African American communities, with youth and women the most vulnerable (CDC Fact Sheet, 2007). In the US, especially in the most vulnerable communities, FBO responses to HIV/AIDS messages show some similarity to the Malawi response. Although churches, especially in diverse communities, have long been seen as likely venues to propagate disease prevention messages, US churches have also been slow to focus on HIV. Like their African counterparts, religious leaders' messages towards youth focus on abstinence and not on condom use (Brown & Williams, 2005). Indeed, federal funding for sex education in the US demands abstinence-only programs (Ott & Santelli, 2007; Santelli et al., 2006).

Within the Malawi context, religious organizations and the government, which should protect women, work against each other and thereby against women. Religious leaders seem to fear that advocating condom use will threaten moral values important to their faith, but they have failed to acknowledge how their messages differentially affect women and men and how the disadvantaged position of women and double standard put women at greater risk for infection. A human rights-public health approach, valuing people's right to knowledge of sound scientific evidence to preserve health and prevent disease, and encouraging people to act responsibly, is an important step for FBOs. Through NGO partners such as GAIA, Malawi nurses often are called upon to provide medically-focused education on HIV in various religious settings. These nurses can play an important role in bridging the science-religion gap by demonstrating that providing access to knowledge and encouraging people to become well informed about risks and preventive strategies, such as condoms, does not preclude maintaining a moral standard of behavior that advocates fidelity and/or abstinence.

Understanding cultural and historical contexts of disease transmission and prevention is becoming increasingly important in providing health care locally and globally. Malawi women are not unique in facing the challenges of survival in their impoverished context; indeed, disenfranchised women from many parts of the world, including the US, share similar problems. Nurses in clinical practice encounter these women, both here and abroad.

AIDS is the global health and moral crisis of our time. As Westerners or members of the developed world, we know little about the complexities of mounting culturally appropriate and effective HIV prevention and AIDS treatment and mitigation programs in the developing world. Without this understanding, harmful assumptions about developing countries and their peoples may be made. As socially conscious citizens of the world, nurses can do much to increase the awareness and responsiveness to the HIV-related suffering and death in countries like Malawi.

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References

- Alubo O, Zwandor A, Jolayemi T, Omundu E. Acceptance and stigmatization of PLWA in Nigeria. *AIDS Care*. 2002; 14:117–126. [PubMed: 11798411]

- Ajzen, I. From intentions to actions: A theory of planned behavior.. In: Kuhl, J.; Beckmen, J., editors. Action control: From cognition to behavior. Springer-Verlag; New York: 1985. p. 11-39.
- Ajzen I. The theory of planned behavior. Organizational behavior and human decision processes. 1991; 50:179–211.
- Bone, D. Malawi Muslims: historical perspectives. Christian Literature Association in Malawi; Kachere book, No. 9, Blantyre, Malawi: 2000.
- Brown L, Macintyre K, Trujillo L. Interventions to reduce stigma: What have we learned? AIDS Education and Prevention. 2003; 15(1):49–69. [PubMed: 12627743]
- Chimbiri AM. The condom is an 'intruder' in marriage: evidence from rural Malawi. Social science & medicine. 2007; 64(5):1102–15. [PubMed: 17240504]
- Dancy BL, Kaponda CP, Kachingwe SI, Norr KF. Risky sexual behaviors of adolescents in rural Malawi: Evidence from focus groups. Journal of National Black Nurses Association. 2006; 17:22–28.
- Department of Planning, Ministry of Health. A joint programme of work for a health sector-wide approach [2004–2010]. Department of Planning, MoH; Lilongwe, Malawi: 2004.
- Dugger, CW. Ending famine, simply by ignoring the experts. The New York Times; December 2. 2007 p. 1p. 6
- Englund, H. Prisoners of freedom; human rights and the African poor. University of California Press; Berkeley: 2006.
- Feldman DA, O'Hara P, Baboo KS, Chitalu W, Lu Y. HIV prevention among Zambian adolescents: Developing a value utilization/norm change model. Social Science and Medicine. 1997; 44(4): 455–486. [PubMed: 9015882]
- Ghosh J, Kalipeni E. Women in Chinsapo, Malawi: vulnerability and risk to HIV/AIDS. Sahara Journal. 2005; 2(3):320–32. [PubMed: 17600974]
- Glynn JR, Ponnighaus J, Crampin AC, Sibande F, Sichali L, Nkhosa P, Broadbent P, Fine PE. The development of the HIV epidemic in Karonga District, Malawi. AIDS. 2001; 15:2025–2029. [PubMed: 11600832]
- Goldin CS. Stigmatization and AIDS: Critical issues in public health. Social Science and Medicine. 1994; 39:1359–1366. [PubMed: 7801171]
- Grieg FI, Koopman C. Multilevel analysis of women's empowerment and HIV prevention: Quantitative survey results from a preliminary study in Botswana. AIDS and Behavior. 2003; 7:195–208. [PubMed: 14586204]
- Gregson S, Nyamukapa CA, Garnett GP, Wambe M, Lewis JJC, Mason PR, et al. HIV infection and reproductive health in teenage women orphaned and made vulnerable by AIDS in Zimbabwe. AIDS Care. 2005; 17(7):785–794. [PubMed: 16120495]
- Jejeebhoy, S.; Bott, S. Regional working paper No. 16. Population Council; New Delhi: 2003. Non-consensual sexual experiences of young people: A review of the evidence from developing countries..
- Kaponda, C.; Norr, KF.; Norr, JL. Using focus groups to adapt and effective HIV prevention intervention for a new setting: A Malawi example. 2000. Unpublished manuscript
- Lindgren T, Rankin SH, Rankin WW. Malawi women and HIV: socio-cultural factors and barriers to prevention. Women Health. 2005; 41(1):69–86. [PubMed: 16048869]
- Lwanda, J. Mutharika, Mbuya¹ and mpando² : when the elephants fight... Malawi Update, 54.. 2005. Retrieved from http://www.malawiupdate.org/index.php?issue_number=54&articleid=110
- MacPhail C, Campbell C. 'I think condoms are good but, aai, I hate those things': Condom use among adolescents and young people in Southern African township. Social science and medicine. 2001; 52:1613–1627. [PubMed: 11327136]
- Malawi Profile. Malawi profile: Religion. 2005 [July 24, 2005]. from <http://www.nationmaster.com/>
- Meekers D, Van Rossem R, Silva M, et al. The reach and effect of radio communication campaigns on condom use in Malawi. Studies in family planning. 2007; 38(2):113–20. [PubMed: 17642412]
- Mhone CS. Autocracy and AIDS: The post-Banda challenge. Country focus: Malawi. AIDS Analysis in Africa. 1996; 6(5):16.

- Monasch, R.; Mahy, M. Young people: the centre of the HIV epidemic.. In: Ross, D.; Dick, B.; Fergusson, J., editors. Preventing HIV/AIDS in young people: a systematic review of the evidence from developing countries: UNAIDS interagency task team on HIV and young people. 2006. p. 15-42. WHO technical report series, no. 938
- Msiska AW. The spread of Islam in Malawi and its impact on rites of passage, 1870–1960. *Society of Malawi Journal*. 1995; 48:49–86.
- Moyo, FL. The AIDS crisis: A challenge to the integrity of the church in Malawi.. In: Ross, KR., editor. Faith at the frontiers of knowledge. CLAIM; Blantyre Malawi: 1998. p. 94-110.
- Muula AS. Condom and sexual abstinence talk in the Malawi National Assembly. *African health sciences*. 2006; 6(1):21–6. [PubMed: 16615822]
- Muyinda H, Seeley J, Pickering H, Barton T. Social aspects of AIDS-related stigma in rural Uganda. *Health and Place*. 1997; 3(3):143–147. [PubMed: 10670965]
- National Statistics Office [Malawi] & ORC Macro. Malawi Demographic and Health Survey 2004. NSO and ORC Macro; Calverton, MD: 2005.
- Newell J. A moment of truth? The church and political change in Malawi, 1992. *Journal of Modern African Studies*. 1995; 33:243–262.
- Niekerk AA. Moral and social complexities of AIDS in Africa. *Journal of Medicine and Philosophy*. 2001; 27:143–162. [PubMed: 11961694]
- Norr KF, Norr JL, McElmurry BJ, Tlou S, Moeti MR. Impact of peer group education on HIV prevention among women in Botswana. *Health Care for Women International*. 2004; 25:210–226. [PubMed: 15195767]
- Osei-Hwedie, Bertha. The role of ethnicity in multi-party politics in Malawi and Zambia. *Journal of Contemporary African Studies*. 1998; 16(2):227–247.
- Ott MA, Santelli JS. Abstinence and abstinence-only education. *Curr Opin Obstet Gynecol*. 2007; 19(5):446–452. [PubMed: 17885460]
- Rangeley WH. Notes on Chewa tribal law. *The Society of Malawi Journal*. 2000; 53(1–2):5–75. (Reprint of 1948 article).
- Rankin W, Brennan S, Schell E, Laviwa J, Rankin SH. The Stigma of Being HIV-Positive in Africa. *PLoS Medicine*. 2005; 2:702–704.
- Rankin SH, Lindgren T, Rankin W, Ng'oma J. Donkey work: Women, religion, and HIV/AIDS in Malawi. *Health Care for Women International*. 2005; 26:4–16. [PubMed: 15764458]
- Rogers, EM. Diffusion of innovation. 5th ed.. Free Press; New York: 2003.
- Sandelowski M. Whatever happened to qualitative description? *Research in Nursing and Health*. 2000; 23:334–340. [PubMed: 10940958]
- Santelli J, Ott MA, Lyon M, Rogers J, Summers D, Schleifer R. Abstinence and abstinence-only education: a review of U.S. policies and programs. *J Adolesc Health*. 2006; 38(1):72–81. [PubMed: 16387256]
- Smith DJ. Imagining HIV/AIDS: Morality and perceptions of personal risk in Nigeria. *Medical Anthropology*. 2003; 22(4):343–372. [PubMed: 14585759]
- Spira R, Lagarde E, Bouyer J, Seck K, Enel C, Kane NT, Piau JP, Ndoeye I, Mboup S, Pison G. Preventive attitudes towards the threat of AIDS: Process and determinants in rural Senegal. *AIDS Education and Prevention*. 2000; 12:554–556.
- Swidler A, Watkins SC. Ties of dependence: AIDS and transactional sex in rural Malawi. *Stud Fam Plann*. 2007; 38(3):147–162. [PubMed: 17933289]
- UNAIDS. Global Report-Malawi data. 2006 [December 9, 2007]. from <http://www.unaidsrsta.org/countries/Malawi/malawi.html>
- United Nations Development Programme. Human development report, 2003. 2004 [July 6, 2004]. from www.undp.org/hdr2003/pdf/presskit/HDR03_PKE_HDI.pdf
- UNFPA United Nations Family Planning Agency & Population Council. Investing when it counts: Generating the evidence base for policies and programs for very young adolescents. 2006. <http://www.popcouncil.org/pdfs/InvestingWhenItCounts.pdf>
- UNFPA United Nations Family Planning Agency & Population Council. State of the world population. 2003

UNICEF. Violence and discrimination voices of young people: Girls about girls.. Expert Group Meeting on the Elimination of Discrimination and Violence against the Girl Child.; Florence. 25–28 September 2006; 2006.

World Food Programme. Country Brief – Malawi. 2004 [July 7, 2004]. from http://www.wfp.org/country_brief/index.asp?region=3

Figure 1.
Factors Influencing the Condom Divide