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Fighting down the scourge, building up the church: Organisational constraints in religious involvement with HIV/ AIDS in Mozambique

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Abstract

Religious organisations (ROs) are often said to play an important role in mitigating the impact of HIV/AIDS. Yet, limitations of that role have also been acknowledged. While most of the literature has focused on ideological and individual-level implications of religion for HIV/AIDS, in this study, we shift the focus to the organisational factors that shape and constrain ROs' involvement in both HIV prevention and HIV/AIDS care and support. Using primarily qualitative data collected in a predominantly Christian area in southern Mozambique, we show that the organisational vitality of a RO as determined by its membership size and its relationships with other churches and with governmental and non-governmental agencies is a pervasive priority of RO leaders. Therefore, all church activities, including those related to HIV/AIDS, are instrumentalised by the religious leadership to achieve the church's organisational aims—maintaining and growing its membership, safeguarding the often precarious coexistence with other churches, and enhancing its standing vis-à-vis the government and powerful non-governmental organisations. As a result, the effectiveness of ROs' involvement in HIV/AIDS prevention and assistance is often compromised.

Keywords

Religion; HIV Prevention; AIDS Care; Africa; Mozambique

Background and conceptual approach

Religious organizations (ROs) are often said to play an important role in mitigating the impact of the HIV/AIDS epidemic in resource-limited settings (Becker and Geissler 2009, Chitanda 2010, Olivier *et al.* 2006, Tiendrebeogo and Bukyx 2004). Public accounts of that role typically stress ROs' unique ideological and organisational advantages for community mobilisation and outreach as well as a long-established tradition of faith-based provision of health care and psychological support to the disadvantaged masses, especially in rural areas. However, many of these public accounts are anecdotal and come from ROs and other faith-based organisations and therefore seldom rely on systematic and impartial analyses of ROs' activities (Bate 2003, Byamugisha *et al.* 2002). Moreover, these accounts are often produced by the religious officialdom that is typically based in national capitals and other large cities and whose target audience is governmental and non-governmental funding agencies. Voices of local religious leaders, not to mention ROs' rank-and-file members, are rarely heard.

The scholarly literature on the role of ROs in mitigating the impact of HIV/AIDS is generally less celebratory, and studies have identified several problematic areas that are

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inherent to most ROs or vary in importance across different types of ROs (Agadjanian and Sen 2007, Casale *et al.* 2010, Francis and Liverpool 2009, Haddad *et al.* 2008, Trinitapoli 2009, Trinitapoli and Regnerus 2006). Thus it has been argued that ROs may contribute to HIV/AIDS-related stigma and discrimination (Keikelame *et al.* 2010, Mbilinyi and Kaihula 2000, Regnerus and Salinas 2007, Zou *et al.* 2009). Perhaps one of the most frequently discussed issues is many ROs' critical or ambivalent stance and practice in regards to condom use (Casale *et al.* 2010, Garner 2000a, Pfeiffer 2004).

Whereas the position of some religious leaders on HIV prevention has aroused occasional controversy, ROs' role in the provision of psychological support, home care, and even material aid to AIDS-affected individuals and families is usually described in strongly positive terms (Maman *et al.* 2009, Trinitapoli 2006). The range and magnitude of ROs' activities aimed at helping the sick, the dying, and the survivors, especially in settings where few viable alternatives are available, deserve considerable praise. However, challenges that ROs may face in carrying out these activities have also been noted (Agadjanian and Sen 2007, Krakauer and Newbery 2007, Watt *et al.* 2009).

The objective of this study is to explore ROs' HIV/AIDS related-activities in a resource-limited setting through an organisational lens. While acknowledging and documenting different forms of ROs' involvement in HIV/AIDS prevention and care, we start by highlighting factors, both internal and external to ROs, that shape and constrain the organisational parameters of this involvement. These factors are demographics of RO membership, ROs' access to financial and material resources, ROs' uneasy coexistence and interactions in an increasingly crowded and saturated religious marketplace, and ROs' complex relationship with secular authorities and institutions. We then examine how organisational pressures rooted in these factors affect ROs' involvement in HIV prevention and in HIV/AIDS-related care and support. We look at prevention and care/support separately because the nature, meaning, and ideological and organisational ramifications of these two types of activities are sufficiently distinct in sub-Saharan settings. However, both types of activities are necessarily interconnected, not only because they revolve around the same broad theme—HIV infection and disease—but also because both, as we intend to show, are part of ROs' efforts to enhance their organisational vitality. We therefore argue that in order to evaluate what ROs do or do not do to help fight the HIV/AIDS epidemic, one must first understand how HIV/AIDS-related activities help ROs in meeting their organisational needs.

Data and method

This case study focuses on Mozambique, a nation of some 23 million inhabitants in southeast Africa that gained independence from Portugal in 1975, lived through a devastating civil war in 1977-1992, and despite political stability and strong macroeconomic growth since the war ended, remains one of the poorest in the world. The data used in this study were collected in Chibuto district, a largely rural area in Gaza province in southern Mozambique. The traditional lineage system of the Changana, the ethnic group that constitutes the overwhelming majority of the district's population, is patrilineal and their marriage is virilocal. The mainstay of the area's economy is subsistence agriculture. The low and unpredictable yields, the lack of local non-agricultural employment, and the proximity to South Africa, have resulted in high levels of primarily male labour out-migration. This large-scale migration may have contributed to the area's high HIV prevalence. While no district-level HIV prevalence estimates are available, HIV prevalence in Gaza province as a whole was estimated at 25% of adult population in 2009, the highest seroprevalence level of all Mozambican provinces (Ministry of Health 2010, p.163).

Our analysis draws primarily from focus group discussions held in Chibuto district in 2009. Seven focus groups were carried out: two in the town of Chibuto, the district's capital, and one in each of the district's five administrative posts (subdivisions). Focus group participants were selected from different local ROs to represent a wide denominational spectrum. All focus group participants were RO rank-and-file members: members with formal leadership duties were not eligible for participation. The number of participants ranged between six and sixteen per group. The five focus group discussions conducted outside the district capital were gender-mixed; in the district capital, one group included only men and the other only women. In total, 74 individuals, 44 women and 30 men, participated in the focus group discussions. The discussions revolved primarily around ROs' activities in areas of HIV education and prevention and provision of care and support to individuals and families affected by HIV/AIDS. The focus group data are used to identify and explore organisational imperatives and constraints in district religious organisations' involvement in these activities.

To provide a background for the analysis, we also use data from a household-based survey conducted in Chibuto in 2008 and an institutional survey of religious congregations carried out in the district in 2008-2009. The sample of the household-based survey consisted of 2019 women aged 18-50 drawn from the population of both the district capital and the five administrative posts. The survey included questions on women's sociodemographic characteristics, religious background and involvement, and on HIV/AIDS-related matters, among other questions. The institutional survey covered all ROs operating in the district (N=811) and consisted of interviews with RO leaders that were focused on congregation characteristics and activities. Both surveys included similar questions on whether RO leaders had addressed HIV/AIDS-related topics during religious services in the several preceding months: in the women's survey questionnaire, a list of specific topics was provided; in the institutional survey, respondents were asked to name all the specific HIV/AIDS-related topics that they could remember. Finally, the analysis includes insights and observations from the authors' numerous interviews and conversations with RO leaders and members alike to illustrate the ideological and organizational narratives employed in navigating ROs' involvement in HIV prevention and AIDS-related care and support.

Organizational dynamics in the religious marketplace

The Chibuto district, like the rest of Mozambique and much of sub-Saharan Africa, is characterised by high levels of religious membership. Thus 88% of the 2008 survey respondents reported being affiliated with a RO. The district's religious population is overwhelmingly Christian, with denominations ranging from the Roman Catholic Church (the dominant church before Mozambique's independence), to mainline, or mission-based, Protestant and Evangelical denominations (e.g. Presbyterian, Methodist, Anglican, Baptist), to international Pentecostal churches, to regionally-initiated Apostolic churches, to locally-grown owner-operated Pentecostal (Zionist) churches. The institutional survey included only two mosques and less than 1% of the women's survey respondents with a religious affiliation were Muslim. Besides, almost all Chibuto Muslims live in the district's administrative capital. Hence this analysis is focused entirely on Christian churches.

Based on our survey data, we estimate that there is approximately one congregation for every 150-200 adult district residents, although congregations vary by membership size and attendance. The small pool of unaffiliated people and the saturation of the religious marketplace reduce the prospects for proselytising. Although the relatively rapid population growth provides a supply of new potential members, this supply cannot satisfy the demands of ever multiplying churches and their leaders' desire to expand their ranks. RO leaders are therefore extremely vigilant about protecting their turf, and any venturing outside its limits

for whatever stated reason can be interpreted as an attempt to 'steal believers' from other churches. The threat of losing members to other churches, while often downplayed by religious leaders, is nonetheless omnipresent. The threat comes, at least potentially, from other congregations operating in the same area as well as from outside-the-district ROs, which are mainly headquartered in Maputo, Mozambique's capital city a couple hundred kilometres to the south, and are relatively well-heeled financially and institutionally. These outsiders, typically led by entrepreneurial pastors, encroach, often quite aggressively, on the already established and apportioned religious territory thus generating resentment and even overt hostility on the part of local religious leaders.

Raising funds for congregation needs and activities is a constant concern of RO leaders. Importantly, while leaders of large mainline congregations often receive a salary and living allowance (however modest) from their churches, most leaders of smaller, Pentecostal and Apostolic congregations have to support themselves. Leaders of such congregations are therefore under constant pressure to generate funds for the congregation operational budget and capital investments (e.g., church building construction) and often for their personal needs. Although most of these leaders hold formal or informal income-generating jobs and are typically better off than most district residents, their individual incomes are not sufficient to cover the church needs. Most RO funds come from congregation members, whose value to the congregation is therefore largely determined by their ability and willingness to make regular and substantial financial contributions. In addition, a substantial portion of Apostolic and Pentecostal ROs' revenues come from the provision of healing services both to congregation members and to non-members. Miracle healing is a trademark specialty of Zionist congregations: 76% of Zionist leaders interviewed in the institutional survey answered affirmatively the question 'Do they usually cure illnesses in your church?' Although no fixed fees are usually charged for treatment (with the exception of the costs of the traditional medicines when such are used), the patients and their families are expected to 'thank' the pastor either in money or in kind (or both). Whereas Pentecostal pastors are typically eager to maximize this revenue stream, unsuccessful treatment may undermine their credibility inside and outside the congregation, while excessive marketing of healing services outside the congregation carries a potential for inter-church frictions.

Partly to reduce the possibility of potential clashes and partly to pool individual ROs' material and political resources, several inter-church coordinating bodies have been established. The Christian Council (the local branch of a national outfit) that brings together most mainline Protestant denominations, was founded before Mozambique's independence and is perhaps the oldest of them. In comparison, the Organization of Zionist Pentecostal Churches of Mozambique, known by its Portuguese acronym 'OISPM' was created just a few years ago. Its regional branch, with membership in Chibuto and other neighbouring districts, organize a sort of rotating credit scheme among its members modelled after the widespread practice of individual resource-pooling locally known as *xitique*. The main purpose of this organisational *xitique* is to assist churches in building or improving their houses of worship; in fact, instead of money, bags of cement are usually distributed. However, as our interviews and observations showed, the OISPM is fraught with conflict and distrust as each cycle of money collection and distribution generates suspicions of unfairness, favouritism and even fraud on the part of the organisation's leaders. The transfer of some of the funds raised through members' annual quotas to the organisation's headquarters in Maputo has also raised discontent. As a result, an increasing number of RO leaders that are nominally part of OISPM refuse to contribute to the organization's coffers.

Another important factor that local RO leaders take into account is their relationship with the government. There are several types of ties that ROs seek to establish and cultivate. The District has a Commission for Religious Affairs (a branch of the national agency that is part

of the Department of Justice). Although the authority of the Commission is limited and largely ceremonial, it is part of the government apparatus and its leadership has close ties with the office of the District's Administrator. For example, it is the Commission's chairman who usually reads the inaugural prayer with which almost all district-level public events, however secular in nature, invariably start. However, the Commission represents but one link between ROs and the government. Other connections with state institutions at both the district and, especially, the sub-district (administrative post, locality, and village) levels are also important and take a variety of forms. Many of them are personal and unofficial: for example, a local administrator, health official, or school principal may double as a church pastor. RO leaders, using their connections, authority, education, and organisational and rhetorical skills, may also establish local non-governmental organisations (NGOs) or become local managers of regional and national NGOs. Because many of the resources that sustain the local community come from outside through the governmental or NGO channels, the RO leaders' strategic positioning vis-à-vis those channels is critical for their organisational efforts in terms of both the resource flow and enhanced legitimacy. Not surprisingly, then, a privileged access to these sources of money and authority by some religious leaders engenders resentment, even if usually tacit, on the part of RO leaders who lack such access.

Religious organizations in HIV prevention

RO-based HIV prevention activities illustrate how ideology is negotiated and deployed to enhance organisational identity and cohesion. Because HIV prevention education aims at raising awareness rather than building skills, it comes easy to religious leaders, sophisticated and passionate orators. Only minimal knowledge about HIV transmission and its consequences is necessary to teach others about the *need* to prevent infection. Not surprisingly, HIV prevention messages are frequently heard in congregations. Thus 81% of leaders interviewed in the institutional survey stated that they had talked about at least one form of HIV prevention during their congregations' main services in the several months preceding the survey, and this percentage did not vary across denominational groups. The share of respondents in the women's survey who said that they had heard their congregation leaders talk about prevention during main services was only slightly lower—75%.

Most religious leaders readily subscribe to well-established moralist clichés about premarital chastity and marital fidelity. Most are tolerant of condom use: in fact, 68% of institutional survey respondents approved of condom use by unmarried couples and 52% by married couples (again, with little denominational variation). It appears from the focus groups and interviews with leaders that higher ideological motives are rarely articulated and followed; local leaders, especially in rural areas, are typically unaware of or indifferent to the official pronouncements of their ROs' national leaders on matters of HIV prevention. This is not to say that at least some church leaders and most educated congregation members are incognizant of the frequent incongruence between religious and secular interpretations of HIV. As one interviewed teacher, who was also an active attendee of his church said, 'For us as religious people, this disease is a punishment for the infractions that we committed before God. Scientifically, I know that it is not true, but I am a religious person.'

Yet the common quandaries of a higher-order discourse—such as whether condoms should be allowed and even encouraged as a form of prevention—rarely take centre stage at the local level. Practical concerns about the church members' individual health and the congregation's collective wellbeing typically trump the directives received from the higher-ups, even in the Catholic Church, whose national leaders, echoing the Vatican, have voiced adamant opposition to condom use. Here is how a man from a rural Catholic parish

explained the choice made by fellow parishioners despite the initial resistance of the parish priest:

We agree that abstinence [from non-marital sex] is advantageous but the big defence is the condom, because among young people and adults alike one partner can easily cheat on the other... It was very difficult to talk about [condoms] in our parish because it was seen as promoting prostitution, but now we have proven that all we do is protect our lives, and even the priest has now talked about both in and outside the church about precautions to take against AIDS.

In churches where condom use is less controversial, the advice to use condoms with extramarital partners is often routinely explicit, as a Zionist man told us: 'On the days of prayer, when we leave [the church] around 6pm, they tell us not to forget condoms when we go out to play.'

Reconciling church ideology with the secular message becomes easier as this message itself evolves. Thus in the case of Mozambique, a transition has taken place from a condom-focused campaign exemplified by the slogan 'Pensa direito, usa Jeito' (Portuguese for: 'Think straight, use condom') to 'Andar fora é manyingui arriscado' ('Fooling around is very risky'), an emphasis with which most church leaders can comfortably agree. Yet the effectiveness of the church formal prevention message, if such is ever articulated, is conditioned not so much by these semantic and vernacular nuances as by the social demographics of its audience. First, the overwhelming majority of church attendees are married women, who typically have no non-marital partners and who in general have little control over their sexual lives. The collective experience of listening to a pastor may heighten their awareness of HIV but the patriarchal norms of unquestionable submission to their husbands' will, typically reinforced in the church, do little to help translate this awareness into effective prevention. Furthermore, the prevention message, as it is usually framed and articulated by church leaders, is misleading as it equates women's propensity toward extramarital sex to that of men.

Unmarried adolescents are a demographic group that potentially stands to benefit from continuing HIV prevention exhortations. Church youth, however, may be a self-selected segment of that group, already with reduced predisposition to early sexual debut and to careless sexual practices. Besides, the dull, repetitive rounds on staying chaste and using condom if chastity becomes impossible can hardly ignite genuine interest among many young people.

Married men under the age of forty, the demographic group that perhaps is most prone to prolonged concurrent sexual partnering, i.e., the sexual behaviour that carries greatest risks, may not be adequately exposed to the church prevention message and to whatever sanctions that non-compliance with this message might trigger. These men rarely show up in the church as many of them work outside the community and are simply too busy or too indifferent to attend church services and other events. Yet, membership of these men is critical to ROs' organisational strength. RO leaders are particular keen on attracting and retaining wealthier male church members because their membership promises significant financial inputs. To attract and keep the favours of such men, religious leaders often turn a blind eye on their conspicuous defiance of key religious moral teachings, such as those pertaining to alcohol use, polygamy, and casual extramarital sex. In the context of southern Mozambique, this rural economic elite is made up largely of current or recent labour migrants who have become relatively well-off from working in neighbouring South Africa. Having the means to pay the ever-rising bridewealth tab, migrants are disproportionately more likely to be polygynous; although most Christian churches officially reject polygyny, wealthy migrants are rarely reproved for having multiple wives. Likewise, while it is widely

believed that migrants and other wealthy men tend to have casual sexual partners and that those partnerships are responsible for the spread of HIV in the community, RO leaders are generally reluctant to reprimand offenders for fear of losing the men's financial support and even their desertion to more accommodating ROs.¹

Whereas prevention messages articulated by church leaderships may be too rare and too abstract for its audience to tune into, much of the HIV prevention-related discussions are carried out without a direct sanction and even without knowledge of the congregation top leaders. These discussions are most likely to happen in church youth groups and, especially, in church women's groups.² Thus, HIV-related conversations can emerge at women's group meetings, typically held on Thursdays in most churches, at which male church leaders are rarely present. A woman from a mainline Protestant church recounted how it happens at her congregation:

At our Thursday meetings, we teach people to prevent AIDS. We teach that for a married couple to have unprotected sex, the two must be faithful to each other. Otherwise, they shouldn't [have unprotected sex]... We teach people that if they don't trust each other, they should get tested... We also teach about female condoms, and that a woman can very well carry a male condom, so that she gives it to her partner at the time of sexual intercourse.

In another mainline Protestant church, as a female member told us, the situation was not much different as prevention matters are discussed by church volunteers once a month, and the church pastor is only called upon to adjudicate between divergent opinions:

We tell people that they should prevent this disease that does not yet have a cure. We explain that if someone has an extra-marital partner, they should use condoms when they have sexual relations... At the end of each month, we get together at 15 o'clock at the church. We pray first and then we talk, and everyone says what they know. And if we don't reach consensus on an issue, we take it to the pastor, and he says what's right and what's wrong.

When asked to elaborate on the content of those conversations, she added:

In the group, we talk about women who don't trust their husbands and how to explain to them that they should use condoms. But some husbands do not accept using condoms and question the motives [behind their wives' suggestions] to use them. And from that point, we talk about what to do to get husbands to accept condom use.

Notably, because the church social space is highly gendered and church women's meetings never overlap with those of men (in congregations where men's meetings take place at all), these conversations rarely become the subject of cross-gender exchanges (Agadjanian and Menjivar 2008). For example, when asked about whether the same topics were raised at men's meetings, the woman just quoted could not come up with an answer: 'You should ask their [men's] counsellors,' she replied. And even without men's physical presence, women's group discussions are imbued with the same patriarchal ideology that places women firmly into a subservient position relative to their husbands in general and instils acquiescence to husbands' sexual choices, in particular.

¹Although Pentecostal leaders are typically more insistent on compliance with church behavioural and moral guidelines than are leaders of other churches, we did not come across any sanctions applied against offenders comparable to those reported elsewhere (Garner 2000a, Parsitau 2009).

²Women's groups typically include married or widowed/divorced women with marital and reproductive experience. In some churches, younger married women with few children (designated in the church lexicon with the Portuguese word *activistas*, or "activists") hold separate meetings from those of older women. Younger, unmarried women usually attend youth groups' meeting.

Although church-based prevention discourse on sexual practices, whether centralised or semi-autonomous, is often redundantly impracticable, confusing, and misdirected, the HIV prevention rhetoric may serve as a powerful tool of institutional mobilisation because it provides an organisational purpose around which church members, especially church women, can rally, and which can further enhance their sense of belonging and therefore the church's strength and vitality. Involvement in HIV prevention activities also gives church leaders an opportunity to connect with secular authorities. Collaboration with state prevention campaigns, whatever their content and ideological colouring, helps enhance the status and legitimacy of the church in the eyes of both own church members and the leaders and members of other churches. At the same time, this collaboration does not directly jeopardize inter-church relations as church prevention efforts rarely cross congregational boundaries.

The organisational benefits of church HIV prevention discourse create incentives for church leaders to continue this discourse indefinitely. RO-based prevention education thus shares the same irony that plagues its secular counterpart: in order to go on it must be perceived as ineffective. This paradoxical state of mind is arrived at through two main assumptions. First, not unlike the secular prevention messages, church-based prevention efforts assume that people are chronically under-informed about the risks of HIV/AIDS or that they choose to act foolishly and dangerously despite receiving exhaustively clear behavioural guidelines. In both cases, individual choices and agency are seen as central to the success of prevention education while structural constraints that influence and circumscribe individual behaviour are typically ignored or downplayed.

Second, even when church members receive abundant and forceful instructions that they can understand, they are seen as incapable of executing them once they step into the sinful world outside the congregation walls. An interviewed man expressed his view: 'We talk at church about [prevention], but at school, in the market people undo what they hear [in church].' Yet even the message of prevention within the church when spread peer-to-peer is often not heeded—perhaps precisely because it is articulated by people who have no greater authority than any other of their church peers. Another interviewee put it this way:

Ah, there is a saying 'a prophet is not honoured in his own land,' which [in this case] means that if we who are from the same church teach each other, people ask themselves: 'what does he know that he's talking about it.' But if it's someone they don't know, they, I believe, will take notice.

The apparent failure of prevention efforts creates a sense of hopelessness. 'We are dying, we are asking to please give us a solution,' said one participant, 'The condom doesn't work anymore, we are tired... even Adam and Eve sinned because that thing is so sweet, so how can we leave sweet things to rot?' Her words were echoed by another interviewee: 'We all say the same... just lament that God has given up to the evil, that Satan has more power than God. We ask every day, but God doesn't hear us, but Satan, for whom no one prays, has got more strength.'

Satan is powerful, and neither faithfulness nor condoms can stand up to him. Divine intervention becomes the only plausible hope, and the church prevention message thus morphs into one praising god and denouncing the devil. A male focus group participant thus summarised where he puts his trust:

I want to ask my religious brothers to pray a lot in God's name, so that like the people of Israel we will be redeemed. On the day He decides He will eliminate this disease, like it happened with this last war [Mozambique's civil war, 1978-1992] that ended abruptly. That's why I want to beg them so that we continue to pray hard, ask our pastors to let us pray for this cause at the end of the service to end this

[evil] that scientists cannot defeat and thus to show His power over us who praise Him.

Continuing collective praying, which shifts both the liabilities and the hopes surrounding the infection away from individual and societal actors into the realm of the divine, may diffuse the focus and the force of the prevention message but at the same time, serves as a powerful stimulant for congregation loyalism.

This is not to say that church-based prevention efforts cannot yield the intended benefits. Thus, one important area where these efforts can be truly effective is in encouraging people to get tested. This encouragement, however, benefits primarily young church members who consider marriage. Yet, for the majority of active church members—married women—this encouragement is of little use as a growing share of them undergo de facto mandatory HIV testing at antenatal consultations. And again, because married men's attendance of church services and of men's group meetings is so limited, many men simply do not hear this encouragement.

Perhaps the most notable (and often overlooked) contribution of RO-based teachings to HIV prevention is not in instilling righteous sexual attitudes and guiding corresponding behaviour but in advising church members to avoid contact with unclean cutting and piercing objects, especially those used in traditional healing practices. Thirty-eight percent of the women's survey respondents said that their congregation leaders had offered this advice during main services. This advice is the least controversial ideologically and is fully congruent with the secular prevention message (even though the secular message, fixated on sexual transmission, has pushed the matter to the margins of HIV prevention). Once again, however, the real enemy of the church is not the infected razor blade used by a witchdoctor but the witchdoctor herself, a competitor to many churches, especially of the Pentecostal bend, in the healing business and a threat to church members' ideological devotion to the church and therefore to the church's organisational and ultimately financial health.

Religious organizations and HIV/AIDS-related assistance

Forty-five percent of women's survey respondents indicated that they heard their leaders say during main services that congregation members should help AIDS patients. Yet the survey data also point to very limited involvement of ROs in the provision of assistance specifically targeted at AIDS-affected individuals and families. When asked whether they knew if their congregations had offered any sort of assistance to persons with AIDS or illnesses that looked like AIDS in the 12 months preceding the survey, only 10% of respondents answered affirmatively and only 3% knew that such assistance had been provided to more than two people.

Several factors may hamper ROs' active and effective involvement in the provision of care and support to HIV/AIDS-affected individuals and families. Some of these barriers are universal and are inherent to any community-level efforts to provide HIV/AIDS-related assistance. Thus congregation-based involvement in assistance to HIV-infected individuals is hindered by the still widespread stigma and fear of disclosure of a positive diagnosis. Although religious congregations are often said to be in a better position than other community organizations or state agencies to deal with these issues by gaining people's trust, no clear support for this argument has emerged from our data. As one Zionist woman noted: 'When someone has this disease, they don't want to know anything, they don't want to be visited [by church volunteers] because they think that those people after the visit will spread the news [of their disease] in the streets.' Of course, church volunteers do routinely reach out to sick congregation members and their families and survivors regardless of the nature and manifestation of their ailments. However, because HIV diagnosis is either

unknown or undisclosed, HIV/AIDS-specific assistance, such as encouraging antiretroviral therapy initiation and adherence, cannot be offered.

In addition to the lack of diagnosis, the lingering stigma and the fear of disclosure of HIV status, ROs' ability to provide targeted care to their HIV-infected adherents is limited by a cloudy understanding of HIV-related opportunistic infections and their symptoms. Connections that some churches have with the health sector through their members facilitate church volunteers' education about these matters. In this regard, mainline churches hold an advantage over smaller, Pentecostal or Apostolic congregations as they are more likely to have nurses and even physicians among their members (Agadjanian and Menjivar 2008). In particular, district rural and semi-rural congregations' ties with city congregations of their denominations prove beneficial to the former. For example, a man from a mainline Protestant church told us about a physician member of the church, 'Dr. Komba [a pseudonym] who lives in Maputo. Sometimes we invite him here. Last year we invited him twice to give talks about AIDS and about other diseases like breast cancer.'

Any connection with a governmental institution or official is valued in the church as it adds to the church's legitimacy in general and to the reputation of the church leader in particular. As one woman put it, 'Church and government go together. Nothing is done in the church without government's knowledge. Everything should be reported to the government.' 'We can't do anything in the church,' confirmed another woman, 'without informing the government.' Sometimes, local government officials may directly coax church leaders into HIV/AIDS-assistance activities such as praying for the sick in the community, providing home care, or attending funerals. However, our data suggest that such requests are infrequent and are typically made through personal connections. Leaders of urban congregations, in particular those of mainline urban churches, are most likely to have strong personal ties in the government and in the large international NGOs that occasionally sponsor community-based assistance and care activities. As in the case of prevention-focused activities, larger urban congregations are also attractive to donors because of easy access, economy of scale, and their leaders' relatively good literacy skills. Local RO-based NGOs that are established through such funding are then typically limited to a handful of well-connected, urban-based churches, whose leaders get along well, setting aside their ideological and organisational disagreements and personal animosities at least for the time when the money is flowing. As with many top-down community-based programs, these NGOs are poorly managed and their activities are grossly inefficient, with little systematic planning, haphazard selection of assistance targets, and obscure accounting. Also importantly, the exclusive nature of these NGOs generates suspicions and even resentment on the part of the religious leaders who for one or another reason are left out.

Bottom-up cross-denominational collaborative initiatives, on the other hand, are crippled by a lack of financial resources, but perhaps even more so, by the pervasive distrust among religious leaders who often deride one another as not truly Christian and readily suspect proselytising intentions in any attempts by their peers-competitors to step outside of the clearly drawn and carefully monitored membership boundaries. 'It's very difficult to get pastors from Zionist, Catholic, and other churches together in one place [i.e., to work together] because they think that other pastors want to grab their believers,' said one male informant. Even when leaders of different churches get together and discuss, among other topics, AIDS-related matters, these meetings rarely lead to joint actions, especially those involving provision of support to sick members of other churches. 'Sometimes all of us [from different churches] meet to say prayers regarding this disease,' commented an interviewed woman, 'Now, as far as visiting [the sick] and other such things, those have never happened. Each church takes care of its sick.'

To be sure, church leaders are usually quite adept at navigating the organisational boundaries and overt confrontations are extremely rare (and are emphatically denied by most church leaders during interviews). Yet, simmering tensions occasionally erupt into outright clashes, and health, healing, death and burial, more than other issues or events, seem to trigger such eruptions. The following story told by a woman from a mainline Protestant congregation offers an illustration:

There was a person in my church who had that disease [AIDS] but did not tell us about it. He left our church and went to a Zionist church to see if he gets better, but he ended up dead for he refused to accept that AIDS kills... On the day of his funeral we went there to sing our chants, but we were prohibited by that Zionist church who alleged that only they had the right to do it because the deceased had belonged to them.

While centrally orchestrated and deployed, church HIV/AIDS-assistance is fraught with risks of transgressing organisational borders and therefore may be resisted by distrustful competitors. Such assistance, when delivered as largely informal, minimally coordinated, and by the low-key efforts of church rank-and-file members, especially women, may not elicit similar reactions simply because these efforts may not be construed by outsiders as church-organised undertakings. These activities normally revolve around home-based personal and household care; specific targets for them are typically decided upon at church women's meetings and they are carried out individually or in small groups, usually on an irregular, ad hoc basis. Importantly, in most instances of such informal assistance, knowledge or suspicion of HIV diagnosis or HIV-related illness is not an explicit criterion for selecting or prioritising assistance targets.

Conclusion

The scale, vibrancy, and diversity of religious expressions in contemporary sub-Saharan Africa has reflected on many aspects of public life (Garner 2000b, Gifford 1998) and have long invited expectations that religion could be a major force in fighting the sub-continent's most dreadful scourge. However, the role of religion and ROs as effective agents of HIV/AIDS mitigation efforts has also been questioned. Research on the involvement of religion and religious organisations with HIV/AIDS has paid considerable heed to ideological and moral dilemmas shaping religious leaders' attitudes, pronouncements and actions. Issues surrounding condom use or stigma and discrimination have been at the centre of both scholarly and general public attention. Without discounting the significance of the ideological and moral discourse and the variation in how different denominations place emphases and accents in that discourse, our study has attempted to highlight other common factors that hinder the participation of ROs of all denominational banners in HIV prevention and care activities.

While many, if not most, religious leaders may be genuinely concerned about the health and wellbeing of the congregation members and other community residents, institutional pressures often overshadow these concerns. With a diminishing reservoir of unaffiliated individuals to satisfy the membership needs of a growing number of religious congregations and, accordingly, an ever exacerbating competition for new members, church organisational health becomes an increasingly important priority for many a religious leader. When an RO's organisational goals come into conflict with its ideological or moral codes, organisational goals may prevail. Political alliances—with government agencies and officials, powerful secular NGOs, or with other ROs—are entered to ensure the church's organisational vigour thereby often further compromising its ideological and moral principles.

Ironically, while HIV prevention may be ideologically quite controversial, prevention activities, due to their low financial, organisational, and logistical costs, yield a higher 'profit margin' in terms of organisational mobilisation and legitimacy than do care and support-related efforts. Not surprisingly, then, prevention is greatly favoured by religious leaders. Emotionally charged yet devoid of personalised and concrete substance, the incessant prevention message is easy to articulate and to carry on indefinitely. This message helps galvanise church loyalty and mobilise members around a common perennial goal. At the same time, it is harmless for the church's relationships with the State, NGOs, and other churches. In contrast, HIV/AIDS-related assistance is costly, organisationally complex, and because it targets concrete individuals who may or may not be part of the church, it may generate frictions and even overt clashes with other churches. In matters of HIV/AIDS care and support, religious leaders are then faced with an uneasy dilemma: on the one hand, individual congregations are usually too small numerically and weak financially to actively engage in effective HIV/AIDS-focused assistance. On the other hand, however, any attempt to achieve an economy of scale and to ensure effective provision of support to HIV/AIDS-affected persons beyond the congregation limits, entails a potential for inter-church conflict.

It was not our intention to perform a formal assessment of success (or failure) of ROs' role in mitigating the impact of the HIV/AIDS epidemic in southern Mozambique. We should stress, however, that the constraints and contingencies identified and examined in our study, while hindering ROs' engagement in the fight against HIV/AIDS, do not prevent this engagement. In fact, ROs remain perhaps the most prominent community organisations that provide critically needed services to individuals and families affected by HIV/AIDS, especially in rural areas, where secular community organisations are ineffective or non-existent. As Garcia and Parker (2011) recently showed for Brazil, ROs can overcome their ideological and organisational differences and forge alliances to leverage resources and to deploy effective interventions among the population segments most affected by the HIV/AIDS epidemic. Although developing a recipe for a similar success in a setting like rural southern Mozambique is beyond the scope of this article, we believe that the path to success lies not only through building consensus and cooperation among ROs' leaders but even more so through harnessing the loosely organised yet tireless labour of ROs' volunteers, especially women, for whom, as Agadjanian and Menjivar (2008) and Igreja and Lambranca (2009) showed, the church offers an unparalleled venue for social interaction, peer solidarity, spiritual and emotional self-fulfilment, and community service.

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