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The Interpersonal Communication Approach to HIV/AIDS Prevention: Strategies and Challenges for Faith-Based Organizations

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Abstract

This study examines the interpersonal communication approach to HIV/AIDS prevention within Faith-Based Organizations (FBOs) in Jamaica. Applying concepts from the social influence and social learning theories, the study examines communication strategies, challenges and concerns that religious leaders face in their communication efforts. Data gathered qualitatively through focus groups and in-depth interviews indicate that FBOs are social and cultural entities with potential to influence knowledge, attitude and behaviour for HIV/AIDS prevention. However, issues related to content, context, culture, the prevailing AIDS-related stigma alongside religious leaders' personal characteristics hamper their communication initiatives. Capacity building of leaders as HIV/AIDS communicators and behaviour change facilitators and a collaborative effort between FBOs and health organizations would enhance their HIV/AIDS response.

Health communication encompasses mass and interpersonal communication in promoting and sustaining desired health behaviour change (Bertrand 2004; Rogers 1994). In the past three decades, the field has experienced a shift of focus away from issues of treatment and towards an emphasis on health promotion and disease prevention through changing individual behaviours (Morton and Duck 2001). However, HIV/AIDS has emerged as one of the greatest public health challenges that has proved difficult to stop in spite of the public health community having dramatic success in other areas of disease prevention (Bertrand 2004).

With an estimated 38.6 million people worldwide living with HIV/AIDS (UNAIDS 2006) there is a growing recognition that AIDS is not just a serious health issue but a major developmental catastrophe that threatens to dismantle the social and economic achievements of the past half century (World Bank 2000). An estimated 400,000 persons infected and an overall prevalence of HIV infection of 2.11 per cent (UNAIDS 2006) places the Caribbean region second to sub-Saharan Africa in rates of infection. In Jamaica 70 per cent of those diagnosed are in the age group of 25–44, but AIDS is the leading cause of death among the 18–45 years age group (Ministry of Health [MOH] 2004).

Prevention is the main goal of various HIV/AIDS communication interventions. Since the early 1990s, national AIDS programmes worldwide use media campaigns to disseminate the information about the epidemic (Myhre and Flora 2000). The history of HIV/AIDS communication and prevention is, however, disastrous due to lack of results especially with regard to combating the epidemic in developing countries (Tufte 2005). Identified gaps lie in the extensive focus on mass media campaigns as a cost-effective strategy but one that creates the discrepancy between awareness and behaviour change (Bertrand 2004; Rogers 1995). Audience resistance arising at each stage of response from exposure to behavioural implementation and not reaching the audience and attaining attention to the message are also issues in media campaigns (Atkin 2001).

In the past few years scholars have become ambivalent concerning the effectiveness of mass media in changing behaviours (Dutta-Bergman 2005a; Morton and Duck 2001) with a need to examine alternative communication strategies beyond mass media campaigns. Researchers (Atkin 2001; Bertrand 2004; Duggan 2006; Rogers 1995) provide evidence that providing people with knowledge about a disease may have little or no impact on their behaviour. However, other types of communication strategies that provide information about the consequences of performing the behaviour, about groups that support behavioural performance, about ways to overcome barriers to behavioural performance or all three can be affective (Cappella et al. 2001). Melkote and Steeves (2001) emphasize a combination of dialogic communication, spiritual practice and other forms of religious communication as central in a behaviour change strategies.

With a focus on Jamaica, this study examines interpersonal communication initiatives within Faith-Based Organizations (FBOs) as an alternative strategy for HIV/AIDS prevention. As social and cultural institutions FBOs influence in people's everyday lives shaping values, beliefs and sexuality-related behaviours and self-

understanding, both intentionally and unintentionally. In communities with limited education or access to the mainstream media, religious leaders serve as sources of knowledge on various issues that affect society and most often considered as opinion leaders and role models. There is evidence of FBOs' contribution in the health sector, providing support and infrastructure for physical and psychological support, capacity building through training programmes and mobilizing large number of volunteers to contribute to causes they consider worthy (Calderón 1997; Green 2003; Lazzarini 1998). The HIV/AIDS epidemic brings new challenges prompting FBOs broader responses. The study examines prevention initiatives, specifically the interpersonal communication strategies, and challenges that FBO face in their prevention efforts.

Interpersonal Communication in Disease Prevention

The unique and irreplaceable role of interpersonal communication in information dissemination and influencing attitudes, beliefs and behaviours is widely studied and strongly recommended in health and behaviour change interventions. This approach to communication identifies information giving and sharing processes, interpersonal sensitivity and partnership building as core communication skills that predict better outcomes (Duggan 2006). The approach also includes community empowerment and participation in addressing issues that affect society (Kar and Alcalay 2001). HIV/AIDS is one of those issues that require moving beyond dissemination of information to include interpersonal dialogues on risk factors and prevention strategies with participation of social institutions whose influences are critical in changing societal norms, cultural beliefs, attitudes, behaviours and practices that contribute to the widespread epidemic.

The bulk of the health communication studies that focus on interpersonal communication have however often focused on provider–patient communication and where patient satisfaction in the medical context has been the subject of extensive investigation in the field of health communication (Brown et al. 2003; Dutta-Bergman 2005a). Extant research has concentrated on provider–patient communication particularly in negotiating roles and outcomes during different stages in this interaction in relation to communication styles and patient satisfaction (Dutta-Bergman 2005a). Research has also evidenced the critical role of interpersonal communication in increasing illness vulnerability (Duggan 2006); in the decision-making process creating a win–win situation within the medical encounter (Ratzan 1993); and in achieving compliance (Backer et al. 1992). Citing Beisecker and Beisecker (1990), Dutta-Bergman (2005b: 293) uses the term 'consumerist style' to

refer to the active patient participation, which, they argue, leads to actively informed patients who are able to contribute substantively to the process of decision-making. Such active participation and collaboration enables patients to make informed decisions and consequently achieve their desired health goals.

Outside of the medical circle, media campaigns have dominated health communication and behaviour change interventions, using a variety of strategies to reach the audience. Close contacts with the focal individuals also referred to as opinion leaders contribute to effective campaigns. This is sometimes a two-step process with mass media influence at the national and community level as well as motivating personal influencers or opinion leaders (Atkin 2001; Rogers 1995). This approach motivates interest, attention and behaviour change while addressing the Knowledge, Attitude and Practice (KAP) gap that exist in media health campaigns. On lessons learned from reproductive health communication, Piotrow and Kincaid (2001) emphasize strategic communication, which, they note, encompasses a wide variety of public health interventions that combine mass and interpersonal strategies selected based on problem, audience and media analysis to determine appropriateness prior to the campaign implementation.

McGuire (2001) observe that the impact of the source in the communication process is influenced by the characteristics of the source as well as by the source–audience relationship which he noted contributes to persuasiveness where source credibility, attractiveness, power and source–audience similarity all tend to increase persuasive impact. For example, source variables relate to risk perception at various levels whereby identification with the source of communication mediates the relationship between communication and perceptions of both personal and societal risk from the AIDS (Morton and Duck 2001). Berlo (1970) also refers ingredients of effective communication, which include knowledge and attitude of the source, communication skills and social–cultural contexts in which they communicate. Such considerations are critical in a communication programme that seeks to go beyond awareness to influence understanding and change in attitudes, beliefs, values and behaviours.

Theoretical Perspectives

Theoretical models used in HIV/AIDS prevention are associated with the lack of behaviour change particularly in developing countries. For instance, in reviewing the HIV/AIDS communication interventions in Africa, Asia, Latin America and the Caribbean based on these theories Airhihenbuwa et al.(2000) note that the current

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models view behaviour change as a linear relationship between individual knowledge and action. Studies also criticize current models for focusing on individual behaviour rather than on the social context within which the individual functions and for disregard for the influence of contextual variables (Dutta-Bergman 2005b; Melkote et al. 2000; Parker 2004). The social learning and social influence theories explain behaviour change or lack of it therefore, taking into consideration factors related to individuals' experience and perceptions of their environments in combination with their personal characteristics.

Social influence theory (Fisher 1988) explains why some people listen to others. The theory addresses the limited powers of the mass media in influencing behaviour change and emphasizes the pivotal role of opinion leaders. To this theory, when ordinary people make decisions on such matters as to what to believe, purchase, join, avoid, support, like or dislike, they turn to opinion leaders. Often the opinion leader's personal influence is both given and received without either party consciously recognizing it (Lowery and DeFleur 1995). This theory therefore explains why religious leaders would influence the attitudes, beliefs and behaviours of members in their religious organizations.

The influence of opinion leaders becomes more effective when there is a set structure for communication and interaction with opinion followers. Lowery and DeFleur (1995) further argue that the values in small groups (as in faith communities) are a source that draws people to the groups as sources of influence and interpretation, where people with similar values tend to be drawn towards each other and to form close-knit groups. They note that when people are in a system of close and interdependent interrelation with one another, they tend to demand of each other a high degree of conformity.

Bandura's (1986) social learning theory also addresses specific behaviours and factors that contribute to certain behaviour formation and change, or lack of it thereof. The theory addresses health behaviour at the interpersonal level with the goal of not only developing better understanding but also addressing factors related to individuals' experience and perceptions of their environments in combination with their personal characteristics. The theory explains the role of interpersonal communication in impacting knowledge, attitudes and existing beliefs and attempts to explain how people process the information they receive and how they construct messages from their cognitive structure. According to Bandura, imitation and identification with others explain how people learn certain behaviours and practices from those considered as role models.

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A basic premise of the theory is that people learn not only through their own experiences, but also by observing the actions of others and the results of those actions (Bandura 1986). Though the theory focuses more on the role of the media, other communication channels are equally important in influencing behaviour formation and change. In many communities of the developing world, social and community networks are equally important in transmitting values, beliefs and the social system norms. Religious leaders are role models in their communities who, as Atkin (2001: 53) argues, 'can provide positive and negative reinforcement, exercise control (by making rules, monitoring behavior and enforcing consequences), shape opportunities facilitate behavior with reminders at opportune moments, and serve as role models'.

Several health and behaviour change interventions use Bandura's theory. For example, the Global AIDS Program (GAP) of the Centres of Disease Control and Prevention (CDC) uses role models in entertainment to educate and reinforce HIV/AIDS media messages in southern Africa (Galavotti et al. 2001). Galavotti and colleagues argue that the use of real-life role models such as friends, family members and opinion and other community leaders can be extremely powerful in influencing behaviour change for health purposes.

Research Questions

The article is based on the following three broad research questions:

1. What interpersonal communication strategies do FBOs use in HIV/AIDS prevention?

2. In what context does HIV/AIDS communication occur within FBOs in Jamaica?

3. What challenges and concerns affect how FBO leaders, as community role models, address the HIV/AIDS epidemic in their communities?

Methods and Procedures

Data for this qualitative study were gathered from three Jamaican Parishes (out of 14) with the highest HIV/AIDS prevalence—Kingston and St Andrew, St James and St Catherine (MOH 2004). The intent of qualitative research is to understand the deeper structure of a phenomenon and to increase understanding of the phenomenon within cultural and contextual situations. The best way to gather such information is to immerse oneself in the world in which they are occurring with a desire to uncover the story behind the statistics (Trauth 2001). Methodologically, previous studies have

criticized the emphasis on quantitative research results in HIV/AIDS and behaviour change communication-related research, especially when applied to contexts of Africa, Asia and the Caribbean, which they argue distorts interpretation of the meanings and realities in observed behaviours (Airhihenbuwa et al. 2000; Dutta-Bergman 2005a). This study sought to understand the HIV/AIDS epidemic and FBO communication initiatives within the Jamaican cultural context.

Participants were recruited from 12 FBOs with highest membership based on the International Religious Freedom Report (2002), which uses the census data on religious affiliation. The 12 are as follows: Church of God (21 per cent), Seventh-Day Adventists (9 per cent), Baptist (9 per cent), Pentecostal (8 per cent), Anglican (6 per cent), Roman Catholic (4 per cent), United Church (3 per cent), Methodist (3 per cent), Jehovah's Witnesses (2 per cent), Moravian Church (1 per cent), Brethren (1 per cent) and Others (Rastafarians, Hindus, Jews, Muslims and Bahai) (9 per cent). The largest number (24 per cent) of the Jamaican population is unlisted. From the category 'other', the Rastafarian and Bahai faiths were selected due to their prominence in the Caribbean.

Focus Groups

In all, 12 focus groups were conducted, 10 with FBO members and two with People living with HIV and AIDS (PLWHA). For each participating FBO, one member was contacted and requested to recruit about 10 others based on the specifications provided: that they were of reproductive age and were not related to each other through blood or marriage. The two PLWHA groups were recruited through their support office and these were mixed groups— men and women—due to the low number of volunteers. In total, 100 persons participated in the focus groups with 18 being in the two PLWHA focus groups. All group participants were required to sign a consent form prior to participating in the study. For confidentiality purposes, audio recording of all focus group discussions started after participants introduced themselves to the group members, thus ensuring that personal information, names or other identifiers were not included in the recordings.

In-depth Interviews

We conducted 30 in-depth interviews among leaders from FBOs listed above and among leaders of the PLWHA support groups. Interviews sought information related to their perceptions and understanding about HIV/AIDS, current initiatives and challenges participants faced in addressing HIV/AIDS within their communities. At least two leaders from each selected denomination participated. In addition, four

leaders from the selected PLWHA organizations were interviewed along with two medical professionals who are strongly affiliated with churches or are dealing directly with HIV/AIDS. Interviews occurred concurrently with the focus groups over the 6-month period, each lasting about 2 hours. The interviews were also audio recorded and transcribed for analysis.

Analysis

Data for this study were analyzed qualitatively using descriptive and interpretive techniques. Denzin (2001: 83) refers to this interpretiveness as the thick description that gives rigour to qualitative analysis and 'presents detail, context, emotion and the webs of social relationships that join persons to one another'. Three Jamaican natives transcribed verbatim information from the focus groups and in-depth interviews to ensure accuracy. Though English language was used in the study, Patois, the Jamaican Creole was used by some respondents hence the need for translation in few cases.

While keeping the original research questions in mind, respondents' statements were read, and categorized by colour-coding and information arranged by recurring themes. Rather than compiling numbers of participant responses, which is not appropriate for focus group research (Krueger and Casey 2000), thematic analysis of responses from focus group was used. This type of analysis involves focusing on the general agreement among participants in each group (for example, did other members hold this attitude or belief in the same focus group?) (Mathews et al.2006).Phrases such as 'Several participants indicated that…'or 'There was consensus that…' were used to convey the level of agreement with a statement or attitude (Krueger and Casey 2000).

For credibility and validity of study findings, we used a member-checking method. Kuzel and Like (1991) note that member checking, which consists of the researcher restating, summarizing or paraphrasing the information received from a respondent, ensures that what was heard or written down is in fact correct. Member checking was done continuously during and after each focus group, through repeating respondents' statements and prompting for clarification where necessary. Following the completion of the study, findings from the study were presented at several local conferences on HIV/AIDS for feedback from the local communities. The findings formed the basis for the capacity-building workshops for FBOs leaders in HIV/AIDS communication. Workshop participants, majority of whom had participated in the study, discussed the findings in detail providing feedback and critical commentary to ensure accuracy of interpretations. Member checking add credibility, accuracy and richness to a final report (Kuzel and Like 1991).

FINDINGS

This study has several key findings that indicated the significant contributions of FBOs in response to the HIV/AIDS epidemic in Jamaica. Observed responses ranged from provision of care and support for persons living with HIV/AIDS, through meeting their basic needs— food, clothing, clothing and care for orphaned children, to social and psychological support. Prayer and faith healing, a practice deeply embedded in the Jamaican culture, is prominent within several FBOs that believe in the anointing of religious leaders with healing powers. In the midst of HIV/AIDS-related stigma, acceptance and encouragement provides the psychological support for PLWHA, which is necessary for coping purposes to avoid self-destruction or further spread of the epidemic. The focus of this article, however, is on FBO communication initiatives that seek to prevent the widespread epidemic, particularly the context in which such communication occurs as well challenges leaders face in addressing AIDS-related issues.

HIV/AIDS Communication Context and Strategies

The context for HIV/AIDS is communication, which is a concern within FBOs. As participants noted, by FBO leaders speaking directly with a religious congregation about the AIDS epidemic, would be the most appropriate approach to averting risky behaviour. However, only a handful of leaders interviewed indicated having openly discussing health-related issues. For instance, Baptist leaders directly or indirectly addressed social issues, such as the increase in number of unmarried young mothers and the absentee fathers, which contributed to crime and violence situation in Jamaican communities. These are issues with serious health implications to Jamaican communities. The Rastafarian leaders also addressed 'fornication' and 'bed-hopping', which they believe are the problems that contribute to the AIDS epidemic. This strategy of directly addressing AIDS-related issues at the pulpit was appreciated by respondents, some of whom noted was an indication of their leaders' concern for their members' physical and psychological well-being, thus providing information for the body and soul.

However, there were concerns about speaking about AIDS in church among some respondents who thought this was not appropriate given demographic make-up of their congregation. Many indicated addressing the subject within the wider health context, or within age- and gender-specific groups. The bulk of health communication activities within occur outside of the regular congregation and within

existing FBO programmes and interest groups such as Mother's Union, youth and men programmes that address health and family-related issues to some extent. Several leaders agreed that addressing HIV/AIDS within the context of sexuality and sexually transmitted diseases (STDs) would be appropriate.

A common FBO strategy is through health fairs, which enables interaction between health professionals and members of the public. The health fairs use interpersonal strategies allowing health professionals to share information and discuss at a personal level health issues that affect the public, among them HIV/AIDS. This strategy has contributed to a better understanding of the AIDS epidemic, and to some extent encouraged HIV counselling and testing among attendees.

Additionally, many FBOs also have organized workshops and seminars for their members, often after a Sunday congregation. These seminars involve a visit from a health professional who addresses AIDS-related issues to the FBO members and some by the members who have the expertise on the topic. As one leader noted in an interview:

> I know that some of the members of the congregation have been actively involved in the National HIV/AIDS programme and there are other persons who are trained as professional counselors… the church leaders have also started to meet persons with HIV/AIDS who are letting them know that they are HIV positive (Male leader, Moravian Church).

Such interpersonal interactions between community members and health professionals are useful in increasing understanding while dispelling myths and misconceptions about AIDS and other disease. They offer opportunities to reinforce or clarify messages widely delivered through the mass media. There is, however, limited collaboration between FBOs and health organizations in Jamaica, which participants noted would enhance their efforts in curbing the AIDS epidemic.

Challenges in Sexuality Communication

Interpersonal contacts and communication is a critical component in health and behaviour change communication. Throughout the study, respondents emphasized the social influence of their religious leaders across age groups, one participant noted, 'If they speak, people will listen'. By actively communicating about the AIDS epidemic, leaders reinforce HIV/AIDS media messages. This finding supports literature on the influence of opinion leaders in shaping people perceptions and influencing behaviours through interpersonal interactions (Atkin 2001; Lowery and

DeFleur 1995; Rogers 1995). Research in the past two decades has also emphasized the role of interpersonal interactions in enhancing understanding of mass media messages within various social–cultural contexts (Cappella et al. 2001; Duggan 2006; Friedman and Hoffman-Goetz 2006; Morrill and Noland 2006; Odedina et al. 2004, Piotrow et al. 1997; Ratzan 1993; Rogers 1995). The process is sometimes a two-step process where interpersonal influencers get information from the media through them to the communities (Atkin 2001; Lowery and DeFleur 1995). However, there are challenges in addressing sensitive issues such as HIV/AIDS using this interpersonal approach.

The Sexuality Taboo

In spite of their prescribed role as communicators and behaviour change facilitators, addressing the AIDS epidemic is a major challenge for many religious leaders. The nature of the disease involving sexuality, linking it to homosexuality, makes it a sensitive topic. Sexuality and sexual orientation are taboo issues not openly discussed in the Jamaican society, thus making it problematic for leaders to discuss HIV/AIDS-related topics.

Throughout the study, there was a consensus on the lack of communication about sexuality-related issues even among people in sexually relationships. As noted by one leader,

> Many people don't talk about sex at all within their relationships but sex is supposed to be something that bond two people together, but because of how we exercise our sexuality, sometimes by the time we come to get married to somebody or to be committed in a life long way to somebody, I'd say the rubber band is stretched out (Male leader, United Church).

Such cultural taboos put FBO leaders in an awkward position discouraging some from addressing HIV/AIDS-related topics. Many are still struggling with that challenge in spite of its impact in the Caribbean societies, while others deny its existence in their communities like one participant who noted, 'We will talk about it when we have a need to do so, but right now we don't have that problem in our midst' (Male Leader, Methodist Church). Participants unanimously agreed treating sexuality as a taboo and therefore not communicating about it contributes to the HIV/AIDS epidemic. This is particularly true where sexual partners fail to discuss or negotiate condom use even where the risk of infection is evident. Respondents noted that due to imbalance in gender relations where women are often younger, inexperienced and poorer, than the male partners, such negotiation is almost absent

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in a sexual relationship.

Problems with Condom Promotion

Concerns about promoting condom use for HIV/AIDS prevention within relationships came up alongside communication issues. Several leaders were concerned about promoting condom use within their faith communities due to their organizations' policies on contraceptives and partially due to their personal beliefs that contraceptives, specifically condoms promote promiscuity. Some argue that they encourage people to engage in extramarital sexual relationships, while others worry about the early sexual début among the youth. Such perceptions justify FBOs position against contraceptives, some of them affirming the abstinence-only policies as clarified by this respondent:

> Abstinence is for everyone including those who are married. When one is away from home, it means he or she has to abstain from sex, not to use condoms, and that is the message that all of us should be communicating regardless of which religion belong to (FBO leader, Church of Christ).

Not every leader is however opposed to use of condoms or other forms of contraceptives. Discussing how and when to introduce condom use, respondents agreed that it is necessary to do so when there is a lack of trust in a relationship. There are however several implications as noted by one health professional who also serves as a leader in his faith organization:

> I am supportive of the use of condoms in a relationship but to introduce them into a relationship is not simply a mechanical thing because there are vibes concerning trust and fulfillment of pledges that are made at a marriage. I do not feel that it is always necessary to introduce condoms if the marriage is based on openness and trust but in relationship where there is less trust or more uncertainty I think that there is a place for condom use but it is sometimes in those very relationship where it is difficult to negotiate for condom use because people find it difficult to broach the subject of mistrust (Male leader, United Church).

The role of FBOs in preserving marriages makes it appropriate in addressing the issue of trust, which is also the proper context to address the risk of AIDS and condom use due to its dire consequences. However, lack of HIV/AIDS policies within FBOs prevents leaders from introducing protection issues due to the limited options—abstinence, faithfulness and condom use. The Catholics and Rastafarians, for instance, prohibit all forms of contraception but other FBOs indicated flexibility

if condom use are promoted within the family planning and reproductive health contexts. Only the Baptist church, however, had a policy document to guide their HIV/AIDS prevention activities. Several other FBOs lacked the knowledge or capacity to develop one.

Perceptions about HIV/AIDS

Knowledge is a crucial component in effective communication (Berlo 1970). In HIV/AIDS communication, leaders need to have a clear understanding of the disease and surrounding factors as a prerequisite for effective communication. Only a few leaders, however, indicated proper understanding and comfort about educating others about this disease many citing lack of adequate understanding.

Questions and concerns that focus group participants raised indicated a general lack of understanding. For example, participants discussed concerns about sharing the communion cup with PLWHA. Though the practice of cup sharing has changed in many churches, a few of them, particularly in rural Jamaica, has retained that tradition. With the AIDS epidemic, this is increasingly becoming a concern within faith communities as this participant noted:

> When its time for communion I jump very quickly in the line before everyone gets up. I don't trust people you know, even when the Father [Catholic priest] tells them not to come if they are sick, but you see if you miss too many communions, people will start getting suspicious. So they will not stop until it becomes obvious, and then they don't come to church (Female, Catholic Church).

Respondents whose organizations have the cup-sharing policy indicated low risk perception through comments such as 'the cup is wiped after every sip' and 'the drink contains alcohol which will kill the virus'.

Sharing the baptismal pool was a concern for FBOs that baptize through emersion. Again leaders whose churches have this policy indicated little health requirements to immerse anyone in the pool. In fact, baptism is one means of healing and therefore recommended for the sick persons. Members were, however, concerned about PLWHA, which they believed would contaminate the water particularly if they had lacerations on their bodies. This has become a major challenge for the leaders some of whom were not sure how they would react if someone with HIV requested a baptism, some resorting to anointing method rather than emersion. There were however a few who indicated little concern given their understanding of

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how HIV is transmitted. For example, one leader noted:

> We can't think about that possibility because you cannot tell who has the virus and who doesn't. We have used the pool for many years and we have never heard of anyone getting any kind of disease from it. The way I understand it, you cannot catch it from sharing a pool, it has to be through blood or sexuality. Otherwise, everybody would get it from swimming since you can't tell who has HIV when you go swimming (FBO leader, Baptist Church).

There were, however, indications of the leaders spiritual powers to cleanse the baptismal pool, as noted by the Rastafarian leader that 'We don't worry if someone is sick. I dip the rod in the water and bless it and call upon the higher one to come down and sanitize it [water] and to receive his own people'. The leader indicated having performed baptism with the spring water (Catherine's mountain peak water), which he considered spiritually clean.

These statements indicated respondents' perceptions and their limited understanding about HIV/AIDS. Such factors have served to instigate stigma against those infected and affected by the disease. Notably, PLWHA had a better understanding and raised no concerns about spreading the disease though some indicated vulnerability due to their compromised immunity. Participants indicated actively seeking information about the disease from various sources but noted that many Jamaicans only do so when they or someone they know becomes infected. Respondents particularly raised concerns about religious leaders' ignorance in spite of the fact that they viewed them as credible sources of information. Several focus group participants accused them for harbouring AIDS-related stigma, as demonstrated by the way they treated PLWHA and the remains of AIDS victims. Many focus group participants also, for example, talked about some leaders' refusal to perform a religious vigil raising concerns about bringing the remains of AIDS victims inside the church. Many participants associated this treatment to their convictions about how people contracted the disease, through what they consider immoral behaviour.

This finding is in contrast to the recognized role of faith communities in providing care and support to those with health and medical needs particularly in the current recognition of spirituality in healing (Aldridge 2000). Studies have continued to support the value of spirituality and religious practices in dealing with adverse situations and chronic illnesses and the relationship between spirituality and well-being in terminally ill adults (Woodard and Sowell 2001). The response of FBOs to

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the HIV/AIDS epidemic has however been impacted by AIDS-related stigma that prevail in many societies.

Stigma and Discrimination Concerns

HIV/AIDS-related stigma is one of the major challenges to communication and prevention efforts in Jamaica, where people tend to condemn others due to preconceived attitudes and beliefs about how people contract it. One respondent noted, 'Because they associate HIV with homosexuality and death so they become very comfortable denouncing homosexuality and bisexuality'. Faith communities in Jamaica view the two practices as sinful, illegal and therefore punishable by law and God. In some cases, however, people assume the responsibility of casting this punishment thus causing harm and injury to those suspected of practicing homosexuality or infected with HIV.

Jamaica is one of the most homophobic countries in the world, with uncountable cases of homosexuality- or AIDS-related violence and deaths (Human Rights Watch 2004). The fear of being labelled as a homosexual has caused many persons not to reveal their HIV status as noted in the focus groups: One participant noted:

> Society is going to say him love man [meaning they are homosexuals], so they discriminate against him all over. There is fear because you never know how they will act, so better to keep to yourself (Male, focus group participant, PLWHA).<quote ends>

The fear of how people will react to homosexuals has lead some people to lead a double life, as a married homosexual couple, where the spouse seeks extra-marital relationships with male partners. This was discussed in great detail in the PLWHA focus groups where one respondent noted:

> Say for example, a man goes outside and find one-night stand and when he comes back he might give his wife the virus. But because of discrimination, he might be afraid to tell his wife [about his other relationships] because she might not understand. She too will say he went to another man, but he probably did not get it because he slept with a man. He could have got it from the woman (Male focus group participant, PLWHA).

PLWHA participants also noted that many persons who contract the virus

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have sometimes purposively infected others with the virus because they do not reveal their status or use protection for fear of being stigmatized. For example, a focus group participant noted how some of those infected knowingly infect their sexual partners:

> I know of a situation where the man has it and because he was afraid of the reaction he would face after explaining to her his story, he keep it inside and him take it on [infect] another person. It is because of fear (Male, PLWHA).

Another PLWHA noted:

> I think to myself that HIV is spreading because of fear. As a whole, there is a part about unfaithful, that is true, but we have no compassion in ourselves. When we know we infect a negative person spitefully [purposively]. But the whole thing boils down right to the fear and that individuals are going to feel it. What others will do or say to them if they find out [that they are HIV positive]. Many people just keep quiet and say nothing to anyone and they just go with their life as normal and give it to other people (Female, focus group participant, PLWHA).

These statements from PLWHA are strong indications of the impact of stigma and its contribution to the widespread epidemic in the Caribbean. When a PLWHA slips into hiding there is a lack of contact with the rest of community, which not only intensifies stigma, but also reinforces myths and misconceptions about the disease.

The existence of HIV/AIDS-related stigma and discrimination within churches came out strongly in the focus group discussions. Many participants felt the need to protect themselves from the PLWHA, many of them indicating the need to quarantine HIV positive persons to prevent further spread of the epidemic. Statements such as 'lock them up', 'kill them' or 'send them away', 'ask them not to come to church' or 'have them sit at the corner or by themselves' were constantly repeated in focus group discussions about what to do with persons with HIV/AIDS in their churches. Others recommended mandatory testing and eliminating HIV/AIDS positive persons who might spread it to others.

Such responses indicated that FBOs are not exempt from the AIDS-related stigma that looms the Caribbean today, which has challenged the nature of communication, and extent to which FBOs address the epidemic. There is recognition to address the epidemic effectively, communicator must address such stigma as this respondent noted:

> The view that the church is basically judgmental has affected that area of the ministry. In fact like in coming weeks now we are going to be talking among ourselves as pastors and ask, how do you treat homosexuals per se? And a number of pastors have had crusades and people are coming and got baptized and they will find out that homosexuals are part of the church. The challenge of how to treat them is a major one. And a number of us are talking about that and trying to come to a common ground, common position on how we are going to deal with it. And soon you will hear people talk about a ministry to homosexuals (Male leader, Baptist).

As noted by Patterson (2005) stigma has to do with fear, and with ignorance, when people fear the unknown and mysterious, fear things they do not understand and fear the untreatable or incurable disease. According to UNAIDS (2000: 10) a series of powerful metaphors are mobilized, which serve to legitimize AIDS stigmatization. These include:

> HIV/AIDS as death (e.g. through imagery such as the Grim Reaper); HIV/AIDS as punishment (for immoral behavior); HIV/AIDS as a crime (in relation to innocent and guilty victims); HIV/AIDS as war where the virus need to be fought; HIV/AIDS as a horror in which infected people are demonized and feared; and HIV/AIDS as "otherness" in which the disease is an affliction of those set apart.

Several FBO leaders noted that the magnitude of this problem requires collaborative with health professionals and government ministries. This would ensure addressing HIV/AIDSrelated stigma from both social and medical perspectives.

Individual Characteristics

Associated with the HIV/AIDS stigma is the lack of understanding, personal attitudes and beliefs that individual leaders hold about the disease. Based on Bandura's theory, role modelling is an effective strategy for influencing behaviour and attitude formation and change. From the PLWHA perspective, FBOs have not provided leadership in addressing the AIDS epidemic partly because of the attitudes of individual leaders as discussed in one group:

> If I were to go to church right now and tell the Pastor, he would say it is because of my sin that's why I have HIV. He is not supposed to be judgmental and I am supposed to go to church and seek warmness, because that is part of the cure, not to be beaten down. Give a person a chance; don't tell us because of our sin. Yes we sinned, but give us some hope and show us

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how to redeem ourselves; we are not irredeemable as they treat us. That's why HIV is spreading! Don't tell me no nonsense (Male, PLWHA focus group).

There was a consensus from PLWHA that many leaders instigate stigma in their communities based on how they behave toward those affected by the epidemic. Their statements indicated a great deal of contempt toward religious leaders due to this treatment, which did not match societal expectations of them as caring and forgiving spiritual leaders and role models

When asked about their position as role models in HIV/AIDS prevention, several leaders also acknowledged that they are not immune HIV/AIDS or the associated stigma, which makes it difficult for them to address it. A few members indicated that they would not pass as role models, which they thought was a key challenge when it comes to HIV/AIDS. One leader noted:

> As leaders, we are aware that people are seeing us as role models. We shy away from that because it is a burden because that is the truth, people see you as a role model and that comes with a lot of responsibilities in terms of how you behave and how you act. That is because as a role model you are always under scrutiny (source).

Role modelling requires taking leadership in several aspects including setting a tone for addressing AIDS-related stigma in how faith communities treat PLWHA. A participant who is also a health professional noted that,'Many of them need to re-examine their own behaviors and values, because that by itself should prevent them from condemning others especially because some have the same behaviors that they condemn and therefore cannot be good role models'.

Personal characteristics of FBO leaders also determine how they related to the PLWHA or if the later will relate to them or if they will reveal their HIV status to them. It is clear from the PLWHA focus groups participants that all religious leaders did not react to them in the same way. Though revealing HIV status is a critical step towards success in HIV/AIDS communication, several respondents had concerns related to stigma and confidentiality. These concerns prevent many people from revealing their HIV status to the FBO leaders or others in the faith community. This failure to reveal one's HIV status has on the other hand contributed to a sense of denial in the existence of HIV/AIDS in the faith communities in spite of the current data and the media messages that point to the increasing number of persons with AIDS in Jamaica.

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Conclusion

It is evident from this and previous studies that FBOs are positioned to address the HIV/ AIDS epidemic. In Jamaica, findings indicate that religious leaders' social and interpersonal influence makes them credible sources to educate and influence people's HIV/AIDS-related perceptions and risk-taking behaviours. Several organizations have initiated programmes that seek to address the epidemic through interpersonal communication strategies—health fairs, counselling services, seminars and workshops or openly addressing the topic within their faith communities. This approach differs from the dominant media campaigns but reinforces media prevention messages.

This study contributes to literature that emphasized the role of interpersonal communication in behaviour change. Findings demonstrate that effective interpersonal communication approach to HIV/AIDS is more complex than simply talking to people about abstinence and faithfulness, which is the key message within FBOs. There are several challenges and concerns that faith communities face when using this approach in HIV/AIDS communication. Such challenges include message content involving sexuality and sexual practices; a culture that does not openly discuss sexually related issues and context in which HIV/AIDS communication should take place. These factors put religious leaders in an awkward position challenging their communication initiatives. Few others are struggling to determine the best context to respond to the AIDS epidemic due to religious beliefs, perceptions about the disease, prevailing stigma and discrimination, organizational policies and personal characteristics that determine how and to what extent FBOs deal with the problem.

Capacity building through education and skills building among FBO leaders would enhance religious understanding equipping them as communicators and behaviour change facilitators. Such capacity is necessary in the development of HIV/AIDS programmes and policies to guide FBO communication and prevention initiatives. Further research is required to examine the impact of such interventions and on the effective means of collaboration between health and faith organizations to address HIV/AIDS from both theological and medical perspectives and to influence policies that strongly oppose use of prevention methods such as condoms.

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