

# Level of preparedness of Religious Leaders for the Prevention of HIV/AIDS in Nigeria

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## Abstract

### Objective

HIV/AIDS is a pandemic affecting over 3.2 million Nigerians. Over 90% of the African population belong to religious congregation and are often influenced by the religious leaders. Since health education is a very effective tool in the control of HIV/AIDS, it is expedient to assess the level of preparedness of religious leaders for the prevention of HIV/AIDS so as to maximize opportunities of controlling this menace. This study aims to assess the preparedness of religious leaders to promote and support HIV/AIDS prevention.

### Methodology

This is a cross sectional study involving 252 religious leaders (Christians and Islamic) from Oyo and Kaduna State Nigeria randomly selected across the senatorial districts of the state. Questionnaire was used to collect information about demographic characteristics, knowledge about HIV/AIDS education/promotion, history of HIV/AIDS training and the level of preparedness of the respondents for prevention of HIV/AIDS.

### Results

Of the 252 respondents, from Oyo State (122) and Kaduna State (130), majority were male (96%), over 30 years of age (96.6%), willing to be screened for HIV(64.7%) and educated their congregation about HIV/AIDS (51.2%), had minimum of secondary education (89.6%) while 22.6% ever tested for HIV. Though 96.4% acknowledge the need for basic knowledge on HIV/AIDS, only 23.8% wanted to know its presentation while 5.6% wanted to know how to care for persons affected with HIV.

### Conclusion

Religious leaders had demonstrated high preparedness for the prevention of HIV-AIDS in this study. However, appropriate and consistent education and promotion is required for the clergy to identify challenges early and be capable of proffering appropriate solution.

### Key words

HIV, AIDS, Religious leaders, HIV/AIDS education, faith-based organization, preparedness.

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## Introduction

Human Immunodeficiency virus (HIV) is a pandemic that cuts across race, tribe, gender and religion. In 2013, the prevalence in the adult Nigerian population was 3.2% with 210,000 estimated HIV/AIDS related deaths.<sup>1</sup> With over 90% of Africans participating regularly in some religious congregation, it implies that the religious organizations are affected by the resulting challenges.<sup>2</sup>

The religious leaders in African American community in the United States had risen to the challenge by disseminating HIV/AIDS information for congregants and the surrounding community through interpersonal communication and the use of the mass media.<sup>3</sup>

The involvement of religious leaders in HIV/AIDS is affected by their belief about

appropriate sexual behavior and particular congregational characteristics.<sup>4</sup>

In Senegal, HIV transmission had been linked to lifestyle and perceived morality. The religious leaders actively participate in regular HIV prevention education which includes voluntary counseling, HIV screening and condom use.<sup>5</sup>

In Malawi, it was observed that individuals who belong to congregations led by clergies that frequently deliver formal messages about HIV, monitor the sexual behavior of members and privately encourage condom use report greater adherence to the ABC of HIV prevention.<sup>4</sup>

Thus, religious congregations are relevant for the sexual behavior of members and for better understanding of the forces shaping individual behavior in the context of the African AIDS

epidemic.

Religious leaders are highly esteemed and may use their position and frequent interaction with the public to promote HIV/AIDS awareness, fight stigma and discrimination, and exercise compassion for people living with HIV/AIDS (PLWHA).<sup>6</sup>

Religious leaders and their organizations are already playing a role in HIV prevention but their responses are not uniform.<sup>7</sup> They could improve their role in the fight against HIV/AIDS with education and sensitization specifically aimed at dismantling the myths about HIV transmission and the stereotyping of susceptible sub-populations and consultative dialogue between PLWHAs and religious leaders are pivotal to a successful faith-based HIV intervention.<sup>6</sup>

When the religious leaders are adequately prepared they could promote various forms of social control for HIV prevention, contribute to care and support of the AIDS affected and provide social spaces for challenging stigmatization.<sup>8</sup>

However, where this is lacking moralistic attitudes and reinforcement of conservative gender ideologies prevail. Thus resulting in a conflict religion based world-view rather than the acceptable and adaptable evidence-based public health strategies for HIV prevention.<sup>9</sup>

Hence, the need to overcome knowledge gaps and provide appropriate educational information that will be acceptable to the faith-based audience without the fear of losing congregation. The integration of HIV/AIDS topics into sermons using diverse approaches to HIV prevention is important.<sup>10</sup>

This study aims to assess the preparedness of the religious leaders to promote and support HIV/AIDS prevention.

## Methods

### Study Design

This is a descriptive cross sectional study involving 252 religious leaders from Oyo and Kaduna State who were randomly selected from the 3 senatorial district of the states. In all 122 were from Oyo State and 130 from Kaduna State.

### Study Area

Oyo state is situated in the south-western Nigeria, with its capital at Ibadan. The state is bounded in the north by Kwara State, in the south by Ogun State, in the east by Osun State and in the west by Ogun State and Republic of Benin. She occupies a total land space of 28,454km<sup>2</sup> and has a population of about 5.6 million people by 2006 population estimate.<sup>11,12</sup>

There are about 20 types of Churches and 10 types of Mosques in Oyo State. Out of which 11 Churches and 7 Mosque denominations/sects are registered or structured.<sup>18</sup>

Kaduna State, with her population of 6.1 million people occupying an area of 7,627.2Km<sup>2</sup> is bounded in the north by Zamfara, Katsina and Kano

States, in the south by Nasarawa State and the Federal Capital Territory, in the east by Bauchi and Plateau States and in the west by Niger State.<sup>12</sup>

In Kaduna State, Islam and Christianity play important roles in the lives of the inhabitants. Almost everyone is affiliated with one of the two religious institutions (mosques and churches) in the state.

### Target Population

The target population is the Religious Leaders of registered/structured Churches and Mosques in Oyo and Kaduna States in Nigeria. These are the Pastors and Imams who lead congregational worships in various Churches and Mosques.

### Sampling Procedure and Sample Size

A multi-stage sampling technique was used. The names of all registered Churches and Mosques in both States were obtained from the Christian Association of Nigeria (CAN), the Ja'amatNasirulIslamiyat (JNI) and the Muslim Association of Nigeria (MAN).

These were grouped within the three senatorial districts in the States. In Oyo Sates, they were Ibadan/Ibarapa, Oyo/Oke-Ogun and Ogbomoso senatorial districts, while in Kaduna State they were Kaduna metropolis, Kafanchan and Zaria senatorial districts.

In the second step, the churches and mosques were stratified into different denominational groups - thirteen (13) denominations of churches and seven (7) sects of mosques for each state.

In the third step, 50% of each denominations/sect of churches and mosques in these three districts were randomly selected using the table of random numbers based on weighted ratio of 5:2:1 for the senatorial districts as follow:

1. Oyo State: Ibadan/Ibarapa (5), Oyo/Oke-Ogun (2) and Ogbomoso (1)
2. Kaduna State: Kaduna metropolis (5), Kafanchan (2) and Zaria (1).

Finally, a total of two hundred and fifty-two (252) Religious Leaders (RLs) were selected from the congregation above cutting across Christianity (CRLs) and Islam (IRLs).

### Data Collection

A semi-structured questionnaire was used for the collection of data from the RLs. These include demographic characteristics, knowledge about HIV/AIDS education/promotion, history of HIV/AIDS training and religious leaders state of preparedness to participate in HIV/AIDS prevention education. Validity describes the ability of an instrument to measure what it is expected to measure<sup>19</sup>.

The questionnaire was reviewed in-house by experts in health promotion and education for face, construct and content validity. To ensure reliability, a pre-test study was carried out using the

final draft of the validated questionnaire on 10 respondents (5 CRLs and 5 IRLs) in Oshogbo, Osun State, Nigeria before the final administration of questionnaire was conducted.

In each State, 5 trained research assistants fluent in English and the local language of the area of study were deployed to collect the data from respondents after their worship (Sundays for CRLs and Fridays for IRLs).

Interviews were conducted mostly in English language. The questionnaire administration was done over six weeks in each State.

### **Ethical Consideration**

Ethical approval was obtained from University College Hospital Ethical Committee in addition to verbal approval from the headquarters of the religious groups.

### **Data Management and Analysis**

The data were analyzed using both inferential and descriptive statistics (mean, range, ANOVA).

### **Results**

#### **Socio-demographic characteristics of respondents**

Table 1 shows the socio-demographic characteristics of the respondents. Most (96.0%) were males while only 4.0% were females. Their age ranged from 20 to 81 years with mean age of  $48.6 \pm 12.7$  years.

Most of the respondents were married and had tertiary education. Majority of them preach 2 or more times per week.



### Respondents' awareness and knowledge about HIV/AIDS

Table 2 shows that 98.8% of the RLs are aware of HIV/AIDS. Their major source of information was the media and health workers.

Though 47.6% have correct understanding of the relationship between HIV and AIDS, 86.1% acknowledged that healthy looking people could have HIV/AIDS.

**Table 2: Respondents' awareness of HIV/AIDS**

<b>Respondents' awareness of HIV/AIDS</b>	<b>n(%)</b>
<b>Awareness:</b> Yes No Total	 249 (98.8%) 3 (1.2%) <b>252</b>
<b>Sources of information:</b> Friends Newspaper Radio Television Health worker Others: Seminar Total	 20 (7.9%) 25 (9.9%) 105 (41.7%) 54 (21.4%) 34 (13.5%) 8 (3.2%) <b>246</b>
<b>Belief that HIV/AIDS exists:</b> Yes No Total	 248 (98.4%) 4 (1.6%) <b>252</b>
<b>Correct relationship between HIV and AIDS:</b> Yes No Total	 120 (47.6%) 132 (52.4%) <b>252</b>
<b>Possibility for a healthy looking person to have HIV/AIDS:</b> Yes No Total	 217 (86.1%) 35 (13.9%) <b>252</b>

**Respondents' history of previous participation in HIV/AIDS training program**

Table 3 indicates that only 105 (41.7%) respondents had ever attended any type of training program on HIV/AIDS. "Not been invited" (42.9%) topped the list of respondents' reason for not attending any training program, while lack of interest is the least reason (5.4%).

Some got the training through seminars (26.6%), while others got it through workshops (18.3%), conferences (9.5%) and part of basic school training (9.1%).

**Table 3: Respondents' history of previous participation in HIV/AIDS training program**

History	N=252  n (%)
<b>Ever attended any training program on HIV/AIDS:</b>	
Yes	105 (41.7%)
No	147 (58.3%)
<b>Reason why they did not attend any training program:</b>	
Not invited	63 (42.9%)
No opportunity to attend	28 (19%)
No time	15 (10.2%)
No interest	8 (5.4%)
No answer	33(22.5%)
<b>Form of training attended on HIV/AIDS:</b>	
Training workshop	46 (18.3%)
Seminar	61 (26.6%)
Conference	24 (9.5%)
Part of school basic training	23 (9.1%)

**Respondents' history of HIV testing and perceived susceptibility**

Table 4 showed that only 57 (22.6%) respondents had ever been tested for HIV. Of which

more than half (59.6%) had HIV test done over six months before the survey.

Though 64.7% would want to know their HIV status, majority feel they are not at risk.

**Table 4: Respondents' history of HIV testing and perceived susceptibility**

<b>History of HIV testing</b>	<b>N=252</b>
	<b>n (%)</b>
<b>Ever been screened for HIV:</b>	
Yes	57 (22.6%)
No	195 (77.4%)
<b>When last were you screened for HIV?</b>	
Within 3 months	13 (22.8%)
3 to 6 months ago	10 (17.5%)
over 6 months	34 (59.7%)
<b>Total</b>	<b>57</b>
<b>Would you want to be screened for HIV:</b>	
Yes	163 (64.7%)
No	87 (34.5%)
<b>Total</b>	<b>250</b>
<b>Your chances of getting HIV/AIDS:</b>	
Small	85 (33.7%)
Moderate	5 (2.0%)
Great	9 (3.6%)
No risk	91 (36.1%)
Don't know	57 (22.6%)
<b>Total</b>	<b>247</b>

**Respondents' history of educating members of congregation on HIV/AIDS prevention**

In table 5, 51.2% respondents had ever educated members of their congregation on HIV/AIDS prevention. This had been done through

sermons (50.4%), counseling (15.5%) and seminars (10.1%).

Major challenges had been lack of adequate materials (96.6%) and lack of adequate personnel to handle HIV education programs (50.6%).

**Table 5: Respondents' history of educating members of congregation on HIV/AIDS prevention**

<b>History of Educating members</b>	<b>N=252</b>
	<b>n (%)</b>
<b>Ever educated members of congregation on HIV/AIDS prevention:</b>	
Yes	129 (51.2%)
No	123 (48.8%)
<b>Reasons for not educating members:</b>	
Not well knowledgeable on HIV/AIDS	34 (27.6%)
It was not on my mind to preach on HIV/AIDS	12 (9.8%)
I only teach what is in the Holy book	9 (7.3%)
Don't have any experience to preach on HIV	8 (11.3%)
No comment	63 (51.2%)
<b>Type of HIV/AIDS educational activities carried out in the last 3 months:</b>	
Sermon/preaching on HIV/AIDS	65 (50.4%)
Training workshop/Seminar	13 (10.1%)
Health talk	7 (5.4%)
Outdoor program	2 (1.6%)
Counseling	20 (15.5%)
Not specified	22 (17%)
<b>Ever encounter problem in carrying out HIV/AIDS educational activities:</b>	
Yes	29 (11.5%)
No	194 (77.0%)
<b>Total</b>	<b>223</b>
<b>Problems encountered in carrying out HIV/AIDS activities:</b>	
Lack of materials	28 (96.6%)
Lack of personnel to handle the materials	

**Respondents' state of preparedness to participate in HIV/AIDS prevention education**

As shown in table 6, 95.6% respondents' accepted that HIV/AIDS should be discussed in their congregation. Even if the clergy were HIV positive, 61% asserts that the HIV positive ministers should be allowed to continue their duties in the congregation. Over 94% agreed that the RLS should be active in HIV/AIDSs prevention and control programs.

They were all averse to limiting service to unmarried people, HIV positive persons, prostitutes and homosexuals as well as those who requested only. Over 82% said the congregation should set money aside for HIV/AIDS information, education and counseling materials.

Though over 90% prefer promotion of abstinence as a means of preventing premarital sex but about 30% agree to the use of condom.

**Table 6: Respondents' state of preparedness to participate in HIV/AIDS prevention education**

State of preparedness	N=252	
	Agree n (%)	Disagree n (%)
Acceptable for HIV/AIDS to be discussed	241 (95.6%)	11 (4.4%)
If a Pastor/Imam has the AIDS virus should he/she be allowed to preach	154 (61.1%)	98 (38.9%)
RLS should render AIDS prevention	238 (94.8%)	14 (5.6%)
RLS should be involved in the HIV/AIDS control program	239 (94.8%)	13 (5.2%)
RLs should make money available for HIV/AIDS IEC materials	207 (82.1%)	45 (17.9%)
HIV/AIDS prevention counseling should only be rendered to unmarried	0	252 (100%)
If my members don't ask me, I will not bother to teach	0	252 (100%)
RLs should render AIDS prevention to members who are infected with HIV	0	252 (100%)
AIDS prevention education in Churches/Mosques cannot prevent members from contacting HIV	0	252 (100%)
Only prostitutes & homosexuals should listen to HIV/AIDS education	0	252 (100%)
RLs should encourage their members to abstain from	228	24

## Discussion

This study reveals that 98.8% of the participating religious leaders (RLs) were aware of HIV/AIDS while 98.4% believed that it exists. This may be attributed to the exposure of religious leaders to the media and the efforts of the government through the National Action Committee on AIDS, to increase awareness and sensitization among the general population and stakeholders about HIV/AIDS as highlighted in the objectives of the HIV/AIDS policy in Nigeria. It might also have occurred as a result of the efforts of the All African Council of Churches and interfaith HIV/AIDS Council of Nigeria Organization, whose goal is to present a common front to fighting HIV/AIDS.<sup>13</sup>

Although knowledge about HIV mode of transmission was generally high among religious leaders, some misconceptions and erroneous beliefs about HIV transmission still exist. Religious leaders still have misconceptions that sharing of food with infected persons, kissing, mosquito bites, hugging or shaking hands with infected persons and witchcraft could transmit HIV.

These erroneous misconceptions may be related to respondents' belief that since HIV can be transmitted by blood transfusion and mosquitoes feed on human blood then it is possible to pass the virus from an infected person to an uninfected person. Also, the belief that since the devil is capable of using his powers to inflict diseases on human, then it is possible for HIV to be transmitted through witchcraft. This finding is supported by a survey conducted in Nigeria that the high knowledge of HIV has little impact on misconceptions about HIV transmission<sup>14</sup>. The RLs identified mother to child transmission of HIV during pregnancy. Thus the need to look into other mode of HIV transmission other than perception of its etiology from sinful practices by RLs.<sup>15,16</sup> The World Council of Churches had asserted that RLs are familiar with the means of HIV transmission and prevention.<sup>17</sup>

The findings of this study revealed that few religious leaders (22.6%) had ever been screened for HIV and their perceived risk of contracting HIV is mostly low. This is a confirmation of a previous survey conducted by NARHS in 2003 where 72% of respondents who have heard about AIDS said they stood no chance of contracting HIV.<sup>14</sup>

Only 64.7% of the religious leaders stated that they would want to be screened for HIV. This indicated the need for more education to encourage RLs to accept screening. About 42% RLs had ever attended a training program on HIV/AIDS. This had earned the Faith-based Organizations the name 'sleeping giant' in relation to HIV prevention.<sup>18</sup> No wonder, a report of Health and Science in 2005, which stated that Muslims have assumed for a long time, that HIV/AIDS is an issue that would not affect them.<sup>16</sup> Nevertheless, the willingness of most of the RLs (96.4%) to gain basic knowledge on HIV/AIDS gives hope.

Although most religious leaders are

prepared and are willing to participate in HIV/AIDS prevention by agreeing to the following statements: acceptable for HIV/AIDS to be discussed in church/mosque (95.6%); religious leaders should deliver HIV/AIDS prevention lessons as part of their sermons in churches/mosques (94.8%); religious leaders should make money available for HIV/AIDS educational materials (82.1%); and religious leaders should encourage their members to abstain from premarital sex (90.5%), majority of the religious leaders also suggested various methods/strategies for initiating and sustaining HIV/AIDS prevention lessons in Churches/Mosques.

These findings may be due to the efforts of the All African Council of Churches and Interfaith HIV/AIDS Council of Nigeria Organization, who are committed to building the capacity of the faith community in Nigeria with a goal of bringing the two major religious groups (Christians and Muslims) together to present a common front to fighting HIV/AIDS.

While some RLs assert that all means of preventing HIV/AIDS should be sought, others vehemently perceive condom use as anti-religious and an invitation to premarital sex among young people.<sup>19-21</sup> No wonder, the 90.5% support for abstinence and 32.1% vote for condom use in HIV prevention echoes the stand of various RLs round the world.<sup>16,21</sup>

This implies that more education must be provided about mode of HIV infection not due to infidelity that can result in discordant couples and put partners in danger.

## Implications of the findings for health education

The findings of this study revealed the preparedness of religious leader to play pivotal role in the education and mobilization of resources for the prevention of HIV/AIDS. However, there is room to facilitate voluntary adaptation of behavior conducive for health in their congregation through persistent and consistent education and reinforcement of principles of public health rather than uphold traditions that will worsen the disease burden of HIV/AIDS in the country.

Such consistent effort will clarify misconceptions and erroneous beliefs about HIV/AIDS and engender effective and sustainable faith-based intervention of lasting advantage to the community.<sup>22</sup>

## Conclusion

There is a high level of preparedness of the religious leaders to mobilize resources for the fight against HIV/AIDS. However, the level of HIV/AIDS-related preaching is very low. Though HIV/AIDS discussion is acceptable in the religious institutions, the tolerance for clergy who are HIV positive was low. The limitation to the RLs' promotion of HIV/AIDS activities includes lack of appropriate materials, lack of personnel and poor attendance.

With appropriate support, religious leaders in Nigeria will be able to achieve similar fit as in Senegal and Malawi.<sup>4,5</sup>

### Recommendations

1. Religious leaders need training and retraining using the results of this study for developing an evidence-based curriculum.
2. Condom use promotion should be included in the training curriculum designed for religious leaders
3. Advocacy visits to the headquarters of faith-based organizations is required for the adoption of condom use promotion by religious leaders.
4. A universal preaching curriculum on basic knowledge of HIV/AIDS should be developed as a working tool to aid religious leaders in carrying out HIV/AIDS preventive education promotion among their congregations.
5. Adequate provision of educational materials and resource persons are expedient without limiting the use of mass media.

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