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Christians' perceptions of HIV prevention in Benin City, Nigeria: Implications for HIV/AIDS communication

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Abstract: Christians' perceptions of HIV prevention and the extent to which their perceptions influence communication about the different options for HIV prevention in Benin City is examined in order to suggest possible HIV-communication strategies. Qualitative data collected from 85 participants in Benin City, Nigeria, through unstructured interviews are analyzed. Analysis of the qualitative data collected reveals a prevailing belief among Christian leaders and members of their churches that being a Christian insulates one against HIV. The analysis also reveals the characterisation of HIV/AIDS as a disease of sinners or people with loose morals and HIV is regarded as a divine punishment by some of the participants and mostly a problem of homosexuals. The study provides the grounds for developing health communication intervention practices, using one of the key community influencers such as pastors to reach communities in efforts to stem the tide of HIV infections in Africa. The findings identify the views of Christians that can be used in considering HIV communication in the city studied.

Subjects: Communication Ethics; Development Communication; Health Communication

Keywords: Religious beliefs; condom use; divine punishment; HIV/AIDS communication

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PUBLIC INTEREST STATEMENT

Religion influences people's worldviews. Hence, the view that Christian religious principles will weigh heavily in the approach taken by residents in Benin City in both personal and social issues cannot be ignored as the majority of the people profess to be Christians. Consequently, studies have started to notice the influence of pastors and members of churches on social issues such as the adoption of HIV/AIDS preventive behaviour. This study contributes to the literature by highlighting the views of pastors and their members about HIV prevention. The study points out Christians' perceptions of HIV prevention and the extent to which their perceptions influence communication about the different options for HIV prevention in Benin City, Nigeria. The study thus provides a basis for developing health communication intervention practices, using one of the key influencers in the communities such as pastors to help mitigate and slow the rate of HIV infections.

1. Introduction

As HIV/AIDS became prevalent across many countries in the 1980s, the belief of Christian establishments was evident in the way they reacted judgmentally to the epidemic. The response reflected their defining values and emphasis on the meaning and purpose of human life, which Speakman (2012) noted has influenced Christians' perceptions of HIV. In the light of this response, debates have raged on how to confront and relate to people living with HIV/AIDS (PLWHA) and how to accentuate the discourse of HIV within Christian establishments. This is important because some Christian establishments tend to take a moralistic stance about what is acceptable or unacceptable in interpreting social reality, which in turn, affects their discourse about HIV/AIDS.

In this article, the argument is that religion (Christianity) affects the general worldview of people about HIV because, according to Anderson, Scrimshaw, Fullilove, Fielding, and Normand (2003), people's health is influenced by their religious and cultural beliefs with respect to treatment decisions and options. Such beliefs influence some Christians to assume that PLWHA are people of "loose morals" and therefore deserving of their punishment (Hartwig, Kissioki, & Hartwig, 2006; Parker & Birdsall, 2005) because the common infection route for HIV is unprotected sexual intercourse.

Sexual intercourse before and outside marriage receives a hardline response from many Christians because it is a behaviour incompatible with Christianity (Jonsen & Stryker, 1993). Responses, such as labelling PLWHA as having "loose morals," has found expression in the literature because groups such as homosexuals, drug users, and prostitutes are considered to be more at risk than others (Olaore & Olaore, 2014) due to their lifestyles. Given this line of thought, AIDS is perceived as a "just reward" for immorality because "the mouth that eats pepper feels" its sting (Alubo, Zwandor, Jolayemi, and Omudu 2002, p. 123). Although this view has shifted remarkably in many parts of the world, the "strong urge to identify and preserve essential elements" of its doctrines and practices (Jonsen & Stryker, 1993, p. 122) has kept Christian religion more in the conservative box than in the progressive one. This article seeks to discover how the perceptions of Christians in Benin City, the capital of Edo State in Nigeria, influence Christian discourse about HIV prevention and specifically, how the church as a communicative space is used in the discourse about HIV prevention. The novelty of this study is the fact that even though a significant portion of the population of the city professes to be Christian, a study of how Christianity has impacted the fight against HIV/AIDS is not evident. To my knowledge, very few studies have explored pastors and their church members' responses to the HIV pandemic and none with respect to HIV prevention in Benin City, Nigeria. The lack of formal investigation raises the question of how churches can appropriately respond to the HIV pandemic given the enormous influence of pastors in their communities (Edwards, 2016; Francis & Liverpool, 2009).

The intention of this study is to assist with answering the following research questions: First, what are the perceptions of church leaders and their members regarding HIV prevention? Second, how have church leaders and members' perceptions influenced how churches in Benin City are used as a communication space to spread information about HIV prevention? Third, following the pastors and their church members' perceptions of HIV prevention, what appropriate HIV-communication interventions can be suggested? These questions are answered with a qualitative analysis of unstructured interviews with pastors, elders, and members of churches across Benin City. Using this approach, the article contributes to HIV communication research by pointing out the possible role of Churches in fighting HIV. Discussion of literature relevant to this study, especially the state of Christianity among Edo-speaking people, the impact of religion on health communication, and the research method adopted for this study, follows.

2. Context of the study: Christianity in Benin City

The study area is Benin City, capital of Edo State, Nigeria. Benin City is a multicultural city with a sizeable number of people from different ethnic (Osadolo & Finlayson, 2007) and religious backgrounds. The city serves as the principal administrative and socio-economic centre for Oredo, Egor, and Ikpoba-Okha Local Government Areas. Like many cities in Nigeria, Benin City is

characterised by religious diversity, with foreign religions such as Christianity being more prominent than Muslim and traditional religions. According to the National Population Census (National Population Census [NPC], 2006), the city's population is 1,149,584.

Christianity has been a powerful force since the colonial era in the Ancient Benin Empire, dating back to the Portuguese missionaries in the 15th century (Bandia, 2001). In the present-day Benin City, the ubiquitous places of worship and Christian-related social service organisations mean that there is hardly a count of two or three streets in the city without one or two churches. This includes different brands of Christianity in the form of Protestant, Catholic, and Spiritual Churches (the Seraphim and Cherubim)—all professing to be social havens for the unsuspecting city dwellers who are faced with unemployment and its associated social malaise. Christianity as a form of spiritual identification is so widespread in the city that the city's cultural and spiritual custodian, the Oba of Benin, also has a Church (the Holy Aruosa) specifically set up for him, his family members, and his chiefs.

The gravitas with which Christianity was regarded took a quantum leap in the early 1980s with the rise of one of the city's evangelists, Archbishop Benson Idahosa. His brand of Pentecostal Christianity in which freedom from “forces of darkness” was evidently displayed in the form of healing people from all sorts of diseases led to a surge of interest and conversion from traditional religions to Christianity. In addition, his promotion of the gospel of prosperity—that God desires all Christians to be wealthy and that faith is equal to prosperity (Spinks, 2003)—resonated with the populace of the city. This has resulted in the exponential growth of Christianity in the city, a now deeply embedded phenomenon. As observed by a participant in this study, everybody in Benin City professes to be Christian because it is a social shame to say in public that one is not, and this, according to Coakley (2012), is a situation capable of influencing the socio-political identity formation of people. It is crucial, therefore, to examine the discourse about HIV with a view to seeing how churches are used as a communicative space for HIV prevention in the city. In the next section, a discussion of the influence of religion on health communication is provided.

3. Religion and health communication

Religion influences social integration and people's worldviews because of its overwhelming effect on people's attitudes and behaviours (Mbiti, 1989). Woldehanna et al. (2005) stated that religion provides common values around which the diverse members of society uphold their togetherness. It is therefore necessary to look at HIV prevention within the communication space afforded by religions such as Christianity. Previous studies have focused on how to manipulate social effects, such as linking health behaviours to religion or using the norms of the faith as a source of positive or negative sanction. In this respect, Campbell et al. (1999) observed that accentuating feelings of religious pride or shame can encourage attitudes towards health practices. The study conducted by Woldehanna et al. (2005) revealed that faith-based organisations such as churches are potential instruments for HIV/AIDS prevention. Woldehanna et al. found that faith-based organisations provide useful social resources and commitment between scientific prevention efforts and socio-cultural contexts. In other words, churches enable an effective communication setting and location in which HIV/AIDS-awareness and -prevention messages can take place.

PLWHA, especially women, face people's judgmental attitudes because they are regarded as promiscuous or sex workers and thus deserving of their condition (Alubo et al. 2002; Wingood et al., 2007). While a judgmental attitude describes people's feeling towards PLWHA, Christianity's teaching of monogamy and abstinence from sexual intercourse is identified as a challenge for HIV/AIDS-health communication and intervention. In this respect, Trinitapoli (2009) concurred that abstinence from sexual intercourse and a monogamous relationship have a considerable chance of reducing vulnerability to HIV, but they have been cited as factors that could contribute to the spread of HIV because both counteract the use of protective measures such as condoms. A seeming advantage of religion, which is regarded as a disadvantage, is its facilitation of interpersonal networks that enhance the diffusion of HIV-related information but equally, is a network in which harmful

doctrine may hinder the spread of HIV information (Takyi, 2003). For example, several strategies of HIV prevention, which excludes prayer, may be characterised as unchristian by some religious leaders and therefore adoption of such strategies is tantamount to doubting the potency of prayer. This is true especially in a communication space where people have a habit of seeking succor from religion to make sense of unexpected health situations such as being infected with HIV and cancer. In such cases, prayer, faith in God, and other forms of religious practices have commonly been cited by people living with HIV and AIDS in African countries as coping strategies (Mokoae et al., 2008). In Uganda, the belief that prayer can cure HIV has also been cited as an inhibition to communication about other methods of HIV prevention. Although only a few participants in Wanyama et al.'s (2007) study held this belief, they pointed out in their study of ARV adherence in Uganda that PLWHAs discontinued their treatment because they believed that they had been cured after prayer.

In Nigeria, there is an incorrect assumption that has heightened the level of stigmatization of HIV/AIDS. In Benue State, Nigeria, due to incorrect information about the disease, PLWHA who passed on were not laid in state, not given the usual 7–14 days mourning period, and would be hurriedly buried (Alubo et al. 2002). The stigma also applied in the way family members of PLWHA would be isolated and rejected by the public (Muoghalu & Jegede, 2013). Likewise, Ucheaga and Hartwig (2010) study revealed that religious leaders used stigmatising remarks and messages that implied harsh punishment toward PLWHA. While the studies cited cannot be generalised to all states in Nigeria, the research revealed lack of awareness and incorrect assumptions among people and religious leaders.

The general low level of awareness and information deficit has been reported in both past and recent studies in Nigeria. Findings have revealed that religious leaders in Cross Rivers State do not actively promote HIV/AIDS education in their churches, particularly for the youth and that education of their church members needs to improve (Ucheaga & Hartwig, 2010). Another study about adolescents' perceptions in Benin City revealed a low level of awareness about HIV/AIDS and the cause of the disease, and many believe that the disease can be cured and prevented with drugs (Unuigbe & Osafu, 1999). Consistent with Unuigbe and Osafu's study is Aguwa's (2010) study; Aguwa reported that a decade after a notice was given about the occurrence of HIV/AIDS in Nigeria, many Nigerians did not demonstrate adequate HIV/AIDS knowledge, and there was an unacceptably high level of stigmatisation of AIDS. However, there is a shift regarding HIV/AIDS information; recent studies have shown a marked increase in HIV/AIDS' awareness and a willingness to undergo HIV tests among many students in a privately-owned university in Nigeria (Abiodun, Sotunsa, Ani, & Jaiyesimi, 2014). Most of the studies discussed in this section used quantitative approaches. The qualitative approach used in the current study is explained in detail in the following section.

4. Method

4.1. Participants

A total of 85 participants took part in the study, including 20 pastors and 65 church members and elders in different Pentecostal Churches in Benin City, Nigeria. The participants were between the ages 20 and 70, with an average age of 30 years. The sample of church members and elders was 60% males and 40% females. The sample of pastors was 12 males and 8 females. There are more males in the priesthood than females among Edo-speaking people; moreover, the fact that many female pastors were not comfortable with the subject matter contributed to their lower representation in the study.

One of the criteria used to select the participants was that church members and elders must be from the churches managed by the pastors represented in the study. The pastors were selected on the mutual understanding that they would allow their members to be interviewed. During the screening process, potential participants were informed that the subject matter for discussion would be their views about HIV prevention as represented in their Churches.

Data for the current study were gathered through 30–40 minute interviews with each of the participants. A few of the pastors requested to respond in writing because they were not always

available when the research assistants went to their churches to interview them. The research assistants had undergraduate degrees and experience in data collection using interview guides. Further training specific to this study was given.

Interviews that consisted of unstructured conversations with the participants (pastors, elders, and members) were audio-recorded and transcribed. Borg (2006) described interviews as verbal encounters with participants in a research context and suggested interviews are more appropriate for collecting data and examining phenomena than are other methods. In this study, an unstructured interview was used to conversationally engage participants for the purposes of gaining a comprehensive picture of their views in line with the purpose of the study. The main aim of the study was to discover participants' views as Christians about HIV prevention and how such views could be construed within the communicative space of their churches in order to plan HIV-communication interventions. Questions asked took into consideration the position of the participants in their churches. Hence, different interview guides were used for the different categories of participants. Some of the unstructured questions in the interview guides were the same; however, some questions put to the ordinary members were such that they were able to confirm and/or refute accounts given by their pastors and elders. The demographic information of the participants was collected in preliminary meetings before the interview process.

4.2. Procedure

Participants were interviewed on Sunday and Wednesday after church services. A few of the participants were interviewed in their homes. Because the interviews were audio-recorded, pseudonyms were used to identify the participants while the interviews proceeded. Consent forms were given to the participants to read and sign. This was after the purpose of the study was explained again in addition to what the participants were told in the preliminary meetings. Participants were told the study was anonymous and that they could withdraw from the study any time. Because the interviews were audio-recorded, the research assistants and researchers encouraged participants to use pseudonyms and not to mention their churches' names. In addition, participants were asked to seek clarity about any questions asked that were not clear to them.

Following the unstructured interview approach, participants were allowed to provide further information in addition to the responses they had given in order for them to delve deeper into what they felt were appropriate responses. At the conclusion of the interviews, participants were then provided with 300-naira phone recharge vouchers as a reward for participating in the study.

4.3. Data analysis

Audio-recorded transcripts were checked to ascertain their accuracy by the researcher and research assistants. Data analysis was guided by the framework analysis approach as explained by Srivastava and Thomson (2009) and Krueger and Casey (2000). The framework analysis approach is appropriate for analysing data collected through interviews because it allows the researcher to either analyze data during the collection process or after the data has been collected (Srivastava & Thomson, 2009). Thus, the analysis went through a five-step process suggested by Ritchie and Spencer (1994), which are familiarisation, identifying a thematic framework, indexing, charting, and mapping the interpretation. In other words, the analysis went through a process of identification and reporting patterns (themes) within data. Organising and transcribing interviews were followed by going through each individual participant's interview data systematically and identifying codes in the form of labelling words and phrases. To make the reporting of the data easy, these descriptive codes were put together to extract the themes used in the discussion of the findings.

5. Results

Findings in this study are discussed in this section as they relate to the themes used to organize the participants responses. To ensure anonymity of the participants and for ease of analysis and discussion, the participants were referred to by their positions in the church, and each of the participants cited was assigned a letter of the alphabet and a number. For example, the first pastor

cited was referred to as P1 and the second as P2, and this continued with mention of other pastors. The same applied to elders in the church, such as E1 and E2, and members of church, such as M1 and M2. The quotes or the voices of participants that best represented the essence of what the sample as a whole conveyed were used in the analysis.

5.1. Moral high ground

Most of the participants framed their responses to questions asked along the lines that the often-suggested HIV-prevention method, which is the use of a condom, is for “worldly people” and Christians who are in the world. In other words, the participants responses seemed to insinuate that there was no need to talk about HIV prevention because the disease was for unbelievers and Christians who do not adhere to the mores of Christianity. These participants argued that they are less apprehensive about HIV because being a Christian reduces the chances of being infected. A pastor (P1) whose response echoes this view commented as follows:

We are not overly concerned about HIV, let alone its prevention, as the programmes on TV and others are mostly on prostitutes or aberrant behaviours as the cause of HIV. These are not behaviours of Christians. This is not what we teach in our church. Christians need not fear HIV because a true believer will not do any of those things that will make them susceptible to it, and a true believer is covered in the blood of Jesus Christ. Yes, it will surprise me if true followers get HIV because the Bible is clear about sexual intercourse before marriage.

P1's response reveals that he does not use his church pulpit to reinforce the several HIV/AIDS-prevention strategies presented in mass media such as newspapers, radio and television. Instead of the pastor seeing the question of HIV and the consequences as social problems facing both Christians and non-Christians, he chose to take a moralistic stance that lays claim to the view that prostitutes are sinners and Christians are believers and righteous. To P1, HIV infects prostitutes and promiscuous people. Hence, he argued that Christians need not fear HIV. Similarly, an elder (E1) said it was not convenient to talk about HIV prevention in his church because that would amount to an admission that it was okay for members to indulge in sexual intercourse for pleasure. He said as follows:

It will be ridiculous to use the pulpit to discuss HIV prevention. When we start talking about HIV in the manner you have raised with our members, it means we are saying immorality is better and that sexual intercourse is cool outside marriage and before marriage. In fact, how do you leave from gospel message for such thing?

For E1, HIV is a product of an immoral act, and telling members of his church about HIV-prevention methods was antithetical to behaviour their members expect from them.

Several church members pointed out they had not heard about HIV and its preventive methods from their pastors or elders from their church, and no church's programme had been held for such purposes. Their arguments were consistent with their pastors' views because they felt HIV issues were not for the church to countenance. One of the responses that captured the views of some of the church members (M1) in this respect was as follows:

I think that our church does talk about HIV prevention in the sense that if you adhere to the message of righteousness and refrain from the worldly things the church condemns, you won't get HIV. So, what can be more preventive?

To these church members, the church preaching was a prevention strategy against HIV, and this view resonates in another church member's (M2) response: “The simple fact that you are not to indulge in sex before marriage and outside marriage is an HIV-prevention method.” M2's response clearly demonstrated her lack of knowledge about other routes of HIV infection besides unprotected sexual intercourse.

Some members were of the opinion that the church should not be used as communication space for HIV prevention. According to one of the members (M3): “I do not expect to hear the chattering of the streets in the church—it does not portray seriousness about the church’s purpose. Likewise, a participant (M4) said, “You hear about HIV prevention in schools and TV; I do not believe my church should be talking about sex ... for what reason?”

M3 and M4s’ responses are indicative of how HIV and the question of sex are perceived by churches. Their responses confirm a suggestion of shame and stigma associated with HIV and suggest that HIV is for the people in the secular space, such as schools and TV, and should not be tolerated because it would debase the church’s purpose.

From the excerpts above, some pastors, elders, and church members regarded HIV a consequence of a behaviour of sinners; hence, their responses articulated morals specific to their religious beliefs. However, not all pastors, elders, and church members had this holier than thou view, as can be seen in the responses of participants below who believe they have to lend their voices to existing messages about HIV prevention.

5.2. Complementary voices to the existing message and the need to reach out

Unlike the participants referred to above, some participants believed they had a role as Christians to complement available HIV-prevention measures because of their cardinal positions in the church and community. These participants know that pastors are central to the enduring influence religion has on people’s behaviour at both the individual and group levels (Oluduro, 2010; D. J. Smith, 2004), and some pastors admitted that they could influence the attitudes of their members through their church activities. For example, one of the pastors (P2) lauded the media representations of HIV messages, especially the emphasis on prevention (abstinence and faithfulness to partners) and stressed the fact that pastors have to complement media messages about HIV prevention to their respective communities. In his words, P2 said as follows:

Several facts about HIV accepted in the Western societies have not got acceptance in Nigeria, especially among our people in Benin City. The facts are that AIDS can kill anyone no matter who you are. We tell our members to condomise if they cannot control their urge to confine their sex needs to their territory. I am not just going to pretend that my members are not members of this same community that are affected by the push and pull of social vices—they are. We have to allow them to know the truth as I am particularly not given to seeing members suffering, let alone the type they have to go through as infected members. In the same vein, the church standing on abstinence and faithfulness to partners remains ... don’t get me wrong.

When pressed to explain what he meant about “confine their sex need to their territory,” P2 explained that Christians should learn to do things among themselves as Christians, and this also applies to seeking to marry a church member to escape the urge of sinning by fornication and decrease the chance of acquiring HIV. In addition to P2’s assertion, several other pastors maintained the view that Christianity is a daily response to social vices. Hence, they would offer their churches as a communicative space to explore the consequences of being infected with HIV by laying bare what HIV is and how it can be prevented. In this regard, a pastor (P3) said as follows:

I preach always about HIV and how members can prevent it. I drive home my message by citing prominent members who have succumbed to the disease. Christianity is about life, and I feel I have an obligation as a man of God to tell my members about the disease. I use media clips both from local and international media to support my message because seeing is believing. Above all, I emphasise a sinless life as an insurance against HIV.

Similarly, a pastor (P4) said there was an overwhelming evidence of HIV in her community and because it was not “business as usual,” she had to take steps which involve the following:

... making HIV issues front and centre of our preaching. We are lucky we have nurses, doctors and all caliber of people with good knowledge of HIV as members, and they were very helpful in spreading the message. However, the catalyst of our HIV message came when a member volunteered to step forward to declare she was HIV positive, and she detailed the daily struggle she had to put up with as a sufferer. The member had since died, but her pain and exit from this world left a lasting change in our members. I have not seen or heard of a member with the disease after the death this member. If there is one, we will beat the disease with prayer and resources available for treatment.

P4 further pointed out that she felt an obligation to talk about HIV prevention in her constituencies across the city because many young girls were taking up prostitution as an occupation in European cities, and these girls would return to the city to spread the disease to unsuspecting young boys. She (P4) further added the following:

We do this by evangelising in the communities, and I tell you any gospel message that does not include how to deal with how HIV spreads across communities and from Europe to Africa and from Africa to Europe and America is incomplete.

An elder (E2) of a church recounted a personal experience of HIV in his family, pointing out that it took him and his family members by surprise because it (HIV) struck a family member who they thought was not vulnerable. He did not elaborate further why this family member was not considered vulnerable, but his revelation that the family member was a married man gave an indication surrounding the use of the words “not vulnerable.” E2 narrated that his family’s experience was a culture shock in his church and had hitherto defined the church’s view about HIV, so much so that the church now has:

... a social affairs department headed by a youth because HIV is more of a youth issue, even though we recognize it doesn’t recognize age and status. We capacitate the social affairs department with appropriate communication materials to drive knowledge about HIV, especially how it is prevented, stressing sin of fornication as one major factor.

The accounts of P4 and E2 resulted in significant knowledge about HIV born out of their experience. Their accounts also reveal why HIV disclosure is important: It enables concerned friends and family to roll out resources to mitigate the effect of the disease, and it provides a case study for preventive measures. This has been acknowledged in a previous study by Waddell and Messeri (2006), who asserted that disclosure helps to improve knowledge about HIV, especially its diagnosis and treatment.

Linked to the data above were participants who felt that HIV is a social problem and that there is a need to reach out to those infected. The findings show that many pastors see their work as a calling to reach out to all, Christians and non-Christians. To pastors and elders in this category, Christianity is about showing compassion to those facing difficulties. According to one of the pastors (P5), the church should be seen as a “solution provider to social problems.” In support of P5’s assertion, a pastor (P6) said, “We are for those who are called and not called and even those not deserving our presence.”

P6 went further to quote the book of Matthew in which was cited an example of how Jesus Christ reached out to people in need, citing how He (Jesus) touched a leper and his leprosy disappeared (Mathew 8:2–3). P6’s reference to a leper highlights how Christians refer to people afflicted with diseases as “other” and therefore not deserving of their attention as pastors. This view was in sharp contrast to P5, who said the church should face the challenges faced by Christians and non-Christians alike, and P6, who believed the church was being magnanimous for reaching out to others not deserving of their presence. The leper-affected person touched by Jesus Christ was seen as not worthy of Jesus Christ’s presence, let alone having bodily contact with him. Hence, the reference to the leper-affected person was used as an example of how Christians should reach out to all.

The participants agreed that reaching out to people informs their church's objectives, and this was manifested in the way pastors talked about HIV prevention. Members responses to the unstructured questions were consistent with the pastors' responses. One elder (E3) said as follows:

Compassion is our goal in our relationship to all, including people with HIV. Besides, we do go to people in the streets, spots where we are likely to see prostitutes and social gatherings, to raise awareness about HIV. A few years ago, I knew of an HIV sufferer who I led to God, and he got saved. I am not sure of what has become of him as he relocated out of this city, but he looked healthier before he left because of the support the church gave him.

Due to the need to reach out, a pastor (P7) narrated a practice in his church where public health experts who were not members of his church were used to develop approaches for HIV prevention, especially during casual sex. He said the approaches emphasised the use of condoms during casual sex, and for P7, all sexual relationships before marriage, whether long-term or otherwise, are casual sex.

In addition, some of the participants were very upbeat and saw HIV/AIDS as occurring within some specific social contexts. They were very consistent in their views that Christians should worry less about being infected with HIV/AIDS but were also unanimous in admitting the fact that pre-marital sexual intercourse is a social phenomenon that has evolved over time such that it is being seen much less as sin but as the height of expression of love by heterosexual people. Thus, sexual intercourse is couched as an expression of love and not an act of sin. However, participants warned that it is important that members take a preventive attitude towards sexual intercourse so that they do not end up being infected with HIV. Participants also said that their pastors have always warned them to remain committed to their wives or husbands, to remain chaste until they marry, or to use a condom if they have to engage in sex. Following this view, a participant's (M5) argument goes as follows:

Make no mistake, HIV is real; it is one of the worst social problems of our time. Being a Christian, I am not worried about it, but that is equal to not facing its threat honestly. I am single—I have it as my responsibility to reach out to brothers and sisters to seek preventive measures if they fall into immoral sexual desire. God willing, among brothers in this church or churches elsewhere is my future husband. I will hate it after professing love to a guy to later discover he has HIV. My church requires that people must get tested before marriage.

M5's view captured the view of many young and educated members of churches interviewed. One member (M6) said, "I strive to live a clean life, but I am a human being who goes with the trend of the society." Generally, the pastors and the elders agreed that HIV is a social challenge and that parents are not comfortable discussing it with their children. Hence, the church has to talk about preventive measures even though they believe Christians should care less about HIV.

5.3. Tacit approval of men's resistance to condom use

As revealed by the data collected, some pastors, elders, and members of churches approved of men's resistance to the use of the condom. Some pastors said they would not advocate the use of condoms by married men as they believe it should not be an issue to countenance for married couples, especially Christian married couples. According to a pastor (P8):

Men and women get married to leave many issues behind and settle down as Christians. As a pastor, I advise my members that if they cannot bear the heat of remaining single and chaste, they should get married. It becomes unethical to advise such people to use condoms.

However, P8 was not able to explain what she would do when lady members of her church express feelings that their husbands are not faithful to them and they would like their husband to use a condom until a test proves otherwise. In response to this concern, P8 argued for a message consistency, saying as follows:

When I advise my members to marry because I felt marriage is a pathway out of HIV challenge, I should not be the one also telling them to do what I tell the unmarried members of my church to do—that is, they have to use condoms to prevent HIV.

Of importance in P8's response is the need to send out consistent messages to her church's members. The pastor did not deny that there may be circumstances in which the sanctity of marriage might be violated by one of the couples, but it appears to her that it was odd advising a man to use a condom after he had taken step away from a worldly life to embrace a Christian's prescribed, ideal situation, which requires a man to marry and settle down.

The Christian's world is portrayed as infallible. Thus, people who project themselves as Christians want to wear the mask of a flawless personality as opposed to those who are not Christians. This view pertains to why some men use their religion to justify their refusal to use condom. A member (M7) of a church said:

I cannot not go to the local shops to buy condoms because I am well-known in the community. I should not be doing things that will make the shopkeepers to question my belief as a Christian, let alone a married Christian. Indeed, the shopkeepers would be surprised as to why I have come to buy condoms because to them, only unmarried men use condoms.

M7's response echoed P8's view to some extent in that both do not think it is necessary for a married man to use condoms. However, a member (M8) argued that the use of a condom by married men needs to gain traction among Christians while also declaring as follows:

Sincerely, this is an open fact, but you know Christianity has a culture of looking at the other side in favor of what is thought to be the ideal thing. We know most married men - and some are Christians—do infect their wives. I have not seen this pointed out in the church, let alone indicating the context to explain why men should use condoms. This needs to change.

Although M8 agreed on the context in which men have to use condoms, her metaphor of “the ideal thing” bears similarity to P8's argument for consistency. In other words, M8 and P8's views suggest that it is imperative to encourage church members toward the ideal life of marriage relationship in order to be less worried about HIV infection. They are both projecting Christianity and marriage as the ideal way of life, much like the external appearance of Christians that looks like they are really observing the principles and teachings of the Bible but in actual fact, are also admitting that although there could be people not living to these standards, for the sake of consistency, they have to project one view.

5.4. Divine punishment and homophobic view

The view that HIV is a divine punishment to those who have sinned by ways of fornication, homosexuality, and adultery are still prevalent among a significant percentage of the participants in this study. To these participants, behavioural activities resulting in HIV are uncharacteristic of Christians. Thus, HIV evokes a feeling of bad behaviour among these participants. Several pastors and elders stated that their messages about HIV should be seen through the dividing line of a sinner and a righteous person. They argued that a Christian who fornicates or commits adultery will receive divine punishment in the form of HIV. To these pastors and elders, a view such as this communicated through their pulpits is a HIV-prevention message. In this regard, a pastor (P9) said, “What can be better than letting members know that their behaviours in the darkness will surely be exposed by daylight by God. I think this is an HIV-prevention strategy.”

A participant (M9) said even though she was worried about HIV, she took solace in the fact that “there is no hiding place for the wicked” apparently referring to her partner or men who are promiscuous and this view got a nod from two other women participants, one (M10) of whom said, “HIV/AIDS is used to fish out those who cannot remain faithful to their partners, and I pity the young ones who cannot remain pure before they get married.”

Most of the participants also saw HIV as a problem of homosexuals. A common argument among the participants was that HIV originated from homosexual acts and that a greater percentage of them (homosexuals) have the virus. To this, a pastor (P10) said he was not very worried about the HIV virus because there were no homosexual people in his Church, not that he would allow them anyway. He said for homosexuals, the punishment was clear, referring to the Bible as follows:

And the men, instead of having normal sexual relationships with women, burned with lust for each other. Men did shameful things with other men and, as a result, suffered within themselves the penalty they so richly deserved (Romans 1:27).

P10's argument and reference to the Bible is homophobic and tantamount to divine justification by citing a Biblical text such as "suffered within themselves the penalty they so richly deserved" (Romans 1:27).

In line with this view, many pastors and elders said they offered a space for their members to engage with the consequences of HIV, stressing that in their preaching, they pointed out that God sees whatever his children do on earth, and He can punish them for the wrong in which they indulge. Members of churches expressed the divine punishment metaphor either directly or by implying it. For example, an elder (E4), who responded through emails in addition to a face-to-face interview, justified her argument for divine punishment with the following books and chapters in the Bible, saying, "The Old Testament contains many references to plague and pestilential disease, often in the context of divine wrath and punishment (Gen. 12:17; Lev. 26:6, 26:21; Num. 8:19, 11:33)".

Another participant (M11) emphasised that among many things about which God's patience is not to be tested is the question of sex, especially when people do not follow the doctrinal recommendations in the Bible. He referred to the book of Exodus, for example, where God admonished his children that, "For now, I will stretch out my hand, that I may smite thee and thy people with pestilence (Exodus 9:15)".

The participants' views in this section are akin to the moralistic stance expressed in the previous sections. However, participants in this section resorted to divine justification in referring to HIV as a consequence of behaviours uncharacteristic of Christians. They also supported the homophobic view portrayed by P1. The following section discusses other communication platforms used by the participants in portraying their views about HIV prevention.

5.5. Low-key presence of HIV in other communication platforms used by church

Following the perceptions of church leaders and their members, there was a need to find out other communication platforms used by the church besides the pulpit or face-to-face communication with their members and the community. Analysis revealed that most of the churches have newsletters and social media (Twitter and Facebook), and some have TV presences, but these are used solely for evangelism and church-related works, not to spread HIV/AIDS messages. HIV/AIDS did not feature as a part of the evangelical message except in two churches where HIV/AIDS was cited in a newsletter as a consequence of immorality. Social and community problems, such as marriage breakup, unemployment, crimes, and diseases including HIV, were featured in several communication channels used by churches as examples of what the church could do to set people free from the problems mentioned. Particularly, HIV/AIDS was mentioned in most of the communication channels used by the churches as one of the diseases they could deliver nonbelievers from if they became Christians. In other words, HIV/AIDS was a good rallying cry for the pastors to convince unbelievers to attend their church programmes, such as open-air deliverance services and normal church services. In the use of these communication channels, no mention was made about how HIV/AIDS can be prevented; not even the church-preferred advice of abstinence from sex is mentioned in these communication channels.

The zest with which HIV/AIDS was mentioned in the communication channels such as television and radio appearances was not matched in the normal church services or programmes. As narrated by a member (M12):

... the television is a sort of advertisement for what the church can do for people who are not believers and are sinners. The fact that they come in to the church and less is said about HIV or its prevention doesn't mean it [HIV] is forgotten. Remember, once you accept Christ and surrender your plights to him, He will deal with them as you have requested in prayer. So, the pastor's purpose is to lead you to Christ and to always emphasise what Christ can do so that you on your own can take up the initiative to tell Him your personal problem.

The assertion by M12 reflects the general views of the pastors and elders regarding the use of communication to reach non-believers, and it perfectly squares with the view that has been expressed openly and implicitly across the findings discussed: HIV/AIDS is an affliction of non-Christians. M12 also portrayed the deeply held view that Christianity is an individual relationship with God and is consistent with Cohen, Wu, and Miller (2016) assertion that religion is a personal matter, and through it, one's personal faith is expressed in his or her relationship with God. In addition, many Christians take a theological position that salvation is personal. In this light, the pastors and the church authorities do not see the need to use the several channels of communication at their disposal for an HIV-prevention message because, given M12's account, once the non-believers are led to God, it becomes their personal initiative to communicate with God themselves. In other words, how a Christian uses his/her salvation to deal with his/her personal plight such as HIV is his/her personal choice. M12's response is also consistent with other members' (M1 and M2) arguments that acceptance of Christ or being a Christian is itself an HIV-prevention measure because as a Christian, one is not expected to engage in behaviour that will make one vulnerable to HIV.

6. Discussion and implications for practice

The aim of this study was to examine how Christian leaders and their members in Benin City perceive HIV prevention and whether their perceptions influence communication about the different options of HIV prevention to their members in order to suggest possible HIV-communication strategies. The data elicited from pastors, elders and church members provided a mixture of views about the participants' perceptions of HIV prevention in Benin City.

The responses from participants showed a tendency to moralize views about HIV prevention. Most participants are of the view that HIV is for people who they regard as sinners, such as prostitutes and homosexuals. This view is typical of some Christians who habitually take a moral perspective to issue about life, and this applies to how they perceive a disease such as HIV. Hence Jonsen and Stryker (1993) remarked that epidemic diseases regularly arouse a moral response among Christians because they blame a sinful way of life and prescribe repentance as a solution. In this regard, the findings are consistent with Muoghalu and Jegede (2013) study in which the participants indicated that HIV/AIDS afflicts immoral people.

With HIV being viewed as a consequence of immoral behaviour, some of the participants argued that the Church should not give a communication platform for HIV prevention because such communication is a "chattering of the streets" that should not be entertained if the church wants to be taken seriously. In addition, pastors, members, and elders who were very positive and seemed well-informed about HIV/AIDS were unanimous in their views that being a Christian insulates one from HIV infection. Indeed, the views expressed by these participants are essentially a theological position of some churches regarding the implication of sexual intercourse before marriage and outside marriage, and because of the moral spin to the views, it makes the church an agent of stigmatization toward PLWHA (Zou et al., 2009).

Much of what is implied in the responses provided by the participants is an allegory of being a good Christian as a buffer against HIV. Thus, for a real Christian, the chances of being infected with HIV, as repeatedly advanced in the analysis of the findings, is less. However, this is a very

simplistic way of tackling the challenges of HIV because unprotected sexual intercourse, which is one of the commonest modes of HIV infection, represents a metaphor of two individuals' amorous desire under a normal situation. In this light, because all the participants' perceptions of HIV infection pointed to sexual intercourse as an infection route, it may also take a good Christian and pseudo-Christian to engage in sexual intercourse to acquire HIV because the pseudo-Christian may be a route to infection for the real Christian. Because the pseudo-Christian is someone that is only imagined and difficult to point out because of the complexity of human behaviour, the view that real Christians should be less worried about HIV is not accurate.

Another important consideration worthy of discussion is the question of Christian principles over the reality on the ground. For example, some pastors maintained that they would not advise married men to use condoms because married couples should ideally not be worried about HIV. For these pastors, this is considered as the ideal view to project in the Church in order not to sound inconsistent in their communication with their members. In other words, the pastors argued that because marriage is the preferred relationship between a man and a woman and that they have always suggested it to their members to leave the life of fornication in order to prevent exposure to infection of HIV, it would be ridiculous and inconsistent if they advised married couples to use condoms. To these pastors, HIV is not a burning issue to married people, but they are not taking into consideration that there might be a need to control the spread of HIV from an infected partner as indicated in the line of questioning to the participants.

Evidently posited in the findings is the view that HIV is a divine punishment to those who are infected with the disease because they have sinned. This is another aspect of the findings that revealed what some Christians use to characterise what befalls sinners. HIV is used as a negative selling point to non-believers to embrace Christianity. The sinners in this case are the gay and lesbian people whose sexual orientation is considered immoral. Like all sins in the Bible, there is a punishment, and it is HIV, as repeatedly suggested by some of the participants. Reference to the chapters and verses in the Bible showed the degree to which some Christian participants in this study believe that divine punishment is in agreement with their religion. Previous studies have also alluded to similar findings. Aniebue (2006) noted that the Nigerian clergy are unanimous in attributing HIV/AIDS to a divine punishment from God and to the activities of demonic forces. Likewise, a study by Zou et al. (2009) revealed that in Tanzania, shame-related HIV stigma was strongly associated with religious beliefs of divine punishment and that HIV/AIDS sufferers are disobedient to words of God. Equating HIV to a disease of sinners or a punishment orchestrated by God to punish sinners can only be done because of the misapprehension about the social and biological contexts of the disease. It reflects a deep-seated attitude that provides a pretext to religiously condemn certain means of HIV prevention as well as certain individuals and group behaviours (Green, 2001). It is a view that has been roundly condemned by scholars because of its potential to result in a fatalistic attitude (Zou et al., 2009) that makes people frown upon HIV treatment (Hess & McKinney, 2007).

As can be seen from the findings, some of the participants' responses were negative; they chose to take a moral stance that does not advance the cause of HIV prevention. Some of the negative views cast aspersions on the homosexuals as the cause of HIV, even when there are reports that HIV infection rate in men who have sex with men has dropped significantly (See Nir, 2017). The participants (for example, pastors) are key influences in their communities, and this means their erroneous views that seek to blame some members of their communities because of their sexual orientation needs to be called out to minimize misinformation in their constituencies. There is nothing as dangerous as having people who influence opinion from a misinformed premise. The implication is that as religious leaders, they need more information about HIV/AIDS so that they can educate those in their respective religious communities. The use of pastors and religious leaders as an effective communication tool has been cited in past studies. For instance, religious leaders in Malawi, according to Trinitapoli (2011), effectively promote primary behaviour change, such as abstinence and faithfulness to partners, as strategies for HIV prevention.

Notably, a positive result from this study was that some pastors were open and were communicating about HIV prevention in their churches. It means there is a possibility that pastors could be persuaded to go beyond their main responsibilities to take up health promotion activities such as HIV-prevention awareness. For communication effectiveness, and given that several studies (Djupe & Gilbert, 2002; Edwards, 2016; Oluduro, 2010; G. A. Smith, 2005) have attested to the fact that religious leaders have the power to influence behaviours and raise awareness, they (religious leaders) should be involved in the planning and design of HIV/AIDS-communication interventions in their communities. The involvement of Christian religious leaders in HIV communication would enable a mutual examination of how the traditional church practices of preaching and prayer can be integrated in communication to achieve the objective of HIV prevention. This is evident in Green's (2001) study where some HIV/AIDS sufferers reported that prayer gave them hope, and others claimed that prayer made them adhere to their medication routine. Such a communication approach could be used to explore how best the church can promote their favored HIV-prevention methods of abstinence and no sex before marriage without negating other HIV-prevention methods such as condoms.

With regard to the stigmatization of HIV, which was apparent in some of the participants' responses, pastors and their church members can be used to tackle shame-related HIV stigma in their churches. Stigmatisation in any form is usually from an ill-informed premise, but the passion with which the participants advanced their arguments means if they are given the right information about HIV, they would equally be potent forces against HIV stigma. They would therefore be able to help their communities cope with the challenges of HIV.

Given that there were participants who were of the opinion that acceptance of Christ was a better form of HIV prevention, and some pastors claimed they could cure HIV with prayer, it is imperative to understand what factors motivate their reasoning. Participants who believe that acceptance of Christ is better than any available HIV-prevention strategy are directly articulating that religious activities, such as prayers and fasting, can cure HIV. The same also applies to pastors who claimed they could cure HIV as shown in the advertisement of their churches or during their outreach programmes designed to convince unbelievers to be Christians. There is a possibility that these participants lack basic knowledge about HIV and the available prevention strategies. Although some of the participants in this study were clearly well-informed about HIV, a possible reason for those participants who showed little or no knowledge about HIV might be because Nigeria has not made any significant progress in raising awareness about HIV, and this extends to city level in the case of Benin City. One of the church members who echoed this lack of HIV awareness in Nigeria said, "I cannot claim knowledge of any government department or agency saddled with responsibility of disseminating HIV messages. The little we know comes through non-government organisations".

The doubt about the existence of HIV by some members reveals the dire state of awareness campaign by the city government. It also speaks of the urgent needs for an awareness communication campaign focusing in part on testimonials from PLWHA to drive home the reality of the disease in the community to those who seem to be doubting the seriousness of the disease. In this regard, Olaore and Olaore (2014) suggested that healthcare providers should have unfettered access to accurate and updated information about the modes of transmission and prevention so that they can equip other stakeholders, such as the pastors, who are vital agents of change in the community. Moreover, an approach that will properly articulate and explain the contexts surrounding HIV infection and prevention is required in the education of some the pastors and their church members, given the low levels of awareness revealed in the findings of this study. Principles of good communication, including clarity, empathy, and community engagement, have helped many HIV programmes to mitigate health crises. For the purpose of narrowing the information deficit for the pastors, the aforementioned principles of good communication are necessary. Equally, as suggested by Francis and Liverpool (2009), faith-based leaders could provide a platform for HIV prevention strategies because they are regarded as credible source of information. Hence, it is

necessary for secular organisations such as non-profit organisations, government agencies and others to provide resources to church's leaders to communicate HIV prevention strategies in Christian setting (Francis & Liverpool, 2009).

The originality of this study is that it has shown the likely perspectives with which to approach communication intervention for Christians as a target audience. Given the moralistic stance taken by the participants in this study, communication intervention could be used to emphasise that morality should not be taken as an objective fact that applies to all people without leaving room for tolerance of others, such as homosexuals, that were vilified in the participants' responses. Put differently, it means any moral stance that negates a solution to problems of social living such as HIV deserves to be challenged by planners of HIV-communication intervention. This is because HIV is seen as a product of individual action. Combatting HIV requires a way of thinking that moves from individual to collective action. Thus, the responsibility to address HIV prevention should be a shared effort, rather than an individual effort; the shared effort should be given a prominent place by pastors and their members because of their positions in the social sphere of the city in which this study is based.

Dispelling the myths that informed participants' views about sin and HIV would help communication interventionists to use the church as a communication space because pastors have community credibility (Francis & Liverpool, 2009) or are regarded as paragons of moral values in their communities. Thus, the pastors could be counted on to offer one-to-one and one-to-many targeted forms of communication to their members and the communities' members because information from them will be trusted.

7. Limitations of the study

Some of the participants responded to the questions asked in the presence of their pastors. This may have introduced bias in the responses. Attempts were made to minimise this bias by telling the participants to feel free to respond to the questions as they deemed fit and having the pastors to assure the participants that their responses must be honest and genuine.

The sheer number of churches with different approaches to spiritual matters meant that participants' responses to the interviews could not project a common perception with respect to HIV prevention. As such, no claims are made to the generalisation of the results. In addition, this study only focused on the Pentecostal Churches. As members of Catholic and spiritual Churches were not participants in this study, the finding cannot be generalized to all Christians.

However, it is hoped this study has provided different perspectives about how to approach communication intervention, especially when the target audience is a religious community. It needs to be pointed out that Pentecostal Churches have a dominant presence in Benin City and other cities where Christianity is the dominant religion in Nigeria. The findings therefore can be generally extrapolated to Pentecostal Churches in Nigeria. The method used to collect data was another strength of the study. Using the unstructured interview approach, participants were able to respond to the questions asked freely, and the approach also allowed probing for more clarity and capturing some importance nuances motivating the responses given. In addition, the fact that some of the findings presented in the current study are consistent with others in the literature also suggests some degree of confirmability. Hence, the study warrants consideration in future HIV communication targeting church leaders and their members.

8. Conclusion

This study has revealed mixed views on the part of Christians in Benin City. The dominant view is one that revolves around morality as a basis with which to approach HIV prevention. In this regard, this study emphasised an implication for practice by locating what a morality stance by some Christians may mean for HIV prevention in Benin City.

The study provides a ground for developing health communication intervention practices using one of the key community influencers such as pastors to reach communities. The increasing emphasis on planning and designing communication with community members suggests the importance of developing a meaningful communication practice in order to best understand the ways in which the community may be mobilized against diseases such as HIV. The findings of this study have clearly indicated the views of Christians that could be tapped into when considering HIV communication in the city studied, as well as cities with significant Christian religion presence in Nigeria. Thus, the examination of Christian religious leaders and their members' perceptions of HIV in this study will help with understanding how Christian health communication may be planned, especially how such communication may impact the attitudes and behaviours of the target audience.

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