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Gender, religious involvement, and HIV/AIDS prevention in Mozambique

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Abstract

Using survey and semi-structured interview data collected in various religious congregations in urban and rural areas of Mozambique, this study analyzes how gender differences in perceptions of HIV/AIDS and preventive behavior are mediated by religious involvement. Logistic regression is employed to examine the effects of gender and of the interactions between gender and type of denomination—"mainline" (Catholic and Presbyterian) or "healing" (Assembly of God, Zionist, and Apostolic)—on female and male members' exposure to HIV/AIDS-related prevention messages, knowledge and perception of risks, and practice of prevention. The analysis detects women's disadvantage on several measures of knowledge and prevention but also suggests that gender differences are less pronounced among members of "mainline" churches. The semi-structured interview data further highlight how gender differences are shaped in different religious environments. Although the potential of faith-based institutions in combating the HIV/AIDS pandemic is undeniable, policy-makers need to heed important differences among these institutions when devising ways to harness this potential.

Keywords: HIV/AIDS prevention; Religion; Gender; Mozambique; Sub-Saharan Africa

Introduction

The literature on gender differences in HIV/AIDS-related knowledge, attitudes, and preventive behavior in sub-Saharan Africa typically notes women's informational disadvantage and disproportionate vulnerability to infection (e.g., Adetunji & Meekers, 2001; Bassett & Sherman, 1994; Frasca, 2003; Haram, 1996; Susser & Stein, 2000; Turmen, 2003). Yet seldom do researchers and policy-makers scrutinize specific contexts in which these differences are shaped and manifested. My study examines how gender differences in HIV/AIDS views and prevention choices are mediated through membership and participation in religious organizations. While in dialog with the literature on gender and HIV/AIDS prevention, this study also expands on the small but growing body of literature pointing to religious differences in HIV/AIDS-related attitudinal and behavioral outcomes throughout sub-Saharan Africa and in other regions. This literature typically argues that religion and religiosity may discourage risky behavior and therefore serve as a barrier to HIV infection (Green, 2003; Gruenais, 1999; Lagarde et al., 2000; Takyi, 2003). Several studies, for example, have examined differences between more and less conservative Christian denominations, usually concluding that adherents of Pentecostal-type churches are less likely than members of other

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denominations to engage in non-marital sex (Garner, 2000; Gregson, Zhuwau, Anderson, & Chandiwana, 1999; Hill, Cleland, & Ali, 2004).

The importance of triangulating gender, religion, and HIV/AIDS risks and prevention, as proposed in this study, is underscored by high levels of religiosity and religious involvement, particularly among women, in sub-Saharan Africa (Agadjanian, 1999a; Gifford, 1994, 1998; Jenkins, 2002). The literature on religious dynamics in the sub-continent suggests three interrelated assumptions for my study: first, religious beliefs and involvement in the sub-Saharan context are central to the social construction of wellness and health risks; second, this role of religion is gendered; and third, specific configurations of gendered views and choices are predicated on characteristics of religious institutions involved.

This study focuses on Mozambique, a country of some 19 millions in southeastern Africa, where the most recent official estimate of adult seroprevalence is 15% (Mozambique, 2004). Yet although HIV/AIDS has established itself in Mozambique as a major public health concern and a prominent topic of public discourse and policy, individuals' practical encounters with confirmed cases of the disease remain relatively rare and popular perceptions and informal communication regarding HIV/AIDS are still characterized by considerable uncertainty, ambivalence, and stigmatization (Agadjanian, 2002).

Conceptualization

This study contrasts women's and men's views and behavioral choices regarding HIV/AIDS and examines how these gendered views and choices vary across two types of religious denominations—long-established, "mainline" churches, such as the Roman Catholic and Presbyterian churches, on the one hand, and smaller yet numerous and rapidly growing newer, Pentecostal-type churches—such as Zionist, Apostolic, and the Assembly of God. Although the latter group may be even more diverse in organizational and doctrinal terms than the former, the denominations included in it share a strong emphasis on divine cure of physical ailments and social misfortunes (Agadjanian, 1999b). Not surprisingly, healing churches attract many poor and otherwise socially disadvantaged people, especially women (Agadjanian, 1999a, b; Pfeiffer, 2002). At the same time, both types of denominations, like most religious institutions across the world, stress the importance of family values and related moral and behavioral standards in their social teachings.

The theoretical premises of this study are adapted from an earlier analysis of religion and fertility behavior (Agadjanian, 2001), which in turn arose from two research traditions—first, the literature on the place of value systems in demographic change (e.g., Lesthaeghe, 1983; Lesthaeghe & Wilson, 1986; Simons, 1982, 1999) and second, studies of the role of social interaction in demographic, primarily fertility-related, behavior (e.g., Agadjanian, in press; Rogers, 1995; Rogers & Kincaid, 1981; Rutenberg & Watkins, 1997). My study (Agadjanian, 2001) argued that the spread of fertility control in low-contraception societies is influenced, among other factors, by the social settings in which women spend much of their lives and in which reproductive knowledge and preferences are exchanged, discussed, and reevaluated. The religious congregation, with its numerous and frequent activities, figures prominently among such settings, especially given the generally high degree of religious involvement among sub-Saharan women. My analysis showed, however, that even though all churches' "official" teachings and pronouncements on family, gender, and childbearing matters do not vary greatly, different types of churches create different types of environments for the spread of such technological and cultural innovations as contraception. I found that the relative social diversity, doctrinal and organizational openness, and political connections with the secular authorities and institutions that are characteristic of mainline denominations result in greater exposure of their members to reproductive and contraceptive innovations, compared to members of the generally more homogenous, inward-looking, and politically marginalized Pentecostal-type (healing) churches.

Elaborating on the findings of that study as well as on insights from my other related research (Agadjanian, 1999a, b), I propose here that while both types of denominations advocate premarital abstinence and marital fidelity as preferred forms of HIV/AIDS prevention, the ideological, organizational, and political differences between the two types of churches have important implications for HIV/AIDS-related views and prevention practices. Thus, the greater doctrinal and organizational openness and social diversity of mainline churches, which was detected in earlier research, should allow for greater cognitive flexibility and behavioral choices, relative to Pentecostal-type churches, and as a result, greater receptivity of the secular prevention messages, even if such messages contradict the church official teachings, especially those concerning condom use. This tendency may be further reinforced by mainline churches' historically strong political connections with the local secular establishment. While this tendency is not expected to efface completely the gender differences in HIV/AIDS-related views and behavior within mainline churches, it should lead to de facto more egalitarian gender relations (even if not more egalitarian official gender ideology) and reduce women's disadvantage in access to information and the ability to practice prevention—at least in comparison with

Pentecostal-type churches. In the analysis below, I test this conceptual model both directly and indirectly using a combination of quantitative and qualitative data from Mozambique.

Data and methods

The data for this study come from a survey and semi-structured interviews carried out in 2003 among religious congregations in peri-urban areas of Maputo, Mozambique's capital, and in Chibuto, a predominantly rural district some 200 km north of Maputo. Despite the stark socioeconomic contrast between the two areas, both are part of the same Tsonga (Shangana-Ronga) ethnocultural region and are historically knit together through rural–urban migration. In addition, both areas are similar in types of predominant religious denominations (the main exception being Islam, which is much less widespread in Chibuto than in the capital). Finally, the two areas have rather similar adult HIV prevalence estimates of around 16–17% (Mozambique, 2004).

The survey sample included 731 respondents, a roughly equal number of men and women, participating in the following religious denominations: Roman Catholic, Presbyterian, Zionist, the Assembly of God, Apostolic, and Islam (only in Maputo). The choice of these denominations, or types of churches, was driven by their demographic presence in both areas. Both the selection of specific congregations within these denominations and the selection of respondents within each congregation were probability-based (although specific sampling techniques varied depending on the congregation size and circumstances). Because women typically outnumber men among churchgoers, especially in Zionist churches, we had to oversample Zionist congregations to achieve the desired gender balance. The survey questionnaire, administered in Portuguese or Tsonga, contained questions on HIV/AIDS-related views and behaviors, informal exchanges and negotiations of HIV/AIDS-related information, as well as on perceptions of gender roles, on religious participation, and on sociodemographic characteristics.

Approximately 8% of the survey respondents also participated in short semi-structured interviews that followed the survey interviews and were designed to give the selected respondents an opportunity both to elaborate on their responses to survey questions and to address additional relevant topics. Specifically, the semi-structured interviews explored informants' own experiences in dealing with risks of HIV/AIDS infections, their assessments of different prevention strategies, and their views on the role of faith and church in HIV/AIDS prevention.

Only members of Christian denominations are included in this analysis (the tiny subsample of Maputo Muslims is excluded). The Roman Catholic and Presbyterian congregations constitute the "mainline churches" category; members of Zionist, Apostolic, and Assembly of God churches make up the Pentecostal or "healing" churches category. (Only 12% of Catholics and 8% of Presbyterians answered affirmatively to the question on whether in their churches illnesses were being cured. In contrast, the share of positive responses to this question ranged from 70% among the Assembly of God members to 90% among Zionists.) The healing churches' emphasis on miraculous cure through direct interaction with the Holy Spirit does not only define their raison d'être but also imprints many of their organizational and procedural aspects as well as most of their social activities. Although the differences between the two types of churches are strong and pervasive, preliminary explorations of the data and my extensive field observations also point to considerable similarities in how most churches, mainline and healing alike, articulate their official positions on matters of gender, family, sex, and reproduction.

My analysis focuses on selected KABP-type HIV/AIDS indicators, such as exposure to HIV/AIDS-related messages (both inside and outside the church), basic general knowledge about HIV/AIDS, practical encounters with AIDS, perception of individual risks of infection, level of worries about getting infected, and main forms of practiced HIV/AIDS prevention (spontaneously reported). I first examine the bivariate distributions of the outcomes of interest and then present and discuss the results of multivariate tests for key outcomes. The knowledge and attitude outcomes are operationalized as dichotomies, whereas practice of prevention is operationalized as a trichotomy (no prevention practiced, use of condoms, or use of other forms of prevention). Logistic regression for dichotomous and polytomous outcomes, respectively, is employed for multivariate analysis. Besides the main predictors of interest—gender and the type of denomination—the multivariate tests also include age/generation (under 30 vs. 30 years or older), area of residence (Maputo or Chibuto), marital status (currently in union or not), educational level (less than completed primary education vs. completed primary or more), a simple index of material status (constructed on the basis of household ownership of a radio, a TV set, a motorcycle, and a car), and frequency of church attendance (once or twice a week vs. three times or more) as control variables. The models predicting HIV/AIDS-related knowledge, attitudes, and prevention behavior also control for exposure to formal HIV/AIDS education. In addition, the prevention practice model controls for respondent's worries about getting infected. Because some of the survey respondents were drawn from the same congregations and therefore may share some unobserved characteristics, I obtain conservative, robust

standard error estimates (by using the Huber/White/Sandwich estimator) to reduce the bias that might result from observation clustering. The multivariate model estimations are done using the Stata statistical software package (Stata, 2004).

Analysis of survey data

Bivariate associations

Table 1 summarizes selected statistics by gender and the type of denomination. Several important observations can be made from these statistics. Overall, they attest to a rather high level of exposure to formal prevention messages outside of church (measured by recent attendance of HIV/AIDS-related lectures and meetings) but also to HIV/AIDS-related information circulated within congregations. The respondents also demonstrated considerable basic knowledge and great personal concerns about HIV/AIDS risks and prevention, yet a relatively low level of practical exposure to HIV/AIDS (as measured by their knowledge of AIDS cases, confirmed or suspected), especially taking into account the rather advanced stage of the HIV/AIDS epidemic in the area. The data also show that even among churchgoers male condoms (female condoms were all but unheard of) have gained considerable acceptance: condoms are much more likely to be mentioned spontaneously as a form of HIV/AIDS prevention and almost one-third of respondents were using them for that purpose.

The two types of churches differed considerably on a number of indicators, and the pattern of these differences suggests that members of mainline churches are generally better positioned with respect to prevention than members of healing churches. Thus, the former reported slightly higher attendance of secular HIV/AIDS-related lectures or other formal events than did the latter. The gap between the two types of denominations was much wider in exposure to HIV/AIDS-related messages that occurred in church or through church activities. Members of mainline churches were more likely to think that a healthy looking person could be HIV-positive and that other STIs tend to increase the risks of contracting the HIV virus. While members of healing churches were somewhat more likely to know at least one person who had AIDS (or had died of the disease), they had a smaller percentage of those who could spontaneously name a method of preventing HIV infection, such as marital fidelity, premarital abstinence, or condoms. Both groups revealed very similar levels of concern about getting infected, but a somewhat higher share of mainline church members reported practicing a form of prevention. Interestingly, whereas members of healing churches were slightly more likely to choose fidelity and abstinence, members of mainline churches were relatively more inclined to opt for condom use. It is also notable that members of mainline churches were much more likely to support an HIV-negative woman's right to insist on condom if she knew or suspected that her partner was HIV-positive.

Table 1 also captures gender differences and similarities with respect to HIV/AIDS knowledge and prevention. Although men and women reported similar levels exposure to both secular and in-church prevention messages, men demonstrated considerably better basic knowledge of HIV/AIDS risks and prevention. At the same time, women and men showed an almost identically low likelihood of having had practical encounters with HIV/AIDS. Despite the similarity, however, women felt at a greater risk of infection and were more likely to worry about getting infected than men. Yet, as it is common in other settings (e.g., Adetunji & Meekers, 2001), women were much less likely than men to report practicing prevention, and especially to report use of condoms in their sexual relationships. Finally, in a curious twist of enduring

Table 1
HIV/AIDS-related indicators by type of denomination and gender (percentages)

	Healing church	Mainline church	Women	Men	Total
Attended a lecture or meeting on HIV/AIDS	40.9	57.7	45.3	51.6	48.2
Thinks that healthy person can be HIV+	60.2	75.2	53.7	81.3	66.7
Thinks that STIs increase the risks of HIV infection	70.1	79.9	67.6	82.0	74.3
Knows at least one case of AIDS	54.9	63.7	58.9	58.4	58.7
Spontaneous reported fidelity/abstinence as form of prevention	50.3	60.4	49.4	60.6	54.7
Spontaneously reported condom as form of prevention	77.1	84.3	72.1	89.5	80.2
Considers self at high risk of getting infected	37.4	36.5	42.2	31.1	37.0
Worries a lot about getting infected	78.2	81.2	82.9	75.6	79.5
Practices some form of prevention	69.7	76.5	53.1	94.9	72.6
Uses condom with either main or occasional partner	27.9	37.5	18.7	47.3	32.1
Thinks that HIV− woman can insist on condom with HIV+ partner	62.5	74.2	63.8	71.8	67.6

Table 2
Multivariate analysis of HIV/AIDS knowledge and attitudes (logistic regression models for the entire sample and each denomination type)

Predictors	Attended an AIDS lecture outside church			Heard about AIDS in church			Healthy person can be HIV+			STIs increase the risk of HIV infection			Knows someone with AIDS			Considers self at high risk			Worries about getting infected		
	All	Main	Heal	All	Main	Heal	All	Main	Heal	All	Main	Heal	All	Main	Heal	All	Main	Heal	All	Main	Heal
Mainline church member		na	na	+	na	na	+	na	na	+	na	na		na	na		na	na		na	na
Woman							–	–	–	–		–				+		+	+		
Maputo resident					+		+	+	+							–				+	
Has 6+ years of school	+		+	+						+										–	
Material status index	+		+						–				+	+							
Age 30 or older						+							+		+						
Currently married																+		+	+		+
Attends church 3+ times/week																				–	
Attended a lecture on AIDS	na	na	na	na	na	na	+	+	+	+	+		na	na	na				+	+	+
Pseudo-R^2	0.07	0.03	0.12	0.05	0.08	0.02	0.22	0.29	0.19	0.08	0.10	0.07	0.03	0.02	0.02	0.03	0.03	0.04	0.04	0.07	0.05
Number of cases	670	290	380	670	290	380	670	290	380	670	290	380	670	290	380	668	289	379	668	289	379

Notes: "Main" mainline church; "Heal" healing church; na not applicable; + positive effect significant at $p<0.05$; − negative effect significant at $p<0.05$.

gender ideology, women's right to insist on condom use with partners who might be HIV-positive garnered much stronger support among men than among women—mainly because a large share of women were undecided.

Multivariate results

The results of multivariate logistic regressions for some of the indicators of HIV/AIDS-related knowledge and attitudes discussed above are summarized in Table 2. The "+" and "−" indicate positive and negative effects, respectively, on the outcome, significant within the 95% confidence interval ($p<0.05$). The relative magnitude of these effects is noted in the text whenever necessary. All other effects are not statistically significant. Non-significant effects are not shown. For an easier presentation and interpretation of the interactions between gender and type of denomination, the results of separate models for each type of denomination are also presented.

As Table 2 shows, in exposure to secular HIV/AIDS prevention lectures and similar events, the denominational differences, already moderate at the bivariate level, disappeared statistically after controlling for other factors, especially education. Gender differences were not significant either, and this was also the case when I looked at them by the type of denomination. Among other predictors, education, most notably, had a powerful positive effect on the likelihood of exposure to formal prevention measures, illustrating the bias of such measures in favor of better educated segments of the population. The effect of education was statistically significant regardless of the type of denomination: in both mainline and healing churches, more-educated people were more likely than the less-educated ones to report formal exposure to HIV/AIDS education. It should be noted that the effect of education was considerably weaker (even if statistically significant) in mainline churches, which conforms to my conceptualization of these churches as facilitating greater exposure to secular prevention messages regardless of individual educational levels. It is also interesting to note that material affluence overall increased the likelihood of having attended a secular HIV/AIDS educational event, but when the sample is broken down by the type of denomination, this association was only present in the healing churches. An interpretation similar to the one that I just used for the differences in the impact of education can be proposed: the general social marginalization of healing church members may increase the importance of their individual material resources in gaining access to secular informational resources.

Unlike the case of formal secular campaign exposure, the advantage of mainline denominations in exposure to HIV/AIDS information through church activities remained statistically significant after the addition of the control variables. However, as we already observed at the bivariate level, no gender differences were noticeable either in the overall sample or in the two denominational sub-samples. Among other variables, education positively affected the odds of having heard about HIV/AIDS in church in the overall sample (but not in either subsample) and so did Maputo residence among mainline church members. Notably, frequency of church attendance did not show any effect on the chances of being exposed to HIV/AIDS through church activities.

The denominational differences in basic knowledge about HIV/AIDS remained statistically significant. Thus, mainline church members were more likely than members of healing denominations to think that a healthy looking person could be HIV positive and more likely to state that STIs increase the chances of getting infected. The multivariate tests also confirmed that women are greatly disadvantaged with regard to HIV/AIDS knowledge: women were significantly less likely than men to agree that an HIV-positive person could display no sign of illness and to know that an STI might increase the risk of infection. With respect to the former indicator, the gender differences held across the denominations, but in the case of the STI-HIV risks connection, arguably a more complex of the two measures, women's disadvantage was concentrated in healing churches (despite the large magnitude, the corresponding odds ratio in the mainline church model was not statistically significant). It is also worth mentioning the positive overall effect of education on knowledge of the STI-HIV risks connection.

The patterns of practical exposure to the epidemic, measured by respondent's knowledge of AIDS cases, contrasted with those of more abstract knowledge about HIV/AIDS. The controls effaced whatever denominational difference in such exposure that was observable at the bivariate level. Echoing the bivariate pattern, no statistically significant difference between men and women in such practical exposure to AIDS could be discerned either. In fact, the only predictors that showed some relevance were material status (mainline churches) and age (healing churches).

The multivariate tests confirmed that women overall were more likely than men to feel at a higher risk of getting infected. Yet when we examine this outcome by type of denomination, only in healing churches were women significantly different from men. The analysis of a related outcome—being worried about getting infected—alludes to the same pattern (even though the corresponding odd ratios fall just short of the chosen threshold of statistical significance). These results may again point to greater vulnerability of healing-church women. Notably, among other predictors, only marital status had a significant effect for both outcomes, as those who were in marital unions were more likely to

Table 3
Multivariate analysis of practice of HIV/AIDS prevention (multinomial logistic regression, reference category "Does prevention other than condoms"; odds ratios and 95% confidence intervals)

Predictors	All churches			Mainline churches			Healing churches		
	OR	95% CI		OR	95% CI		OR	95% CI	
Does not practice any prevention									
Mainline church member	1.18	0.73	1.93						
Woman	12.62	6.22	25.6	19.07	7.88	46.2	10.58	3.73	30.0
Maputo resident	0.59	0.37	0.96	0.33	0.12	0.92	0.76	0.49	1.17
Has 6+ years of school	0.55	0.31	0.96	0.36	0.20	0.64	0.85	0.44	1.63
Material status index	0.88	0.76	1.01	0.93	0.71	1.23	0.84	0.72	0.99
Age 30 or older	0.71	0.40	1.26	0.55	0.16	1.86	0.77	0.39	1.50
Currently married	0.89	0.50	1.58	0.95	0.30	2.95	0.78	0.46	1.32
Attends church 3+ times/week	1.07	0.65	1.75	0.88	0.49	1.58	1.60	0.82	3.12
Attended a lecture on HIV/AIDS	0.32	0.20	0.53	0.48	0.18	1.30	0.24	0.14	0.40
Worries about getting infected	0.99	0.60	1.61	1.03	0.42	2.54	0.92	0.49	1.74
Uses condom with partner									
Mainline church member	1.03	0.58	1.83						
Woman	0.50	0.30	0.85	0.59	0.23	1.55	0.35	0.18	0.69
Maputo resident	1.23	0.74	2.03	1.78	1.20	2.66	0.78	0.37	1.63
Has 6+ years of school	2.29	1.47	3.57	1.73	0.75	4.00	2.73	1.52	4.92
Material status index	1.02	0.88	1.19	0.98	0.77	1.26	1.12	0.93	1.35
Age 30 or older	0.25	0.17	0.39	0.19	0.08	0.42	0.35	0.20	0.63
Currently married	1.07	0.67	1.70	1.01	0.46	2.26	1.31	0.60	2.82
Attends church 3+ times/week	0.68	0.37	1.23	0.47	0.22	0.97	1.03	0.47	2.24
Attended a lecture on HIV/AIDS	0.76	0.47	1.26	1.20	0.78	1.85	0.50	0.23	1.09
Worries about getting infected	2.30	1.49	3.55	1.56	0.81	2.99	2.91	1.47	5.76
Log likelihood		−545			−224			−307	
Pseudo-R^2		0.25			0.28			0.25	
Number of cases		668			289			379	

Note: OR odds ratio; CI confidence interval.

feel at risk and to express worries about getting infected. Yet when the sample is broken down by the type of denomination, only the healing church model produces this pattern convincingly.

Table 3 displays the results for practice of HIV/AIDS prevention. The polytomous logistic regression model compares practicing no prevention and using condom as the main form of prevention to using a form of prevention other than condom (primarily marital fidelity and abstinence). Being worried about risks of infection is added to the list of control variables. The results are presented as odds ratios: a value above (below) unity indicates higher (lower) odds of the outcome in the category in question, relative to the reference category (or to the mean, for continuous variables).

Not surprisingly, women were much more likely than men to report taking no prevention measures. The gender gap was dramatic in both types of denominations, yet especially wide in mainline churches. In general, women were much less likely than men to report condom use with partner, relative to practicing another type of prevention. Women's disadvantage in reported condom use, however, was statistically significant only in the healing-church subsample. An interesting and complex pattern thus emerges: against the backdrop of women's overall disadvantage and vulnerability, membership in a healing church, relative to membership in a mainline church, positions women somewhat better with respect to what would be any church's favored prevention choice—abstinence or fidelity. Yet it also makes women more vulnerable with respect to the de facto preferred method of the secular prevention efforts, i.e. condom use.

The effects of several other predictors should also be noted. Thus, a higher schooling level increased the chances of practicing some prevention over not practicing any as well as the likelihood of choosing condoms over other forms. Yet, education's benefits for condom use are statistically noticeable only in the healing subsample. In mainline churches, with their comparatively greater acceptance of the secular prevention message, education, like gender, becomes largely irrelevant to the choice between condoms and other prevention methods. At the same time, frequency of church

attendance significantly decreases the odds of condom use only among mainline church members. Church attendance is commonly treated as a proxy for religiosity and for the degree of adherence to the church's official doctrine—and as part of this doctrine, to its emphasis on chastity and fidelity. However, as the test suggests, this assumption may hold only in church settings where deviations from the religious doctrine are more easily tolerated. In such settings, as my theoretical reasoning would follow, personal worries about getting infected may not affect the choice between abstinence/fidelity and condoms, unlike in the less-tolerant settings, where the fears of the disease may help overcome the church's declared dislike of "safer sex." The statistical results provide support to this reasoning.

Notably, the models predicting practice of prevention have generally the highest values of pseudo-R^2 among all the models tested, indicating a better fit of the data. On the other extreme are the models predicting knowledge of HIV/AIDS cases, self-assessment of personal risks, and worries about getting infected; these models explain only a tiny fraction of the variance in the respective outcomes suggesting that these outcomes are shaped mainly by some other, unobserved characteristics.

Insights from semi-structured interviews

The semi-structured interviews provide valuable illustrations and details of how gender differences with respect to HIV/AIDS are articulated and how these differences are predicated on women's and men's religious beliefs and environments. This evidence, however, is very subtle—partly because of all churches' vocal and indefatigable advocacy of the same assortment of "family values." At the same time, HIV/AIDS remains a complicated and even mysterious problem generating ambiguous and ambivalent reactions and assessments. Not surprisingly, interviewed members of the same congregations often gave diametrically opposed opinions regarding their churches' HIV/AIDS-related pronouncements and activities.

What is certain, however, is that HIV/AIDS-related issues permeate church members' worldviews and daily lives—directly and, more often, indirectly. Informants saw their faith as an important factor in their dealing with HIV/AIDS because it teaches them virtuous behavior, especially in matters of family life, and because it instills both fear and reason to help them better heed prevention messages. Informants also stressed the importance of the advice and psycho-social support offered by other congregation members in making the right choices to reduce the risks of infection.

Direct and specific discussions of HIV/AIDS and prevention in church settings, however, are rare. Most such discussions happen outside of main religious services, in specialized and less-formal gatherings that take place during the week: (married) women's meetings, men's meeting, or (childless) youth's meetings. HIV/AIDS-related messages are therefore tailored to each of these audiences: while a youth meeting may focus squarely on condom use (at least in some churches), a men's meeting would tuck the issue of condoms into a discussion of marital fidelity, and at a women's meeting, dominated by exhortations to be good wives, mothers, and homemakers, condoms may not be mentioned at all.

Gender ideology is therefore recreated in the church as women and men are held to different standards and expectations. Being faithful or having outside relationships is really men's dilemma. In contrast, women's main role in HIV prevention is reduced to pleasing their husbands sexually and otherwise so as to discourage them from seeking relationships outside of marriage (not surprisingly, then, some women mentioned personal hygiene or house cleanness among AIDS prevention methods advocated by their churches). And when infidelity enters the range of admonitions directed at women, the arguments may be as pragmatic as they are moralistic. Thus, women may be reminded that if they find themselves lovers and decide to leave their husbands for them, they will have no right to the family property (and by implication, children). This gender-specialized prevention emphasis seems to be most pronounced in healing churches, particularly in the Assembly of God and Apostolic churches.

Informants' answers to questions on whether and how condoms are talked about in their congregations are particularly contradictory: some informants would first acknowledge that condoms are openly discussed by church leaders but later state that condoms are never mentioned. These contradictions reflect the churches' ambivalent position on condoms—an uneasy compromise among three conflicting realities: the "ideological" rejection of condoms—and of promiscuous behavior they supposedly engender—as incompatible with Christian moral and family values; the deeply rooted popular assumptions about sexuality and sexual networking; and the growing realization of the scale of the epidemic.

No church is keen on promoting condoms. Yet the condom message makes its way into the teachings of even most conservative denominations—directly and especially indirectly. Church leaders and churchgoers alike use the expression "prevention" (or sometimes "protection") as a euphemism for condom use; such condom-centered "prevention" becomes a standard—even if not explicitly articulated—addition to all churches' favorite repertoire of premarital chastity and marital fidelity.

The main differences between the types of churches, as the interviews and field observations suggest, are not so much in the content and form of the messages they

direct to their male and female members but in the social milieu—inside and outside the congregation—in which people find themselves by virtue of their church membership. While the *religious* discourse on HIV/AIDS does not seem to differ much between mainline and healing churches, members of larger mainline congregations, as the survey data analysis already implied, are more exposed to HIV/AIDS prevention information through their congregations. First, mainline congregations frequently coordinate activities and exchange visits with sister parishes that are often socially very heterogeneous. Visits by delegations from urban congregations may be particularly beneficial for members of peri-urban and rural ones. Second, mainline congregations are more likely to include higher status individuals who are either professionally more knowledgeable about HIV/AIDS (e.g., nurses) or politically better connected to governmental and non-governmental health agencies and therefore can attract their propagandist machine more easily. Targeting larger mainline congregations rather than tiny and dispersed healing churches for HIV/AIDS prevention activities also offers the secular institutions involved in such activities an important economy of scale. And third, mainline congregations area in general more ideologically tolerant and accommodating: while the core of social and family values that they officially champion may not differ much from those promoted by healing church leaders, they are typically more lenient in when it comes to enforcing their members' compliance with those values. As a result, mainline churches get more consistent, direct, and continuous exposure to HIV/AIDS prevention messages and efforts coming from outside of the churches. Even if mainline church leaders themselves do not raise the controversial issues of condoms and safer sex, they allow—willingly or not—for much more discussion of these issues within their congregations than do leaders of healing churches.

Conclusion

In this study, I attempted to bring to light the importance of the context in which gendered views of HIV/AIDS and corresponding preventive behaviors are shaped. I hypothesized that different contexts, in this case represented by the type of religious congregation—mainline vs. healing—could significantly affect the gendering of HIV/AIDS-related knowledge, attitudes, and behavior. This study's findings with regard to the understanding of HIV/AIDS risks, perceptions of own risks, and condom use for prevention generally support the expectations that the gender gap—and arguably, women's disadvantage—would be more pronounced in healing churches than in mainline churches. Notably, however, no differences could be detected in exposure to both the secular propaganda outside churches and HIV/AIDS-related information circulated within the congregations. The qualitative data helped to reconcile these seemingly contradictory patterns, by highlighting ideological, organizational, and political factors and mechanisms that shape women's and men's exposure to information, knowledge, perceptions, and behavior within each type of churches. They also helped to understand how denomination-specific differences in gender outcomes may arise even when both men *and* women subscribe to the same gendered stereotypes of women's subaltern roles in social, economic, and reproductive decision-making.

Some limitations of this study should be acknowledged. First, the study covered only a handful of congregations in one region of Mozambique: in other settings the religious context may affect the examined gender patterns differently. Second, the chosen classification of religious denominations, constrained by the type and size of the sample, does not capture considerable doctrinal and organizational distinctions within each of the two categories. Thus, the Roman Catholic Church is, of course, different from the Presbyterian Church (and other mainline Protestant churches) in many doctrinal and organizational respects; some Catholic or Presbyterian parishes may be more socially conservative than others. While some healing congregations, especially of the Zionist bent, may turn a blind eye to non-marital sex or alcohol consumption, others, especially those affiliated with the Assembly of God, may take a much less lenient stand on these "sins." I realize that these distinctions may bear on the gendered response to the epidemic. My argument, however, is that the chosen classification reflects the important relevant differences in the social milieu (rather than in explicit teachings) that the two types of churches foster.

This study points to an overall advantage of members of larger, mainline denominations vis-à-vis secular prevention efforts. It can, of course, be contended that the differences between the two types of churches are the product of self-selection: healing churches grow, to a large extent, thanks to conversions from mainline churches, and women and men of certain characteristics—usually the poor and marginalized—are more likely to convert than others. Yet trying to disentangle the effect of healing churches' social milieu from that of its members' selectivity is hardly a plausible task since the very social milieu that becomes instrumental in shaping HIV/AIDS attitudes and prevention *is* largely shaped by converts' backgrounds, motivations, and expectations.

The potential of a faith-based response to the HIV/AIDS epidemic in sub-Saharan Africa and elsewhere is widely lauded by religious institutions and sympathetic governments and NGOs (e.g., Byamugisha et al., 2002; Green 2003; Kagimu, Marum, & Serwadda, 1995). Yet

while looking for ways to harness this potential, policy-makers should pay attention to how different types of religious institutions may differently position their members, women and men, with respect to prevention information and resources. The gendered importance of religious institutions is further underscored by the predominance of women among active church members. In fact, for many women, especially in rural areas, church membership may be the only form of non-kin association, and increasingly the only reliable source of spiritual, psychological, social, and even material support. As HIV/AIDS continues to exact its toll in Mozambique and other sub-Saharan countries, distorting their demographics, weakening their economies, and undermining their traditional and civil institutions, religion may offer uniquely effective structure and mechanisms to help mitigate the social impact of the epidemic on society, and especially on its most vulnerable segment—poor women.

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