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Exploring religiosity and spirituality on the meaning of HIV/AIDS and service provision in Malawi

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EXPLORING RELIGIOSITY AND SPIRITUALITY ON
THE MEANING OF HIV/AIDS AND SERVICE PROVISION IN MALAWI

by

Sung Ah Choi

A Dissertation
Submitted to the University at Albany, State University of New York
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the Requirements for the Degree of
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Exploring Religiosity and Spirituality on
the Meaning of HIV/AIDS and Service Provision in Malawi

by

Sung Ah Choi

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Dedication

To my parents, Soonboon Lee and Yongrok Choi in South Korea

To my siblings, Jinah and Seongho Choi in Malawi,

To my husband, Junho Han & my precious daughter, Eden Choi Han,

Last but certainly not least to my Lord, Jesus who has empowered me to overcome many socio-economic and cultural barriers in my academic journey in the U.S.A.
Acknowledgements

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Abstract

Background: Almost two-thirds of the total HIV/AIDS infected populations in the world live in Sub-Saharan Africa. HIV/AIDS stigmas are major obstacles to HIV/AIDS interventions in Sub-Saharan Africa. The literature suggests that diverse factors associated with HIV/AIDS stigma should be investigated to effectively reduce HIV/AIDS stigmas. However, little is known about religion as a cultural factor in the construction of HIV/AIDS stigma in Sub-Saharan Africa. NGOs and FBOs have played a significant role in the work of the HIV/AIDS intervention and prevention in the area. However, in spite of the importance of religion and spirituality among the front-line workers at non-governmental organizations (NGOs) and faith-based organizations (FBOs) in Sub-Saharan Africa, religiosity and spirituality in relation to the construction of HIV/AIDS stigma have not been fully investigated yet.

Purpose: The aims of this study were to explore how service providers working with HIV/AIDS affected populations understand the meaning of HIV/AIDS stigma in relation to their religious beliefs, and to explore the role of religiosity and spirituality among service providers working in NGOs and FBOs in southern Malawi.

Method: A qualitative approach using the Internet via online Google forms and emails was used to collect the questionnaires and narrative data from Malawi. Study participants included twenty service providers working in thirteen NGOs or FBOs in southern Malawi. Fourteen participants were Malawians; six were from abroad, including Australia, Canada, Dutch, South Korea, Zimbabwe, and England. All participants are self-identified Christians. The qualitative data was analyzed using ATLAS.ti (version 8.0), and the quantitative data were analyzed by STATA (version 14.2).

Results: The findings of the study showed that social stigma and social constructionism
were theories relevant to exploring HIV/AIDS stigma as a social construct in the Sub-Saharan context. Service providers participating in the study variously understood HIV/AIDS as a punishment of God, a consequence of sin in the fallen world, a result of human behavior, an opportunity to help PLWHA (People Living With HIV/AIDS), and as a medical disease. The participants described religiosity and spirituality as important health assets that support them in working with PLWHA in NGOs and FBOs in Malawi.

**Conclusion:** Religion serves as an important cultural influence, with power to both negatively affect the construction of HIV/AIDS stigma in society, and positively reconstruct the meaning of HIV/AIDS. The findings of the study suggest that it is critical to deconstruct and reconstruct the meaning of HIV/AIDS by focusing on religion as the means of grace and love, not of morality. Service providers must be required to carefully examine their own prejudice toward PLWHA, and social work education can equip HIV/AIDS specialists to more effectively deal with HIV/AIDS-related problems at the local, national, and global levels in the field of international social work.
Chapter 1: Introduction to the Study

Background of the Study

We live in an era of the HIV/AIDS pandemic, a crisis that is not only of urgent importance to the Global South but also to the Global North. Approaching this epidemic just as a medical problem means seeing it from a limited and narrow view, since the disease is rooted in socio-economic, cultural, and educational concerns. In the context of Sub-Saharan Africa, an area that has been ravaged by this pandemic, the pandemic reflects a complexity of unjust socio-economic structures of globalization, gender inequality in Sub-Saharan African countries, and oppressive cultural and religious beliefs in the African communities. HIV/AIDS has become a global crisis to the point where the United Nations endorsed a “Declaration of Commitment on HIV/AIDS” in June 2001 (United Nation, 2001). According to the World Health Organization (WHO), approximately 36.7 million people were living with HIV/AIDS worldwide in 2015. Two million people died of AIDS-related illnesses worldwide in 2008. In 2015, 1.1 million people died from AIDS-related diseases in worldwide. 30 million people were living with HIV in low and middle-income countries (WHO, 2008). In this report, WHO (2008) states that since the late 1990s, the prevalence of HIV among adults 15-49 years old had stabilized at about 0.8% worldwide. However, the number of people living with HIV worldwide had continued to grow, and was more than 20% higher in 2008 than in 2000 and three times higher than in 1990.

Approximately 25.6 million people, constituting almost two-thirds of the total HIV/AIDS infected populations across the world, are from Sub-Saharan Africa (WHO, 2017). “Sub-Saharan Africa” refers to forty-eight African countries south of the Sahara desert; the area is further divided into regional components: Central Africa, East Africa, West Africa, and Southern Africa (Berglee, 2013). Among the Sub-Saharan regions, Southern Africa—including South Africa,
Swaziland, Lesotho, and Botswana— is the area affected the worst by the HIV/AIDS epidemic. According to most recent UN reports, in 2012, Swaziland had the highest HIV prevalence rate of any country in the world (26.5 percent), while Botswana (23 percent) and Lesotho also had high prevalence rates (UN, 2013). South Africa, with 6.1 million people living with HIV and a prevalence of 17.9 percent, has the most extensive HIV epidemic in the world; the remaining countries in the Southern Africa region have HIV prevalence rates between 10 and 15 percent (UN, 2013).

The average life expectancy in many African countries has fallen down to the 30s due to AIDS-related diseases (Benotsch et al., 2008). In South Africa, approximately 7.1 million people were living with HIV/AIDS in 2016 (UNADIS, n. d.). Nearly 800 people die daily of AIDS-related diseases (Ackermann, n. d., p. 4), and in the region of KwaZulu-Natal in South Africa, approximately 600 people get infected with the HIV/AIDS virus every day (Haddad, 2005). The HIV/AIDS pandemic is a serious threat to people living in Sub-Saharan African countries.

**Statement of the Social Problem**

HIV/AIDS-related stigma has played a significant role in the global HIV/AIDS pandemic, significantly threatening the well-being of the Sub-Saharan African community. HIV/AIDS stigma is defined as “the prejudice, discounting, discrediting and discrimination directed at people perceived to have AIDS or HIV, their loved ones and associates and the groups and communities with which they are affiliated” (Wagner et al., 2010, p. 208). Prejudice is defined as an unjustified, incorrect, unreasonable, or unfavorable attitude toward an individual solely on the individual’s membership of a social group (McLeod, 2008). In contrast, discrimination is the behavior or action on the basis of a prejudice towards an individual or a social group (McLeod, 2008). PLWHA and their families are often subjected to stigma and
discrimination in society. HIV/AIDS is attached to more severe stigmatization and discrimination than other medical problems, including TB, cancer, or malaria. HIV/AIDS is a more intensely stigmatized disease for the following reasons: 1) it is contagious; 2) it is incurable through current medical science; 3) there is much incorrect knowledge about the disease, combined with a fear of death; 4) and there are perceptions of HIV/AIDS as a consequence of a person’s immoral behavior in a system that considers HIV/AIDS as God’s punishment (Lee, Kochman, & Sikkema, 2002; Phillips, Moneyham, & Tavakoli, 2011). Stigmas associated with PLWHA are major obstacles to effective HIV prevention and intervention (Keikelame, Murphy, Ringheim, & Woldehanna, 2010). It is vital to investigate diverse factors related to HIV/AIDS-related stigma to reduce HIV/AIDS stigma in Sub-Saharan African countries effectively.

**Significance of the Study**

A study in the role of religion as an important cultural factor affecting the construction of HIV/AIDS-related stigmas is highly required in social work research. HIV/AIDS stigma studies focused on cultural factors such as religion and religious beliefs have not been yet thoroughly investigated in Sub-Saharan African countries. As the HIV/AIDS disease rapidly spread and received more attention worldwide, many scholars in diverse academic disciplines have explored HIV/AIDS-related stigmas since the 2000 International Conference in South Africa (Holzemer et al., 2007). However, most existing research has been conducted with a tendency to see stigma as individuals' perceptions of their own experiences regarding HIV/AIDS positive status. For this reason, researchers have focused on finding relations between HIV/AIDS stigmas and individuals' psychological problems at the micro level (Berger, Ferrans, & Lashley, 2001; Kalichman et al., 2009; Lee, Kochman, & Sikkema, 2002; Li et al., 2009; Phillips, Moneyham & Tavakoli, 2011). As a result, few studies have been able to explain the cultural factors—
including religion and religious beliefs—that might have contributed to stigmatization of, and discrimination against PLWHA. Religion significantly shapes individuals' behavioral and value systems and helps build societal norms and values. Among many possible factors contributing to the construction and promotion of HIV/AIDS stigmas, religion needs to receive rigorous scholarly attention.

**Purpose of the Study**

The purpose of this study was to investigate the role of religion in the effort of people in non-governmental organizations (NGOs) and faith-based organizations (FBOs) responding to the HIV/AIDS crisis in Sub-Saharan African countries. This study was designed to explore how service providers working in NGOs and FBOs in Sub-Saharan African countries experience and understand HIV/AIDS stigmas in relation to their own religious beliefs. It also aimed to examine how service providers’ religiosity and spirituality affect their work in responding to the needs of the HIV/AIDS affected populations in the Sub-Saharan African community.

**Research Questions**

The study sought to answer the following questions:

(i) What is the meaning of the HIV/AIDS disease to the service providers working at NGOs and FBOs with PLWHA, given their own religious beliefs?

(ii) Does HIV/AIDS really mean a punishment of God?

a. If not, what does the disease mean to the service providers?

(iii) How does religiosity and spirituality help service providers to continue to work with PLWHA at NGOs and FBOs in Malawi?
Chapter 2: Review of the Literature

The “Review of Literature” chapter provides findings from existing HIV/AIDS stigma studies first. It also explains two contradictory opinions about the role of religion in HIV/AIDS cares. At the end of this chapter, the work of NGOs and FBOs in HIV/AIDS prevention and intervention in Sub-Saharan Africa is discussed.

Effects of HIV/AIDS Stigma

Much of the literature has shown that HIV/AIDS stigma contributed to a variety of social, physical, and psychological problems for PLWHA (Berger, Ferrans & Lashley, 2001; Buseh, Kelber, Stevens, & Park, 2008; Earnshaw et al., 2009; Frost, 2011; Kalichman et al., 2009; Lee, Kochman & Sikkema, 2002; Li et al., 2009; Phillips, Moneyham & Tavakoki, 2009; Sayles et al., 2009; Zou et al., 2009; Varas-Diaz et al., 2005). HIV/AIDS-related stigma leads to significant adverse impacts on the psychological and physical well-being and social relations among PLWHA.

**Psychological problems.** Researchers have found that HIV/AIDS-related stigmatization is associated with many mental problems (Berger, Ferrans & Lashley, 2001; Kalichman et al., 2009; Phillips, Moneyham & Tavakoki, 2009; Zou et al., 2009). Studies have found that having HIV/AIDS has been significantly related to depression, lack of self-esteem or social support, and social conflict among infected people (Moneyham & Tavakoki, 2009; Berger, Ferrans & Lashley, 2001; Phillips et al., 2011). For example, a stigma study conducted in South Africa, Swaziland, and the U.S.A. reported that internalized AIDS stigma is positively associated with depression (Kalichman et al., 2009). When PLWHA internalize stigmatizing experiences, they may feel guilty, ashamed, and inferior. As a result, they may isolate themselves, not want to disclose their HIV/AIDS infected status, and are less likely to actively seek care and support. A
study conducted by Earnshaw and colleagues (2013) found that internalized HIV stigma was strongly associated with lower indicators of effective health and wellbeing, such as helplessness, lower acceptance, and power perceived benefits of HIV, and lower indicators of behavioral health and wellbeing, such as higher gaps between accessing medical care and ARV (anti-retroviral) non-adherence. As a result of PLWHA withdrawal and social isolation, a variety of efforts toward HIV/AIDS intervention and prevention are impeded.

**Physical problems.** HIV/AIDS stigmas affect the physical abilities of PLWHA and lead to a deterioration in their health conditions. A study conducted by Buseh and colleagues (2008) found that physical symptoms of African American men with HIV/AIDS were significantly associated with HIV/AIDS stigma. For example, the participants reported that they had fatigue (98%), fear (92.7%), shortness of breath (92.7%), gastrointestinal upset (85.5%), numbness (80.0%), and headache (76.4%), and their symptom intensity was positively associated with measures of stigma and negatively associated with quality of life (Buseh et al., 2008).

Experiencing stigma is associated with decreased access to medical care (Frost, 2011). Since PLWHA avoid receiving medical care due to stigma, their health can deteriorate faster. For instance, a cross-sectional study held by Sayles and colleagues (2009) found that study participants who reported high levels of stigma were more than four times more likely to report poor access to health care, regular HIV care, and ARV (anti-retroviral) adherence. A longitudinal psychological study conducted by Cole and colleagues (1996) also found that HIV stigma among HIV-positive gay men was associated with accelerated disease progression (Cole et al., 1996 as cited in Frost, 2011).

**Social isolation.** PLWHA face many negative social experiences in their communities. Zou et al. (2009) have argued that “shame about HIV is closely linked to internalized, self-
directed stigmatization, which can lead PLWHA to withdraw from social settings such as their religious community” (p. 2). A study by Varas-Diaz et al. (2005) reported that Latinos in Puerto Rico living with HIV/AIDS experienced “loss of support, persecution, isolation, job loss, and problems accessing health care services” in their communities (p. 169). Kalichman and colleagues (2009) reported that HIV/AIDS stigma was negatively associated with social support. A study by Lee, Kochman, and Sikkema (2002) found that 1) most PLWHA participants had internalized stigma because of their HIV positive status; 2) participants with higher scores for internalized stigma were less likely to have participated in an HIV support group; 3) they knew fewer people with HIV; and 4) their families were less likely to be accepting of the disease (Lee, Kochman & Sikkema, 2002). Social isolation and withdrawal are critical problems threatening both social and psychological well-being of PLWHA. When PLWHA are isolated due to their HIV/AIDS positive status, they become more depressed, and when they become more depressed, they seek out less emotional and social support (Li et al., 2009). Thus, an ongoing cycle is developed between social isolation and depression amongst PLWHA.

Religion and HIV/AIDS Stigma

Religion is one the most important sources of structured social relationships in African countries. Miller (2009) states, “Religions in Africa – Christianity in the South, Islam in the North, and traditional religions across the continent – play a critical role in personal and social life” (p. 280). At the personal level, religion shapes individuals' value systems and guides their behaviors in everyday life. Miller (2009) quoted Mbiti (1992, p. 2) in her journal article that, “Wherever the African is, there is his religion; he carries it to the fields where he is sowing seeds or harvesting a new crop; he takes it with him to the beer party or to attend a funeral ceremony” (p. 280). In the community where people live in poverty, religion also provides resources to
those who are in need through religious organizations such as churches and mosques (Miller, 2009, p. 280). Historically, churches in Africa have provided not only religious services and guidelines, but also a variety of health care, education, and social services to people in need (Tiendrebeogo & Buyckx, 2004).

Since the HIV/AIDS pandemic started, the religious community has sent conflicting messages regarding HIV/AIDS. Two opposite opinions about the role of religion in impacting HIV/AIDS stigma exist. Some argue that religion mitigates HIV/AIDS-related stigmas (Tiendrebeogo & Buyckx, 2004). Others argue that religion promotes HIV/AIDS-related stigmatization (Agadjanian & Menjivar, 2011; Genrich & Brathwaite, 2005; Regnerus & Salinas, 2007, cited in Bauer, 2013; Zou et al., 2009). The relationship between religion and HIV/AIDS-related stigma is a controversial issue that has not been fully investigated. In spite of the significant role of religious organizations and religion dealing with the AIDS crisis in Sub-Saharan Africa, this has yet to be a topic of rigorous scholarly inquiry (Trinitapoli, 2006). Miller (2009) pointed out that “scholars and policy-makers from Western cultures where the impact of religion and religious leaders is relatively modest may underestimate the influence of religion in the life of their target populations” (p. 280). Clearly, religion needs to receive more scholarly attention as an essential factor in dealing with the HIV/AIDS pandemic and stigmas in sub-Saharan African communities. As such, the remainder of this section will explore religion both as a risk factor contributing to the stigmatization of PLWHA, and as a motivating factor in supporting PLWHA.

**Religion as a risk factor of stigma.** Religion maintains a reputation of stigmatizing PLWHA in Africa and the U.S.A. Christianity has influenced many sub-Saharan African countries due to their colonial history. Several scholars, including Christian theologians, have
argued that religious organizations may contribute to HIV/AIDS stigma and discrimination (Agadjanian & Menjivar, 2011; Keikelame et al. 2010; Zou et al., 2009). Many Christian religious leaders confessed at the World Council of Churches (WCC) Conference in Kenya in 2001 that churches had contributed to the spread of HIV/AIDS by having a “judgmental and moralistic attitude” (Paterson, 2005, p. 2). Paterson (2005) states, "Religion as a defender of the moral and social norms of culture, often functions in such a way as to reinforce and ritualize symbolic stigma…. In a religious perspective, violation of cultural and social norms may be understood as sin” (Paterson, 2005, p. 4).

A South African Anglican priest and activist-intellectual, Beverley Haddad (2005) states that the Christian Church remained silent on the HIV/AIDS pandemic until recently, and thus contributed to stigmatization of, and discrimination against PLWHA (p. 29). During the late 1990s, people in South Africa did not refer to HIV/AIDS by name, but often talked about "this thing," or referred to it by using the names of more socially acceptable diseases, such as pneumonia or TB (Marcus, 1999 quoted in Haddad, 2005, pp. 30-32). As a result of South African governmental and nongovernmental awareness-campaigns in the early 2000s, Haddad (2005) states, silence about HIV/AIDS among South Africans has been slowly breaking down, but the church is still slow to openly speak about the disease. Thus, it is important to investigate the questions: 1) what beliefs do religious organizations hold to continue to be silent and further contribute to HIV/AIDS stigma and discrimination? and 2) in what ways do religious organizations and their congregants overtly express stigmatizing and prejudicial behaviors toward PLWHA?

In many Muslim countries, religious belief promotes HIV/AIDS stigmas, and PLWHA who reside in Muslim communities tend to experience HIV/AIDS-related stigma (Hasnain,
Similar to a Christian theology of HIV/AIDS, many Muslim religious leaders believe that HIV/AIDS is a punishment from the Divine God (Tiendrebeogo & Buykx, 2004). A qualitative study conducted in Senegal, a country which is predominantly Islamic, found that many Muslim religious leaders believe the HIV infection is a divine punishment, and HIV infected individuals are responsible for not following Islamic teachings (Ansari & Gaestel, 2010). PLWHA may internalize stigma if they perceive themselves to be living outside of religious principles, and HIV uninfected people can stigmatize PLWHA by verbally condemning them as sinners.

**HIV/AIDS as a punishment from God.** Religious leaders may contribute to stigmatization of PLWHA. Trinitapoli (2006) pointed out that “religious messages about AIDS always connected the disease with sin” (p. 10). Similarly, Haddad (2005) argued, “church leadership is fueling HIV/AIDS stigma and discrimination,” particularly in rural areas where there are limited educational opportunities for the communities (p. 32). Church leaders in Africa often use biblical passages to justify the argument that AIDS is a punishment from God. As such, congregants believe the message that PLWHA die because of their promiscuous behaviors.

Religious beliefs can be strongly associated with shame-related stigma, as one quantitative study of Tanzanian churches reported (Zou et al., 2009). Four hundred thirty-eight survey participants were recruited from Tanzanian churches to examine "how religious beliefs and church environments influence HIV/AIDS-related stigma and beliefs about the cause and possible treatments of HIV" (p. 3). Thirty-six percent of the respondents were Catholic, 37 percent Lutheran, and 26 percent Pentecostal. The study reports that 53.2 percent of participants—about half—believed that “HIV is a punishment from God” and 34.9 percent—almost one third—believed that “those who are HIV-infected have not followed the Word of God” (Zou et al., 2009, p. 5). Since PLWHA are considered as “sinners,” they are not treated...
equally by other community members (Tomaszewski, 2012), and may quickly become marginalized and excluded. For instance, Isabel A. Phiri, known as the first Malawian female theologian stated that some African doctors and nurses refused to treat HIV/AIDS infected people because they do not want to interfere with God’s punishment of PLWHA (2004). When HIV/AIDS-related stigma is expressed in an actual action based on pre-existing stigma, it is called discrimination (Smart, n. d.). PLWHA often experience discrimination manifested both on the individual level, such as facing hostility of people, and on the societal level, such as facing disadvantages in laws and policies of their community. It is crucial for professionals and leaders working at Christian Non-Governmental Organizations (NGOs) and Faith-Based Organizations (FBOs) to utilize a social constructionist viewpoint to deconstruct and reconstruct the Bible from the perspective of the oppressed and marginalized, such as the poor, women, and HIV/AIDS victims.

**Religion as a motivating factor in the fight against HIV/AIDS stigma.** At the same time, there is a robust argument that religion has played a positive role in mitigating HIV/AIDS-related stigmas in Africa. Miller (2009) has argued that African religious entities are well fit to fight against stigmatization and has pointed out why, and how religions have mitigated HIV/AIDS-related stigmas, as follows:

(i) Religious organizations have “tolerance and compassion,” and have “a sense of calling” to help the weak and the oppressed;

(ii) Religious entities are involved in crucial life events of their members, and are already placed in a position as a source of strength and support for those who are in need;

(iii) Religious organizations have well-developed international networks;
(iv) Religious groups can mobilize dedicated volunteers in a way that is impossible for public health agencies;
(v) Religious organizations and leaders are influential, and have a credible voice of moral authority in the community;

Theologians, scholars, and community workers do express positive opinions about the role of religion and religious organizations in the fight against HIV/AIDS stigma in Sub-Saharan Africa. However, such opinions have not been fully investigated using evidence-based research methods.

**NGOs and FBOs in Sub-Saharan Africa**

Many HIV/AIDS prevention and intervention programs have been implemented by international and domestic NGOs and FBOs in Sub-Saharan Africa. An NGO is defined as “a not-for-profit group, principally independent from government, which is organized on a local, national or international level to address issues in support of the public good” (The United Nations Rule of Law, n. d., para. 1). A faith-based organization (FBO) is defined as 1) a religious congregation; 2) an organization, program, project, and a nonprofit organization founded and supported by a religious congregation; and 3) a collaboration of religious congregations and organizations (FACES, n. d., para. 7). FBOs are distinguished from secular humanitarian organizations based on two characteristics: they are motivated by religious faith, and they have a broader constituency than only that limited to humanitarian concerns (Ferris, 2005).

Many scholars argue that NGOs and FBOs have played a significant role in serving Sub-Saharan African communities (Agadjuania & Menjinvar, 2011; Benotsch et al., 2008;
Ssewamala & Ismayilova, 2008; Chikwendu, 2004). Roff (2004) has stated that in the initial stages of their development, NGOs had mostly involved themselves in “relief efforts for the poor” and “alleviation of suffering for victims of war and natural disasters” (p. 202). Today, however, NGOs have the potential to be major role models in providing leadership for social change and direct and indirect services to the poor and marginalized throughout the world. For instance, as Ssewamala and Ismayilova (2008) have stated, in Sub-Saharan Africa, FBOs had been primarily engaged in providing food, shelter, healthcare, and education at first, but have developed and broadened their services in diverse areas. In Uganda, several FBOs have been actively engaged not only in direct services to help orphaned children meet their psychosocial needs, but also in operating social enterprise projects and managing social infrastructure, such as hospitals and schools (Ssewamala & Ismayilova, 2008).

In many Sub-Saharan African countries, FBOs represent primary community resources for HIV/AIDS care, service, and education. In resource-limited settings, FBOs have played an essential function in reducing the impact of HIV/AIDS (Agadjuania & Menjinvar, 2011), and have acquired sufficient experience in providing a variety of services for HIV/AIDS victims in African countries (Benotsch et al., 2008). Zou et al. (2009) have stated that churches can provide support to PLWHA in terms of both daily material needs and spiritual needs, such as “spiritual counseling, prayers, hope for personal spiritual salvation, social and material support, personalized care when they are sick, and assurances of burial after they die” (p. 2).

International and domestic NGOs have taken an important position in providing AIDS care at the grassroots levels when, in many African countries, governments have failed to respond to the HIV/AIDS pandemic promptly and effectively (Chikwendu, 2004), primarily because they have been emphasizing the public health approach. By contrast, NGOs have
provided greater emphasis on broader sociological approaches, and have worked with more sensitive issues such as negotiation of sexual relations, the human rights of PLWHA, dignity in dying, and decisions about reproduction (Chikwendu, 2004).

Many African NGOs and FBOs have engaged in micro level practice, and workers in NGOs and FBOs play significant roles in the lives of PLWHA in Sub-Saharan African communities. How the professionals at NGOs and FBOs perceive HIV/AIDS, and how they understand HIV/AIDS-related stigmas remain critical levers in building professional relationships with, and in providing services to PLWHA. To better deal with the HIV/AIDS pandemic and stigma, it is essential to investigate the broader meanings professionals hold when working directly with PLWHA in Sub-Saharan African communities.

**Religiosity and spirituality for NGO and FBO workers.** Religion and spirituality are known to be a coping strategy for people with life adversities. Religious coping is defined as how people use “their spirituality/religion to manage a difficult situation” (Cotton et al., 2006, p. 10). Research says that spirituality and religion positively affect people coping with HIV/AIDS, diabetes, and other chronic diseases. For instance, Choi and Hastings (2016) found that religion and spirituality have played an important role among African Americans who have a history of homelessness in their diabetes self-management practice by promoting coping skills and resilience. Cotton et al. (2006) reported that HIV/AIDS patients who have positive religious coping strategies have “better perceived outcomes, such as improvements in life satisfaction, self-rated health, and positive effect in patients with chronic illnesses” (p. 11), while patients with negative religious coping strategies—whereby they believe that one’s illness is a punishment from God—showed the opposite result. Religion and spirituality are correlated with psychological well-being in people with terminal and/or chronic illnesses like HIV/AIDS.
According to one study, Christianity, which is expressed through religious activities such as “prayer, scripture reading or religious literature, and church attendance” improves the quality of life of PLWHA (Bauer, 2013, p. 101). However, most studies on the impact of religion and spirituality in addressing medical conditions have focused on the populations with physical and psychological problems, and not on the service providers. As service providers, NGO and FBO workers in Sub-Saharan African countries work in unique and challenging work environments compared to the organizational contexts in developed nations, and need to be focus of further studies in addressing the HIV/AIDS epidemic from a systemic perspective.

**Theoretical Framework**

The theoretical framework of this study is based on social constructionism and Goffman's (1963) theory of social stigma. In this study, HIV/AIDS stigma is understood as a product of social processes and social construction based on individuals’ attributes that the majority of society has discredited and devalued. Social constructionism and the theory of social stigma provide theoretical guidelines to understanding how religion has affected the construction of HIV/AIDS stigmas. Also, religion and spirituality are essential components to conduct the study.

**Social stigma.** Since Erving Goffman introduced the concept of social stigma in 1963, his social stigma theory has been widely used to provide theoretical foundations for many HIV/AIDS-related stigma studies in many academic disciplines. A Greek word in origin, ‘stigma’ referred to a “physical sign, or brand-mark, such as a cut or burn, that was intended to expose something defective about its bearer” (Stiebert, 2004, p. 80). Goffman (1963) re-defined the word to signify “an attribute that is deeply discrediting” (p. 3). Thus, a ‘stigmatized’ person is a person who has “an undesired difference” from what society has anticipated (Goffman, 1964,
p. 5) which causes the individual to fail to have full social acceptance, and thus become stigmatized. A person with a stigma is regarded as “not quite human,” and under this assumption, people exercise a variety of discriminatory actions toward her/him. Goffman (1963) identified three types of stigmas:

(i) “Abominations of the body,” such as physical blemishes or deformities;

(ii) “Blemishes of individual character,” such as weak will, domineering or unnatural passions, treacherous and rigid beliefs, and one’s attributes written in a known record of mental disorder, imprisonment, addiction, alcoholism, homosexuality, unemployment, suicidal attempts, and radical political behavior;

(iii) “The tribal stigma” of race, nation, and religion (p. 4).

According to Goffman’s theory, PLWHA become stigmatized due to their physical symptoms and deteriorated bodies, as well as negative presumptions toward their characters and behaviors.

Goffman’s social theory has limits. In the context of HIV/AIDS study, Goffman’s original concept of stigma as a “discrediting attribute” has come to be understood as a “relatively static characteristic,” rather than as a constantly changing social process (Parker & Aggleton, 2003, p. 14). Stigma is a product of social processes. HIV/AIDS stigma should be understood as a dynamic social process, rather than as a static characteristic of individuals. Later sociologists who have been influenced by Goffman’s original concepts have redefined stigma in more fluid, dynamic terms (Alonzo & Reynolds, 1995; Weiss & Remarkrishna, 2004). For example, in a study conducted by Weiss and Remarkrishna (2004), stigma was redefined as a process of “a socially discrediting situation of individuals” (p. 2). A study by Alonzo and Reynolds (1995) also redefined stigma as “a powerful discrediting and tainting social label that radically changes the way individuals view themselves and are viewed as persons” (p. 304). More recent studies see
the origins of stigma at the societal level, rather than at the level of individuals’ bodies and identities (Frost, 2011). This study also understands HIV/AIDS stigma at the societal level.

**Social constructionism.** Social constructionism is an important theory that provides a sustainable theoretical foundation to understanding HIV/AIDS stigma. It originated in the work of the sociologists Berger and Luckmann (1966). Social constructionism is defined as a theory of knowledge, arguing that what we know is not a reality of the world, but an idea about the world (Payne, 2005). Social constructionists argue that we share knowledge through a variety of social processes, and people behave and maintain the world based on shared assumptions and shared conventions (Payne, 2005). Reality expressed in languages and meanings is socially constructed based on “relationships and agreements” among people in society, and can be deconstructed in ways to liberate the oppressed (Pyles, 2009, p. 10). HIV/AIDS stigma in Sub-Saharan Africa is socially constructed through the shared value systems among people, and can be deconstructed and reconstructed to empower PLWHA and reduce the stigma attached to them.

Stigma is a product of social construction (Herek, 2002; Joffe, 1999, as cited in Deacon, 2006, p. 420). Society creates norms and categorizes people and their attributes. Stigma is conceptualized by community-based ideas on what constitutes “difference” or “deviance,” and is applied by society through rules and sanctions. As a result, a person who is being stigmatized may be described as having a “spoiled identity” (Goffman, 1963). As a social construct, stigma is defined as “an individual's negative attitude toward a social group, which matches the negative evaluations of society towards the attributes held by that group” (Herek, 2002; as cited in Deacon, 2006, p. 420). One's different attribute does not cause stigmatization, but people in society who create and agree on oppressive language and meanings of the appropriate attribution and/or difference stigmatize PLWHA. It is critical to investigate in what manner, and for what
reasons religions, cultures, societal norms and rules of society create HIV/AIDS stigma toward PLWHA in Sub-Saharan African countries. Social constructionism is helpful in deconstructing people’s beliefs and value systems, and reconstructs them in ways to liberate PLWHA from stigma and discrimination. The theory helps social work researchers and community organizers understand “the social construction of human categories” around sexism, classism, racism, and other forms of discrimination that PLWHA living in Sub-Saharan Africa might experience (Payne, 2005, p. 164).

   Stigma is a social process, “drawing on existing forms of social representation that are rooted in social power relations, emerging from an individual psychological blaming and othering response, a cognitive justification for an emotional reaction of fear” (Joffe, 1999; as cited in Deacon, 2006, p. 420). Stigma is interconnected with other social systems that cause inequalities. Issues of power and dominance are central to the development and use of stigmas. Parker and Aggleton (2003) have argued that stigma functions as a critical tool in the production and reproduction of relations of power and control. It causes some groups to be devalued, and other groups to feel superior. Given the impact of stigmas on treatment opportunities, it is critical to understand and conceptualize HIV/AIDS stigma as a function of societal social processes. In most existing HIV/AIDS-related stigma research, stigmatization has been perceived as an individual process (Link & Phelan, 2001). For instance, Oliver (1992) and Fiske (1998) pointed out that many stigma studies have predominantly focused on individuals’ perceptions of stigma and the consequences of stigma at the micro level, and less in terms of structural issues of society (as cited in Link & Phelan, 2001). In a society that is highly individualized, like that of the U.S.A., such an explanation may seem reasonable. However, in communal Sub-Saharan African cultures, stigmatization and discrimination are social and cultural phenomena related to the
actions of a whole community, rather than consequences of individual behaviors. That is, adequate conceptualization of, and interventions around stigma are difficult and complicated practices because stigma is not a matter of individual behaviors or attributes, but a construction of social, cultural and historical phenomena (Kgalemang, 2004). In the proposed study, religion is understood as a significant cultural factor that has affected the construction of HIV/AIDS stigma.

**Religiosity and spirituality.** Religion and spirituality have many definitions (Cohen & Koenig, 2003; Wagenfeld-Heintz, 2009), with no clear consensus (Okunrounmu, Allen-Wilson, Davey, & Davey, 2016). In clinical research studies, the terms have been often interchangeably used since they have not been clearly separable. From amongst different definitions, this HIV/AIDS stigma study adopted the definition introduced by the Fetzer Institute/National Institute on Aging Work Shop Group (1999):

Religiousness has specific behavioral, social, and denominational characteristics because it involves a system of worship and doctrine that is shared within a group. Spirituality is concerned with the transcendent, addressing ultimate questions about life’s meaning, with the assumption that there is more to life than what we see or fully understand. Spirituality can call us beyond self to concern and compassion for others. While religions aim to foster and nourish the spiritual life - and spirituality is often a salient aspect of religious participation - it is possible to adopt the outward forms of religious worship and doctrine without having a strong relationship to the transcendent. (p. 2).

Based on this definition, the study views religion in the context of ideological commitments and institutional memberships such as Christianity, Buddhism, Islam, Taoism, and Shamanism. Religiosity refers to “an institutionalized pattern of values, beliefs, and symbols, and behaviors and experiences that involves spirituality and a community of adherents, transmission of traditions over time and community support functions that are related to spirituality” (Canda & Furman, 2010, p. 76, as cited in Roh, Lee, Lee, & Martin, 2014). Religiosity involves the cognitive, emotional, behavioral, interpersonal, and physiological processes linking religion and
spirituality (Peltzer, 2011). Spirituality, in contrast, is defined as “inner subjective experiences that are not necessarily related to a specific religion, involving a holistic understanding of material, psychological, social, and spiritual aspects of human beings” (Canda & Furman, 2010 as cited in Roh, Lee, Lee, and Martin, 2014). In the first part of this study, only religiosity is used to investigate the meaning of HIV/AIDS within the participants’ religious belief systems. In the second part of the study, participants’ coping and strengths in continuing to work with PLWHA are explored by focusing on both religiosity and spirituality.

In sum, existing research regarding HIV/AIDS-related stigmas has mostly focused on individuals’ experiences and psychological problems. Religion as a powerful cultural factor has not been fully investigated in previous research. This study viewed HIV/AIDS-related stigmas as a social product, and religion as an important cultural factor that has affected the social construction of HIV/AIDS-related stigma in Sub-Saharan Africa. Religiosity and spirituality in HIV/AIDS service providers in Sub-Saharan African countries have not received enough scholarly attention yet; much of the existing research regarding religiosity and spirituality has focused on service users’ aspects. To help address this lack, since NGOs and FBOs play a significant role in the work of HIV/AIDS intervention and prevention, this study focused on the role of religiosity and spirituality from the perspective of service providers working in NGOs and FBOs in Sub-Saharan African.
Chapter 3: Research Methodology

Research Design and Rationale

Hermeneutic phenomenological qualitative research approach. This study used hermeneutic phenomenology as its qualitative research paradigm. Phenomenology is defined as “the study of phenomena as people experience them - human experience in his or her life” (Sloan & Bowe, 2013, p. 1293). Between two major approaches of phenomenology—descriptive phenomenology and hermeneutic phenomenology—hermeneutic research approach was used as the primary methodology for the study. The epistemological position for this study is based on the belief that new knowledge should be investigated at the place where it is created in the real world, via the people who are living the lives affected. The purpose of this study was to find new knowledge and the new understanding of complexity and contexts where HIV/AIDS and HIV/AIDS stigmas occur. For this reason, the qualitative research approach best served to collect and examine the real words from the lived life experiences of the participants to explore HIV/AIDS and HIV/AIDS-related stigmas in detail.

The Role of Researcher

In the hermeneutic phenomenological qualitative research approach, the researcher played a role as a data collector and interpreter. The research took a position of an interpretivist, who is “concerned with how the social world is interpreted, understood, and experienced or produced” (Manson, 1996, p. 4). The researcher’s principal role was to explore the context where the participants lived, worked, and experienced HIV/AIDS-related stigmas to document participants’ understandings and perceptions more accurately.
Rationale for the Study Location: Malawi

Malawi was chosen as the data collection location for the following reasons. First, the HIV/AIDS adult prevalence rate in Malawi is much higher than in the U.S.A. and other countries (UNAIDS, n. d.). For instance, HIV/AIDS prevalence rate among adults ages 15 to 49 in the U.S.A. in 2014 was 0.5% (UNAIDS, n. d.). In 2016, the HIV adult prevalence rate in Malawi was 9.2 %, which ranked 9th highest in the world. HIV/AIDS-related research is more urgently needed in Malawi than in the U.S.A. The Malawi National Statistical Office (2011) reported that there are about 120,000 children who have HIV/AIDS infection in Malawi, and 470,000 Malawian women ages 15 and older are living with HIV/AIDS. A study on HIV/AIDS and the disease-related stigmas is highly necessary in Malawi because of the high prevalence rate of the disease, and the critical effects of the disease related stigma in the Malawian community.

Second, NGOs and FBOs play a significant role in helping the HIV/AIDS infected populations in Malawi. According to the Council for Non-Governmental Organisations in Malawi (CONGOMA), there are about 380 registered domestic NGOs, and about 170 registered international NGOs in Malawi as of November 2016 (www.congoma.mw, n. d.). Considering the number of unregistered NGOs in addition, there are possibly a larger number NGOs and FBOs working in the nation to help PLWHA. Malawi is home to a large number of potential research participants where so many NGOs and FBOs play a significant role in HIV/AIDS prevention and intervention.

Malawi was also chosen to be a study site due to a previously established connection between the researcher and one specific Malawian NGO, Shelter on the Rock (SOTR), located in the town of Lunzu, Malawi. Conducting an international study in Malawi was much more doable than in other Sub-Saharan African countries. The researcher’s personal connection with SOTR
facilitated recruiting the participants in the beginning of recruitment. Additionally, the researcher had experience in working with PLWHA in Malawi in 2004. Familiarity with the nation, and the research environment was a benefit for the researcher to better understand the study participants.

Participants

Research participants consist of people who have had the same experience in a phenomenon (Creswell, 2013). All participants for the study were people working with PLWHA at NGOs and FBOs in southern Malawi.

Inclusion criteria. The inclusion criteria were as follows.

(i) Individuals who have worked at least for one year with HIV/AIDS infected populations in Malawi.

(ii) Individuals who have worked at international or domestic NGOs and FBOs in Malawi.

(iii) Individuals who are older than 18.

(iv) Individuals who have a religion, and regularly participate in a structured form of religion.

(v) Individuals who are professionals, such as social worker, nurse, doctor, teacher, advocate, community developer, clergy, missionary, and other professionals.

(vi) Individuals who can communicate fluently in English.

Sampling Methods

Both snowball sampling and purposive sampling methods were used in the study. Snowball sampling is a widely used data assessing method in qualitative research in many academic disciplines across the social sciences (Noy, 2007). The researcher contacted other informants through referrals from the research participants. Purposive sampling, also known as judgmental sampling, is the most common sampling method in qualitative research (Fortune &
Reid, 1999). Organizations’ websites and Social Network System (SNS) such as Facebook were also used to initiate first contact, and recruit potential respondents in Malawi.

**Internet qualitative research methods.** Data collection utilized the Internet. The Internet qualitative research methods are defined as “Internet methods that are used to collect qualitative data for interviews, observations, and/or document analyses” (Im & Chee, 2012, p. 2). Between synchronous and asynchronous ways, the researcher used asynchronous communication for data collection. Asynchronous communication refers to communication and collaboration over a period of time through “different time-different place” such as email, discussion boards, survey and polls, streaming audio and video, and databases (Ashley, 2003). Since the study was an international research project conducted from the U.S.A. with the populations in a Sub-Saharan African country, Internet technologies were necessary and helpful to “overcome the barriers imposed by space, time, and location” (Heflich & Rice, 1999, p. 3). Using the Internet represented the best manner to collect data because 1) Internet technologies enabled the researcher to collect data beyond geographical distance between the U.S.A. and Malawi, and 2) it enabled the researcher to conduct the study in a financially feasible way.

**Online questionnaire:** The online questionnaire was one of the asynchronous communication tools that the study utilized for data collection. The structured interview questionnaire was posted on a web-based survey site, called Google Forms. The participants visited the designated website through the online questionnaire link which was emailed to them.

**E-mail exchanges.** Email as an asynchronous interview method was used for the study. The questionnaire and the informed consent form were delivered to the participants as an electronic file via email. The participants answered the questionnaire using the MS Word program, and sent back the electronic files to the researcher via email.
**Hardcopy and email.** Six participants completed the questionnaire using hard copies. Those who did not have stable Internet accessibility or computer and preferred hardcopy to Internet methods completed the questionnaire with paper and pen. The contact person in Malawi helped with scanning the questionnaires and consent forms and emailed the documents to the researcher. The scanned documents were then converted to PDF files for data analysis. The original documents were discarded in Malawi to protect confidentiality and privacy.

**Data Collection Procedures**

Data collection was started upon the IRB approval, and continued for about nine months, between May 2016 and February 2017.

**Posting flyers in the community.** Flyers about the study were posted in public places in the community, including hospitals, churches, colleges, markets, and community service agencies in Blantyre, the nation’s biggest commercial city and other towns nearby. The designated contact person in Malawi handed out flyers to professionals, volunteers, clergies working at NGOs and FBOs in southern Malawi in person. Flyers were also posted at a large commercial company to widely spread information about the study.

**Organizations’ websites.** Organizations’ websites were used for purposive sampling. Many NGOs and FBOs in Malawi run their websites or SNS accounts such as Facebook.com to communicate with people in online communities. The scope and vision of organizations, which were displayed on their websites, were reviewed. The researcher contacted several organizations via email to introduce the study and request for participation. However, no one responded back to the researcher via this method. The purposive sampling method with organizational websites was attempted, but failed to recruit an actual participant.
The first potential participant contacted the researcher via email after finding a flyer posted at a local church, and also hearing about the study through Shelter on the Rock in Lunzu. After examining the eligibility for study participation via emails, the researcher sent the informed consent form. The participant reviewed the informed consent form, signed the form, and emailed it back to the researcher via email. Both an MS Word document and the online link to the Google Form were then sent to the participant via email. The participant completed her questionnaire via Google form. The participant works at the national office of an international NGO, and introduced the study to other coworkers. Through the first participant, the snowball sampling was expanded to other NGO workers in Blantyre. Two other participants were recruited through the first participant. In the same way of snowball sampling method, a total of 23 people completed the questionnaire. However, three applicants were excluded for the following reasons: one was agnostic; one had been in Malawi less than a year; and one was a dentist working at a private clinic.

**Data Analyses**

The collected data were imported into a qualitative data analysis software program, ATLAS.ti (Version 8). The qualitative data analyses consisted of the following steps:

(i) *Importing the texts and PDF files into the ATLAS.ti (Version 8):* The data collected via Online Google forms and emails were saved in MS Word documents and imported into the ATLAS.ti (version 8) for data analyses. Six scanned hardcopies were converted to PDF files, and imported into ATLAS.ti (Version 8) for data analysis.

(ii) *Immersing in the Data:* The researcher carefully read the data several times before analyzing the data. In the first phase, which is often called “immersing oneself in the data,” the researcher established an initial interpretation of the data to later develop
coding of the data in subsequent phases of analysis (Cohen, Kahn, & Steeves, 2000, p. 76).

(iii) Categorizing codes and developing themes: The research questions were used to organize the narrative texts, and develop codes and themes. The researcher examined the narrative data line by line, and categorized the narrative texts into codes. Codes were merged continuously, reduced, and transformed into themes.

(iv) Interpreting the textual meanings: The researcher interpreted participants’ narratives through the reflective process of writing and rewriting.

Reliability, Generalizability, and Validity

This research study is a qualitative study using hermeneutic phenomenological approaches. This study does not seek to establish universal laws that can be applicable to, and replicable in other situations. Since this study was conducted with social constructivist and interpretivist perspectives, the researcher believes that reality is socially constructed, and that there are many understandings of reality. Generalizability and reliability are not the goals of the study. The researcher tried to reduce inaccurate interpretations and increase validity to the analysis process. Codes were first created based on the research questions, and then scrutinized, expanded, altered, or discarded to develop the most comprehensive and accurate analysis before being categorized into higher-order themes and subsequent subthemes. Three scholars who were in the doctoral dissertation committee and have known the study for the past four years carefully reviewed all the emerged themes and narrative data, and examined the validity of the data analyses.
Protection of Rights of Participants

The review of the IRB. The Institutional Review Board (IRB) at the University at Albany reviewed the proposed study, and approved the study on May 20, 2016. Since the study was an international research project, an individual who has enough knowledge about the local research environment reviewed the study as part of the IRB review process. The individual in Malawi carefully evaluated the proposed study, and reported in the required document that the study did not contain any potential for harm to local customs, values, mores, and traditions in Malawi. There were no known risks associated with participating in the study. However, participating in the study might have carried the possibility of discomfort in talking about, and sharing stigmatizing behaviors, and thoughts about the organizations and religious communities that the participants are involved in. To address any possible discomfort, information regarding psychological support was provided in the informed consent form. All participants voluntarily participated in the study. No compensation was offered to any participants after the questionnaire completed.

Confidentiality and anonymity. Confidentiality was protected throughout the data collection and analysis procedures. Identification of each participant was coded with a three-digit number. All questionnaires were imported to the ATLAS.ti software program with the coded identification number to protect the participants’ confidentiality. In the dissertation, and in any future publication, anonymity will be maintained to protect the participants’ privacy.
Chapter 4: Results

The results chapter is divided into four parts based on the data analyses procedures to answer the research questions. The first section gives information about the participants’ demographics and organizational backgrounds. The second section focuses on the participants’ perceptions of, and experiences about the society’s general opinions toward HIV/AIDS in Malawi. The third section focuses on the meaning of HIV/AIDS in relation to participants’ religious beliefs, and manifestations of HIV/AIDS stigma in their religious communities. Finally, the fourth section reports on the role of religiosity and spirituality in service provisions for PLWHA in southern Malawi.

Demographics

Twenty individuals participated in the research survey. Eight (40%) participants were women, and 12 (60%) were men. The average age was 35 years ($SD = 13$). The ages ranged between 20 and 65 years. Eleven (55%) of the 20 participants were married, and nine (45%) reported being single or never married.

Nationality and ethnicity. Fourteen (70%) participants were Malawians. Six (30%) participants were from foreign countries, including Australia ($n=1$, 5%), Canada ($n=1$, 5%), Dutch ($n=1$, 5%), South Korea ($n=1$, 5%), England ($n=1$, 5%), and Zimbabwe ($n=1$, 5%). Fourteen (70%) Malawian participants were African; four (20%) participants were white; one (5%) participant was biracial, of white and African descent; one (5%) participant was Asian. Nineteen (95%) participants had more than high school education. One participant, a kindergarten assistant at a Christian NGO in a rural village, had less than high school education. One was a college student who had worked as a volunteer at an international NGO in Blantyre,
Malawi. Twelve (60%) participants had a college education. One (5%) had a Master’s degree in social work.

**Religion.** All twenty (100%) participants were Christians. Three (15%) participants were Catholic Christians, and seventeen (85%) were Protestant Christians. The specific Protestant denomination was not asked to be reported in the questionnaire. One participant noted conversion from Islam in 1996. The average of years in Christianity was 24 years and eight months ($SD=11.34$), ranging between five years and 54 years. Table 1 shows demographic information of the participants.

Table 1

*Demographic Information*

<table>
<thead>
<tr>
<th>Variable</th>
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<tbody>
<tr>
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<tr>
<td>Female</td>
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<td>40</td>
</tr>
<tr>
<td><strong>Age</strong></td>
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<tr>
<td>ranged 20-65 years</td>
<td>$M=35$</td>
<td>$SD=13$</td>
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<tr>
<td><strong>Marital Status</strong></td>
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<td></td>
</tr>
<tr>
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<td>55</td>
</tr>
<tr>
<td>Single or never married</td>
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<td>45</td>
</tr>
<tr>
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<td></td>
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<tr>
<td>College Graduate</td>
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<td>Master</td>
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<tr>
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<tr>
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<tr>
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<td>5</td>
</tr>
<tr>
<td>United Kingdom</td>
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<td>5</td>
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</tbody>
</table>

**Occupation.** The participants’ occupations varied. Four (20%) participants reported being social workers. Four (20%) participants were clergy. Three (15%) participants reported being missionaries. One of the missionaries was a founder of several schools, and an orphanage, in southern Malawi. Another missionary was a director of an NGO working with HIV/AIDS orphans and widows, and the third missionary was an education consultant at a private school in the city of Blantyre. All three missionaries identified themselves as Christian, but had occupational specialties in their organizations.

Of the twelve participants, two (10%) were nurses. Two (10%) participants were teachers. Two (10%) participants were research assistants. Two (10%) were program aides working with HIV/AIDS affected children and youth at a local NGO in a village. One participant (5%) reported being a journalist working at an international NGO that provides a variety of social services to HIV/AIDS affected populations and the poor. Table 2 shows the participants’ occupations.
The length of work experience at NGOs and FBOs. The average length of the participants’ work experience at their current organizations was five years and five months. The length of their work experience at the current NGOs and FBOs ranged from one year to fifteen years \((SD = 4.83 \text{ years})\).

Table 2

*Occupations of the Study Participants*

<table>
<thead>
<tr>
<th>Occupation</th>
<th>N=20</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social worker</td>
<td>4</td>
<td>20</td>
</tr>
<tr>
<td>Clergy</td>
<td>4</td>
<td>20</td>
</tr>
<tr>
<td>Missionary</td>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td>- Education consultant</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>- Director of NGO</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>- Director of orphanage &amp; school</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Teacher</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Research assistant</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Program aide</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Journalist</td>
<td>1</td>
<td>5</td>
</tr>
</tbody>
</table>

Language. Of the 14 Malawian participants, 11 Malawian (55%) participants reported Chichewa as a primary language. Of the 20 participants, six (30%) reported English as a primary language. A participant from Germany who had worked in Malawi for 14 years and five months noted English, Dutch, and Chichewa as primary languages. One (5%) reported Korean as a primary language. One Malawian participant reported Nyanja, which is another tribal language in Malawi, as a primary language. The majority of the participants said that they communicate with clients and coworkers at work both in English and Chichewa. Seventeen participants (85%) were bi-lingual or tri-lingual. Three (15%) out of six native English speakers reported that they
communicated only in English in Malawi. Three (15%) of six native English-speaking foreigners were able to communicate in Chichewa fluently. Among 14 Malawian participants, five reported speaking Chichewa and another Malawian tribal language such as Tumbuka \((n=2)\), Ngonde \((n=1)\), Nyanja \((n=1)\), and Yao \((n=1)\). Both foreign and domestic NGO workers were fluent in English.

Table 3

*Primary Language and Communication Language at Work*

<table>
<thead>
<tr>
<th>Variable</th>
<th>N=20</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Language</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chichewa</td>
<td>11</td>
<td>55</td>
</tr>
<tr>
<td>English</td>
<td>6</td>
<td>30</td>
</tr>
<tr>
<td>Dutch and English</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Korean</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Nyanja</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td><strong>Communication Language</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>English</td>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td>English &amp; Chichewa</td>
<td>12</td>
<td>60</td>
</tr>
<tr>
<td>English, Chichewa &amp; Nyanja</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>English, Chichewa &amp; Tumbuka</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>English, Chichewa &amp; Sena</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>English, Chichewa &amp; Yao</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Chichewa, Tumbuka &amp; Ngonde</td>
<td>1</td>
<td>5</td>
</tr>
</tbody>
</table>

**Organizational information**

**Source of funding.** The twenty participants were recruited from thirteen organizations in Malawi. Of 13, five (38%) organizations were domestic organizations primarily funded by domestic donors in Malawi. Four (31%) were international, with major funding from abroad. Four (31%) organizations were funded by both domestic and international donors.
**Geographic location.** Of 13, eight (61%) NGOs or FBOs are located in the city of Blantyre. Two (15%) Christian NGOs are located in remote villages. One (8%) international NGO has various branches in the city, in rural areas, and in remote village areas in Malawi. One (8%) organization is located both in a rural community and in a remote village. One (8%) international FBO has offices both in city and rural areas in southern Malawi. Table 3 shows information about the organizations where the participants have worked in Malawi.

Table 4

**Organizational Information**

<table>
<thead>
<tr>
<th>Variable</th>
<th>N=13</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of Organization</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domestic</td>
<td>5</td>
<td>38</td>
</tr>
<tr>
<td>International</td>
<td>4</td>
<td>31</td>
</tr>
<tr>
<td>International &amp; Domestic</td>
<td>4</td>
<td>31</td>
</tr>
<tr>
<td><strong>Geographic Location</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>8</td>
<td>62</td>
</tr>
<tr>
<td>Village</td>
<td>2</td>
<td>15</td>
</tr>
<tr>
<td>City &amp; Rural</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Rural &amp; Village</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>City, Rural &amp; Village</td>
<td>1</td>
<td>8</td>
</tr>
</tbody>
</table>

**Years of work:** ranged 1-15  
Mean= 5 years and 5 months  
SD: 4 years and 10 months

**Services provided by the NGOs and FBOs.** The 13 NGOs and FBOs provide a variety of social, medical, religious services for people living with, and without HIV/AIDS. All the organizations offer services related to HIV/AIDS interventions, prevention, and care. The majority of the organizations provide feeding and educational programs as well as medical services to HIV/AIDS affected populations in their communities. Of the 13, one international NGO conducts clinical research and provides direct services to the poor, and the HIV/AIDS
affected people in Malawi. Five organizations are local churches, and five are Christian NGOs. Three of the five Christian NGOs offer religious services to people in the community. Table 4 shows the services that each organization provides in the community.

**Perceptions about the society’s general opinions toward PLWHA**

*Research Question: How Do You Think Malawi’s General Opinion about PLWHA?*

Participants were asked to comment on how they perceive Malawi’s general opinions about PLWHA. Ten (50%) participants commented that general opinions about PLWHA were positive and less stigmatizing in Malawi than in the past. In contrast, 10 (50%) participants commented that general opinions about PLWHA are still negative and highly stigmatizing in the community.

**Negative opinions.** The following quotes provide examples of the participants’ experiences at work and in the community regarding negative opinions about PLWHA. The quotes were regarding what the participants had heard about PLWHA or observed at work and in the community, not what they personally thought. They commented that they had heard people in the community describing PLWHA as being “punished by God,” “responsible for their status,” “useless,” “immoral,” “careless,” and “hopeless.” Table 5 includes several examples of the participants’ comments about their society’s negative perceptions of PLWHA.

Table 5

*Society’s Negative Opinions about PLWHA in Malawi*

<table>
<thead>
<tr>
<th>Theme</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Punished</td>
<td>“HIV/AIDS is a punishment from God. PLWHA are punished by God because of their bad habits.” (40, Malawian, male, social worker)</td>
</tr>
<tr>
<td>Responsible for HIV positive status</td>
<td>“It is just their fault or the world never should have started with the ARV-medication.” (48, Dutch, female, nurse)</td>
</tr>
</tbody>
</table>
Useless

“They worry that they will be discriminated against and therefore not get a job in the first place or that an employer will release them from employment if they find out that he or she has HIV.” (38, British, male, education consultant)

“People with HIV/AIDS should not be employed because they cannot develop the company because they are always sick.” (22, Malawian, female-b, teacher)

“These people have got nothing else to offer/contribute to the growth and development of the nation.” (23, Malawian, male, social worker)

“PLWHA are useless people who cannot do anything in the society and some said that it’s not good to involve them in any community development work because they will not give picture to the children.” (40, Malawian, male, social worker)

Immoral

“Those who are affected are prostitutes.” (28, Malawian, female, teacher)

“HIV/AIDS is for all the people who are prostitutes.” (40, Malawian, male, social worker)

Careless

“Taking them as careless people.” (34, Malawian, female, social worker)

Hopeless

“Their journey of life has come to an end.” (23, Malawian, male, social worker)

“They will die early.” (28, Malawian, female, teacher)

“People without hope.” (37, Malawian, male, clergy)

“To have HIV/AIDS is the end of life.” (20, Malawian, male, program aide)

“[if] they are HIV/AIDS positive, then it is the end of their lives.” (65, Canadian, male, missionary: principal of schools and orphanage)

Positive opinions. In contrast, half of the participants perceived that the general opinions about PLWHA had become fairly positive in Malawi. For instance, one said, “On the whole, I have little or no recollection of negativity towards PLWHA” (65, Canadian, male, missionary: principal of schools and orphanage). Many participants commented that PLWHA were generally “accepted” in society and not being discriminated against despite their HIV status. The general atmosphere had become much more positive than in the past because of the high prevalence rate of HIV/AIDS. Participants noted that HIV/AIDS is a fairly “common” disease in Malawi, and
people know that “anyone can be affected.” One said, “Everyone has a family member who is positive.” Also, the participants mentioned that the various caring efforts of NGOs and FBOs, and the public education and campaigns provided by NGOs and the Malawian Government had worked to reduce HIV/AIDS stigma in Malawi. Table 6 shows examples of positive opinions about PLWHA and the promoting factors of HIV/AIDS stigma reduction in Malawi.

Half of the participants perceived society’s general opinion toward PLWHA as being negative. In contrast, the other half perceived it being positive.

Table 6

*Society’s Positive Opinions about PLWHA and Factors of Stigma Reduction*

<table>
<thead>
<tr>
<th>Factor</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High Prevalence</strong></td>
<td>“There is a general acceptance and support as it is so widespread… The positive opinions exist because HIV/AIDS is so common. Probably every family has a member who is positive. There is no stigma because it is so common.” (54, Australian, female, nurse)</td>
</tr>
<tr>
<td></td>
<td>“Accepting. This situation can happen to anyone.” (34, Malawian, female, social worker)</td>
</tr>
<tr>
<td><strong>The Efforts of NGOs &amp; FBOs</strong></td>
<td>“There are many NGOs giving care and support, people are encouraged to be tested and on medication. There are growing numbers of people who are open to their positive status. There are billboards and radio drama/advertisements encouraging people to be tested and encouraging good attitudes.” (54, Australian, female, nurse)</td>
</tr>
<tr>
<td></td>
<td>“Because of outreach programs implemented by organizations.” (25, Malawian, male, research assistant)</td>
</tr>
<tr>
<td></td>
<td>“The church helped to sensitize people about this [HIV/AIDS stigma].” (59, Malawian, male, clergy)</td>
</tr>
<tr>
<td></td>
<td>“The church has played a major role to bridge the disconnection gap.” (34, Malawian, female, social worker)</td>
</tr>
<tr>
<td></td>
<td>“The church is in the forefront in the fight against HIV/AIDS.” (23, Malawian, male, social worker)</td>
</tr>
</tbody>
</table>
Public Education & Campaigns

“Civic education has really turned the mindset of the people of Malawi to start considering these people to take part in various or to be given different roles in churches or organizations.” (40, Malawian, male, social worker)

“Once we had negative opinions against PLWH, but through public awareness that has come from different stakeholders, Malawi recognizes people with HIV/AIDS like everyone else.” (36, Malawian, male, clergy)

“… because of the vast public awareness campaigns that have been continued through media.” (26, Malawian, female, journalist)

Religious Beliefs and the Meanings of HIV/AIDS

Research Question: What is your thought about the statement, “HIV/AIDS is a punishment of God”?

Each participant was asked to comment on his or her thoughts about the statement, “HIV/AIDS is a punishment of God.” The participants were asked to share their understanding of the meaning of HIV/AIDS in relation to their religious beliefs. Of 20 participants, only three (15%) NGO workers commented that they think that HIV/AIDS is a punishment of God. In contrast, 17 (85%) NGO workers stated that they do not agree with the statement. Several important themes emerged from their narrative data. The themes include 1) HIV/AIDS as a punishment of God; 2) HIV/AIDS as a consequence of sin; 3) HIV/AIDS as a result of human behaviors; 4) HIV/AIDS as a medical disease; and 5) HIV/AIDS as a bridge between God and humanity.

HIV/AIDS as a punishment of God. Of 20, only three participants noted that they agree that HIV/AIDS is a punishment of God. The following quotes are samples of their responses.

“Yes, it is because of disobedience to God’s word. The bible says so.” (41, Malawian, male, clergy)

“I believe that claim ‘may’ be right. This is primarily based on my observations on the Old Testament. Whenever the Israelites disobeyed God, He punished them, and disease
was one of the most common methods. The cases of ancient Israelites are a little bit extreme, but it shows that all disasters have reasons. In my opinion, even natural disasters that seem to have nothing to do with God’s supernatural activities are actually what God had planned ahead. Still, what caused God to allow HIV/AIDS to spread is something we never know. Actually there are billions of reasons for God to sweep us to death… In my country’s religious communities, HIV/AIDS is generally considered a punishment for human being’s indiscriminate sexual behaviors.” (25, Korean, male, research assistant)

“Yes, HIV/AIDS is a punishment of God, because in Revelation the Bible says that at the end most people would suffer from many diseases. People living with HIV/AIDS die. When people die to a disease, we know that God is punishing them.” (22, Malawian, female-a, program aide)

These three participants perceived HIV as God’s punishment. The participants understood that HIV/AIDS is God’s divine action toward disobedient people. All three participants commented that their opinions are based on their interpretation of the Bible. One, in a broad sense, mentioned the Bible, and used the Old Testament as his reference to support his opinion; the other used the book of Revelation in the New Testament. The participants stated that HIV/AIDS is a result of people’s “disobedience to God’s word.” For instance, a 25-year-old Korean man commented that “disease was the most common method” of God to punish ancient Israelites in the Old Testament. The participant understood that every phenomenon, including diseases and natural disasters is caused according to God’s plan and action. He commented, “These diseases could be part of God’s punishment, or could be something God temporarily allows for His plans.” He perceived that although humanity cannot fully understand why God allows HIV/AIDS to spread, it is caused for a reason in God. A 22-year-old Malawian woman understood that one’s death caused by a disease might be an evidence of God’s punishment. The participant’s brief indicates her understanding of a relationship between sin, death, and suffering. For her, death and suffering of PLWHA were interpreted as a sign of God’s punishment. For these three participants, the meaning of HIV/AIDS was God’s punitive action toward disobedient people. They understood that God’s divine will was involved in the disease.
**HIV/AIDS as a consequence of sin in the fallen world.** Several participants noted that a disease like HIV/AIDS is “a consequence of sin, not a punishment from God.” Their understanding about HIV/AIDS was closely connected to the Christian doctrine of sin and evil. The following quotes indicate the link between the meaning of HIV/AIDS and their understandings of sin and evil.

“It [HIV/AIDS] is an illness, a result of our fallen world, just like another illness or injustice.” (54, Australian, female, social worker)

“I don’t believe that our loving and forgiving Father in heaven would punish us [with HIV/AIDS]. This is the wage of sin. Sin has corrupted our world. We have given the keys of the world to Satan, and this [HIV/AIDS] is one of his manifestations.” (37, Zimbabwean, male, missionary: director of NGO)

“HIV/AIDS is not a punishment from God, and only He can heal HIV/AIDS. AIDS comes from the devil because his purpose is to kill, lie and destroy, but God gives abundant life.” (36, Malawian, male, clergy)

“All sickness is a consequence of sin, not a punishment from God. As man chose to rebel against God, we opened the door for the devil to bring sickness into the world and so we live with the reality of our brokenness. For those who are born with HIV or are infected because of the actions of others, this is a consequence of sin in the world, not God punishing them.” (37, British, male, missionary: education consultant)

Four participants stated that HIV/AIDS is neither based on the action of God, nor the will of God. Rather, they perceived that HIV/AIDS to be “a consequence of sin,” “a result of our fallen world,” and “a wage of sin.” For instance, a 48-year-old Dutch participant noted, “God did not create sickness.” Due to the original sin, the world has been fallen and become broken. As a result of the fall, humanity “opened the door for the devil to bring sickness into the world.”

Another participant mentioned that HIV/AIDS comes from “the devil,” and that it is “a manifestation of Satan.” Compared to the participants who understand HIV/AIDS as a punitive act of God, these participants viewed HIV/AIDS as an act of Satan whose purpose is to “kill, lie, and destroy” humanity, not of God. For these participants, HIV/AIDS does not mean God’s
divine action to punish human beings. God was understood as “a loving and forgiving Father” who “can heal HIV/AIDS” and gives “an abundant life.” Diseases like HIV/AIDS and suffering from diseases were interpreted as entering in the world through Satan due to the original sin.

**HIV/AIDS as a consequence of human behavior.** Several participants perceived HIV/AIDS as a result of human behaviors. The following quotes are examples of the link between HIV/AIDS and human behaviors.

“I strongly disagree. HIV/AIDS is a consequence of people’s behavior but not a punishment from God. I think God’s heart breaks to see His children suffer in any way and HIV/AIDS in no exception. People experience the consequences of human behavior in all areas of life, but this is not God’s plan. Jesus came to give us life in all its fullness.” (54, Australian, female, social worker)

“In my life, I see there are consequences to all of my actions. If I drink dirty water, I am likely to become sick. If I am wasteful with my money, I become poor or struggle financially. For some, it might be a consequence of behavior... For some, it might be a consequence of behavior... If I sleep with someone with HIV especially without any protection, I should not be surprised when I find I have HIV. It is part of God's order in the world to have cause and effect.” (37, British, male, missionary: education consultant)

“I disagree. The Lord didn't create sickness: He is our healer. In the Eyes of the Lord, we are all the same. Jesus Christ died for all of us. We all make mistakes, sometimes knowing, and sometimes not knowing. The consequences are for us and it is by His Grace that there is always a new beginning [whether we are] HIV/AIDS positive or negative.” (48, Dutch, female, nurse)

“The issue is not the affliction but whether a person will come to the Lord and or walk with the Lord through it all. Does it make a difference what disease, deformity, impairment [...]? I think not. We all have impairments whether physical or emotional scars, whether mental... even demonic. Yes, that is real or whatever religiosity and lack of knowledge of spiritual things... not knowing God is not an excuse as each person has the free will to call out in sincerity to him. He will hear! He will come! He will save! He will not violate our free choice.” (65, Canadian, male, missionary: principal of schools and orphanage)

A 54-year-old Australian woman noted that HIV/AIDS is neither a punishment of God, nor God’s plan for humanity, but a consequence of human behaviors. A 37-year-old British man noted the law of cause and effect. Based on the law of cause and effect, he understood that
HIV/AIDS occurs to individuals who have involved in the causing behaviors. In the same sense, a 48-year-old Dutch female commented that individuals are responsible for the consequences of their behaviors, and a 65-year-old Canadian missionary emphasized the importance of free will in individuals’ choices. In this perception, individuals’ free will and self-destructive behaviors are the more influential factors in causing HIV/AIDS, rather than the act of God or the devil. The participants believed that one’s self-destructive behavior brought out a negative impact on the individual, since death and suffering are natural part of the fallen world.

**HIV/AIDS as an opportunity to help PLWHA.** A few participants mentioned that HIV/AIDS is an opportunity for Christians to help PLWHA and reach out them.

“I see HIV as an opportunity for us to reach out to broken people. I may not have HIV but I am broken in areas of my life too. We all need Jesus Christ and are all called to be His hands and feet. I believe that Jesus values every human and wants a relationship with people no matter what they have done in the past or sickness that they may suffer from.” (37, British, male, missionary: education consultant)

“The issue is not the affliction but whether a person will come to the Lord and or walk with the Lord through it all. Does it make a difference what disease, deformity, impairment […]? I think not. We all have impairments whether physical or emotional scars, whether mental… even demonic. Yes, that is real or whatever religiosity and lack of knowledge of spiritual things… not knowing God is not an excuse as each person has the free will to call out in sincerity to him. He will hear! He will come! He will save! He will not violate our free choice. “ (65, Canadian, male, missionary: principal of schools and orphanage)

A 37-year-old British man stated, “HIV as an opportunity for us [Christians] to reach out to broken people.” He commented that Christians are the “hands and feet of Jesus” meant to help PLWHA. He noted that every one, regardless of one’s HIV/ADIS status, needs a relationship with Jesus and helping PLWHA can be ways of Christian serving and evangelism. A 65-year-old Canadian man mentioned about “knowing God” in his comments. Both participants emphasized the importance of personal salvation through Jesus.
**HIV/AIDS as a medical disease.** Several participants noted that they understand HIV/AIDS as a medical disease like “cancer, TB, or other illness.” The following quotes are samples of the responses from participants who viewed HIV/ADIS as a medical disease.

“I view HIV/AIDS in the same way as I would view cancer, TB or any illness. Either one that can be caught and passed on or not.” (54, Australian, female, social worker)

“I totally disagree with the statement above. It is a disease as others since it’s a combination of different diseases and there is no any new disease that comes out. All what is associated with HIV/AIDS it has been there before AIDS only that we don’t know the source of the various and this cannot be a punishment from God. HIV/AIDS is a disease for everybody and it can affect anyone because it has different ways how a person can get in not only for unprotected sex with a partner who is HIV positive.” (40, Malawian, male, social worker)

“I look at HIV/AIDS just as any other disease that people can suffer from. Though it is said that it has no cure, personally I understand it [HIV/AIDS] as a curable disease because the bible tells me in Psalms 103 that God is the healer of all the diseases.” (22, Malawian, female-b, teacher)

“The cause of the disease is known; [there is] no need to say that [HIV/AIDS] is a punishment of God.” (26, Malawian, female, journalist)

As the quotes indicate, participants perceived HIV/AIDS as a medical disease that “anyone could have contracted.” A 23-year-old Malawian man said that if HIV/AIDS is a punishment of God, we should say “Malaria is also a punishment [of God] because it is the number one disease taking lives” in Malawi. Participants mentioned that they viewed HIV/AIDS and other diseases to be on equal footing.

**Manifestations of HIV/AIDS Stigma in the Faith Community**

*Research Question: How has religion stigmatized PLWHA in Malawi?*

Each participant was asked about how they think, and have observed how religion has stigmatized PLWHA in Malawi. The participants were asked to share their experiences, and if they have seen any examples. Of 20, nine (45%) participants commented that religion does not stigmatize PLWHA in Malawi, and that they had never seen any stigmatizing events in their
religious communities. Two of the nine participants noted that “the church has played a major role” in reducing HIV/AIDS stigma in their communities. The following quotes are from their responses.

“This is not true. The church has played a major role to bridge the disconnection gap. Churches have taken a leading role in introducing community home-based care groups, whereby church members are part of the group who have the responsibility to provide care and support in the communities to sick people. The group takes care of all sick people who are their church members and others as well. This was started after realizing that a lot of people were sick in their homes and some had nobody to take care of them.” (34, Malawian, female, social worker)

“It is never seen like that, and the church is the forefront in the fight against HIV/AIDS.” (23, Malawian, male, social worker)

One participant talked about community home-care groups as an example of how the church has played an essential role in reducing HIV/AIDS stigma and helping PLWHA.

In contrast, other participants reported stigmatizing situations that had been observed in their community. The participants noted that PLWHA were often accused of immorality, excluded in church, hurt by preaching messages, and forced to fast to assist in healing.

**Being excluded.** The participants commented that PLWHA were excluded in activities, leadership roles, and educational opportunities in the church. The following quotes are samples of their responses.

“Most people who have been positive have been stigmatized in different areas. Some were ignored to be given different roles to play in various activities. This has been a song of the past since most of the church leaders have been involved in different seminars and this has helped a lot.” (40, Malawian, male, social worker)

“Yes, instances where people are denied to participate in leading on church departments because they had confessed to their positive status; not allowed to teach the children in church. Sometimes, churches effuse to send PLWHA to further their education.” (36, Malawian, male, clergy)
Being hurt by preaching and indifference. A 26-year-old journalist said that stigmatization is manifested through “preaching the message that can hurt feelings of PLWHA.” The participant mentioned that the church had stigmatized PLWHA “by not having many teaching and worship for them to get encouraged in their lives.” She viewed the indifference toward church members with HIV/AIDS as a form of stigmatization.

Being forced to fast. The same participant commented about forced long-term fasting in church. She observed that the church leader was “teaching and forcing them [PLWHA] to go for a long fasting for 30 days,” and the long-term fasting made “their bodies to fail to use their medication properly.”

Being accused and judged for immorality. One participant noted that PLWHA are often accused and judged in churches for their sexual immorality. The following quote is an excerpt from his comment.

“Some churches will accuse people who have HIV of being immoral. Unfortunately, this attitude tends to focus mostly girls who are then marginalized or even thrown out by the church but the men are allowed to do what they like without judgment. Sometimes men who have slept with these women still attend church while the girls have been excommunicated. Judgmental religion seriously stigmatizes people with HIV but is often very hypocritical in the way it is applied, especially towards women.” (37, British, male, missionary: education consultant)

He pointed to gender inequality between men and women in churches of Malawi. Women with HIV/AIDS are sometimes excommunicated from their churches for their sexual immorality, but men who slept with these women are still allowed to attend their churches.

Factors Perpetuating Ongoing Stigma in Community

Research question: “Which factors do you think brought out stigmatizing situations to happen in your religious community?”
Several themes emerged from the comments of the participants. The themes include 1) incurability, 2) suffering and visible symptoms, 3) sexual immorality, 4) theology of end times, and 5) misinterpretation of the Bible.

**Incurability.** Two participants noted that incurability of the disease had contributed to ongoing stigma against PLWHA in their religious community. They commented that some people perceived HIV/AIDS as a punishment of God because the disease is still incurable despite modern medicine. The following quotes are examples of their view.

“In the Bible, the sinners were punished with strange diseases. HIV/AIDS is also a strange disease because it is not curable.” (28, Malawian, female, teacher)

“Since there is no cure the disease… This is why people associated the disease with the punishment from God.” (40, Malawian, male, social worker)

Participants commented that some people view HIV/AIDS as a punishment from God because there is no cure for the disease with modern medicine yet. One said that because “in the Bible, the sinners were often punished with strange diseases.” Due to its incurability with modern medicine, some people view HIV/AIDS as God’s punitive method toward sinners.

**Suffering and visible symptoms.** Several participants commented that due to the visible symptoms of the disease and excessive pain that PLWHA experience as the disease progresses, people tend to believe that God is punishing them with suffering through a disease. The following quotes are examples of the theme.

“PLWHA suffer and have visible symptoms like skin lashes, vomiting, and lose of weight.” (22, Malawian, female-a, program aide)

“AIDS patients suffer a lot. There are so many complications in their bodies and because of that, people think it’s a punishment of God.” (22, Malawian, female-b, teacher)

“Those who are on ARVs say that once a person is on these drugs, his body shape changes like deformed body structure and muscle becomes tighter and he develops obesity and mentally unwell.” (36, Malawian, male, clergy)
The three Malawian participants had observed that bodily symptoms of AIDS were visible and suffering from the disease was excessive, so people around PLWHA easily notice individuals’ HIV/AIDS positive status. The participants believed that a link between punishment of God and visible and extreme suffering negatively affects ongoing stigma toward PLWHA in the community.

**Sexual immorality.** Participants stated that PLWHA are stigmatized in their communities because HIV/AIDS is a sexually transmitted disease, and is often associated with “multiple sex partner” and “adultery.” Adultery is a sin that is “against church values” and prohibited by their religion.

“Maybe [it is said as a punishment of God] because someone is adulterous; and people would say that he/she is a horrible person.” (25, Malawian, male, research assistant)

“Because many people contacting it through having unprotected sex or by having multiple sex partners which is prohibited by the church.” (26, Malawian, female, journalist)

“HIV/AIDS is a punishment from God and it is for all the people who are prostitutes. Most people talk badly about PLWHA in their absence. They think all the people who are positive have been involved in multiple sex partners. Some of them think that PLWHA are punished by God because of their bad habits.” (40, Malawian, male, social worker)

“Those that say it is a punishment of God say so because they associate HIV/AIDS with adultery. And, adultery is considered to be a sin… HIV/AIDS is associated with sex and adultery. HIV/AIDS is linked to sin because sin is linked to punishment.” (25, Malawian, male, research assistant)

“One participant pointed out that there is a link between sex and sin, and an association between sin and the punishment of God. The participants commented that these cultural associations have affected ongoing stigma toward PLWHA in their communities.
Biblical interpretations focused on God’s punishment towards sinners. One participant pointed out that the misunderstanding and misinterpretations of the Bible cause HIV/AIDS stigma. She commented that believing “HIV/AIDS is God’s punishment” is ignorance and misinterpretation of the Bible.

“God did not send HIV/AIDS. To believe this is to disregard so much of scripture that describes God’s nature and relationship with humankind. Where it [stigma] does exist, it is based on ignorance and misinterpretation of the Scripture.” (54, Australian, female, social worker)

God’s nature is often described with various positive metaphors such as the God of love, mercy, forgiveness, healing, and grace throughout the Bible. However, scriptures describing God’s anger and punishment towards sinners and the disobedient have been selectively used in many religious communities as a controlling mechanism in Sub-Saharan Africa. Not many participants specifically mentioned misinterpretation of the Bible as a negative factor for ongoing HIV/AIDS stigma. However, interestingly enough, many participants used the Bible as their reference sources to support their own beliefs and opinions. Interpretation of the Bible matters to defining HIV/AIDS as a disease and HIV/AIDS stigma.

Theology of the end times. Two participants viewed HIV/AIDS as a sign of the end times. Both participants used the Bible as their reference. The following quotes are samples of this position by the two participants.

“Yes, HIV/AIDS is a punishment of God, because in Revelation the Bible says that at the end most people would suffer from many diseases.” (22, Malawian, female-a, program aide)

“People relate AIDS as a sign of the end times because the scriptures say in the last days plagues shall escalate.” (36, Malawian, male, clergy)
Religiosity and Spirituality among Christian Service Providers

Research question: How do your religion and religious belief affect you to work with PLWHA in Malawi?

The majority (n=17, 85%) of participants commented that their Christian faith is “central” and “important,” and it is the “key” for them to work with PLWHA. Of twenty, two (10%) participants mentioned, “There is no connection” between their religion and their work with PLWHA. One (5%) participant did not answer the question. The other seventeen participants stated that their faith in God “positively” affects their work with PLWHA. The following quotes provide samples of responses from three of these seventeen participants.

“If I was not a Christian, I believe I would be judgmental and not value people with HIV. My faith leads me to see people as Christ see them. Without God, I would not continue serving the poor in Malawi. God gives me a love for people and a conviction that I am called to work here and so I continue to serve.” (38, British, male, missionary: education consultant)

“It is very important; without it [Christian faith] I would never think to help PLWHA in my heart.” (26, Malawian, female, journalist)

“My faith played an important role in working with PLWHA. The reason for applying for a year in Malawi was to help those in need. This motivation primarily came from my Christian faith.” (25, Korean, male, research assistant)

The three quotes are from a teacher, a research assistant, and an educational consultant. Their comments indicate that their Christian faith is directly related to the reason why they work with PLWHA. One said that he is “called to work” with the poor in Malawi. The other two participants commented that their work with PLWHA was primarily motivated by their religious faith. Some participants believed that working with PLWHA in Malawi is a call from God, and their religious faith deeply motivated them to do this work. Their faith in God gives them a strong “conviction” to work with PLWHA in Malawi, and sustains them to continue to work with PLWHA and the poor in Malawi.
**Research Question: How is your spirituality important for you to work with PLWHA in Malawi?**

**Spirituality as a source of strength.** Spirituality played a significant role among many participants continuing to work with PLWHA. They commented that their spirituality provides them “strength” to serve people in need.

“It [my spirituality] keeps on giving me enablement and capacity to work with PLWHA.”
(59, Malawian, male, clergy)

“Spirituality gives me inner strength.” (37, Malawian, male, clergy)

“My relationship with Jesus and faith is central in my life. My work comes from that relationship. It is important because it keeps me on track to “live as Christ.” My own tendency would be careless, be impatient, etc., but my faith keeps me accountable for my attitude and actions.” (54, Australian, female, nurse)

“Spirituality provides grace to forgive and strength to stand when having done what I can. I could never in my own strength to do what has been done in the years here [in Malawi] … never… never… never…” (65, Canadian, male, principal of schools and orphanage)

“Without God, I would not continue serving the poor in Malawi. God gives me a love for people and a conviction that I am called to work here and so I continue to serve.” (38, British, male, missionary: education consultant)

“I draw strength from it [my spirituality and religious beliefs]. When I see what is happening to someone and I cannot explain why someone so young has it [HIV/AIDS]. I could get angry but that won’t help the person. But because of my beliefs, I’m able to show love, kindness, and tolerance.” (37, Zimbabwean, male, missionary: director of NGO)

The participants noted that through their spirituality, they receive “enablement and capacity,” “accountability,” “grace to forgive,” “strength to stand,” and “love and conviction” to continue to serve people in Malawi. A 37-year-old Zimbabwean man stated that because his religious beliefs and strength of spirituality, he was able to show “love, kindness, and tolerance” to others in his service provisions at work.
Religious Beliefs and Religious and Spiritual Practices

Religious beliefs. Research Question: What religious beliefs help you continue to work with PLWHA?

The participants commented on how, and in what ways their religious beliefs and spirituality positively affect their work with PLWHA. Several themes were closely linked to their non-judgmental mind and attitude toward PLWHA. The themes include 1) God is love, 2) Love your neighbors, and 3) We are created in the image of God.

God is love. Love is one of the most important religious beliefs among several participants working with PLWHA. The participants perceived God as the One who equally loves all and shows grace to all humanity, regardless of one’s HIV/AIDS status. The participants’ religious belief had influence on their non-judgmental and non-prejudicial attitudes toward PLWHA.

“God-fearing has been a major spirituality in my life. God always encourages us to love one another. Love has been a major key for me to do my work very effectively. Without love nothing can be done because when doing community people talk a lot either bad or good but we need to focus ahead. Love is a key to success.” (40, Malawian, male, social worker)

“God is love. We should love each other for our Creator is love.” (37, Zimbabwean, male, missionary: director of NGO)

“The bible says love your neighbor just as you love yourself… Despite having the disease, God still loves them so they can feel at least encouraged and comforted at some point in time.” (22, Malawian, female-b, teacher)

Love your neighbors. The participants viewed love as their responsibility toward neighbors in community. For instance, a 22-year-old Malawian teacher quoted the Great Commandment saying, “Love your neighbor just as you love yourself.” Believing love as God’s nature and their responsibility has affected them to have a non-judgmental attitude toward PLWHA. For instance, a 34-year-old Malawian social worker stated, “The church teaches us to
love one another without considering the status of others as we are all representing God’s image.”

As the quotes above indicate, love is a central belief for many participants working with PLWHA. Many participants noted that their faith in the God of love has taught them to have a non-judgmental attitude toward others. Participants stated that they see and treat people equally, regardless of their HIV/AIDS status because it is what they have believed as Christians. The following quotes are samples of the participants’ responses.

“My religious beliefs compel me to love people without discrimination… There are so many scriptures that guide me to work with people- i.e., “They will know you are my disciples by your love,” and Jesus said, “You do it for the least of these my brethren, you are doing it for me.” I don’t see a difference for me in how my beliefs guide me to work with PLWHA and those who are not. It is all the same.” (54, Australian, female, social worker)

“I don’t think I make a distinction between people with HIV or without. My faith calls me to serve others, especially the poor. Here in Malawi, I meet people with HIV, but I don’t see them any differently than people without. If I am not a Christian, I believe I would be judgmental and not value people with HIV. My faith leads me to see people as Christ sees them.” (38, British, male, missionary: education consultant)

“My faith and God they are very important more than anything else because it is what defines who I am in this life. It is the faith that helps me understand that PLWHA have a future, they can achieve anything they desire in this life and that it’s not the end of the road. My faith helps me to see them in the same way I can see any other human because we are all equal in the eyes of Lord.” (23, Malawian, male, social worker)

The participants stated that their faith in God teaches them to see PLWHA “in the same way” in which they see people living without HIV/AIDS. The participants believed that everyone is “equal in the eyes of the Lord,” and wanted to see people as God sees them. Their non-judgmental attitude toward PLWHA was grounded in their religious beliefs.

The image of God. Several participants quoted a biblical phrase from Genesis 1:27, which says that human beings are created in “the image of God.” A 34-year-old Malawian female social worker responded, “Belief that everyone is an image of God” helps her continue to
work with PLWHA in Malawi. The following quotes are the examples of the comments from the participants.

“My religious belief affects me positively to work with PLWHA because in God’s image and likeness and so we are on.” (22, Malawian, female-b, teacher)

“Belief that everyone is an image of God [helps me continue to work with PLWHA]. The church teaches us to love one another without considering the status of others as we are all representing God’s image.” (34, Malawian, female, social worker)

“God created us in His own image, our spiritual life or purpose is the same regardless of the [HIV] status. God created us in His image, we are all children of God.” (23, Malawian, male, social worker)

The belief in participants that each individual is created in the image of God was a foundation for their non-prejudicial attitude toward PLWHA.

**Religious and spiritual practices.** Research question: *What religious and spiritual practices help you continue to work with PLWHA in Malawi?*

The participants were asked to respond to the question, “what religious or spiritual practices help you continue to work with PLWHA in Malawi?” They noted that prayer, Bible reading and study, and participation in worship service are important religious and spiritual practices for them in continuing to work with PLWHA. Interestingly, five participants noted that love is an important religious and spiritual practice. They viewed love not only as a belief, but also as action and practice.

**Love as a practice.** Of twenty, seven (35%) participants noted that love is a spiritual practice for them to continue working with PLWHA. The following quotes present examples of their responses.

“The bible says we should love one another. Human being has been a main tool that helps me to continue working with PLWHA in Malawi. Some of my relatives have been affected with HIV/AIDS and I don’t see any reason to go away from them.” (40, Malawian, male, social worker)
“Loving, giving and sharing are religious and spiritual practices for me to continue to work with PLWHA. I believe that as a Christian there is a lot that I can offer to other people in terms of physical, spiritual and material support as a way of for filling God’s commandments and for PLWHA. This group of people needs so many things for their daily life.” (34, Malawian, female, social worker)

“Love one another without condition. In John 4:8, it reads, “Anyone who does not love does not know God, because God is love.” It is from this scripture where I get my inspiration as it helps us to understand that we were all created in His own image. We shouldn’t stop loving one another because of status, circumstance, or situations. God loves us all regardless of our status, gender, origin, and background.” (23, Malawian, female, social worker)

“I take loving as a spiritual practice because I learn to have no enemy. This is possible by understanding what individuals love and accept them the way they are. I forgive and speak out what displeases me. Once I do that I make an effort to build the relationship again. I also practice loving myself: loving my body, taking good care of it, and loving what I have.” (28, Malawian, female, teacher)

The participants mentioned love not only as an important belief, but also as an important practice for them to continue working with PLWHA. Love was not a static emotion and feeling to them. Rather, they viewed love as an action to practice what they believe as Christians.

**Prayer:** Ten (50%) participants noted that prayer is important for them in continuing to work with PLWHA. One said, “Praying about my challenges makes working better” (28, Malawian, female, nurse). Another commented, “prayer always gives me strength to continue to work in Malawi” (37, Zimbabwean, male, missionary: director of NGO).

**Bible reading and study.** Six (30%) participants noted that reading and studying the Bible is important for them in continuing to work with PLWHA. For instance, one said, “Bible reading helped me continue my job. Reading the Bible helped me see the world beyond, and realize that this difficult period would end eventually” (25, Korean, male, research assistant).

**Participation in worship service.** Two (10%) briefly mentioned that going to church helps them continue to work with PLWHA, along with other religious and spiritual practices.
Chapter Five: Discussion

Discussion of the Findings of the Study

Twenty service providers from thirteen NGOs and FBOs in southern Malawi participated in an investigation of the meaning of HIV/AIDS in relation to their religious beliefs, and the role of religiosity and spirituality in the service provision for PLWHA. The experiences, observations, opinions, and perspectives of those who participated in the online questionnaire guided interpretation of the HIV/AIDS meanings, and served to identify the role of religiosity and spirituality on HIV/AIDS workers’ service provision. Due to the nature of a hermeneutic phenomenological study, this research does not aim to offer generalizations. Preferably, the findings intend to extend beyond the surface exploration of the HIV/AIDS stigma phenomena in southern Malawi and provide significant implications for social work practice, policy, and future research, as well as the Christian faith community.

Religion refers to the context of ideological commitments and institutional membership, and Christianity was involved in this study. Religiosity is defined as “an institutionalized pattern of values, beliefs, and symbols, and behaviors and experiences that involves spirituality and a community of adherents, transmission of traditions over time and community support functions that are related to spirituality” (Canda & Furman, 2010, p. 76, as cited in Roh, Lee, Lee, & Martin, 2014). The discussions about the participants’ beliefs regarding HIV/AIDS are related to religiosity that has shaped the participants’ understandings of the deity, the devil, sin, fallen humanity, and human suffering. Spirituality is defined as “inner subjective experiences that are not necessarily related to a specific religion, involving a holistic understanding of material, psychological, social, and spiritual aspects of human beings” (Canda & Furman, 2010 as cited in Roh, Lee, Lee, and Martin, 2014). Both religiosity and spirituality are engaged in discussions
about the religious and spiritual factors that helped the participants to continue to work with PLWHA in a challenging work environment.

The statement, “HIV/AIDS is a punishment of God” has been a stigmatizing voice toward PLWHA in society. All the participants were asked what they think about this particular statement. The comments brought new insight into how service providers who are Christians interpreted not only HIV/AIDS, but also human suffering and diseases like HIV/AIDS.

**HIV/AIDS as a punitive method.** Three of 20 participants viewed HIV/AIDS as a punishment from God. These participants noted that God is the one who had brought the disease to punish sinners according to the will of God. Although many participants did not view HIV/AIDS as God’s punitive method toward sinners, a few still had this stigmatizing view on HIV/AIDS. Understanding HIV/AIDS as a punishment of God is based on a problematic biblical interpretation, particularly given that there are numerous depictions in the Bible about a God who takes the side of the poor and empowers the powerless and the marginalized (Dube & Kanyoro, 2004). If HIV/AIDS is believed to be a punishment from God, the participants should sincerely ask, why would God primarily and selectively punish the least dominant groups in the world? This is the critical question that religious leaders, theologians, ordinary churchgoers, and Christians involved in HIV/AIDS-related services must ask. The ones who suffer the most from the disease are the ones who are the most vulnerable, “the poor, women, [blacks], children, homosexuals, displaced people and Africa” (Dube, 2004, p. 6). Working with PLWHA based on this punitive and judgmental religious belief is not useful for HIV/AIDS workers in NGOs and FBOs in sub-Saharan Africa. Having this judgmental mindset can negatively affect one’s service provision, and the quality of the established professional relationship with PLWHA.
A consequence of sin in the fallen world. Some participants perceived that suffering and diseases came into humanity by evil after the fall caused by the original sin. To these participants, human suffering and an illness like HIV/AIDS are understood as a natural part of the reality where the fallen world is located and humans are now living. Collins (2007), a Methodist theologian states that the origin of evil is Satan, not the Creator God; evil has been manifested in sin, death, and suffering in the world due to a fallen humanity. In Christian theology, suffering and death through diseases are neither God’s intentions nor a part of God’s plans but, rather, the consequence of evil in the fallen world. The existence of evil is often linked to human suffering. In many cases, human suffering is caused by systematic and structural evil, defined as “evil which arises from structures within human society rather than from individual wickedness or original sin” (www.wikipedia.org). Slavery, racism, classism, sexism, human trafficking, poverty, and many other forms of oppression and injustice are examples of systemic evil. Based on this Christian worldview, the participants described HIV/AIDS as a critical task assigned to Christian service providers to save the suffering people in the fallen world. For these participants, Christians and Christian professionals are called to fight against the causes of human suffering. People often do not recognize systemic evil as real evil due to their being accustomed to social structures and systems. If service providers apply and expend this religious belief to the concept of structural and social sins, this particular religious view will help service providers to better understand HIV/AIDS phenomena and human suffering from a broader perspective at the macro level, without having a judgmental attitude.

A consequence of human behaviors. A religious position that understands HIV/AIDS to be a consequence of individual’s self-destructive behaviors can easily allow professionals to blame their clients for their HIV positive status. It is not right to blame PLWHA for their
infectious status, since HIV/AIDS is not simply caused by individual's morality. In the context of Sub-Saharan Africa, HIV/AIDS is not solely the fault of an individual. Many of the study participants were aware that the causes of HIV/AIDS are intertwined with issues of socio-economic injustice, sexism, classism, and power and cultural issues. However, if HIV/AIDS workers understand HIV/AIDS merely as the consequence of individual behaviors, it will be easy for them to ignore the ultimate structural problems causing the HIV/AIDS pandemic at the local, national, and international levels. Instead of blaming HIV/AIDS sufferers, recognizing the manifestation of “social sin” and structural sin that causes HIV/AIDS is critical in better understanding and addressing HIV/AIDS stigmas (Cahill, 2016, p. 395). Service providers working with PLWHA need to work from a macro perspective, focusing on international relations, globalization, gender inequality, and poverty. It is much more important to transform the ultimate social and structural causes which drive vulnerable individuals to choose poor behaviors than blaming the HIV infected and focusing on the individual’s behavioral change.

An opportunity to help PLWHA. HIV/AIDS is a crisis in Malawi, but some participants believed that the disease could be ultimately transformed to be an opportunity to reach out to PLWHA in Malawi and help them to know Jesus Christ through their service. One participant commented that helping HIV/AIDS-affected people in Malawi is work that one must “be called” to do, and Christians are “called to be His [Jesus]’ hands and feet.” This fourth theme is closely connected to the doctrine of salvation and the purpose of Christian evangelism and missions. Having a personal relationship with Jesus was described as a way to find new hope for the present, the future, and in life after death. In a holistic view, the fourth view could help service providers to understand humankind as bio-psycho-social-spiritual beings who have needs for spiritual redemption as well as physical, social, and psychological needs. For some
participants, especially foreign missionaries, helping PLWHA to meet their spiritual needs through Jesus Christ was as urgent as addressing their physical needs. Spirituality is an important topic in social work practice. Knowing one’s spiritual need is important for culturally competent social work practice. However, an ethical issue can rise between Christian service providers and non-Christian service users. People with indigenous beliefs or a different religion may feel discomfort in accessing services provided by an organization whose primary goal is to save the soul. Missionaries working at Christian FBOs need to be aware of the fact that their evangelical approach can exclude the most desperate people from receiving the offered services due to a religious difference. Some people in the community may feel pressure to abjure or compromise their cultural values and traditions over Christianity in order to receive services at the faith-based organization. Service providers who are strongly committed to Christian evangelism and mission in Sub-Saharan Africa need to be aware of the danger and possibility that their good work can be a new form of colonialism in a poor country like Malawi.

**A medical disease.** Some participants defined HIV/AIDS as how modern medicine has defined it. For example, some participants described AIDS as Acquired Immunodeficiency Syndrome, using the actual medical term for the disease in discussing its impact. These participants viewed HIV/AIDS as a medical disease, similar to tuberculosis, malaria, and cancer, that anyone can be infected with from diverse causes. This fifth theme is science-based, and nonjudgmental. Knowing the scientific cause of the disease will help the community see HIV/AIDS as equal to other common medical diseases.

When individuals are in a crisis caused by disease or hardships in life, they often try to cope with the adversity by finding spiritual meaning in the difficulty and by reinterpreting that hardship (Choi & Hastings, 2018). Individuals may find different spiritual meanings from
working with those affected by HIV/AIDS, as the 20 participants differently interpreted the meaning of HIV/AIDS and human suffering as these emerged in the five major themes discussed above. The critical task for social workers and helping professionals working with PLWHA is to construct their religious belief in a positive, empowering, and non-judgmental way, so that they can help PLWHA to effectively cope with HIV/AIDS and disease-related problems. It is impossible to change one’s life before HIV/AIDS positive status, but service providers can support and empower HIV/AIDS affected people to overcome the HIV/AIDS-related problems by helping them to find a positive spiritual meaning about the current life.

Social stigma. Social stigma was supported by study findings to serve as a relevant theory to provide a foundational framework in understanding HIV/AIDS stigma. Goffman (1963) explains that when individuals possess physical deformities, blemished characters, or the tribal stigma of race, nation, and religion that the majority of society disgrace, their differences become their "actual social identity" and they are categorized as people with stigma, which means "undesired differentness" (p. 5). The study participants commented that the severity of physical pain and suffering and visible signs of the disease continue to stigmatize PLWHA. As the disease progresses, PLWHA physically deteriorate and often inevitably show visible symptoms of the illness to people around the community. Each account of the bodily decline and reports of suffering are referred to as “stigma symbols,” according to the social stigma theory. Goffman (1963) defines “stigma symbols” as properties that individuals use to convey social information in the community regarding physical differences (1963, p. 43). Physical signs associated with HIV/AIDS deliver social information to the society. The stigma symbols, which the PLWHA might physically possess, create new social identities for the PLWHA in their community. However, it is important to know that one’s HIV positive status is only part of his or
her physical conditions, and it should not be associated with his or her authentic identity as a member of the community.

**Limitation of social stigma.** The findings of the study prove the limitations of the original concept of social stigma that primarily focuses on physical signs and undesired differentness for each individual. The central point of understanding HIV/AIDS stigma is how the majority of the community perceives and interprets the disease. As other recent stigma studies have suggested, the meaning of the stigma symbols and the new social identity describing PLWHA needs to be examined at the societal level in consideration of diverse cultural and structural factors, including religion (Alonzo & Reynolds, 1995; Frost, 2011; Weiss & Remarkrishna, 2004). There may be diverse factors in making an association between HIV positive status and a new negative social identity of PLWHA as being “punished,” “immoral,” and “adulterous.” Among many possible factors, the study findings indicate that religious beliefs are intertwined with HIV/AIDS-related stigma in labeling PLWHA and judging the behaviors of PLWHA with negative characteristics by adding religious meanings to the physical illness.

**Social constructionism.** Social constructionism is another theoretical framework that the study utilized to investigate the meanings of HIV/AIDS among service providers working at NGOs and FBOs in southern Malawi. The study findings prove that HIV/AIDS stigma is socially constructed due to the recognition of one’s HIV positive status in community, and also indicate that the interpretation of the biblical text is central to the social process of creating HIV/AIDS stigma.

**Social process and interpretation of the Bible.** Interpretation of biblical passages is closely related to the social process of HIV/AIDS stigma construction. The study participants used the Bible as their reference to justify their opinions and thoughts. It is important to note that
each participant differently interpreted what he or she read and learned from the Bible regarding the cause of the disease. For example, three participants agreed that "HIV/AIDS is a punishment of God." The statement exemplifies how, to them, their beliefs are true because the Bible tells them so. In contrast, other participants who disagreed with the statement commented that the Bible does not teach them so. One participant pointed out that the statement was constructed by misunderstanding the Bible. Since HIV/AIDS stigma is constructed by misinterpretation of the Bible, it can be deconstructed and reconstructed by theologically sound interpretations of the Bible that can empower PLWHA. An African theologian, Isabel Phiri (2004) points out that an uncritical reading of the Bible is a major problem among African Christians. Due to the history of colonialism, Africans have heard Biblical messages being interpreted from the perspectives of westerners and preached predominantly through male voices in many areas of Sub-Saharan African countries. In times of an HIV/AIDS epidemic, a new theology that interprets biblical narratives from the perspective of indigenous Africans is critical in the process of the deconstruction and reconstruction of interpretations of the Bible in Sub-Saharan African countries.

Religion of morality. Religion has played an important role in shaping and maintaining the moral standards of society. When HIV-uninfected people focus more on religion as a means of shaping individual and societal morality, particular religious beliefs related to sexual behaviors become a critical method to evaluate, condemn and judge people’s behaviors. Participants reported that PLWHA are stigmatized both in society and their religious community because of their “immoral” behaviors. For instance, many participants commented that PLWHA are often perceived in the Malawian community as people being “punished by God,” “immoral,” “sinful,” “wicked,” “adulterous,” “responsible for their status,” “violating religious teaching,”
“useless,” “careless,” and “hopeless.” These descriptions of perceived stigma toward PLWHA are deeply associated with the function of religion as an important means of shaping the morality of society. PLWHA are discriminated against not only because of their HIV/AIDS positive status, but because of violation of religious teachings that their religious communities have taught, valued, and reinforced. Paterson (2005) pointed out that violation of cultural and social norms are often understood as sin. The present study offers concrete evidence that HIV/AIDS stigma is a social construct, and that a religion of morality plays a significant role in the process of perpetuating social stigma.

The religion of grace and love. To create a safe and nonjudgmental environment to help reduce HIV/AIDS stigma, religion needs to move toward being a means of grace, love, and hope, rather than a tool of morality used to judge people’s behaviors when struggling with HIV/AIDS. Christianity is known as a religion of grace and love. In the era of HIV/AIDS, religion needs to play its role not only as a means of building moral standards, but also as a means of grace and love that can help the community embrace the broken world. The participants were motivated and empowered by Christian beliefs and teachings, such as “the God of love and grace,” “love your neighbors,” “children of God,” and “the image of God.” PLWHA need to hear about the message of grace and hope to overcome the sickness and other problems that they face in their lives after being diagnosed HIV positive. Religion, especially Christian beliefs, can be a source of strength and hope for PLWHA if it is used to focus on equally given grace and love for all “children of God.” The findings of the study suggest that service providers working with PLWHA are required to work with holding a religion of grace and love to effectively fight against injustice, discrimination, and prejudice against PLWHA in Malawi.
Constructing a new spiritual identity. The findings of the study suggest that religion can help construct a positive new identity in PLWHA. In the theory of social stigma, a new social identity is given to PLWHA due to their HIV positive status. However, a spiritual identity is a new identity given to PLWHA, regardless of his or her HIV status. From the qualitative data, two significant themes emerged regarding an identity of PLWHA: “children of God” and “the image of God.” The participants perceived PLWHA as “children of God” who were created equally in “the image of God” as non-PLWHA. These two ideas help service providers see the infected and the uninfected equally as God’s creatures. Since HIV/AIDS stigma is a socially constructed identity assigned to PLWHA, their identity can be reconstructed, with a new identity shaped by positive and empowering religious beliefs.

Strengths and Limitations of the Study

Strengths. The study has several significant contributions. First, this study made the voices of service providers working with HIV/AIDS-affected people in southern Malawi heard by the world. Malawi is one of the poorest countries in the world (Burton, 2017). As the nation is insignificant to the majority of the world, the voices of service providers such as teachers, nurses, social workers, and missionaries working in NGOs and FBOs there might be rarely heard by people outside of the Malawian community. By collecting qualitative data from diverse service providers working in southern Malawi, this study created an opportunity to understand the experience of helping professionals working in the most challenging environment in Sub-Saharan Africa. Second, the study is unique and important because little was known about the role of religion and spirituality among service providers working at NGOs and FBOs in Malawi. In the existing literature, spirituality was mostly examined from the perspectives of service recipients such as people with diabetes, depression, HIV/AIDS, or other medical problems. In
spite of the importance of the services offered by service providers working with NGOs and FBOs in Sub-Saharan Africa, their spirituality has not been fully investigated yet. The findings of the study strongly suggest that religiosity and spirituality are important sources of strength among front-line service providers working with PLWHA, and need more scholarly attention. Third, the study contributed to making a bridge between Christian theology and social work practice. Although religious beliefs are closely connected to the worldviews and behaviors of social work practitioners, their individual theological views and religious beliefs are not commonly investigated in social work research. At the same time, evidence-based research is not a specialty of most Christian theologians. This study is important because its findings challenge both Christian faith communities and service providers in social work practice to be aware of the connections between religious beliefs and the actions implemented in their service work.

Limitations. The study has several limitations. First, using structured online questionnaires was unavoidable in the context of geographical distance and this limited opportunities for more in-depth exploration of participants’ opinions and experiences, and for face-to-face interviews that would bring richer narratives from the participants. To fix the issue of inflexibility of data gathering options, some of the participants were contacted by the researcher with further questions and clarifications. In that way, the researcher sought for deeper insights and meaning from the data, even after the surveys were submitted via emails or Google forms. Lastly, although the study included all religions in the inclusion criteria, Christianity was the only religion that study participants were engaged in. Recruiting participants from the Christian faith was much more convenient for the study because Christian churches are more institutionally active than Muslim or other religious organizations in the nation. The findings of
this study are not able to address the impact of religious traditions and beliefs other than Christianity on service providers working with PLWHA.

**Implications for Social Work Practice**

**Examining one’s prejudice.** Social work practitioners need to deeply explore their own prejudice against people with HIV/AIDS. Prejudice is defined as an unjustified, incorrect, unreasonable, unfavorable, or unfavorable attitude towards an individual solely on the individual’s membership of a social group ((McLeod, 2008), while discrimination is behavior or action on the basis of a prejudice towards an individual or a social group (McLeod, 2008). It is critical to investigate the explicit and implicit biases in social workers at the individual level. Maharaj (2009) asks several critical questions for social workers currently who work, or would work with PLWHA, as follows:

- Has the social worker been adequately educated about HIV/AIDS?
- Has the social worker been adequately trained for dealing with HIV-AIDS and related issues?
- Has the social worker adopted an ethical practice protocol?
- Does the social worker operate within the bounds of that ethical protocol?
- Can the social worker identify the institutions that may impact on a client affected by HIV/AIDS?
- Can the social worker identify the prejudices, overt and subtle, that may be present in these institutions, and that may impact on a client affected by HIV/AIDS?
- Does the social worker possess the knowledge and means that may help a client affected by HIV-AIDS to mitigate the effects of such institutionalized prejudice? (p. 15)

Social workers need to examine their own beliefs and values, particularly those stemming from their religiosity regarding human suffering and diseases like HIV/AIDS. Their perceptions and beliefs strongly affect the process and quality of service provision and the professional relationship with PLWHA. Social workers and health care professionals are often trusted by their clients with HIV/AIDS when the latter are most suffering from life adversities. What the service providers think and believe about their clients matters to them. In other words, what HIV/AIDS
workers believe about HIV/AIDS and the cause of disease may strongly affect the quality of service provision through workers’ professional relationships with PLWHA. In addition, at the organizational level, it is highly important that leaders of NGOs and FBOs thoroughly examine the potential prejudices that the institution members may hold. The organizational leader needs to build a strategic plan to address prejudice and discrimination before hiring and while training employees and recruiting volunteers to work with PLWHA.

**Using spiritual assets in social work practice.** Organizational leaders need to recognize that for front-line social workers, spirituality is often an important asset in their profession. For Christian service providers at NGOs and FBOs, spirituality plays a vital role as a source of strength as they do challenging caregiving work. As this study found, religiosity and spirituality were closely connected to participants’ practices in helping PLWHA. Christian service providers at NGOs and FBOs in Malawi did not understand love as an abstract. Love was more than a religious belief and a human emotion to them. It is deeply interrelated to their motivation and practice to help PLWHA. It is noticeable that many participants commented that love is both an important religious belief, and a practice that sustains them to continue to work with PLWHA in Malawi. Gunderson and Cochrance (2012) introduce Religious Health Assets (RHAs) in their book, *Religion and the Health of the Public*. According to his definition, RHAs refer to “potentially crucial components of a comprehensive, sustainable strategy for advancing health” (Gunderson & Cochrance, 2012, p. 44). Trust, faith, hope, and love are intangible and invisible, but they are important religious health assets that promote public health. The World Health Organization conducted a study in Zambia and Lesotho, where health care workers mentioned that best practices should be linked heavily to less visible, and more intangible elements (African Religious Health Assets Programme, 2006, cited in Gunderson & Cochrance, 2012). A study by
Lakoff and Johnson (2003) found that both health care providers and health care seekers rated “compassion” and “love” as the most critical elements to enduring health (cited in Cochrance, 2012). The present study proves the importance of spirituality among helping professionals working in NGOs and FBOs in Malawi.

**Collaborating with the faith community.** Social workers need to develop a concrete partnership with faith communities in Sub-Saharan Africa. Faith-based organizations are an important community resource for HIV/AIDS stigma reduction programs and HIV/AIDS intervention and prevention programs (Tiendrebeogo & Buyckx, 2004). In many Sub-Saharan African countries, the Christian church is already the most well-structured social space where individuals and families in need find support. Due to its high commitment to, and long tradition of building solidarity in community, the church community can be an adequate social space to help reduce HIV/AIDS stigma and build a supportive environment for PLWHA (Campbell, Skovdal, & Gibbs, 2011). In collaboration with the faith community, social workers could build a safe environment for PLWHA for hearing and speaking shared and lived experiences. Through collaborative work between faith communities and social work practice, social workers can utilize the already existing community resources to better offer HIV/AIDS health education, supportive dialog, programs, and practice for healing and support to PLWHA in the community.

**Implications for Social Work Policy**

**Policy for equipping HIV/AIDS specialists in social work education.** Social work education needs to develop policies to equip specialists who are being trained to intervene in a variety of HIV/AIDS-related issues. PLWHA are categorized as a “special population,” and social work practice appears to be emerging as a specialized area in the field of HIV/AIDS (Nathaniel-deCaires, 2009). HIV/AIDS is more than a medical problem in Sub-Saharan Africa. It
is a combination of medical, social, economic, political and cultural issues that require multidisciplinary team efforts to effectively address. Social work is one of the best-fitting professions to advocate for the most vulnerable and oppressed people in the global community. The fields of HIV/AIDS and public health need many more skilled HIV/AIDS social work specialists who can assess the problem and intervene, as a part of a multidisciplinary professional team, in the complexity of the problem involving individuals, families and communities and ethics.

**Equipping global social workers.** Social work education both in the United States and Sub-Saharan Africa is strongly required to equip HIV/AIDS specialists to work in faith-based community organizations in the field of international social work. HIV/AIDS is not a problem only of Sub-Saharan African countries but the global north, including the U.S.A. and other developed countries. No nation is isolated in the global community today, and each part of the globe is interrelated through the complexity of social, economic, political and cultural connections. Thus, social work education must be responsible for developing policies and training to adequately equip HIV/AIDS specialists with knowledge, experience, and skills to deal with the HIV/AIDS pandemic at the local, national, and international levels.

**Policy advocate for PLWHA.** Policy advocacy for those who suffer from stigmatization, discrimination, and HIV/AIDS-related diseases in Sub-Saharan African countries is critical. Payne (2005) states that advocacy is a form of empowerment. In order to empower PLWHA and reduce HIV/AIDS stigma, social workers need to engage more in political advocacy, such as political campaigns and lobbying at the national and international levels. According to Kelly and colleagues (2006), many international organizations have often involved themselves in direct relief services and medical services for the poor and the HIV/AIDS infected in sub-Saharan
African countries. Policy advocacy is equally important to effectively direct relief and medical services for PLWHA.

Social workers are the front-line of human rights workers. Healy (2008) has pointed out that the social work profession has not yet been widely recognized as a global leader in the larger human rights movement due to following reasons: first, social work is often more focused on human needs than human rights; second, social work is more focused on social and economic rights than civil and political rights; third, social workers prefer the case-based approach and micro practices over macro practices; and fourth, social work lacks well-equipped global leadership on human rights that involves organizations that represent the profession. As the U.N. stated in 1994, “human rights are inseparable from social work theory, values and ethics, and practice… Advocacy of such rights must therefore be an integral part of social work, even if in countries living under authoritarian regimes such advocacy can have serious consequences for social work professionals” (The U.N., 1994 as cited by Healy, 2008, p. 746).

Implications for the Faith Community

The role of religious leaders in HIV/AIDS stigma reduction. The religious leaders who interpret biblical texts and preach to congregations need to be aware of the impact of their religious messages. The role of religious leaders is critical to creating a non-judgmental environment in the faith community. Church leaders, such as pastors have high levels of religious authority and power over their congregations. How biblical stories are interpreted, and what pastors preach about HIV/AIDS and human suffering can be influential in shaping and tackling stigmatizing religious beliefs in the congregation. Despite the fact that there are a number of verses and chapters in the Bible which describe God as a loving, caring, and just God, people with power and dominance in religious organizations have selectively chosen texts and
misused them to justify negative judgments against, and oppression of those infected and affected by HIV/AIDS. For example, a study by Kgalemang (2004) reported that some religious leaders and Christians in Botswana interpreted the numerous deaths occluding through AIDS as a sign of the end of time and the coming of the Kingdom of God based on actions taken by those infected. In their minds, the actions of those infected implied they had no fear of God, and thus had brought this end on themselves. This judgmental interpretation and theological view helped construct significant HIV/AIDS stigma in religious communities in Botswana where, based upon these beliefs, PLWHA are considered guilty for having the disease. This study also found that the biblical messages being used regarding God’s judgment toward sinners in the end times were one of the factors perpetuating HIV/AIDS stigma in southern Malawi. What the pastor preaches to the congregation strongly affects congregants’ belief systems. Almedal (2002), a UNAIDS senior staff stated, “would it not be a good program if preachers addressed the stigma attached to AIDS and PLWHA 52 Sundays a year for three years? And it would not cost a cent but might change something” (as cited in Tiendrebeogo & Buykx, 2004, p. 18). Christian preachers might take advantage of their unofficial, but well-organized educational opportunities to educate congregations through their sermons every Sunday. Providing culturally and contextually appropriate biblical teaching remains essential to the Sub-Saharan African faith communities addressing the challenges resulting from this epidemic.

The new theology of hope. The Christian faith-community is required to build a new theology of sin, evil, human suffering to effectively respond to the times of HIV/AIDS. The extreme suffering that PLWHA experience was mentioned as one of the major factors that continually regard PLWHA as people being punished by God. Human suffering in the era of HIV/AIDS is often caused by “structural evil,” and not by individual's sinful behaviors. Christian
theologians need to develop an appropriate theological interpretation of human suffering in relation to structural causes that have perpetuated the HIV/AIDS pandemic in the Sub-Saharan African community. Seeing HIV/AIDS as a punishment from God, a consequence of human fall or a consequence of human behaviors is a narrow-minded perspective that will continue to stigmatize PLWHA. Theological attempts to see human suffering from love, compassion, and the justice-focused views are highly recommended for the Christian theologians living in the era of HIV/AIDS.

**Recommendations for Future Social Work Research**

The study has several directions for future research. First, future research should continue to explore the meaning of HIV/AIDS from the service user’s perspective. PLWHA who receive services from NGOs and FBOs in Malawi would have different views and personal interpretations about the meaning of HIV/AIDS in the context of their religious beliefs. A qualitative investigation on the service user’s interpretation would give new insight to help build effective strategies to work toward the stigma reduction program. Second, a mixed research method will better serve the stigma research in the future. None of the participants, of course, desired to be identified as stigmatizers of PLWHA. The participants often commented about how they perceived society and other people manifesting HIV/AIDS-related stigmatization toward PLWHA. Due to social desirability not to be known as a stigmatizer, it was difficult to assess the study participants’ own prejudices and stigmatizing attitudes toward PLWHA in depth with the structured online questionnaire. In future studies, quantitative research methods might show different descriptions of the participants' personal perceptions and judgmental attitudes, which they did not feel comfortable to express with words in narratives. Third, diverse religious traditions in Sub-Saharan Africa communities need to be included in future research studies to
help explore the meaning of HIV/AIDS. Islam is one of the world’s major religions. One-third of the world’s Muslims live in Africa; about 13% of the population in Malawi are Muslims (Kettani, 2010). Little is known about the effort and impact of Islamic faith-based organizations in HIV/AIDS perpetuating stigma and creating interventions (Tiendrebeogo & Buykx, 2004). Although Christianity is a dominant religion in Malawi, other religious traditions such as Islam and indigenous religions might affect people’s understandings of HIV/AIDS and HIV/AIDS-related stigmas in unique ways. Knowing the different constructions and manifestations of HIV/AIDS in each religion will better serve NGOs and FBOs to develop culturally appropriate HIV/AIDS reduction strategies fitting in each cultural context.

**Conclusion**

This study sought to explore the impact of religiosity on the meanings of HIV/AIDS, and to investigate the role of religiosity and spirituality among Christian service providers at NGOs and FBOs in Malawi. This offers not only an in-depth understanding of the meanings of HIV/AIDS as constructed by people’s religiosity, but also the significance of religiosity and spirituality among professionals working in NGOs and FBOs in Malawi. The findings of the study indicate that religion serves as an important cultural influence, with the power to both negatively affect the construction of HIV/AIDS stigma in society, and positively reconstruct the meaning of HIV/AIDS. Religiosity and spirituality are important health assets that motivate and empower service providers to continue to work with PLWHA in Malawi, in spite of the many challenges that they face at work.

Practitioners in the social work profession are considered to be advocates of human rights for PLWHA, and are often highly trusted by the most vulnerable people in community. What social workers believe about human sufferings and diseases like HIV/AIDS is critical to
understand because it can affect how they behave and work with PLWHA. It is critical for current social workers and future practitioners to thoroughly examine their own’ beliefs and value systems that have been shaped by cultural influences, including religion. This study suggests that the destruction and reconstruction of religious beliefs is important in finding strategies to reduce HIV/AIDS-related stigmas that have been manifested in both overt ways of discrimination and covert ways of prejudice toward PLWHA. To effectively respond to the HIV/AIDS pandemic, social work education has to equip more HIV/AIDS specialists who are well prepared to deal with a variety of unique problems that PLWHA and their families encounter. The faith-communities are called to build justice and grace-focused theologies to heal and empower the HIV infected in the community. The faith-communities also need to create safe environments where PLWHA can honestly share their lived experiences, hurts, and difficulties, find hope for the future, and receive healing and empowerment by knowing their spiritual identity as the children of God. People living in the era of HIV/AIDS need to hear a message of hope and acceptance, not of punishment and condemnation. HIV/AIDS social workers and helping professionals working in NGOs and FBOs in Sub-Saharan Africa need to practice their professions focusing on religion of grace and hope, rather than religion as the code of morality.
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Appendix A: Online Questionnaire

The Role of Religion and Spirituality in Service Provision among Professionals Working at NGOs (Non-Governmental Organizations) and FBO (Faith-Based Organizations) in Malawi

DESCRIPTION OF RESEARCH
Thank you for agreeing to participate in the research. The purpose of the research is to understand the meaning of HIV/AIDS and HIV/AIDS-related stigma in relation to religion and religious beliefs, and to understand the role of religion in the effort of working with HIV/AIDS affected population in Malawi. This questionnaire will gather responses from professionals working with HIV/AIDS affected populations in Malawi. Participants will be asked about experiences, knowledge, and opinions about HIV/AIDS and HIV/AIDS stigmas in relation to religion and religious beliefs. Each person will also respond to questions focused on the role of religion in the workplace when performing duties with HIV/AIDS affected people in Malawi. It is estimated that this questionnaire should take between 1.5 to 2 hours to complete. Be assured that all responses will be kept in the strictest of confidentiality.

NAME/ORGANIZER: Sung Ah Choi, Doctoral Candidate
University at Albany, State University of New York

CONTACT INFORMATION: schoi5@albany.edu
Section 1. Background Information

1. What is your gender?
   a. Male
   b. Female
   c. Other, (specify):

2. What is your age?

3. What is your nationality?

4. What is your ethnicity?
   a. White
   b. African
   c. Asian
   d. Hispanic
   e. Bi-racial
   f. Other, (specify):

5. What is your primary language?

6. What are the languages you communicate with in Malawi?
7. What is the highest degree you have earned?
   a. Less than high school
   b. High school graduate
   c. Associate
   d. Bachelor
   e. Master
   f. Ph.D.
   g. Other, (specify):

8. What is your marital status?
   (Options may include: currently married, widowed, divorced, separated, single–divorced,
   single–widowed, never married, or living with a partner)

9. What is the name of your occupation?
   (i.e., social worker, nurse, doctor, teacher, lecturer, farmer, program manager, therapist,
   pharmacist, engineer, missionary, clergy, etc.)

10. In what specialty have you been certified or licensed?

11. In total years, how long have you lived in Malawi?    years    months

12. When did you first enter Malawi:                   (Month/Date/Year)

13. What is your religion:
   a. Protestant
   b. Catholic
   c. Muslim
   d. Buddhist
   e. Indigenous religion
   f. Other, (specify):
14. How long have you been affiliated to your current religion? (Since what year….)

15. If you converted from another religion, what was your first religion?

16. If you converted to your current religion, how long were you affiliated to the previous religion?
Section 2. Organization Information

Now, I would like to ask you several questions about your organization.

17. What is the name of your organization:

18. If your organization has a web site or online community, please write its URL and page name:

19. Where is the organization located?

   19-1. Is the location
         a. City/Urban
         b. Rural
         c. Village
         d. Other, (specify):

20. What type of organization employs you?
    a. International
    b. Domestic
    c. International + domestic (funded both by international and domestic donors)
    d. Other, (specify):

21. How long have you worked in the current organization?
22. List the major services your organization provides? (i.e., medical service, education, HIV/AIDS intervention and prevention service, domestic violence, feeding, material aid, religious service, etc.)

1.
2.
3.
4.
5.
6.
7.
8.
Section 3. Perceptions about HIV/AIDS

Now, I would like to ask you several questions about your experiences in helping HIV/AIDS affected populations in Malawi, and your thoughts about HIV/AIDS disease. There are no right or wrong answers and no word limit for your answers. Please write your thoughts and opinions in as much detail as possible.

23. Which group do you believe has been the most affected by HIV/AIDS in Malawi?

24. Based on your knowledge, what is the major reason that the people you helped at your organization have been infected by HIV/AIDS virus?

25. Would you share an example of when negative opinions are given toward HIV/AIDS affected people in Malawi?
26. What do you think Malawi’s general opinion about PLWHA (people living with HIV/AIDS)?

27. Why do you agree or disagree with Malawi’s general opinion about PLWHA (people living with HIV/AIDS)?

28. Why do you think those opinions exist?

29. What do you think about when you see a person in your organization that you think is HIV positive?
Section 4. HIV/AIDS Stigma

Now, I would like to ask you questions about your thoughts about HIV/AIDS stigma. Your answers are confidential, and will never be reported to your organization. Please describe your thoughts in as much detail as possible. There is no word limit for your answers. Feel free to illustrate any stories in your answers connected to any experiences in your work and community while responding to the questions.

30. Tell me about whether you have ever felt fear that you could contract HIV while working with HIV/AIDS infected people.

31. Do you agree with the following statement, “people living with HIV could have avoided it if they wanted to?”

32. Why do you agree or disagree with this statement?
33. What are your thoughts about the statement, “People living with HIV/AIDS should feel ashamed of themselves?”

34. Have you seen or met any individuals who were hesitant to take an HIV test due to fear of other’s reaction if the test result is positive?

35. What made them hesitant to take an HIV test? Would you share a few details and examples about what made them hesitant to take the test?
36. Reflecting on your past experiences at work, describe how you have observed your coworkers or people in community talking about PLWHA (people living with HIV/AIDS)?

37. Describe to me the situation or their words and attitudes.

38. Have you heard any stories or situations about PLWHA (people living with HIV/AIDS)? What did you hear about them?

39. If you are not from Malawi and you are a foreigner working in Malawi, how are HIV/AIDS and HIV/AIDS stigmas differently understood by the general population between in your own country and Malawi? (*This question is only for foreigners working in Malawi.)
Section 5. Religion and HIV/AIDS stigma

The next set of questions ask about your understanding about HIV/AIDS and experiences with HIV/AIDS stigma in relation to your religion and religious beliefs. Your answers are confidential, and will never be reported to your organization. If you have any relevant stories and experiences regarding any following questions, please feel free to describe them as detailed as possible. There are no right or wrong answers.

40. Some people say, “HIV/AIDS is a punishment of God.” What is your thought about this statement? Why do you agree or disagree? Please give me examples or your life experiences to support your opinion.

41. In what manners do you think the thought “HIV/AIDS is a punishment of God” has been constructed in your religious community?

42. Describe how HIV/AIDS stigma has been manifested in your religious community (i.e, church, mosque, or temple). If you have seen or heard any situations occurred in relation to HIV/AIDS stigma in your religious community, please describe the situation in detail.
43. Which factors do you think brought out those situations to happen in your religious community?

44. How does your religious tradition/beliefs define disease like HIV/AIDS?

45. How do you personally define/understand HIV/AIDS based on your own religious beliefs?
46. How do you think that religion has stigmatized people living with HIV/AIDS in Malawi? Have you seen or experienced any examples? Please describe it in detail.

47. If you are not from Malawi and you are a foreign worker helping PLWHA (people living with HIV/AIDS) in Malawi, are there any differences how HIV/AIDS has been understood between in your religious community in your native country and Malawian religious community? (*This question is only for foreigners working in Malawi.)
Section 6. Role of Religion and Spirituality

In closing, the last few questions ask about the role of religion and spirituality in your work with HIV/AIDS affected people in Malawi. Please answer the questions in as much detail as possible. No word limit exists for any question. (* PLWHA means people living with HIV/AIDS.)

48. How do your religion and religious belief affect you to work with PLWHA in Malawi?

49. Share with me what life experience or specific life event that encouraged you to work with PLWHA in Malawi.

50. How is your spirituality important for you to work with PLWHA in Malawi?
51. What are the most difficult circumstances that you have faced at your work in Malawi?

52. How does your spirituality help you cope with the difficulties and challenges that you have face at your work in Malawi?

53. What religious beliefs help you continue to work with PLWHA in Malawi?

54. What religious or spiritual practices help you continue to work with PLWHA in Malawi?

Thank you so much for answering the questions. I will be in touch with you via email. If you have any questions or comments, please feel free to contact me at schoi5@albany.edu at anytime.
Recruiting Online Survey Participants

**Description:** A doctoral student at State University of New York at Albany is seeking online survey participants for a doctoral dissertation. The researcher wants to know about how an individual’s religion and spirituality influences work with HIV/AIDS affected people in Malawi.

**Eligibility:**
- At least 18 years old
- Service Providers (paid employees or volunteers)
- Minimum 1-year work experience in NGOs and FBOs helping HIV/AIDS affected people in Malawi
- Practice a religion
- Regularly participate in religious and spiritual activities
- All are welcome!

**Location & Schedule:**
- Online availability.
  The questionnaire is available via email or Google Survey form.

**Time**
- It will take about 1.5 ~ 2 hours to complete the questionnaire.

Please email Sung Ah Choi, Ph.C. at schoi5@albany.edu
or
Call at (1) 973-975-6640 or (265) 9-9603-8368,
if you are interested or would like more information.
Appendix C: Consent Form

Institutional Review Board (IRB)
Informed Consent Information
for Participation in a Research Study

<table>
<thead>
<tr>
<th>Protocol (Study) Number</th>
<th>16-E-242-01</th>
</tr>
</thead>
<tbody>
<tr>
<td>Study Title</td>
<td>The role of religion and spirituality in service provision among professionals working at NGOs (Non-Governmental Organizations) and FBOs (Faith-Based Organizations) in Malawi</td>
</tr>
<tr>
<td>Study Principal Investigator Name</td>
<td>Sung Ah Choi</td>
</tr>
<tr>
<td>Study Principal Investigator Phone #</td>
<td>973-975-6640</td>
</tr>
<tr>
<td>Study Principal Investigator Email address</td>
<td><a href="mailto:schoi5@albany.edu">schoi5@albany.edu</a></td>
</tr>
</tbody>
</table>

Introduction

Sung Ah Choi, MSW, M.Div., & Ph.C. is a doctoral student conducting this study for her doctoral dissertation under the direct supervision of Julia F. Hastings, Ph.D., assistant professor in the School of Social Welfare at the University at Albany, State University of New York.

You are being asked to participate in this research study because of
1) Being a professional (volunteer or employee) working in an international or domestic NGO/FBO that has served HIV/AIDS affected populations in Malawi.
2) Working a minimum of one year within the NGO/FBO in Malawi.
3) Identifying a religion and regularly participate in an organized religious community.

Why is this study being done?

The purpose of this research is to understand the meaning of HIV/AIDS and HIV/AIDS-related stigma in relation to religion and religious beliefs, and to understand the role of religion and spirituality in the effort of working with HIV/AIDS affected population in Malawi.

What are the study procedures? What will I be asked to do?

By signing this consent form, you agree to be available for an online questionnaire via the Internet. During the online questionnaire you will be asked to share your thoughts and experiences in helping people living with HIV/AIDS in Malawi. I will invite you to share your personal and organizational background, your perception about HIV/AIDS and HIV/AIDS-related stigma, and your understanding of HIV/AIDS in relation to your religious beliefs, and the role of your religion in working with HIV/AIDS affected people in Malawi.
**How long will it take?**

The online questionnaire would take approximately 1.5 to 2 hours.

**What are the risks or inconveniences of the study?**

There are no known risks associated with participating in the study. However, participating in this study might carry the possibility of discomfort in talking and sharing stigmatizing behaviors and thoughts about your own or the organization and religious community that you have involved in. If you would need any psychological support due to your emotional distress that you might experience during the survey, available counseling facilities in Malawi will be provided to you upon your request.

**What are the benefits of the study?**

Although you may not receive direct benefit from your participation, others may ultimately benefit from the knowledge obtained from this research. It is believed that findings of this study will enrich our understanding of HIV/AIDS stigma and contribute advocacy for people living with HIV/AIDS in Sub-Saharan African communities. Research findings will be developed into implications to help NGOs, FBOs, and religious leaders plan how to reduce HIV/AIDS stigma and how to promote the professionals’ motivation to continue their services to help PLWHA.

**Will I receive payment for participation? Are there costs to participate?**

There is no compensation or incentive for participating in the study.

**How will my personal information be protected?**

This project has been approved by the University at Albany Institutional Review Board. Approval of this project only signifies that the procedures adequately project the rights and welfare of the participants. Please note that absolute confidentiality cannot be guaranteed due to the limited protections of Internet access. Please be sure to close your browser when finished so no one will be able to see what you have been doing. Your name will not be collected in the survey form. Your identity will never be revealed in any reports on the research. Data collected via email and online survey form will be always protected with a user ID and passcode for the researcher’s personal computer. Any printed data will be kept in a locked file during the study, and then destroyed after the study completion.

All information obtained in this study is strictly confidential unless disclosure is required by law. In addition, the Institutional Review Board, the sponsor of the study (e.g. NIH, FDA, etc.) and University or government officials responsible for monitoring this study may inspect these records.
Can I stop being in the study and what are my rights?

You should also know that participation in research is entirely voluntary. Even after you agree to participate in the research, you may decide to leave the study at any time without penalty or loss of benefits to which you may otherwise have been entitled. You should also be aware that the investigator may withdraw you from participation at her professional discretion.

Whom do I contact if I have questions about the study?

Take as long as you like before you make a decision. We will be happy to answer any question you have about this study. If you have further questions about this project or if you have a research-related problem, you may contact the principal investigator.

Whom do I contact if I have questions about my rights as a study participant?

Research at the University Albany involving human participants is carried out under the oversight of the Institutional Review Board (IRB). This research has been reviewed and approved by the IRB. If you have any questions concerning your rights as a research subject or if you wish to report any concerns about the study, you may contact University at Albany Office for Pre-Award and Compliance Services at 1-866-857-5459 or hsconcerns@albany.edu.

You will be given a copy of this document to keep.
CONSENT TO PARTICIPATE IN ONLINE SURVEY

Statement of Online Interview Consent:

I have read of the information about this study. I understand the purpose of the study. I have been informed of the risks and benefits involved, and all my questions have been answered to my satisfaction. Furthermore, I have been assured that the researcher will answer any future questions I may have in the future. I voluntarily agree to take part in this study. I freely participate in this online survey.

________________________________
Printed Name of Participant

________________________________
Initials or Signature of Participant

________________________________
Email address

________________________________
Date

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