

Faith-Based initiatives in Response to HIV/AIDS in Jamaica

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HIV/AIDS continues to advance relentlessly in the developing countries with the Caribbean ranking second to sub-Saharan Africa in rates of infection. Using the social influence theory that recognizes the role of opinion leaders in social and behavioral change, this study examines the contributions of faith-based organizations (FBOs) in addressing the HIV/AIDS epidemic in Jamaica. Through data gathered qualitatively from FBO members and persons living with HIV/AIDS (PLWHA), this article demonstrates that religion plays a crucial role in the Jamaican culture and that religious leaders have the potential to address the widespread HIV/AIDS epidemic in their communities. Many of them have established programs that provide social, psychological, and physical support and have collaborated with health organizations to initiate health educational programs that seek to impact understanding to motivate behavioral change. This FBO integrative approach complements mass media public awareness HIV/AIDS campaigns but is hampered by HIV/AIDS-related stigma, socio-cultural and religious beliefs, the lack of HIV/AIDS policies, and the inadequate capacity among religious leaders to address the epidemic. This article recommends further research on strategies to incorporate spirituality into health communication interventions, as well as on the overall impact of the FBO approach to HIV/AIDS prevention in the Caribbean region.

The human immunodeficiency virus (HIV) that causes the Acquired Immunodeficiency Syndrome (AIDS) is spreading fast in the world, thus becoming a catastrophic health and development concern. It continues to advance relentlessly, emerging as one of the greatest public health challenges in contemporary times (Bertrand, 2004). The Caribbean has been hard hit by the HIV/AIDS epidemic, with a current estimate of 230,000 [210,000 – 270,000] people living with HIV (UNAIDS, 2007) and an overall HIV prevalence of 2.11% of the population (Camara, 2005). AIDS is now the leading cause of death among the 18-45 year age group, but the severity of the epidemic in the Caribbean region is often

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overlooked because the population in the Small Islands Development States (SIDS) is relatively small (Kelly & Bain, 2003).

The primary mode of transmission in the Caribbean is through heterosexual intercourse. In Jamaica, epidemiological data from the Ministry of Health (MOH) indicates that heterosexual transmission accounts for 72% of HIV/AIDS cases, compared to homosexual transmission (2%), Bisexual male transmission (3%), drug injection (1.5%), mother-to-child transmission (6%), blood transfusion (0.3%), other (0.2%), and unknown (24%). The high incidence of heterosexual infection is demonstrated by an increase in HIV-positive babies whereby, out of 1,000 pregnant women, 13 babies are infected (MOH, 2007). Studies have identified other contributing factors to the relatively high HIV infection rates which include: an early age of sexual debut (median age of 14 for boys and girls), multiple sexual partners, a robust sex industry linked with tourism, lack of male circumcision, presence of cancrroids and other sexually transmitted diseases, age disparity between partners (a pattern of older men having transactional or coerced sex with younger girls), relatively high levels of alcohol and drug use, as well as related factors such as poverty, labor emigration, male absenteeism, violence, homophobia, and stigma associated with AIDS (Camara, 2005; Green, 2003; Human Rights Watch, 2005).

In response to the AIDS epidemic, several organizations in Jamaica, like in most developing countries, have invested millions of dollars over the past two decades in programs that focus on prevention through behavioral change, many of which focus on sexual practices and intravenous drug use (Bertrand, 2004; Melkote, Muppidi & Goswami, 2000; Parker, 2004). Key areas of investment have been allocated toward increasing awareness and knowledge, reinforcing attitudes and maintaining interests, motivating cues to action and demonstrating simple skills, increasing demand for health services and reinforcing behaviors, as well as building social norms (McKenzie, Neiger & Smeltzer, 2005). However, not all of these programs are successful, and sometimes they fail to bring about appropriate behavioral change. Some researchers suggest changing the communication approaches to incorporate other strategies that seek to increase understanding and therefore motivate compliance (e.g., Backer, Rogers & Sopory, 1992; Bertrand, 2004; Cappella, Fishbein, Hornik, et al., 2001; Duggan, 2006; Dutta-Bergman, 2005). Others recommend communicating within social, political, and cultural contexts for behavioral change to occur (Friedman & Hoffman-Goetz, 2006; Morrill & Norand, 2006; Melkote, et al., 2000; Muturi, 2005).

This study examines faith-based initiatives in Jamaica with special attention to their communication strategies in HIV/AIDS prevention. Globally, faith-based organizations (FBOs) are an integral part of life and society, found within every community. They have much credibility because of their involvement at the grassroots level, their involvement with the people in every aspect of their lives, and for the many services they offer (Parry, 2003). As social and cultural institutions, FBOs shape social norms, beliefs, attitudes, and people's realities with regard to sexual self-understanding, which makes them a crucial partner in HIV/AIDS prevention.

There is evidence of FBOs' contributions in the health sector, providing care and support, building infrastructure, capacity building through training programs, and mobilizing large numbers of volunteers to contribute to causes they consider worthy (Calderon, 1997; Green, 2003; Lazzarini 1998). Globally, many

FBOs have contributed or are still searching for an effective approach to responding to the HIV/AIDS pandemic (Calderón, 1997). In Uganda, for example, the major religious organizations (Catholic, Anglican, Muslim) collaborated with the government in prevention through promotion of the ABC approach (Abstinence, Being faithful and Condom use), which is believed to have contributed to the decline of HIV prevalence among pregnant women from 21.1% to 6.1% between 1991 and 2000 (Hogle, 2002). Similarly, collaborative efforts between the government and religious organizations of all faiths contributed to partner reduction and the rise of age of sexual debut from 16.4 in 1993 to 17.5 in 1997 as well as the reduced rate of HIV infection, making Senegal one of the African success stories concerning the HIV/AIDS epidemic (Green, 2003). And in Latin America, education on HIV/AIDS and capacity building among church leaders has benefited from their contributions in prevention interventions (Calderón, 1997).

At the same time, many FBOs have been associated with obstacles in HIV/AIDS prevention, opposing use of prevention measures such as condoms and sexuality education, instead advocating abstinence and mutual monogamy strategies, which have been proven ineffective (Green, 2003; Pisani 1999; Parry, 2003). In the Caribbean, Green observes that their contributions are neither well-researched nor well-documented. Instead, their positive efforts are overlooked, and some even criticized for being anti-condom, for fueling AIDS-related stigma and discrimination, and for forbidding Christian burial of those suspected of having died of AIDS. While acknowledging such accusations, this study examines their contributions through care and support for those affected by the disease as well as initiatives for preventing further spread of the epidemic. The study also examines the challenges that hamper their communication and prevention efforts.

Theoretical Context

Current health communication interventions are based on solid theoretical frameworks that address behavioral change, including the social cognitive theory (Bandura, 1986), theory of reasoned action (Fishbein & Ajzen, 1975) and social influence theory (Fisher, 1988). Common health communication models like the AIDS risk reduction model (Morisky & Ebin, 2001), the health belief model (Janz & Becker, 1984; Mattson, 1999; Rosenstock, 1974), and the extended parallel process model (EPPM) of fear appeal (Witte, Meyer & Martell, 2001) have also informed health communication interventions.

These theories and models explain why various forms of communication work or fail in causing the desired change. For instance, the EPPM is used to justify the use of fear appeal in motivating behavioral change as in the case of Uganda, now labeled an African success story for having a 66% decline in HIV prevalence between 1992 and 2002 (Green & Witte, 2006), whereas the diffusion theory used extensively to inform interventions in developing countries provides insight into the difficulty of achieving the behavioral change necessary to curb the HIV/AIDS epidemic (Bertrand, 2004; Rogers, 1995).

In reviewing the HIV/AIDS communication interventions in Africa, Asia, Latin America, and the Caribbean, Airhihenbuwa, Makinwa and Obregon (2000) note that current models view behavioral change as a linear relationship between individual knowledge and action with the assumption that individuals can or will exercise total control over their sexual behavior. These models are criticized for disregarding the

influence of contextual variables – social, cultural, political, and socioeconomic contexts within which the individual functions – as well as other related differentials of self-efficacy and power in sexual interactions (Airhihenbuwa et al., 2000; Melkote, et al., 2000).

The role of mass media and other communication strategies in behavioral formation and change is clearly documented. Studies also emphasize the critical role of interpersonal communication and of opinion leaders to influence behavioral change at an individual level (Morisky & Ebin, 2001; Rogers, 2005). Atkin (2001), for instance, notes the importance of personal influencers in changing the beliefs, attitudes, behaviors, and practices of those who trust and follow them or through social interactions. Religious and other community leaders fall in this category of change agents at an individual, societal, and policy level, and are therefore appropriate in addressing HIV/AIDS related issues at these levels.

The Social Influence Theory

Social influence theory explains why some people listen to others (Fisher, 1988) and how one person persuades others to change their beliefs, opinions and attitudes (Turner, 1991). Research has found that people are willing to go against their own beliefs to harm another when instructed to by an authority, while some use opinions of others as a guide to reality in situations that are ambiguous and uncertain (Cline, 2003).

The theory focuses on the social realities of participants with implications for understanding social influence, messages, and meanings from their viewpoint. From this perspective, social influence consists of the processes whereby people agree or disagree about appropriate behavior and form, maintain, or change social norms and the effects thereof, as well as the social conditions that give rise to such norms (Cline, 2003). The particular mechanism of social influence includes social norms, network membership, conformity pressures, media influences, social comparison, and modeling (Morisky & Ebin, 2000). There is evidence that people form and conform to social norms, and that there are influences inherent in social relationships and implicit pressures for agreement, even without instructions to agree or explicit group memberships (Turner, 1991).

In HIV/AIDS prevention, social influence and social norms directly impact high-risk sexual behaviors. For example, in their study among adolescents' perceptions on condom use, Kirby and DiClemente (1994) found that those who perceive that their peers support condom use are more likely to use them. Social influence approaches emphasize behavioral expectations and standards (social norms) present in the environment and prepare the learner to resist pressure to engage in risk-taking behaviors (Morisky & Ebin, 2001). Examining smoking behavior, Cline (2003) also observes that social influence through everyday interpersonal interactions in social networks may serve to disseminate health information or, conversely, to reinforce risk-taking behavior as a social norm as in the cases of smoking and other peer-influenced behaviors like sexual practices or drug use. In the case of HIV/AIDS, Cline concludes that, "everyday interaction is significant in creating a "shared reality" of illnesses which she argues is "a socially constructed product and process of everyday talk" (p. 291). Such construction sometimes determines how the disease is addressed based on how social networks view it and its impact within their environment or network. The theory explains the potential of religious leaders as social

influencers and the impact FBOs might have in addressing HIV/AIDS-related issues like stigma and discrimination based on their socially constructed norms and their role in society.

Research Questions

Given the influence and social responsibility role of FBOs in addressing issues that affect society, this study used the following broad research questions to examine their contributions to HIV/AIDS prevention:

1. How have religious organizations contributed toward the fight against the HIV/AIDS epidemic in Jamaica?
2. What communication strategies do FBOs use and how do they differ from other health communication approaches in addressing the HIV/AIDS epidemic?
3. What are the challenges that religious leaders face in their attempt to address HIV/AIDS-related issues within their communities?

Methods and Procedures

This is a qualitative study that sought to gather information on the current faith-based HIV/AIDS initiatives in Jamaica. The intent of qualitative research is to understand the deeper structure of a phenomenon and to increase understanding of the phenomenon within cultural and contextual situations. The best way to gather such information is to immerse oneself in the world in which these phenomena are occurring with a desire to uncover the story behind the statistics (Trauth, 2001). Such techniques seek to describe, decode, translate, and otherwise come to terms with the meaning, not the frequency, of certain more or less naturally occurring phenomena in the social world (Maanen, 1983).

Information was gathered through focus groups and in-depth interviews from FBOs, support groups for persons living with AIDS (PLWHA), and health professionals who practice within faith-based initiatives and are directly involved in HIV/AIDS interventions. Data was gathered from three (out of 14) Jamaican Parishes with the highest HIV/AIDS prevalence — Kingston and St Andrew, St James, and St Catherine (MOH, 2007). We recruited from 12 FBOs with the highest membership based on the International Religious Freedom Report (2002) which uses the census data on religious affiliation. The 12 are as follows: Church of God (12%), Seventh-Day Adventists (9%), Baptist (9%), Pentecostal (8%), Anglican (6%), Roman Catholic (4%), United Church and Methodist (3%), Jehovah's Witnesses (2%), Moravian Church (2), Brethren (1%), and Other — Rastafarians, Hindus, Jews and Bahai (9%). The largest (24%) of the Jamaican population was unlisted. From the category 'other,' the Rastafarian and Bahai faiths were selected due to their prominence in the Caribbean, while the PLWHA, medical professionals and others who participated, represented the unlisted category because their organizations do not represent any religious faiths.

Data collection took about six months, with each interview lasting a minimum of two hours. Though English language, which is widely spoken across Jamaica, was used in information-gathering, a Jamaican native who served as a research assistant elaborated in Patois (the Jamaican Creole) any questions that respondents seemed not to understand. This clarification was necessary for accurate responses.

Focus Groups: Twelve focus group discussions were conducted, ten groups with FBO members and two with PLWHA. For each participating FBO, one member was contacted and requested to recruit about ten others for the study based on age and gender. Also, participants could not have blood or marital relationships. The two PLWHA groups were recruited through their support office and these were mixed groups – men and women – due to the low number of volunteers. In total, 100 persons participated in the focus groups, 18 of them PLWHA. All group participants were required to sign a consent form prior to participating in the study and the information they provided was tape-recorded for further transcription and analysis.

In-depth Interviews: Thirty in-depth interviews were conducted, 24 of them with FBO leaders. The interviews sought to gather information related to their knowledge and understanding about HIV/AIDS, current interventions that they have initiated or supported, their communication strategies, and challenges in addressing HIV/AIDS within their communities. At least two leaders were interviewed from each Christian denomination and other faiths, from different parishes. Interview participants included church ministers, elders and deacons, and others who have a leading role in their faith communities. In addition, four leaders from the selected PLWHA organizations were interviewed along with two medical professionals who are strongly affiliated with churches and have played a role in their HIV/AIDS initiatives. Only one leader was a medical doctor who specializes in communicable diseases including HIV/AIDS and is therefore well-known to PLWHA.

Analysis

A qualitative analysis using descriptive and interpretative techniques followed the transcription of information. Once transcribed, an additional research assistant was contracted to assist in organization and analysis of participant responses, which was done thematically rather than compiling numbers, which is not appropriate for focus group research (Krueger & Casey, 2000). We identified themes that emerged from the responses, creating a running list of metaphors and phrases that were repeated across the texts while keeping in mind the original research questions. This type of analysis involves focusing on the general agreement among participants in each group (e.g., Was this attitude or belief held by other members in the same focus group?) (Mathews et al., 2006).

For credibility and validity of study findings, we used a member-checking method. Kuzel and Like (1991) note that member-checking, which consists of the researcher restating, summarizing or paraphrasing the information received from a respondent, ensures that what was heard or written down is, in fact, correct. Member-checking was done continuously during and after each focus group, through repeating respondents' statements and prompting for clarification where necessary. Following the completion of the study, findings from the study were presented at several local conferences on HIV/AIDS

for feedback from the local communities. Study findings were also presented at a capacity-building HIV/AIDS workshop for FBO leaders. Workshop participants, the majority of whom had participated in the study, discussed the findings in detail, providing feedback and critical commentary to ensure accuracy of interpretations. Member-checking adds credibility, accuracy, and richness to a final report (Kuzel & Like, 1991).

Findings

This section addresses key findings of the study, identified based on the recurring themes from the focus group discussions and in-depth interviews, but keeping in mind the research questions that helped focus the study. The first question sought information on FBO initiatives and strategies used in addressing the AIDS epidemic in Jamaica. We started by assessing the respondents' perceptions on the impact of the epidemic in the communities and the role of FBO leaders and members in preventing the widespread epidemic. Based on their responses, it was clear that respondents were aware of the impact of HIV/AIDS in Jamaica and in their local communities. Most of the information they had was based on media reports and other health campaigns that address the AIDS epidemic in Jamaica. Every participant had heard the messages either on radio or television, or had seen the posters that are prominently displayed across the island. This finding confirms the awareness role of mass media in health communication campaigns (Atkin, 2003; Rogers, 1995), though that awareness did not necessarily lead to behavioral change.

With an awareness of the AIDS epidemic across the island confirmed, participants were asked what they considered the role of their religious organizations to be in preventing it. A common response was that religious leaders were responsible for communicating with the public, not just their members, about issues affecting society such as AIDS and risky behaviors contributing to HIV-infection at the church and other community gatherings. This is based on their social status and influence in people's lives as emphasized in the following comment: "if you go and give your testimony and if the Pastor say let us all pray they are all going to pray if the Pastor say don't pray, they don't pray." Another respondent noted that in situations requiring personal attention, "they can visit you personally any time even at night if there is a problem or if they want to talk to you about something and nobody will question them." Several participants gave examples in which they had consulted with religious leaders about their problems whom they felt were more capable of helping than could anyone else including family members.

This finding is in line with studies that have indicated the social influence of religious leaders as trusted and credible sources of information in their communities (e.g., Calderón, 1997; Green, 2003; Parry, 2003; Pisani 1999), which makes them ideal for HIV/AIDS communication. When asked the same question, leaders also acknowledged that AIDS was an issue that required their aggressive intervention and many of them indicated their involvement either directly or indirectly in addressing it. The extent of their involvement varied, some did more than others, but generally, all FBOs indicated some form of initiative to address the epidemic in Jamaica.

FBO HIV/AIDS Initiatives

FBOs play a major role in healthcare, providing care and support for those with health and medical needs in their communities. Many of them have responded to the HIV/AIDS epidemic through various ways in recent years and others struggle with the impact of the epidemic. FBO response in Jamaica is, however, scantily documented. One respondent noted:

I have no facts and figures about who is doing what, but I can tell you about what is happening or some of what is happening in the Jamaican churches. They are doing a lot about the AIDS problem in our communities, but nobody knows about it out there because everyone is doing their own thing and we don't go public about it (Female, FBO leader, Anglican Church).

FBO contributions in Jamaica range from offering prayers and other spiritual or psychological support through counseling and other forms of communication for prevention and behavioral change, to direct care and support through medical support and other forms of assistance in meeting the basic needs among those infected and affected by the AIDS virus. Respondents interpreted this role of FBOs as caring for body and soul, which is a more comprehensive way of dealing with the epidemic. However, as Green (2003) points out, most of the FBO efforts are not systematically documented.

Social and Psychological Support

A number of conceptual and empirical studies have continued to document the relationship between spirituality and health, particularly the role of spirituality in health and helping those with serious illnesses, especially where spirituality is viewed as a strong predictor of people's quality of life (e.g., Aldridge, 2000; Buck, 2006; Calderon, 1997; Goodier & Eisenberg, 2006; Mathews, Berrios, Darnell & Calhoun, 2006). This role of religion continues to receive attention with the emergence of chronic illnesses like HIV/AIDS. Buck (2006) argues that spirituality influences adaptation to chronic illness and mediates uncertainty. Spiritual meanings are linked to actions, and those actions have consequences that are performed as prayer, meditation, worship, and healing. In some instances, ecology of treatment at various physical, psychological, social, and spiritual levels all meet the needs of the sick, which includes prayer, laying-on of hands, and a celebration of their faith (Aldridge, 2000).

Jamaican FBOs have been central in the provision of physical, social, and psychological support to those affected by HIV/AIDS and other illnesses. In all the focus group discussions, members indicated going to their religious leaders and asking for prayers once diagnosed with any kind of illness. PLWHA focus groups stressed the role of prayers in helping them cope particularly in the early days post-diagnosis. For example, a female PLWHA noted:

I used to be very sick but a friend took me to her church where they prayed for me and I accepted Jesus as my savior. Since then I pray a lot for strength and I feel better and strong whenever I pray. Now I have even put on some weight because I have the

strength to eat and go on but before I was a lonely and depressed person with no hope for life.

Throughout the study, PLWHA emphasized the role religious leaders have played in their lives especially during HIV post-diagnosis. This is a time that, without prayers or proper counseling, some respondents indicated contemplating suicide or revenge by infecting others. For instance, a statement was made by one such respondent:

When I learned that I was positive, I went to see my pastor because I was so angry at myself and everyone else. I hated the world, but I decided to go see him because I had nobody else to talk to and I had thought I would kill myself. When I went there I told him I was sick I wanted him to pray for me before I kill myself and he did even without asking me what the problem was, then we talked about and I told him what I had (Male, PLWHA).

This statement implies the role of spirituality in diverting destructive behavior whether directed to oneself or others by failing to reveal their status or use protection. These findings support what Duggan (2006) argues, that enacted social support, or intentional acts conveying concern, aid, or information, can buffer individuals from negative effects or stress and enhance health and well-being.

Spiritual Healing

In addition to prayer, spiritual or faith healing is one of the FBO initiatives for Jamaica and practiced widely across the wider Caribbean. This practice is deeply rooted in the Jamaican culture where the crucial role spirituality plays in people's health is widely acknowledged within FBOs. As one FBO leader indicated in an interview:

We believe there is a strong connection between health and religion. In our work, we see that religious people tends to cope well in times of illnesses compared to others and of course as a pastor I certainly believe that faith does have a part in the process of healing, the power of the mind, and the power of conviction (Male, FBO leader, Methodist).

With a general consensus that people's faith and spirituality contributes to healing of various illness, we asked participants about their views on HIV/AIDS healing given the fact that there is no medical cure for the disease. Again, a majority of respondents emphasized the power of prayer and faith in healing regardless of the nature of the disease. Demonstrating the role of prayer in AIDS cure, one focus group participant amid support from others indicated "prayer is a powerful method that can move mountains. I believe in prayer and anointing which is healing power." Another respondent narrated a case where spiritual healing was evident and noted:

I met this nice lady who testified to me that her pickney (child) had AIDS though she didn't want people to know. I told her to come see Priest Doctor Dermot Fagan [Rastafarian leader], and the priest anointed her, set bath for her, pray for her, then

rain and thunder and lightening came, and we constantly pray for her, week after week until one day she too go HIV clinic for test, she is now HIV negative (Male, Rastafarian).

Many respondents shared this sentiment in all group discussions giving several examples where they believed people with HIV/AIDS have been cured physically or had negative test results for HIV. Clarifying how this healing process works, a respondent who has indicated having witnessed the healing noted:

I know of the science man. Jesus himself is the science man, the father and the son, he is the greatest healer, if you go to him sincerely, really clean and sincerely, you will get cured. If people believe in him the hospital would not full so much, neither the AIDS place.

Though the island is predominantly Christian, faith healing exists across religions. Embedded within Jamaican folk religions is the belief in spiritual healing and the supernatural powers that reside within their spiritual leaders (*Obeah men and women*), root doctors and herbalists especially within the cults, derived from African rituals carried over from Africa through slavery and by African immigrants (Barrett, 1976; Patrick & Payne-Jackson, 1996). The Jamaican cult cultures of *Myal*, *Kumina*, *Pukumina*, *Convince* and *the Zion Revivalist* practice faith healing widely. The Rastafarians, a Jamaican folk religion that believes in the Bible, also practice spiritual healing. Healing in these religions take the form of music, drumming and exorcism, prayers, laying-on of hands, and baptism (Barrett, 1976; Chevannes, 1995). Laguerre (1987) compares the health practice to the *houngan* (voodoo priest), *docteur-feuille* (leaf doctor), *accoucheuse* (midwife), *docteur zo* (bone setter), and *docteur sangsue* (blood letter through the use of *ventouses* or anelid worms) of the Haitian peasantry (p. 55).

Traditional healers use magic, herbs, and exorcism in the treatment of HIV/AIDS, but the Christians rely on prayer and spiritual healing by the anointed leaders. This role of leaders in healing was confirmed by several respondents, some of whom indicated possession of that power to cure several illnesses. One respondent noted that "For Christians ministers to make themselves available to persons who are ill with whatever illness is, it is at the core of Christian teachings coming from the scriptures that God gave his disciples the healing power to use where necessary." The general view was that religious leaders had a role in the healing process.

There is, however, recognition that not all leaders have been "anointed" or have the healing power, and not everyone believes in faith healing. Several leaders acknowledged their lack of power, but they indicated their strong beliefs in the role spirituality plays in healing. A few persons living with HIV/AIDS also noted the need to combine prayer with medical treatment and relaxation:

Well, mankind is made up of physical and spiritual and mental; I believe in three of them, no matter what you say if you are Christian, you better exercise, read your Bible and sing and reach out. I almost got mad [angry] and wanted to commit suicide and I lost weight, I lose 100 pounds. Then I start to read my Bible and I take my medication and prayer. I start to put on back weight. If you want to come back good you have to

*combine everything, take your medicine, eat right exercise, pray and read your Bible.
(Male, PLWHA).*

Not every case, however, has worked well with faith healing along as indicated by a PLWHA whose common-law wife and later his 'baby mother' died from AIDS three years apart because they relied on faith and herbal medicines alone. This experience taught him to expand his options combining faith, proper diet, medical care, and exercise, which has helped him live with HIV for more than ten years.

An Integrated Approach to HIV/AIDS Prevention

Several studies have criticized the linear model of information dissemination in health communication campaigns; that is targeted toward modifying sexual behaviors (Airhihenbuwa, et al, 2000; Bertrand, 2004; Parker, 2004; Dutta-Bergman, 2004; Cherie, Mitkie, Ismail & Berhane, 2005; Muturi, 2005; Tufte, 2005). These, among other studies, have emphasized a change in communication approaches to incorporate other strategies that are more culturally appropriate in achieving compliance and in changing risky behaviors and attitudes.

Several FBO in Jamaica have used an holistic and integrated approach in addressing the AIDS epidemic that complements the mass media awareness campaigns. Beyond social and psychological support, which has contributed to prevention in certain ways, many FBOs also provide medical assistance and support for physical needs, including food and other financial support to individuals or PLWHA organizations, counseling services for those infected and affected by the epidemic, and most importantly, shelter for those who have been excommunicated by their families. The Bethel Baptist approach of caring for the total man includes running a health clinic within the church compound that provides care and treatment for all illnesses, including those that are AIDS-related. One respondent notes:

We have many people coming to us, some of them homeless and sick. We take them in at the clinic and treat them. Some have AIDS and they can't go home. They have no home because they are thrown out by family and they need our help (Female leader, Bethel Baptist).

Rather than attend AIDS clinics, many respondents stated preference for FBO health centers where AIDS is treated like any other disease, and is therefore less stigmatized. The clinics are also not only affordable due to subsidies from the parent faith organization, but respondents noted that health professionals were more understanding compared to those in public health ones who are known to discriminate against PLWHA. Notable also is the direct care and support program within the Roman Catholic Church which supports PLWHA groups with medication and other social services. The island-wide "Food for the Poor" program also provides food, shelter and clothing to the homeless, some of whom are victims of AIDS-related stigma and discrimination.

Several FBOs address the AIDS epidemic within their existing social programs. For example, the Anglican 'Mothers Union' program focuses on reproductive health issues including maternal-child health, while men and youth programs promote healthy lifestyles. By integrating AIDS-related issues within such

programs, some leaders noted the ease in addressing a sensitive disease that many people don't want to talk about. The widespread epidemic, however, demands a change of focus; more must be invested in the needed care and support services, including payment of hospital bills among other financial and basic needs. An example of such contributions was noted by a women's health coordinator in St. Ann who noted:

We help everyone who comes to us. I can give you an example. We found one of the persons in our group from a side of a street and we brought him in. The old man in his 60s had gone to the hospital because he was very sick but when he got back his family had burned his mattress, so he had nowhere to go so we took him in. We have found him a place to live though he is at the late stages of AIDS now (Female, Catholic Sister).

The Rastafarian faith community also cited several cases where they provide support to members who relocate to their enclosed communal living regardless of their HIV status, but have gone a step further in support of PLWHA, as noted by the leader of the Zion School of Vision. Their leader indicated inclusion of persons with HIV/AIDS in their communities and support through provision of shelter, prayers, faith healing, and other physical needs.

There were few groups that indicated offering financial support to PLWHA agencies and support networks such as the Jamaica AIDS Support for Life (JAS) and Jamaica Network for Seropositives (JN+). PLWHA leaders acknowledged this support but noted that more needs to be done in this initiative, with FBOs setting examples in their communities, although some of them have not joined in the initiative. Specifically, respondents noted that collaboration between FBOs and PLWHA support groups would be an effective approach, particularly in addressing AIDS-related stigma and discrimination that prevails in the Caribbean region.

Communication Strategies within FBOs

Along with recognition of the role of religious organizations and the social influence of leaders in the Jamaican culture, group participants emphasized the need for religious leaders to take a lead in addressing the HIV/AIDS problem in their communities. This led us to the second research question that sought to identify communication strategies and tactics that Jamaican FBOs use in addressing the AIDS epidemic based on their influence in the Jamaican society. We asked about some of the communication strategies that were considered to be appropriate for religious organizations. Participants discussed several communication strategies they considered culturally appropriate for Jamaica. Though not everyone agreed that the topic should be addressed at the pulpit, there was a general consensus that leaders should talk openly about the AIDS epidemic when time and space allows, so that people can be aware and protect themselves from the risk of infection. Younger participants, for instance, indicated that they would actually enjoy hearing their leaders in an open forum about HIV/AIDS and sexuality-related issues that are not discussed elsewhere.

Some leaders use the pulpit to talk to their audience about AIDS. Notably, the Baptist Church occasionally published AIDS-related information in Sunday bulletins which were distributed and briefly

discussed in church. The Rastafarian community also occasionally addressed health issues as part of the sermon. In an interview following a Sabbath meeting, the leader noted: "*We talk about fornication and why this is against God's law because it is because fornication and bed-hopping that God brings AIDS, gonorrhoea and all these diseases.*"

The need for AIDS education and prevention has led some FBOs to be proactive, dealing directly with specific target groups that are considered to be at high risk within the faith communities as noted here:

I will say that a number of churches have been making efforts to have educational awareness programmes and they put together structures to deal with HIV/AIDS. The Diocese of Jamaica, that is the Anglican Church, we have a committee which we took 2 years to get organized. And for example on National AIDS Day, they were able to have an outreach to young people from ten of the Anglican schools and some others including young people from as far as St. Elizabeth and Glenmuir, May Pen, and they had a quiz about HIV/AIDS which they had to study for. That was one way of giving the information to those who listen to the quiz. They had an essay competition and an Art competition (Female, Anglican).

Such active learning is appropriate in creating knowledge and understanding about HIV/AIDS and offers an opportunity to interact with those who have expertise on the topic. It differs from the mass media campaigns that seek to create awareness on the epidemic because there, the education component is lacking. Strategically addressing segmented groups by age and gender was the most preferred approach for FBOs rather than taking a one-size-fits-all approach in addressing the AIDS problem. Regardless of which approach was used, however, a consensus among all participants was that failure to communicate about AIDS and sexuality-related issues is a key contributor to the widespread epidemic.

Counseling Strategy

Interpersonal communication through counseling is a core function of faith-based organizations. Often, this counseling has a focus on mental or marital problems, but as FBO leaders indicated, the focus in counseling services has expanded with the AIDS epidemic to include sexuality issues within and outside of marriage, HIV/AIDS, and related factors. Counseling was found appropriate for the Jamaican cultural context due to the private nature of disease and to the role it plays in interactive learning at an interpersonal level, as well as addressing myths and misconceptions about the epidemic. FBO members indicated that this was a more effective communication strategy, particularly when performed by their leaders, whom they trusted, because it addressed behavior at a personal level.

The majority of leaders interviewed indicated having trained in counseling and are therefore equipped to address sensitive situations, including death. Others indicated having acquired training with the increase of requests for counseling services that emerge with the AIDS epidemic. As one leader noted for example:

I had to get some training in counseling for HIV/AIDS because we kept having people come to us and we didn't know what to do with them. You see in Jamaica, some people have nobody to talk to, so they come to church and they expect us to help. Others just have issues and want to talk to someone about them, and that person is us (Male leader, Moravian Church).

Counseling is not only necessary for those affected by HIV, but also for those deeply affected by HIV/AIDS stigma which is associated with homophobia, ignorance, and fear of the unknown. Studies have shown that HIV counseling and testing is an essential component in preventing the spread of HIV (Morrill & Noland, 2006; Parker 2004). Parker, for instance, noted that some of the successes in the United States in gay communities made use of a range of vertically and horizontal organized communication activities and resources that included a combination of interaction with health and counseling services, epidemiological tracking and disease management, political activism, and peer counseling and support. This strategy, however, does not receive adequate attention in media-based campaigns for behavioral change.

Health Fairs as a Communication Strategy

FBO health fairs, often held annually, are crucial initiatives for reaching communities with HIV/AIDS and other prevalent health problems. These initiatives provide opportunities for health care professionals to interact with the public about their health concerns. Such interpersonal interaction is rare in the Jamaican society where the gap between health professionals and their clientele is noticeably wide. HIV/AIDS stigma widens this gap, thus preventing many PLWHA from seeking medical advice and services from health professionals. Health fairs attempt to close the gap, enabling the information flow and communication between health professionals who have knowledge and expertise and information seekers.

The need for knowledge on effective prevention measures, including proper condom use, is particularly high among the youth. A respondent who indicated having worked in the health field noted the general lack of understanding about prevention methods and the need for FBO initiatives to include this education. She noted:

Coming from the Ministry of health perspective, we spend a lot of time showing people how to use condoms. And a lot of people who have been using condoms all along, when you have the education program and you make them try to put it on you find out that they have been doing it wrong all along, having been using it for 10 years. In the same way, we don't have any comparable programs showing people how to put them on properly.

Many FBOs use this opportunity to demonstrate effective prevention measures. However, several others have policies that prevent condom promotion and only support abstinence-only approaches to AIDS prevention. Overall, however, FBO initiatives go beyond persuading people to use condoms and focus on understanding and behavioral change, with a strong emphasis on abstinence and gaining a better understanding of the epidemic. Unlike media campaigns that target mass audiences, health fairs are

strategically designed for those who voluntarily seek health information, ensuring a two-way discussion with the experts on these concerns. Referrals are also provided at the fairs where medical follow-up is necessary. For example, PLWHA focus groups also indicated having learned about different support groups from various health fairs. As noted by a respondent in the PLWHA group,

I learned about our support group from the fair last year from the Baptist Church fair. The woman who was at the AIDS booth spoke to me about the group and gave me a name and number to call. I don't go to that church but I was glad I went because I needed to speak to someone. That is how I learned about their support for PWA, and I called her several days later to speak with the person she told me (Participant, PLWHA focus group).

A few FBOs have collaborated with PLWHA organizations at the fairs. Some respondents indicated having met and interacted with a PLWHA while others got their HIV test at the fairs. Through collaboration with health organizations, HIV counseling and testing has been incorporated in the FBO health fairs. An example was given in which close to 80 participants, the majority of whom were aged 18 to 25, volunteered for testing, with arrangements for follow-up counseling and services at the collaborating health centers.

Seminars and Workshops

In addition to health fairs, many FBOs organize health seminars and workshops that address various health topics, including HIV/AIDS. Such seminars are often organized by age and gender and are highly interactive. It was noted in some cases that FBOs have health professionals, mostly nurses, who take the initiative to implement such programs with the support of their religious leaders who did not necessarily participate in the workshops. Some of them collaborated with the Ministry of Health, PLWA organizations, or other health organizations, but they were conducted within a religious context. Leaders from the PLWHA organizations pointed to their speakers' bureau that trains their members to openly disclose their HIV status, participate in prevention programs, and fight the AIDS stigma. One respondent who regularly participates in such programs noted:

What I have found in my experience is that when people say 'I don't want to have nothing to do with somebody with AIDS' it is because they don't know [anyone]. They say all of them [PLWHA] are like dead. When I stand up to them I get the 'aha... I need to listen I need to learn' and they realize this person is living with AIDS and they are not looking at a zombie, he is like me, he has nose, eyes and mouth, he is not a monster (Leader, PLWHA support group).

To many participants, small group sessions are effective in HIV/AIDS education. They are also considered more appropriate when addressing the widespread stigma and discrimination, particularly when PLWHA are involved in the education process.

Though providing people with knowledge about a disease may have little or no impact on their behavior, Cappella, et al., (2001) argues that the types of information about the consequences of performing the behavior, about groups that support behavioral performance, about ways to overcome barriers to behavioral performance, or all three can be effective. Through small group seminars and workshops, participants not only gather information on various AIDS-related issues, but also have the opportunity to learn skills for behavior performance, such as proper condom use or self-efficacy skills for risky behavior avoidances.

Challenges in HIV/AIDS Communication

FBOs have made contributions in HIV/AIDS control and prevention globally, but they have also been accused of being "sleeping giants" in the age of HIV/AIDS for not addressing the epidemic to their fullest potential (Parry, 2003). In Jamaica, as current initiatives indicate, FBOs have much potential based on their social influence and the role spirituality plays in the Jamaican culture. There are, however, several criticisms for their inadequate contributions, particularly concerning care and support of those affected by the disease and the overall prevention of the epidemic.

Though a majority of the FBOs that participated in the study indicated having a program in place, there are several with no HIV/AIDS response program while others have inadequate responses. For example, out of all FBOs, only the Baptist Church has a HIV/AIDS policy to guide their activities. Participants associated the lack of involvement with denial and ignorance about HIV/AIDS, as well as the apathetic status of their leadership alongside the general AIDS-related stigma and discrimination, from which FBOs are not exempt. Some leaders, on the other hand, indicated the lack of knowledge and capacity to deal with the epidemic. In one interview, the leader was asked if they have ever considered initiating or contributing to AIDS prevention or support programs, to which he responded: "*We would like to help, but we don't know where or how to go about it.*" This was an interesting response given the widespread media campaigns supported by government ministries, non-governmental organizations, and the PLWHA support groups, including the Jamaica AIDS Support.

Among those FBOs with HIV/AIDS response programs, several challenges were discussed that hamper their efforts, which was the third research question in the study. One of the identified challenges involved the nature of the disease involving sexuality and sexual practices. This is considered a taboo topic in Jamaica and therefore poses a communication challenge for religious leaders. As one of the leaders noted:

That is part of the problem. The average Jamaican family does not talk about sex with their family. The children hear about sex and sexuality among their peers and fortunately at school now from the Guidance Counselor but they are afraid to talk to their parents about it. I know cases where some people challenge the guidance counselor about what they are talking to their kids about. It is a long journey of moving away from a culture where children were seen and not heard and there are certain things that they dare not ask about like where they come from. Where then do we start to discuss sexuality matters to enlighten them? (Male leader, Anglican Church).

Though sexuality is strongly embedded in the Jamaican culture as demonstrated by cultural activities such as the Carnival and Dancehall music (Cooper, 2004; Royes, 1999), there is very little communication when it comes to sexuality issues, particularly with regard to sexually transmitted infections, including HIV infection and other implications of risky sexual practices. Few leaders indicated addressing condom use as a family planning measure, which is more acceptable within faith communities. As noted in one interview, *"Condoms have been in existence since the beginning of time and we can go back to the Bible to point to them where they were used."* It is, however, more challenging for leaders to address the misconception about the disease, especially because some leaders share similar perceptions.

Respondents discussed the strongly held beliefs and attitudes about the cause of AIDS, religious beliefs and values that associate the AIDS epidemic with sin and immorality, which are punishable by death. Such beliefs, alongside policies that prevent use of contraceptives, hinder effective response to the epidemic. For instance, one leader noted:

Part of the problem is the way that religious leaders analyze the epidemic, there is still the idea that AIDS is a punishment of God. There is still the idea that people who contracted HIV lived sinful lives ... so they become very comfortable denouncing – homosexuality and bisexuality. I think it was last year the church held a forum where they have about five to six denominations on the panel where the question was, "Is HIV a result of sin or a sexual transmitted disease?. Is it about sin or epidemiology?" The answer was about sin. That was the conclusion they came to (Male leader, Moravian Church).

This categorization puts many FBO members in a lower risk perception category based on their sexual practices. The dilemma emerges when the person infected does not fall in a "sinner's" category, such as older, married, heterosexual, and religious women. Several leaders indicated that there was a problem with dealing with such cases and suggested that is where existing health programs come into play.

Stigma and Discrimination-Related Challenges

HIV/AIDS-related stigma and discrimination, which is widespread across Jamaica, is a key challenge to the HIV/AIDS interventions, and FBOs are not exempt. Defining stigma generally as attributes that mark the bearer as culturally unacceptable or inferior to others in the social group, Patterson (2004) notes that it is often interpreted as punishment or retribution for violating community norms where the stigmatized person is held responsible for real or imagined ills that afflict the community, which can only be cleansed by the expulsion of, or isolation of the polluting influence. Such stigma has contributed to violence against PLWHA who are suspected to contract HIV through homosexual practices (Human Right Watch, 2004).

One surprising finding is the high level of contradiction between the level of FBO compassion for the sick and what is conceived as the hardcore stigma and discrimination against persons with HIV/AIDS within some religious organizations and their leaders. For instance, when asked how they would deal with

a person with HIV/AIDS, several focus group participants pointed to fear and discomfort about personal contacts. In one group, for example, a participant stated:

If I know one of the [church] sisters have AIDS I would tell her to stay outside because they person have the HIV, and it's a crowd of people, I don't know what she is going to take up, I don't know what she is going to do, so I have to be careful (female, Church of God).

Participants in a women's focus group recommended quarantine of those infected with HIV or eliminating them entirely as a strategy for eliminating the epidemic from their midst. For example, one woman said: "When they have it [HIV], lock them up with an iron key. Some of them have it and they don't talk. My concern again is, honestly, even though I am in church, kill them. " In support of this statement another women emphasized:

Me say the same thing. Even if it is Ms Carol [group member] I would feel sorry for her (laughter). But to tell you the truth, lock them away. Lock down the first one, so it would not spread so fast [another respondent added] and throw away the key (Female, Catholic).

Similar concerns were raised in a different group where participants equated the disease to a death sentence and stressed the need to protect themselves from those infected. One female participant noted:

My concern about the is others even more, not that I am not concerned about that individual with HIV or AIDS, but because you know that is death business, so to loose all that amount of people in the crowd because of one person, its very bad to have to take that one aside. Death sentence that. So take him away and let him die, kill him and save all the others in the crowd before he does any harm to others (Female, Pentecostal).

The fear of the consequences has driven many "at risk" people underground, thus preventing HIV testing, counseling, and disclosure, which only contributes to further spread of the disease. While discussing the issue with the leaders of PLWHA support groups, one respondent noted:

The hostility against people living with HIV and AIDS make them realize the problems likely to happen to them if they reveal their status, that down the line you will be living on the streets. The family will kick you out and you have to sleep outside. The environment is not good for that person, and the church is not helping either (Male, PLWHA support group leader).

Many PLWHA participants accused religious leaders of instigating stigma and discrimination against persons with HIV/AIDS. For instance, in discussions with leaders of PLWHA support groups, they accused their religious counterparts for not setting examples in their communities as social leaders and community influencers. Instead, they pass the wrong messages as noted in this interview:

The thing is the church is already bringing a message to the people. They ready have messages about HIV/AIDS and very strong opinion about people who are infected but the thing is to transform those messages from negative into positive and be supportive, and that is the challenge (Male, PLWHA support group leader).

Few religious leaders admitted being affected by AIDS-related stigma like everyone else and therefore not being able to serve as role models as society expects of them. There was a general indication of a need for capacity-building among leaders to help them address the epidemic adequately. Such capacity would not only enhance their knowledge about the disease, but equip them with skills to lead their communities in addressing various AIDS-related issues.

Conclusion

Findings from this study demonstrate that FBOs in Jamaica as cultural and social institutions have responded to the AIDS epidemic in a variety of ways. Literature emphasizes the need for a multisectoral response to the HIV/AIDS epidemic and a culture-centered approach to HIV/AIDS communication (Airhihenbuwa, et al., 2000; Dutta-Bergman, 2004, 2005; Kelly & Bain, 2003; Tufte, 2005). FBOs' responses to the epidemic complement the national public communication campaigns that disseminate general information about the epidemic. Their integrated approach incorporates physical, social, and psychological support for those infected by the epidemic, as well as education for prevention and behavioral change.

The emphasis on education and interpersonal communication in small segmented groups is strategically and culturally appropriate in Jamaica given the nature of HIV/AIDS, especially in a culture where sexuality issues are not openly discussed. Additionally, the non-medical participatory communication approach used in seminars, workshops, and health fairs enable two-way interaction between health professionals, religious leaders and the public, thus contributing toward better understanding of the disease and its related factors from a theological perspective.

This study also finds that spirituality and healing are central in Jamaican culture, where a strong history and beliefs in occult powers exist. Such a culture puts religious leaders at the core of people's daily lives, earning them credibility and trustworthiness necessary for effective behavioral change communication. Their influence at social and individual levels is widely acknowledged across Jamaican communities, which make them ideal for HIV/AIDS communication and motivating behavioral change. However, many traditional HIV/AIDS interventions tend to disregard religious leaders to some degree due to their policies related to prevention measures, mainly on condom use. Such policies within some religious organizations impede their efforts to effectively respond to the AIDS epidemic. Other challenges that FBOs face in spite of their contributions include the widespread AIDS-related stigma and a lack of HIV/AIDS policies, as well as personal values among religious leaders that hinder their roles as facilitators of behavioral change.

Though FBOs generally emphasize abstinence, faithfulness, and partner reduction in the ABC model of HIV prevention, some leaders have incorporated other prevention interventions based on the need for rapid measures to control the epidemic. Some do so indirectly through collaboration with health professionals while others focus on condoms as family planning contraception, which is a widely acceptable practice and prevents sexually transmitted infections, including HIV. Furthermore, the involvement of PLWHA in their HIV/AIDS initiatives plays a role in addressing AIDS-related stigma. These collaborations with health organizations and the PLWHA communities have received attention from the government ministry as well as the international communities that support capacity-building programs for religious leaders in HIV/AIDS voluntary counseling, testing, and more recently, behavioral change communication.

Like other qualitative studies, this exploratory study has several limitations in terms of sample size and non-random methods used in data collection. The study, however, sets the stage for further research on the potential roles of religious leaders as social influencers in HIV/AIDS prevention and on the overall impact of FBO initiatives in HIV/AIDS control and prevention. Examination and proper documentation of FBOs' initiatives would enhance their current responses and motivate others to participate in health interventions. The study therefore recommends further research on strategies to incorporate spirituality in health and behavioral change interventions, particularly in addressing the HIV/AIDS-related stigma and discrimination in the Caribbean region and in the meaningful involvement of PLWHA in the fight against the epidemic. There is a specific need to understand the contrast between the FBOs' compassion for the sick and the escalating stigma and discrimination against those with HIV/AIDS as demonstrated in this study. A better understanding of FBO initiatives from a more empirical perspective is required – how they work and their overall approach to HIV/AIDS care and prevention. Such an understanding will add to the range of options for public health practitioners. This could be achieved by combining both qualitative and quantitative methodologies to provide more generalized results that will inform and therefore expand the current Jamaica FBO interventions.

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