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

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Theme and theory

Although gender differences in HIV/AIDS-related attitudes and behaviors are often brought up in the literature (e.g., Adetunji and Meekers 2001; Bassett and Sherman 1994; Harram 1996; Susser and Stein 2000; Turmen 2003), seldom do researchers scrutinize specific contexts in which these differences are shaped and manifested. This study focuses on how gender differences in HIV/AIDS views and prevention choices are mediated through membership and participation in different types of religious institutions. While in dialog with the literature on gender and HIV/AIDS, this study also expands on the small but growing body of literature pointing to religious differences in HIV/AIDS attitudinal and behavioral outcomes throughout sub-Saharan Africa (Takyi 2003; Garner 2000; Gregson et al. 1999; Gruenais 1999; Kagimu et al. 1995; Lagarde et al. 2000).

The importance of the triangulation of gender, religion, and HIV/AIDS proposed in this paper is underscored by high levels of religiosity and religious involvement, especially among women, in Africa (Agadjanian 1999a; Gifford 1994; Jenkins 2002). The analysis rests on three interrelated assumptions: first, that religious beliefs and involvement in the sub-Saharan context are central to the social construction of wellness and health risks; second, that this role of religion is gendered; and third, that the specific configurations of gendered views and choices are predicated on characteristics of religious institutions involved.

This study focuses on Mozambique, a country where adult HIV prevalence is estimated at 13.6% (Ministry of Health 2003) and HIV/AIDS has established itself as a major health problem and a prominent topic of formal public discourse, but where popular perceptions and informal communication regarding HIV/AIDS are still characterized by considerable uncertainty, ambivalence, and stigmatization (Agadjanian 2002).

In this study I contrast women's and men's views and behavioral choices regarding HIV/AIDS and examines how these gendered views and choices vary across two types of religious denominations—"mainline" churches, such as the Roman Catholic and Presbyterian churches, on the one hand, and smaller yet numerous "new" Pentecostal-type churches—Zionist, Apostolic, Assemblies of God and the like, on the other. Although the latter group may be even more diverse organizationally and doctrinally than the former, the denominations included in it share a strong emphasis

on divine cure of physical ailments and social misfortunes (Agadjanian 1999b). Not surprisingly, healing churches attract the poorer and otherwise socially disadvantaged people, especially women (Agadjanian 1999a). While both types of churches stress the importance of family values and related moral and behavioral standards, the "healing" churches seem to be particularly concerned with maintaining these values and standards.

The theoretical framework of this study is adapted from an earlier study of religion and fertility behavior (Agadjanian 2001) which in turn arose from two research traditions—the literature on the place of value systems in demographic change (e.g, Lesthaeghe 1983; Lesthaeghe and Wilson 1986; Simons 1982; Simons 1999) and studies of the role of social interaction in demographic, primarily fertility-related, behavior (e.g., Roger 1995; Rogers and Kincaid 1981; Rutenberg and Watkins 1997). I hypothesize that, while both types of denominations advocate premarital abstinence and marital fidelity as preferred forms of HIV/AIDS prevention, the mainline churches would allow their members greater cognitive flexibility and behavioral choices that may result both in more egalitarian gender views and in greater receptivity to the secular prevention messages that prioritize condom use.

Data and methods

The study is based on a survey and semi-structural interviews carried out in June-August 2003 among religious congregations in peri-urban areas of Maputo, Mozambique's capital, and in Chibuto, a predominantly rural district some 200km north of Maputo. Despite the stark socioeconomic contrast between the two areas, both are part of the same Tsonga (Changana-Ronga) ethnocultural region and are historically knit together through rural-urban migration. In addition, both areas are similar in terms of types of predominant religious denominations (the main exception being Islam which is much less widespread in Chibuto than in the capital).

The survey sample included 731 respondents, a roughly equal number of men and women, participating in the following religious denominations: Roman Catholic, Presbyterian, Zionist, Assembly of God, Apostolic, and Islam (only in Maputo). The choice of these denominations or types of churches was driven by their demographic weight in both areas. Both the selection of specific congregations within these denominations and the selection of respondents within each congregation were

probability-based (although specific sampling techniques varied depending on the congregation size and circumstances). Because women typically outnumber men in all Christian denominations, we had to oversample Zionist congregations to achieve the desired gender balance.

The survey questionnaire, administered in Portuguese or Tsonga, contained questions on HIV/AIDS-related views and behaviors, informal exchanges and negotiations of HIV/AIDS-related information, as well as on perceptions of gender roles, on religious participation, and on sociodemographic characteristics.

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

Only members of Christian denominations are included in this analysis. The Roman Catholic and Presbyterian congregations constitute the "mainline churches" category; members of Zionist, Apostolic, and Assembly of God churches make up the "healing churches" category.

The study looks at the sources and type of HIV/AIDS-related information that men and women receive, the exchange of this information in their church-based social networks, their knowledge and perceptions of risks and prevention, their assessments of personal risks, and the prevention measures they take. I first examine the bivariate distributions of the outcomes of interest and then present and discuss the results of multivariate tests for key outcomes. These outcomes are operationalized as dichotomies, and logistic regression is therefore employed as the tool for multivariate analyses. The multivariate tests include gender, type of congregation, age, place of interview (Maputo or Chibuto), marital status (currently married or not), and education as predictors.

Bivariate results

Demographics of religious involvement

Attendance of religious services and other related events taking place in congregations was an important part of respondents' life: both men and women in the survey reported going to church on average three times a week, with a significantly higher attendance in healing churches than in mainline churches (2.4 vs. 3.6 times on average). It is important to remember, however, that we oversampled men to achieve a balanced representation of both sexes, and in the overall population women are more likely to attend church and to do it more frequently than men.

Both men and women had close relationships with other congregation members, but their social ties are influenced by gender differences. Thus 63% of surveyed women and only 42% of surveyed men said they knew all *female* congregation members by their first names. The gender gap was much wider in healing churches (67% vs. 38%) than in mainline churches (58% vs. 47%). At the same time, 47% of women and 50% of men said they knew first names of all *male* congregation members, with a moderate gender gap in each type of church.

The partners of married respondents belonged overwhelmingly to the same churches. As one would expect, respondents also tended to belong to the same churches as their blood kin. However, while 76% of men had at least one sibling in the same church, only 59% of women did. This difference is due to women's higher rates of conversion—either to their husbands' churches or to churches that they feel better address their spiritual and social needs.

Religious participation largely determines the circle of significant social others beyond one's kin: 59% of respondents said that the majority of their friends belonged to the same congregations, and this share was somewhat higher for women than men in both types of churches.

Church members do not just meet in church with their co-religionists but also share leisure time with them: over half of both men and women said that they recently attended a party or a celebration with other church members (with a higher proportion in mainline churches).

Basic knowledge about HIV/AIDS

Basic knowledge about HIV transmission, AIDS symptoms, and prevention options was practically universal among both men and women in both rural and urban areas. However, the level of exposure to HIV/AIDS propaganda and understanding of infection risks varied.

Thus, a somewhat higher share of men than women (52% vs. 45%) said they had recently attended a meeting or lecture dealing with HIV/AIDS. In line with my conceptual reasoning, the overall level of participation in such activities was somewhat lower and the gender gap is wider (46% vs. 37%) among members of healing churches than mainline churches.

Gender gap was also manifested in respondents' understanding of risks of infection: while 81% of men agreed that a healthy-looking person can be a carrier of the HIV virus, only 54% of women thought so (27% of women thought it was impossible). Again not surprisingly, the level of the correct perception was lower and the gender gap was much wider among members of healing churches, compared to members of mainline churches (78%-45% vs. 86%-65%).

Women were much less likely than men to correctly report the positive association between STDs and HIV infection risks (67% vs. 82%). Members of mainline churches tended to know this connection better than members of healing churches (80% and 70%) and the gender gap was again somewhat smaller in mainline churches (86%-74% vs. 79%-63%).

The survey confirmed that, despite the ubiquitous HIV/AIDS propaganda, practical encounters with AIDS remain limited. Over 40% of respondents said they knew no one who had AIDS or had died of it (the question referred to both confirmed and suspected cases). While the gender differences among this group were trivial, men had a slightly larger proportion of those who knew three or more cases (30% vs. 24%). Although the gender gap was similar in both types of churches, members of mainline churches overall had a significantly lower share of those who did not know any AIDS patient (36% vs. 45%).

Knowledge of HIV prevention

Respondents were asked to name all methods of prevention, and their spontaneous responses were recorded. These responses are not indicative of the actual knowledge of different types of methods but rather of the importance that individuals attribute to them in deciding whether to mention them or not.

The gender gap forcefully manifested itself in the probability of reporting no methods: while less than 1% of men did not name any method, the corresponding share among women was 15%. Healing church women looked particularly disadvantaged: 20% percent of

them could not (or chose not to) mention any method, compared with 8% among mainline church women.

Among those respondents who mentioned at least one method, there were no significant gender differences within either type of churches in the percentage of those who named marital fidelity and abstinence prior to marriage, which reflects all churches' vigorous pitch for marital and sexual virtuousness. Yet, interestingly, the share of those who mentioned marital fidelity and premarital abstinence, 60% of those who knew of at least one method, was much lower than the corresponding share for condoms (88%). Also, with respect to condoms, the difference between the shares of women and men was moderate but statistically significant (85% vs. 90%, respectively), and the gender gap was comparable in both types of churches. Not surprisingly, condom was named as the best methods of prevention by the majority of women and men who mentioned at least one method in both churches.

The respondents were asked whether they thought it was acceptable for a wife to insist on condom use with her husband if she suspected that he might be infected. While the opinion measured by this question is hardly an indication of the likelihood of condom use within marital unions, it nonetheless sheds some interesting light on the gender divide. Although the idea gathered considerable overall support—68% of respondents answered affirmatively—this support proved more common among men than women (72% vs. 64%), largely because a relatively large number of women were undecided. Interestingly, however, the gender gap was noticeable and statistically significant only among members of healing churches (69% vs. 56%, respectively). Overall, members of mainline churches were much more likely to find condom use in such situation acceptable (74% vs. 62%).

Another pair of questions, also aimed at exploring respondents' views of gendered strategies of dealing with HIV/AIDS risks, asked whether it would be acceptable for someone to leave his/her spouse if the spouse had AIDS. In general, this option did not prove popular: 20% of all respondents were in favor of abandoning an AIDS-stricken wife and 16% an AIDS-stricken husband, with no significant gender differences in either case. Once again, this homogeneity may reflect all churches' emphasis on family values and cohesion, as well as the traditional, religion-unrelated importance of marital commitments.

Worries and practice of prevention

Worries about getting infected were widespread: 79% of respondents said they were very worried about getting HIV. Notably, such worries were significantly more common among women than men (83% vs. 76%), conforming to commonly observed patterns. The two types of churches did not differ much in the levels of worries, but the gender gap was somewhat greater among healing church members (82% vs. 74%, for women and men, respectively).

In a similar gender pattern, women were more likely than men to say that they were at a higher risk of getting infected with HIV (42% vs. 31%), and the difference was statistically significant. However, when we separate the two types of denominations, it becomes clear that this difference is due largely to the gender gap among healing church members. Thus, in mainline churches, 40% of women and 33% of men considered themselves at a high risk of getting infected with HIV, and this difference was not statistically significant. In contrast, the corresponding gap in healing churches was much wider and statistically significant—44% vs. 30%. Interestingly, the overall levels of self-defined high risk were very similar in both types of congregations.

Not surprisingly, women were much less likely to take measures to prevent infection: only 53% of them took at least one of such measures, compared to 95% of men, the gender gap being equally strong in both types of churches. As the literature from other settings suggests (e.g., Adetunji and Meekers 2001), the gender gap is particularly wide with respect to condom: while 47% reported using it to prevent HIV (as a sole method or along with other forms of prevention), the corresponding share of women was only 19%. This gap further widens in healing churches, mainly due to a much lower condom use reported by women (11% as compared to 47% among men). The gender gap in mainline churches is much smaller (47% vs. 28%) but is also statistically significant. Remarkably, men in both types of congregations display the same levels of condom use.

Informal communication on HIV/AIDS matters

The survey respondents were asked where they had recently heard people talk about HIV/AIDS; respondents' spontaneous responses were recorded. Almost a quarter of respondents, 23%, mentioned their church—about the same share as that of those who mentioned a health institution and a much higher share than that of those who heard about it at home or in other settings involving relatives only. In the overall sample, the percentages of women and men who heard about HIV/AIDS at church were statistically indistinguishable, but when we break down the sample by the type

of church, we can see that mainline church women were significantly more likely than men to hear about AIDS in their congregations (34% vs. 23%). In healing churches the gender difference tended in the opposite direction but was not statistically significant (17% vs. 20%). It is also noteworthy that members of mainline congregations as a whole were more likely than those of healing churches to have heard about HIV/AIDS in their congregations (28% vs. 18%).

HIV/AIDS is a popular topic of conversations. For this analysis, we are particularly interested in gender and denomination-type differences in such informal communication. Women were much less likely than men to *talk* about HIV/AIDS with others inside their congregations (33% vs. 52%), and this tendency holds equally strongly for both types of denominations. A similar gender gap characterized the likelihood of HIV/AIDS-related conversations *outside* the congregations (although overall such conversations were understandably more likely than in-church conversations). Again, members of healing churches had a much higher share of those who held such conversations compared to members of mainline churches (81% vs. 70%) and also displayed a somewhat wider gender gap (62%-79% vs. 75%-88%).

The survey explored within-church social interaction in greater detail and probed the topic of HIV/AIDS-related communication from a social network angle. The respondents were asked to identify up to three church members (other than their marital partners and church leaders) with whom they had the closest relationship. A number of questions were then asked about the respondents' interactions with those people and specifically about conversations in which HIV/AIDS-related topics were brought up. Again, women proved to be less likely to report having talked about HIV/AIDS with their network partners than did men (59% vs. 71%), and the gap was almost equally wide in both types of churches.

The spontaneously reported topics of HIV/AIDS-related conversations with network members were then classified into several categories. Thus, 38% of respondents reported having a conversation with at least one network partner in which HIV/AIDS prevention (either needed/desired or practiced) was mentioned. The overall female-male gap was significant—32% vs. 44%, but when broken down by the type of congregation, was large and statistically significant only among healing church members.

Multivariate results

The results of multivariate logistic regressions for some of the outcomes discussed above are summarized in Table 1. The results are presented as odds ratios: a value above (below) unity indicate a higher (lower) odds of the outcome in the category in question, relative to the reference category. For an easier presentation and interpretation of the interactions between gender and type of congregation, the results of separate models for each type of congregations are also presented.

Table 1 about here

Basic knowledge about HIV/AIDS

The multivariate tests confirmed a strong disadvantage of women in basic knowledge about HIV/AIDS. Thus women were significantly less likely than men to agree that a healthy-looking person can be infected with HIV and to know that STD can increase the risk of infection. Also conforming to the bivariate pattern, members of mainline churches in general were significantly more likely than members of healing churches to think that a healthy-looking person can be HIV-positive, regardless of other factors. The same tendency emerged with respect to the knowledge of the connection between STDs and infection risks, but the difference between the types of denominations was only marginally significant ($p<.10$).

Membership in a mainline denomination significantly increased the likelihood of having heard about AIDS in church, confirming the association first observed at the bivariate level. While the overall gender differences were only marginally significant, the patterns differed between the types of congregations. In healing churches no gender differences existed, whereas in mainline congregation women were significantly more likely to have heard about AIDS in church than were men, which may point to benefits that this type of churches provides to their female members.

The tests for the likelihood of AIDS-related conversations with social network members within the congregation were also quite instructive. 0verall women were less likely than men to talk about AIDS prevention with their closest friends. Yet when we examine this association separately by type of denomination, it holds only for healing churches (as was the case in the bivariate comparison), underscoring their female members' disadvantage in informal exposure to AIDS prevention information.

As the bivariate exploration already suggested, no differences between men and women by type of denomination could be observed

in personal knowledge of HIV/AIDS cases. This test, however, confirmed that members of mainline churches overall were significantly more likely to know at least one HIV/AIDS patient, compared to members of healing churches, which may point to the former group's bigger social networks and greater practical exposure to the epidemic.

Risk perception and prevention

The multivariate tests also confirmed that women overall were more likely than men to feel at a higher risk of getting infected. Yet when we examine this outcome by type of denomination, only in healing churches were women significantly different from men, which may point to greater vulnerability of healing-church women.

Not surprisingly, women were less likely than men to report any action to prevent HIV infection, and this tendency was equally strong in both types of churches. The same pattern was present with respect to condom use (by respondent or respondent's partner). However when we limit the analysis to respondents who reported having used some form of prevention, women's disadvantage was statistically noticeable only among healing church members, conforming again to the picture of greater vulnerability of women in healing denominations.

Finally, the question on whether it would be acceptable for a wife to insist on condom use if she suspected her husband of being infected, a proxy for respondents' perception of women's right to control their bodies, sexual life, and related risks, did not produce a significant difference between men and women. The marginally significant tendency registered among healing church members—women were *less* likely to support the idea—may be indicative of a lesser decision-making power of these women. Notably, however, membership in a mainline church was more conducive to such a view than membership in a healing church, as were city residence and a higher educational level.

Insights from semi-structured interviews

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

same congregations often gave diametrically opposed opinions regarding their churches' HIV/AIDS-related pronouncements and activities.

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

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

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

The informants' answers to questions on whether and how condoms are talked about in their congregations are particularly contradictory: some informants would first acknowledge that

condoms are openly discussed by church leaders but later state that condoms are never mentioned. These contradictions reflect the churches' ambivalent position on condoms—an uneasy compromise between the "theoretical" rejection of condoms as incompatible with Christian moral and family values, the deeply rooted popular assumptions about sexuality and sexual networking, and the realization of the catastrophic scale of the epidemic.

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

The main differences between the types of churches, therefore, are not so much in the content and form of the messages they address to the male and female members but in the social milieu—inside and outside the congregation—that membership in these types of churches establishes. While the religious discourse on HIV/AIDS does not seem to differ much between the mainline and healing churches, larger mainstream congregations in general get more exposure to the *secular* AIDS information. First, they frequently coordinate activities and exchange visits with sister parishes that are often socially very heterogeneous. Visits by delegations from urban congregations may be particularly beneficial for members of rural ones. Second, mainstream churches are more likely to include higher status individuals who are either professionally more knowledgeable about HIV/AIDS (e.g., nurses) or are politically better connected to governmental and non-governmental health agencies and therefore can attract their propagandist machine more easily. Targeting larger mainstream congregations rather than tiny healing churches for HIV/AIDS prevention propaganda also offers the secular institutions an economy of scale. As a result, mainstream churches get more consistent, direct, and continuous exposure to secular prevention messages. Thus even if mainstream church leaders themselves do not raise the controversial issues of safer sex, they allow for much more discussion of these issues within their congregations than do leaders of healing churches.

Discussion and conclusion

In this paper I attempted to highlight the importance of the context in which gendered views of HIV/AIDS and corresponding behaviors are shaped. I hypothesized that the different contexts, in this cases represented by the type of religious congregation—mainline vs. healing—can significantly affect the gendering of HIV/AIDS-related knowledge, attitudes, and behavior. The study findings generally support the expectations that the gender gap—and arguably, women's disadvantage—would more pronounced in healing churches than in mainline churches. Yet, at the same time, the study also shows that some gender patterns—both of differences and of similarities—persist regardless of the type of the religious environments.

Some limitations of this study should be acknowledged. First, the study covered only a handful of congregations in one region of Mozambique: in other settings the religious context may affect the examined gender patterns differently. Second, the chosen classification of religious denominations does not capture considerable doctrinal and organizational distinctions within each of the two categories. These distinctions may also bear on the gendered response to the epidemic. My argument, however, was that the chosen classification reflects the important relevant distinctions in the social milieu (rather than in teachings) that the two types of churches creates.

It can be also argued that the differences between the two types of churches are the product of self-selection: healing churches grow to a large extent thanks to conversions from mainline churches and women and men of certain characteristics—usually the poor and marginalized—are more likely to convert than others. Yet trying to disentangle the effects of healing churches' social milieu from those of its members' selectivity is hardly a plausible task since that very social milieu that becomes instrumental in shaping HIV/AIDS attitudes and prevention *is* largely shaped by converts' backgrounds, motivations, and expectations.

While addressing the role of religion in dealing with the HIV/AIDS epidemic in sub-Saharan Africa, researchers and policy makers should pay attention to how different types of religious institutions may differently position women and men with respect to prevention information and resources. The gendered importance of religious institutions is further underscored by the predominance of women among active church members. In fact, for many women, especially in rural areas, church membership may be the only form of non-kin association, and increasingly the only

reliable source of spiritual, psychological, social, and even material support. As AIDS continues to exact its toll in Mozambique and other sub-Saharan countries, undermining other traditional and civil institutions, religion may offer uniquely effective structure and mechanisms in mitigating the social impact of the epidemic on society, and especially on its most vulnerable segment—poor women.

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TABLE 1. Logistic regression results, Survey of Religious Congregations, Southern Mozambique 2003

	All Odds Ratios		Healing Odds Ratios		Mainline Odds Ratios	
A healthy looking person can be HIV+						
Woman	0.28	*	0.26	*	0.26	*
Mainline church	2.06	*				
Maputo resident	3.51	*	2.24	*	10.23	*
Has 6+ years of school	1.99	*	1.87	*	1.84	+
Age 30+	1.23		1.31		1.33	
Currently married	1.41	+	1.42		1.61	
Likelihood ratio chi-square	152.0	*	68.8	*	78.46	*
Number of cases	669		379		290	
STDs increase the risks of infection						
Woman	0.52	*	0.53	*	0.49	*
Mainline church	1.39	+				
Maputo resident	0.88		0.78		1.15	
Has 6+ years of school	2.63	*	2.96	*	2.19	+
Age 30+	1.50	*	1.46	+	1.64	
Currently married	0.91		1.14		0.63	
Likelihood ratio chi-square	47.6	*	25.1	*	16.9	*
Number of cases	674		381		293	
Heard about HIV/AIDS in church						
Woman	1.40	+	0.89		1.91	*
Mainline church	1.55	*				
Maputo resident	1.34		0.84		2.15	*
Has 6+ years of school	2.16	*	1.78	+	2.50	*
Age 30+	1.36	+	1.50		1.53	
Currently married	0.68	+	0.84		0.61	+
Likelihood ratio chi-square	37.4	*	4.9		32.8	*
Number of cases	677		383		294	
Talked about prevention with church network members						
Woman	0.61	*	0.57	*	0.70	
Mainline church	1.02					
Maputo resident	0.72	+	0.60	*	1.01	
Has 6+ years of school	1.66	*	2.38	*	0.88	
Age 30+	1.33	+	1.38		1.36	
Currently married	0.87		0.84		0.82	
Likelihood ratio chi-square	21.0	*	23.4	*	4.1	
Number of cases	677		383		294	

TABLE 1. Logistic regression results (continued)

Does not know of any AIDS case						
Woman	0.98		0.86		1.09	
Mainline church	0.68					
Maputo resident	0.74	+	0.63	*	0.96	
Has 6+ years of school	0.90		0.83		0.93	
Age 30+	0.69	*	0.62	*	0.87	
Currently married	0.95		1.22		0.73	
Likelihood ratio chi-square	13.7	*	11.3	*	2.1	
Number of cases	673		381		292	
Consider her/himself at high risk of getting infected						
Woman	1.53	*	1.71	*	1.36	
Mainline church	1.01					
Maputo resident	0.63	*	0.62	*	0.68	
Has 6+ years of school	1.03		1.19		0.76	
Age 30+	1.10		1.05		1.14	
Currently married	1.60	*	1.94	*	1.22	
Likelihood ratio chi-square	26.5	*	18.9	*	10.1	+
Number of cases	673		380		293	
Practices a form of prevention						
Woman	0.07	*	0.07	*	0.06	*
Mainline church	1.08					
Maputo resident	2.09	*	1.32		4.97	*
Has 6+ years of school	3.23	*	2.59	*	3.83	*
Age 30+	0.95		0.97		1.13	
Currently married	1.29		1.45		1.30	
Likelihood ratio chi-square	228.7	*	124.6	*	111.5	*
Number of cases	675		381		294	
Self or partner uses condom (all respondents)						
Woman	0.29	*	0.20	*	0.35	*
Mainline church	1.26					
Maputo resident	1.55	*	0.92		2.60	*
Has 6+ years of school	2.83	*	2.91	*	2.46	*
Age 30+	0.28	*	0.34	*	0.23	*
Currently married	1.12		1.65	+	0.88	
Likelihood ratio chi-square	179.8	*	98.8	*	86.9	*
Number of cases	676		382		294	

TABLE 1. Logistic regression results (continued)

Self or partner uses condom (respondents who use a prevention method)						
Woman	0.56	*	0.40	*	0.64	
Mainline church	1.19					
Maputo resident	1.20		0.86		1.70	
Has 6+ years of school	2.11	*	2.40	*	1.56	
Age 30+	0.26	*	0.34	*	0.20	*
Currently married	1.06		1.54		0.80	
Likelihood ratio chi-square	91.4	*	46.8	*	48.7	*
Number of cases	488		264		224	
It is acceptable for wife to insist on condom if she thinks husband is HIV+						
Woman	0.85		0.68	+	1.00	
Mainline church	1.53	*				
Maputo resident	1.88	*	1.56	+	2.44	*
Has 6+ years of school	1.88	*	1.65	*	2.04	*
Age 30+	0.80		1.02		0.60	
Currently married	1.19		1.29		1.18	
Likelihood ratio chi-square	56.07	*	18.78	*	33.35	*
Number of cases	675		381		294	

*Notes: Omitted categories: Man; Healing church; Chibuto resident; Has less than 6 years of school; Yonger than 30; currently not in permanent union. Significance level: * significant at p<.05; + significant at p<.1.*