



The Importance of Considering Religious and Spiritual Ontologies in the Care of HIV Patients in Zimbabwe - A Scoping Literature Review

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Abstract: Background: HIV continues to have a major impact on morbidity and mortality in Zimbabwe. Religion/Spirituality (R/S) including traditional beliefs and practices (TP) play an important role for most people living with HIV (PLWHIV) in Zimbabwe. PLWHIV conceive and practice healing holistically, embracing not only the physical conditions, but also the spiritual, psycho-emotional, social, and ecological dimensions. Objective: This scoping review aims to systematically map the research done around R/S and TP and HIV in Zimbabwe. It intends to describe what is known about the role and influence of R/S on the experience of living with HIV in Zimbabwe in general and especially, to illustrate the influence of R/S and TP on the physical and psychological wellbeing of PLWHIV, and the access to HIV care. Design: This scoping review followed the Joanna Briggs Institute's guidelines. The online databases Medline & ATLA were used to identify articles published between 2010–2021 about R/S and TP and HIV in Zimbabwe. The review includes textual papers, qualitative, quantitative, and mixed studies. Results: 638 records were found and screened for inclusion. 46 records were considered relevant for the qualitative and quantitative synthesis. Most articles (27) addressed the influence of traditional beliefs and practices on health and HIV and 16 records examined the influence of religious beliefs and religious groups' attitude on HIV. The qualitative synthesis illustrates the influence of R/S and TP on physical and psychological wellbeing and on access to HIV care of PLWHIV in Zimbabwe, thus portraying the medical relevance of R/S issues and TP. Further synthesis identified three areas of conflict with biomedical practice: The bio-psycho-socio-spiritual understanding of health and illness, the notion of patriarchy, and the perception of sexuality and procreation. Here religious/spiritual ontologies may lead to compromised biomedical therapy outcomes. Conclusion: This scoping review includes papers of authors from different backgrounds (theology, medicine, sociology). The synthesis of the content of the records revealed a coherent picture of themes addressed and problems identified. Thus, this review is a fair description of the experience of living with HIV in Zimbabwe and the medical relevance of R/S and TP. The findings show that religious/spiritual ontologies need to be considered and integrated into the design of new health programs. It must be the aim to avoid compromised therapy outcome and to further a holistic support of PLWHIV. This is only possible in collaboration with religious stakeholders and traditional practitioners.

Keywords: HIV, AIDS, Religion, Traditional Practice, Zimbabwe

1. Introduction

1.1. Background

With a prevalence of about 12.7% [1] among adults aged 15 to 49 years, human immunodeficiency viruses (HIV) continues to have a major impact on morbidity and mortality in Zimbabwe. Although 85% of PLWHIV are on ART, only 73% have a suppressed viral load [1]. Thus, attrition from antiretroviral therapy (ART) remains a serious challenge [2]. Therefore, new methods of care are needed that address risk factors and protective factors to ART adherence that have not been considered sufficiently.

In Zimbabwe religion/spirituality (R/S) plays a major role in daily life, substantially influencing people's health behaviour. Research by Shoko et al explain that in the Shona understanding, healing is conceived and practiced holistically, it includes not only the physical condition, but also spiritual, psycho-emotional, social and ecological dimensions [3]. As health is often seen as a gift from God, R/S and healing are intrinsically intertwined [4]. Ten percent of the respondents of a demographic health survey conducted in 2012 indicated that they thought it was possible to contract HIV from witchcraft or other supernatural means [5]. O'Brien and Broom rightly point out that if the origin of a disease is not framed biomedically, then biomedical treatment is less likely to be appreciated or enacted [6].

In Harare it has been observed that religious affiliation influenced women's readiness for cervical cancer screening [7]. According to the demographic health survey, most Zimbabweans would call themselves 'Christian' [5]. Many different types of Christianity and many Christian sects exist in Zimbabwe. Studies have highlighted that church affiliation is an important factor to the response to HIV [8]. While some churches advocate antiretroviral therapy (ART) of HIV infection as a gift from God, others do not allow biomedical aid, some stigmatize people living with HIV/AIDS (PLWHA), and some emphasize prayer healing [9]. During Africaid/Zvandiri's most recent study in 2016-2017 among adolescents with HIV in Zimbabwe, up to 73% of deaths were due to cessation of ART sanctioned by caregivers, probably motivated by faith healing [10]. The World Council of Churches (WCC) recognizes faith healings as a major obstacle in HIV care [9]. In 2002, the WCC highlighted "harmful cultural practices and theological and ethical fault lines in the practice of ministry in the churches and theological institutions" [11].

Local researchers [12] published a paper last year stating that people living with HIV (PLWHIV) in Gweru Zimbabwe defaulted medications because they believed in faith healing, alternative medicines, perceived spirituality as the main cause of HIV and AIDS. Furthermore, they had an allegiance to church values. They showed the need to provide HIV and AIDS education to leaders of religious organizations so as to harmonize religion and HIV and AIDS treatment [12]. The importance of finding ways to engage R/S stakeholders in HIV care is also highlighted by Becker & Geissler who argue

that religious groupings are instrumental in, instrumentalised by, and instrumentalising the organisation of HIV-related interventions [13]. There is at least one example where a church in Zimbabwe successfully initiated a rural community program to support PLWHIV in a tripartite partnership consisting of the Mission Hospital staff, the Church, and the community (including schools, villages, local chiefs, and a village headmen) [14].

Stigma, violence and intimate partner violence (IPV) are very important factors that have been shown to increase risk of HIV infection and lower medication adherence. [15] While such insight is important, it is crucial not only to identify the factors influencing adherence, but also to learn about the underlying root causes (beliefs, norms and attitudes behind the factors) leading to stigma and IPV. One discriminating name for HIV/AIDS in Zimbabwe is 'chirwere chepfambi' meaning 'disease of prostitutes'. It was suggested that the stigmatisation of prostitutes as carriers of the virus, as opposed to their clients, may signal a general belief about women whose sexuality is not under the control of male partners, fathers or elders [16]. Blaming and stigmatisation is very common. In Zimbabwe Homosexuals are not only stigmatized, but also criminalized [17].

In addition to religion as an influence, many Zimbabweans consult Traditional Practitioners (TP) for health-related issues and spiritual problems. The choice to consult TP and to use herbal medicines is usually based on various factors; the primary ones being inaccessibility and unaffordability of western medicine coupled with a strong belief in herbs as effective, affordable and accessible [18]. People readily combine Christian beliefs and rituals with aspects of traditional culture and religion [19]. Western medicine, traditional practices, herbal medicine, as well as faith healings are often used simultaneously. A recent exploratory qualitative study in six eastern and Southern African countries has shown that medical pluralism, manifesting across traditional, faith-based and biomedical health-worlds, contributes to delays and interruptions of care along the HIV cascade, as well as mistrust between health providers. It is argued that the role of sociocultural beliefs necessitates the adoption of culture-sensitive approaches, intervention designs and policy reforms [20].

Integrating TP into the HIV care could be an opportunity to benefit from their useful herbs and therapies, while offering the chance to dispel practices that might exacerbate the spread of HIV. While herbal medicine has the potential to reduce adverse drug reactions to ART, some herbal formulations have been identified as having pharmacokinetic interactions with antiretroviral drugs [21]. Also, some traditional healing methods, like the frequent use of skin cutting gadgets, might further the spread of HIV [22]. Batisai argues that integration of the western and traditional medical systems might be complementary in their merits and achieve what neither would alone [18].

1.2. Rationale for Scoping Review

So far, R/S issues and TP are hardly considered in the

biomedical approach in Zimbabwe. TP and religious stakeholders are not officially integrated into the HIV care. A preliminary search for existing scoping reviews on the topic of R/S and HIV in Zimbabwe was conducted on the 18th of January 2021 in Epistemonikos and Pubmed without result. There are several individual, mainly qualitative, studies with relevant results. Many of these studies have been known by the authors of this study and are included in the introduction. However, the body of literature has not yet been comprehensively reviewed and thus it seems these results stand alone. Therefore, a scoping review was conducted to systematically map the research done in this area and to summarize and synthesize the findings of the different authors of various fields of expertise (theology, medicine, sociology). The findings allowed a fair description of the influence and medical relevance of R/S and TP for PLWHIV in Zimbabwe that should be recognized by the stakeholders of all three health sectors (religious, traditional and biomedical).

2. Review Question

What is the role/influence of religion/spirituality (R/S) and traditional practice (TP) on people living with HIV (PLWHIV) in Zimbabwe? Sub questions: What are enhancing or deterring R/S and TP factors affecting HIV therapy and related health outcomes? What are the religious/spiritual ontologies that are foundational of specific beliefs and social norms (=underlying root causes beliefs, norms and attitudes)? What are the challenges and opportunities for engaging R/S and TP stakeholders in HIV care?

3. Inclusion Criteria

Religious, cultural, and economic landscapes are dynamic and diverse. This is especially true for Zimbabwe's economic situation. To get a meaningful result, this scoping review focusses on Zimbabwe only. There are various descriptions, interpretations and meanings for the terms "religion" and "spirituality". In this paper the term "religion" refers to organised and/or shared faith practice or belief and the term "spirituality" refers to the way people relate to the transcendent, including traditional practices and beliefs.

HIV/AIDS remains a primary concern in Zimbabwe. Therefore, the paper focusses on HIV/AIDS. The nationwide rollout of ART in Zimbabwe in 2008-2012 has changed the perception of HIV/AIDS from being a death sentence. This might influence the role of R/S for HIV patients. Consequently, the review only includes papers published after 2009.

4. Review Objective

The objective of this scoping review is to systematically map the research published in this area, to describe what is known about the role and influence of R/S on the experience of living with HIV in Zimbabwe in general, and especially to

illustrate the influence of R/S and TP on the physical and psychological wellbeing of HIV patients and the access to HIV care. The review further seeks to identify religious/spiritual ontologies that are foundational of specific beliefs and social norms that have a negative impact on PLWHIV in Zimbabwe and to show ways of how to mitigate this.

5. Methodology

This section documents how the reviewers searched for relevant sources of information for inclusion in the scoping review. It describes the individual research strategies for the two databases, documented in the Appendix.

5.1. Search Strategy

The preliminary search for existing scoping reviews on the topic of R/S and HIV in Zimbabwe in Epistemonikos and Pubmed yielded no result.

Reasons for choosing MEDLINE and ATLA databases: For the initial search, Pubmed database was chosen because it contains citations not only from the biomedicine and health fields, but also from related disciplines. The final search was then done in MEDLINE because of the added value of using the National Library of Medicine (NLM) controlled vocabulary, Medical Subject Headings (MeSH®), to index citations. This allowed for a more focused search, avoiding citations that are out of scope. ATLA religious database was chosen because it is believed to be the premier index for literature in all fields of religion and theology.

Composing of search strings: The first step was an initial limited search in Pubmed and ATLA for papers including religion or faith or belief or tradition and HIV or Aids and within Zimbabwe. This initial search was then followed by an analysis of the text words contained in the title and abstract of the retrieved papers, and of the index terms used to describe the articles. Yale MeSH analyzer (<https://mesh.med.yale.edu/>) and (`cgi-bin/miner/miner2.cgi`) were used to find additional relevant MeSH terms. All identified words and terms were then combined in the search string to use for the search in the Medline database (Appendix: Doku Suchstring). The search identified 616 records. An information specialist of Basel University translated the search string for the search in ATLA (Appendix: Doku Suchstring) and the search in the ATLA database identified 22 records. There were no duplicates. The search in both databases was conducted on the 8th of February 2021.

5.2. Study Screening and Selection

All 638 records were screened for the source of evidence. Only primary studies, population survey studies, textual papers and reviews were included. Further criteria were:

1. Record needed to be relevant for Zimbabwean context (study population from Zimbabwe, or text about Zimbabwe)
2. The title or abstract needed to address one or more of the following themes:

- The role/influence of religion/spirituality (R/S) (including traditional beliefs and practices) on HIV patients.
- Enhancing or deterring R/S factors affecting HIV therapy and related health outcomes.
- Underlying root causes beliefs, norms and attitudes leading to R/S factors affecting HIV therapy and related health outcomes.
- Challenges and opportunities for engaging R/S stakeholders and traditional practitioners in HIV care

The screening was done individually by the two reviewers. Discrepancies were discussed using the selection criteria. Out of the 92 references that met the selection criteria, 43 references were considered to be only widely or indirectly connected and therefore excluded and 49 references were selected as directly relevant for full text screening.

Four additional records were found by searching the reference list of identified articles. There were no additional records through contact with authors.

Seven records were dismissed because they did not directly relate to HIV, the data was too old, or the approach did not meet the scientific requirements (due to the small case load and the conduct of interviews with closed questions).

6. Analysis and Presentation of Results

46 records were used for the qualitative and quantitative synthesis.

6.1 Quantitative Synthesis

Firstly, we mapped the records according to the

characteristics. Four records were textual papers and all others were studies. Table 1 groups the studies into qualitative studies, mixed studies and quantitative studies, and also indicates the individual case load and the means of data generation.

Study Type: Most of the studies, namely 24, were qualitative studies, followed by 13 studies with a mixed approach and 4 quantitative studies out of which, 3 were population-based studies.

Means of data collection: The main data source were interviews, followed by Focus Group Discussions (FGD). Semi-structured interviews (SSI), in-depth interviews (IDI) and key informant interviews (KII) were used in 34 studies (=74%). This is not surprising, as religion/spirituality (R/S) and traditional practice (TP) are a social phenomenon, and of a personal nature. Focus Group Discussions were used in more than a third of the studies.

Population: The people interviewed were predominantly Zimbabwean, people living with HIV (PLWHIV) and key informants (KII). Key informants are people who are affected by HIV (for example, parents, religious leaders, teachers and traditional practitioners). The respondents were adolescents and adults, including men and women as well as a few transgender participants.

First author R/S and TP are shaped by local context. Comprehensibly most of the first authors (more than two thirds) have an African background and some were able to conduct the interviews in the local language.

Setting: All studies included were done in Zimbabwe or used statistical data from Zimbabwe.

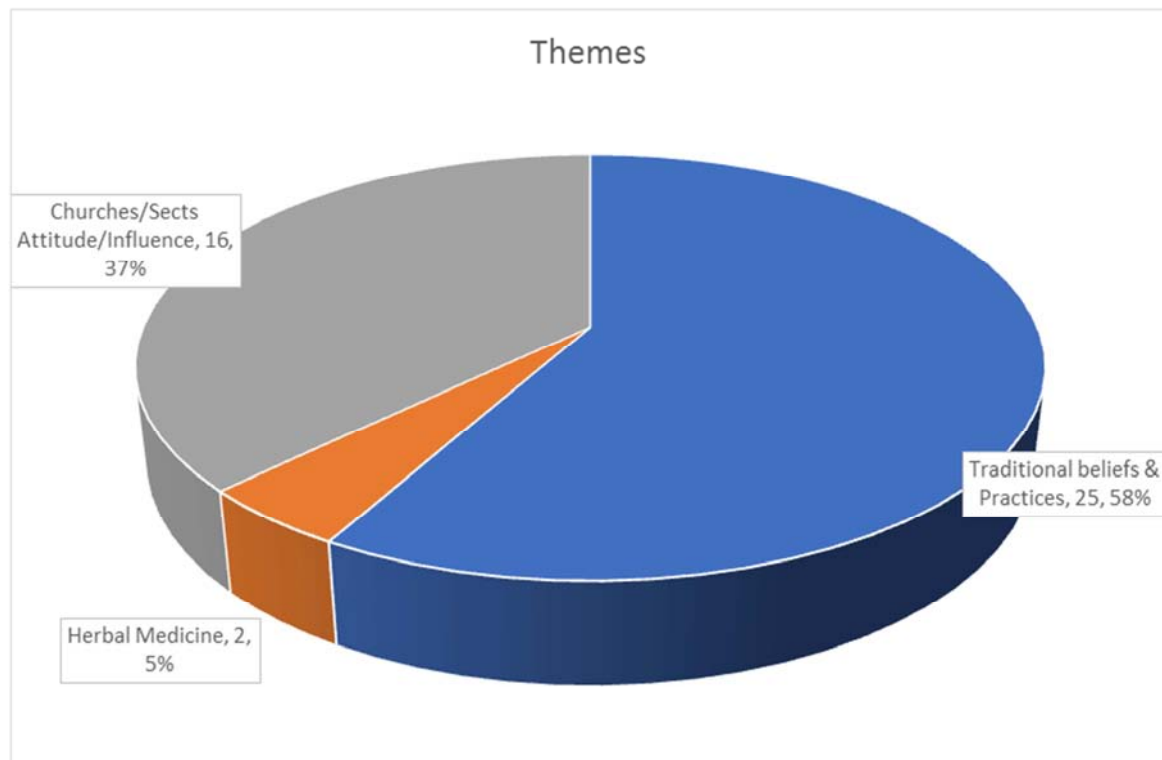


Figure 1. Records' Themes Mapping.

Table 1. Study Type Mapping.

Qualitative Studies (24)	Mixed Studies (13)	Quantitative Studies (4)
D. D. Hallfors (2016) N=35 Interviews with female six graders	K. Batisai (2016) Qualitative data n=25 Interviews with PLWHIV (adult), informal KII and literature research	M. Mhaka-Mutepefa (2015) 327 participants Resilience Scale and World Health Organization Quality of Life Questionnaire (WHOQOL-BREF)
W. Mavhu, (2012) N=243 24 FGD adults + 3 KII	C. T. Dzimir, (2019) Qualitative data n=28 (FGD & 18 KII) with church and official documents	D. D. Hallfors (2013) Data from 2007-2010 randomized clinical Trial & Zimbabwe Demographic Health Survey 2006
S. Mhizha (2015) N=22, participatory approach 16 adolescents (12-18) and 6 KI	W. Mavhu L (2011) Qualitative data n=170 for FGD & data from quantitative survey (adults)	R. Manzou, (2014) Population Survey Study (Manicaland Study 1998-2000 / July 2003-August 2005) males aged 17-54, females aged 15-44
M. Moshabela (2017) N=357, multi-country explorative study, Interviews with 258 PLWHIV, 48 family members of PLWHIV and 53 healthcare workers	T. G. Monera-Penduka (2016) Cross-sectional observational study (60 pharmacies, 11 herbal shops) & laboratory assessments.	M. Mapingure (2021) Population Survey Study
S. Moyo (2013) KII, FGD, IDI with old men n >=56	S. Moyo (2017) 185 adolescents for cross-sectional survey and a qualitative study 15 FGD & 21 KII	
E. Mpofu (2011) N=23 FGD adults	E. Mpofu (2012) Qualitative Study n=95 interviews and document study	
E. Mugweni (2012) N=64 KII, 4 FGD, 36 IDI (adults)	T. Mudzviti (2012) 318 Interviews adult PLHIV and medical record study	
A. Müller (2018) N=50 IDI, multi-country study	W. N. Nunu (2020) Literature review, qualitative & quantitative study in progress	
K. Munyaradzi (2016) N=15 KII	N. Mudonhi (2019) N=600 Questionnaire with qualitative and quantitative questions (300 adolescents 17-18 and 300 parents)	
J. Mutambara (2020) N=25 15 PLWHIV, 10KII	T. Nyatsanza (2017) key policy documents and 91 KII	
Z. Nyati-Jokomo (2016) N=231 for 23 FGD and 8 KKI	D. Simmons (2011) Qualitative study N=150 IDI with traditional healers and document study	
S. O'Brien (2013) N=60 IDI adults affected or infected by HIV	S. Chirongoma (2016) Literature review and qualitative study N=15 KII	
S. O'Brien (2014) 1 N=80 IDI adults affected or infected by HIV	T. Shoko (2015) Literature review and interviews N=12	
S. O'Brien (2014) 2 N=60 IDI adults affected or infected by HIV		
M. Skovdal (2011).1 N=115 for 37 Interviews and 5 FGD with 53 adults on ART plus 25 healthcare providers		
M. Skovdal (2011) 2 N=78 Interviews with 53 adult male ART users and 25 health care providers		
Tsang EY (2019) N=15 Interviews with adult male sex workers		
F. Scorgie (2013) N=191 Multi-country-study with 55 IDI, 12 FGD with 106 female & 26 males and 4 transgender		
K. Shumba (2017) N=16 9 IDI & 7KII		
T. N. Taylor (2011) N=424, two cohorts 200 patients from 24 healers and 200 patients from health-centers plus 24 healers (400 interviews, plus observational and participatory research		
J. Velloza (2020) N=67 multi-country study Interviews with females (16-24)		
J. Musevenzi (2017) N=> 200 66 KII & 9 FGD (>15 participants) & participatory research		

Qualitative Studies (24)	Mixed Studies (13)	Quantitative Studies (4)
J. Marashe (2014) N=18 8 questionnaires with KI, 10 KII & FGD S. O'Brien (2014) 1 N=80 IDI adults affected or infected by HIV		

Articles/texts (total 5): Machingura F. (2011), V. Magezi and P. Manzanga (2020), C. Banda and S. Mudzanire (2019), I. Mhike & E. K. Makombe (2018), M. Machinga (2011)

Figure 2 shows the records according to their content. The majority of records (25) addressed the influence of traditional beliefs and practices regarding health and HIV. Due to the fact that this study is interested in the medical relevance of R/S and TP, the two records investigate the effect and use of herbal medicine are listed separately. Sixteen records examined the influence of religious beliefs and religious groups' attitude on HIV (=Churches/Sects).

6.2. Qualitative Synthesis

To identify the information available in literature regarding the influence of Religion/Spirituality & Traditional Practice, this section presents a descriptive qualitative content analysis, including basic coding of data. As the selected studies cover different fields of expertise (sociological, theological, anthropological, medical) the Framework Method [22] was used to analyze and identify the different themes of the studies. The framework created a structure to summarize and synthesize the studies' content. The founder and director of the George Washington Institute for Spirituality and Health,

explains that spirituality and religion are medically relevant, if a spiritual issue leads to distress or suffering (e.g. lack of meaning, conflicting religious beliefs, inability to forgive). The spiritual issue is the cause of a psychological or physical diagnosis (such as depression, anxiety, acute or chronic pain) or is a secondary cause, or affects the presenting psychological or physical diagnosis (e.g. refusal or delaying of therapy because of religious beliefs) [23].

Leaning on this understanding of the medical relevance of spiritual/religious issues, the themes were grouped into the following eight categories: The role/influence of R/S & TP on HIV patients; Enhancing R/S & TP factors; Detering R/S & TP factors; Root causes, beliefs, norms, attitudes; Challenges for engaging R/S stakeholders in HIV care; Challenges for engaging TP in HIV care; Opportunities for engaging R/S stakeholders in HIV care; Opportunities for engaging TP in HIV care.

Quotes of the 46 studies were coded (=key findings), re-assembled and summarized or grouped in codes and then assigned to one of the eight categories. This process was repeated and refined until both researchers agreed with the result.

Table 2. Codes (categories and subthemes) and Key Findings.

Codes	Key Findings	Studies
Category: The role/influence of R/S & TP on HIV Patients		
Beliefs about Health:	disease and illness are categorized according to cause	[6, 18, 24-27]
Bio-psycho-social-spiritual	treatment according to cause of illness	[18, 24, 26]
	Herbal remedies are chosen because they are endemic	[18]
	breaching taboos, especially sexual ones, results in illness	[18, 26, 28]
	HIV is linked to witchcraft	[26, 29]
	Bad luck, difficulties have spiritual cause	[26, 30]
	Aids=variety of illnesses, cannot be treated with one medicine	[26, 28]
	Serious illness carries social stigma – fear of hospitalization	[29]
	Death of illness is will of God	[27]
	Illness as alert to search for spiritual cause	[6]
	illness caused by contact or contamination by, substance considered unclean or impure	[25]
	Mixing blood of different constitutions linked to HIV	[25]
	Health, disease sickness have spiritual foundations	[12, 24, 25, 31-33]
	Shona believe ancestral spirits influence health	[6, 26, 31]
	Health= blessing from God and sickness=curse from devil	[31]
	Indigenous belief system relying on faith healing	[34]
	Sickness as reason to join Spiritualist church	[8]
	Only Holy Spirit can heal	[25]
	Use of biomedicine shows lack of faith	[25]
Church Role	Churches Leaders Association finding solutions to HIV problem	[14]
	Successful church community program	[14, 35]
	Prophets intercede between living and Spirit world and can drive out demons that cause illness	[30, 36]
	Ultimate goal of church is spiritual health of its members	[33, 36]
	Church has a healing mandate	[37]
	Church considered alternative health care system	[25, 36]
	metaphysical explanations for health give church control of members' health	[36]
	Christian Hospitals and Churches cared for PLWHIV from Beginning=role model for government	[25, 35]
	Missions played important role in care of rural HIV patients	[37]

Codes	Key Findings	Studies
Churches' influence on sexual & health seeking behaviour	Church did not reach out to apostolic sect members	[25]
	Church networked with authorities – police turns a blind eye on crimes in within churches (e.g. child marriages)	[38]
	Church silent on socio-cultural issues (intimate partner violence)	[39]
	different beliefs, teachings and practices on sexual & health seeking behaviour	[32]
	Christian teachers required to teach abstinence	[26, 37]
	Less sexual partners among Christians	[32]
	No teaching about contraceptive use for adolescents	[38]
	No contraceptive use for some	[30]
	The anti-medical approach of the Johanne Marange Church has been weakened by FBO interventions	[27]
	Sex outside marriage is sin	[26]
Religion determinant of response to HIV epidemic	Churches played important role in reduction of HIV risk	[8, 41]
	Number of sexual partners linked to religious affiliation	[8]
	HIV is seen as God's punishment for fornication	[12, 29]
	Homosexuality is sin	[29]
	Spiritual beliefs influence the way HIV is understood and form of help sought	[6]
	HIV is God's punishment for defiant sexual behaviour	[12, 29, 32]
	Adolescents cannot disclose sexual activity and/or access PrEP	[41]
	Medical versus traditional & religious male circumcision	[42, 43]
	Evidence that opinions of traditional practitioners can influence medication choices	[6, 33, 44]
	Traditional knowledge contributes information about herbal products	[44]
Traditional Practitioners	90% of healers treat STIs	[28]
	Objective of healing is twofold: to identify the underlying cultural causes of sickness and misfortune and to alleviate the physical pain and suffering	[4, 24, 26]
	six types of n'anga—spirit mediums, diviners, herbalists, faith healers, midwives, and injectionists (nonspiritual healers)—each of which practices a distinct genre of healing	[4]
Category: Enhancing R/S Factors	Biblical ethos	
	Using biblical ethos in support of HIV care	[14]
	Compassion as religious obligation “faith without actions is dead	[14]
	Services are free of charge	[31]
	Healing mandate of churches	[37]
	Church lead community program for palliative care	[14]
	Church providing spiritual care to HIV patients	[14, 35]
	People joined church for spiritual healing	[45, 36]
	Spirituality as coping factor	[46]
	Acceptance of self and life	[46]
Coping	Best support for carers (=grandparents) by Church members	[46]
	Praying to God when faced with insurmountable difficulties	[30]
	Use of religious or spiritual strategies as coping mechanism	[30]
	Visiting TP for spiritual remedies in distress	[30]
	membership gives sense of belonging, purpose, and community	[14, 36, 46]
	Religiosity fosters social cohesion	[45]
	Trust, quality relationships	[46]
Category: Deterring R/S factors	Apostolic Churches	
	Apostolic Church members are not allowed to use medicine	[18, 25, 31, 42]
	Increased risk of HIV infection for women	[25, 31, 36, 45, 47]
	Child marriages common	[33, 36, 38, 45]
	Pressure/deception as reason for marriage	[45]
	No HIV testing because Church and husband don't allow	[31, 45]
	No family planning allowed	[31, 45, 47]
	No immunization allowed	[45]
	Not allowed to go to hospitals and clinics	[31, 45]
	Polygyny common	[25, 31, 36, 38, 45, 47]
	Wife inheritance	[36]
	Competing value system of church and school	[25, 36]
	Number of wives increases status in church	[36]
	Failed virginity test leads to forced marriage with older man	[25]
	Individual's responsibility compromised by Holy Spirit	[36]
	Use of biomedicine is sign of lack of faith	[12, 31]
	Doctrinal support of high fertility	[31]
	Dual behaviour by church members	[25]
	accessing modern biomedical health services secretly	[25]

Codes	Key Findings	Studies
Self-condemnation	Increase in acceptance of Health services without church support	[25]
	Allopathic approach heathen, of the devil, putting men above God	[25]
	Aids is a worldly disease not in church	[25]
	Low knowledge of HIV	[47]
	Self-image as possessed by evil spirits or being bewitched	[30]
Traditionalists	Thieves like us cannot go to church	[30]
	Negative religious-spiritual self-image	[30]
	Negative implications on psychological functioning, moral behaviours, and social relations	[30]
Abstinence only	Higher risk behaviour amongst Traditionalists could reflect health beliefs founded on	[8]
	Ancestral spirits and witchcraft – rather than Western explanations of sickness	[48]
Barrier to health	Adolescent HIV prevalence higher in indigenous populations	[29, 49]
	Facts about HIV and AIDS underemphasized in education	[41]
HIV/AIDS Stigma	Adolescents cannot disclose sexual activity	[31, 12]
	Religion as barrier to health care in Zimbabwe	[12]
	Not able to take tablets during fasting times	[41]
	PrEP use is a challenge in most churches	[40]
Homophobia	Condom use is anti-Christian	[12, 18, 25, 26, 28, 29, 35, 41, 50]
	HIV related to sexual immorality	[18, 32]
	gendered and spiritualised ideas about 'blame', 'transmission' and 'treatment'	[6, 27, 41, 28]
	HIV related to prostitution	[27]
	Idea of individual destiny	[6]
	Patriarchal forms of social control inherited from colonialism	[28]
	It is the guilty one who gets sick	[28]
	Guilty of breaking rules– mainly women are guilty	[35]
	Leading to exclusion from church membership	[35]
	Suffering from AIDS is sign of lack of faith	[25]
	HIV caused by demonic forces	[25]
	Aids as worldly disease not affecting church members	[26]
	Mukondombera=fatal disease	[51]
	HIV is disease of women (=weak)	[17]
	Homosexuality is sin	[17]
Ubuntu	Reproduction is part of marriage – increases stigma	[17]
	Religion strong driver of the perceived stigma	[35]
	riddled with patriarchal and oppressive elements that disadvantage women	[35]
Medical work as Evangelism	practices that fuelled HIV spread	[35]
	values human touch leading to heightened risk of infection	[35]
	Doctor sees medical work as a tool of evangelism	[35]
	blurring the line between medical care and proselytizing	[35]
Category: root causes beliefs, norms attitudes	Duality of accountability (mission and state)	[35]
	Churches did not reach out to members of other churches	[25]
Pluralistic medical approach	Bio-psycho-social-spiritual understanding of health:	[4, 18, 26, 28, 31-33]
	Choice of treatment depends on (accessibility, affordability, efficacy, cause)	[4, 20, 33]
	If treatment option does not give relief, alternative explanations and treatment are adopted	[21]
	Herbal remedies used to alleviate discomforts caused by adverse drug reactions of ART	[33]
	TP blend traditional practices with Christian concepts	[4]
	Going to hospital is last resort for serious illness	[4, 18, 20, 26, 28, 32, 33]
	Complementary use of medicine is common	[4, 20]
	Medical pluralism can cause delay in care	[42]
Health decision is family affair	Early infant circumcision not only decided by parents	[20, 33]
	Decision making is sequential and slow	[18]
	wellness is derived from the role of family, community, and the spiritual world	[14]
Endemic problem-solving Mechanisms	Chief's granary	[14]
	volunteerism embedded in Shona culture	[14]
	Idiom: “do not laugh when your neighbour is in trouble”	[14]
	cultural ethos of Ubuntu fostered social cohesion	[33]
	Pre-colonial Africans were self-sustained	[33]
	Utanu- refusal to accept ill health- positive philosophy of life	[53]
	Sexual offence reparation in the form of ‘mwombe nemwana wayo’ [two head of cattle] serves as prophylaxis	[18]
	proper healing is holistic=harmony and correct relationship with the spiritual worlds	[8, 26, 35, 53]
Patriarchy	central role of polygyny within Shona religion	[18, 33, 47, 50, 53, 54]
	Women cannot decide autonomously on health and sex	[54]
	Women are voiceless	

Codes	Key Findings	Studies
Teenage marriage	Wife belongs to the husband	[54]
	Women cannot ask for safe sex practice	[35, 47, 50, 53, 54]
	Preserving marriage more important than safe sex	[54]
	Economic dependence on husband	[32, 54]
	Marriage is affair of two families	[54]
	Shona word for divorce=rejected	[54]
	Husbands' entitlement to sex	[54]
	Forced sex in marriage common	[54]
	wives face barriers to safer sex at individual, relational and community levels	[32, 35, 47, 54]
	Women are cause of disease	[18, 28, 29, 32, 35]
	patriarchal norms promoted as solution to HIV	[18, 27]
	Experienced violence and vulnerability of sex workers	[55]
	Hospitals are female territory where men don't go to.	[50, 51]
	Men may not allow wife to take ART or steal it from her	[50]
	Intimate partner violence is common	[39]
	Patriarchal practices promote spread of HIV	[26, 35, 47]
	Women carry highest HIV burden	[25]
	No alternative (poverty, poor grades, ill treatment)	[45]
	Pressure/deception as reason for marriage	[25, 38, 45]
	Pregnancy is common reason for marriage	[45]
One offspring needed	Loss of virginity as reason for marriage	[25, 45]
	Large age discrepancy between husband and wives is common	[25, 45]
	Teenagers have to replace older sisters as wife	[26, 35, 45]
	Infertility leading to extra-marital affairs	[56]
Importance of female Virginity	TP & RS claim power to impregnate childless women	[20]
	Increases stigma for homosexuals	[17]
	Brother in law allowed to sleep with wife	[35]
	R/S stakeholders claim power to impregnate childless women	[56]
Adolescent sexuality is taboo	Contraceptives believed to encourage early sexual debut	[53, 57]
	Pre-marital sex is seen as prostitution	[57]
	early sexual debut, despite the socio-cultural and economic contexts	[57]
	Limited information of reproductive health and contraceptive use for adolescents	[57]
	No contraceptives for adolescents=high risk of HIV infection	[57]
	Unwanted pregnancies of adolescent end in unsafe abortions	[57]
Men sexuality	no curriculum to teach reproductive health to adolescents	[57]
	Difficult access to contraceptives for adolescents	[57]
	double moral/standard for boys and girls	[57]
	Limited contraceptive use among adolescents is a result of interplay of demographic, policy, socio-cultural, religious and economic factors.	[57]
	Teachers are constrained in teaching sexual health	[49]
	Pre-Exposure Prophylaxis linked to promiscuity	[41]
	multiple and concurrent sexual partnering is accepted	[27, 32, 50, 51, 58]
	Concurrence more acceptable in specific social contexts, including infertility and lack of a male heir	[57, 58]
	Male infertility carries overtones of failure, frustration, pain, social ostracism, stigma, marital instability, suicide	[56]
	Infertility treatment exclusively sociocultural	[56]
Homophobia	Condoms emasculate	[51, 57]
	Pre-marital sex to display features of manhood	[57]
	low rates of HIV testing and treatment due to reasons of stigma and the challenge to (male) identity	[32, 50, 51]
	Men are tough, can defend themselves – against HIV	[51]
	societal homophobia as reason for lack of support	[17, 59]
	Criminalization of same sex/gender activities	[17, 59]
	Social stigma for gender minorities	[59]
	Cultural contamination leading to disaster for family	[17]
	No access to reproductive health services	[59]
	Homosexuals as origin of HIV	[29]
	Homosexuality is not African, came from abroad	[29]
	Social isolation	[17]
	No-disclosure	[17]
	Pressure to get married	[17]
Sacredness of body parts	Media slanders sex-workers especially men	[17]
	Homosexuals are abnormal and unclean	[17]
	infant's removed foreskin should be given to child's relations	[42]
	Fear discarded foreskin could be used to perform witchcraft	[42]
	Fear that sperms found in condoms could be used by witches	[40]

Codes	Key Findings	Studies
Reluctance of biomedicine to collaborate	leads to non-disclosure & potential compromised effectiveness ART denied because of feared drug interaction Conflict of healthcare systems	[20] [20] [20]
Sexual education	mistrust between providers operating in different health-worlds traditionally sex is not a public subject Sex is sacred culturally exclusive domain of aunts and uncles Traditional sex education weakened, focusing on gendered sexual socialization, not promotion of sexual health	[20] [25, 26, 29] [26] [57] [57]
Risky cultural practices	Cultural initiation linked to high STI prevalence in adolescents adolescent pregnancies and HIV associated with cultural practices such as forced / early teenage marriage, traditional cleansing, wife pledging and HIV cleansing risky practices were rituals surrounding open fontanelle, toning of child's sexual libido, initiation of sex after childbirth, treatment of eye & ear infections, tongue-tie and pre-mastication sucking father's penis for open fontanelle and paternity testing girl child's sexual libido is toned down through rubbing the father or maternal uncle's penis on the girl's genitals	[48] [26, 48, 52, 53] [52] [52]
HIV came from abroad	Mother's milk squeezes into eyes, nose and genitals baby's napkin with vaginal and seminal fluids used to rub the baby's genitals Pre-mastication Cutting of tongue tie Impossibility of living without sex Link to labour migration Biological warfare by white colonial regime Deliberate ploy by Westerners to decimate black Africans Political conspiracy Mixing of different blood (=races) "American Ideas of Discouraging Sex"	[52] [52] [52] [52] [26] [29, 32, 53] [29] [29] [18] [28] [26]
National AIDS strategy	Condoms are European culture contradict African culture Skepticisms towards motives of foreign donors At times contradictory and politically driven State is moralizing – linked HIV and sexual transgression High vulnerability of sex workers/homo due to criminalization Treatment guidelines only for monogamous relationships Disclosure of sex work undermines diagnostic accuracy and treatment effectiveness Overt discrimination of sex workers/homos Sex workers/homos find it difficult to get tested Sex workers find it difficult to access healthcare Health providers abusive even withholding treatment for sex Workers/homos Healthcare workers blaming sex-worker/homos for illness Mission hospitals partner with Ministry of Health Economic decline and poor health systems lead to mushrooming of faith healing ministries and revival of TP Difficult for working men to take medicine in time Confidentiality breached by health workers Non-conformity to social rules leads to social isolation Little collaboration between the three health care systems	[40] [42] [18] [18] [17, 55] [17, 55] [17, 55] [17, 55] [55] [17, 55] [17, 55] [17, 55] [37] [33] [51] [17, 57] [17, 55] [20, 48]
Category: Challenges for engaging R/S Stakeholders		
Compromising care	Delays due to certain health beliefs Healers claim to heal HIV and ask to stop ART Church elders not allowed to take medication No teaching of contraceptive use for adolescents Sexuality is taboo subject in Churches Religion forbids divorce for wife of unfaithful husbands deviance-responsibility: Work hard, be good, have faith and you will be cured – individual is in control Opposition to allopathic approach because procedure in health-centers lack religious aspect mistrust between providers of different health-worlds Demonizing of TP	[20] [12, 20] [12] [57] [57] [54] [27] [43] [57] [33]
Focus only on Evangelism	no communal approach to health and healing	[33]
Category: Challenges for engaging TP		
Toxicity of herbal medicines	Need of regulatory body Heavy metal and microbial contamination is concern with HIV Moringa samples were contaminated with bacteria and fungi mistrust between providers operating in different health-worlds potential of altered ART pharmacokinetics	[18] [44] [44] [20] [21]

Codes	Key Findings	Studies
Opposition to Circumcision	separates circumcision from adolescent initiation	[42]
	Involvement of women (mothers) not acceptable	[42, 43]
	Needs to be secretive cultural ritual	[43]
	Circumcision in health-centers lack religious aspect	[43]
	Only circumcised men should do procedure	[43]
Cultural practices in conflict with allopathic approach	Adolescents sexual health can cause conflict	[48]
	Practices exposing infants to bodily fluids that may contain HIV are a cause of concern	[52]
	Use of unsterile instruments	[26]
	exploitation of PLHIV by opportunistic traders and healers	[20]
	TP claiming to heal HIV	[26]
	Incision, biting, circumcision	[26]
Category: Opportunities for engaging R/S Stakeholders		
Spiritual Care	Pastors, Church Members can provide Spiritual Care	[14]
	Supplementing biomedical care for psycho-socio-spiritual needs	[18, 20]
	Spiritual Health Care system provides hope	[31]
	Pastoral care for all, not only church members	[39]
Church Community	examples of successful community program	[14]
	Good position to address social issues	[39]
Reproductive Health	Adolescents wish teaching	[57]
	Churches need to address reality	[35]
	Sexual ethic leading to lower risk of infection	[8]
Integrative approach	Complement not antagonize	[31, 33]
	Work together with community leaders to fight IPV	[39, 53]
	Ubuntu emphasizes aspects such as hospitality, care, solidarity and Interdependence	[35]
	See all health practitioners as agents of God	[33]
	TP and faith-healers refer patients to biomedical services	[20]
	Subset of biomedicine practitioners refer to TP or faith healers	[20]
Category: Opportunities for engaging TP		
Zimbabwe National Traditional Healers Association (ZINATHA)	1980 formation of ZINATHA	[18]
Integrative Approach	Allowing traditional and western medical systems to coexist	[18, 43]
	to supplement the care to fulfil psycho-socio-spiritual needs	[18, 20, 53]
	collaboration needed to perform circumcision according to cultural and religious norms	[43]
	great convergence between allopathic and African vernacular explanatory frameworks for infectious disease	[28]
	STIs have moral overtone are treated well by TP	[28]
	Indigenous term “dirt” could be used as idiom for HIV	[28]
	TP can complement allopathic healthcare system’s shortfalls	[18, 28]
	distinct cultural sensibilities of Un’anga, traditional healers provide culturally salient explanations and ritual solutions for illnesses such as HIV/AIDS, as well as the pragmatic alleviation of symptoms.	[4, 18]
	Utanu concept used in wider context	[33]
	Collaboration with police in case of abuse possible	[53]
	Rituals give sense of community belonging	[18]
	Part of holistic care	[18]
	TP and faith-healers refer patients to biomedical services	[20]
	Subset of biomedicine practitioners refer to TP or faith healers	[20]
Herbal/traditional remedies	Musakavakadzi & Peltoforum africanum reduce adverse drug events	[21]
	Moringa oleifera used as nutritional supplement and immune enhancer by HIV	[44]
	existing knowledge systems used to treat male impotence and infertility	[56]
	Endemic problem solving mechanism	

These findings were further summarized and synthesized in Figure 2. The aim of this next synthesis is to illustrate the social, cultural, and religious context of the experience of living with HIV in Zimbabwe. Deterring and enhancing R/S and TP factors influencing HIV patients need to be understood and seen in this unique context. Figure 2

illustrates the influence of R/S and TP on the physical, psychological, spiritual, and social wellbeing of HIV patients and their access to reproductive health information and services, their compliance with HIV therapy and the risk of HIV infection. This Figure illustrated the medical relevance of R/S and TP issues.

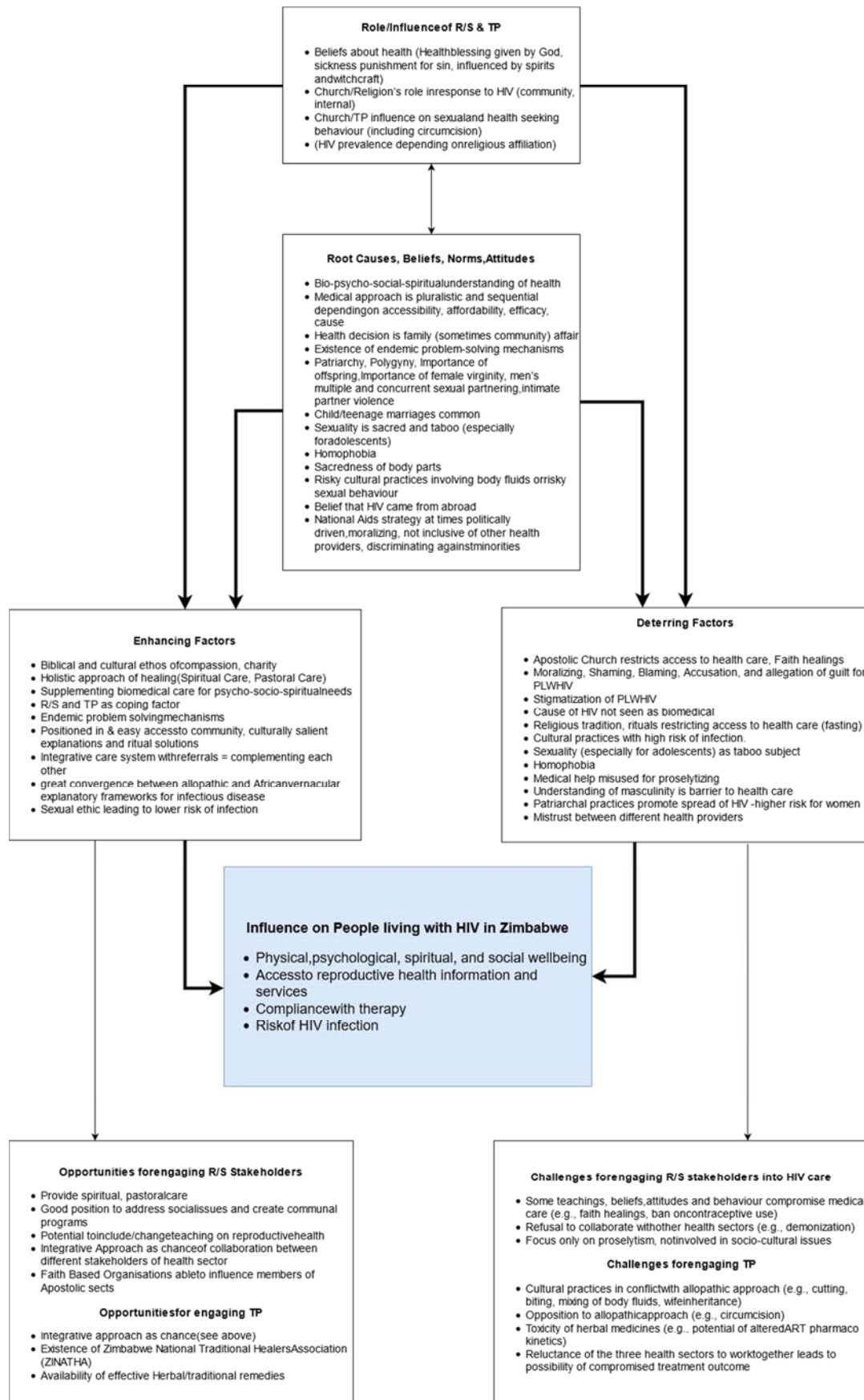


Figure 2. Summary of the findings in the socio, cultural and religious context of PLWHIV in Zimbabwe.

Figure 2 confirms the medical relevance of R/S issues and TP. This is not surprising to most of the individual authors of the included studies. This is what many of them have tried to show in their own studies. By giving an overview of the findings of all relevant studies published in the last 11 years, the claim of medical relevance of R/S and TP was endorsed. This scoping review allowed to go even a step further. Analyzing the data of all 46 records combined in Table 2 + Figure 2 made it possible to recognize formal relations (recurring patterns, units of social organization, as well as cause and effect relations and/or social mechanisms). This helped to identify three main areas of concern (=red flags), where R/S and TP influence and shape underlying beliefs, norms, and attitudes that conflict with the allopathic medical approach and compromise the therapy outcome (shown in Figure 3 at the end):

The bio-psycho-social-spiritual understanding of health and illness is crucial to the Zimbabwean health system. The

allopathic medical approach does not meet all aspects of that holistic understanding. Therefore, people use the religious and/or traditional health system to supplement allopathic therapy or choose the health system according to their perceived need. The parallel use of the three health systems can lead to concurrency, delayed access to allopathic health care, increased suffering, and compromised therapy outcome.

Patriarchal norms were long promoted as a solution to HIV. The records in this scoping review demonstrate the opposite. Patriarchal norms act as barriers to HIV care and increase the risk of becoming infected by HIV. Arguably, they are the source of much suffering for men, women, and children.

Cultural, religious, and societal norms of sexuality are very relevant in the Zimbabwean context. Sexuality is sacred, a taboo subject, moralized, and for some PLWHIV criminalized, and stigmatized.

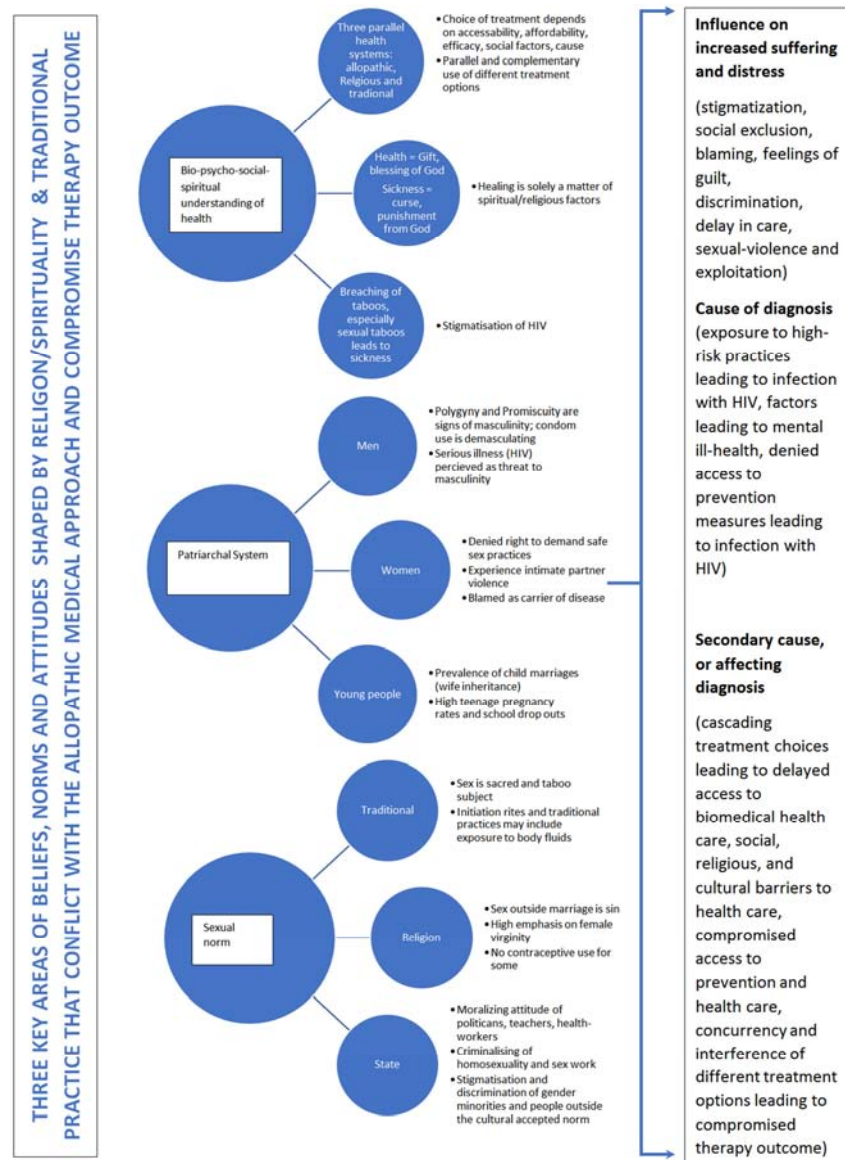


Figure 3. Underlying beliefs, root causes and attitudes leading to increased suffering, or being cause or secondary cause of a HIV infection, or affecting the diagnosis of HIV.

7. Discussion

Puchalski's argument of the medical relevance of R/S in case it is the cause or secondary cause of a disease, increases the suffering, or interferes with the treatment [23] and the claim of Kendrick's recently published systematic Literature review of studies in the USA that R/S can be a barrier or a facilitator to treatment for HIV, [60] were used to code and group the content of the 46 records (Table 2). The synthesis of these findings enabled to take out the influence of R/S on the experience of living with HIV in Zimbabwe in general, and especially to illustrate the influence of R/S and TP on the physical and psychological wellbeing of HIV patients and the access to HIV care (Figure 2). Figure 2 describes the socio, cultural and religious context of PLWHIV in Zimbabwe and illustrates how R/S and TP play a role as facilitator and/or barrier to HIV care and wellbeing of PLWHIV and so are medically relevant.

Further synthesis of the content of the 46 records by authors from different disciplines (sociology, theology, and medicine) revealed great coherence. It was possible to recognize social relations which helped to identify three key areas where underlying beliefs, norms and attitudes directly conflict with the biomedical approach, and potentially compromise the therapy outcome (Figure 3). Thus, religious, and spiritual ontological concepts are accentuated in the identified three key areas: understanding of health, the notion of patriarchy, and sexuality. To mitigate the negative impact of specific beliefs, attitudes, and social norms, religious and spiritual ontologies need to be considered, integrated, and valued equally to secular ontologies when designing health development programs. The importance of the role of religion in health development has also been pointed out by Dijk and other anthropologists, who explain that the relationship between religion and religious responses to HIV and the biomedical approach to HIV is complex, diverse, and ever changing [61].

The focus of the synthesis of this scoping review was based on Puchalski's criteria of medical relevance of R/S. This led to a one-sided emphasis on negative health impacts. However, the enhancing factors and opportunities of the contribution of R/S and TP for PLWHIV in Zimbabwe shown in Figure 2 are equally important: R/S and TP supplement the biomedical treatment by responding to the psycho, social, and spiritual needs of PLWHIV. Spirituality plays a key role in coping. Mutambara has already shown this in one of her previous publications [62]. The importance of religious coping is widely acknowledged and was also pointed out in a recently published study from a Brazilian context [63]. Furthermore, Simmons explains that there is a great convergence between biomedical and African vernacular explanatory frameworks for infectious disease [28]. Thus, secular, and religious/spiritual ontologies do not need to clash but may together form a common basis for future health development. Figure 2 also shows that religious, spiritual, and traditional communities and practices provide a sense of

belonging and mutual support. They are often the most accessible, culturally relevant, and affordable way of getting help. Such positive impacts of R/S on PLWHIV have also been shown in other studies, like in a recently published scoping review by Vigliotti and others. They found that more than half of the studies in their review documented a positive/protective association between religion, faith, spirituality, and HIV prevention activities [64].

Hence, the findings of this scoping review demonstrate that R/S and TP influence PLWHIV in positive and negative ways and that religious and spiritual ontologies are to be taken seriously. This is in line with, Pool's and other anthropologists' call for equal appreciation and consideration of religious and secular ontologies in health development projects. They see an urgent need for a development dialogue that draws on various ontologies and that understands religion as an integral part of such a meta-ontology [65].

The WHO Bangkok Charter for Health Promotion in a Globalized World declared in 2005 that health promotion should offer an inclusive concept of health, encompassing emotional and spiritual well-being. The WHO traditional medicine strategy 2014-2023 acknowledges the importance of traditional medical practice and its contribution to health and wellbeing and a people centred healthcare [67]. The findings of this scoping review should be interpreted in this context. By portraying the importance of Religion/Spirituality including traditional beliefs and practices in the context of HIV in Zimbabwe, they underline the importance of an inclusive, value-driven approach to health development that duly respects an integral part of religious and spiritual ontologies and so becomes more people centred.

8. Conclusion

Religion and spirituality (including traditional practice) play an important role in the life of PLWHIV in Zimbabwe. R/S and TP influence the health, wellbeing, and access to care in positive and negative ways. The findings of this scoping review ask for twofold action: Firstly, future health development programs should consider and integrate religious/spiritual ontologies alongside secular ontologies to avoid competitive approaches and compromised therapy outcomes. Secondly, religious stakeholders, traditional practitioners, and biomedical experts need to evaluate their own approach and teaching individually and in their communities. The three health-systems (religious, traditional, biomedical) in Zimbabwe have the potential to compliment and/or supplement each other's shortfalls. Together they can form a holistic system of care for people living with HIV in Zimbabwe. Collaboration between the three systems is needed to reduce concurrency, mistrust, and compromised therapy outcomes. Together they can achieve what neither could alone: Ending the AIDS epidemic as a public health threat by 2030 (third Sustainable Development Goal).

Appendix

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(Theology)" OR DE "Worship" OR DE "Visions" OR DE "Animism" OR DE "Faith" OR DE "Idols and images" OR DE "Mysteries, Religious" OR DE "Polytheism" OR DE "Positivism" OR DE "Proselytizing" OR DE "Religious life" OR DE "Religious thought" OR DE "Women and religion" OR DE "Spirituality" OR DE "Messianism") OR (DE "Spiritualism" OR DE "Caodaism" OR DE "Channeling (Spiritualism)" OR DE "Levitation" OR DE "Mediums" OR DE "New Age movement" OR DE "Occult sciences" OR DE "Spirit writings" OR DE "Seances" OR DE "Materialization" OR DE "Spirit portraits" OR DE "Soul mates") OR (DE "Occult sciences" OR DE "Alchemy" OR DE "Clairvoyance" OR DE "Demonology" OR DE "Divination" OR DE "Gematria" OR DE "Geomancy" OR DE "Hermetism" OR DE "Kundalini" OR DE "Mediums" OR DE "Satanism" OR DE "Witchcraft") OR (DE "Religion, Primitive" OR DE "Ancestor worship" OR DE "Animism" OR DE "Celts -- Religion" OR DE "Cultus, Roman" OR DE "Fetishism" OR DE "Fire-worshippers" OR DE "High gods" OR DE "Household shrines" OR DE "Incubation (Religion)" OR DE "Mana" OR DE "Mother goddesses" OR DE "Nativistic movements" OR DE "Orientation (Religion)" OR DE "Priests (Primitive religions)" OR DE "Shamanism" OR DE "Sky gods" OR DE "Superstition" OR DE "Taboo" OR DE "Totemism") OR (DE "Supernatural" OR DE "Miracles" OR DE "Demonology" OR DE "Divination" OR DE "Prophecies" OR DE "Psychical research" OR DE "Spirits" OR DE "Superstition" OR DE "Revelation" OR DE "Marvelous, The" OR DE "Automatic writing") OR (DE "Church work" OR DE "Basic Christian communities" OR DE "Chaplains, Hospital" OR DE "Church management" OR DE "Church officers" OR DE "Church renewal" OR DE "Clergy" OR DE "Evangelistic work" OR DE "Institutionalism (Religion)" OR DE "Interdenominational cooperation" OR DE "Laity" OR DE "Leadership, Religious" OR DE "Ministry" OR DE "Missions" OR DE "Missions, City" OR DE "Pastoral associates" OR DE "Pastoral counseling" OR DE "Pastoral theology" OR DE "Public relations -- Churches" OR DE "Revivals" OR DE "Rural clergy" OR DE "Sunday schools" OR DE "Visitations (Church work)" OR DE "Women in church work" OR DE "Church-night services" OR DE "Church entertainments" OR DE "Internet in church work" OR DE "Retirees in church work" OR DE "Youth in church work" OR DE "Pastoral care" OR DE "Recreation in church work" OR DE "Married people in church work" OR DE "Mentoring in church work" OR DE "Telephone in church work" OR DE "Books in church work") OR (DE "Chaplains" OR DE "Chaplains, Court" OR DE "Chaplains, Hospital" OR DE "Chaplains, Industrial" OR DE "Chaplains, Military" OR DE "Chaplains, Nursing home" OR DE "Chaplains, Police" OR DE "Chaplains, Prison" OR DE "Chaplains, School" OR DE "Chaplains, University and college") OR (DE "Guilt" OR DE "Shame") OR (DE "Social stratification") OR (DE "social norms") OR (DE "literature and morals") OR (DE "Culture" OR DE "Acculturation" OR DE "Art and culture" OR DE "Biculturalism" OR DE "Cross-cultural studies" OR DE

"Ecology and culture" OR DE "Intercultural communication" OR DE "Language and culture" OR DE "Liturgy and culture" OR DE "Material culture" OR DE "Personality and culture" OR DE "Popular culture" OR DE "Socialization" OR DE "Cultural policy" OR DE "Politics and culture" OR DE "Culture diffusion" OR DE "Subculture" OR DE "Political culture" OR DE "Cultural pluralism" OR DE "Educational anthropology" OR DE "Communication and culture") OR (DE "Psychology and religion" OR DE "Jesus Christ -- Psychology" OR DE "Bible -- Psychology" OR DE "Qur an -- Psychology" OR DE "Clergy -- Psychology" OR DE "Conference proceedings -- Psychology and religion" OR DE "Missionaries -- Psychology" OR DE "Prayer -- Psychology" OR DE "Psychoanalysis and religion" OR DE "Psychology, Religious" OR DE "Religious attitudes" OR DE "Seminarians -- Psychology" OR DE "Tests and measurements in religion" OR DE "Preaching -- Psychology") OR (DE "Alternative medicine" OR DE "Holistic medicine" OR DE "Homeopathy" OR DE "Medicine, Magic" OR DE "Medicine, Oriental" OR DE "Mental healing" OR DE "Mesmerism" OR DE "Traditional medicine" OR DE "Energy medicine") OR (DE "Polygamy" OR DE "Harems" OR DE "Polyandry") OR (DE "patriarchy") OR (TI guilt OR AB guilt) OR (TI gender OR AB gender) OR (TI "social representations" OR AB "social representations") OR (TI spirituality OR AB spirituality) OR (TI attitud* OR AB attitud*) OR (TI ethnic* OR AB ethnic*) OR (TI religi* OR AB religi*) OR (TI practitioner* OR AB practitioner*) OR (TI practice* OR AB practice*) OR (TI denomination* OR AB denomination*) OR (TI preach* OR AB preach*) OR (TI prayer OR AB prayer) OR (TI prayers OR AB prayers) OR (TI church OR AB church) OR (TI churches OR AB churches) OR (TI ruvheneke OR AB ruvheneke) OR (TI Christ* OR AB Christ*) OR (TI catholic* OR AB catholic*) OR (TI protestant* OR AB protestant*) OR (TI bapti* OR AB bapti*) OR (TI spirit* OR AB spirit*) OR (TI shaman* OR AB shaman*) OR (TI faith* OR AB faith*) OR (TI heal* OR AB heal*) OR (TI tradition* OR AB tradition*) OR (TI nanga OR AB nanga) OR (TI n'anga OR AB n'anga) OR (TI spell OR AB spell) OR (TI witch* OR AB witch*) OR (TI ritual OR AB ritual) OR (TI myth* OR AB myth*) OR (TI belief OR AB belief) OR (TI beliefs OR AB beliefs) OR (TI believ* OR AB believ*) OR (TI apostolic OR AB apostolic) OR (TI prophet* OR AB prophet*) OR (TI sect OR AB sect) OR (TI sects OR AB sects) OR (TI ancest* OR AB ancest*) OR (TI sin OR AB sin) OR (TI demon* OR AB demon*) OR (TI theolog* OR AB theolog*) OR (TI islam* OR AB islam*) OR (TI muslim OR AB muslim) OR (TI bible OR AB bible) OR (TI Quran OR AB Quran) OR (TI hindu OR AB hindu) OR (TI "buddhis* demon*" OR AB "buddhis* demon*") OR (TI meditation OR AB meditation) OR (TI chanting OR AB chanting) OR (TI purification OR AB purification) OR (TI occult OR AB occult) OR (TI Occultis* OR AB Occultis*) OR (TI satan* OR AB satan*) OR (TI magic* OR AB magic*) OR (TI "cast out" OR AB "cast out") OR (TI "casted out" OR AB "casted out") OR (TI bewitched OR AB bewitched) OR (TI mapositori OR AB mapositori) OR (TI

omen OR AB omen) OR (TI holy OR AB holy) OR (TI evil OR AB evil) OR (TI goblin OR AB goblin) OR (TI goblins OR AB goblins) OR (TI curse OR AB curse) OR (TI "Johane Masowe" OR AB "Johane Masowe") OR (TI apostle OR AB apostle) OR (TI apostles OR AB apostles) OR (TI priest OR AB priest) OR (TI priests OR AB priests) OR (TI pastor* OR AB pastor*) OR (TI elder OR AB elder) OR (TI elders OR AB elders) OR (TI supernatural OR AB supernatural) OR (TI shrine OR AB shrine) OR (TI altar OR AB altar) OR (TI mirac* OR AB mirac*) OR (TI doctrine OR AB doctrine) OR (TI preach* OR AB preach*) OR (TI pentecostal* OR AB pentecostal*) OR (TI gospel OR AB gospel) OR (TI missionary* OR AB missionary*) OR (TI indigen* OR AB indigen*) OR (TI Jesus OR AB Jesus) OR (TI God OR AB God) OR (TI Allah OR AB Allah) OR (TI Buddha OR AB Buddha) OR (TI omen OR AB omen) OR (TI omens OR AB omens) OR (TI vapostori OR AB vapostori) OR (TI "white garment" OR AB "white garment") OR (TI methodist OR AB methodist) OR (TI Zion OR AB Zion) OR (TI "African tradit*" OR AB "African tradit*") OR (TI evangeli* OR AB evangeli*) OR (TI Jehovah OR AB Jehovah) OR (TI magaya OR AB magaya) OR (TI deliverance OR AB deliverance) OR (TI "born again" OR AB "born again") OR (TI prophecies OR AB prophecies) OR (TI prophesy OR AB prophesy) OR (TI worship* OR AB worship*) OR (TI salvation OR AB salvation) OR (TI jewish OR AB jewish) OR (TI jew OR AB jew) OR (TI judaism OR AB judaism) OR (TI jesuit OR AB jesuit) OR (TI chaplain OR AB chaplain) OR (TI sermon OR AB sermon) OR (TI bishop OR AB bishop) OR (TI referent OR AB referent) OR (TI herbalist OR AB herbalist) OR (TI herbal OR AB herbal) OR (TI medium OR AB medium) OR (TI totem OR AB totem) OR (TI mutopa OR AB mutopa) OR (TI makumbi OR AB makumbi) OR (TI mishonga OR AB mishonga) OR (TI mapipi OR AB mapipi) OR (TI hun'anga OR AB hun'anga) OR (TI kusvikiro OR AB kusvikiro) OR (TI shave OR AB shave) OR (TI mudzimu OR AB mudzimu) OR (TI svikiro OR AB svikiro) OR (TI charm OR AB charm) OR (TI charms OR AB charms) OR (TI mystic* OR AB mystic*) OR (TI taboo OR AB taboo) OR (TI exorcis* OR AB exorcis*) OR (TI Sorcer* OR AB Sorcer*) OR (TI Superstiti* OR AB Superstiti*) OR (TI Pastoral OR AB Pastoral) OR (TI Chaplaincy OR AB Chaplaincy) OR (TI chapel OR AB chapel) OR (TI moral* OR AB moral*) OR (TI values OR AB values) OR (TI rites OR AB rites) OR (TI polygamy OR AB polygamy) OR (TI misogyny OR AB misogyny) OR (TI ubuntu OR AB ubuntu) OR (TI patriarchy OR AB patriarchy) OR (TI fidelity OR AB fidelity) OR (TI "world view" OR AB "world view") OR (TI custom OR AB custom) OR (TI customs OR AB customs))

AND ((DE "Hiv Infections" OR DE "Hiv Infections -- Africa" OR DE "Hiv Infections -- Congresses" OR DE "HIV Infections -- England -- London" OR DE "Hiv Infections -- Peru" OR DE "Hiv Infections -- Prevention -- Congresses" OR DE "Hiv Infections -- Prevention -- Moral and ethical aspects" OR DE "Hiv Infections -- Prevention -- Religious aspects -- Catholic Church" OR DE "Hiv Infections --

Prevention -- Religious aspects -- Christianity" OR DE "Hiv Infections -- Statistics" OR DE "Hiv Infections -- Testing" OR DE "Hiv Infections -- Transmission -- Thailand") OR (DE "HIV-positive persons" OR DE "AIDS (Disease) -- Patients" OR DE "Church work with HIV-positive persons") OR (DE "Health behavior" OR DE "Patient refusal of treatment") OR (DE "Sex customs" OR DE "Premarital sex" OR DE "Puberty rites" OR DE "Sex in literature") OR (DE "Sexual ethics" OR DE "Abortion" OR DE "Adultery" OR DE "Bioethics" OR DE "Celibacy" OR DE "Incest" OR DE "Premarital sex" OR DE "Prostitution" OR DE "Chastity" OR DE "Sexual consent") OR (DE "Sex education" OR DE "Sex education -- Religious aspects" OR DE "Sex education - - Religious aspects -- Catholic Church" OR DE "Sex education -- Religious aspects -- Christianity" OR DE "Sex education -- Religious aspects -- Islam" OR DE "Sex education -- Religious aspects -- Judaism" OR DE "Sex education for youth -- Great Britain" OR DE "Sex education for youth -- Religious Aspects") OR (DE "Condoms" OR DE "Condoms -- Complications") OR (DE "Sex crimes" OR DE "Bigamy" OR DE "Incest" OR DE "Pedophilia" OR DE "Rape" OR DE "Sodomy" OR DE "Fornication" OR DE "Child sexual abuse" OR DE "Adultery") OR (MH "domestic violence+") OR ((DE "Sexually transmitted diseases" OR DE "Syphilis") OR (DE "Sexual health")) OR (DE "Hygiene, Sexual") OR (TI HIV OR AB HIV) OR (TI "human immunodeficiency virus" OR AB "human immunodeficiency virus") OR (TI "Acute Retroviral Syndrome" OR AB "Acute Retroviral Syndrome") OR (TI "HIV/AIDS" OR AB "HIV/AIDS") OR (TI AIDS OR AB AIDS) OR (TI "acquired immunodeficiency syndrome" OR AB "acquired immunodeficiency syndrome") OR (TI PLHIV OR AB PLHIV) OR (TI PWA OR AB PWA) OR (TI PLWA OR AB PLWA) OR (TI PLWHA OR AB PLWHA) OR (TI ARV OR AB ARV) OR (TI antiretroviral* OR AB antiretroviral*) OR (TI "anti-retroviral therapy" OR AB "anti-retroviral therapy") OR (TI ART OR AB ART) OR (TI condom OR AB condom) OR (TI condoms OR AB condoms) OR (TI health OR AB health) OR (TI "intergenerational relationships" OR AB "intergenerational relationships") OR (TI "child marriage" OR AB "child marriage") OR (TI sex OR AB sex) OR (TI sexual* OR AB sexual*) OR (TI "domestic violence" OR AB "domestic violence") OR (TI "partner violence" OR AB "partner violence"))

AND ((TI zimbabwe* OR AB zimbabwe*) OR (TI harare OR AB harare) OR (TI shona OR AB shona) OR (TI ndebele OR AB ndebele) OR (TI n'debele OR AB n'debele) OR (TI venda OR AB venda) OR (TI tonga OR AB tonga) OR (TI rhodesia OR AB rhodesia) OR (TI bulawayo OR AB bulawayo) OR (TI manicaland OR AB manicaland) OR (TI masvingo OR AB masvingo) OR (TI matabele OR AB matabele) OR (TI Gweru OR AB Gweru) OR (TI Chiota OR AB Chiota) OR (PP Zimbabwe) OR (DE "Zimbabwe" OR DE "Bulawayo (Zimbabwe)" OR DE "Zimbabwe Assemblies of God Africa" OR DE "Zimbabwe Council of Churches" OR DE "Zimbabwean literature" OR DE "Zimbabweans"))

Limiters - Year Published: 2010-3000

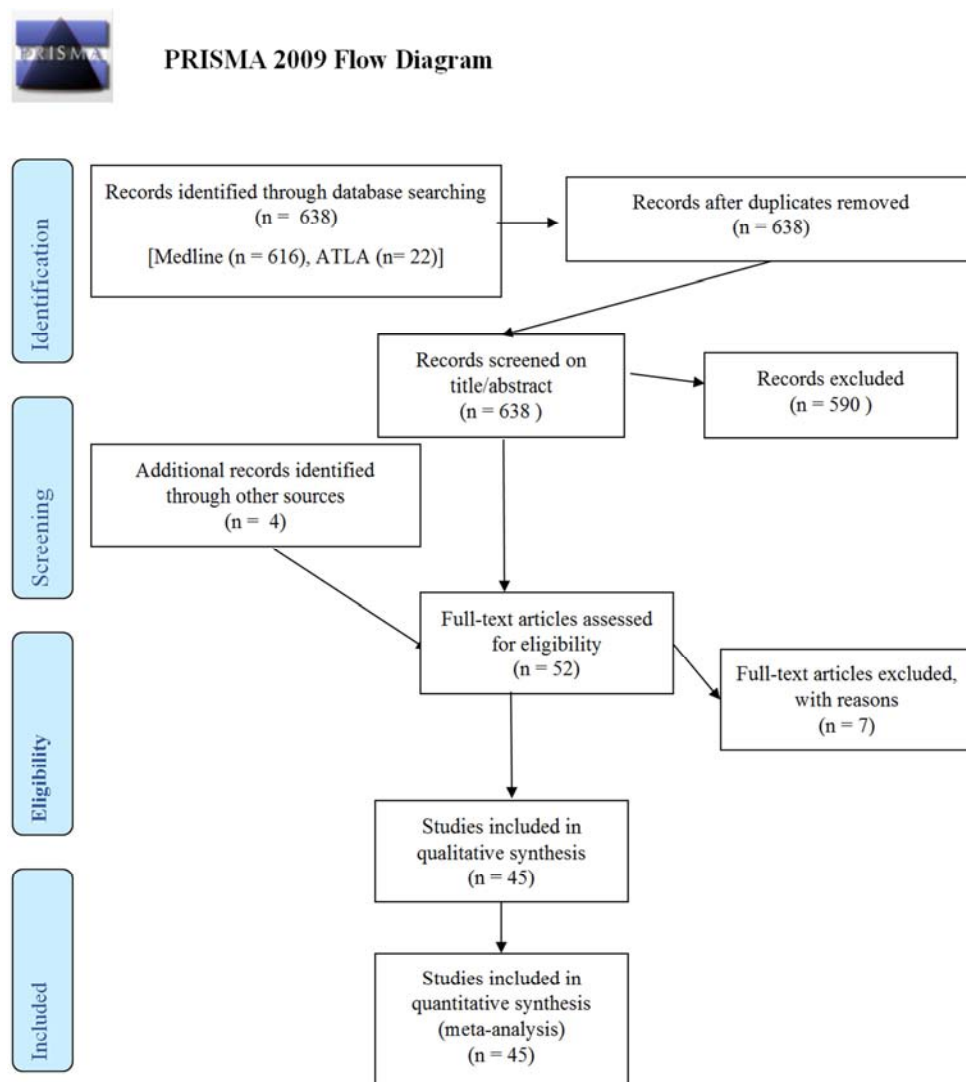


Figure 4. PRISMA Flow diagram.

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