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The Role of Faith-Based Organizations in HIV Prevention and Care in Central America

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Preface

Faith-based organizations (FBOs) have historically played an important role in delivering health and social services in developing countries; however, little research has been done on their role in HIV prevention and care, particularly in Latin America. The HIV Outreach in Latin America (HOLA) project aimed to address this gap by conducting an exploratory, qualitative study of FBO involvement in HIV/AIDS in three Central American countries hard hit by the HIV/AIDS epidemic: Belize, Guatemala, and Honduras. The study involved key informant and stakeholder interviews with health and FBO leaders and site visits to FBO-sponsored HIV/AIDS clinics, hospices, programs, and other activities.

This report summarizes the findings of this exploratory study. It provides an overview of the epidemics in each country studied and the range of HIV prevention and care activities conducted by FBOs. Further, it discusses the facilitators of these activities, as well as the challenges to FBO involvement in HIV prevention and care. Finally, it provides recommendations for promising ways that FBOs can address the HIV epidemic, both independently and in collaboration with other entities, such as ministries of health. The findings should be of interest to funders, policymakers, and health and FBO leaders who want to understand the role that FBOs can play in the fight against HIV/AIDS.

This work was sponsored by several entities. The fieldwork activities (interviews, site visits, and preliminary analyses) that served as the basis for the report were supported by RAND's continuing program of self-initiated research; support for such research is provided,

in part, by the generosity of RAND's donors and by the fees earned on client-funded research. RAND Health and RAND's International Health Program provided support for the writing of the report. Publication of the report was supported by Grant Number R01-HD50150 from the National Institute of Child Health and Human Development (NICHD). However, the report's contents are solely the responsibility of the authors and do not necessarily represent the official views of RAND or of NICHD.

The research was conducted in RAND Health, a division of the RAND Corporation, a nonprofit institution that helps improve policy and decisionmaking through research and analysis. A profile of RAND Health, abstracts of its publications, and ordering information can be found at www.rand.org/health.

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Summary

HIV/AIDS in Latin America has been called “the overlooked epidemic,” because it has been overshadowed by epidemics of larger scale and severity in sub-Saharan Africa and Asia. Addressing HIV in Latin America has been described as an opportunity to prevent epidemics as devastating as those of sub-Saharan Africa, and to apply lessons learned from Africa and Asia, but government efforts to address the epidemic in Latin America have fallen short. Churches and other FBOs have long been known to have an extensive reach and diverse presence in Latin America, so it is natural to ask what kind of role FBOs might play in addressing HIV/AIDS. At the same time, there are potential barriers to FBO involvement, including FBO “moralizing” about HIV/AIDS and FBOs’ lack of experience in being held accountable for spending and documenting the impact of programs.

This study attempts to shed light on these issues by focusing on the current and potential future role of FBOs in HIV prevention and care in the three Central American countries: Belize, Honduras, and Guatemala. At the time we initiated our study (2007), these countries had among the highest reported prevalence of HIV in Latin America: Belize with 2.5 percent prevalence, Honduras 1.5 percent, and Guatemala 0.9 percent. We performed a literature review and conducted key informant and stakeholder interviews with health and FBO leaders in the three countries along with site visits to FBO-sponsored HIV/AIDS clinics, hospices, programs, and other activities.

The Scope of HIV and AIDS in Belize, Guatemala, and Honduras

Across the three countries, HIV affects mostly young adults, men who have sex with men (MSM), and sex workers. In Honduras and Belize, the Garífuna peoples, descendants of African slaves, are also highly affected. Women in general represent a growing portion of the HIV-positive population, although this trend may simply reflect the natural spread of the epidemic over time. In all three countries, but especially Guatemala, HIV/AIDS care is not widely available in the health system, and hospitals and health care personnel with experience in HIV are centralized mainly in capital and major cities. In general, there is greater emphasis by government on treatment over prevention, although the need to sustain antiretroviral (ARV) coverage over the long term has not been addressed. Discrimination and stigma also pose considerable problems.

Current FBO Activities in HIV Prevention and Care

Our study found that many FBOs are already engaging in some activities related to HIV prevention and testing, care and support services, and stigma reduction and advocacy.

Prevention and testing. To date, FBOs have had relatively limited involvement in HIV prevention. Most FBO prevention activities focus on education for children and youth, and very few are directed toward high-risk, highly stigmatized populations, such as MSM or commercial sex workers. FBO leaders have widely varying attitudes on condom use, though the majority of FBO leaders were either anti-condom or willing to mention condoms only under limited circumstances and for limited purposes (e.g., for sero-discordant couples). A few FBOs, e.g., in Honduras, have started to offer rapid HIV testing (saliva and blood), both to the general population and to high-risk groups.

Care and support services. FBOs were not often involved in providing medical or mental health care. A few FBOs (typically faith-based nongovernmental organizations [NGOs]) provide such services

as clinical care management, administration of ARVs, and treatment of opportunistic infections. In contrast, a relatively large number of FBOs, especially in Guatemala and Honduras, have been involved in providing hospice or shelter for people living with HIV (PLWH), though these facilities range considerably in size and quality. FBOs in all three countries are also involved in counseling, prayer, care for the dying, support groups, and other forms of pastoral care. Very few FBOs focus specifically on improving the social and economic well-being of PLWH (e.g., through formal assistance with food and nutrition or income generation).

Stigma reduction and advocacy. Some FBOs are involved in stigma reduction activities, including solidarity marches, sermons, workshops, and interactions with family members. Some also engage in advocacy, such as promoting human rights of PLWH, educating PLWH about their workplace rights, advocating for treatment access, and preparing religious leaders to train others in their congregations to carry out HIV prevention and care activities.

Facilitators of and Barriers to FBO Involvement in HIV/AIDS

Our interviews with health and FBO leaders provided insights into ways in which FBO involvement might be facilitated, as well as barriers that can hinder involvement.

Facilitators

Broad reach and influence. There was an overall sense that FBOs in the three countries could leverage their broad reach and influence to raise awareness and decrease stigma toward PLWH and to provide support and care to PLWH, particularly where gaps exist, such as in nutrition and income-generating activities. Some health and most FBO leaders noted that FBOs' influence among youth and in remote areas could help them raise awareness and diffuse prevention messages.

Barriers

FBO attitudes and beliefs. Judgmental attitudes on the part of FBOs toward gays, MSM, and commercial sex workers and their limited reach into these groups were seen by health leaders as significant challenges to FBO involvement in supporting PLWH. Health leaders were also concerned about FBO leaders' tendency to interpret HIV in religious terms. HIV prevention efforts are further impeded by FBO leaders' difficulty in discussing sex as well as FBO prohibitions against condom use and/or reluctance to promote condoms.

Organizational barriers. A number of health leaders noted that there is no one structure that brings together all faith groups, and this makes it hard to coordinate more broadly with this sector. This challenge can be further compounded by the multiculturalism of the population.

Resource barriers. FBO leaders emphasized that many churches do not have resources for HIV/AIDS activities. They also noted that although churches exist in nearly all geographic areas and communities, health care resources do not, making coordination with health care providers in rural areas difficult.

Disagreements and tensions between FBOs and secular health organizations. The interviews revealed fundamental differences in values between religious and health leaders that led them in different directions on HIV prevention and also served as barriers to trust, thus limiting their ability to work collaboratively in relationships. Most importantly, many religious leaders favor some prevention methods (such as abstinence or "being faithful") and oppose others (such as condoms) based mostly on religious beliefs, with less emphasis on evidence of effectiveness. In contrast, health leaders favor prevention methods that have been proven effective in preventing HIV transmission.

Conclusions and Future Directions

Based on the findings from our interviews, we identified several potential roles for FBOs in addressing HIV/AIDS in the three countries.

FBOs might take a larger role in prevention and testing, in partnership with public health providers. It is unrealistic to expect many FBOs to shift their focus toward high-risk populations and promotion of condom use. It is more constructive to accept that different organizations, whether FBO or non-FBO, have entirely different comfort levels with regard to specific approaches to behavioral risk reduction, and to find ways for organizations to work together while respecting those differences. Nonetheless, there is still a lot that FBOs could do in the fight against AIDS—e.g., by encouraging people to get tested and get information about HIV—particularly because churches exist in all communities. FBOs that provide testing in partnership with public health providers can send a constructive message that HIV is a disease for which treatment is available and that people should know their status.

FBOs might become more involved in providing care and support services (especially some services that are rarely addressed). FBOs already provide many services of this sort. These activities might be expanded to include other needed services, such as transportation, food, housing, and income-generating activities.

One important role that certain FBOs seem uniquely qualified to undertake is that of reducing the stigma associated with HIV in the faith community and the broader population. In view of FBOs' moral authority, broad reach, and ability to influence attitudes, stigma reduction is an area in which FBOs could have an especially strong impact. Indeed, stigma reduction seems critical to realize the full capacity of congregations to address the needs of PLWH.

Advocacy is another area in which the role of FBOs might be expanded. Some FBOs have assumed an advocacy role for PLWH, advocating for greater access to health care, ARV, or workplace rights. These advocacy efforts can be quite important in countering the effects of discrimination or simple lack of attention.

Collaboration with other organizations is needed. If FBOs are to play a constructive role in addressing HIV in collaboration with the health care system, they must also recognize the unique and complementary strengths that each sector can bring to addressing it. There are

also a series of activities that they can assume in collaboration with the health care system:

- *Complement* the activities of others by addressing gaps outside the scope of others' missions or that others are unable to complete, e.g., by establishing housing projects for PLWH and hospices and facilitating income-generating activities in which PLWH could engage once their health has been stabilized by ARV.
- *Reinforce* the activities undertaken by others, e.g., by reinforcing prevention messages, counseling congregations on safe sex practices, and encouraging people to get tested.
- *Facilitate* the activities of other organizations, e.g., by offering opportunities for health leaders to promote the use of condoms in conjunction with other activities that FBOs are directly responsible for organizing.
- *Support* the activities undertaken by others, e.g., by recognizing the efforts of others and encouraging people to support other organizations' programs.

FBOs can also allow others, such as the Ministry of Health or similar agency, to observe, monitor, and evaluate FBO programs using objective criteria and rigorous analysis. There is also need to build FBO capacity to evaluate their own programs.

The findings of this study suggest that leaders in the public health sector might find it worthwhile to think creatively about ways to make effective use of the strengths and capabilities of FBOs in addressing some of the critical needs posed by the HIV epidemic. Donor organizations can also play a critical role in fostering collaboration between FBOs and public agencies by providing the funds to evaluate and sustain such partnerships.

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Any errors are, of course, the responsibility of the authors.

Abbreviations

AHSOVI	Asociación Hondureña de Solidaridad y Vida
ART	antiretroviral therapy
ARV	antiretroviral
CBO	community-based organization
CDC	Centers for Disease Control and Prevention
CRS	Catholic Relief Services
FBO	faith-based organization
FSW	female sex worker
FUNSAUD	Fundación Mexicana Para La Salud (Mexican Health Foundation)
HOLA	HIV Outreach in Latin America
MoH	Ministry of Health
MSM	men who have sex with men
NAC	National AIDS Commission (Belize)
NGO	nongovernmental organization
PAHO	Pan American Health Organization
PEPFAR	President's Emergency Plan for AIDS Relief
PLWH	people living with HIV
PMTCT	prevention of mother-to-child transmission
RCB	religious coordinating body

UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
VCT	voluntary counseling and testing
WHO	World Health Organization

Introduction

HIV/AIDS in Latin America has been called “the overlooked epidemic,” because it has been overshadowed by epidemics of larger scale and severity in sub-Saharan Africa and Asia. The number of people living with HIV (PLWH) in Latin America reached 1.7 million by the end of 2007 (UNAIDS, 2008a). The World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS project (UNAIDS) estimated that the epidemic will increase to 3.5 million by 2015 unless a scale-up in prevention occurs. Although AIDS accounts for a relatively small fraction of all adult deaths in most Latin American countries, the economic effects can be large because AIDS strikes in the most productive years of life (Abreu, Noguer, and Cowgill, 2003). Addressing HIV in Latin America has been described as an opportunity to prevent epidemics as devastating as those of sub-Saharan Africa, and to apply lessons learned from Africa and Asia before it is too late (Snell, 1999).

Within Latin America, Central America has been recognized as the most vulnerable for the spread of HIV (Cohen, 2006b). Four of the six countries in Latin America with the highest HIV/AIDS adult prevalence (age 15–49) are in Central America (Belize, Honduras, Guatemala, and Panama). The small size of Central American countries makes the epidemic a serious threat to their populations and economies. HIV/AIDS has placed a significant economic burden on both governments and households in these countries. Nevertheless, government efforts to address the epidemic have fallen short of the levels

needed to provide effective prevention and widespread access to treatment (Izazola-Licea et al., 2002).

While Central America is characterized by diversity in its ethnicity, languages, cultures, and economies, one shared aspect of the three countries is a predominantly Christian population. Churches and other faith-based organizations (FBOs) have long been known to have an extensive reach and diverse presence in developing countries. Given the limitations in public health infrastructure and resources available to address the epidemic, and given that FBOs play an important role in providing health and social services in developing countries, it is natural to ask what kind of role FBOs currently play and might play in the future in addressing HIV/AIDS.

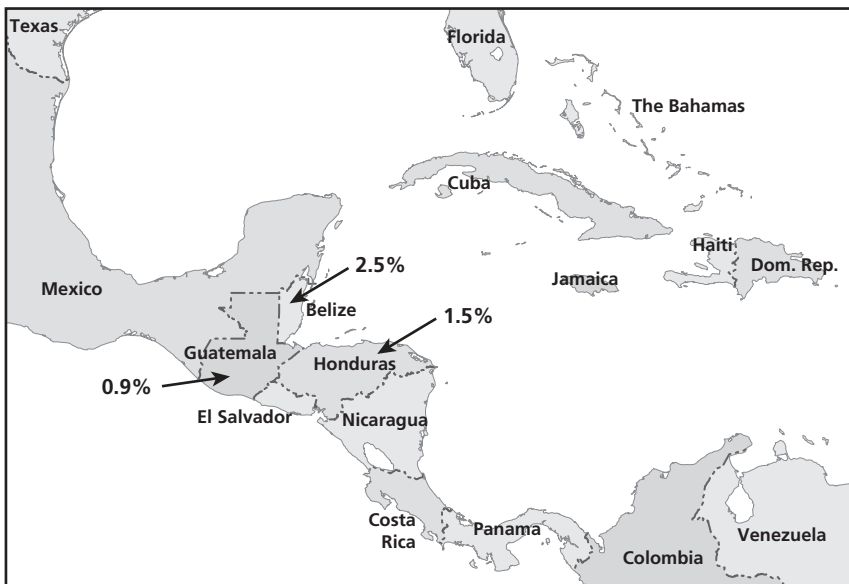
Local and international HIV/AIDS experts have agreed on the need for a multisectoral response to the epidemic (Schwartländer, Coutinho, and Loures, 2002; Henry J. Kaiser Family Foundation, 2007) and many have called specifically for the increased integration of FBOs in the fight against HIV/AIDS. For example, organizations such as the U.S. Agency for International Development (USAID), United Nations Population Fund (UNFPA), Population Services International, Family Health International, and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) program have stressed the extensive reach of FBOs, their experience in providing health and social services in developing countries, their strong influence on adherents and the community more generally, and the fact that religious leaders serve as gatekeepers to effective engagement with some communities.

At the same time, organizations such as the Global Fund and UNAIDS have also stressed that, while working with FBOs is important, partnerships and capacity-building are needed for FBOs to make a positive contribution, given the "moralizing" that has accompanied many of the early FBO responses to the epidemic (e.g., seeing HIV as divine punishment). Some organizations are further concerned that FBOs do not have much experience in being held accountable for their spending and documenting the impact of programs. These concerns suggest that there may be critical barriers to FBO involvement in addressing HIV/AIDS.

This study attempts to shed light on these issues by focusing on the current and potential future role of FBOs in HIV prevention and care in the three Central American countries that, at the time we initiated our study (2007), had the highest HIV prevalence: Belize with 2.5 percent prevalence, Honduras 1.5 percent, and Guatemala 0.9 percent (see Figure 1.1) (UNAIDS, 2007a, 2007b, 2007c). We examined the scope and impact of HIV/AIDS in each of the three countries, the range of services currently available (through public or private sources), HIV/AIDS activities in which FBOs have been engaged to date, and facilitators and barriers to FBO involvement, as perceived by a variety of stakeholders.

In the remainder of this introduction, we provide some background information on the three countries and the reasons they were chosen for this study, the scope of the study, and our approach, including the limitations of this study.

Figure 1.1
Overall Prevalence of HIV/AIDS in Belize, Guatemala, and Honduras, 2007



Background

The Three Countries: Guatemala, Honduras, and Belize

For several reasons, we chose to focus on the three countries of Guatemala, Honduras, and Belize. First, as noted above, these countries had the highest HIV prevalence in the region at the time we initiated the study.¹ Second, we wanted to focus our study at the country level so that we could get a clear picture of HIV/AIDS activities in each location, and these countries are small enough to allow us to interview most of the “key players” in each country (government, health care providers, nongovernmental organizations [NGOs], FBOs, etc.). Third, as a qualitative and exploratory study, we were most interested in examining the range of responses by FBOs, and although the three countries are contiguous, they are quite diverse in population, economics, and government policies, including the response to HIV/AIDS. This variation allowed us to examine the role of FBOs across a range of socioeconomic and policy contexts. Fourth, we knew from reviewing the literature and discussions with key informants that FBOs had been involved in HIV/AIDS in all three countries. Further, like other countries in Latin America, the population of each country is predominantly Christian, ranging from about 91 percent in Belize to roughly 97 percent in Guatemala and Honduras (World Christian Database, 2005). Thus, exploring what kind of roles FBOs have played in HIV could be informative for future efforts across a range of contexts found in Latin America.

Currently, little is known about the role of FBOs with respect to HIV in Central and Latin America. To date, research on the role of FBOs in the fight against HIV/AIDS has focused mainly on Africa (Tiendrebeogo and Buykx, 2004; Foster, 2004; Agadjanian and Sen; 2007, Bazant and Boulay; 2007, Hartwig, Kissioki, and Hartwig, 2006; Otolok-Tanga et al., 2007). A few studies have focused on selected countries from other regions (Nussbaum, 2005; Woldehanna, Ringheim, and Murphy, 2005), or one country in the Caribbean (Muturi,

¹ As explained in Chapter Two, these figures were later revised downward due to a revised approach to estimating prevalence worldwide. However, the three countries continued to have among the highest prevalence in Central America and Latin America as a whole.

2008; Genrich and Brathwaite, 2005). In general, these studies indicate that, in the regions studied, care and support activities are considered traditional strengths of FBOs (particularly Christian FBOs), while HIV prevention efforts have been highly contested within religious circles, often disrupting collaborative efforts (Parker and Bird-sall, 2005; Tiendrebeogo and Buykx, 2004; Woldehanna, Ringheim, and Murphy, 2005). After reviewing reports and descriptive materials on FBO activities related to HIV/AIDS in Africa, Tiendrebeogo and Buykx (2004) noted that “the interwoven issues of religious doctrines, ethics, morality, and the official positions of religious hierarchies, when juxtaposed with issues of sexuality, gender, and HIV/AIDS can be quite incompatible” (Tiendrebeogo and Buykx, 2004).

Scope of This Study

To understand the current and potential roles of FBOs in HIV prevention and care in Belize, Guatemala, and Honduras, we explored the following questions:

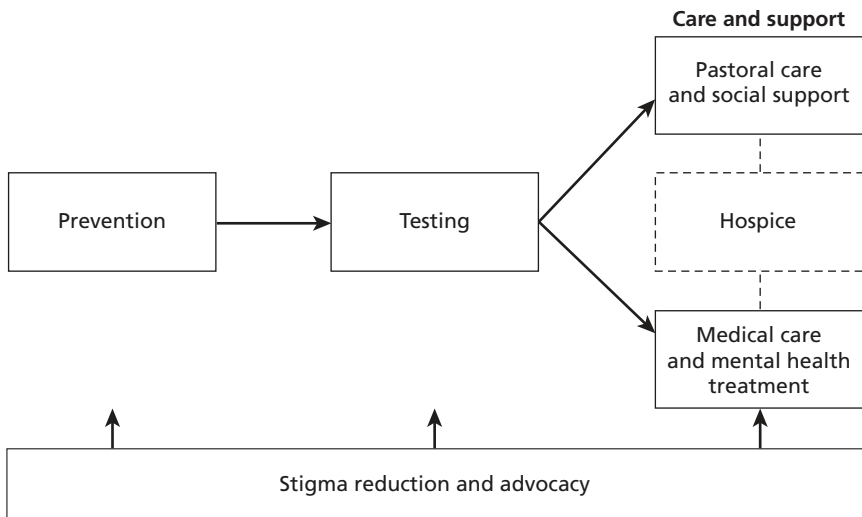
1. What is the need for HIV/AIDS services in each of the countries? Who is most affected by the HIV/AIDS epidemic and what services are currently available, either from public or private sources? (Chapter Two)
2. How have FBOs been involved in HIV/AIDS—e.g., what is the range of activities in which they have engaged and how has this varied over time and/or across different countries and types of FBOs? (Chapter Three)
3. What are the facilitators and barriers to FBO involvement in HIV/AIDS? (Chapter Four)
4. Given what is known about the epidemic and past FBO involvement, what are the most important roles for FBOs? What can make FBOs more effective in the fight against HIV/AIDS? (Chapter Five)

Framework

In examining the scope of current HIV/AIDS activities and considering how FBOs are already involved and might be involved in the future, we use the framework shown in Figure 1.2. The figure divides HIV/AIDS activities into several phases, which correspond to an individual's position on the continuum of HIV/AIDS care: Prevention, Testing, and Care and Support Services (the latter of which is divided into pastoral care and social support, hospice care, and medical care and mental health treatment). Another category of activities, Stigma Reduction and Advocacy, spans all the phases, suggesting that activities in this area can influence individuals' utilization of the range of prevention, testing, and care and support services.

We acknowledge that some HIV/AIDS activities address multiple phases of HIV/AIDS care. Nonetheless, in this report we discuss FBO activities in relation to these phases in order to shed light on which phases of the continuum are and are not being adequately addressed.

Figure 1.2
Framework for Understanding the Range of FBO-Sponsored HIV/AIDS Activities



Approach

To answer our study questions, we conducted key informant and stakeholder interviews with health and FBO leaders who worked in at least one of the countries of interest, and we conducted site visits to FBO-sponsored HIV/AIDS clinics, hospices, programs, and other activities. Health leaders included representatives from government agencies (e.g., ministries of health, national AIDS programs and commissions), bilateral assistance agencies (e.g., UN-related), and local and international nongovernmental agencies (e.g., organizations of people with HIV) and health care providers. FBO leaders included clergy, lay leaders, and representatives of faith-based NGOs, some of whom were also health care providers. We also conducted an environmental scan of the literature (journal articles, published reports, and Internet websites) to supplement information gathered through the interviews, as well as to provide a context for our study.

Between March and July 2007, we conducted three separate site visits to each country, spending approximately nine days in each country to conduct the in-person interviews. We also conducted some key informant and stakeholder interviews via telephone (through December 2007). In all, we interviewed a total of 111 people representing various sectors—FBO, government, bilateral assistance agencies, health care providers, people living with HIV, and other NGOs.

As described in Table 1.1, we categorized individuals interviewed for this study according to their main profession or organizational affil-

Table 1.1
Our Interviewees

Health leaders	Persons working or affiliated with secular organizations Includes ministries of health, national AIDS programs or commissions, PLWH advocacy organizations, etc. Does not take into account any personal religious affiliation or leadership position these individuals might have
FBO leaders	Persons working or affiliated with FBOs Includes congregations, religious denominations, and interdenominational coordinating bodies; religiously affiliated hospices, clinics, and hospitals; religiously affiliated international relief or development organizations, etc. Does not take into account any formal health training or credentials that these individuals might have

iation, although we recognize that some individuals have both a health-related and a religious affiliation.

Following the practice established in an earlier study on the response of FBOs to orphans and vulnerable children (Foster, 2004), we involved a variety of FBOs in the study, including:

- Congregations and/or their clergy: a local grouping of believers (such as a church) that meets on a regular (usually weekly) basis
- Religious coordinating bodies (RCBs): intermediary organizations responsible for coordinating and supporting congregations
- Nongovernmental organizations: faith-based NGOs employ staff, receive external donor support, and are answerable to a broader group than a congregation or RCB
- Community-based organizations (CBOs): local groups differentiated from NGOs because they do not employ full-time staff.

Given the religious make-up of Central America, we distinguish among different denominational groupings, including Catholic, Evangelical, and Pentecostal, as well as Historic or Mainline Protestant denominations.

Table 1.2 provides information about the number of individuals interviewed for each organizational type and across the three countries. In some cases, group interviews were conducted, so the actual number

Table 1.2
Number of Persons Interviewed, by Organization Type and Country

Organization Type	Belize	Guatemala	Honduras	Total
Government and bilateral assistance	3	11	9	23
NGOs	6	10	6	22
Catholic	1	5	11 ^a	17
Evangelical	2	7	23 ^a	32
Mainline Protestant/ Ecumenical	7	1	9	17
Total	19	34	58 ^a	111

^a The higher numbers among Catholic and Evangelical groups in Honduras are due to the fact that several of our key contacts organized group interviews (involving partners, program participants, etc.) for us to get broader perspectives.

of interviews was smaller (24 for Honduras, 24 for Guatemala, and 16 for Belize, or a total of 64 interviews involving 111 people). More details on our methods (sampling strategy, analysis, etc.) are contained in the appendix.

Limitations of the Study

Our study has several limitations. First, we used a qualitative study design, which provides rich data and specific examples pertaining to the issues we were exploring. However, as is true with most qualitative study designs, we did not try to obtain a statistically representative sample of the population but instead used a purposive sampling design, where we selected a range of stakeholders to represent different sectors. This method does not allow for a generalizable and quantifiable description of how frequently FBOs engage in particular HIV/AIDS activities and encounter particular facilitators or barriers to these activities. Rather, the results contribute toward establishing the range of ways that FBOs address HIV/AIDS and the range of facilitators and barriers to these activities, which can inform future studies. Furthermore, while every attempt was made to interview representatives from various sectors (FBO, health care providers, government, international, local NGOs, including PLWH), it is possible that some perspectives were systematically absent from the results if those who were not interviewed tended to hold shared beliefs or attitudes about FBOs and HIV/AIDS activities. Finally, by choosing Belize, Guatemala, and Honduras, we examined AIDS epidemics that either are still concentrated, or until recently have been concentrated, in contrast to areas of sub-Saharan African, where HIV is more generalized (i.e., spread to the general population), and we limit our examination to Christian-based FBOs (given that the overwhelming majority of FBOs in these countries are Christian). Our study cannot inform how organizational and philosophical structures of other faith communities, such as Muslims, Buddhists, Hindus, or Jews, might influence their abilities to adapt to the epidemic in their own regions. Despite these limitations, this research, as the first multicountry study of FBO involvement in HIV/

AIDS in Central America, can inform funders, policymakers, and health and FBO leaders who are interested in the role that FBOs can play in the fight against HIV/AIDS.

Background and Overview of the Region

To fully understand the role that FBOs currently play in addressing HIV/AIDS, and the role they might play in the future, it is important to appreciate first the scope of needed services for HIV/AIDS prevention and care. This chapter draws on published reports to provide a brief overview of the contexts regarding HIV epidemiology and HIV services in Belize, Honduras, and Guatemala. Epidemiologically, we focus on who is affected by HIV/AIDS and describe the scope and distribution of HIV/AIDS in these countries. Organizationally, we consider what HIV/AIDS services (including prevention and treatment) are provided in each country and what policies are in place regarding HIV/AIDS.

Who Is Affected by HIV and AIDS?

Demographic and epidemiologic data provide a picture of the populations in the three countries and of those most affected by HIV/AIDS. We first highlight overall population indicators, then examine HIV/AIDS-specific indicators within each country, and finally discuss those populations that are considered most vulnerable to HIV/AIDS. Understanding which age groups and populations are affected can help us understand what kinds of services are most needed, and thus can point to some ways in which FBOs might be involved. Further, these data can help identify which populations are most in need of services, which can help determine to what extent FBOs are well positioned to address the epidemic.

Overall Population Indicators

Though total population varies, all three countries have young and growing populations. As shown in Table 2.1, total population varies greatly among the three countries, with Guatemala (~13 million) nearly twice the size of Honduras (~7 million) and Belize much, much smaller (under 300,000). Approximately half of the populations of Belize, Guatemala, and Honduras fall into the 15–49 age group, the group most affected by HIV. The three countries also have the three highest population growth rates in all of Latin America and the Caribbean (data not shown).

The countries vary along racial and ethnic lines. Belize is the most heterogeneous, with 49 percent mestizo or ladino (mixed indigenous and European ancestry), 25 percent Creole (mixed African-European ancestry) 11 percent indigenous, 6 percent Garífuna or of African ancestry, and 9 percent other ethnicities (East Indian, white, Chinese, etc.). The Garífuna are descendants of African slaves who have lived in Latin America for over 200 years. Guatemala has two principal ethnicities—about 59 percent mestizo or ladino, 40 percent indigenous, and a very small percentage (<1) of Garífuna or other blacks, and other ethnicities. Honduras has the highest proportion of mestizos, at 93 percent, with indigenous groups representing 6 percent and Garífuna or other blacks about 1 percent.

A high percentage of people in the region are disadvantaged. In Honduras, 69 percent of the population is living in poverty, and 25 percent of people age 15 and older are illiterate; in Guatemala, 55 percent live in poverty, and 32 percent are illiterate; and in Belize, 25 percent live in poverty, and 7 percent are illiterate. Similar proportions of the population in all three countries are living in urban areas (48–50 percent).

Prevalence and Mortality from HIV/AIDS in the Three Countries

Epidemiologic data provide a broad overview of who is affected by HIV/AIDS in the three countries. However, we must note that our understanding of the scope of HIV and AIDS in Belize, Guatemala, and Honduras is constrained to some degree due to a lack of consistent data. HIV surveillance in the three countries does not provide suffi-

Table 2.1
Country Demographics and Socioeconomic Indicators

Indicator	Belize	Guatemala	Honduras
Total population	294,000	13,677,000	7,322,000
Population age 15–49 (%)	53	47	51
Race/ethnicity (%)			
Mestizo/Ladino	49	59	93
Indigenous	11	40	6
Creole (African-European)	25	n/a	n/a
Garifuna/Black/African	6	<1	1
Other	9	<1	
Urban (%)	50	50	48
Living in poverty ^a (%)	25	55	69
Illiteracy among those age 15+ ^b (%)	7	32	25

SOURCES: CEPAL, 2008 (for total population and percentages of population age 15–49, urban, living in poverty, and illiterate); Central Statistical Office, 2000 (for race/ethnicity); Censos Nacionales XI de Población y VI de Habitación, Guatemala, 2002 (Guatemala); González, 2006.

^a The Belize poverty figure is from the Pan American Health Organization's (PAHO's) *Health in the Americas 2007* (data on the percentage living in poverty were unavailable for the 2000 Belize Census). Percent poverty indicators are reported from 2006 for Guatemala and from 2007 for Honduras. According to the *Statistical Yearbook*, poverty is defined as the percentage of people whose income is less than double the cost of a "basic food basket" (CEPAL, 2008).

^b Percent urban is calculated by dividing the number of people in urban areas, divided by the total population. Definitions of "urban" vary by country. According to the UN's *Demographic Yearbook* (2007), in Guatemala, urban areas are "Municipality of Guatemala Department[s] and officially recognized centers of other departments and municipalities," whereas in Honduras urban areas constitute "localities of 2,000 or more inhabitants, having essentially urban characteristics"; definition for Belize not found.

cient coverage and tends to underdiagnose and underreport the number of cases (World Bank, 2003) (UNAIDS and WHO, 2007). Data on vulnerable populations, such as men who have sex with men (MSM), female sex workers (FSWs), and ethnic groups, are scant throughout the region. Further, testing has not been widely available, and an estimated 70 percent of all HIV-positive cases are diagnosed only after symptoms occur (World Bank, 2003). Nevertheless, examining overall trends with available data can be informative for understanding what role, if any, FBOs can and have played in addressing HIV/AIDS in the region.

The relatively high prevalence rates of HIV/AIDS in the three countries pose serious challenges. Table 2.2 provides 2007 estimates of HIV prevalence rates and numbers of PLWH and AIDS deaths across the three countries. Estimated adult (age 15–49) prevalence rates were 2.5 percent in Belize, 1.5 percent in Honduras, and 0.9 per-

Table 2.2
HIV/AIDS Prevalence, Cases, and Mortality

	Belize	Guatemala	Honduras
HIV Prevalence			
Overall prevalence (age 15–49) [range]	2.5% [1.4–4.0]	0.9% [0.5–2.7]	1.5% [0.8–2.4]
MSM prevalence	n/a	12.1%	12.4%
FSW prevalence	n/a	4.3%	9.6%
Garífuna prevalence	8–14%	n/a	8–14%
HIV/AIDS Cases and Mortality			
Number of persons over age 15 living with HIV [range]	3,700 [2,000–5,700]	61,000 [37,000–100,000]	63,000 [35,000–99,000]
Number of AIDS deaths [range]	<500 [<1,000]	2700 [1,600–4,000]	3700 [2,000–6,200]
Ratio of male to female AIDS cases	1:1	2:1	1:1

SOURCES: UNAIDS, 2007a, 2007b, 2007c; PAHO, 2007a, 2007b, 2007d; PAHO Family Community Health Country Offices, 2005; Soto et al., 2007 (data collection 2001–2002); and WHO, 2005a, 2005b, 2005c.

cent in Guatemala. When the study began in 2007, these were among the highest rates of HIV/AIDS in Latin America. However, we should note that in 2008, estimates of adult (15–49 years) HIV prevalence, and therefore the numbers of PLWH, were revised downward in many countries in the world, including those in our study (to 2.1 percent in Belize [WHO, UNAIDS, and UNICEF, 2008a], 0.8 percent in Guatemala [WHO, UNAIDS, and UNICEF, 2008b], and 0.7 percent in Honduras [WHO, UNAIDS, and UNICEF, 2008c]). According to UNAIDS and WHO, these downward revisions resulted from better data, particularly on the prevalence among specific subpopulations, and revised assumptions in the light of those better data (Ghys et al., 2008). Nevertheless, given that Honduras's prevalence rate was halved (from 1.5 percent to 0.7 percent), a fair amount of confusion regarding the absolute prevalence remains.¹ In addition, even with the downward revisions in HIV prevalence estimates, these three countries continue to have among the highest prevalence in Latin America and to thus experience real challenges as a result.

The overwhelming majority of infections (~94 percent) are transmitted sexually (PAHO, 2007d; UNAIDS, 2008b). Most of these cases are reportedly transmitted through heterosexual sex, though underreporting of same-sex relations among men is likely. According to survey data covering 1983–2000, approximately 72 percent of reported AIDS cases in Central America were due to heterosexual sex, 13 percent to sex between men, 5 percent mother to child, 3 percent other means, 5 percent unknown means, 1 percent injection drug use, and 1 percent contaminated blood products (Abreu, Noguera, and Cowgill, 2003). Data on transmission for individual countries are limited.

HIV/AIDS is having a significant impact on young adults in all three countries and poses a serious threat for loss of human capital and the workforce. In Belize, HIV/AIDS is the third leading cause of death (and the only leading cause due to preventable illness) for the 20–29 year old age group and the first leading cause in those

¹ For example, as of December 2009, the Centers for Disease Control and Prevention (CDC), as part of its Global AIDS Program, continues to report the 1.5 percent adult (age 15–49) HIV prevalence rate for Honduras (CDC, 2008).

30–39 and 40–49 (National AIDS Commission of Belize [NAC], 2007). In 2004, more than 80 percent of new HIV infections in Belize occurred in the 15–49 age group, and 22 percent of these were in the 15–24 age group (NAC, 2007).

In Honduras and Guatemala, the estimated numbers of PLWH and reported AIDS deaths tend to affect a slightly older age group than in Belize; nonetheless, the greatest number of cases are found among those age 25–29 and 30–34 (Arandi, 2008, PAHO, 2007d). For example, in Guatemala, 83.2 percent of AIDS cases are found among people age 15–49, and 52.1 percent of AIDS cases affect those age 20–34 (PAHO, 2007b). HIV/AIDS was the sixth leading cause of death for males age 25–44 (PAHO, 2007b). In Honduras, HIV/AIDS was the sixth leading cause of death for the overall population (PAHO, 2007d). Additionally, AIDS was the leading cause of death among Honduran women of childbearing age and the second-leading cause of hospitalization among both men and women (USAID, 2005).

The number of deaths due to HIV/AIDS has likely been underreported. In Belize, some clinicians may not report HIV/AIDS on death certificates in order to protect individuals and families from stigma and discrimination (PAHO, 2007a). In Honduras, medical registries for causes of death are considered to be poor, and the only national profiles are based on mortality registries from the Ministry of Health and Social Security Institute hospitals, which represent only 20 percent of all deaths in Honduras (PAHO, 2007d). In Guatemala, only 64 percent of deaths in 2003 were certified by physicians, suggesting that AIDS may not always be accounted for as a cause of death (PAHO, 2007b). Since HIV in these countries tends disproportionately to affect the poor, who have less access to health services in general, it is likely that persons who die of AIDS-related causes are more likely to die outside of health care settings and therefore AIDS is underreported as a cause of death.

Vulnerable Populations

Understanding which populations are most vulnerable to HIV/AIDS has important implications for FBO involvement. Overall, those considered vulnerable to HIV/AIDS in the three countries include MSM,

FSWs, and the Garífuna peoples.² Prisoners are another vulnerable group. There are also recent trends that may be pointing to increasing risk among women in general.

As shown in Table 2.2, high HIV prevalence has been found among MSM in both Honduras and Guatemala. The prevalence rates in these countries are 12.4 percent and 12.1 percent, respectively, rates that are 8–13 times higher than overall prevalence rates for those age 15–49 (Soto et al., 2007; UNAIDS and WHO, 2007). In Honduras, the Ministry of Health has indicated that there is evidence of declining prevalence and increasing consistent condom use among MSM (Secretaria de Salud de Honduras, 2007a as cited by UNAIDS [2007]). We were unable to obtain any estimates on HIV prevalence among MSM in Belize, as it has been noted that various attempts to obtain baseline data on MSM in that country have failed because of the fear that results from still existent stigma and discrimination against this population (NAC and UNAIDS, 2008)

The highest levels of HIV seropositivity among female sex workers in Central America have been found in Honduras (9.6 percent) and Guatemala (4.3 percent). This compares with 3 percent in El Salvador and 0.2 percent in Nicaragua and Panama (Soto et al., 2007). One suggested reason for the high prevalence among FSWs in Honduras is that there was a large increase in sex work (and unprotected sex) to service the large U.S. military presence in Honduras that developed during the Cold War in response to civil wars in neighboring Guatemala and Nicaragua (UNAIDS and WHO, 2007). Recent studies conducted by the Honduran Ministry of Health show that HIV prevalence among FSWs in the major cities of Tegucigalpa, San Pedro Sula, and La Ceiba has in fact dramatically decreased, and consistent condom use during the previous 30 days was high in all three cities (>80 percent in Tegucigalpa and San Pedro Sula,

² The quality of the data available on vulnerable groups across the three countries varies greatly, with surveillance of vulnerable populations in Belize particularly limited. Surveillance of MSM and FSWs in Guatemala and Honduras has been done through the *Estudio Multicéntrico* (the Multi-site Study), a cross-sectional study involving 2,466 FSWs and 1,418 MSM recruited in 2001–2002 across five Central American countries (El Salvador, Guatemala, Honduras, Nicaragua, and Panama) (Soto et al., 2007).

98 percent in La Ceiba with paying clients, 87 percent or more with non-regular partners) (Secretaria de Salud de Honduras [2007b], as cited by UNAIDS [2007]). These findings suggest that condom promotion and prevention efforts have been successful. We were unable to obtain HIV prevalence estimates for FSWs in Belize, and none of the three countries report HIV prevalence for other types of sex workers (e.g., transgender).

Already marginalized from the majority of the population, Garífuna communities in Belize and Honduras have also been hard hit by the HIV/AIDS epidemic. Prevalence is estimated to be as high as 14 percent among Garífuna communities in Belize, which are located predominantly in the southern portion of the country. In Honduras, prevalence among the Garífuna peoples of the northern coast and islands is estimated between 8 and 14 percent (WHO, 2005c), an increase from the 6.8–8.0 percent estimated in 2002 and 2003 by UNAIDS and WHO (Stansbury and Sierra, 2004). In Honduras, many young Garífuna men are compelled to leave their communities for work (principally in fishing villages, aboard merchant ships, or in the United States), and this is undoubtedly a contributing factor to the epidemic, as their status as “economically peripheralized workers” and members of an ethnic minority puts them at increased risk for infection (Stansbury and Sierra, 2004). Further, although a substantial portion of Garífuna women (60 percent) and men (70 percent) affirm that using condoms is a way to avoid HIV/AIDS, condom use appears to be low due to personal preferences (e.g., believing condoms are unpleasant and uncomfortable, or that fidelity is better) (Stansbury and Sierra, 2004).

Prisoners are another vulnerable group in the region. A study conducted by the Belize Ministry of Health in 2005 found an overall HIV seroprevalence of 4.6 percent among the country’s prisoners, and study authors suggested that HIV was likely contracted through male-male sex prior to incarceration, although underreporting of sexual behaviors in prison was likely (Gough, 2005). HIV prevalence among prison populations in Honduras has been estimated to be 7.6 percent (Cohen, 2006a). Data were not available on HIV prevalence among Guatemalan prison populations.

Women represent a growing proportion of HIV/AIDS cases in Latin America, although the implications of this trend are unclear. The percentage of females with AIDS grew from 6 percent of all AIDS cases in 1994 to 31 percent in 2005. In Honduras and Belize, the male-female ratio of HIV/AIDS has shifted from 2:1 to 1:1 in the past decade (PAHO, 2007d, Gough, 2005). Estimates vary in Guatemala, but do not clearly point to an increase among women. According to an October 2007 estimate from the National Epidemiological Center in Guatemala, as reported in United Nations General Assembly Special Session on HIV/AIDS (UNGASS) (2008), nearly 70 percent of the AIDS cases were male and 30 percent female, and the male-female ratio has remained around 2.3:1 since 1994 (Arandi, 2008). However, other reports state that the male-female ratio has been decreasing drastically: for example, a 2007 Pan American Health Organization (PAHO) report stated that the ratio went from 8:1 in 1988 to 2:1 in 2006, dropping sharply beginning in the year 1997 (PAHO, 2007b).³

The growing proportion of HIV/AIDS cases among women may simply reflect the natural epidemiological spread over time from higher-risk to lower-risk portions of a population. However, taboos related to sexuality could also be influencing women's vulnerability, as traditional gender hierarchies allow promiscuity among men while discouraging women's ability to negotiate condom use. Further, the increase in the number of cases of HIV infection parallels an increase in violence against women and also undermines HIV prevention efforts among women (WHO, PAHO, and UNAIDS, 2006b).

In sum, epidemiological trends suggest that groups particularly vulnerable to HIV in the three countries include MSM, FSWs, the Garífuna, prisoners, and, potentially, women. Better understanding who is affected by HIV/AIDS helps provide a context for FBO involvement and can elucidate the extent to which FBOs are linked to populations in need.

³ The PAHO report actually says that the ratio went from 8:1 in 1988 to 2:4 in 2005, but we determined that 2:4 is a typo and verified from the PAHO website that their estimated male-female ratio in Guatemala was 4:1 in 2005 and 2:1 in 2006.

What Health Care Services Are Available to Prevent and Treat HIV/AIDS?

An examination of the availability and accessibility of HIV/AIDS services can help identify where unmet need exists, and consequently, where FBOs could have a role in potentially filling gaps. We begin by describing HIV/AIDS prevention, then treatment efforts, and finally HIV/AIDS policies, national strategic plans, and additional legislation regarding HIV.

HIV/AIDS Prevention Efforts

The three countries have made a number of HIV/AIDS prevention efforts, although these have emerged on a formal basis only after the scale-up in treatment. According a 2003 study conducted by SIDALAC, a regional AIDS initiative carried out by the Mexican Health Foundation (FUNSALUD), most countries in Latin America spend less than 30 percent of their HIV/AIDS budget on prevention; the bulk of spending is on antiretrovirals (ARVs) (World Bank, 2003). Prevention activities include education about sexual transmission and HIV/AIDS prevention, condom distribution and instruction, and voluntary counseling and testing for HIV. In Belize, the Ministry of Education has been particularly involved in prevention efforts through its National Policy on Health and Family Life. Curricula and training guides emphasizing HIV/AIDS prevention were finalized in 2005 and piloted in 12 primary and secondary schools in 6 districts in Belize (PAHO, 2007a). The Belizean Ministry of Education also supports an annual training for teachers on HIV/AIDS (WHO, PAHO, and UNAIDS, 2006a). Prevention has also been a focus of the public sector in Honduras, particularly in education and communication activities (Izazola-Licea et al., 2002). The Guatemalan government spends only about 15–25 percent of its HIV/AIDS expenditures on prevention (about half of which is dedicated to condom distribution) and instead promotes private sector involvement in prevention (USAID, 2005, Programa Nacional de Prevención y Control de ITS, 2005).

Table 2.3 provides some indicators of national prevention efforts across the three countries, according to each country's UNGASS

Table 2.3
National HIV Prevention Program Indicators

Prevention Program Indicator	Belize	Guatemala	Honduras
Percentage of donated blood units screened for HIV in a quality-assured manner	100%	100%	46%
Percentage of HIV-positive women who received ARVs to reduce mother-to-child transmission	78%	16%	21%
Percentage of most-at-risk populations reached with HIV prevention programs			
FSWs	Not available	92–93%	23%
MSM	Not available	73–79%	24%
Garifuna	Not available	Not applicable	58%
Percentage of schools that provided life skills-based HIV education in last academic year			
Primary schools	Not available	<1%	21%
Secondary (high) schools	Not available	32%	18%

SOURCES: NAC and UNAIDS, 2008; Arandi, 2008; UNAIDS, 2008b.

reports for the period January 2006–December 2007. It is important to note that these are self-reported data, usually based on local survey efforts.

Prevention of mother-to-child transmission (PMTCT) programs were among the first types of prevention programs implemented in all three countries and have been a consistent priority; however, actual coverage of HIV-positive women ranges widely. Approximately 5 percent of HIV infections are due to mother-to-child transmission. One of Belize's first HIV/AIDS developments was to develop guidelines for clinical management of PMTCT in 2001. Between 2003 and 2005, PMTCT programs were implemented and are now offered in all public health care centers and four private facilities (WHO, PAHO, and UNAIDS, 2006a; PAHO, 2007a). As Table 2.3 shows, 78 percent of HIV-positive women in Belize now receive antiretroviral (ARV) prophylaxis for PMTCT (NAC and UNAIDS, 2008). In Honduras, PMTCT protocols have existed since 2004; however, only 21 percent of HIV-positive women there received ARV

prophylaxis for PMTCT (UNAIDS, 2008b). In Guatemala, protocols have existed since 2002; however, even a smaller percentage of HIV-positive women in Guatemala (16 percent) are estimated to have received ARV prophylaxis for PMTCT (Arandi, 2008).

Also of note in Table 2.3 is that the percentage of donated blood units screened for HIV in a manner that meets quality standards is reportedly high in Belize and Guatemala (100 percent each) but quite low in Honduras (46 percent). Guatemala reports reaching large portions of high-risk groups with prevention programs (73–79 percent of MSM and 92–93 percent of FSWs), whereas Honduras reports much lower reach (24 percent of MSM, 23 percent of FSWs, and 58 percent of the Garífuna). Life-skills-based HIV education is taught at 21 percent and 18 percent of Honduran secondary and primary schools, respectively, and 32 percent of secondary schools and <1 percent of primary schools in Guatemala. Belize does not report data on most-at-risk groups or on school-based HIV education efforts.

HIV/AIDS Treatment

Throughout Central America, HIV/AIDS care is not widely available in the health system, and furthermore, hospitals and health care personnel with experience in HIV exist mainly in capital and major cities (Wheeler et al., 2001; PAHO, 2007c). Integration of services into primary care is also limited. Health care related to HIV/AIDS is highly centralized in Guatemala and Belize and to some degree in Honduras. For example, one clinic in Guatemala City does 60 percent of all HIV tests in Guatemala and has found that people who live farther from the clinic are less likely to return for their results (only 60 percent of those tested returned) (Samayoa et al., 2003; World Bank, 2003). In Honduras, an estimated 1.54 percent of all health facilities have the capacity to deliver appropriate care to people living with HIV and AIDS (UNGASS, 2005). HIV testing in Belize is done almost exclusively by the Ministry of Health–sponsored Voluntary Counseling and Testing (VCT) centers, and testing as well as clinical services for HIV remain highly centralized and concentrated in Belize District (NAC, 2007).

ARV coverage in Belize, Honduras, and Guatemala is much lower than in Latin America as a whole. Although overall ARV coverage is currently estimated to be 72 percent in Latin America (the highest coverage rate in the developing world), coverage in Belize, Honduras, and Guatemala is much lower (WHO, UNAIDS, and UNICEF, 2007). Table 2.4 provides information on ARV coverage. An estimated 37 percent of people needing ARVs in Guatemala are receiving them, compared with 47 percent and 49 percent of people needing them in Honduras and Belize, respectively (WHO, UNAIDS, and UNICEF, 2008a, 2008b, 2008c).

In the three countries in our study, access to full antiretroviral therapy (ART) began to grow rapidly from 2002 to 2004 (USAID, Bureau for Global Health, 2004). About 90 percent of ARV coverage comes from the public sector in Honduras, and this is true to a lesser extent in Guatemala, where over 60 percent of the government's HIV/AIDS expenditures are allocated toward ARVs (USAID, 2005; Programa Nacional de Prevención y Control de ITS, 2005).

As recently as 2000, no Central American country except Panama offered ARVs through its Ministry of Health. ARVs were only available to the general population through purchase from private pharmacies. At that time, of the three countries included in our study, only Guatemala offered some coverage to the general HIV-infected population through its social security system and covered perinatal trans-

Table 2.4
ARV Coverage

	Belize	Guatemala	Honduras
Number of people receiving ARVs [range]	600 [500–600]	7,800 [7,400–8,200]	5,600 [5,000–6,100]
Number of people needing ARVs [range]	1,100 [740–1,700]	21,000 [15,000–28,000]	12,000 [7,900–19,000]
ARV coverage [range]	49% [32–76%]	37% [28–51%]	47% [29–71%]
Reported number of sites that provide ARVs	8	6	22

SOURCES: WHO, UNAIDS, and UNICEF, 2008a, 2008b, 2008c.

mission through the Ministry of Health and Social Security (Wheeler et al., 2001).

The year 2003 is regarded as the milestone for expanded ARV coverage in Central American countries. Two important factors contributed to drug coverage expansion around this year: (1) negotiations to reduce drug prices as part of various regional purchasing efforts, such as the Accelerating Access Initiative (through regional meetings of the Council of Ministers of Health of Central America), agreements between the Caribbean Community (CARICOM) and six pharmaceutical companies, and PAHO/WHO's Regional Strategic Fund for Medical Supplies; and (2) the disbursement of the first round of Global Fund grants in Honduras in 2003 and in Guatemala and Belize in 2004.

Although ARV coverage has been prioritized in the region since 2003, policies do not explicitly address the need to sustain long-term ARV coverage. Honduras has offered free ARV medications, voluntary counseling and testing, and services to prevent mother-to-child-transmission since 2002, yet it does not yet have an official policy or strategic plan to sustain ARV coverage. Belize also does not have national policies on comprehensive ART or testing for HIV, but the Ministry of Health began providing ART free of charge in December 2004. Treatment guidelines were adapted from PAHO standards for Belize. Guatemala adopted PAHO and CDC standards for the clinical management of HIV. Across all three countries, procurement of drugs and access to treatment are fairly centralized, and access to treatment is far more accessible in capital cities (WHO, 2005a, 2005b, 2005c; PAHO, 2007a, 2007b, 2007d).

HIV/AIDS-Related Policies

Each of the three countries has established national-level policy on HIV/AIDS, including national strategic plans and other legislation. At the same time, the governments of the countries have recognized the need for a multisectoral plan to address HIV/AIDS, and this is most often where the role of FBOs have been included.

The national strategic plans seek to coordinate national responses from all sectors to HIV/AIDS. Honduras's second national strategic plan (PENSIDA II), developed for 2003–2007, was broadened to include PLWH, civil society, chambers of commerce, and the religious community. The most recent national strategic plan for Belize (2006–2011) aims to support a multisectoral approach to HIV/AIDS, including the health sector and organizations both within and outside government. The plan was developed with input from many governmental and nongovernmental agencies, community groups, labor and professional associations, private sector representatives, media representatives, donors, technical partners, and PLWH (NAC, 2007). Guatemala's most recent strategic plan, launched in May 2006, has adopted the United Nations Millennium Development Goals (United Nations, 2008), which include a goal to combat HIV/AIDS. This could allow AIDS to be linked to other problems affecting the country, such as maternal and infant mortality, and childhood malnutrition, and could make it easier to receive aid that would otherwise not be available for HIV/AIDS-related programs.

Additional legislation in each country supplements the national strategic plan. In Guatemala, an HIV/AIDS Act was adopted in 2000 to establish a legal framework for the implementation of HIV/AIDS education, prevention, epidemiological surveillance, research, treatment, and follow-up and to protect and defend the human rights of PLWH. National legislation in Honduras also includes a Special HIV/AIDS Act, which was enacted in 1999. It established HIV/AIDS as a national priority, identified coordinating mechanisms to respond to the epidemic, and defined the rights and obligations of PLWH. In Belize, a National Policy on HIV/AIDS that adopts a human rights and responsibilities perspective was approved by Cabinet in December 2005.

Legislation protecting the rights of PLWH in workplaces, health care, education, and other arenas has been passed but may have limited effects. HIV/AIDS legislation addressing the human rights of PLWH has been passed in Honduras and Guatemala, and the National AIDS Commission (NAC) of Belize has been working on legislation addressing stigma and discrimination. The Special HIV/AIDS

Act in Honduras prohibits the discrimination of PLWH in receiving health services, receiving education, or making hiring or firing decisions. Guatemala passed a similar Special Law in 2000 that protects PLWH from discrimination, violations of confidentiality, autonomy, privacy, work, access to health care, and education.

However, workplace rights for PLWH are not clearly defined. Compulsory testing is prohibited by law in Honduras and Guatemala; however, the Guatemalan labor code allows employers to request HIV testing at hiring, suggesting contradictory legislation (World Bank, 2006). Laws in both Honduras and Guatemala require mandatory partner notification of HIV-positive test results. In 2005 the Belizean government adopted a workplace policy with a stated “human rights and responsibilities perspective.” Nevertheless, protection of PLWH’s rights through workplace policies may have limited reach, given the large percentage of the populations employed through the informal sector in Central America (and thereby not generally covered by workplace policies); for example, 71 percent of Guatemalans are employed through the informal sector (PAHO, 2007b). Furthermore, discrimination has been frequently documented (World Bank, 2006; PAHO, 2007b).

Conclusion

In this chapter, we saw that across the three countries, HIV is affecting mostly young adults, MSM, and sex workers. In Honduras and Belize, the Garífuna peoples are greatly affected. Women in general are a growing portion of the HIV-positive populations. These all raise the question, “To what extent are FBOs linked into these populations?”

In addition, data systems to track the epidemics are weak, and there is a great deal of underreporting both because of this and because of stigma. Further, in all three countries but especially Guatemala (the largest of the three) HIV services are very centralized, raising the question of whether FBOs could help extend services and diminish stigma because they often have “reach” in remote areas as trusted and influential community institutions.

Finally, in general across the three countries, governments emphasize treatment over prevention, but this emphasis has not necessarily resulted in plans for sustaining ARV coverage to everyone who needs it. In addition, although human rights legislation regarding HIV/AIDS has been passed in all three countries, discrimination still seems to be a problem. These findings suggest that FBOs, along with other NGOs, could help fill the gap in prevention and/or be involved in advocacy efforts to ensure that more resources are dedicated to prevention, to sustaining ARV coverage over time, and to enforcing legislations designed to protect the rights of PLWH.

Faith-Based Organizations' HIV/AIDS Activities

To understand how FBOs might best be engaged in addressing HIV/AIDS in Central America, we first examine what HIV/AIDS-related activities they are currently involved in, since that provides an initial indication of what they are able and willing to do. We examine those activities in this chapter, reporting results from our fieldwork in Belize, Guatemala, and Honduras. This fieldwork included qualitative interviews of a range of stakeholders, including FBO leaders, government officials, health care providers, people living with HIV, representatives of bilateral assistance agencies, and leaders from other NGOs, as well as site visits to FBO HIV-related programs.

We examined the range of activities that FBOs are engaged in around HIV/AIDS in the three countries utilizing the framework noted earlier: Prevention, Testing, Care and Support Services (which is divided into pastoral care and social support, hospice care, and medical care and mental health treatment), and Stigma Reduction and Advocacy. We found FBOs involved across all these categories of activities, with the majority related to providing care and support for PLWH.

Prevention and Testing

In Table 3.1, we summarize the types of prevention activities that FBOs are engaged in and provide examples of FBOs involved in such activities in the three study countries. Most of the activities listed in this table were initiated relatively recently. Prevention activities range from primary prevention education (e.g., providing education on risk, trans-

Table 3.1
Types of FBO Activities Related to HIV Prevention and Examples of FBOs Involved in Such Activities (2007)

Type of Activity	Belize	Guatemala	Honduras
Prevention education for children and youth	Anglican Church (schools) Cornerstone Foundation Seventh Day Adventist Church (church camp) Youth with a Mission	Compassion (schools) CRS/FUNDSIDA Juven Fami (abstinence pledges)	Unión Bíblica Confraternidad Evangélica CRS/Caritas (Proyecto Dignidad) Episcopal Church Inter-Religious Committee (UNFPA) Jóvenes en el Umbral de la Vida Mennonite Church (Proyecto MAMA) World Vision
Prevention education for high-risk populations		CRS/Proyecto Vida (sex workers, MSM)	AHSOVI Episcopal Church (Siempre Unidos) Samaritan's Purse (Garífuna Hope) TEAR Fund/AMIGA (Garífuna)
Prevention education for PLWH and families, self-care, condoms		CRS/Proyecto Vida	CRS/Caritas (Proyecto Dignidad) Episcopal Church (Siempre Unidos)
HIV testing	Claret Care		CRS/Caritas (Proyecto Dignidad) Samaritan's Purse (The Power of Knowing) Episcopal Church (Siempre Unidos) Evangelical Hospital

NOTE: AHSOVI = Asociación Hondureña de Solidaridad y Vida.

mission, and protective strategies) for the general population or high-risk groups, to secondary prevention education or positive prevention (education of PLWH and their families to encourage safe sex practices and self-care), to HIV testing. Prevention activities include education—i.e., providing information about HIV, how it is transmitted, and how it can be prevented—as well as provision of services or materials to help

people act on the information (e.g., providing condoms, HIV testing). The number of examples listed for each type of activity is meant to illustrate the relative frequency with which of the type of activity was mentioned during the interviews, and is not intended as an exhaustive list of all FBOs involved in such activities.

A majority of prevention activities focus on education. Children and youth are the primary targets of education efforts, but PLWH and their families also receive some attention. Some use formal curricula implemented through schools (e.g., Anglican Church of Belize) or community-based organizations (e.g., World Vision Honduras working with local congregations and other organizations), and some are less formal and take a broader community approach (e.g., the Expo Sida approach used by several FBOs in Honduras in which street theater, games, and other interactive methods are used to teach community youth about HIV). Still others provide prevention education to youth who attend other FBO activities (e.g., a church camp). FBOs that provide prevention education for PLWH and their families tend to connect with these groups through their clinical care or community-based support groups.

Very few FBOs direct their prevention education efforts toward high-risk, highly stigmatized populations, such as MSM or commercial sex workers. FBOs that do work with MSM and sex workers tend to be those that provide clinical services to PLWH, perhaps sensitizing them to the needs of stigmatized groups. Nevertheless, the decision to serve highly stigmatized groups can present difficulties for FBOs. One FBO leader explained that his organization had to move its clinic location several times because of violent opposition from people in the neighborhood. In fact, one time, the neighbors organized and broke into the clinic, took out all the furniture and put it under a tree, and used a new lock to lock clinic staff out. For nine days, they held clinic under that tree, the leader explained:

We always remember this tree because it was nobler than human beings were. Because it gave us the warmth and shade that human beings couldn't give us.

FBOs' prevention messages are strongly influenced by theology. A Protestant leader in Honduras stated that her church teaches that prevention—i.e., taking care of oneself—comes out of a belief that all people are made in the image of God and that prevention is necessary for church members to serve as witnesses of the Christian faith to others:

Each talk that we give is about the same thing—we end with how we should prevent HIV/AIDS. And how we, made in the image of God, should take care of our body. Because Jesus gives us a commandment: Love one another. And also he tells us in what way we should love our brother, “Love your neighbor as you love yourself.” And if we don’t love ourselves, how are we going to love others? So if we don’t take care of our body, if we don’t take care of our life, how can we be a witness to others?

An evangelical FBO leader in Guatemala also stressed the importance of providing information about HIV to help people make informed decisions. However, the message of this organization focuses on the negative consequences of having premarital sex, similar to the Old Testament prophets declaring that “bad things are coming”:

What happens a lot is what the prophet [Hosea] said, “My people perish for lack of knowledge.” We believe that giving knowledge is our work: announcing that bad things are coming, and [people] are responsible for the decisions they make.

FBOs have widely varying attitudes on condom use. FBO attitudes toward condoms fell along a continuum from (a) anti-condom (condoms are a bad thing); (b) silence on condoms (don’t ask/don’t tell); (c) promote/mention condoms under limited circumstances and for limited purposes (e.g., for sero-discordant couples); (d) promote condoms in general but as the least important mechanisms of ABC (abstinence, be faithful, and condoms); (e) promote condoms as equally or most important mechanisms in general prevention. We found examples of FBOs across this continuum, although most tended to cluster under “a” (anti-condom) or “c” (promote for sero-discordant couples).

For example, at the time of our study, Catholic Relief Services (CRS) personnel could discuss condoms with PLWH, but not with the general population.¹ Further, there was a general perception across all three countries that the Pope had approved the use of condoms among serodiscordant couples, although there has been no such papal statement issued.² In our study, one leader of a Catholic FBO explained that, by appealing to the value of “protecting life,” they can provide information about condoms, and, although Catholics are not allowed to distribute condoms, they can direct people to the Ministry of Health and other sources that can provide them:

The [Catholic] Church's approach is about “protecting life,” that is what they call it. So in that sense we provide all the information people need to make a decision, including information about condoms. We speak to people transparently about condoms, explaining that they are a form of prevention, and that they can be more effective if used correctly and consistently. We give people absolutely all of the available information about all the prevention methods that there could be. As I told you, “protecting life” is a very personal decision that each individual has to make. What we do not do is distribute condoms; we do not do that at any of our events. But in any case we always direct people to where they can get condoms, such as from the Ministry of Health. They do a lot of joint activities. A lot of times they'll bring their stand, and they have condoms there to give out to people who want them. But the issue is not taboo within our organization.

¹ It appears that this policy has been changed after it was exposed that CRS in Zambia was promoting educational materials related to condom use, which led to a scandal regarding CRS's condom policies overseas—see Barra, 2009.

² This perception is probably related to the debate within the Catholic Church regarding the use of condoms as a way to prevent HIV transmission rather than as a way to prevent conception. For example, various cardinals have made statements indicating that condoms may be the “lesser evil” in combating the spread of AIDS, and in 2006 the Pope asked the Vatican Office for Health Care to prepare a document on the question of condoms and AIDS (Clark, 2006).

Only a small number of FBOs were willing to teach about condoms to the general population, and an even smaller number were willing to distribute condoms.

Even when they make specific exceptions, FBO leaders are reluctant to be seen as *promoting* the use of condoms in general. For example, a Protestant religious leader in Honduras explained that sometimes the context requires that condoms be taught, even though an FBO policy is not to “promote” condoms:

It's not that we promote [condoms], but if in a particular instance, as a nun explained to me in a forum in La Ceiba, “Personally, we don't promote condoms, but if in a particular instance a young person says to me, ‘I can't abstain from [sex], I'm with my girl, and [the opportunity] presents itself to me,’” well, [then we say], “You have to use this [a condom].”

Promotion of condoms among the more general population seems to have a negative connotation among a wide range of religious leaders—with the concern that this gives the message that it's “okay” to be promiscuous.

Many FBO leaders described their approach to condom education as “practical” or “realistic.” While FBO leaders do not promote condom use, they recognize that they cannot avoid the issue in their discussions of HIV/AIDS. For example, an evangelical pastor in Belize explained that although his church does not have an official policy or stance on condoms, churches in this denomination remain “objective and practical” on this issue and present information on condoms when discussing HIV/AIDS. He explained that the church still promotes abstinence as the most important strategy and teaches self-control, but also acknowledges that some people need to use condoms for “protection, not promotion to be promiscuous.” A health worker from a Catholic FBO in Guatemala also noted that, although his organization teaches abstinence and faithfulness, since this is not what everyone chooses, they cannot avoid the issue of condoms:

I can train many young people in workshops, workshops, workshops. “Sexual abstinence . . . until marriage . . . faithfulness.”

Here they tell you, "Yes, sure, I'm faithful to my wife." Or, "Of course, yes, sure." The young people [say], "Yes, of course." When sex is about to happen, this doesn't work. They forget and aren't thinking, "The Church prohibits me from [having sex]." I'm sorry, but they aren't thinking, "Oh, the Father . . . the pastor . . . the priest said no." No. They have sex. So, we can't avoid this [issue of condoms]. Well, [we have to say], "You aren't faithful and you're going to be at risk, protect yourself because you as well as your wife can contract the virus."

Others, while acknowledging the effectiveness and importance of condoms in HIV prevention, expressed frustration at always being asked about their position on condom use, as if this were the only important issue regarding their involvement in HIV.

Most FBO leaders place education about condoms within the context of a more comprehensive set of counseling and pastoral care issues. For example, a Protestant leader in Belize explained that his church would certainly advocate condom use for sero-discordant, married couples, but that the church would need to counsel individuals about the issue of condoms and not merely advocate the large-scale distribution of condoms:

The media always sticks the mic[rophone] in your face and says, "What about condoms?" As far as they are concerned, once the Church is involved and it's HIV/AIDS, you bet they will ask the issue about condoms. "Where do you stand on condoms?" Obviously the Church, by way of its nature, will say faithfulness and abstinence are the ideal, but we live in a real world where people are also faced with [other] realities. The Church looks upon that situation and will certainly, for instance, advocate the use of condoms in committed relationships, where one of the two individuals is discovered to be HIV-positive. When we talk about committed relationships, we are talking about a marriage situation. . . . We won't go and necessarily be a part of throwing condoms off the back of a truck into a crowd as our way of fighting it. We feel we have an obligation to counsel people through some of these things. And so counseling and pastoral care would have

a part of the umbrella under which the whole issue of condoms would have come up for us.”

Some FBOs have started to offer rapid HIV testing (saliva and blood), both to the general population and to high-risk groups. FBOs in Honduras have been particularly active in trying to extend rapid testing into outlying areas of the country (e.g., CRS/Caritas through Proyecto Dignidad and in collaboration with the Ministry of Health, Samaritan's Purse with the Garífuna, and the Episcopal Church through Siempre Unidos clinics). At the time of our study, we heard of only one FBO leader in Belize (a Catholic priest) who was doing HIV testing and counseling.

Medical Care and Mental Health Treatment of PLWH

Table 3.2 provides examples of the types of medical care and mental health treatment activities in which FBOs are involved in the three countries as well as names of some FBOs involved in each type of activity. Services in this category include clinical care management, CD4 and viral load testing, provision or administration of ARVs, mental health treatment, home visits and/or home-based care, and treatment of opportunistic infections. As with Table 3.1, the number of examples listed for each type of activity in Table 3.2 is meant to illustrate the relative frequency with which of the type of activity was mentioned during the interviews, and is not an exhaustive list of all FBOs involved

Table 3.2
Types of FBO Activities Related to Medical Care and Mental Health Treatment of PLWH and Examples of FBOs Involved in Such Activities (2007)

Type of Activity	Belize	Guatemala	Honduras
Medical care and mental health treatment	Hand in Hand Ministries (children)	CRS/Proyecto Vida	AHSOVI Clinic Evangelical Hospital Episcopal Church (Siempre Unidos)
Referrals/facilitate care			Compassion (children) Samaritan's Purse (Garífuna)

in such activities. Some FBOs also provided medical services through hospices (addressed in the next section).

We heard more frequently about activities involving medical care and mental health treatment in Honduras, although all three countries included examples of such care. However, this type of activity was relatively infrequent compared with, for example, provision of hospice care (discussed next). In Honduras, Siempre Unidos, an FBO associated with the Episcopal Church, has played a key role in a collaboration with the AIDS Healthcare Foundation and the Honduran Ministry of Health to scale up ART (Main et al., 2004). Another faith-based clinic in Tegucigalpa run by AHSOVI (Asociación Hondureña de Solidaridad y Vida) provides medical management of a small number of HIV-positive patients, and the Evangelical Hospital in Siguatepeque provides medical care, though not ART, to AIDS patients. In Guatemala, Proyecto Vida, a Catholic organization, provides care to PLWH in the western part of the country and is one of the few providers of such care outside of the capital, Guatemala City (Proyecto Vida, 2009). In Belize, Hand in Hand Ministries provides medical management (provision of medications and monitoring) for HIV-positive children (Hand in Hand Ministries, no date), and The Cornerstone Foundation has provided training to FBOs and others regarding home-based care and care of HIV-positive children (The Cornerstone Foundation, no date).

Hospice Care and Home-Based Care

A relatively large number of FBOs in the three study countries have been involved in providing hospice or shelters for PLWH and home-based care. A regional health leader explained that hospice care was one of the initial avenues through which FBOs became involved in HIV/AIDS care:

FBOs, they didn't call them like that then, but they were some of the first to really show up and extend a hand to people living with AIDS. This was like in times of the Bible when people had leprosy

or in the Middle Ages, [people] that needed to seek the church, whichever denomination that extended a hand and assisted. In Honduras it started with shelter homes, these were places to die with dignity because there was no treatment at the time. People were just fed, taken care of, loved if you will. And they died there. Basically they [the FBO-sponsored shelters] took care of paying for the coffin, for a piece of land where they would be buried in the cemetery. . . . FBOs have been there since the early days and continue to be there providing support to people living with AIDS.

Table 3.3 lists examples of organizations providing hospice and home-based care across the three countries. We visited several FBO-sponsored hospices or shelters in Guatemala and Honduras during our site visits. These hospices ranged from small, informal, and resource-poor endeavors (e.g., a two-room rented apartment with no running water that houses 20 HIV-positive persons in a clean and well-organized manner) to large, well-funded, and self-contained campuses containing several buildings to provide sleeping quarters, dining facilities, schools, and clinics, with on-site, trained health care personnel.

We did not learn about any FBO-sponsored HIV/AIDS hospices in Belize. One faith leader there explained that FBOs in Belize have

Table 3.3
Hospice, Shelter, and Home-Based Care Provided by FBOs

Type of Activity	Belize	Guatemala	Honduras
Hospices/ shelters		FUNDVIDA Hospice (Life Unlimited Ministries) Hogar Cristiano Emanuel San José Hospice Santa Maria (Proyecto Vida/CRS)	Amor y Vida Foundation Casa Pasionista Casa Zulema Hospice Corazón de la Vida Fuerza Hospice San José Hospice
Home/other care	COMFORTH (training) Hand in Hand Ministries (children) Cornerstone Foundation	CRS/Proyecto Vida	Compassion (children) Episcopal Church (Siempre Unidos)

purposely not developed hospices because they fear it will contribute to stigma and will diminish family support:

From time to time people talk about having a hospice, but we feel that it will do more harm than good. We feel that it will not advance the fight against AIDS at all. Just the opposite; we have gone through that at great length. At least with the faith-based community we have arrived [at the conclusion] that it is not a good thing. [PLWH] are cared for by families; there are other agencies that provide help. Again, it has to be dealt with as just an ordinary disease. By moving to a hospice, people relinquish their responsibilities because illness requires family support and family intervention.

Pastoral Care and Social Support of PLWH and Families

Some FBOs are also involved in providing care and social support for PLWH and their families, as shown in Table 3.4. These activities include

- pastoral care, including counseling, prayer, and care of the dying
- support groups
- targeted assistance (food, income generating, housing).

Concerted efforts have been made in each of the three countries to engage more congregations in providing pastoral care to persons infected and affected by HIV. For example, in Belize a collaborative effort has been established between the United Nations Children's Fund (UNICEF) and the Belize Council of Churches (the local affiliate to the World Council of Churches) to develop a theological framework and plan of action for faith-based involvement HIV/AIDS care and support. Between 2002 and 2006, this effort engaged religious leaders from all the country's principal faiths and denominations in conferences and workshops. The effort produced a *Faith-based Manual for the Response to HIV and AIDS: Empowerment and Support for Families* (Manzanares, 2006). In Honduras and Guatemala, other

Table 3.4
Pastoral Care and Social Support Activities for PLWH and Examples of FBOs Involved in Such Activities (2007)

Assistance Provided	Belize	Guatemala	Honduras
Pastoral care/ counseling/ support groups	COMFORTH (training) Hand in Hand Ministries (children) My Refuge Christian Ministries	CRS/Proyecto Vida Juven Fami	CRS/Caritas (Proyecto Dignidad) CRS/UNICEF (children) Episcopal Church (Siempre Unidos) Jóvenes en el Umbral de la Vida (Ministerio de Mujeres de Hoy)
Nutrition	Hand in Hand Ministries (children)		
Income- generating/ microfinance projects			CRS Siempre Unidos (Siempre Sol)

faith-based NGOs have started working at the congregational level, including World Vision through their Canales de Esperanza or Channels of Hope training (World Vision International, 2008), the Episcopal Church of Honduras, and Samaritan's Purse.

Very few FBOs focus specifically on improving the social and economic well-being of PLWH. Such efforts might include assistance with food and nutrition, income generation, or housing. A number of interviewees, both FBO and health leaders, mentioned “food insecurity” (i.e., uncertainty about having enough to eat or having enough money to buy food) as a barrier to HIV prevention and care (especially ART adherence). However, few FBOs reported ongoing efforts in these areas (except for hospices where food was provided as part of the care, or clinics such as Siempre Unidos that provide meals to patients at the clinic). Hand in Hand Ministries in Belize through its outreach center provides nutritionally appropriate daily meals and snacks to HIV-positive children, as well as cooking courses for caregivers that cover nutritional basics, healthy eating, and complementary feeding (the transition from exclusive breastfeeding to solid foods). Very few FBOs were focusing on income-generating and microfinance projects

for PLWH. The Episcopal Church in Honduras, through its Siempre Unidos clinics, had developed a small cottage industry (Siempre Sol) that makes baby clothes, hospital gowns, bags for professional conferences, and other organizations, mostly in the United States. CRS and Caritas in Honduras sponsor a microfinance program to promote small business development among PLWH.

Stigma Reduction and Advocacy

As shown in Table 3.5, some FBOs are also involved in stigma reduction and advocacy activities. Stigma reduction activities sometimes focus on FBO leaders, parishioners, family members of PLWH, and/or on the general population, and include health or HIV awareness/solidarity marches, sermons, workshops, pastoral care, and interactions with family members. Advocacy efforts focus on promoting human rights of PLWH and PLWH networks and organizations, advocating for treatment access, and reducing HIV stigma and discrimination.

Table 3.5
HIV Stigma Reduction and Advocacy Activities of FBOs and Examples of FBOs Involved in Such Activities (2007)

Type of Activity	Belize	Guatemala	Honduras
Decrease HIV stigma and discrimination	Seventh Day Adventist Church (health marches) Cornerstone Foundation	Consejo Ecu­m­e­n­ico Cristiano CRS/Proyecto Vida	
Promote human rights of PLWH		CRS/FUNDSIDA	AHSOVI CRS/National Commission for Human Rights
Strengthen PLWH networks/ organizations		CRS/Gente Unida	
Advocate for treatment access	Hand in Hand Ministries (2nd line pediatric meds)	CRS/FUNDSIDA	

FBO leaders generally agree that decreasing stigma toward PLWH is an appropriate activity for FBOs. For example, a Protestant pastor in Guatemala described what he saw as the two most important roles of FBOs in HIV/AIDS—shaping public opinion and raising awareness to decrease stigma and discrimination toward PLWH:

Well, I keep coming back to the issue of shaping public opinion. [In other words], that pastoral people—pastors, priests, and bishops—are well informed enough to be able to inform others with objectivity and responsibility so as to overcome the stigmatization and discrimination [of PLWH], in first place. And then, a second step, through raising awareness [about HIV/AIDS], educate people so that they can be respectful and recognize the dignity of [HIV-positive] people, and recognize that they are children of God. I would say this is our task and should be the task of evangelical, Protestant, and Catholic churches in our country and in [all] the countries of the world.

Health and FBO leaders both described extensive HIV stigma and discrimination across the three countries, which affect those already identified as positive, as well as those at risk or not yet identified. They told us that this stigma is often prevalent even in the most intimate relationships, especially the family. For example, a majority of the members of an HIV-positive support group in Honduras told us that they had not disclosed their positive status to their family members. We also heard of family members who disclosed being HIV-positive and were rejected by their families (thrown out of the house) or kept “hidden” so that others in the community do not know because families fear negative repercussions. Some health workers who provide care to PLWH expressed their perception that many PLWH become isolated out of shame and fear and are abandoned and die alone. For example, a health worker from an FBO in Guatemala shared a particularly poignant story about one such case that he encountered in his work in rural communities:

And look, I always, always tell God, “I need a lot of strength” because I don’t know how many more I’ll need to accompany

through dying. My heart hurts to think about how many are still going to die. Apart from that, there is also pain in my heart because as part of the project I run, in which I do home visits, I always, always find people who have passed away, who did not go to [medical] appointments, where they had to die in isolation. Where they had to die having faced discrimination. Where they were not given any water to drink before they died. Where they could not recite a prayer to comfort them in death. Where no one has told them how they can face reality. Where no one has ever told them about the Bible and that God has a place for them.

I also remember the case of a 22-year-old woman in my community. She was dying of AIDS but she was isolated. She was not in the family's house. She was [kept] outside the house in a wooden shed covered with a plastic tarp. And when I went, she was covered in ants. Ants . . . insects . . . eating her. There are bats around here too. Bats are animals with wings that suck blood, and the bats were eating her nose and the toes of her feet.

I went to visit her. I spent three hours with her family trying to convince them to take her to the hospital. They didn't want to. They didn't want to [take her] at all.

Although this case seems rather extreme, we heard stories of similar cases from FBO workers who described difficulties working with PLWH in their congregations. They described cases where families kept AIDS patients hidden from the community, even from the pastors of their churches. We were told that this acute stigma was a reason why it is hard to get a handle on HIV epidemiology, since some die never having been registered by the health care system as an HIV/AIDS case. We also heard that even when cases have been identified as HIV-positive, sometimes their deaths are not registered as HIV/AIDS-related. A regional health leader explained how stigma can cause family members to hide the fact that the cause of death was AIDS:

People just die without having been exposed to ART or having been tested, and the death certificate says pneumonia or diarrhea, but it won't be identified as an AIDS-related infection because

they were never even tested. Or if they were tested, the family requested the physician to put another cause of death because of the stigma and discrimination related to AIDS.

Many FBO leaders told us that their organizations' work tries to decrease HIV stigma and discrimination. Such activities often focus on the family, since PLWH often suffer first from discrimination from their own family. For example, clinic staff from an FBO that does home visits described a recent case that reflected the stigma associated with HIV—family members saw the disease as a curse and preferred to let their family members die rather than seek care:

Sometimes it's really hard because one would think families would provide support. Last week I had an experience visiting the home of a young female patient who was bed-ridden. I began talking with her mother, telling her about the clinic, giving her information—offering support. And [the family] told us “no.” That they preferred to let her die; they did not want help from anyone.

The male interviewee added:

Yes, because they [people] see the disease as a curse or a punishment, that it is “better to let them [patients] die.”

The other interviewee continued:

So the young woman died, and the husband was left in charge of their four daughters. The husband even came to the clinic and said he was at home when I came to the house. He explained that he couldn't make the decision at that time because his mother-in-law had said “no,” and she was the [patient's] mother and the one who would have the final word. So the husband was looking for information and came to the program. There are many [patients] who receive help and support from their families, but others who do not. I think the hardest thing has been to raise awareness among family members so that they care for patients.

A Catholic FBO leader in Guatemala explained that his/her organization aims to raise awareness about HIV/AIDS and in turn promote dignity and self-esteem for PLWH:

The other thing we've tried to do is that people see the Church as a place where they can come for information, that it's not just charitable compassion or sitting with the dying, which is part of our work, but it's not the main work. The real work is getting the message out there. It is about the dignity of life and raising self-esteem.

A handful of organizations appear to be focusing specifically on reducing stigma and discrimination more generally in the population. They do this, for example, by sponsoring HIV awareness parades, such as one that we observed in western Guatemala on the Day of Solidarity for PLWH. The Cornerstone Foundation in Belize has also organized similar marches.

FBOs find a strong biblical rationale for reducing stigma and discrimination against PLWH. A number of FBO leaders drew a parallel between the stigma of leprosy in biblical times and HIV today and referenced stories about Jesus healing lepers, not being afraid to touch them, and treating them with love. In fact, a number are using these biblical references to create educational materials designed to reduce stigma. For example, a Protestant pastor from Honduras said he had developed such materials to show the parallel between PLWH today and blind people and lepers in biblical times:

I prepared a few PowerPoint presentations about pastoral care and HIV/AIDS, highlighting biblical passages where Jesus goes against stigmas. [One example was] with the blind man who was told he had sinned because he was born blind. There are various theories involving this case. And Jesus said, "No, he was not born genetically blind nor was he born as a result of his parents' sin, but so that he could live out the glory of God." The most solemn of these passages involves the story of the leper. It has really been the passage which can most closely be compared to people living with HIV/AIDS—people who are excluded, stigmatized, scorned, marginalized, all of that—just as the leper was.

So there is a whole lot of theological work [on HIV/AIDS] that needs to be done, especially with the religious sector.

A Pentecostal pastor from Belize described the religious motivation behind his efforts to reduce stigma regarding HIV/AIDS:

Frankly speaking, we preach from the pulpit. This [COM-FORTH] manual that we're talking about is a specific guide to help people and teach them so they know. I have seen that their families have AIDS and they just close them out of their lives. Sometimes they put a little house in the corner of the yard, and they try and segregate them [family members who test positive]. I personally teach [the manual], but many churches don't have much to do with it.

Interviewer: Why do you think that you responded maybe a little differently than some of the other pastors?

When Jesus saw the multitudes, he saw them as sheep without their shepherd, and he had compassion. [I was] born and raised in a family of six children, and I have a legacy in my family of 12+ pastors. From when I was a child, I saw that my mother always gave assistance to strangers, and always she would be cooking for other family's kids. If they had a problem, they would come see her. That encourages me to have compassion; that is why we have the ministry.

Some FBOs are involved in advocacy efforts to educate PLWH regarding their human rights, including workplace rights.

An example is the work of CRS, which joined with the Honduran National Commission for Human Rights to form a watchdog group to monitor the rights of people living with HIV/AIDS. In Guatemala, CRS is supporting Gente Unida, a national network of PLWH.

Some FBOs are advocating greater access to health care for PLWH. For example, Hand in Hand Ministries in Belize played an important role in helping to obtain second-line pediatric medications for those not responding to first-line therapy.

Some FBOs are engaged in intra- and inter-denominational efforts to sensitize and train religious leaders (clergy and lay) about PLWH. The goal of such efforts is to prepare leaders to train others in their congregations to carry out congregation and community-based HIV prevention and care activities. Table 3.6 provides examples of organizations that are participating in this type of training.

These training activities often emerged from already established inter-denominational networks, such as the Belize Council of Churches, the Consejo Ecueménico Cristiano de Guatemala (Christian Ecumenical Council of Guatemala), and the Confraternidad Evangélica de Honduras (Evangelical Alliance of Honduras). Sometimes the training activities are initiated by faith-based international development or assistance agencies (World Vision, Samaritan's Purse), secular agencies desiring to engage the religious sector in HIV/AIDS efforts (Inter-Religious Committee of UNFPA in Honduras and the vari-

Table 3.6
Coordination/Training among Religious Sectors on HIV/AIDS (2007)

Coordination/ Training Among Religious Sectors	Belize	Guatemala	Honduras
Intra- denominational		Pastoral de la Salud (Catholic)	Episcopal Church
Inter- denominational	COMFORTH (Belize Council of Churches, UNICEF)	Christian Ecumenical Council World Vision (Channels of Hope)	Comunidad Teológica de Honduras Confraternidad Evangélica Inter-Religious Committee (UNFPA) ^a Inter-Religious Forums (Tegucigalpa, San Pedro Sula, La Ceiba) Samaritan's Purse (Prescription for Hope) World Vision (Channels of Hope)

^a Includes representatives from various denominations (Roman Catholic, Seventh Day Adventist Church, Episcopal, Christian Reformed) and inter-denominational organizations (Latin American Council of Churches, Theological Community of Honduras, Confraternidad Evangélica de Honduras).

ous in-country Inter-Religious Forums), and individual religious leaders within denominations (Pastoral de la Salud in Guatemala and the Episcopal Church in Honduras).

When asked about one FBO's successes that have come out of these trainings, one leader described how moved and committed people are when they leave the religious leader trainings:

We have contributed by capturing the key leadership from the different denominations that we mentioned. The methodology really is a methodology that takes you from working on each person's value judgments all the way to getting each person to make a commitment [to do something about HIV]. When people leave [the training], they leave with tears in their eyes, right? Moved, committed because they go all through a sensitization, until they see what they used to think, and after having the technical knowledge and also getting the piece about the commitment they should have with all these groups [of people]. The principal success is also the agreements that we have established with them [the religious leaders and denominations].

Conclusion

FBOs have engaged in a wide range of HIV/AIDS activities, but have tended to focus on certain ones. We found evidence of some FBO activity in HIV prevention with high-risk groups (sex workers, MSM) and broader involvement in "abstinence only" strategies targeted at youth. Less frequently conducted prevention activities included HIV testing, and condom education and distribution. We also found FBOs involved in a wide range of care and support activities, most frequently medical care and pastoral care and social support of PLWH and families. Less frequent social support activities include those related to nutrition, income generation, and housing. Finally, we found evidence of FBO involvement in a variety of stigma reduction and advocacy-related activities, including raising general community awareness about HIV as well as targeted efforts to build networks of PLWH and ensure treatment access. What activities FBOs undertake undoubtedly relate to

perception of needs, congruence with overall mission or philosophy, and access to different types of resources. In the next chapter, we examine the key challenges to FBO involvement in HIV/AIDS as perceived by FBO and health leaders.

Facilitators of and Barriers to FBO HIV/AIDS Activities

Our interviews with health and FBO leaders not only also described the range of HIV/AIDS-related activities in which FBOs were involved, but also provided insights into the ways in which FBOs are well suited to get involved in HIV/AIDS as well as the barriers that can hinder involvement. These insights can be important to consider when examining the role of FBOs in HIV/AIDS, since they suggest areas of particular strength (i.e., areas in which FBO involvement could be expanded) as well as challenges that could limit effectiveness or might need to be addressed to enhance effectiveness. In this chapter, we report on these insights, first describing the strengths of FBOs when it comes to HIV prevention and care; these were things that our interviewees highlighted that FBOs were doing well, or that they were well positioned to do and could be doing more often. Then we discuss the challenges to FBO involvement; these were things that our interviewees noted that FBOs were not doing well, or that they were not well positioned to do. In some cases, these barriers might be overcome; in other cases, not.

Advantages/Facilitators of FBO HIV Activities

Interviewees, including FBO and a range of different health leaders (those representing government, PLWH, secular NGOs, bilateral assistance agencies, etc.) described a number of advantages that FBOs bring to HIV activities, which we will discuss in detail in this section:

- broad reach and influence, especially among youth and people living in remote areas
- experience in providing medical and hospice care
- potential to provide a range of supportive services
- potential to raise awareness and diffuse prevention messages.

Most health and FBO leaders saw the broad reach and influence that FBOs have in their countries and communities as an asset that can be leveraged for HIV/AIDS activities. For example, the director of bilateral assistance agency in Honduras noted that FBOs bring a particular advantage because of their association with and influence on young people:

[FBOs] are important partners [because of their] penetration into youth and [other] groups. [This penetration] is envious for whatever political party, for whatever—i.e., the strength they have, the form and structure that they have to be able to reach large, mass quantities of adults or youth.

Health and FBO leaders both voiced support for FBOs' role in caring for and supporting PLWH and their families. As described in the previous chapter, some FBOs are already involved in activities to provide medical care and mental health treatment, support for those dying and rejected (e.g., hospice), and support to help people and their families return to social and economic health. In general, interviewees felt that such care for PLWH represents an extension of the role FBOs already play in people's lives. FBO-sponsored hospices and shelters in Honduras and Guatemala often provide care to PLWH who have been rejected by their families, and these organizations can compensate for gaps in government services. Some denominations in all three countries have a long-established tradition of providing health care through congregations (e.g., health posts attached to churches), so incorporating HIV care has been seen as an appropriate extension of this activity.

Health and FBO leaders in all three countries indicated that there is great unmet need for supportive services for PLWH. They listed food assistance, income-generating or microfinance projects, and other employment opportunities as examples of services that are

needed to support PLWH. However, respondents also indicated that the availability of such services was limited or nonexistent. In particular, interviewees noted that many HIV patients find it difficult to adhere to ART because they do not have enough food and/or have sold their medications to buy food for their families. In general, across the three countries, we did not hear of many projects to provide food, employment, or microfinance/income-generating projects to PLWH. Respondents mentioned that disruptions in employment are common since most HIV cases are diagnosed when the person is already symptomatic (e.g., with AIDS).

Some health leaders believe that FBOs are well situated to provide these supportive services to PLWH that they have not yet generally provided, such as income-generating activities and nutrition programs. This is because FBOs have broad reach across a variety of communities (urban/rural, various ethnic groups) and are often involved in helping to meet basic needs of their congregations and communities. For example, a health leader of an NGO in Belize said that FBOs are well situated to providing food, microloans, and medications for opportunistic infections, while allowing other organizations to promote condoms:

That has been my thing—if condoms are not your thing, that’s no problem, I’ll do the condom for you. But there is something that *you* can do, you know from a more humanitarian standpoint. Even providing the VCT [voluntary counseling and testing], the issue with the testing with the Catholic Church and the priests and whatever—it’s like there are many other things, like the food bank. That is not threatening, is it? So [FBOs] could just provide food [to PLWH], you know? Or like I saw in Honduras they did microloans or micro grants for people [living with HIV]. Or they had one clinic St. Vincent de Paul’s where they treated opportunistic infections in Honduras and got donated medications. Since [even for] the government, opportunistic infections are expensive and you know the issues with those—especially things like anti-fungus and pain relievers—things they were able to access from other agencies. They [an FBO] had a clinic that they ran, and they gave those [medications] out. I think they were giving

out ARVs at that clinic, but the point is that is something else they [churches] could have done. And there were nurses. That is another thing I don't understand, the church [could do] VCT, because there are Catholic nuns that are trained nurses and doctors that could come and assist, no?

Some feel that pastors need to become more engaged in conversations about what FBOs can do for PLWH so the FBOs can step in to address the need for supportive services. As noted by one evangelical pastor in Belize, "What is the practical use of churches? If we're not there in the spot where we're needed, what's the use?" Further, health leaders emphasized that FBOs' efforts to provide care and social support would succeed only if FBOs refrained from engaging in judgmental and stigmatizing attitudes (discussed further in the "Challenges/Barriers" section below).

Across the three countries, there was general consensus among our respondents that most attention and funding is given to treatment and that prevention "comes up short." Respondents offered several reasons for this. First, it was stated that many international donors give funding specifically for treatment, perhaps because it is often the most obvious and urgent need. Second, governments have received a great deal of local and international pressure to provide care, in particular ARVs, through the efforts of organizations that serve PLWH. For example, one health leader in Guatemala felt that the government there provides treatment because it is mandated by laws (that advocacy groups were instrumental in getting passed) but neglects prevention. Third, from an ethical perspective, some expressed their view that addressing the most critical and in some ways easier-to-address issues surrounding treatment of those already identified as positive should take precedence over large-scale prevention efforts. For example, one government leader shared:

I'm trying to play catch-up, yes. I'm trying to put everybody who requires treatment on treatment before I can start doing real prevention strategies. For the time being, I'm just playing catch-up.

Some health and most FBO leaders feel that FBOs' broad reach and influence among youth and in remote areas are assets that could help them play important roles in raising awareness and diffusing prevention messages. As we saw in the previous chapter, many FBOs are already involved in educational efforts to help prevent HIV/AIDS, although the messages of such campaigns often emphasize only abstinence and being faithful within marriage. Some interviewees noted that FBOs could expand their educational efforts. For example, a health worker for a nonprofit provider of HIV care in Guatemala observed that even with religious prohibitions on condoms, there is still a lot that FBOs could do in the fight against AIDS—by encouraging people to get tested and get information about HIV—particularly because churches exist in all communities:

But at a minimum, another type of information that [churches] could disseminate that doesn't have anything to do with, nor is it against, what they believe, just fundamental information: that people go get tested, that people go to information centers, that women access treatment to save their babies, or that young people need information. Take a type of leadership [role]—that's what churches could do perfectly well. They could do so much, but they aren't doing it. The ideal thing would be that all these FBOs get involved in country-level round tables or workgroups to help make sure that information gets to all sectors. If you go to the more remote areas of the country, sometimes you see a church but no school.

Some health leaders were less enthusiastic about trying to expand FBOs' role in HIV prevention due to concerns about FBO policies that prohibit condoms; nonetheless, these leaders support FBO involvement in mitigating the effects of HIV/AIDS. For example, this issue was highlighted by a health leader in Belize:

Another area is mitigation, and that is where we're trying to focus the attention of the faith-based response. Leave the prevention messages to us. If you have an issue with the condoms, that's fine, we just ask that you get involved in the other areas of mitigation, which includes long-term counseling, income-generating initiatives and programs, supportive services (long-term) like nutrition

and adherence counseling. These are issues that are very weak in our response. Because of that, there is a lack of confidence among persons living with HIV to come forward; they don't trust the services.

Even though some health leaders indicated that FBOs were limited in what they could do in prevention, the important role of FBOs in society was acknowledged by nearly all respondents, and some, like this regional health leader, continue to see them as an important ally:

The three most important prevention avenues are mentioned in ABC, and we share two with the Church if the assumption is that they are really being implemented. We agree until C comes along that we have to part ways. We encourage an approach to work together in A and B, then part ways with C. We see the Church, particularly the Catholic Church, as important in delivering a prevention message to a particular group. Most of the world has a religion, no matter where. If churches are in a position to address a big crowd with a prevention message, then that's an important step; an important ally.

Challenges/Barriers to FBO Involvement in HIV/AIDS

FBO and health leaders identified a number of challenges or barriers to FBO involvement in HIV/AIDS. We have grouped these barriers into four categories: FBO attitudes and beliefs regarding HIV, FBO organizational barriers, FBO resource barriers, and barriers related to a lack of evidence regarding FBO impact. The first category (FBO attitudes) is more ideological and thus poses internal barriers to being involved (FBOs with certain attitudes will not want to be involved in HIV). The second and third categories (organizational and resource barriers) are not so much related to intent as to the ability to follow through (an FBO may want to be involved but doesn't have the infrastructure or resources to do so). The fourth category (lack of evidence regarding FBO impact) is more a barrier from the perspective of health leaders or the scientific community. As shown in Table 4.1, FBO and health leaders tended to differ on the relative emphasis given to each challenge.

Table 4.1
Challenges to FBO Involvement in HIV/AIDS, as Reported by Health and FBO Leaders

Reported Challenges to FBO Involvement	Health	FBO
FBO attitudes and beliefs		
See HIV as divine punishment	√	√
Encourage PLWH to stop meds and to rely on prayer	√	√
Have difficulty discussing sex and HIV (stigma)	√	√
Condemn MSM, sex workers	√	
Prohibit condom use or say not effective	√	
FBO organizational barriers		
No formal structure/divided/not well organized	√	√
Not enough pastors trained in HIV		√
Resources		
Many churches are small and/or lack resources		√
Lack of health care in rural areas		√
Lack of funding for abstinence/be faithful strategies		√
Lack of evidence regarding FBO impact		
No follow-up after trainings of FBO leaders	√	
Abstinence/be faithful strategies not effective	√	
No valuation/assessment of FBO efforts	√	

NOTE: Leaders were classified by their affiliated organization type (health/secular versus FBO), regardless of other affiliations they may have had.

FBO Attitudes and Beliefs

Some FBOs see HIV as a divine punishment. Both FBO and health leaders mentioned this barrier. This view increases the stigma against PLWH and also discourages people from getting tested and/or revealing their HIV-positive status to their congregations. For example, one health leader from a bilateral assistance agency in Guatemala observed that mixing health-related issues with religion (i.e., moral judgments regarding behavior) actually impedes prevention:

Some people [of faith] talk badly about HIV-positive persons and say that they are being punished. [These people think] that they got [HIV] from bad behavior. The problem is that when you mix health concepts with religious issues, you impede prevention of transmission of illnesses, or impede an adequate plan for treatment of people who are sick. This is the central point. . . . But on the positive side, there are many ways that [FBOs] can be involved [in HIV].

A Protestant pastor from Guatemala indicated that the majority of churches there are evangelical and have a condemnatory attitude toward those who are HIV-positive:

Of course in Guatemala the majority of churches are evangelical, and when we say evangelical, it is in its connotation in English of being conservative, almost fundamentalist. So these topics [of HIV/AIDS] are related to sin. You should not touch them, and he who is HIV-positive is that way because s/he has sinned, and they must be condemned.

FBO attitudes toward HIV/AIDS are related to attitudes about homosexuality. FBO leaders expressed a variety of attitudes toward gay individuals, although they tended to concur that homosexuality was “abnormal” and inconsistent with biblical teachings. Some groups (particularly the more conservative ones) said they would not accept gays at all in their churches or seminaries, and some use counseling to “treat” homosexuals (i.e., to change them to heterosexuals). An evangelical FBO leader in Guatemala explained that his church sees homosexuality as a sin that needs to be changed once someone wants to live within the church:

I believe that homosexuals and people with these tendencies are people that have deviated from their development. Just as they fell into this problem, they can come out of it. So what we need to do is return them to their correct [sexual] identity, not so much in helping them or preparing the community to live with people like that. It's the same thing as sin. The church is a workshop of saints. Those of us with problems or who have sinned go there, and we

want to be returned to the ideal state where God wants us to be, without sinning. Now, we are not blind, we do not believe that we do not sin now. We are still vulnerable. But we can help ourselves sin less. So the idea is that “we are not sinners because we sin, but we sin because we are sinners.”

There was general consensus among health leaders who worked with MSM across the three countries that gays feel shamed and guilt-ridden by FBOs because of FBO teachings that homosexuality is a sin, that homosexuals are not children of God, and that homosexuals are rapists. Sometimes these teachings can lead to increased risk of HIV for gays, particularly if they become homeless (due to rejection by their families) and have to resort to sex work or other high-risk behaviors, as noted by a health leader in Honduras:

There have been cases with youth who have come to discover their [homo]sexuality and their families reject them because they belong to a religious group that is telling them, “Kick him out of your house.” Because once someone is homosexual, [these churches teach that] he is no longer “a son of God.” The church sometimes plays an important role in manipulating families. We come in to help people when they have been kicked out and realize they have to go to the streets or resort to [commercial] sex work to survive, to have a roof over their heads.

Some health leaders felt that religious groups help fuel anti-gay sentiment and in extreme cases might even promote some of the violence being committed against gays in the region. A health leader in Guatemala shared:

Churches are the ones that promote hate crime assassinations against sexual identity in Guatemala. I hope they don't want to kill us, but they do promote it. In 2005, four police officers killed [a transgendered sex worker]. We don't know why they killed her but I suspect it was because of religious prejudice.

Several respondents argued that HIV stigma is largely due to its association with promiscuity and male-male sexual contact. They told us that, because of machismo, women are generally scorned more than men are for promiscuity—i.e., it is somewhat expected of men to have lots of sexual experience and multiple, simultaneous sexual partners, but women are expected to be virgins before marriage and to remain faithful to their husbands. On the other hand, an FBO leader in Belize indicated that women are probably less scorned than men for being HIV-positive, because of the association in people's minds of HIV with male-male sex:

In terms of promiscuity, male promiscuity seems to win a little more social acceptance, but every now and again you will hear people say “men are dogs.” But somehow it is not really scorned upon, if I may use that term. Whereby a promiscuous woman is likely to be dealt with more harshly in terms of public opinion, and they would find rather derogatory words to describe her. In terms of HIV/AIDS there may be in some ways a reversal. And I am no authority here, but a male sufferer of HIV/AIDS may be looked upon even more unkindly than a female sufferer. My best take on that is it is often male homosexuality that is truly scorned upon. Female homosexuality, interestingly, wins a little more social acceptance. So you have a strange combination: promiscuity more accepted in the male than in the female, [but with] HIV/AIDS you find a little more compassion towards females than males.

In all three countries, many respondents pointed to gay male populations as the earliest communities affected by HIV and the most affected communities. We were told that, in addition to being rejected by their families and churches, HIV-positive gay men were also reportedly marginalized by government hospitals that sometimes refused to give medicine and care. For example, one NGO leader in Honduras shared:

They denied integrated care to us gays, perhaps because we belong to a different community. They treated gays or the commercial sex workers as if we didn't have any right to life.

Both health and FBO leaders commented that putting a number on the proportion of HIV cases that are due to male-male sexual contact was difficult because a great deal of stigma toward homosexuality exists in the region. When FBO leaders did discuss MSM, they described the stigma associated with homosexual activity similarly. We were told by both FBO leaders and health leaders that, in these countries, men who engage in homosexual activities have difficulty admitting this to others, which makes determining the number of individuals who became HIV-positive through homosexual contact very difficult. We were also told that the societal stigma against homosexuality was so strong that many surveys in the region did not even include “male-male sexual contact” or “homosexual orientation” as options to describe how HIV was acquired. Further, a health leader in Honduras explained that the MSM role in the epidemic has been underreported because MSM often consider themselves heterosexual if they also have sex with women. Therefore, studies that do ask respondents about diverse sexual orientation/practices will still tend to find that male-male sexual contact has been underreported.

Some FBO leaders said they try to refrain from “judging” and discriminating against gays, while still maintaining that they are not in agreement with their “lifestyle”—i.e., “loving the sinner not the sin.” Further, a Protestant minister from Belize stressed that HIV should be seen just like any other disease:

The danger I have discovered is with a condemnatory attitude [toward the person with HIV] . . . but HIV is simply another disease, just like cancer, leukemia, whatever. And until we get to that stage around the world, not only here at home, we will not overcome the barrier of discrimination. It is simply another illness, end of story. Until we treat it in that way, we will not overcome it.

Nonetheless, very few of the FBO leaders we interviewed expressed complete acceptance of gays and same-sex relations.

Attitudes toward HIV appeared to be changing in some churches, particularly as epidemics become more generalized. An NGO leader in Belize felt that most churches have moved from a condemnatory attitude to one of compassion, at least for women and children, but

still lack information that would help them relate more closely to the epidemic:

I think basically churches want to do what is best, and I think they have moved from [a perspective of HIV/AIDS as] “divine retribution.” That’s what it was initially. . . . [Now the attitude is more like] “What about the women, what about the babies?” What are you going to do, say it’s good for them and stuff like that? So there was quite a bit initially of that type of thing, [PLWH] just kept away because [churches] preach hell and damnation, but that has changed significantly. I still think it’s that individual fear [churches] have as well. [Churches] don’t know the information and they don’t want you to know that they don’t know the information, so they have this little attitude. Once [churches] are able to get the information, they are able to recognize, “it could be my brother, my sister.”

We heard anecdotal reports of some pastors and other religious leaders encouraging PLWH to stop their medications and rely instead on prayer. For example, a health leader from an NGO in Guatemala that provides care to PLWH confirmed that there are stories of some religious congregations encouraging PLWH to rely on prayer instead of ART, but this health leader’s organization required all volunteers to go through a rigorous training on HIV and limited the type of involvement that congregations can have in their facility. Congregations/volunteers can provide pastoral care and religious services, but cannot come in only to perform religious “healings.” This NGO leader acknowledged that occasionally religious groups have interfered with ART in public hospitals, possibly leading some patients to refuse drugs:

Public hospital clinics that distribute ART have in fact had many problems with religious groups coming in, principally with ones that come in to do “healing campaigns.” Soon enough someone who has been taking their ART for six, seven months, or even a year starts to feel much better—they go to a *jornada de sanación* (a healing campaign) and someone heals them, and they abandon treatment. And afterwards they develop drug resistance. I am not

sure if this is a beneficial way to tackle the issue; it can be a big problem for controlling patients' treatment. But fortunately, as I told you, our experience [with faith-based groups] has been positive. Overall you have to have a fair balance.

An evangelical pastor in Honduras noted that he had heard about pastors telling members to stop taking their medications, but he felt that the majority of pastors want to know more about HIV and how they can collaborate with the public health system:

Not long ago I was at a forum and so I shared a little about the Evangelical Church's work with AIDS. Many, a large proportion of the participants, said that there were many pastors who, after praying for an ill person, would say [to a patient] "Stop taking your medicine." This is what some people say, but we have not found this to be commonplace based on some interviews we have done with pastors. But it is likely that there are some pastors, because these types of impressions aren't usually publicized broadly. It is likely that there are some such pastors, but they don't represent the majority. The majority—such as the ones participating in the meetings we had—the majority of them say the following: "We want to learn more." The second thing they said was "We want to know how to have a better relationship with the public health system, because we don't know who to go to or how to approach it."

FBO and health leaders agree that HIV prevention efforts are impeded by the fact that FBOs have difficulty discussing sex. For example, a Catholic leader in Guatemala felt that this difficulty discussing sex is why the church has instead focused more on care for PLWH:

We at the church have no trouble talking about HIV; it's talking about sex. I mean 95 percent of our people are HIV-positive because of sexual transmission, so I think that's the biggest thing and, I think that's why it's much easier for the church to bend towards caring for the really sick.

FBO leaders suggested that stigma has sometimes prevented HIV/AIDS from being discussed openly. For example, a Protestant FBO leader in Honduras believed that the spread of HIV/AIDS in his country was due to the Church not talking about it:

It's a job of breaking down walls so the Church is aware of HIV/AIDS. You need to talk [about HIV/AIDS] in public and openly. In my view, HIV/AIDS has advanced in Honduras in large part because it was always kept a secret. It was something that wasn't talked about [openly].

Some FBO leaders saw challenges to FBO involvement because HIV is so taboo. FBO leaders indicated that many pastors either resist any discussion of HIV or believe that their congregational members are not at risk. For example, an evangelical leader in Honduras observed that some Christians and/or religious leaders feel that they and their members are not affected by HIV:

Christians feel that just because of the fact that they are Christians means that they are already protected. Priests think that HIV walks down the street but does not enter their church.

FBO leaders also noted that HIV/AIDS is not discussed openly in many congregations and that this makes it difficult to mobilize congregational resources for supporting PLWH. Some FBO leaders stated that pastors are ill-prepared to deal with HIV and that training is needed. Further, because of the stigma and discrimination toward PLWH, many HIV-positive congregational members do not want anyone else in their churches to know of their status, which makes it difficult for the congregation more broadly to provide support. For example, an evangelical pastor in Honduras talked about how evangelical churches are providing support, but it is hard to know the extent to which this is occurring, because these activities need to be done “under the radar” since they deal with HIV/AIDS:

One of the barriers they often mention is confidentiality. Pastors said, “We feel like we have our hands tied because we can't

talk about it, and we can't generate the full amount of support churches are able to generate." For example, if someone in the congregation has cancer or any other problem, the pastor says in public, "Brothers, we are going to pray for this person who has cancer." And so they are able to generate a lot of support, collect food, do other things. But in these cases [of HIV-positive persons], they cannot [provide the same kinds of support] because they can't talk about it. So that is a barrier. It is also for that reason [because of confidentiality] that I cannot tell you how many of the more than 10,000 congregations in Honduras do these types of activities.

The need to "keep quiet" about involvement in HIV/AIDS can pose a barrier to building a broader base of support for their efforts to help PLWH.

Judgmental attitudes on the part of FBOs toward gays, MSM, and commercial sex workers and FBOs' limited reach into these groups were seen by health leaders as additional challenges to FBO involvement in prevention and supporting PLWH. For example, it was noted that, in Guatemala, the epidemic is more concentrated in groups (MSM, sex workers) that the church does not generally reach:

It is important to think about where the epidemic is concentrated, and to look at what that means. [In Guatemala] the epidemic is concentrated in stigmatized groups, which are not particular priorities of the church—we're talking about MSM and sex workers here. So to think of a world in which the church—with its strong organization and membership—could instead begin to offer support such as by providing medications [to these stigmatized groups]. It seems strange to me, because I do not see much respect or good will toward these populations by the church. So the church would have to begin to reach out to these populations.

FBO prohibitions against condom use and/or reluctance to promote condoms are also seen as important barriers by health leaders. One health leader in Guatemala stated that this prohibition or reluctance is the biggest obstacle to allowing FBOs to take a positive role in the fight against HIV:

Basically, the lack of condom use is a negative thing. We cannot talk with youth or anyone else about abstinence because it's not real. So we need to present all the options, and each person has to make an informed decision. But with [FBOs] you cannot do this because they only talk about abstinence, about faithfulness. You cannot [talk about condoms]. I think that this is the biggest obstacle. Although the former Pope said that sero-discordant couples could use condoms to prevent HIV transmission. But that seems so discriminatory, since it means that only people with HIV can use [condoms] to keep from infecting their partner.

A leader of a regional HIV advocacy organization familiar with the situation in Honduras felt that evangelical churches and the Catholic Church in particular have stymied HIV prevention efforts, mostly because of anti-condom views:

Evangelical churches have been such an obstacle in terms of prevention, especially because Honduras is always trying to increase and improve its sex education and the Catholic Church and Archbishop are so anti-condom.

An HIV-positive person in Guatemala explained the consequences of FBO anti-condom policies in this way:

For example, in my case, neither my parents nor the school nor the church ever talked about condoms. I learned about them out of curiosity, but I never used one, and that's why I got infected.

The anti-condom policies of many Catholic and evangelical churches have led FBOs to have a bad reputation among more secular groups working in HIV. In all three countries, we encountered organizations that had faith-based beginnings or connections (e.g., funding, volunteers) but chose to present themselves as humanitarian rather than faith-based organizations. A leader of one of these organizations in Guatemala explained that her organization retains its religious principles but projects a nonreligious identity so that the organization can reach groups that would not normally be reached by evangelical churches:

From the beginning, our vision has always been this: Don't give a religious image, but rather work with [religious] principles and be able to go where evangelical churches do not normally go. Because the moment we are identified as very evangelical, doors close. We have worked hard to retain this balance. We are careful not to promote a specific church, [but] we work with God's principles, and that helps us.

Organizational Barriers

FBO and health leaders both acknowledged a number of organizational barriers to FBO involvement in HIV/AIDS efforts. Such barriers are especially prevalent given the proliferation of different types of denominations and nondenominational churches across Central America. The Catholic Church remains the largest denomination in all three countries but without the hegemony of the past, with approximately 50 percent of Belizeans (Central Statistical Office, 2000), 57–68 percent of Guatemalans (Bureau of Democracy, 2007), and 47 percent of Hondurans (Cid Gallup, 2007) identifying themselves as Catholics. However, other Christian groups, especially evangelical, Pentecostal, and/or nondenominational groups, have grown to the point that they now collectively represent 30–40 percent of the population, but no one non-Catholic denomination represents over 10 percent.

Some health leaders have found it challenging to work with the faith community because of its diversity. For example, a number of health leaders noted that there is no one structure that brings together all faith groups, and this makes it hard to coordinate more broadly with this sector. Further, a health leader in Guatemala saw challenges in working with churches not only because of diversity among denominations and religions but also multiculturalism of the country's population:

A problem we have in Guatemala is that it is so idiosyncratic and multicultural. I remember working with some doctors years ago in a remote area of the country close to the Mexico border where there was no transportation. People in remote areas of the country still practice very traditional religions where they speak of

the rain, the volcano, and the mountain. There are 23 languages spoken in Guatemala, including the Mayan and Xinta languages, along with the Caribbean ones. There has to be a way to unite people who speak these languages.

Inter-denominational associations of like-minded churches do exist, for example, the *Confraternidad Evangélica de Honduras* (the Evangelical Alliance of Honduras), as well as some more ecumenical coalitions that bring together Catholics and Protestants, such as the Belize Council of Churches and the *Consejo Ecueménico Cristiano de Guatemala* (the Ecumenical Christian Council of Guatemala). Interestingly, these associations have been behind some of the more visible efforts around HIV/AIDS in these countries, along with denomination-specific efforts such as the Episcopal Church's work in HIV prevention and treatment in Honduras, the Catholic Pastoral de la Salud's work in HIV in Guatemala (*Proyecto Vida*), and the Anglican Church's school-based HIV education in Belize.

Resource Barriers

FBO leaders were quick to note the lack of resources for FBO HIV activities. First, they emphasized that many churches are small and do not have resources, while the larger, more wealthy churches tend to have little interest in matters related to social justice. For example, a regional leader of an international FBO that works with evangelical churches in both Guatemala and Honduras observed:

Many of the churches have modest resources; and thinking of the largest ones, they tend to concentrate on preaching a "theology of prosperity," right? So there is very little interest in any other issues of the economy, justice, or health. There is very little interest. The emphasis is on other things.

But beyond the congregational level, it is also important to consider resources at the denominational, inter-denominational, and international levels. Much of the HIV/AIDS activity at these higher levels seemed to be related to opportunities to obtain external funding (e.g., through the Global Fund, or from private donors that supported an

FBO mission). Some FBO leaders lamented that international funding has focused mostly on condom-based HIV prevention strategies. This made it difficult for FBOs to secure funding for their abstinence and “be faithful” strategies.

The second challenge has to do with resources. Unfortunately when we talk about a position of primary prevention—here we are talking about the “ABC” strategy in which “A” is abstinence, “B” is “be faithful,” and “C” is condoms—there are not many funders who support “A” and “B” as primary prevention. “A” and “B” are not very popular. We don’t have a source of funding. So the big challenge is to present ourselves as having a contribution for the national epidemic. Because people begin to see us as “those religious people who just want to promote abstinence” and thus responsible for how bad [the epidemic] has gotten. People blame us. So condoms, the whole response, all the funding is directed there [towards condoms]. When we present ourselves as being on polar opposites, we don’t reach any solution. That is why the challenge is for us as the body of Christ to understand how to present our side: the “A” and “B” side. Someone has to do it. Thinking of our preschool kids and adolescents, we could just present it simply and plainly that sexual activity is not healthy in pre-adolescence and we see what the biological and physiological consequences are.

In contrast to the FBO leaders, many health leaders noted access to resources as a strength of FBOs rather than a challenge. Their perception was that FBOs receive many financial donations and are strong in the area of volunteer capacity. FBO volunteer capacity—i.e., the ability to utilize human capital with strong altruistic/service orientations—as well as access to people in general (for education, stigma reduction, etc.) are very useful assets in the fight against HIV/AIDS.

FBO leaders also found it challenging to coordinate with health care providers, given their uneven distribution particularly in rural areas. For example, an FBO leader in Honduras whose organization does HIV testing explained that doing testing in more remote areas of the country that do not have facilities that provide HIV care or strong referral networks creates a real dilemma for them:

One of the huge things when we worked out in these communities which are so far away from basic needs is that when you go and offer the test to somebody and they're positive, you know, [it's like] "Thanks for telling me I'm positive." So I've found it very difficult with one particular community that is quite far. So we have to take it to the next level, whether it's not [our organization] doing it, but making it more of a need to make communications or networks with other organizations to really refer these individuals.

Interviewer: Because if they test positive there really isn't a place for them to go?

There is [in a more distant city], but then you have the problem that they don't have the money or the transport [to get there].

Interviewer: But there is no place out in their community?

For HIV/AIDS and medications, no. The Ministry of Health assigns patients to a particular clinic or system to maximize [their efficiency] because there are low levels of adherence among these populations—there are no adherence programs or house visits—so they have to go to the [health centers in larger cities where there is a Ministry of Health office]. The ideal thing would be to study how the system works in each community.

Disagreements and Tensions Between Faith-Based Organizations and Secular Health Organizations

Quite apart from the barriers to FBO involvement in HIV/AIDS described above, the interviews revealed fundamental differences in values between religious and health leaders that lead them in different directions on HIV prevention and also limit their ability to work collaboratively in relationships. Most importantly, many religious leaders favor some prevention methods (such as abstinence or "being faithful") and oppose others (such as condoms) based mostly on religious beliefs, with less emphasis on evidence of effectiveness. In contrast, health leaders favor prevention methods that have been proven effective

in preventing HIV transmission. The difference in preferred methods is probably less divisive than the difference in fundamental values that underlie these preferences, which serve as barriers to trust.

While some FBO leaders lamented the lack of funding for “abstinence” and “be faithful” prevention strategies, health leaders were concerned that these strategies have not been proven effective. Many health leaders noted that although FBOs were engaged in many activities, there has been little assessment of their impact. For example, a health leader of a bilateral assistance agency in Honduras attributed the lack of evaluation to the fact that there is often little to no financial accountability for the monies and donations that churches receive (FBOs rely heavily on donations), and that there is no sound evidence that the programs administered by faith-based communities are effective. Some studies have been done but are flawed by methodological problems.

I think faith-based organizations often rely on donations for financing [their organizations, work], so we have to look at the accountability surrounding that financing. We have often discussed with FBOs the topic of “what I do or do not do with this money.” I am not speaking in the sense of doing a formal financial audit, but rather in the sense that [FBOs] should report certain types of costs, as is standard practice [by other organizations]. It involves bureaucracy and it can be hard for a recipient organization to get used to keeping financial statements. So that is one topic on the administrative side. Another topic has to do with how interventions are carried out. We still have trouble with a few FBOs around the issue of methodology. Many methodologies [chosen by FBOs] tend to focus more on issues related to religious conversion than on aspects truly concerning prevention. And that is a challenge because we have come so far in that area. Sometimes, and I think this may be just personal opinions, you will see a program facilitator speaking doubtfully about condoms, things like that. But I wouldn't say that it is like a complete institutional block. So I think we still need to work on defining and clarifying the nature of [FBO] interventions, and how we are going to continue partnering with FBOs. If we are going partner with FBOs, we need to be true partners in working together for the common good.

Conclusion

FBOs were perceived by both FBO and health leaders as having broad reach and influence, especially among youth and people living in remote areas; experience in providing medical and hospice care; potential to provide a range of supportive services; and potential to raise awareness and diffuse prevention messages, thereby extending HIV/AIDS prevention and care. However, challenges were noted, particularly in prevention, given FBOs' lack of experience with and sensitivity toward high-risk groups, such as MSM and sex workers, and most FBOs' unwillingness to promote condoms more generally. Health and FBO leaders recognized many of the same challenges to FBO involvement in HIV/AIDS: FBOs' tendency to interpret HIV in religious terms and thus to advocate a purely spiritual, rather than medical, response to the disease; and FBOs' general inability to discuss sexuality. Health leaders also emphasized other issues, including uncertainty over the impact of FBO efforts and FBOs' stigmatizing attitudes toward MSM. FBO leaders tended to emphasize organizational and resource barriers. Nevertheless, there was an overall sense that FBOs could make important contributions by leveraging their broad reach and influence to raise awareness and decrease stigma toward PLWH and provide support and care to PLWH, particularly where gaps exist, such as in nutrition and income-generating activities. FBO involvement in prevention was perceived as more problematic than care and support services by many of the health leaders.

Discussion

In previous chapters, we reviewed the need for HIV services in Belize, Guatemala, and Honduras (Chapter Two), the way that health and FBOs have been involved in HIV in these countries (Chapter Three), and the facilitators of and barriers to FBO involvement (Chapter Four). In this chapter, we draw together findings of earlier chapters and discuss implications for the roles that FBOs might most effectively play in addressing the HIV epidemic in these countries.

Although HIV/AIDS in Latin America has received less international attention than has the HIV epidemic in sub-Saharan Africa, the epidemic has had far-reaching consequences in the region, and especially so in Central America. Each of the three countries we studied has been profoundly affected by the epidemic. Government efforts to address the epidemic have fallen short of the levels needed to provide effective prevention and widespread access to treatment, yet at the same time, have claimed resources needed to address other critical needs.

Given the limitations in public health infrastructure and resources available to address the epidemic, and given that FBOs play an important role in providing health and social services in developing countries, it is natural to ask whether the response to the epidemic in these countries can be strengthened by engaging more FBOs to work alongside governmental and private organizations in the fight against HIV/AIDS. To engage FBOs effectively in the fight against HIV/AIDS, it is important to begin with a realistic, analytically based assessment of what these organizations are able and willing to do. The present

research is a systematic attempt to make such an assessment for Belize, Guatemala, and Honduras.

As we discussed in Chapter Two, the challenges posed by the HIV epidemic in these countries span a continuum of need ranging from prevention to HIV testing, medical care and support services, and stigma reduction and advocacy. Previous discussion and debate regarding the potential role of FBOs has often focused rather narrowly on FBOs' ability or willingness to address specific needs along this continuum—for example, condom promotion or distribution—where the values and priorities of many FBOs and public health agencies may be in conflict. An assessment that examines potential matches between HIV-related needs and FBO capabilities along the full continuum is likely to provide a more comprehensive and balanced understanding of the ways in which FBOs might realistically contribute most effectively in the fight against HIV/AIDS.

Roles for Faith-Based Organizations

The starting point in analyzing the roles that FBOs can play in addressing the epidemic is the range of activities that they have already undertaken, as described in Chapter Three. These are roles that FBOs have willingly assumed, regard as consistent with their mission, and have the capacity to undertake. But the analysis must not stop there, unless we are willing to conclude at the outset that FBOs' capacity and willingness have been stretched to their limits. To develop a realistic assessment of what FBOs can do beyond what they are already doing, as well whether it is feasible to get more FBOs engaged in the fight against HIV/AIDS, we must grapple with a series of questions:

- How do FBOs' activities and roles fit with their mission and values?
- Which segments of the population are reached by FBO activities?
- How effective have these activities been in meeting their goals?
- To what extent do these activities utilize FBOs' capacity?
- What are the major facilitators and barriers?

- What is the relationship between FBOs and governmental organizations, and how might they work together as partners, or in parallel, in complementary but mutually supportive roles?

Below we discuss our analysis, based on answers to these questions, of potential roles of FBOs in each of the four major categories of activity discussed in this report: Prevention, Testing, Care and Support Services, and Stigma Reduction and Advocacy.

HIV Prevention

Current FBO activities have tended to focus on low-risk groups, such as children and youth. HIV prevention activities consist of two broad, partially overlapping categories: education regarding HIV and promotion of behavioral risk reduction (e.g., abstinence, being faithful, and condom use). We found that most of FBOs' prevention activities focused on education, with the primary targets being children and youth. This is as one might expect, given that moral instruction is seen as a core, mission-related activity by many if not most FBOs in Latin America.

However, the intensive focus on children and youth results in a relative lack of attention to high-risk, highly stigmatized groups, notably MSM and commercial sex workers. Education targeted at groups whose behavior is most likely to result in HIV transmission will, if it is effective, have a greater impact on the HIV epidemic than education aimed at groups at lower risk.

We did find a few FBOs that focused prevention education efforts on high-risk and stigmatized populations. For example, one FBO in Guatemala directs prevention efforts to both MSM and commercial sex workers, and several FBOs in Honduras work with PLWH and their families. However, efforts such as this are much less common.

It is unrealistic to expect many FBOs to shift their focus toward high-risk populations, but such efforts, when feasible, should be supported. There are several possible explanations for why FBOs tend to direct most of their prevention efforts at relatively low-risk groups. First, FBO leaders who are not health care providers or professionals themselves rarely mentioned MSM to us when discuss-

ing vulnerable populations. Their view of the HIV epidemic differed markedly from that of health leaders. For FBO leaders, MSM—and perhaps other vulnerable populations—are largely hidden from view, since stigma keeps them from making their presence known. Second, the preferred prevention message of many or most FBOs emphasizes abstinence, and the most natural targets for this message are children and young people. To the extent that FBOs consider targeting this prevention message to other populations whose sexual behavior puts them at risk, they might reasonably conclude that it would be a harder sell. Third, it is possible that some FBOs are less comfortable with stigmatized populations such as MSM, or that they consider those populations less deserving of their attention. Of course, the lack of comfort seems to go both ways, as many gays or MSM do not feel comfortable with FBOs. Regardless of the reason why FBOs mostly target children and young people in their HIV prevention efforts, the fact that they do so reveals a preference that suggests that it may be unrealistic to expect them to shift their efforts to other populations, such as MSM, that are more vulnerable from an epidemiologic perspective.

However, efforts to prevent the spread of HIV/AIDS among high-risk and stigmatized populations, such as commercial sex workers, have a high potential payoff. Thus, these efforts deserve support in the form of careful evaluation aimed at assessing and improving quality, and external funding support if available.

FBOs displayed a wide range of attitudes and approaches toward promoting behavioral risk reduction, and different “comfort levels” should be respected as organizations work together to prevent the spread of HIV/AIDS. Among FBOs, the most common approach, not surprisingly, was “abstinence only” messages aimed at youth. Although many FBOs took firm anti-condom positions, others maintained a pointed silence on the issue of condom use (don’t ask, don’t tell), and still others endorsed condom use under limited circumstances or granted them third-tier status in a three-tiered “ABC” strategy (abstinence, be faithful, and condoms). Still others were comfortable promoting condoms as an important prevention method for the general population.

FBOs' positions on condom use, though highly diverse, generally have deep theological roots. Nothing is to be gained from arguing about differing positions, since they are not likely to change. It is more constructive to accept that different organizations, whether FBO or non-FBO, have entirely different comfort levels with regard to specific approaches to behavioral risk reduction, and to find ways for organizations to work together while respecting those differences. As noted by Halperin et al. (2004), the emphasis placed on the individual elements of the ABC approach (abstinence, be faithful, condoms) needs to vary according to the target population and it is not essential that every organization promotes all three.

HIV Testing

Many FBOs seem well suited to provide HIV testing in partnership with public health providers. Such involvement could be very beneficial, since access to testing is uneven in the three countries, particularly in rural areas. Some FBOs may welcome such a role. In fact, we found that some FBOs, especially in Honduras, have already been offering rapid HIV testing to the general population and to high-risk groups.

In addition to extending access to this service to more people, FBOs that provide testing can send a constructive message that HIV is a disease for which treatment is available and that people should know their status. Provision of testing through FBOs may therefore help to normalize HIV/AIDS as a health issue rather than a moral one and thereby reduce stigma.

Care and Support Services

The most common type of activity in which FBOs were involved across the three countries was providing care and support services to PLWH and their families. These services can take several forms, including pastoral care; hospices, especially for children and orphans; support groups; medical care (provision of ART, treatment of opportunistic infections) and mental health treatment; referrals; and home-based care. The role many FBOs have played in providing services and support for PLWH and their families is generally congruent with the

role that FBOs already play in other aspects of people's lives. Several denominations have long provided health services through congregations, for example, and incorporating HIV care is a natural extension of that role.

FBOs might become more involved in providing these kinds of services, especially some services that are rarely addressed. These include targeted assistance with food, housing, income generation or microfinance, and transportation services to link PLWH who live far from the urban locations where the services they need may be found. Facilitating access to such services could be a concrete way that FBOs could contribute to addressing the epidemic.

Those seeking to encourage or fund FBOs to provide such services may be more successful in targeting faith-based NGOs or receptive religious leaders rather than congregations per se, although faith-based NGOs or receptive religious leaders could in turn influence congregations. Our study found that HIV care and support services are commonly provided by faith-based NGOs or by religious leaders acting as individuals rather than by individual congregations. One possible reason for the lack of congregational involvement is that stigma may pose a greater barrier in congregations than it does for faith-based NGOs or individual religious leaders, since the services must be provided more publicly and there are more stakeholders to raise objections in congregations. Further, faith-based NGOs are usually not under denominational governance structures in the same way as congregations and are therefore not subjected to the same doctrinal restrictions. Finally, faith-based NGOs often have access to a broader range of resources (e.g., external funding, international donors) than individual congregations, which is particularly important for resource-intensive services such as provision of medical care and support services.

Stigma Reduction and Advocacy

Across all three countries and within all types of faith communities, HIV is a highly stigmatized disease. In some cases, fear of being stigmatized leads individuals who test positive not to disclose their status to their own family members; those who do often face a real possibility of being rejected by their families. Stigma and discrimi-

nation often isolate PLWH and cut them off from people who might otherwise support them. In addition, stigma forms a critical barrier to the delivery of effective prevention, treatment, and support services, since it undermines support for programs targeting stigmatized groups.

Although some FBOs have been complicit in stigmatizing PLWH, stigma reduction is an area in which FBOs could have an especially strong impact. The association of HIV with male-male and promiscuous heterosexual activity has led some FBOs (among others) to hold condemnatory views toward PLWH, viewing them as suffering divine punishment for their sins. Not surprisingly, FBOs are seen by many health leaders as having promulgated these views, thereby contributing to HIV-related stigma. However, some leaders in the faith community see it as a natural role for FBOs to raise awareness about HIV and to reduce stigma and discrimination, both in the faith community and in the larger population.

They reported a wide range of activities aimed at reducing stigma, including talking more openly about HIV within the church, delivering stigma-reducing messages from the pulpit, advocating on behalf of PLWH with their families, advocating for treatment access and workplace rights, raising awareness of HIV and how it is spread in a way that promotes the idea that it is just another disease, and providing training to other religious leaders. These efforts are based on a biblically grounded rationale that draws a parallel between stigma attached to leprosy in the time of Jesus and HIV today, and that Jesus reaching out to lepers provides a model for overcoming HIV-related stigma today.

Although only a few FBOs in our study reported specific activities designed to reduce stigma associated with HIV, stigma reduction seems critical to realize the full capacity of congregations to address the needs of PLWH. In view of FBOs' moral authority, broad reach, and ability to influence attitudes, stigma reduction is an area in which FBO leaders could have an especially strong impact. They enjoy respect and trust from their communities and possess moral authority within society as a whole; as value-based institutions, they have direct "jurisdiction" over issues of personal behavior, morality, family life, and belief (Parker and Birdsall, 2005). Stigma among congregations impedes pastors' ability to mobilize congregational resources

more broadly. Research in Africa has found that pastors are one of the first persons to whom women living with HIV would disclose their status; however, church members were the most frequently mentioned group from which participants wanted to hide their status (Miller and Rubin, 2007).

It may be possible for a small number of FBOs or individual religious leaders, with the proper resources and support, to accomplish a significant amount of change over time, locally if not nationally. Research in Ghana indicated that hearing a leader speak about HIV/AIDS had a substantial effect on congregants' provision of support to PLWH (Bazant and Boulay, 2007). Studies elsewhere (e.g., Jamaica, Trinidad, Tanzania, Uganda) have found that FBOs can move from fostering to dissuading stigma through trainings that increase knowledge and understanding of HIV/AIDS among clergy and congregation members, increased personal contact between congregational leaders and PLWH, and direct involvement of PLWH in FBO prevention, care, and advocacy efforts (Muturi, 2008; Genrich and Brathwaite, 2005; Hartwig, Kisioki, and Hartwig, 2006; Otolok-Tanga et al., 2007).

Stigma-reducing activities are most often carried out by FBO leaders using communication-based strategies. These efforts might be undertaken more frequently, and perhaps more effectively, if leaders could be provided with information about strategies that others have used with apparent success (or failure, since that can be instructive as well). Developing and disseminating curricular materials on communication and other strategies (such as providing contact with members of stigmatized groups) might be a useful way for foundations and other funders to encourage and support such efforts to address stigma.

Advocacy is another area in which the role of FBOs might be expanded. Some FBOs have assumed an advocacy role for PLWH, advocating for greater access to health care, ART, or workplace rights. These advocacy efforts can be quite important in countering the effects of discrimination or simple lack of attention, and in this way, are a type of or mechanism for stigma reduction. Advocacy may also benefit PLWH by validating the legitimacy of their rights to fair treatment. Some FBOs have also engaged in efforts to train and sensitize religious

leaders about PLWH. These efforts build support for efforts by other FBOs to address the needs of PLWH in a compassionate way.

Need for Collaboration Between Faith-Based Organizations and Other Organizations

After considering the wide range of activities carried out by FBOs, it is clear that no one organization is suited to do everything. In addressing the challenges to FBOs' involvement in fighting the HIV epidemic, it is important to keep in mind that health leaders, other institutions, and FBO leaders have different mandates, and their activities will necessarily be different. Some of these mandates will be carried out independently, whereas others are best carried out in coordination.

Effective collaboration between the health care system, other governmental agencies, NGOs, and FBOs must transcend moral judgments rooted in their distinctive value systems. Pointing fingers over the deficiencies of the other sector yields no benefit. If FBOs are to play a constructive role in addressing HIV in collaboration with the health care system, they must recognize, first, the nature and extent of the epidemic, and, second, the unique and complementary strengths each sector can bring to addressing it.

Both sectors (health and faith) need to cooperate to build a comprehensive set of activities that address the needs of the entire population. Concerted action is especially necessary to identify the cracks in the system through which vulnerable populations may fall. Thus, in addition to activities that FBOs may undertake on their own, there are many collaborative activities that they engage in—or could engage in—that demonstrate a range in terms of the control that FBOs have over the activity and their level of participation.

Table 5.1 provides examples of this range across our framework of prevention, testing, care and support services, and stigma reduction and advocacy. Here we briefly discuss each type of collaborative activity, starting with those that FBOs have the most control over and continuing to those where they have the least:

Table 5.1
Examples of Types of HIV/AIDS Activities Across the Spectrum of Coordinated and Uncoordinated FBO Activities

Type of HIV/AIDS Activity	Tasks That FBOs Perform Alone	FBOs' Role in Tasks Performed with Other Organizations			
		Complement (Address Gaps)	Reinforce	Facilitate	Support
Prevention	Promote abstinence, being faithful Teach about correct and consistent use of condoms ^a		Counsel congregants on safer sex practices Refer congregants to MoH for prevention counseling	Allow MoH to provide info on condoms at FBO event	Thank CBOs working with sex workers, MSM Provide donations to CBOs working in prevention
Testing	Conduct HIV testing ^a	Conduct HIV testing in rural areas	Encourage congregants to get tested	Congregation-based HIV testing by MoH	Provide volunteers for MoH testing event
Medical care and mental health treatment	Establish clinics ^a	Establish clinics in rural areas	Refer people to medical care	Invite local health providers to speak at church services about the importance of treatment	Provide donations to clinics
Pastoral care and social support	Pray for and with PLWH Counsel PLWH Organize support groups for PLWH Organize congregants to provide support to PLWH	Establish housing projects for PLWH Establish hospices Establish income-generating activities Address food insecurity of PLWH	Refer PLWH to support groups organized by others Refer PLWH to housing, hospice, income-generating, nutrition projects	Provide space at church for PLWH support group sponsored by external entity	Provide donations to AIDS hospice Serve as chaplain at AIDS clinics and hospitals
Stigma reduction	Raise HIV awareness among religious leaders, congregants, and community	Raise HIV awareness in rural/underserved areas and populations	Encourage members to participate in community-based stigma-reducing activities	Provide space at church for stigma-reduction workshop by MoH	Recognize stigma-reducing activities of local CBO

Table 5.1 — Continued

Type of HIV/AIDS Activity	Tasks That FBOs Perform Alone	FBOs' Role in Tasks Performed with Other Organizations			
		Complement (Address Gaps)	Reinforce	Facilitate	Support
Advocacy	Organize advocacy efforts related to prevention, treatment, and supportive services		Encourage members to participate in advocacy efforts	Have external entity organizing advocacy efforts speak at church services	Contribute to letter-writing campaign of other organization

NOTE: MoH = Ministry of Health.

^a Requires special training, equipment, and/or funding.

- **Complement the activities of others by addressing gaps outside the scope of others' missions or that others are unable to complete.** Here, FBOs act as innovators and control the what, where, when, and how. The burden of resources as well as responsibility for success and failure fall on the FBOs. Examples include the establishment of housing projects for PLWH and hospices and facilitating income-generating activities in which PLWH can engage once their health has been stabilized by ART.
- **Reinforce the activities undertaken by others.** Here, FBOs exert effort, but in concert with other organizations—for example, by reinforcing prevention messages, counseling their congregations on safe sex practices, and encouraging people to get tested. This kind of coordination is critical for tasks that require reaching a critical mass (e.g., social messages/social marketing, mass testing, stigma reduction, etc.).
- **Facilitate the activities of other organizations.** Here, FBOs help other organizations carry out their missions, either by providing access to their congregations or providing limited resources to facilitate the other organization's tasks. In general, the FBOs involved need to agree that the mission being facilitated is similar to theirs, but they do not control the details or expend much effort or resources. For example, they might provide an opportunity

for health leaders to promote the use of condoms in conjunction with activities that FBOs are directly responsible for organizing. Although many FBOs are much more comfortable addressing the “Abstinence” and “Be faithful” parts of the “ABC” approach, they allow health leaders to address the “C” part (condom use). FBOs neither address it directly nor condemn its use, but instead provide a space in which activities are carried out side-by-side by the two types of institutions. Another example is opening churches up for others to come in and do testing, or to refer people to other health and social support programs.

- **Support the activities undertaken by others.** Here, FBOs recognize that there are many types of interventions that are beyond their mission or means. Typically, such support requires few resources and can be accomplished by simply recognizing the efforts of others and encouraging people to support the other organization’s program. For example, a pastor or priest might recognize that several local CBOs are working with sex workers in the community and publicly thank them for their efforts. In another example, a congregation might gather donations (food, clothing, etc.) for a local AIDS hospice.

In addition to the above, FBOs could also allow others to observe, monitor, and evaluate their programs using objective criteria and rigorous analysis in the interest of both accountability and quality improvement. Partnership with the Ministry of Health or a similar agency is likely to require such evaluation to justify claims on scarce resources from both local and international funding sources. Further, there is much to be gained from building FBO capacity to evaluate their own programs, by developing simple systems for monitoring progress and identifying areas that are working and areas where they need to make modifications. As noted by Woldehanna et al. (2005), FBO HIV strategies and programs are based on “a varying mix of religious philosophy and empiricism”—i.e., science is not generally ignored, but the message is often tailored to be consistent with moral beliefs. Further, many FBOs function on the basis of motivation and trust: Responses are based on having a “good heart” to help,

rather than focusing on the effectiveness or efficiency of the organization or program (Foster, 2004). Some funders have recognized this and have initiated targeted efforts to build the capacity of FBOs to conduct monitoring and evaluation of their own programs (CORE Initiative, 2006). This kind of internal evaluation system is critical if FBOs are to improve the quality of their own interventions.

Implications

Our interviews with leaders of FBOs, public health officials, and NGO leaders in all three countries revealed striking differences in perspectives on the HIV epidemic and the challenges it poses for their respective missions and mandates. Given these differences in mission, underlying values, and positions on specific issues, such as homosexuality and the ethics of condom use, it would be easy to draw a rather guarded conclusion about the potential role that FBOs can play in addressing the challenges posed by the HIV epidemic viewed from a public health perspective. Yet to do that would be a mistake, in our view. First, considering the wide range of challenges posed by the epidemic and the areas in which FBOs are making significant contributions to address important needs, it would be myopic to focus on the specific areas in which many FBOs have a different perspective on what should be done or on what they are willing to do. Second, attending to people's material and physical needs, including their health needs, fits squarely within the mission of many or most FBOs, providing a substantial overlap with the mission of public agencies and many NGOs and establishing a basis for common cause. For these reasons, the differing perspectives of faith-based and non-faith-based organizations need not be a barrier to collaboration, as is often assumed.

The differing perspectives of FBOs and non-FBO organizations may offer opportunities for learning, however. For example, many FBO leaders seem not to fully appreciate the extent to which the epidemic has been concentrated in high-risk populations, such as MSM. In the absence of clear and accurate information about the service needs resulting from the epidemic, FBOs are likely to have a difficult

time allocating their resources in ways that have a strong impact on the epidemic. A broadened understanding of HIV epidemiology might lead some of them to think differently about where to direct their own prevention efforts, overcoming the natural tendency to avoid dealing with stigmatized groups who are often at high risk. An obvious solution to this problem is to create informational linkages between those who are more familiar with the epidemic and FBO leaders. This would likely begin with Ministry of Health personnel but could also include NGOs and advocacy groups.

Undoubtedly, there are ways that public health leaders could learn from FBOs and apply these lessons in their own public health role. For example, although some FBOs resist any efforts to incorporate education about the correct and consistent use of condoms as an appropriate HIV prevention strategy, there are significant numbers of FBOs that see condoms as appropriate under certain circumstances, but they prefer to see the issue within a broader set of pastoral counseling issues than some public health leaders. For example, if a woman wants her husband to use condoms because she fears he is being unfaithful, an FBO leader would counsel the women (and possibly her husband) on the broader relationship issues rather than merely encouraging the couple to use condoms. FBO leaders might be willing to share what they have learned about these broader issues among their congregants with public health leaders, and this dialogue could enhance public health efforts.

An important implication of our analysis for leaders in the public health sector is that they may find it worthwhile to think creatively about ways to make effective use of the strengths and capabilities of FBOs in addressing some of the critical needs posed by the HIV epidemic. FBOs provide a conduit into the hearts and minds of a large proportion of the population, and therefore have great potential value as instruments for dissemination of information about HIV/AIDS. While there may be some problem areas in delivering comprehensive prevention messages, other topics, such as factual information about transmission and the importance of HIV testing, can likely be disseminated by FBOs in ways that are fully consistent with public health goals.

Our analysis has identified a variety of ways that FBOs and public agencies can work together to address the critical needs posed by HIV. These vary both in closeness of collaboration and the degree of control exerted by FBOs versus other organizations. Although we observed some examples of collaboration between FBOs and public health or other organizations, there is considerable potential for a greater amount and variety of collaboration to occur, benefiting the missions of all parties.

One important question is the extent to which the implications of our analysis can be generalized to countries other than those we studied. We believe that, in many important respects, they can. The missions of FBOs and the range of activities in which they have engaged are broadly similar across the three countries, and the potential areas of engagement that fall within their comfort zone are also similar. The differences in perspective between FBOs, public agencies, and other organizations are also similar. It seems likely that a similar differentiation in roles and activities occurs in other Central American countries as well, with constructive collaboration between FBOs and other organizations falling short of what may be possible. Therefore, one of our principal conclusions is likely to be robust across Latin American settings: that FBOs, public agencies, and other organizations can work together more effectively if they accept and respect the differences in their perspectives and values, accept that not every organization needs to do everything, and acknowledge that there are many needs that can be met in different ways. Country-specific factors are more likely to emerge in the specifics of which groups in the population are most affected and what are the areas of greatest unmet need. However, it seems likely that efforts to help these affected populations and address these unmet needs will benefit from collaboration between FBOs, public agencies, and other organizations. Nevertheless, it is unclear how FBO responses to HIV/AIDS might be different in regions with more generalized epidemics (e.g., Africa), where significant portions of congregations' regular members are infected, and how this may change the demand for FBO services as well as FBO attitudes and rhetoric.

Donor organizations can potentially play a critical role in fostering such collaborations and providing the funds to evaluate and sustain

them. Even when missions overlap, it can be difficult for organizations to adopt the broader cross-agency perspective that is often necessary to ensure continuing success of a joint initiative. Donors can provide the resources that make it possible to have someone with this broader perspective dedicated to the task.

Study Approach and Methods

Data Collection Activities

Data collection occurred principally between November 2006 and November 2007 and consisted of three primary data collection activities:

1. Searches of published literature, grey literature,¹ and organizational websites for information about HIV in Central America and/or FBO involvement
2. Telephone interviews with key informants or community experts familiar with the region to collect initial information about their HIV activities and/or identify key stakeholders and FBO projects/activities that we should attempt to visit and/or interview during our site visits
3. Nine-day visits to each country (Honduras in March 2007, Guatemala in May 2007, and Belize in July 2007) to interview stakeholders and conduct site visits to FBO-sponsored HIV/AIDS projects and activities.

¹ This refers to materials not easily found through conventional channels, such as publishers, and includes organizational reports, technical reports from government agencies or scientific research groups, working papers, white papers, etc.

Participants

Through the published literature, organizational websites, and key informants, we identified principal stakeholders involved in HIV in Belize, Guatemala, and Honduras. These stakeholders included persons affiliated with government agencies, bilateral assistance agencies, FBOs, other NGOs (international and local), and organizations representing PLWH. During site visits, we interviewed a purposive sample of members of organizations that represented the range of organizations involved in HIV. Further, within the FBO group, we aimed to include individuals representing a range of denominational groups (Catholic, Evangelical, and Mainline Protestant).

In addition to purposive sampling, we used snowball sampling, where individuals interviewed were asked to identify other individuals or organizations in any of the above stakeholder categories. Because our purpose was to understand how FBOs had been involved in HIV/AIDS and what were some of the successes and challenges of that involvement, we focused on FBOs that in fact had been involved in some way in HIV/AIDS. It could have been informative to interview FBOs that had *not* been involved to understand some of the challenges, but because of limited resources, we opted not to include this group. On the other hand, although we also tried to include representatives of other stakeholder groups (e.g., government, bilateral assistance, NGOs) that also had some experience with or knowledge of FBOs involved in HIV/AIDS, this experience or knowledge was not necessarily critical because their perspectives of FBO involvement (awareness of activities, challenges to involvement, etc.) were equally as informative.

Interview Methods

Two separate but overlapping interview protocols were developed for interviewing (1) leaders of faith-based organizations (FBO leader protocol) and (2) leaders representing other types of organizations (health leader protocol). The FBO leader protocol focused on the particular FBO's

- involvement in HIV/AIDS (populations served, types of activities, collaboration with other organizations, challenges faced, major successes of efforts)
- denominational/ organizational policies regarding HIV/AIDS
- attitudes toward HIV/AIDS (respondent, organizational, and broader community).

The health leader protocol focused on

- leaders' perspectives of HIV/AIDS in their respective countries (prevalence, groups affected, major routes of transmission, principal actors involved, economic burden, treatment and prevention policies)
- their experience with partnerships for HIV prevention and care and with which entities (including FBOs)
- their perception of FBOs and the care and prevention of HIV/AIDS (knowledge of FBO involvement, how effective, efforts of government and NGOs to partner with FBOs in HIV prevention and care, barriers to collaborating with FBOs)
- HIV/AIDS in the context of other health priorities.

Both protocols were approved by the RAND Human Subjects Protection Committee. Each protocol was translated into Spanish by a bilingual RAND staff member and reviewed by bilingual HIV Outreach in Latin America (HOLA) team members (discrepancies were resolved by consensus). The majority of the interviews in Guatemala and Honduras were conducted in Spanish; all the interviews in Belize were conducted in English. All of the RAND staff members involved in the interviews and communicating with key informants were fluent in Spanish.

Interviews generally lasted from one to two hours and were audio-recorded. Most interviews took place in offices, or at a meeting place of the interviewee's choice; a few took place in cars while driving to locations. Most interviews had two RAND team members present, one leading questioning and the other note-taking. Notes were then enhanced by listening to audio recordings within a day or so of the

interview, and by having at least one other team member review and add to the draft notes before finalizing. In addition to notes taken during interviews, RAND team members had ongoing team discussions immediately after interviews to review what was said during the interview, compare reactions, share insights, and take additional notes. These notes provided an additional record of the interviews and site visits and helped in the completion of the note finalization process. Later, after analyses of notes and theme identification (described below), we re-listened to portions of the audio-recordings to pull out verbatim quotations that best illustrated these themes. Finally, many interviewees gave us written information about their organization and/or programs (pamphlets, brochures, HIV educational materials used in programs, surveillance and other internal reports, program descriptions, etc.). We used this supplementary material to further enhance our notes about organizational efforts.

Site Visits

In addition to the interviews, we obtained firsthand information about in-country HIV/AIDS activities by visiting local clinics, hospitals, hospices, orphanages, HIV support groups, an HIV/AIDS awareness day parade, and a prison. Since note-taking was not appropriate during these visits, we audio-recorded team discussions, involving those who had participated in the site visit, immediately afterward (usually driving to our next site visit or interview) to document conversations and observations made during the visit, as well as any insights gained. Notes were then constructed from the audio-recordings.

Analysis

To analyze our qualitative data, we used grounded theory approaches to coding qualitative data (Strauss and Corbin, 1998; Miles and Huberman, 1994), which identify key themes inductively, in combination with content coding procedures (Krippendorff, 1980; Weber, 1990;

Altheide, 1996). Two team members experienced in qualitative data analysis read through interview notes and developed a list of themes for coding. Themes included both the topics that were part of the interview protocol and additional themes that emerged from the close reading of interview notes and identification of patterns in the discussions. Once a final list of themes was agreed on, the team analysts re-read the notes and organized the text with a data display matrix (Ryan and Bernard, 2000, 2003), by copying and pasting text into cells of an Excel spreadsheet. The spreadsheet was arranged so that rows represented individual interviews and columns represented themes, facilitating comparison across themes and stakeholders. Because the protocols for health and FBO leaders differed somewhat, two separate spreadsheets were created for each country, one for health leaders and one for FBOs.

Once all interviews were coded using this process, the two team members met and read through the text in each column of each spreadsheet. The goal was to summarize the issues that emerged across cases for each type of interview. The two team analysts independently wrote down lists of issues that emerged from reading the text in each column, compared lists, and came to consensus on one list for each theme. After each theme was analyzed, the lists were organized by topic. The themes that emerged from the health leader interviews were compared and contrasted with the themes that emerged from the FBO interviews. Once analysis of all themes was completed, we identified prominent themes for illustration with quotations. The goal of the quotation selection was to identify comments that represented either the most commonly expressed ideas or less common quotations that illustrated the range of opinions about particular topics. We selected quotations that best represented these dimensions for inclusion in the results description.

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