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

Kathryn Pitkin Derose, David E. Kanouse, David P. Kennedy, Kavita Patel, Alice Taylor, Kristin J. Leuschner, Homero Martinez

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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 incoming-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.