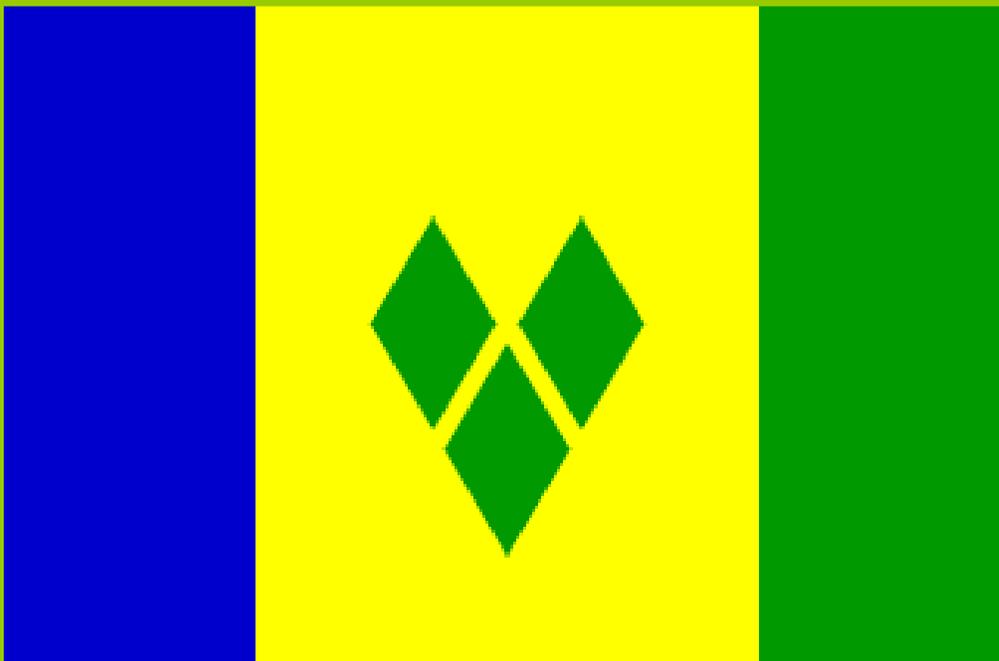


# The Role of Faith-Based Organisations in HIV Prevention and Services

## A Situational Analysis in St Vincent and the Grenadines



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## Foreword

It is with pleasure that we present this report *The Role of Faith-Based Organisations in HIV Prevention and Services: A Situational Analysis in St. Vincent and the Grenadines*. The study was undertaken by the International HIV/AIDS Alliance (IHAA), Caribbean HIV&AIDS Alliance (CHAA) and the University of California, San Francisco (UCSF) with funding from the United States Agency for International Development (USAID). The goal of this situational analysis was to understand Faith-Based Organisations' (FBOs) willingness and capacity to engage in HIV prevention and care services. The study also sought to better understand the barriers and facilitators to design and implement HIV activities by undertaken by FBOs.

The overall aim of the EC-CAP is to work with vulnerable communities to increase access to HIV and AIDS services in four countries of the Eastern Caribbean; Antigua and Barbuda, Barbados, St. Kitts and Nevis, and St. Vincent and the Grenadines. The research carried out under this project assists in building programmes that are relevant, culturally appropriate and effective within the countries, in partnership with National AIDS Programmes and civil society. The research will also inform behaviour change, counselling and testing and palliative care/home based care projects or capture lessons learnt for application to future efforts.

CHAA is a regional NGO and recently became a linking organisation of IHAA. CHAA works specifically to mobilise vulnerable communities to carry out HIV prevention and education activities, counselling and testing and promoting access to care and support with three key populations: men who have sex with men (MSM), sex workers (SW) and people living with HIV (PLHIV) and AIDS (PLWA). The portfolio of the CHAA consists of five main elements, as follows: (1) prevention; (2) promoting and facilitating access to health services; (3) care, support and empowerment of PLHIV and PLWA; (4) peer support; and (5) acceleration of the private sector response to HIV and AIDS.

In keeping with the philosophy that partnerships are a critical part of our strategic vision, this report was developed as a joint effort of a team of researchers from CHAA and the University of California at San Francisco with the support of the Government of St. Vincent and the Grenadines. It represents a strategic and proactive approach to HIV programming and demonstrates a model of systematic programme-oriented research. This study builds on an effort initiated by the Pan Caribbean Partnership Against HIV/AIDS (PANCAP) when, in November 2005, it hosted the Champions for Change II Regional Conference of Faith-Based Organisations to Reduce Stigma and Discrimination. One key result of this conference was the Declaration of Commitment by Faith-Based Organisations to reduce Stigma and Discrimination against People Living with, and Affected by HIV and AIDS. This assessment extends the options for reaching people at risk for HIV transmission and PLHIV through partnerships with faith-based organisations.

## List of acronyms

AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral therapy
BBSS	Biological/ Behavioural Surveillance Surveys
CAREC	Caribbean Epidemiology Centre
CCC	Caribbean Conference of Churches
CDC	US Centers for Disease Control and Prevention
CHAA	Caribbean HIV&AIDS Alliance
FBO	Faith-based organisation
GLBT	Gay, lesbian, bisexual or transgender
HIV	Human Immunodeficiency Virus
IHAA	International HIV/AIDS Alliance
IRB	Institutional Review Board
MSM	Men who have sex with men
NAS	National AIDS Secretariat
NGO	Non-Governmental Organisation
PHSC	Protection of Human Subjects Committee
PLHIV	People living with HIV
PLWA	People living with AIDS
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SVG	St. Vincent and the Grenadines
SW	Sex worker
UCSF	University of California, San Francisco
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
US	United States of America
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

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The Caribbean HIV&AIDS Alliance and the University of California at San Francisco would like to express our sincere gratitude to all those individuals and organisations who contributed to the successful planning and execution of this study. Special thanks to the staff of the Ministry of Health and the National AIDS Secretariat for their guidance during the process and for freely providing us with requested information. We also acknowledge the invaluable contribution of the St. Vincent Association of Evangelical Churches, the St. Vincent Seventh Days Adventist Coordinating Committee and the St. Vincent Christian Council and their individual members who provided feedback and support for this study as well as the Rastafarian representatives who provided guidance for work with their group. We also acknowledge the invaluable support from CHAA St. Vincent and the Grenadines country office staff. This study would not have been possible without the participation of the representatives of the Faith-Based Organisations who gave us a lot of their precious time, provided extremely useful information, and openly discussed sensitive issues. Finally, special thanks are extended to USAID for providing the funding to support this much- needed situational assessment.

# Executive Summary

## Background

Faith-based organisations (FBOs) play an important role within Caribbean societies and religious leaders have considerable influence. Many FBOs are already engaged at various levels in HIV prevention and services or have acknowledged their potential leadership role in the response to HIV and AIDS, including engaging in HIV prevention and other related services. However, little is known about the roles they are playing or could play in HIV and AIDS programming in the Caribbean. In light of this, a study was carried out with FBOs in four countries: Antigua and Barbuda, Barbados, St. Kitts and Nevis and St. Vincent and the Grenadines (SVG). The research was conducted by the International HIV/AIDS Alliance, Caribbean HIV&AIDS Alliance (CHAA), in partnership with the University of California at San Francisco (UCSF), with funding from the United States Agency for International Development (USAID).

The study was developed to assess the feasibility and acceptability of implementing HIV prevention interventions and other services through FBOs. The specific aims of the study were:

1. To assess the willingness and capacity of FBOs to participate in HIV prevention activities
2. To assess the level of HIV related stigma among those organisations
3. To identify the barriers and facilitators to implementing HIV prevention interventions by or in partnership with FBOs.

## Methods

A combination of qualitative and quantitative data collection methods were used to carry out this study. Primary data were collected via two methods. First, the research team conducted 10 interviews with representatives of selected denominations using a semi-structured interview guide. Second, a survey was conducted using a standardised questionnaire to interview 50 representatives from a broad cross-section of FBOs. Secondary data from published reports available from government and online sources provided context for the design of the instruments and for the findings from the interviews and surveys.

Participants were asked about:

- Relevant FBO doctrines and teachings
- Current HIV programming
- Interest, facilitators and barriers to expanding programming, and
- HIV stigma within the organisations.

## **Results**

Participant descriptions and demographics

### **Description of FBOs**

Fourteen denominations were represented in this study, varying in size from 15 to 450 congregants. Most FBOs were affiliated with an umbrella group. The greatest number said they were affiliated with the Caribbean Conference of Churches (n=3), the Pentecostal Assemblies of the West Indies (n=3) and the Evangelical Association of St. Vincent and the Grenadines (n=3). FBOs were staffed with either paid staff or a combination of paid staff and volunteers.

### **Respondent Characteristics**

Interviewees in the qualitative component of the study (the semi-structured interviews) identified themselves as bishop, head or coordinator and chief administrator, major, minister, senior pastor, and ordained sister. Some interviewees reported more than one role within their FBO. Among survey respondents, more than three-quarters identified themselves as pastors or priests of their churches (n=39). Eight identified themselves as church members. One identified himself as the Assistant Pastor. One said he was an administrative worker and one said he was the youth leader.

### **FBO Congregations**

Congregants in FBOs were reported to be predominantly women (approximately 75% in most FBOs). Many of the women who attend FBOs are young single mothers. Most congregants have completed high school, vocational school or have some high school preparation. Attendance at FBO services is said to be declining among youth, although FBOs with targeted programmes and an open attitude to youth issues had more success retaining youth. In general, most interviewees were not aware of gay, lesbian, bi-sexual or transgender (GLBT) members at their FBOs. The number of People Living with HIV (PLHIV) who had openly disclosed their status within the FBOs was either very limited or non-existent.

Willingness and capacity of FBOs to participate in HIV programming

### **HIV as a priority among FBOs**

While most (42 out of 50) respondents to the quantitative surveys answered that HIV was a very important issue for their FBOs, the level of priority given to HIV as an issue among FBOs represented in the qualitative interviews varied.

### **Messages around HIV and AIDS**

Explicit HIV prevention messages delivered by FBOs are abstinence for those who are unmarried and fidelity for those who are married, non-discrimination towards PLHIV and, in some cases, condom use for married couples. Distribution of safer sex literature, promoting condom use or doing condom demonstrations were not considered viable messages within most FBOs.

Interviewees said that FBOs were supportive of congregants learning about HIV transmission and risk in order to protect themselves and as a way of dispelling myths regarding HIV and challenging discrimination against PLHIV.

FBOs are interested in providing more prevention and other HIV-related programmes, particularly services for youth, women and PLHIV and anti-stigma sensitisation among congregants. Some services to PLHIV have already been provided, mostly on an informal basis, in the form of financial assistance and care in end of life situations.

### **Potential stigma related to HIV**

Participants in the qualitative interviews stated that FBOs, according to doctrine and philosophy, do not discriminate against PLHIV and encourage the congregations not to be judgemental. The level of leadership amongst FBOs to combat stigma, however, varied. Interviewees acknowledged the need for stronger messages coming from FBO leaders, including pastors, to help sensitise congregants about stigma and discrimination. In some cases, church leaders were identified as people among whom HIV-related stigma still exists.

Most participants agreed that there is still the attitude among some that PLHIV should be ostracised, punished and that it is their fault they have been infected, since HIV is associated with having multiple partners. Interviewees said that PLHIV may be welcomed in church in a general sense, but some congregants may express some reservations and have difficulty reaching out or relating to someone living with HIV.

### **Barriers to implementing HIV prevention interventions through FBOs**

The promotion of abstinence and fidelity as primary HIV prevention messages was seen by some as a limitation when confronted with the reality of people being sexually active, and particularly in cases where women's husbands are having sex outside the marital relationship. As noted above, many congregants were single mothers, and messages of fidelity within marriage or abstinence are unlikely to be relevant to many of the realities they face in their personal lives.

A few participants noted that the inability to teach contraception and talk about condom use prevented FBOs in being involved in some sorts of HIV prevention. Further, sex work, including transactional sex, and homosexuality are generally considered wrong, sexually immoral and unacceptable, severely constraining the ability to engage in HIV prevention activities with key populations such as sex workers and men who have sex with men. However, some respondents expressed ambivalence about conventional FBO views on these issues, expressing willingness to provide some support in recognition of the involvement of some people in SVG in behaviour that puts them at risk of HIV.

Leaders of FBOs were said to fear a negative response from some congregants if they talk more openly about sex or condom use. Some respondents perceived that talking about condoms or demonstrating condom use will encourage people to have sex and that it will contravene religious doctrine. Knowledge about HIV may not be strong enough to override entrenched HIV perceptions and myths amongst some congregants.

As regards care and support, research participants indicated the willingness of FBOs to provide services to PLHIV. However, PLHIV do not seem to be willing to disclose their status and seek services at FBOs for fear of stigma and discrimination and breach of confidentiality.

There are limitations in the reach and capacity of FBOs to conduct HIV programmes. Fewer men than women are likely to be reached by HIV prevention activities by FBOs, given the predominance of women among congregants. While FBOs do some HIV work there may not be a uniform policy within the denomination (not just in-country but also regionally) and some people within denominations may be uncomfortable confronting the issue or seeing it as part of the FBO role to talk about HIV prevention. Respondents cited resource constraints including few skilled people to implement HIV programmes or to write project proposals and seek funding.

### **Facilitators to implementing HIV prevention interventions through FBOs**

FBO representatives expressed interest in developing further HIV programming. HIV activities and health programmes are already underway in some FBOs. They tend to take place because of the initiative, convictions, beliefs, commitment, and personality of a few persons within an FBO, whether religious leaders or lay persons. These initiatives may not be the result of an organisational approach and may not have the widespread support and backing within the FBO or the denomination at large. This fact could be both a facilitator and barrier to implementing programmes.

There are congregants who because of their wealth, social status, education, authority, caring attitudes and perceived motherly or fatherly image can hold considerable influence over other congregants, including their beliefs. Tapping into these human resources, and including professionals who are members of FBOs such as doctors or nurses, holds potential for increasing the impact of HIV programmes.

There are already some partnerships and collaborations between the National AIDS Secretariat (NAS) and faith-based umbrella organisations such as the Caribbean Conference of Churches, the St. Vincent Christian Council or the Evangelical Association of St Vincent.

### **Recommendations**

#### **Stimulating FBO involvement in programming**

A meeting of FBOs may be arranged to bring together leaders to discuss a strategy for the involvement of FBOs in various aspects of HIV programming such as prevention strategies, key populations to involve and care and support for PLHIV. FBO leaders who are already active and committed with regard to HIV may be supported in arranging this meeting by the NAS. In discussing strategy, it is important to recognise diversity among FBOs, and allow for different levels of involvement of different FBOs. Plans of action should be developed in partnership with each denomination willing to be involved in some way. The NAS and its key partners, including CHAA, should be kept apprised of developments in FBO HIV activity planning in order to ascertain the support that can be provided in terms of capacity building and HIV programming. This may include support to the formation of a network of FBOs whose leaders are willing to participate in HIV programming.

## **Capacity development for FBOs**

A training curriculum should be developed for church leaders and church members that is designed to be implemented in a structured and consistent manner over a fixed period of time. The following are areas useful to include in the curriculum:

How FBOs can support the spiritual needs of PLHIV

How to use Biblical messages and church teaching to support inclusiveness, reduce stigma and discrimination and increase confidentiality

How to promote church leadership around risk reduction using a public health approach

Basic HIV and AIDS knowledge including epidemiology, prevalence, transmission myths and prevention methods

Human sexuality and other sexual and reproductive health issues

Most-at-risk populations and vulnerabilities

Vulnerabilities of girls and women

Risk behaviours among young people (including substance abuse as well as sexual behaviour)

The human rights based approach to universal access to HIV services and freedom from discrimination

Palliative care and home-based care

Basic principles of monitoring and evaluation

Of note is that the Pan Caribbean Partnership Against HIV/ AIDS, as part of its Champions for Change initiative, has developed a stigma and discrimination toolkit, including a module for FBOs. This toolkit was developed with technical support from CHAA. The possibilities for using this toolkit to build capacity to combat stigma and discrimination among FBOs in SVG should be explored.

PLHIV may be included as facilitators within training for FBO personnel to talk about their experience of living with HIV and AIDS. This may assist with dispelling myths related to HIV and AIDS. It may not be possible in SVG to identify PLHIV who have already disclosed their HIV status and are willing and able to conduct such facilitation. The possibility of bringing PLHIV from other Caribbean countries who are experienced in this kind of work should be explored. Agencies such as the Caribbean Regional Network of People Living with HIV/AIDS (CRN+) and CHAA may be able to assist in identifying suitable facilitators.

Church leaders, in the process of further engagement in HIV programming and in training initiatives with them, should be encouraged to recognise differences between facts and values regarding the disease.

They should be assisted to appreciate their ability to impart accurate information about HIV to FBO members and thus challenge stigma and discrimination. They could, for example, be trained in counselling related to HIV testing, and supported to compile suitable Bible study materials with HIV prevention messages.

### **Building on Global Initiatives**

Internationally, there are numerous HIV initiatives with FBOs, some of these spanning the globe. Programme implementers should try to make material from these initiatives available to FBOs in Antigua and Barbuda or direct them to websites and sources of support such as the Ecumenical AIDS Alliance, the World Council of Churches and Christian Aid.

### **Youth**

Formative assessments with young people who attend FBOs are recommended to design HIV programmes that are relevant, acceptable and appealing to them. These may include peer outreach to young people in wider communities within which the church is located. Programmes may be developed that are acceptable to the church but are still geared towards youth such as sports programmes or dances and socials that allow mingling in a relaxed atmosphere. They may also focus on developing communications skills and family life. Theatre initiatives for HIV education with youth may be pursued, such as the “With Open Arms” theatre project currently implemented by some FBOs in SVG.

Leaders in the church, not just youth leaders, should be trained in counselling techniques appropriate for youth. This should include the topics of health and sexuality, particularly adolescent sexuality. They should also be trained in developing parental communication skills among members of their congregations around topics of sex and sexuality within the boundaries of what is acceptable for the church.

### **Gender issues**

Formative assessments may be conducted with a view to implementing programmes with women who attend FBOs, including single parents. These should address issues including managing relationships, building self-esteem, improving communications with partners and children and negotiating safer sexual practices. They should be developed and implemented in careful consultation with FBOs since faith-based messages for women sometimes follow biblical interpretations that promote traditional gender roles. The feasibility of implementing evidence-based interventions for HIV prevention among church-going women should be explored. In St. Kitts and Nevis, CHAA is currently working with women in industrial estates to adapt an evidence-based intervention called SISTA.<sup>1</sup>

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<sup>1</sup>University of California, San Francisco and Caribbean HIV & AIDS Alliance (2010) *Assessing the Feasibility and Acceptability of Implementing Evidence-Based HIV Prevention Interventions for Women Working in Industrial Estates in St. Kitts, Port of Spain, Trinidad and Tobago*: Caribbean HIV&AIDS Alliance.

This intervention was originally developed for African American women and includes an emphasis on both self-esteem and building communication skills in personal relationships. The possibility of adapting such an intervention among women in SVG may be explored.

While men may not represent the majority in most church congregations, there are opportunities to address male gender norms that may increase vulnerability to HIV. Via sermons and outreach activities, FBOs are well placed to encourage men better to consider their responsibilities with regard to their own vulnerabilities and to prevention of HIV transmission to their partners. Messages regarding the risks of multiple partnerships and promoting condom use may be particularly suitable for male audiences.

## **Conclusions**

This study provides a preliminary assessment of the current and potential engagement of FBOs in SVG in HIV programming. Contextual data was generated by semi-structured interviews, while the survey generated basic information on a broad range of FBOs. This report, however, does not seek to publicise information on the specific HIV-related programmes of a particular FBO or denomination. To protect privacy, the research team has not disaggregated the results by organisation or denomination.

The findings indicate that messages and programmes must be tailored to the ability and willingness of individual FBOs to engage further in HIV prevention. They may, for instance, be most willing to promote abstinence and fidelity as HIV prevention messages and counselling and palliative care as support strategies for PLHIV. It may be difficult to engage them in activities involving condom promotion and work with sex workers and men who have sex with men. The reach of FBOs among women and young people is considerable and further assessments and collaborative work with FBOs are needed to develop HIV programmes with FBOs that are appropriate to these populations.

The information in this report may be utilised to extend the options for reaching people at risk for HIV transmission and PLHIV through partnerships with FBOs. Informed by these findings, further collaboration between FBOs, the National AIDS Programme, CHAA and other agencies, will augur well in increasing the impact of HIV prevention and care programmes in St. Vincent and the Grenadines.

# 1.0 Introduction

Faith-based organisations (FBOs) play an important role within Caribbean societies and religious leaders have considerable influence. Adherence to religious teaching remains a cultural norm within significant sections of the Caribbean population even though behaviours do not always reflect their influence. The importance of religious bodies in mobilising the response to HIV and AIDS in the Caribbean is demonstrated by the emphasis which continues to be placed on FBOs in regional and national strategic plans. Many FBOs are already engaged to some extent in HIV prevention and services or have acknowledged their potential leadership role in the response to HIV and AIDS, including engaging in HIV prevention and other related services. However, little is known about the specific roles they are playing or could play in HIV and AIDS programming in the Caribbean.

The United States Agency for International Development (USAID) provided funding to the International HIV/AIDS Alliance (IHAA)/Caribbean HIV&AIDS Alliance (CHAA) to conduct the Eastern Caribbean Community Action Project. This included an assessment of FBOs in four Eastern Caribbean countries, as follows: Antigua and Barbuda, Barbados, St. Kitts and Nevis and St. Vincent and the Grenadines (SVG). These studies were conducted in partnership with the University of California at San Francisco (UCSF) and were developed to assess the feasibility and acceptability of implementing HIV prevention interventions and other services through FBOs. The specific aims of the study were:

1. To assess the willingness and capacity of FBOs to participate in HIV prevention activities;
2. To assess the level of HIV related stigma among those organisations.
3. To identify the barriers and facilitators to implementing HIV prevention interventions by or in partnership with FBOs.

This report presents the findings for SVG.

## 2.0 Background

The nation of SVG is made up of 32 islands and cays and forms part of the Windward Islands, with an estimated population in 2008 of 118,000 (1). Canouan, Bequia, and Union are the largest and most populated of the Grenadines. Most of the population resides on the island of St. Vincent, with Bequia being the second largest, having approximately 5000 inhabitants (2). SVG was a British colony until independence in 1979. The country now has a democratically elected government. The official language is English, and the capital, Kingstown, is located on the island of St. Vincent.

The fertility rate in SVG as of 2007 was 2.2 children per female, and the crude birth rate was 20.1 per 1,000, down from 23.6 in 1995 (3). Although local health authorities are concerned with what they perceive to be an increase in teenage pregnancies (4), statistics indicate that teenage births are also on the decline. The National Family Planning department released figures indicating that 464 teenaged women gave birth in 2000, but that 398 did in 2003 (5). Overall, there were 8,166 live births in 2000-2003 and 20% were to teenage mothers (6).

### 2.1 HIV IN THE CARIBBEAN

The Caribbean ranks second in the world with regards to HIV prevalence, only surpassed by Sub-Saharan Africa (3). Since the first HIV cases of the epidemic in the region arose in the early 1980s, AIDS has become one of the leading causes of death for those aged 25 to 44 years. At the end of 2008, an estimated 240,000 people were living with [HIV](#) and [AIDS](#) in the Caribbean. Some 20,000 people were newly infected during 2008, and there were 12,000 deaths due to AIDS.

HIV is transmitted mainly through sexual intercourse (4). Although in the region HIV was first seen in homosexual men, prevalence among women has grown. The annual HIV incidence for females aged 15 to 24 is three to six times higher than for males of the same age (5). Men who have sex with men (MSM), however, still remain an at-risk group (4). The epidemic has been fuelled by unprotected sex, multiple partnering, transactional sex and existing laws against sex work and homosexuality. These laws help to perpetuate stigma and discrimination, resulting in clandestine risk-taking behaviour (6) and contributing to driving the epidemic underground and effectively making the task of prevention and access to care and treatment more difficult (7).

### 2.2. HIV IN ST VINCENT AND THE GRENADINES

The first case of HIV in St Vincent and the Grenadines was reported in 1984 (8). At the end of 2006, the prevalence rate in SVG was estimated at 0.4% (472 reported cases), based on a population of 106,253 persons (9). The current ratio of men to women with HIV is 1.3 to 1.

The 2008 United Nations General Assembly Special Session on HIV/AIDS (UNGASS) country progress report acknowledges that “HIV/AIDS remains a serious health challenge in SVG affecting primarily those who are often socially and economically vulnerable” (10). Those most vulnerable are aged between 20 and 49, accounting for 74% of total infected persons identified in 2006-7. This is consistent with AIDS being one of the leading causes of death for those aged 25 to 44 years in the Caribbean region (8).

The main form of transmission is believed to be through heterosexual contact. Early sexual debut is common in SVG; just under a quarter of those aged between 15 and 24 reported having sex before the age of 15 (10).

The SVG government has created an HIV and AIDS National Strategic Plan in response to the epidemic. The six priority areas of the strategic plan for the period 2004-2009 are to:

1. Strengthen intersectoral management, organisational structures and institutional capacity;
2. Design and implement care, support and treatment programmes for PLHIV and their families;
3. Develop and implement HIV/AIDS/STI and control programmes with priority given to youth and high-risk/vulnerable groups;
4. Conduct research and training programmes;
5. Upgrade surveillance systems; and
6. Implement advocacy programmes (11).

According to the 2008 UNGASS Report, the plan emphasises care services and services to among others, high risk vulnerable groups, with the National AIDS Secretariat (NAS) responsible for coordinating all activities in collaboration with different stakeholders such as NGOs and FBOs (12).

A Behavioural Surveillance Survey (BSS) that took place in 2005/2006 among the general population aged 25-49 years old found that Vincentians have a high level of HIV and AIDS knowledge, with 99% of the 979 participants displaying such knowledge. The question remains how to translate this knowledge into positive behavioural change, since only 37% reported consistent condom use with casual partners within the past 12 months (12).

## **2.3 HISTORY OF FAITH-BASED ORGANISATIONS IN THE CARIBBEAN**

### **2.3.1 Pre-Emancipation**

FBOs have a long history in the establishment of Caribbean society and culture, and strong religious influences and practices still permeate throughout the region. Catholic and Anglican institutions were established early in the history of European colonisation, with Anglicanism being the dominant religion among the planter class in the English colonies.

With the rise of sugar cane as the primary plantation crop in the Caribbean in the mid-seventeenth century came the need for additional manpower. The British slave trade of Africans began, leading to a black majority in the population (13). However, the conversion of the enslaved population to Christianity was initially fought against by the planter class who believed that “the admission of slaves to membership in the church would lead to their entertaining notions of equality which would disturb social order” (14). Local clergy were also against the proposed missionary outreach amongst enslaved people. This idea changed, however, as the colonies moved towards the abolition of slavery, under pressure from the abolitionists in England to improve the spiritual and physical conditions of the slaves (15).

In 1824, the colonial government decided that conversion to Christianity would provide motivation to the labouring class to continue working hard on the sugar plantations (16). The conversion of many people of African descent to Christianity was also influenced by the presence that the so called “nonconformist” religions had gained in the West Indies by that time. One of the nonconformist groups, the Quakers, arrived in the 1660s to the islands of Barbados, Jamaica and Nevis (17). Missionaries from other nonconformist churches, such as those from the Methodist, Moravian and Baptist faiths, arrived in the Caribbean in the latter half of the 18th century, in conjunction with the evangelical movement in England (18). The Baptist influence was brought to Jamaica, not from England, but by an indentured labourer from Virginia, in the USA. Their following grew so rapidly, though, that the London Baptist Missionary Society in England was invited to send missionaries to provide assistance to the leaders, with the first arriving in 1814 (19). The “nonconformist” churches may have had a “far more profound influence on religion in the West Indies than the Anglicans” (20). Enslaved people also continued to be involved in variations of African religious practices, often adapting and integrating them with Christian practices, leading to the development of syncretic religious forms (21).

### **2.3.2 Post Emancipation**

The emancipation of the slaves in the West Indies occurred in 1834 as voted by the British Parliament. A year later, the same Parliament proposed a grant to educate the formerly enslaved people, and this was made available to the Church of England and other denominations. This represented an acknowledgement from the colonial government of the presence of the various Christian groups in the region, not just the established church (22). By 1838, there were more than 73,000 students in day and Sunday schools across the British colonies, with Barbados providing the majority of the educational opportunities. For the most part, the responsibility in providing the education and organising the setting up of schools resided with the churches (23).

With freedom came the desire and ability by formerly enslaved people to seek out available land for peasant holdings which led to their migration both within and between islands. This migration reduced church attendance in current settlements but also led to the spread of various denominations to other parts of the Caribbean (24). Over time, the privileged position of the Church of England began to diminish. In 1868, the imperial grant to the Church of England was abolished, having been in place since 1824. Many local governments also adjusted their subsidy payments to be more equitable amongst different denominations (25).

In the twentieth century, the Christian denominations maintained their importance in the region. They tended to reduce their reliance on Europe and more recently North America to provide clergy, and instead established a local leadership base (26). The arrival of apocalyptic, fundamentalist, and Pentecostal churches brought another wave of religious influence to the Caribbean (27). For example, Pentecostalism was introduced predominately from churches on the North American eastern seaboard in the early 1900s (28).

This church embedded itself to such an extent in the Jamaican society that by the 1980s, it could claim approximately half a million Jamaican followers or almost a quarter of the country's population. The movement reflected a change in influence in the region as the legacies of Britain's colonialism were gradually overtaken by North America (29). This North American influence can be seen in the growth of groups such as Jehovah's Witnesses, Seventh Day Adventists and the various representations of the Church of God in Christ.

## **2.4 RECENT HIV INITIATIVES INVOLVING CARIBBEAN FBOS**

The Caribbean Conference of Churches (CCC), founded in 1973, serves as an implementing agency that promotes development and sustainability through various programmatic initiatives of churches in the Caribbean. Its work in 34 territories of the region has fostered mutual relationships between ecumenical organisations on a territorial, regional and international level. The CCC has gained support from the Canadian International Development Agency (CIDA).

CCC's membership of 33 faith-based organisations has successfully collaborated and established programmes and initiatives that have benefited the Caribbean, including the comprehensive 3 year regional program, "Building a Faith-based Response to HIV and AIDS in the Caribbean". The programme's aim is "to mobilise and enhance the response of Faith-based Organisations (FBOs) to the HIV epidemic" (30).

CCC is a member of the Pan Caribbean Partnership Against HIV/AIDS (PANCAP). CCC has thirty- four member churches in thirty-three countries across the Caribbean. Its role is to serve the churches in the cause of unity, renewal and joint action (<http://www.oikoumene.org/gr/member-churches/regions/caribbean/ccc.html>).

PANCAP hosted the Champions for Change II Regional Conference of Faith-Based Organisations to Reduce Stigma and Discrimination in November 2005. A result of this conference was the Declaration of Commitment by Faith-Based Organisations to reduce Stigma and Discrimination against People Living with, and Affected by HIV and AIDS. In addition, the Caribbean Conference of Churches was nominated to work with CARICOM / PANCAP "to establish a working committee to carry forward the elements of the Plan of Action arising from the Champions for Change II Regional Conference" (31).

The CCC, with support from the Canadian International Development Agency, has also developed an action plan in order to build a faith-based response to HIV and AIDS in the Caribbean, recognising the need for each FBO to implement such a plan within the confines of its own beliefs. The CCC aims to "facilitate the formation of a strategic alliance among Caribbean FBOs to combat HIV and AIDS". SVG is one of the 14 target countries for the project (32). The guidelines of the action plan are based around the following headings: leadership; prevention; care, support and counselling; human rights and advocacy; death and burial; education; and gender. The report identifies youth and young adults, especially females between the ages of 15-19 as being the most vulnerable group in the region.

## **2.5 FAITH-BASED ORGANISATIONS IN ST VINCENT AND THE GRENADINES**

According to the International Religious Freedom Report, 2005, Christianity is the dominant religion among people who live in SVG (33). The report also states that other denominations include Roman Catholics, Methodists, Seventh Day Adventists and Pentecostals. Other religions such as the Baha'i Faith and Rastafari also attract Vincentians.

Documented reports state that missionaries arrived in St. Vincent as early as 1652 (34). At this time, the island was almost entirely inhabited by a Carib population (35). Records indicate Jesuit priests attempted to convert them, as well as fugitive slaves from other islands who settled in St. Vincent.

Historically, the Anglican faith was the official established religion in SVG in colonial times (36). After emancipation of the enslaved people, efforts were made to convert them to Christianity as the Anglican Church strove to "establish social control over the freed population" (37). The US State Department reports that the Anglican faith remains dominant in SVG, and represents almost half of the population. Twenty-eight percent of the population identifies as Methodists and thirteen percent are Roman Catholics, with other religious groups such as Pentecostals, Seventh Day Adventists, and Hindus also represented (38).

The Wesleyan Methodists, another main Christian group that formed during St. Vincent's colonial past, first established presence in the late 1780s. Their initial mission, in contrast to the Anglicans, was to convert slaves to Christianity. Wesleyan Methodists were successful in building a significant membership. The two faiths competed to attract congregants as a means of raising funds for the Church, a principal concern of missionaries.

The Spiritual Baptist faith, also known locally as the Converted, is a native religion that is a combination of African and Christian liturgy. Many Vincentians, regardless of their religious affiliation, consult with the Converted to perform certain rituals at wakes, funerals, or to sanctify specific locations that are to be considered 'holy' (39).

## **2.6 FAITH-BASED ORGANISATIONS' RESPONSE TO HIV IN ST VINCENT AND THE GRENADINES**

Findings from a qualitative situational assessment also conducted by CHAA and UCSF in SVG in 2008 found that that some FBOs in SVG were already engaged to a degree in HIV prevention and services (40). It also suggested that FBOs have the potential to play a leadership role and have a positive impact in addressing HIV and AIDS because of their influence in the community. In this assessment, we found that some FBOs, however, still do not see HIV prevention as part of their mission or role in society or acknowledge the need to create a caring and compassionate environment which is free of stigma towards congregants who are HIV positive or MSM.

Still, there are FBOs that have responded to the situation of HIV and AIDS in SVG. First, The Caribbean Conference of Churches (CCC) works to strengthen the faith-based response to HIV and AIDS in the Caribbean through its support of initiatives throughout the Caribbean, including SVG (41). In addition, The Bread of Life Community, a Lay Apostolate of the Roman Catholic Diocese, houses orphans of HIV infected parents. The Evangelical Association of the Caribbean conducted a study titled “Survey of the Sexual Practices of Youth Attending Evangelical Churches in Antigua, St. Lucia and St. Vincent”. The study was an exploratory survey among youth who attend Evangelical Churches, as a means to assess how Evangelical Christian youth “handle their sexuality within their understanding of Biblical teaching, scientific accuracy, and culturally appropriate methods”. The study demonstrated that HIV knowledge among this population was deficient, which underscores the urgent need for prevention education toward this demographic.

## 3.0 Methods

A combination of qualitative and quantitative data collection methods were used to carry out this study. Primary data were collected from October 2008 to April 2009 via two methods. First, the research team conducted 10 interviews with representatives of selected denominations using a semi-structured interview guide. Second, a survey was conducted using a standardised questionnaire to interview 50 representatives from a broad cross-section of FBOs. Secondary data from published reports available from government and online sources provided background and context for the instrument design and for the findings from the interviews and surveys.

### **Ethical Approval**

The study approach and methodology was reviewed and approved by the Institutional Review Board (IRB) at UCSF and the Chief Medical Officer in SVG.

### **Consent**

Interviewees and respondents were given a consent form which outlined the reasons for the study, procedures to be followed, privacy of data and other relevant information (see Appendix 1). Once verbal consent to proceed was obtained the interviews or surveys began.

### **Qualitative Interviews**

The research team conducted 10 interviews with representatives of a diversity of FBOs of different denominations. A semi-structured interview instrument (Appendix 2) was used to guide the discussion with participants in the interviews. With the assistance of the CHAA Programme Officer for SVG, the study was introduced and next steps outlined to representatives of two major umbrella organisations, the St. Vincent Christian Council and the Evangelical Association of St. Vincent and the Grenadines as well as to representatives from the Rastafarian community, the St. Vincent Seventh Days Adventist Coordinating Committee, the National AIDS Secretariat (NAS) and the Ministry of Health.

A list of representatives from each denomination was compiled and 10 of these were contacted to provide nominations for interviews. The sample selected for interviews was based on an understanding of the major religions in SVG. The determining characteristic of the nominees were that they be:

Knowledgeable about their faith and how it functions within the context of SVG

Have had experience and/or knowledge of programmes within the FBO arena which address HIV and AIDS

Knowledgeable about the capacity of their organisation to conduct HIV prevention and HIV related stigma work, including barriers and facilitators to conduct this type of work, and possible feasible approaches for FBOs to conduct HIV prevention and activities to decrease stigma.

Participants were asked about their role in the organisation and to describe whether their organisation conducts any work related to HIV prevention, their willingness and capacity to do so, and barriers and facilitators to doing that kind of work. Questions also explored the level of HIV-related stigma existing among those organisations and their congregants. The interviews lasted approximately 60 minutes and were audio-recorded.

### **Quantitative Survey**

A survey was conducted with representatives of fifty FBOs, using a standardised questionnaire completed by the interviewer (Appendix 3). The questionnaire was adapted from another instrument developed by the organisation Balm in Gilead in the US (42) as well as stigma scales validated through other research (43). The instrument included questions about the organisation; estimated number of parishioners; health and HIV-related services currently offered by the denomination; their willingness and capacity to implement HIV related programmes; barriers and facilitators to doing that kind of work and finally stigma levels. Data collection lasted approximately 20 minutes with each respondent.

### **Sampling**

For the purposes of the survey, a list of churches in the country was compiled. The research team divided the island of St. Vincent into geographical areas to obtain a sample that was stratified by geographical region and denomination. Two of the Grenadine Islands were also included. Churches were then selected according to the number of churches per denomination in each of those areas. After sampling across the denominations most often represented, the team selected smaller churches so that diverse denominations were represented across geographical areas.

As part of the capacity-building effort, a team of research assistants from St. Vincent were hired and trained to undertake the surveys.

### **Data Analysis**

Qualitative and quantitative data were first analysed separately as two distinct datasets as described below. Subsequently, the qualitative and quantitative datasets were compared in order for both the qualitative and quantitative findings to inform and supplement and complement each other. In this report, qualitative and quantitative findings have been integrated and are reported together unless specified or indicated otherwise. Findings based on qualitative data are described as findings from “interviewees” or “participants” whereas data described from surveys is described as that of “respondents.”

### **Qualitative Interviews**

Four researchers at CHAA and UCSF, including the two staff who conducted the interviews, participated in data analysis. Each of the transcribed interviews was summarised into a matrix (Appendix 4). The matrices were organised into categories in order to include the topics covered in the semi-structured interview guide as well as any salient themes that emerged from the interviews. The analysts first worked in dyads.

One analyst summarised each interview onto the matrix. Then a second analyst read and compared each of those summaries to the interview transcripts in order to verify the information in the matrix and capture any relevant information missing from the summaries. After that, the four analysts worked together to compare the 10 matrices in order to identify similarities and differences among the different denominations interviewed. Differences and discrepancies in the findings noted by each analyst were resolved through discussion among the team. This iterative process of summarising and verification helped to ensure that the salient themes emerging from the data and relevant to the study questions have been captured.

### **Survey data**

Survey data were entered into a spreadsheet programme. Statistical analysis was performed by running frequencies and means for quantitative responses.

## 4.0 Results

The findings have been organised to describe the FBOs included in the sample, the HIV-related services and messages they currently provide, their views on HIV, and the priority of HIV as an issue amongst FBOs, as well as participants' responses related to HIV-related stigma. Throughout the findings section, participants in the survey are referred to as respondents and participants in the qualitative interviews are referred to as interviewees.

### 4.1 PROFILE OF FBOS

#### Survey Respondent Characteristics

Among survey respondents, more than three-quarters of the respondents identified themselves as pastors or priests of their churches (n=39). Eight identified themselves as church members. One identified himself as the Assistant Pastor. One said he was an administrative worker and one said he was the youth leader.

#### Interviewee Characteristics

The participants in the qualitative component of the study identified themselves as bishop, head or coordinator and chief administrator, major, minister, senior pastor, and ordained sister. Some interviewees reported more than one role within their FBO.

#### Denominations of FBOs represented in the survey sample

Table 1 provides an overview of the denominations represented in the survey sample. Respondents most often indicated that their denominations were Evangelical, Pentecostal, Church of God or Baptists. The remainder of the respondents were from denominations representing the diversity of FBOs across SVG.

**Table 1: Denominations of Churches of Which Survey Respondents were Members**

Denomination	Number	Percentage
Anglican	3	6%
Baptist	5	10%
Catholic	3	6%
Church of God	5	10%
Evangelical	11	22%
Jehovah Witness	2	4%

Methodist	3	6%
Pentecostal	10	20%
Seven Day Adventist	3	6%
Wesleyan Holiness	2	4%
Other	3	6%
Total	50	100%

### **Denominations of FBOs represented in the semi-structured interview sample**

The denominations represented in the qualitative sample were Anglican, Catholic, Methodist, Baptists (two different denominations), Seventh Day Adventist, Evangelical, Pentecostal and Salvation Army.

A Rastafarian representative was included in addition, but it was later decided to exclude the data generated from that interview. While the Rastafarians are influential within a sector of the population in SVG, they do not define themselves as an FBO but as a movement not precisely defined by religion, and thus information about their beliefs and attitudes towards HIV has not been included in the confines of this report. Data collected on the Rastafarians will be used to inform further research regarding their role in HIV service provision.

### **FBO affiliations**

Most FBOs (n=35) were affiliated with an umbrella group and there was great diversity among those groups as named by the respondents. More than one respondent said their church was associated with: the Evangelical Association of St. Vincent and the Grenadines (n=3); the Pentecostal Assemblies of the West Indies (n=3); and the Caribbean Conference of Churches (n=3). Two respondents said their church was a member of the Evangelical Association of the West Indies and two with the Methodist Churches of the Caribbean and Americas. The remainder (n=20) were members of different and diverse affiliated groups.

### **FBO structure**

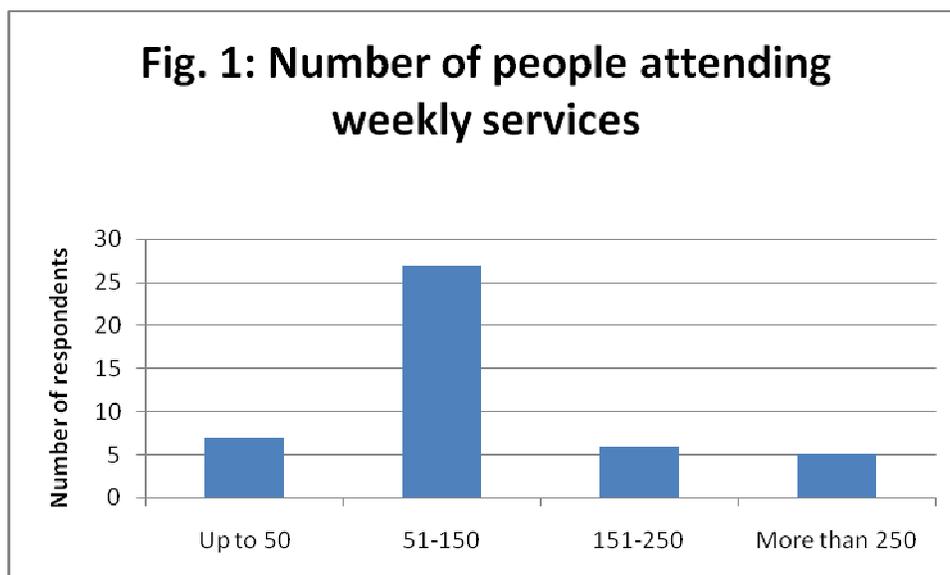
The structure of different FBOs included in the sample varied. Interviewees described a range of structures for their respective FBOs ranging from a very defined and hierarchical quasi-military structure, to a fellowship. The number of congregations in SVG within the same FBO denomination ranged between two and forty. According to their denomination, FBOs were organised, for example, into circuits, districts, or parishes. Many FBOs were affiliated with other FBOs of the same denomination within the Caribbean, North America or Europe

## FBO human resources

The number of lay or religious persons working within the FBOs as pastors, emotional counsellors and teachers or other positions in charge of administering different programmes was also diverse. In terms of staffing, many respondents said that their organisation had paid staff (n=28), while some relied on a combination of paid staff and volunteers. Most often, paid staff were pastors, priests or ministers (n=30), cleaners or maintenance workers (n=10) or secretaries (n=4). In some cases, the persons volunteered within the FBO but had a job outside the FBO.

## Size of FBO and congregation

The number of congregants or members differed according to the location of the FBO, and whether it was urban or rural. The number of congregants reported by interviewees to attend the main religious service at the different denominations was between 15 and 450. Quantitative data from the survey showed that most weekly services were attended by up to 150 people (Fig. 1).



## Characteristics of the Congregation

Reports on the characteristics of churchgoers differed depending on the location of the FBO, be it urban or rural. Education, gender, and age of the congregants varied. In general, interviewees stated that congregants have completed high school, vocational school, or have some high school preparation. Approximately 75% of the congregants are women. Some noted that many of the women who attend the FBOs are young single mothers, though churches generally put emphasis on the nuclear family as ideal.

Some interviewees reported that the percentage of young people under 21 years old among the congregants ranged between 15 and 60%. Other interviewees reported that young adults between 18 and 30 seemed to be harder to retain within FBOs and were described as being “sadly dwindling” and having “filtered out of the church” or emigrated. A few participants commented on the need for their FBOs to be more proactive and have targeted programmes to attract youth and especially young men. These would need to be engaging and respond to the needs of young people. A participant, for example, stated that attracting youth would require involving “somebody who is knowledgeable in the field and who can share in a way that will hold their attention, give them something that they want.”

Most interviewees were not aware of gay, lesbian, bi-sexual or transgender (GLBT) members at their FBOs, but a few stated that it was rumoured or suspected that some of the congregants may be GLBT because of their mannerisms or the fact that they were not married. They reported that those persons are treated like everyone else in the congregation. Only one interviewee mentioned that a congregant disclosed to him that he was gay. Some interviewees knew PLHIV who were part of or attended the FBO, but these PLHIV had not openly disclosed their status to the congregation.

#### **4.2 HEALTH-RELATED ACTIVITIES AT FBOS**

According to their size, how they define their mission, and the financial and human resources available to them, FBOs offered services to the community, including soup kitchens, food-assistance programmes, homeless shelters, and homes for children or teenagers. FBOs have specific ministries, departments or educational, social and health-related programmes for children, youth, and women, including single persons who are heads of household. A few FBOs had their own school day-care programmes and one had a medical clinic. Active promotion of health-related activities varied among the different FBOs. Some FBOs provided health promotion programmes or events at certain times of the year or in conjunction with “family life week” such as talks related to prostate or breast cancer. Tests for diabetes and hypertension were offered annually in collaboration with the Ministry of Health.

Of the survey respondents, the majority (n=30) said that their church had health-related programmes or activities. Of those with health programmes, 17 said they had one programme, 8 said they had 2 programmes, 4 said they had 3 programmes and 1 said they had 7 programmes. Most of these programmes (n=22) targeted the entire congregation. Youth-focused health programmes were also part of some churches’ activities. In addition to spiritual needs, the programmes for youth focused, for example, on personal development issues such as puberty, sexuality, dating, courtship, self-esteem, careers and skill building. Programmes for youth also include other topics such as hygiene and music. One interviewee stated that their church’s programme for young children between 7 and 10 years old includes signing a “purity covenant” to remain faithful to God’s commands and to practise abstinence remain abstinent until marriage.

### **4.3 CURRENT HIV PREVENTION AND HIV-RELATED SERVICES PROVIDED BY FBOs**

Some FBOs currently provide HIV-related presentations or educational talks conducted with the support or involvement of the NAS or other health personnel. These talks may be organised sporadically or to coincide with certain significant dates such as World AIDS Day. Apart from such events some FBOs may not be very active around HIV. HIV as an issue affecting the country may also be mentioned from the pulpit and HIV may also be included in programmes or activities within the youth, women's, and/or men's departments or ministries.

No FBO had an AIDS ministry in place. However, some survey respondents reported (n=21) that their church held HIV-related programmes. Most of these HIV-related programmes were focused on education and prevention (n=20) and/or spiritual counselling (n=9). Some (n=6 each) provided HIV-related substance abuse services or outreach services. When asked what changes have taken place in their organisation or group as a result of providing HIV-related services, 17 said that HIV and AIDS knowledge had increased among participants.

Most FBOs did not have programmes that addressed sexuality and relationships, but did incorporate lessons regarding appropriate sexual practices from a Christian point of view. Those lessons may be addressed in youth groups and in bible studies and from the pulpit. Home-based care and food packages for PLHIV and PLWA were provided by one FBO with the support of other FBOs and the NAS through an organisation called House of Hope. In some other cases, home, hospital or prison visitations or palliative care had been provided to PLHIV and PLWA on an individual basis by the pastors or other staff or members of an FBO.

Housing and palliative services to PLHIV and PLWA may be congruent with the FBOs' mission of providing to the sick and needy. Some activities, such as home visitation and outreach may not be part of a formal programme but part of the ordinary life of many FBOs and take place in the context of praying and providing meals, and financial and logistical assistance for PLHIV and PLWA who are sick or dying. The previous sexual behaviours of a PLWA were said to be less relevant to providing assistance when the person was bed-ridden or close to death. In many cases, FBO lay or religious persons providing those services may not even be aware that the person has HIV or AIDS.

### **4.4 MESSAGES AROUND HIV AND AIDS**

The mission, beliefs and doctrine of an FBO influence the prevention messages and HIV-related services provided by the organisation. They also affect the FBO's willingness to provide expanded services. Interviewees said the main HIV-related prevention messages delivered by all FBOs are abstinence before marriage and fidelity in marriage or when living together. These prevention messages were consistent across FBOs. Other messages delivered by FBOs related to HIV and HIV risk and included compassion for people living with and affected by AIDS, forgiveness for those who are infected, repentance for sins that may have led to infection, and commitment to Christian values as a way to stay safe from infection.

HIV prevention messages often only come up in the context of other activities or services offered by the FBO, such as specific programmes for youth or women. In one FBO where HIV was considered a high priority, messages on HIV awareness and prevention are presented at special activities called “mission’s service”; as well as through regular bulletins produced by the parishes, which often include information on the HIV situation in the country, statistics on the number of persons infected, and other messages on changing lifestyles and against stigma and discrimination.

### **Lifestyle messages**

One participant stated that their church, in focussing on HIV prevention, would emphasise teaching persons how to change their lifestyle to avoid certain behaviours. Another participant said her church was “in a war against sin” and does not condone or accept certain types of sexual behaviours. In this case, in order for someone to become a member of the FBO, he or she needs to repent from past behaviours in order to be “saved.”

### **Messages about safe sex and condoms**

FBOs were supportive of congregants learning about HIV transmission and risk in order to protect themselves and as a way of dispelling myths regarding HIV and challenging discrimination against PLHIV. However, distribution of safer sex literature, promoting condom use or doing condom demonstrations were often not considered viable strategies. Some interviewees said that these methods would be controversial or not appropriate for the entire congregation. In general, the perception among FBOs was that promoting safer sex messages would go against the message of abstinence and encourage congregants to have sex. As stated by a participant, distribution of condoms, for example, was a “ticklish issue” within his church.

### **Prevention within marriage**

Some FBOs allowed condom use according to circumstances and marriage status of the congregants. A few FBOs, for instance, had no objection to condom use within marriage. That was left up to the individuals. When FBOs did not agree with artificial means of birth control, the use of condoms even within marriage was not an option.

### **Prevention outside of marriage**

Some interviewees acknowledged that many female congregants are young single mothers. One appeared to have accepted but did not like this fact, as demonstrated when he said, “Whether we want it or not, some of our, our young girls within the church are, are getting pregnant.”

Occasionally, participants’ perspectives differed from church doctrine. Some participants expressed ambivalence between their own views on HIV prevention and the views of their FBOs. For instance, one participant stated that, faced with the reality of young single women becoming pregnant, she personally would provide people with all the options, including condom use, although her FBO did not approve of that.

I would give people the choices because we see it real where our young people are getting pregnant and they come into the church with the baby to be baptised. So there is the possibility that that person was at risk for HIV so that you have to give them all the options. Another participant believed that the church needs to provide HIV education as well as promoting the abstinence message. “So, if you choose to have sex, then, probably well, then, choose safe sex.” Likewise, a participant stated that the FBO needs to help youth understand the value of abstinence but agreed that those not prepared to abstain should find a way of protecting themselves. Another person stated that in his small FBO the pastor would advise someone who is already sexually active to use condoms.

### **Membership attitude to safe sex and condoms**

Some interviewees stated that even if the FBO would be willing to endorse condom use or include condom demonstrations as part of their HIV related activities, congregants may think and perhaps complain that the FBO was promoting sexual activity among the faithful. As stated by one interviewee, distributing safer sex literature may have the implication of condoning “fornication,” and subscribing to indiscriminate sex. The moment you demonstrate a condom, you are saying, people interpret that, ‘oh, you are giving the young people license now, you are endorsing, you are allowing them now, you are going to be encouraging a group of fornicators.’ So, culturally and doctrinally, and not that we are going to change our doctrine, but the perception of some people is that if you have certain programmes, you are endorsing people’s lifestyles or people’s choices.

### **HIV Counselling and Testing**

None of the interviewees said that their FBO provided HIV counselling and testing, but some said they would refer congregants when requested or appropriate to HIV testing sites and to family planning services. FBOs took different stances regarding the degree to which they would proactively promote or refer congregants to HIV testing. One participant stated, “There is no stigma in getting tested” and said that people need to get tested to know early if they are positive, so that they can have access to early treatment. One participant said the FBO would not “stifle” a congregant from getting tested but they did not promote testing. In other FBOs, HIV testing may be encouraged in the context of pre-marital programmes or counselling for couples about to get married as an avenue for partners to look at their sexual history and get tested. A participant stated that if an HIV counselling and testing programme were to be initiated, the related message would be that any kind of knowledge empowers people to make informed choices.

One respondent stated that, if approached by a congregant regarding HIV testing, she would provide the appropriate referral, then follow up whether the person got tested and talk and counsel him or her as needed. Another respondent provided an example of what a post-test conversation with a congregant would be like when she said, “You tell them, ‘change your behaviour, you may be free this time but next time you may not.’ I may tell them or encourage them to change their behaviour, you know.” Another participant stated that because persons who come forward for testing are sexually active, the counselling would include risk reduction and partner testing.

#### **4.5 COLLABORATIONS WITH OTHER ORGANISATIONS**

In the survey, respondents indicated their church collaborated with Health Departments (n=8) or the National AIDS Programme (n=6) to carry out HIV related programmes. In the qualitative interviews, participants said that when carrying out an HIV-related health programme, they often collaborated with the NAS. In these cases, church leaders often talked about HIV as an issue affecting the country. They also invited the NAS to conduct HIV-related presentations or educational talks with support or involvement of NAS or other health personnel. Depending on the church, talks were organised ad hoc or were scheduled to coincide with certain dates such as World AIDS Day. Other than these ad hoc events, however, most FBOs were not very active around HIV.

One interviewee referred to a partnership with the NAS, whereby NAS staff visited FBOs to talk about all prevention methods with the condition that they only did condom demonstrations at a person's request and in private, but not as part of an open forum. When asked about the possibility of distributing safer sex materials, some FBO representatives stated that the Bible already provides the required literature and precepts. For materials provided by other organisations, it would be a matter of seeing the exact content of the literature before deciding whether they would be appropriate for distribution.

#### **4.6 FBO VIEWS ON THE RELEVANCE OF HIV MESSAGES TO CONGREGANTS**

FBO views on congregants' behaviours and HIV prevention messages were also influenced or determined by doctrine and beliefs. In the view of some interviewees, HIV is an issue that affects everyone and not just those particular population segments traditionally considered at risk. As stated by one respondent, FBOs need to take HIV seriously, consider their responsibility to the congregants and remind themselves about what Jesus would do in order to foster HIV prevention and potentially save the lives of the congregants. Another participant echoed a similar thought when he said, "It's the philosophy of Jesus that we've come to seek the lost. The emphasis on 'seek'. If we are deliberate in doing, it's our job, it's our ministry, it's our mission, right. So demonstrate that people, broken people, ought to be mended".

In other FBOs, HIV was not thought to be relevant. Under the assumption that congregants need to practise abstinence until marriage and that partners are monogamous within marriage, HIV was not considered to be an issue of relevance for individuals other than homosexuals, men and women having multiple sex partners and sex workers.

#### **Views on PLHIV and PLWA**

Participants unanimously stated that they fostered acceptance and inclusion of PLHIV within the FBOs. At the same time, they acknowledged variation in the opinions and perceptions of the FBOs they belonged to and the congregants themselves regarding acceptance of PLHIV. Stigma towards PLHIV and PLWA was acknowledged to exist among some church leaders in SVG, though none of the interviewees reported that they had stigmatising attitudes themselves.

## Views on homosexuality, sex work and youth sexuality

In general, homosexuality and sex work, including transactional sex, were considered wrong, sexually immoral and unacceptable sexual deviations. Referring to these sexual behaviours, some interviewees used some variation of the statement, “God loves the sinner but not the sin”, thus condemning the behaviour because it is wrong and “against God’s teachings” and forbidden by the Bible or scriptures. A participant explained,

*We view homosexuality... the act of homosexuality as condemned in scripture. But the homosexual we love. And that might sound as a paradox. It's what we say, 'we hate the sin but the individual, as a human being, we love that person.' And we want to see that person change his lifestyle to become in line with what the bible teaches.*

However, these issues may or may not be openly discussed or addressed by FBOs. In some FBOs, there seemed to be a tacit policy not to discuss homosexuality. It was said that unless someone publicly acknowledged they were gay; FBOs did not have to deal with the issue. An interviewee stated that there were not any GLBT members in his FBO and added, “Ah, sometimes I would be tempted to say thank God for that but that’s kind of discriminatory.”

Some FBO representatives said that they found it difficult to strike a balance between trying to avoid discrimination and condemning homosexual behaviour; “Sometimes, we have to be careful of the statements because it, it brings a hate context.” In other FBOs, homosexuality was publicly condemned:

*We consider it an abomination unto the Lord. Yes, and not only to the congregation alone but to the community members as well. Like when we have evangelistic outreach programmes, we pitch our tents, have our crusades and so forth. These are issues we would bring to the fore, so there is no cover whatsoever.*

On the other hand, a participant explained that his FBO would accept gay congregants without discriminating against anyone. He referred to homosexuality as follows,

*The Bible says no to it so that is what the pastor preaches. It is also a criminal offence in St Vincent. But if that's their life, I don't think anybody should force them out of it. You advise them that according to the Holy Bible, this is wrong. But if they insist, you still try to protect them. One of these days they'll come out [of that lifestyle]. I don't think anybody has any authority to discriminate. God in his own infinite mercy understands and he knows best.*

One participant stated that if a FBO member was suspected of being involved in sex work, the pastoral duty was to contact that person to discuss the situation. It was not clear from the interview, however, how that conversation would be handled or what reaction the pastor would get from the “suspect” congregant. The view in at least one FBO is that the connection with God and spiritual guidance would allow congregants in general and youth in particular to avoid certain behaviours. A participant explained that the focus of his FBO was first and foremost to address spiritual needs and to rely on the youth’s spiritual connection to God to guide them through all other influences and temptations. The basis of their programmes is to steer the youth away from distractions they may find in the outside world.

For example, some camps are deliberately planned for the Carnival weekend, in order to remove the temptations of participating in Carnival. As realistically observed by that FBO's participant, however, people may not always act in accordance with their FBO's beliefs.

From a spiritual or religious point of view, the thing is, if someone, if someone remains under the influence of Jesus Christ then one ought not to behave in such way. And the feeling in a lot of cases is that sometimes we miss them because we fail to understand where they are in terms of their relationship with Christ, and also where they are in terms of the influences that come from outside, the temptations and so on.

### **Views on national prevention messages**

A couple of participants discussed HIV prevention messages that were broadcast in SVG. One of them considered some of the HIV prevention messages in SVG offensive. She thought that a sign outside the airport promoting AIDS awareness was inappropriate. Her opinion was that education about condoms could be done in private and by referral instead of publicly. Another respondent thought that the national media overemphasised "condomising" as one of the three aspects of ABC (abstain, be faithful, use condoms).

## **4.7 KNOWLEDGE, ATTITUDES AND PERCEPTIONS OF HIV RISK AMONG CONGREGANTS**

The level of HIV knowledge among congregants was described by interviewees to be from moderate to relatively high. For one participant, the level of HIV knowledge among congregants reflected that among the general population. *"Whatever the public sees they may also see. So that I would say whatever the public sees that's probably how educated they are. We haven't educated them beyond that."* Another interviewee emphasised the need for more education to remove all the myths about casual transmission of HIV which may contribute to stigma and fear towards PLHIV.

Even if people are knowledgeable about HIV, interviewees said they may not perceive HIV as something that concerns them, but rather as someone else's problem. A participant observed, *"There are some people who walk around with their heads buried in the sand; it can't happen to us because we are Christians."* Participants said that an appropriate role for FBOs in general and pastors specifically is to sensitise and share with congregants what they know about HIV. Sometimes, influential members of the FBO may have an impact on the beliefs or attitudes of other congregants.

According to interviewees, youth may not get tested for HIV because they are afraid of finding out the results. They may still consider having HIV as a death sentence and they may fear being ostracised and would rather not know. As mentioned by one interviewee, *"Some of the young people don't want to know and if they know they're not going to change their lifestyle anyway. Some people are in denial, especially the young, because they do not think it can happen to them."*

#### 4.8 HIV AS A PRIORITY AMONGST FBOs

Most (n=42) respondents to the quantitative surveys answered that HIV as an issue was very important for their FBOs. For the many FBOs surveyed in which HIV was said to be a priority, a further question was asked about how important it was for the organisation to establish, or further develop an HIV ministry or programme in order to reduce and prevent the spread of HIV and AIDS. Most (n=43) respondents said it was “very important.”

Interviewees and respondents in the qualitative and quantitative parts of the research differed in their responses as to how great an emphasis HIV should receive. For some interviewees, HIV constituted a priority and a national health issue to be addressed by their FBOs. One participant stated, *“It is a high priority. We place a high priority on it because of the way that health is one of the essential components of man’s development and man has been afforded the physical, the mental, the social, the spiritual. So we pay equal emphasis on each aspect of human development.”* Some interviewees noted that the priority given to HIV may depend on the interest and commitment of any local officers, or members of the congregation such as doctors or nurses who are interested or involved in running it.

For some other interviewees, HIV was not a priority within their FBOs. One participant seemed to indicate that this was a wasted opportunity. *“As a faith-based organisation, as a church, we have a lot of power but we are not using it right, because everybody from the community comes in to the church and we have enormous power we are not using and I think that we are not doing enough”.* Another participant said, *“I don’t think that’s a priority in our preaching. I don’t think any, I don’t think any priest would be talking about AIDS in particular because that’s not really...like a top issue.”* And yet another interviewee expressed the same sentiment when he said:

*To be very honest we haven’t placed a lot of emphasis on it, although from the pulpit I would speak about it and encourage people to have a lifestyle that prevents the contracting of AIDS... HIV, that is. But as a pivotal part of our church programme, I would say that we don’t have an emphasis there... an ongoing emphasis. But it is something that I think we need to pay more attention to.*

Another participant stated that in his FBO they no longer preach that AIDS is a judgement from God, but when the disease is referred to in sermons the overtone is still usually negative and carries a little punishment as if it were a consequence of sinful behaviours. The same respondent indicated that he does not hear sermons that refer to dismantling discrimination and encouraging congregants to reach out to PLHIV. He believed, however that the endorsement of the FBO leaders was needed for discrimination to be avoided.

For one participant, the interview for this study was a chance to reflect and think aloud regarding HIV needs within his FBO, *“The thing is, sometimes it is just the motivation and the awareness. The awareness, then the motivation. And to me even as we are talking here this morning this to me is like awareness, bringing the needs to my awareness.”* He reflected that they had young people, an education department that could be in charge of activities, and personnel that had been trained in VCT.

Therefore they had human resources to be able to put a programme together and take it outside the church and into the community. This quote illustrates how some FBOs may be just one step away from readiness to initiate HIV programmes and could perhaps channel existing resources towards implementing HIV related activities.

#### 4.9 STIGMA AND DISCRIMINATION AMONGST CONGREGANTS

Participants in the qualitative interviews stated that FBOs, according to doctrine and philosophy, do not discriminate against PLHIV and that they encourage the congregations not to be judgemental. FBOs' messages regarding PLHIV were said to be based on principles of inclusion and compassion. As one participant observed, PLHIV need to be treated *“with dignity just like all of us. Treat them with dignity because they are human beings and they are God's children.”* She added, however, that not all leaders in her FBO would be accepting of PLHIV. Some of them have openly expressed their ill-feelings for somebody who is HIV positive. While interviewees said that PLHIV would generally be welcomed, they noted that some congregants may express some reservations and have difficulty reaching out to or relating to a PLHIV, depending on their own educational levels and their awareness about how HIV is spread.

Only one participant suggested specific messages for PLHIV to be included in programmes, as follows:

1. Normalise living with HIV instead of considering it a death sentence;
2. Seek and receive care and treatment; and
3. Change their sexual practices and protect others from infection.

In your congregation, how many mothers would not want an HIV infected person to feed their children?	1.7
In your congregation, how many people would not share dishes or glasses with someone who has HIV?	1.8
In your congregation, how many people would not want an HIV infected person cooking for them?	1.8
In your congregation, how many people avoid visiting the homes of people with HIV?	0.9
In your congregation, how many people think that HIV-infected people have brought shame on their families?	1.4
In your congregation, how many people think that if you have HIV you have done wrong behaviours?	2.0
Statement	Mean score*
In your congregation, how many mothers would not want someone with HIV to hold their new baby?	1.4

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In your congregation, how many people think people with HIV are paying for their karma or sins? 1.3

In your congregation, how many people think that people with HIV should feel guilty about it? 1.4

In your congregation, how many people think that a person with HIV is disgusting? 0.9

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The person added the view that some PLHIV do not want to take any responsibility and perhaps even want to infect others. This last statement reflects some ambivalent and negative feelings towards PLHIV, and views such as these, if publicly expressed, may counteract the efficacy of the messages she suggested.

Respondents were asked to assess the stigma and discrimination-related perceptions of people in their FBOs, using a standardised scale. Table 2 and Fig. 2 present the mean scores on this scale according to each of the questions asked.

**Table 2: Survey respondent reports of stigma and discrimination-related perceptions of people within the congregation**

NOTE: \* The scale of 0 to 3 was used to quantify the responses which represent the following options:

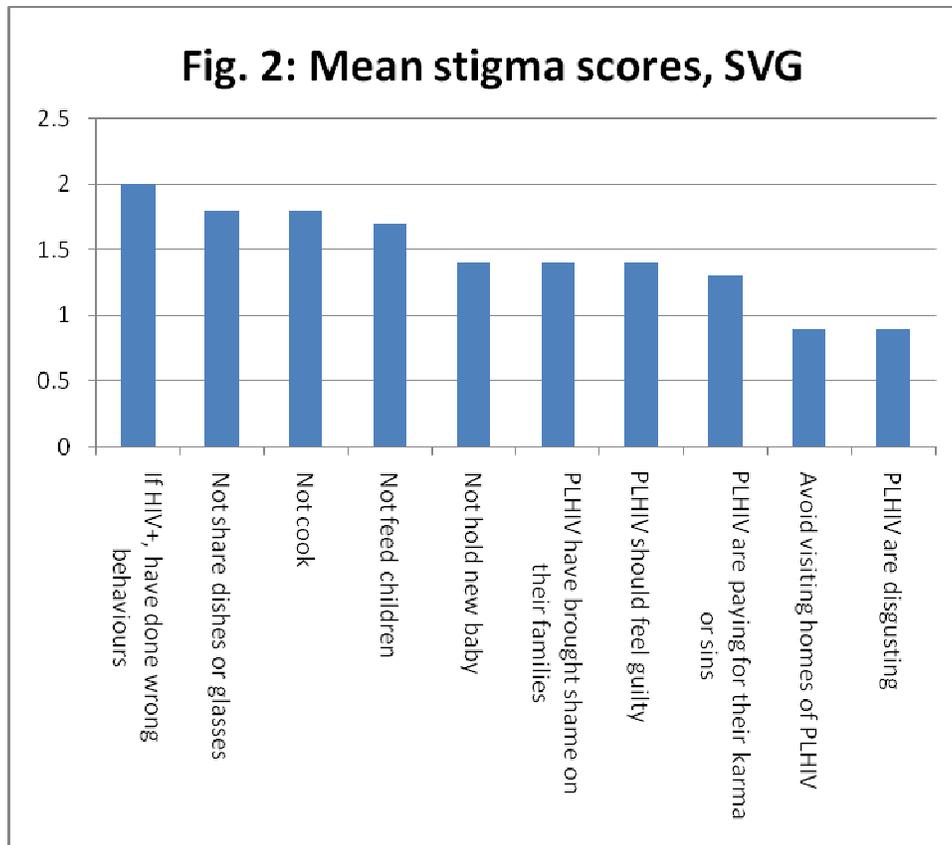
= No one

= Very few people

= Some people

= Most people.

**Fig. 2 ranks the statements from those that elicited responses indicating the highest level of stigma to those indicating the lowest.**



The highest mean score was for the question about how many people in the congregation think that if a person has HIV, they have done wrong behaviour. This is a significant level of stigma and implies that the congregants are placing a moral judgement on PLHIV. There were also mean scores over 1.5 in questions relating to food sharing and preparation.

Participants in semi-structured interviews stated that stigma and discrimination still exist among FBO members together with misperceptions and myths regarding HIV transmission. Participants observed that stigma and discrimination among congregants may reflect the same in society in general. “Don’t care how much you tell people, explain them [that] this only can be contracted by, by sexual activity or intravenous needles and that type of thing, people still discriminate.”

In addition, because of stigma and depending who they are and how they got infected with HIV, not all PLHIV may be treated the same within an FBO: With people, you not only have to look at the disease itself, you have to look at the spiritual implications. So is somebody who is HIV positive ‘a sinner’ and is being sinful or is this person an innocent victim?

And you'd have problems with that within the congregation because you gonna have little whisperings behind your back and that can affect the person, affect the fellowship within, within the organisation.

The implication thus is that the treatment of PLHIV by members of the congregation depends somewhat on moral judgements and gossip regarding how they were infected. For instance, a wife infected by her wandering husband might get sympathy, but not the husband.

Some participants knew or had known or had assisted a very small number of PLHIV attending their denominations. For the most part, a very limited number of staff and/or congregants seemed to be aware of their HIV status. In general, PLHIV do not appear to disclose their HIV status within FBOs.

One participant asserted that her FBO did not discriminate against PLHIV as they regarded them as the same as other people who needed spiritual healing.

*Well we have one and two persons in our church. Because of the kind of evangelism that we do, we go out and we throw the gospel net and some people come into the church already infected. And when they come in, we accept them. There is no social barrier, no discrimination. We encourage them to get their medication and what have you...No discrimination whatsoever. 'Cause we believe that all of us are being infected, affected by sin. We view the church as a hospital for sinners. And in a hospital we have people with all kinds of physical conditions... some with amputated legs and another one with liver problems. Just so, in a spiritual sense, the church is like a spiritual hospital with all kinds of spiritual illness and ailments and we treat everyone alike.*

Some interviewees were asked whether a PLHIV could become a leader of an FBO. One participant stated that they could not become ordained ministers. Another respondent stated,

*Well you see the thing is, it's not because they have this HIV status that they would [be excluded], but when we take candidates for the priesthood or a religious life or anything like that, usually they are screened on their health, general health. Now if they have a major health problem that could maybe be either costly or difficult to do the ministry because of their illness, they probably wouldn't have been admitted for, or they probably wouldn't be granted admission. But it wouldn't be because they were HIV positive. It would be more of a general health issue. But let's say that you have somebody who was already admitted and they find out that they had HIV, I don't think that people would condemn them and say, 'Well, they can't be anything more because they have that.' I think, most people know that it is not always sexually related and it is not always a homosexual disease and there are many ways that you can get HIV.*

Another interviewee elaborated on the same issue to add that an HIV positive status may not disqualify them from leadership but certain lifestyle practices may. And someone else stated, *"I don't see any reason why not. If that person had come to the realisation that they had sinned and they have repented, that person is then able to move on. We do not think that there is any sin that would preclude you from becoming a leader."*

However, when asked whether a GLBT could become an FBO leader, the same participant contradicted the statement above and replied, “Absolutely not.”

#### **4.10 FUTURE PROGRAMMES**

FBOs are interested in developing further programming related to HIV. FBO HIV programmes, however, would need to fit within the boundaries of the FBO’s beliefs and for the most part exclude explicit discussions of safer sex and condom use. As one participant said when asked about the possibility of distributing safer sex literature that included condom use, “That would depend on the content”. When asked the same question, another interviewee raised the objection that the FBO may be seen as condoning indiscriminate sex.

A participant expressed that future programmes need to be designed professionally in order to be able to compete with other influences via television, school or the Internet. According to interviewees, the content of future programmes should include:

- Education about HIV and sensitisation regarding stigma for the congregation at large
- Prevention for those at-risk for HIV, and
- Work with PLHIV

While acceptance from the denomination would be needed to conduct these programmes, the participant expressed concern that PLHIV may be reluctant to get involved in such programmes because of stigma.

An interviewee observed that programmes for youth would need to be preceded by a needs assessment to find out what type of programmes would be of interest to youth. Another participant stated that programmes for youth would need to involve a youth coordinator and include developing personal skills, general character and support of family life. The same participant added that, considering the high percentage of women in the congregation, messages would need to include developing skills for women to deal with societal pressures to have children and make them realise they have a choice regarding instances of unprotected sex.

Thirty seven FBOs sampled through the surveys expressed the need to develop an AIDS ministry. In the qualitative interviews, some participants also expressed the desire to have one, particularly related to youth, but they did not provide any details or specifics about what those ministries would entail.

## 5.0 Discussion

FBOs are a powerful societal force in the Caribbean in general and in SVG in particular. Our findings confirm that greater involvement of FBOs in HIV programming holds the potential to extend the reach of HIV interventions, especially among women and young people. Interviewees expressed support for the greater involvement of their FBOs, noting in many instances that this was consistent with Christian teaching regarding compassion and support for fellow human beings in need. They were particularly supportive of ideas involving greater ministry to PLHIV, improving skills among FBOs to improve counselling, testing, care and support and provision of home-based and palliative care. Interviewees indicated that FBOs could play important roles in altering misinformation and improving knowledge about HIV in their congregations, potentially reducing HIV-related stigma and discrimination.

Interviewees noted their responsibility not to discriminate against PLHIV or portray them in a negative light, as consistent with Christian attitudes of charity. Yet responses to the stigma scale included in the survey indicated continued presence of some stigmatising attitudes among congregations, such as that PLHIV have “done something wrong” and that sharing food or drink with them is dangerous. Some interviewees themselves expressed negative views of PLHIV, such as that they do not take responsibility for their actions and that some deliberately try to infect others. Thus, while interviewees indicated that they would like to create a more supportive environment for PLHIV, some additional training for FBO representatives is likely to be necessary on the meanings and manifestations of HIV stigma and discrimination. Interviewees also noted challenges of lack of confidentiality in the small-island setting of SVG. FBOs could play an important role in educational initiatives to combat this and improve the environment for disclosure of HIV status for PLHIV. At present the ability of FBOs to provide support to PLHIV appears to be constrained by the fear of the possible negative consequences of disclosure among PLHIV who may attend FBOs.

Regarding HIV prevention, a variety of views were expressed. Many respondents indicated their support for the “A and B” of the “ABC” approach to HIV prevention, namely “Abstain and Be Faithful”. These were widely seen as consistent with Christian teaching regarding abstinence before marriage and fidelity in marriage. The third element, “Condomise”, met with mixed reactions. Some expressed the view that promoting condoms would encourage behaviours inconsistent with Church teaching, such as multiple partnerships. Some saw dangers in providing greater access to condoms among young people since it appeared inconsistent with the message of abstinence until marriage. From these points of view, FBOs might be more comfortably involved in HIV prevention interventions that involve promotion of abstinence and fidelity than in those that promote condom use. However, it should also be recognised that there is very little scientific evidence to demonstrate the efficacy of abstinence-only prevention programmes (44).

Some participants expressed ambivalence about the position of their FBOs on the condom issue or indicated that some people within their FBO might be willing to become involved in HIV prevention interventions that involve condom promotion.

This was based on the recognition of certain realities of sexual behaviour, such as sexual activity outside marriage, evident for instance by the number of unmarried mothers among their congregations. It was therefore seen by some respondents as a responsibility of the church to provide information to enable safer sex. At the same time, respondents noted a difficulty in that promotion of condoms may meet with a negative reaction among members of the congregation. From this point of view, condom promotion is unlikely to meet with a great deal of active support among FBO members.

Several interviewees expressed the idea that support should be provided to PLHIV regardless of their past deeds on the basis that one should “love the sinner, not the sin” and that all human beings have sinned. Despite this seemingly open attitude, working with key populations such as MSM and sex workers is likely to prove challenging for FBOs. Some interviewees appeared to draw the line when it came to accepting MSM. For instance, one interviewee said he did not see any reason why PLHIV could not assume church leadership, but when asked the same question about MSM he said, “Absolutely not”.

Others regarded homosexual behaviour as wrong but said that FBOs should still support people engaged in that behaviour. No respondents were neutral in their views about homosexuality and all regarded it as contrary to Christian teaching. Some FBOs with more tolerant attitudes among their leadership may nevertheless be willing to refer people to services that offer support to MSM, such as those provided through CHAA.

While FBOs can extend the reach of HIV programmes, it is important to consider the potential impact of this in the context of the seemingly concentrated epidemic that exists in SVG. While there are weaknesses in the epidemiological surveillance system in SVG as in other parts of the Caribbean, available data suggest that general population prevalence is relatively low. HIV prevalence surveys conducted with key populations throughout the Caribbean, however, suggest that HIV risk is likely to be several times higher among populations such as MSM and sex workers.

Our findings indicate that the role of FBOs in supporting key populations and in condom promotion may be severely limited. In that sense FBO programmes may not make a highly significant contribution to HIV prevention. However, FBOs can operate in a complementary fashion to programmes that can provide support to key populations, through referral and through cultivation of a more supportive environment for PLHIV. Working with their most numerous members, women and young people, holds the promise to change social attitudes in the interest of reducing the impact of HIV in SVG as a whole, increasing knowledge and upholding the value of compassion.

## 6.0 Limitations

This study provides an assessment of the current and potential engagement of FBOs in SVG in HIV programming. Contextual data was generated by semi-structured interviews, while the survey generated basic information on a broad range of FBOs. Following are some limitations of the study:

The report focuses only on Christian FBOs. It therefore presents some salient issues for the majority of people in SVG who are of Christian faith, but does not cover the concerns of people from other faiths such as Hinduism or Islam.

The report does not seek to publicise information on the specific HIV-related programmes of a particular FBO or denomination. To protect privacy, the research team has not disaggregated the results by organisation or denomination.

Random sampling methods and statistical sample size calculations were not used in the selection of the FBOs included in the survey component of the research. Thus the FBOs included may not represent the picture for FBOs in SVG as a whole.

The use of qualitative methods to generate much of the data on FBO representatives' views and attitudes is appropriate for understanding a situation through the voices and perceptions of participants at a specific location at one point in time, but this approach limits generalising the results.

The respondents were generally in leadership positions within their FBOs and their views and perceptions may not accurately reflect those of the general FBO membership. While the methods are appropriate for the aim of reflecting the involvement of FBOs in HIV programming, further studies with broader representation from church congregations would be necessary to reflect the behaviour and attitudes of the general membership.

## **7.0 Recommendations**

### **7.1 STIMULATING FBO INVOLVEMENT IN PROGRAMMING**

The National AIDS Secretariat should bring together FBO leaders to discuss a strategy for the involvement of FBOs in various aspects of HIV programming. In this process, it is important to recognise diversity among FBOs, and allow for different levels of involvement of different FBOs in various aspects. Plans of action should be developed in partnership with each denomination. The NAS and its key partners, including CHAA, should ascertain the support that can be provided to each FBO in terms of capacity-building and HIV programming.

Meetings to develop action plans should include a specific and candid discussion of each FBO's doctrine and beliefs and the boundaries that these will require with regard to HIV prevention messages. Information should be supplied to each FBO on the range of HIV services available in SVG so that they can refer people, especially if they feel unable to provide similar services themselves. A referral system should be built and links scaled up with organisations where congregants can go to talk about different issues, including HIV prevention, health services, counselling and testing, domestic violence, education and training.

### **7.2 CAPACITY DEVELOPMENT FOR FBOS**

A training curriculum should be developed for church leaders and church members that is designed to be implemented in a structured and consistent manner over a fixed period of time. The following are areas useful to include in the curriculum:

- Basic HIV and AIDS knowledge including epidemiology, prevalence, transmission myths and prevention methods
- Human sexuality and other sexual and reproductive health issues
- Stigma and discrimination (including discussions on confidentiality)
- Most-at-risk populations and vulnerabilities
- Vulnerabilities of girls and women
- Risk behaviours among young people (including substance abuse as well as sexual behaviour)
- Human rights
- Palliative care and home-based care

Of note is that the Pan Caribbean Partnership Against HIV/ AIDS, as part of its Champions for Change initiative, has developed a stigma and discrimination toolkit, including a module for FBOs. The possibilities for using this toolkit to build capacity to challenge stigma and discrimination among FBOs in SVG should be explored.

PLHIV may be included as facilitators within training for FBO personnel to talk about their experience of living with HIV and AIDS. This may assist with dispelling myths related to HIV and AIDS. It may not be possible in SVG to identify PLHIV who have already disclosed their HIV status and are willing and able to conduct such facilitation. The possibility should be explored of bringing PLHIV from other Caribbean countries who are experienced in this kind of work. Agencies such as the Caribbean Regional Network of People Living with HIV/AIDS (CRN+) and CHAA may be able to assist in identifying suitable facilitators.

Church leaders, in the process of further engagement with HIV programming and in training initiatives with them, should be encouraged to recognise differences between facts and values regarding the disease. They should be assisted to appreciate their ability to impart accurate information about HIV to FBO members and thus challenge stigma and discrimination. They may be trained in counselling related to HIV testing, and assisted in compiling suitable Bible study materials with HIV prevention messages.

Resources or training should be provided to FBOs to assist in writing project proposals dealing with HIV.

### **7.3 BUILDING ON GLOBAL INITIATIVES**

Internationally, there are numerous HIV initiatives with FBOs, some of these spanning the globe. Programme implementers should try to make material from these initiatives available to FBOs in Antigua and Barbuda or direct them to websites and sources of support such as the Ecumenical AIDS Alliance, the World Council of Churches and Christian Aid.

### **7.4 YOUTH**

Formative assessments with young people who attend FBOs are recommended to design HIV programmes that are relevant, acceptable and appealing to them. These may include peer outreach to young people within the wider communities where churches are located. Programmes may be developed that are acceptable to the church but are still geared towards youth such as sports programmes or dances and socials that allow mingling in a relaxed atmosphere. They may also focus on developing communications skills and family life. Theatre initiatives for HIV education with youth may be pursued, such as the "With Open Arms" theatre project currently implemented by some FBOs in SVG.

Leaders in the church, not just youth leaders, may be trained in counselling techniques appropriate for youth. This should include the topics of health and sexuality, particularly adolescent sexuality. They may also be trained in developing parental communication skills among members of their congregations around topics of sex and sexuality within the boundaries of what is acceptable for the church.

## 7.5 GENDER ISSUES

Formative assessments may be conducted with a view to implementing programmes with women who attend FBOs, including single parents. These should address issues including managing relationships, building self-esteem, improving communications with partners and children and negotiating safer sexual practices. They should be developed and implemented in careful consultation with FBOs since faith-based messages for women sometimes follow biblical interpretations that promote traditional gender roles.

The feasibility of implementing evidence-based interventions for HIV prevention among church-going women should be explored. In St. Kitts and Nevis, CHAA is currently working with women in industrial estates to adapt an evidence-based intervention called SISTA (38). This intervention was originally developed for African American women and includes an emphasis on both self-esteem and building communication skills in personal relationships. The possibility of adapting such an intervention among women in SVG may be explored.

While men may not represent the majority in most church congregations, there are opportunities to address male gender norms that may increase vulnerability to HIV. Via sermons and outreach activities, FBOs can encourage men better to consider their responsibilities with regard to their own vulnerabilities and to prevent HIV transmission to their partners. Messages regarding the risks of multiple partnerships and promoting condom use may be particularly suitable for male audiences.

Pre-marital counselling programmes may provide avenues to promote messages around testing for HIV, sexual rights and reproductive health in a more structured way.

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# Appendices

## APPENDIX 1

Consent form for potential respondents in surveys

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

SURVEY INFORMATION SHEET REGARDING

PARTICIPATION IN A RESEARCH STUDY

Study Title: Eastern Caribbean Community Action Project Needs Assessment of Faith-Based Organisations' Willingness to Participate in HIV Prevention and Services

This is a research study about working with faith-based organisations to develop strategies to prevent the spread of HIV to at-risk people, to encourage HIV testing and to provide care and treatment services to people with HIV. The study researchers from the Caribbean HIV/AIDS Alliance or from the University of California, San Francisco will explain this study to you.

Research studies include only people who choose to take part. Please take your time to make your decision about participating, and discuss your decision with your family or friends if you wish. If you have any questions, you may ask the researchers.

You are being asked to take part in this study because you are a staff member at a faith-based organisation.

Why is this study being done?

The purpose of this study is to learn more about culturally appropriate faith-based strategies we can develop in order to reach people at risk for HIV.

Who pays for this study?

The United States Agency for International Development (USAID) pays for the conduct of this study, including salary support for the study researchers. Other than salary support, the researchers have no financial interest in this study or its outcomes.

How many people will take part in this study?

About 200 people will take part in this study.

What will happen if I take part in this research study?

If you agree, the following procedures will occur:

You will be asked to complete a survey. Surveys will include information about your organisation, such as denomination, estimated number of parishioners, and services currently offered in their communities.

The survey will take about 20 minutes to complete.

At the end of the survey you will be thanked for your time.

All these procedures will be done at your organisation's office.

How long will I be in the study?

Participation in the study will take a total of about 20 minutes.

Can I stop being in the study?

Yes. You can decide to stop at any time. Just tell the study researcher or staff person right away if you wish to stop being in the study.

Also, the study researcher may stop you from taking part in this study at any time if he or she believes it is in your best interest, if you do not follow the study rules, or if the study is stopped.

What side effects or risks can I expect from being in the study?

It is possible that you may feel uncomfortable during the survey, but you are free to decline to answer any questions you do not wish to answer or to stop answering questions at any time.

For more information about risks and side effects, ask one of the researchers.

Are there benefits to taking part in the study?

There will be no direct benefit to you from participating in this study. However, the information that you provide may help health professionals better understand/learn more about faith-based strategies for preventing the transmission of HIV to at-risk people and about how HIV providers can work with faith-based organisations to improve services.

What other choices do I have if I do not take part in this study?

You are free to choose not to participate in the study. If you decide not to take part in this study, there will be no penalty to you.

Will information about me be kept private?

We will do our best to make sure that the personal information gathered for this study is kept private. However, we cannot guarantee total privacy. Your personal information may be given out if required by law. If information from this study is published or presented at scientific meetings, your name and other personal information will not be used.

Organisations that may look at and/or copy your research records (without your name or other identifying information) for research, quality assurance, and data analysis include:

The University of California San Francisco's Committee on Human Research

The United States Agency for International Development (USAID)

The International HIV/AIDS Alliance and their regional office, the Caribbean HIV/AIDS Alliance

What are the costs of taking part in this study?

The only cost of taking part in this study is your time.

You will not be charged for any of the study procedures.

Will I be paid for taking part in this study?

You will not be paid for participating in this study.

What are my rights if I take part in this study?

Taking part in this study is your choice. You may choose either to take part or not to take part in the study. If you decide to take part in this study, you may leave the study at any time. No matter what decision you make, there will be no penalty to you.

Who can answer my questions about the study?

You can talk to the interviewer or to the researcher below about any questions or concerns you have about this study. Contact the researcher Dr. Janet Myers at UCSF at 1 (415) 597-8168 or Rosemary Lall at the Caribbean HIV/AIDS Alliance in Trinidad at (868) 623-9714. Collect calls will be accepted at these numbers.

If you have any questions, comments, or concerns about taking part in this study, first talk to the researcher (above). If for any reason you do not wish to do this, or you still have concerns after doing so, you may contact the office of the Committee on Human Research, UCSF's Institutional Review Board (a group of people who review the research to protect your rights).

You can reach the CHR office at 415-476-1814, 8 am to 5 pm, Monday through Friday. Or you may write to: Committee on Human Research, Box 0962, University of California, San Francisco (UCSF), San Francisco, CA 94143, USA.

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## CONSENT

You have been given a copy of this information form to keep.

**PARTICIPATION IN RESEARCH IS VOLUNTARY.** You have the right to decline to be in this study, or to withdraw from it at any point without penalty or loss of benefits to which you are otherwise entitled.

## Consent form for potential participants in semi-structured interviews

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

INTERVIEW INFORMATION SHEET REGARDING

PARTICIPATION IN A RESEARCH STUDY

Study Title: Eastern Caribbean Community Action Project Needs Assessment of Faith-Based Organisations' Willingness to Participate in HIV Prevention and Services

This is a research study about working with faith-based organisations to develop strategies to prevent the spread of HIV to at-risk people, to encourage HIV testing and to provide care and treatment services to people with HIV. The study researchers from the Caribbean HIV/AIDS Alliance or from the University of California, San Francisco will explain this study to you.

Research studies include only people who choose to take part. Please take your time to make your decision about participating, and discuss your decision with your family or friends if you wish. If you have any questions, you may ask the researchers.

You are being asked to take part in this study because you are a staff member at a faith-based organisation.

Why is this study being done?

The purpose of this study is to learn more about culturally appropriate faith-based strategies we can develop in order to reach people at risk for HIV.

Who pays for this study?

The United States Agency for International Development (USAID) pays for the conduct of this study, including salary support for the study researchers. Other than salary support, the researchers have no financial interest in this study or its outcomes.

How many people will take part in this study?

About 40 people will take part in this study.

What will happen if I take part in this research study?

If you agree, the following procedures will occur:

The researcher will interview you for about an hour and a half (90 minutes) in a private room. The researcher will ask you to describe your role in your organisation and to describe whether your organisation currently conducts any work related to HIV prevention, your organisation's willingness and capacity to do so, and barriers and facilitators to doing that kind of work. Questions will also explore the level of HIV-related stigma existing among your organisations

and its parishioners and what approaches and points of entry you consider useful to your faith-based organisation to conduct HIV prevention and to decrease stigma.

The researcher will make a sound recording of your conversation. After the interview, someone will type into a computer a transcription of what's on the tape and will remove any mention of names. The sound recording will then be destroyed.

Study location: All these procedures will be done in a private space that is convenient for you, most likely in your church.

How long will I be in the study?

Participation in the study will take a total of about 90 minutes.

Can I stop being in the study?

Yes. You can decide to stop at any time. Just tell the study researcher or staff person right away if you wish to stop being in the study.

Also, the study researcher may stop you from taking part in this study at any time if he or she believes it is in your best interest, if you do not follow the study rules, or if the study is stopped.

What side effects or risks can I expect from being in the study?

It is possible that you may feel uncomfortable in the interview, but you are free to decline to answer any questions you do not wish to answer or to leave the group at any time.

For more information about risks and side effects, ask one of the researchers.

Are there benefits to taking part in the study?

There will be no direct benefit to you from participating in this study. However, the information that you provide may help health professionals better understand/learn more about faith-based strategies for preventing the transmission of HIV to at-risk people and about how HIV providers can work with faith-based organisations to improve services.

What other choices do I have if I do not take part in this study?

You are free to choose not to participate in the study. If you decide not to take part in this study, there will be no penalty to you.

Will information about me be kept private?

We will do our best to make sure that the personal information gathered for this study is kept private. However, we cannot guarantee total privacy. Your personal information may be given out if required by law. If information from this study is published or presented at scientific meetings, your name and other personal information will not be used.

Organisations that may look at and/or copy your records (without your name or other identifying information) for research, quality assurance, and data analysis include:

The University of California San Francisco's Committee on Human Research

The United States Agency for International Development (USAID)

The International HIV/AIDS Alliance and their regional office, the Caribbean HIV&AIDS Alliance

What are the costs of taking part in this study?

The only cost of taking part in this study is your time.

You will not be charged for any of the study procedures.

Will I be paid for taking part in this study?

You will not be paid for participating in this study.

What are my rights if I take part in this study?

Taking part in this study is your choice. You may choose either to take part or not to take part in the study. If you decide to take part in this study, you may leave the study at any time. No matter what decision you make, there will be no penalty to you.

Who can answer my questions about the study?

You can talk to the interviewer or to the researcher below about any questions or concerns you have about this study. Contact the researcher Dr. Janet Myers at UCSF at 1 (415) 597-8168 or Rosemary Lall at the Caribbean HIV/AIDS Alliance in Trinidad at (868) 623-9714. Collect calls will be accepted at this number.

If you have any questions, comments, or concerns about taking part in this study, first talk to the researcher (above). If for any reason you do not wish to do this, or you still have concerns after doing so, you may contact the office of the Committee on Human Research, UCSF's Institutional Review Board (a group of people who review the research to protect your rights).

You can reach the CHR office at 415-476-1814, 8 am to 5 pm, Monday through Friday. Or you may write to: Committee on Human Research, Box 0962, University of California, San Francisco (UCSF), San Francisco, CA 94143, USA.

\*\*\*\*\*

## CONSENT

You have been given a copy of this information sheet to keep.

**PARTICIPATION IN RESEARCH IS VOLUNTARY.** You have the right to decline to be in this study, or to withdraw from it at any point without penalty or loss of benefits to which you are otherwise entitled.

## APPENDIX 2: INTERVIEW GUIDE

Interview #

Country:

Name of FBO or Faith Based Movement :

Denomination:

FBO Address:

Town/Area of Island:

FBO Telephone:

Fax:

Email:

Pastor or Contact Person:

Introduction

Thanks for agreeing to talk with me today. As you know, many people, especially young people, are at high risk for HIV. Although many different HIV prevention programs have been developed and implemented we think that faith-based organisations or spiritual movements can play an important role in this effort considering that many men and women feel connected to their faith communities and to their sense of spirituality. The University of California San Francisco (UCSF) and the Caribbean HIV/AIDS Alliance (CHAA) are working together on this collaborative project to speak to members of faith-based organisations (FBOs) to learn more about culturally appropriate faith-based strategies we can develop in order to reach people at risk for HIV.

### I. Faith-Based Organisation Profile

Please tell me a little bit about your organisation. [Let participants describe the group. Probe as needed to cover the following issues]

- a. What is the name of the religious/spiritual movement/group to which you belong ?
- b. Please describe your movement's/FBO's organisational structure or hierarchy.  
Council? Board? Community representation?
- c. Do you have bivocational (part time) spiritual leaders? If yes how many?

Do you have full time paid spiritual leaders? If yes How many?

- d. Do you have a central administrative office for your movement/FBO?
- e. How many full time staff work at this office? What are their main duties?
- f. Do you have spiritual/religious services regularly? If so, at what intervals?
- g. Approximately how many members of the movement/FBO do you have at your main (weekly, monthly, etc) service?
- h. Approximately, what percentage of these members are men and women?
- i. What proportion of the men and women are between 18 to 30 years old?
- j. Please estimate the proportion of your members with the following levels of education (make sure this adds up to 100%):

\_\_\_\_\_ Graduate/Professional School (includes University)

\_\_\_\_\_ College (includes Bible School, Seminary etc.)

Vocation School or Other Two-Year Degree

High School Graduate

Less Than High School

k. Does your movement/FBO have a fellowship hall or place where social activities take place? If so, describe in detail

l. Are you aware of any gay, lesbian, bisexual, or transgender (GLBT) people in your movement/FBO?

m. How are they treated by other members of your movement/FBO?

II. Health Promotion and Disease Prevention Programs in the FBO

Does your movement/ FBO have any kind of health promotion/disease prevention programs? If so, please describe. If not, why not?

Does your movement/FBO partner with any private/public health promotion agencies? If so, please describe

Does your movement receive any kinds of grant monies for its health promotion/disease prevention programming/Ministries? If yes, please describe. If no, why not?

If no, would your movement/FBO be interested in applying for/receiving outside funding to start new program dedicated to HIV prevention?

How big a priority is HIV/AIDS for your movement/FBO? Please explain.

Does your movement/FBO have an HIV/AIDS ministry/program? If so, please describe. If not, ask whether there is a need for that [Probe: If it does not come up ask if they conduct any HIV programs with other FBOs]

What would you say is the level of knowledge about HIV and other STDs in your movement/FBO? Is it low, moderate, or high?

What type of messages about HIV/AIDS awareness and prevention are talked about or preached?

[Probe here e.g. Let me give you a scenario-what if someone comes to you and says they want to go for an HIV test- what would you do at that point?

How much is being done about HIV/AIDS outside your movement/FBO in your country

Probe, Other FBOs, NGOs, Ministry of Health

How does your movement view sex work? (probe for teachings, doctrines, etc). Is that something that is mentioned/discussed at all?

In what forums do these ideas get communicated?

What do your members/congregants believe about sex work?

How do you think your movement's/FBO's teachings about this topic differ from other FBOs, if at all?

How does your movement view homosexuality? (probe for teachings, doctrines, etc). Is that something that is mentioned/ discussed at all?

In what forums do these ideas get communicated?

What do your members/ congregants believe about homosexuality?

How do you think your movements/FBOs teachings about this topic differ from other FBOs, if at all?

Does your church have any laws/policy/guidelines on GLBT?

What types of programs does your movement/FBO have for young adults (under 30 years old)?

Please describe these programs for me.

OR IF THEY DO NOT HAVE ANY

If your movement were to run a program for young adults, what do you think would be needed?

Who do you think would come/often come to those programs?

Please describe the different types of young adults from your movement that such a program would likely miss?

What strategies do you think would be effective in reaching out to them?

What kinds of barriers do you see to conducting HIV prevention programs in your movement?  
[Probe for barriers to other kinds of HIV programming other than prevention as well]

What kinds of programs do you think your movement would be willing to run?

How likely would your movement/FBO be to support the following types of activities or events (Probe: Ask about the ones they did not mention as well as any mentioned as part of the earlier qu on health promotion programs. Also, what would their willingness be dependent on? Also, In terms of capacity what help would they need to be able to run/expand these programs):

Distribution of safer sex and HIV-related literature \_\_\_\_\_

Social activities or parties for young adults \_\_\_\_\_

Small discussion groups on safer sex topics \_\_\_\_\_

Condom distribution \_\_\_\_\_

Counselling and testing for HIV \_\_\_\_\_

Small discussion group for young adults \_\_\_\_\_

Programs for people who are HIV-positive \_\_\_\_\_

Palliative care (home based programs) \_\_\_\_\_

What kinds of barriers do you see to conducting HIV prevention programmes in other FBOs?  
[Probe for barriers to other kinds of HIV programming other than prevention]

If your movement/FBO were to run an HIV prevention programme, what are messages that your movement would want to convey about how men and women can protect themselves against becoming HIV-positive or infecting others?

If your movement were to run a program that provided HIV counselling and testing, what are the messages that your movement would want to convey related to HIV testing?

If your movement were to run a program that provided support services for people who were HIV infected, what are the messages that your movement would want to convey about how men and women with HIV should be treated?

How many members/congregants do you think accept an HIV positive person into fellowship?

What do you think are the levels of stigma and discrimination in your movement/FBO? Can you think of a situation or scenario related to stigma and discrimination?

Would a PLWH be a spiritual/religious leader in your church/movement?

Would someone who is openly GLBT be a spiritual/religious leader in your church/movement?

Are there members/congregants who are more respected or influential among your members?

How likely are they to influence beliefs among your members/congregants?

24) What makes them more influential? Their profession, personality, beliefs, financial situation?



Is your denomination affiliated with an umbrella organisation or organisations (such as the Caribbean Council of Churches)? IF YES: Which one/s?

Are there any paid staff working within your organisation

No

Yes

If yes, how many?

# Full Time Staff	Position/Title
# Part Time Staff	

**ABOUT HEALTH-RELATED PROGRAMS:**

Does your group currently provide any health-related programs or activities? (These are programs which contribute to the physical, mental, emotional, nutritional and psychological well being of an individual)

No

Yes → If yes, what are the names of those programs and areas of health? What are the target population/s for these programs?

Program	Areas of Health targeted	Target population/s (examples: entire congregation, youth)

**ABOUT HIV/AIDS-RELATED PROGRAMS:**

Does your group currently provide any kind of HIV/AIDS-related activities/programs?

No IF NO, SKIP TO 13

Yes

10. Which of the following does your organisation/group provide (or support)? (WHILE SHOWING CARD WITH DIFFERENT ACTIVITIES/PROGRAMS READ AND ASK:)

And how long have you been providing these activities?

How often are they provided?

How Long (specify months or years)	How often?	
		HIV/AIDS Education and Prevention
		HIV Testing Services (directly on site)
		HIV/AIDS Risk Reduction Counselling
		Referrals for HIV Testing
		Condom distribution
		AIDS Orphan support services
		Diagnosis and treatment of tuberculosis and other sexually transmitted infections
		Prison Outreach
		Medical treatment for HIV/AIDS
		HIV/AIDS Housing and/or Housing Assistance
		Substance Abuse/Counselling/Prevention Services
		Spiritual Counselling
		Meal (Food) programs for Persons with HIV/AIDS
		Bereavement Support Program
		Outreach services
		Employment of PLWH
		Advocacy for Employment for PLWH
		Advocacy for Legislation supporting PLWH
		Palliative care (such as home based care
		Other (please specify)

What type(s) of organisation(s) are you currently collaborating with to provide HIV/AIDS-related services? (CHECK ALL THAT APPLY)

- Not Collaborating with other organisations
- Other faith-based organisations
- Social Service agencies
- Health Departments
- National AIDS Secretariat
- University/College
- Businesses or the business community
- Community Groups
- International Agencies (e.g. USAID, Red Cross)
- Schools
- Other (specify) \_\_\_\_\_

What changes have taken place in your organisation or group as a result of providing HIV-related services? (CHECK ALL THAT APPLY)

- N/A
- Increased HIV/AIDS knowledge in congregation
- Began HIV testing
- Started an HIV/AIDS ministry
- HIV/AIDS policy development
- Counselling workshops on human sexuality
- Other (please specify) \_\_\_\_\_

SKIP TO Q 14:

Have members of your church discussed beginning any kind of HIV/AIDS-related activities/programs?

- No
- Yes

Comments: \_\_\_\_\_

In fulfilling your church's mission, how important is it for you to establish, or further develop an HIV/AIDS ministry/program in order to reduce and prevent the spread of HIV/AIDS? Would you say very important, somewhat important or not important?

(READ FOLLOWING SCALE TO RESPONDENT)

Very important

Somewhat important

Not important

15. Can you tell me how much you know about how HIV programs are planned in your community? (READ FOLLOWING SCALE TO RESPONDENT)

Not much

Have some knowledge, but would like more information

Very knowledgeable about this process

Other: \_\_\_\_\_

IN GENERAL (NOT HIV-specific)

16. Now I'd like to ask you about services your church might be interested in. Tell me, would your church benefit from training or consulting services to enhance your ability to...(READ FOLLOWING SCALE TO RESPONDENT)

Do fundraising? Yes No

Conduct Strategic planning? Yes No

Manage volunteers? Yes No

Understand health issues among parishioners? Yes No

Establish HIV/AIDS ministries? Yes No

Market church programs to the community? Yes No

Build collaborative relationships with other community organisations? Yes No

Other (please specify) \_\_\_\_\_

## STIGMA

We are almost done, but before we finish, we are going to switch topics and I have a series of questions about how people in this community relate to people with HIV/AIDS.

(INTERVIEWER: READ TO PARTICIPANT WHILE SHOWING CARD WITH QUESTIONS AND THE SCALE):

17. I will describe some stories that some people may have heard. Tell me whether you have heard about any of these things happening to others. After each story, I will ask you how often you have heard it: Never, Rarely, Sometimes or Frequently:

(INTERVIEWER: Begin each story below with the following:)

In the last year, how often have you heard stories about...	Never	Rarely	Sometim es	Frequentl y
HS1. ...People being forced by family members to leave their home because they had HIV?	0	1	2	3
HS2. ...A village/community isolating someone because they had HIV?	0	1	2	3
HS3. ...Someone being refused care from their family when they were sick with HIV?	0	1	2	3
HS4. ...People looking differently at those who have HIV?	0	1	2	3
HS5. ...Families avoiding any relative who has HIV?	0	1	2	3
HS6. ...People being refused medical care or denied hospital services because of their HIV?	0	1	2	3
HS7. ...People being mistreated by hospital workers because of their HIV?	0	1	2	3
HS8. ...A healthcare worker not wanting to touch someone because of his or her HIV?	0	1	2	3
HS9. ...A healthcare provider talking publicly about a patient with HIV?	0	1	2	3
HS10. ...A hospital worker making someone's HIV infection publicly known by marking HIV on their medical records?	0	1	2	3

(INTERVIEWER: READ TO PARTICIPANT WHILE SHOWING CARD WITH QUESTIONS AND THE SCALE):

18. Based on your own experiences and what you've seen and heard, please tell us how many people in your congregation believe each of the following statements. After each statement, I will ask you how many people in your congregation believe it according to the following: No One, Very Few People, Some People, or Most People.

	No One	Very Few People	Some People	Most People
FS1. In your congregation, how many mothers would not want someone with HIV to hold their new baby?	0	1	2	3
FS2. In your congregation, how many mothers would not want an HIV infected person to feed their children?	0	1	2	3
FS3. In your congregation, how many people would not share dishes or glasses with someone who has HIV?	0	1	2	3
FS4. In your congregation, how many people would not want an HIV infected person cooking for them?	0	1	2	3
FS5. In your congregation, how many people avoid visiting the homes of people with HIV?	0	1	2	3
FS6. In your congregation, how many people think that HIV-infected people have brought shame on their families?	0	1	2	3
FS7. In your congregation, how many people think that if you have HIV you have done wrong behaviours?	0	1	2	3
FS8. In your congregation, how many people think people with HIV are paying for their karma or sins?	0	1	2	3
FS9. In your congregation, how many people think that people with HIV should feel guilty about it?	0	1	2	3

FS10 In your congregation, how many people think that a person with HIV is disgusting? 0 1 2 3

19. How long have you been in this church/organisation? \_\_\_\_\_/ Yrs

20. How old are you? \_\_\_\_\_/ yrs

WRAP UP:

Thank you for your time completing this survey.

Please write any additional comments below.

NOTES: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Profile of FBO	Yes	No	Comments
Role of Interviewee			
Structure of FBO			
Independent			
Bi-vocational/ spiritual leaders			
Full-time paid leaders			
Hierarchy, Decision-Making/Leaders/groups within FBO			
Central admin office			
Full-time staff in office			
Services			
FBO Hall			
Member Profile			
# of attendees			
% of: men/women			
Age			
GLBT members			
Education			
Current Health Promotion			
Health Promotion programs			
Partnerships			
Grant Monies			
If not, why not?			
HIV/AIDS ministry/ program			

**APPENDIX 4: FBO MATRIX TEMPLATE**

FBO need Response from congregants to HIV activities to run/expand these activities?			
Potential Health Promotion			
A need for HIV/AIDS awareness program			
Support for the following activities/events:			
Distribution of safer sex literature			
Distribution of HIV-related literature			
Social activities/ parties for young adults			
Small discussion groups on safer sex topics			
Condom distribution			
Testing for HIV			
Counselling for HIV			
Small discussion group for young adults			
Programs for people who are HIV-positive			
Palliative care (home based programs)			

UCSF/ CHAA FBO Study

Name:

Location:

More Detailed Responses:

### **Youth**

Retention of youth in FBO  
Current Programs  
Future Programs  
FBO Messages  
HIV testing  
HIV awareness and prevention

### **Sex work**

Homosexuality  
Treating PLWH within FBO  
FBO Views  
HIV testing

HIV awareness and prevention  
Sex work

### **Homosexuality**

Treating PLWH within FBO  
Views outside of the FBO  
HIV testing  
HIV awareness and prevention  
Sex work  
Homosexuality  
Knowledge and Priority  
Level of knowledge about HIV & other STDs in FBO  
Priority of HIV/AIDS in the FBO  
Priority of HIV/AIDS outside of the FBO  
Barriers  
HIV prevention programs in the FBO  
HIV prevention programs in other FBOs  
HIV prevention programs in St Kitts

### **Stigma and Discrimination**

Levels of stigma and discrimination in the FBO  
Levels of stigma and discrimination on St Kitts  
Ways to combat stigma  
Leadership and Inclusion  
Possibility of PLWH leader in FBO  
Possibility of GLBT leader in FBO  
Influential members

### **Other Notes**

## CHAA COUNTRY OFFICES



### **Antigua and Barbuda**

Newgate Street  
St Johns  
Antigua  
Tel (268) 562 7327 -8

### **Barbados**

Beaumont House  
Hastings, Christ Church  
Barbados  
Tel (246) 228 4306

### **Jamaica**

24 Haining Road  
Kingston 5  
Jamaica  
Tel (876) 631 2280 / 9103-4

### **St Kitts and Nevis**

10 Rose Lane  
Greenlands  
St Kitts  
Tel (869) 466 3909 / 465 0496

### **St Vincent and the Grenadines**

P.O Box 2995  
Kingstown  
St Vincent and the Grenadines  
Tel (784) 451 2044 / 2046



### **CHAA'S VISION**

A region where people do not experience discrimination or die of AIDS.

### **CHAA'S MISSION**

To facilitate effective and collective community action to reduce the impact of HIV and AIDS across the Caribbean.

### **CONTACT INFORMATION**

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