

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

A Situational Analysis in Antigua and Barbuda



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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 Antigua and Barbuda*. The study was undertaken by the International HIV/AIDS Alliance (IHAA)/Caribbean HIV&AIDS Alliance (CHAA) and the University of California at 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.

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. Three key populations provide the focus of CHAA activities: men who have sex with men (MSM), sex workers (SW) and people living with HIV (PLHIV). 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; (4) peer support; and (5) acceleration of the private sector response to HIV and AIDS.

The overall aim of the Eastern Caribbean Community Action Project (EC-CAP) is to work with key populations 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.

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, UCSF, local researchers from Antigua and Barbuda and with the support of the Government of Antigua and Barbuda. 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.

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## List of acronyms

AIDS	Acquired Immunodeficiency Syndrome
BBSS	Biological/ Behavioural Surveillance Surveys
BCC	Behaviour change communication
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
FSW	Female sex workers
GLBT	Gay, lesbian, bisexual or transgender
HIV	Human Immunodeficiency Virus
IEC	Information, education and communication
IHAA	International HIV/AIDS Alliance
IRB	Institutional Review Board
MSM	Men who have sex with men
NGO	Non-Governmental Organisation
NAP	National AIDS Programme
NAS	National AIDS Secretariat
PHSC	Protection of Human Subjects Committee
PLHIV	People living with HIV
PLWA	People living with AIDS
S&D	Stigma and discrimination
SISTA	Sisters Informing Sisters on Topics about AIDS
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SW	Sex workers
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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# Executive summary

## Introduction

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 care 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. 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:

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

## Methods

The qualitative and quantitative data collection methods used in Antigua and Barbuda were the same as in the other countries included in this study. Primary data were collected via two methods. First, the research team conducted interviews with representatives of selected denominations using a semi-structured interview guide. In Antigua and Barbuda, eight FBO representatives were interviewed using this method. Second, a survey was conducted using a standardised questionnaire to interview representatives from a broad cross-section of FBOs. Forty-nine FBO representatives participated in the survey in Antigua and Barbuda. 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.

## Results

The results presented here are from the research carried out in Antigua and Barbuda. Findings from the other countries will be presented in separate reports.

## Participant description

The denominations represented by participants in semi-structured interviews were Anglican, Baptist Assemblies, Baptist Association, Methodist, Moravian, Seventh Day Adventist, Wesleyan and an independent church.

Of the 49 participants in the survey, 10 represented independent churches and the remaining 39 represented 17 different denominations. Anglican, Baptist, Pentecostal and Roman Catholic denominations were most commonly represented, each by 4 or more participants.

### **FBO congregations**

Congregations were said to vary in size between 15 and 2000 people, with around half of congregations being under 200 people. The percentage of female church members was said to vary between 60 and 85%. Three of the interviewees reported the percentage of young people aged 18-30 in their FBOs to be between 25 and 40%, while four interviewees reported between 60 and 75% of their members within this age group.

### **Health and welfare activities at FBOs**

All FBOs had procedures in place to care for the sick and needy, consistent with concepts of Christian charity. Some helped “poverty stricken” families and the elderly with food items or other basic necessities. Some FBOs had their own schools, day-care programmes or, more rarely, clinics. Activities included health talks, seminars, workshops and fairs that were supported by doctors and nurses from the FBO or from the Ministry of Health in Antigua and Barbuda. Health issues are sometimes discussed from the pulpit, occasionally setting a special time during the church service when health matters will be covered.

The welfare of youth was an important focus of activity of some FBOs. A wide variety of activities were mentioned, including retreats, Bible study, camps, dances, music, drama and sports groups.

### **HIV-related activities at FBOs**

According to the quantitative survey, 71% of FBO respondents reported that they had HIV-related programmes. The invitation of a guest speaker (doctor, nurse or researcher) was the most commonly cited approach to address the issue of HIV, according to participants in semi-structured interviews. Occasionally, HIV positive persons would be invited to talk to the congregation. These events would often be arranged in collaboration with the National AIDS Secretariat (NAS), the Ministry of Health or the Health Hope and HIV Network (HHHN, a non-governmental organisation). Initiatives for young people sometimes included HIV among the topics covered. One FBO held a month of HIV-related activities every December, starting with World AIDS Day (1st December).

Three interviewees reported that leaders from their FBOs have attended training and workshops on HIV held by the Caribbean Conference of Churches in collaboration with the NAS and the Ministry of Health. Workshops have included sessions on ways FBOs can support people living with HIV (PLHIV) to “manage their own situation and enable them to feel as though they are still part of a community”, including via the provision of palliative care. One FBO had been involved in a Red Cross initiative to train youth in HIV peer education.

No FBOs represented in semi-structured interviews had an established voluntary counselling and testing (VCT) programme. However, one of these FBOs had members trained in VCT. Only one of these FBOs had a specific support programme for PLHIV, consisting of a food drive twice yearly.

## **Messages around HIV prevention**

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. FBOs reconciled standard HIV prevention messages about abstinence, being faithful and using condoms (the so-called ABC of HIV prevention) with Biblical teachings about sexual relations, whereby sex is only considered acceptable between married, heterosexual couples. Sex work, homosexual sex and sex outside a marital union are considered immoral and irresponsible behaviours. Seven of the 8 interviewees said that people can only be truly empowered to prevent HIV transmission through abstinence before marriage and fidelity in marriage.

Opinions regarding condom use varied. Some completely disapproved their use, as they were considered to be an invitation to extra-marital sex and multiple partnerships. Some only approved condom use as a means of birth control for married couples. Others thought that condom use could be approved in specific circumstances, such as when a spouse had been unfaithful, when one or both spouses were HIV positive, or among people who could not exercise sufficient self-control to abstain or be faithful. There was a level of acceptance among some respondents that condoms were important to prevent HIV transmission, but no-one interviewed approved condom use unconditionally.

## **Attitudes to sex workers and men who have sex with men**

Sex work, including transactional sex, and homosexual behaviour were considered wrong, sexually immoral and unacceptable. Some interviewees adopted the attitude of “Love the sinner but not the sin”, explaining that sex workers (SW) and men who have sex with men (MSM) could be accepted into the church, but they would be counselled to change their lifestyles to conform to church teaching. Four interviewees expressed the desire to understand the motivation behind involvement in sex work so that they could alleviate the circumstances that led to this activity. Some FBOs were said to impose penalties on church members known to persist with sex work despite having counselled to stop. These could include public denouncement of the person with subsequent cessation of the ability of the person to partake in church ceremonies. With the exception of one, all interviewees stated that MSM could be accepted into the church once they were not overt in displaying their sexual orientation.

## **Attitudes to PLHIV**

Interviewees reported that they had an accepting and inclusive attitude to PLHIV. This was largely based on the notion that, as stated by an interviewee, “all sins are forgivable, and all persons should be treated with God’s love.” Two interviewees knew of HIV positive members in their congregations, and a further two had hosted a talk at church by a PLHIV. Fear, stigma and discrimination against PLHIV were said to vary between church members. Some “condemned” PLHIV based on assumption of past immoral behaviour. One interviewee regarded HIV as a “judgement” from God, but said that redemption was possible: “In the midst of judgement, there is grace and mercy for those who desire”. Some said the treatment of an HIV+ positive person by churchgoers may depend on beliefs about the way in which s/he was infected with the virus. One interviewee said that some infected persons may be “innocent”, such as a wife who contracts the virus from sex with her husband, as contrasted with someone who was infected through a homosexual encounter, who, by implication, would be considered “guilty”.

## **Stigma and discrimination**

Interviewees expressed the view that HIV may be associated with sinful behaviour. In the opinion of one interviewee, stigma was in fact appropriate as a spur to moral activity if it focussed on sins:

When a church historically and Biblically defines homosexuality as a sin we are not unhappy with such activities being stigmatised. We [the church] want all sin to be stigmatised – theft, murder, adultery, whatever....So I think it goes too far when they talk about removal of stigma.... Shame is an important motivator for moral activity. To make a case for the removal of shame you are going to lose a lot of conservative members of the church.

The difficulty here may be in making sure that the shame attaches only to the behaviour (“sin”) and not the person (“sinner”), as the same interviewee seemed to acknowledge when he asserted that stigma in some circumstances was acceptable, “so long as people who choose a lifestyle are not harmed or have their civil rights removed.”

A further contributor to stigma and discrimination is fear concerning the possibility of infection via casual contact.

People are not very comfortable with the fact that people are saying that HIV cannot be caught this particular way. They’re not quite sure whether the doctors or the specialists really have the story down right or whether they’re trying to hide the real truth about AIDS. There are people who disbelieve that AIDS can’t be caught by, you know, just shaking hands, being in somebody’s presence, so people are very afraid of the whole idea of AIDS, so that misconceptions of how it can be passed on sometimes warp people’s mind.

The survey included responses to a validated scale to measure perceived levels of stigma and discrimination among church congregations. The highest average stigma scores indicated fears about sharing food and drink, e.g. not wanting a PLHIV to feed one’s children, nor to eat food cooked by a PLHIV or to share dishes or glasses with someone with HIV. Responses to the scale also indicated that some people think that if a person has HIV they have “done wrong behaviours.”

## **Future programmes**

Interviewees were generally willing to assist in improving accurate knowledge about HIV so that PLHIV would feel more welcome in FBOs. It was mentioned that individuals in FBOs need more education on HIV, its means of transmission and treatment. Interviewees expressed a desire for more outreach programmes for and with PLHIV.

A further major area of interest was in counselling and testing. There were calls for increased personnel and other resources for this. At the same time, interviewees recognised the challenges posed by possible lack of confidentiality that may deter people from coming forward for testing.

Interviewees stated they were open to distributing materials to promote safer sexual behaviour with respect to HIV, but the contents would have to be vetted by the FBO for conformity to the religious belief system.

## Discussion

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

There are some study limitations:

The report focuses only on Christian FBOs. It therefore presents some salient issues for the majority of people in Antigua and Barbuda 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 Antigua and Barbuda 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.

The findings indicate that greater involvement of FBOs in HIV programming holds the potential to extend the reach of HIV interventions. Most FBOs in Antigua and Barbuda appear to be involved in HIV activities to some extent. Interviewees expressed support for the greater involvement of their FBOs, noting that this was consistent with Christian teaching regarding compassion and support for fellow human beings in need.

While interviewees expressed that they did not discriminate against PLHIV, some also noted the view shared by many in their FBOs that HIV was usually associated with sinful behaviour. Stigma was said to result both from judgements regarding the (supposed) behaviour that lead a PLHIV to be infected and from fear of infection via casual contact. There were also concerns expressed about the levels of confidentiality that may make it difficult for PLHIV to disclose their status within FBOs. While church leaders appear willing to help PLHIV, these attitudes and lack of confidentiality must be addressed in order to make the social environment more welcoming to PLHIV.

As regards MSM and SW, interviewees expressed the notion of “love the sinner and not the sin”, making it clear that if they attended church they would have to “repent their sins” and cease having homosexual or paid sex.

While there is some scope for FBOs to refer MSM or SW to other services on the basis of compassion, FBOs' ability to provide the range of prevention and care services needed by these vulnerable populations is constrained.

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 SW and MSM.

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 Antigua and Barbuda. Available data suggest that HIV prevalence among the general population 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 SW. Our findings indicate that the role of FBOs in supporting key populations and in condom promotion may be 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.

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 NAS, CHAA and other agencies, will augur well in increasing the impact of HIV prevention and care programmes in Antigua and Barbuda. Working with FBOs holds the promise to:

- improve HIV care and support
- change social attitudes in the interest of reducing the impact of HIV and reduce S&D against PLHIV
- increase knowledge on HIV and STIs and
- uphold the value of compassion.

## **Recommendations**

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

FBO leaders who are already active and committed with regard to HIV should seek to mobilise their peers to become similarly involved. 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 willing to be involved. The NAS and its key partners, including CHAA, should be kept apprised of developments among the FBOs 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 initiatives.

## **Capacity development for FBOs**

Given, on the one hand, the interest expressed by FBOs to expand their programming, and on the other, the finding that there may be fairly high levels of stigma and discrimination; it is recommended that training curricula be developed or adapted for church leaders and church members. The following are areas considered useful to include in any such curricula:

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 challenge stigma and discrimination among FBOs in Antigua and Barbuda should be explored.

The NAS is encouraged to build a strong and collaborative referrals system between FBOs and other agencies involved in HIV programming. This will enable FBOs to make referrals for services that they are unable to provide themselves.

## **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.

## **Messages for Church Congregations regarding Stigma and Discrimination**

Appropriate methods for relaying messages regarding acceptance of PLHIV should be explored. In some FBOs, messages from the pulpit may be effective and could, for instance, provide Biblical illustrations of instances when Jesus embraced people who were sick or were socially marginalised. Messages could emphasise forgiveness, mercy and unconditional love.

While congregants reflect the values of the general population in Antigua and Barbuda regarding fear of HIV, FBOs could provide the catalyst and the leadership to overcome the dichotomy between Christian values of love and compassion and existing stigma towards PLHIV and other key populations.

### **Youth**

Our research indicated that some FBOs have predominantly young people as members of their congregations. In others, young people constitute a smaller but still substantial proportion of members. Working with young people via FBOs may be a way to reach substantial numbers of them. Formative assessments with young people who attend FBOs are recommended to design HIV programmes that are relevant, acceptable and appealing to them.

### **Gender and relationship issues**

Interviewees reported that up to 75% of their congregants are women, and Caribbean epidemiological evidence suggests rising HIV incidence among females. Working via FBOs may be a way to include substantial numbers of women in HIV prevention activities. Formative assessments may be conducted with a view to implementing programmes with women who attend FBOs. These should address issues including managing relationships, building self-esteem, improving communications with partners and children and negotiating safer sexual practices.

The feasibility of implementing evidence-based interventions for HIV prevention among churchgoing 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> This intervention was originally developed for African American women and includes an emphasis on self-esteem and building communication skills in personal relationships. The extension and possible further adaptation of this intervention to suit churchgoing women should 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 to consider their responsibilities with regard to their own vulnerabilities and HIV prevention.

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<sup>1</sup>Caribbean HIV & AIDS Alliance and University of California, San Francisco (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.

# 1.0 Introduction

Faith-based organisations (FBOs) play an important role within Caribbean societies and religious leaders have considerable influence. An external show of compliance with 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 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 activities 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) for the Eastern Caribbean Community Action Project, which was implemented by the Caribbean HIV&AIDS Alliance (CHAA). 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. 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 includes findings for Antigua and Barbuda. A later comparative analysis of FBOs across all target countries may support efforts to engage the FBO sector in HIV and AIDS programming at a regional level. Research was conducted solely among Christian FBOs, who represent the majority of the population in the countries included in the study.

## 2.0 Background

Antigua and Barbuda are among the Leeward Islands in the Eastern Caribbean. In 2009, the twin-island nation had an estimated population of 85,632, the crude birth rate was 16.59 per 1,000 population, the annual population growth rate was 1.3% while the net migration rate was 2.38 migrants/ 1,000 population (1). Having gained its independence from the United Kingdom in 1981, Antigua and Barbuda remains a member of the Commonwealth of Nations. The official language is English, the capital is St John's, and the majority of persons are of African origin, with a few of British, Portuguese, and Levantine Arab descent (2).

### 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 (4).

The primary route of HIV transmission in the Caribbean is through sexual intercourse. Although in the region HIV was first seen in homosexual men, it has become increasingly prevalent among women, fuelled by unprotected sex, multiple partnering, transactional sex and existing laws and social discrimination against sex workers (SW) and openly gay men, resulting in clandestine high risk taking sexual behaviour. 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. S&D have affected the prevalence of the HIV and AIDS epidemic in the region (6), contributing to drive the epidemic underground and effectively making the task of prevention and access to care and treatment more difficult. S&D act to reinforce already existing discriminatory views towards vulnerable population segments, such as women, homosexuals, bisexuals, SW and drug users. This leads to a moral judgement being made on those who are HIV positive (7).

From a programmatic point of view, HIV has become more than just a health issue for the Caribbean. It challenges the overall development of the region, as there is no social class or group that has not been affected by the epidemic. A UNAIDS report released in 2006 noted an increased involvement of Caribbean governments in HIV and AIDS programmes, as well as a move to a multi-sectoral approach. There is still, however, a lack of coordination of the various groups by the national AIDS bodies which results in unilateral projects operating without a common focus and thereby inhibiting their potential impact (8).

### 2.2 HIV IN ANTIGUA AND BARBUDA

The first case of HIV in Antigua was recorded in 1985. As at September 2007, a total of 663 people had been diagnosed with HIV with the majority of those being in the 15-49 age bracket. There have been equal numbers of men and women diagnosed with HIV, and the main form of transmission is reported to be heterosexual contact. AIDS has become the leading cause of death in the broad age range of 20-59 years (9).

According to the country's Strategic Plan for the National AIDS Response to HIV/AIDS for 2002-2005, the spread of the epidemic is influenced by multiple sexual partnerships, sex work (including with tourists), and irregular condom use (10).

Seroprevalence studies among key populations have not been conducted in Antigua and Barbuda. Studies in other Caribbean countries and anecdotal evidence suggest that those who are most at risk include youth, MSM and female sex workers (FSW) (11). A Behavioural and HIV Seroprevalence Survey was piloted by the Ministry of Health among MSM and FSW; however it was considered not feasible, as it proved impossible to identify adequate numbers of participants. Reasons given for this included lack of networking within these groups, fear of S&D and concern in being identified as associated with illegal activities. These factors also adversely affect access to HIV prevention and treatment by these populations (12).

The National AIDS Secretariat (NAS), a division under the leadership of the Ministry of Health, is responsible for coordinating and implementing HIV and AIDS strategies and programmes with the stakeholders (13). For people living with HIV (PLHIV), the public hospital provides antiretroviral drugs free of charge. A non-governmental organisation called the Health, Hope and HIV Network (HHHN) provides a support group for PLHIV and is actively engaged with the National AIDS Programme (NAP) and also receives support from CHAA. The provision of a food bank for PLHIV is one of the activities of HHHN.

The 2008 UNAIDS-funded HIV and AIDS country progress report recognised several challenges facing the successful execution of NAP activities. These included, among other things, the lack of empirical data on the HIV epidemic and the limited collaboration taking place in implementation between different parties (14). Other challenges, important to protect the rights of key populations, include:

- Unavailability of updated policies, guidelines and protocols on HIV and AIDS
- Lack of anti-discriminatory legislation for the protection of PLHIV
- The need to review and revise existing policies and laws for protection of human rights.

CHAA provides support to HIV programming in a number of areas. Community Animators support key populations to make safer sexual choices and enable them to access and utilise services provided by government and community organisations. CHAA has also supported the development of a community-based counselling and rapid testing programme. Capacity building sessions are provided to a variety of civil society, community and government partners in a wide range of technical areas. Information, Education and Communication (IEC) are provided via a variety of special events. In 2009, CHAA's Antigua and Barbuda office worked with four grantees that implement projects on gender-based violence and HIV, counselling and testing and community care and support. The office also participated in a project entitled, Sexual and Reproductive Health and HIV Integration: Female Condom Project for Spanish-Speaking Sex Workers.

The CHAA Antigua and Barbuda Country Office works closely with the Ministry of Health, the National AIDS Programme, the Directorate of Gender Affairs and with community partners including HHHN, the Antigua and Barbuda HIV&AIDS Network, Women Against Rape, the Anglican Youth Diocese and many others.

CHAA has also collaborated with a number of international and regional organisations for in-country trainings including the Caribbean HIV/AIDS Regional Training Network, the US Centers for Disease Control and Prevention, The Foundation for AIDS Research, Caribbean Vulnerable Communities, El Centro de Orientación e Investigación Integral and the Caribbean Harm Reduction Coalition.

## **2.3 HISTORY OF FBOS 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 (15). 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” (16). 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 (17). 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 (18).

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 (19). 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 (20). 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 (21). The “nonconformist” churches may have had a “far more profound influence on religion in the West Indies than the Anglicans” (22). 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 (23).

### **2.3.2 Post Emancipation**

The emancipation of the enslaved people 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 (24).

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 (25).

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 (26). 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 (27).

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 (28). The arrival of apocalyptic, fundamentalist, and Pentecostal churches brought another wave of religious influence to the Caribbean (29). For example, Pentecostalism was introduced predominately from churches on the North American eastern seaboard in the early 1900s. (30) 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 (31). 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 a coordinating body and implementing agency that promotes development and sustainability through various initiatives of churches from several denominations in 34 territories of the Caribbean. Among the CCC's initiatives was the 3 year regional programme, "Building a Faith-based Response to HIV and AIDS in the Caribbean", funded by the Canadian International Development Agency (CIDA). The programme's aim was "to mobilise and enhance the response of FBOs to the HIV epidemic". Among the activities in Antigua and Barbuda under this programme was a buddy system for PLHIV, called "2 by 2 – Caring and Sharing." CCC is a member of the Pan Caribbean Partnership Against HIV/AIDS (PANCAP).

PANCAP held 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 CCC 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" (32).

The CCC, with support from CIDA, 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.

Antigua and Barbuda was one of the 14 target countries for the project (33). 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 identified youth and young adults, especially females between the ages of 15-19, as being most vulnerable to HIV infection in the region. The CCC action plan was partly based on findings regarding priorities for action from self-administered questionnaires completed in 2004 among 259 religious bodies in 16, mostly English speaking, independent territories in the Caribbean. The current study, informed by the CCC action plan, was designed to assess the actual engagement, capacity and needs of FBOs in 4 Eastern Caribbean countries with regard to HIV prevention, care and support.

In 2008 in Antigua and Barbuda, CHAA funded an anti-stigma and discrimination activity over the Christmas period, executed by the Anglican Youth Ministry (34). This project, as part of the Anglican Ministry's Christmas activities entitled "A Festival of Lessons, Music and Dance" aimed to bring about consciousness on HIV-related S&D. It included a workshop on S&D which attracted over 250 participants. In addition, around 500 "Gifts of Love" packages were distributed to members of the congregation. Packages contained anti-S&D messages, and included fact sheets about HIV transmission. The event was broadcast on national television on Christmas Day. The Anglican Church developed its work on S&D for its members with the collaboration of the Health, Hope and HIV Network, hosting a literary arts competition on HIV. This intervention showed the potential of FBOs' engagement in the national response to the HIV epidemic.

Also in 2008 in Antigua, CHAA hosted a 3-day Workshop in Behaviour Change Communication for Leaders in Faith-Based Organisations (35). The 18 participants represented 12 denominations and 6 independent churches. An independent evangelical pastor working closely with the local network of PLHIV helped to organise and mobilise other religious leaders to participate. Following is a quote that the pastor made in the workshop.

I encourage leaders to stop the discrimination, stop stigmatising, do not talk negatives when you are preaching at the pulpit, but just reach out to the community, open your services, open your offices, so that any person can come in to be counselled. If we do that, I think we will break down this barrier, and even eliminate the stigma and discrimination. We should plan positive programmes with regards to HIV and AIDS and not discriminate against gays and lesbians. It's not that you are supporting gay and lesbians actions, but you are saying to others, because they are Gods creation, because they are human beings they have a soul and feel. Do not look in their faces and call them names not written in the Books. All of that is what I want to say to faith-based leaders....

Several participants from FBOs made presentations on the local HIV situation and HIV work in which they had been engaged, and debated issues of HIV-related S&D. The consultant who was the chief facilitator made a series of presentations with opportunities for participation, including sessions on:

- What is Behaviour Change Communication (BCC)?
- Differences between BCC and IEC
- Issues and challenges in behaviour change
- BCC Planning: Process and Approaches
- Writing the Plan of Action
- Identifying behaviours
- Writing behavioural objectives

- Identifying determinants
- Using data to identify problems, behaviours and determinants
- Behaviour theories
- BCC intervention approaches and strategies
- Matching theory and strategy

During practicum sessions, participants worked in dyads to develop plans of action. The workshop also included a presentation by a member of the CHAA Strategic Information team about the objectives of the FBO research. The workshop thus helped sensitise and mobilise support for this research project. Following the workshop, leaders identified the following changes in themselves:

Motivation to increase involvement in prevention, care and support

Realisation that PLHIV can live a normal life

Increased understanding of how they can be better involved in working on HIV and AIDS

Increased learning about caring, especially behaviour change

Increased awareness of their own beliefs and practices linked to HIV

Another important success of the workshop was agreement from participants to continue meeting and supporting each other around their HIV and AIDS work, in recognition that there is strength in a unified voice and response from faith leaders.

## **2.5 FBOS IN ANTIGUA AND BARBUDA**

Antiguans are afforded freedom of religion in their constitution (36). Christianity is the dominant religion in Antigua, with the Anglican faith having the largest following of an estimated 26% of the population (37). Each of the Moravians, Methodists and Roman Catholics have less than a 10% membership per group. These four denominations, as well as the Salvation Army, make up the members of the Antigua Christian Council (38), with the government maintaining a close relationship with this organisation. Another umbrella group in Antigua is the United Evangelical Association which encompasses most independent evangelical churches and is estimated to represent 25% of the population. Other denominations in Antigua and Barbuda include the Jehovah's Witnesses, Rastafarians, Muslims, Hindus and those of the Baha'i Faith. Public schools have no religious affiliation and do not include religious instruction as part of the curriculum.

As elsewhere in the Caribbean, the relationship between Christian churches and the State remains strong in Antigua and Barbuda and religious views often enter Parliamentary and media discussion. The National AIDS Secretariat engages frequently with FBOs. For instance, for World AIDS Day there are religious services where the NAS makes presentations and a day of prayer is designated on the Sunday after World AIDS Day. The NAS also often facilitates linkages between churches and PLHIV who are willing to speak to congregations.

## 3.0 Methods

A combination of qualitative and quantitative data collection methods were used to carry out this study among Christian FBOs in Antigua and Barbuda. Primary data were collected from June to October 2009 via two methods. First, the research team conducted 9 in-depth interviews with representatives from selected denominations using a semi-structured interview guide (Appendix 2). Second, a survey was conducted using a standardised questionnaire (Appendix 3) to interview 50 representatives from a broad cross-section of FBOs (45 in Antigua, 5 in Barbuda). Secondary data from published reports available from government and online sources provided context for the instruments' design and for the findings from the interviews and surveys.

### 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 began.

### ETHICAL APPROVAL

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

### QUALITATIVE INTERVIEWS

Representatives from 10 denominations were invited to attend in-depth interviews. A semi-structured guide (Appendix 2) was used for the discussion with participants during the interviews. Upon initiation of this study, discussions were held with the head of the CCC Antigua office who indicated that there were a number of FBO umbrella organisations in Antigua and Barbuda. Meetings were set up with representatives from these bodies, during which the study was introduced and next steps outlined. A list of representatives from each denomination was compiled based on their recommendations and ten of these representatives were contacted to provide nominations for interviews. The sample selected for interviews was based on an understanding of the major religions in Antigua and Barbuda. The determining characteristic of the nominees were that they be:

- Knowledgeable about their faith and how it functions within the context of Antigua & Barbuda
- 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 activities and HIV-related stigma work.

Nominees were received from the FBOs selected and interviews conducted. 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 estimated level of HIV-related stigma existing among those organisations and their congregants. The interviews lasted approximately 60 minutes and were audio-recorded.

## **QUANTITATIVE SURVEY**

Fifty representatives of different FBOs were invited to participate in interviews. These interviews were completed 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 (39) as well as stigma scales validated through other research (40). 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. Two nationals of Antigua and Barbuda were trained to undertake the surveys.

## **SAMPLING**

For the purposes of the survey, the research team sought to include in the sample FBOs from different denominations and geographical areas and parishes. First a comprehensive list of FBOs in Antigua and Barbuda was compiled according to denomination and parish. FBOs were then selected according to the number of churches per denomination in each parish and geographical area. After sampling across the denominations most often represented, the team selected smaller denominations so that diverse denominations were represented across geographical areas.

## **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, supplement and complement each other. In this report, qualitative and quantitative findings have been integrated and are reported together unless specified or indicated otherwise

## **QUALITATIVE INTERVIEWS**

Four researchers at CHAA and UCSF, including one of the two people who conducted the interviews, participated in data analysis. Each of the transcribed interviews was summarised onto a standardised matrix (Appendix 4). The matrices were organised into categories in order to include the topics covered in the semi-structured guide for interview participants, 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, three analysts worked together to compare the 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 research team captured the salient themes emerging from the data and relevant to the study questions.

## **QUANTITATIVE SURVEYS**

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

## 4.0 Findings

The findings have been organised to describe the characteristics of study participants and FBOs included in the study, the health and HIV activities and services they provide, FBO messages around HIV, attitudes to vulnerable populations, attitudes to PLHIV, S&D and plans for future programmes. Throughout the findings section, participants in the survey are referred to as respondents and participants in the qualitative interviews as interviewees.

### 4.1. PROFILE OF FBOS

#### Denominations of FBOs Represented in the Interview Sample

While representatives from 10 denominations were contacted and invited to participate in interviews, one of the representatives was unable to participate during the time allocated to fieldwork. This person was a representative of the Roman Catholic Church. An interview was conducted with a Rastafarian representative but this interview was later excluded from the data analysis and will be used to inform further research. While the Rastafarians are influential within a sector of the population in Antigua and Barbuda, 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 do not fit the confines of this report.

The denominations represented by the participants in the 8 qualitative interviews were Anglican, Baptist Assemblies, Baptist Association, Methodist, Moravian, Seventh Day Adventists, Wesleyan Holiness, and Restoration Ministries (an independent church). One of these interviews (for the Methodist church) was conducted with two people, making a total of 9 participants.

#### Roles of Interviewees within their FBOs

Self-defined roles of interviewees included:

Two Pastors

Senior Pastor

Musician and resource person for the FBO's programmes.

Superintendent Minister

"Leader ". Lay person with major role in the church

Youth director

Two interviewees did not define their role.

#### Denominations of FBOs Represented in the Survey Sample

Fifty people participated in the survey, but data from the interview with the Rastafarian representative was excluded from the analysis for reasons stated above, yielding a total of 49 questionnaires completed. Table 1 provides data on the denominations represented in the survey sample. The participants in the semi-structured interviews did not also participate in the survey.

Of the 49 participants in the survey, 10 represented independent churches and the remaining 39 represented 17 different denominations. Anglican, Baptist, Pentecostal and Roman Catholic denominations were most commonly represented, each by 4 or more participants.

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

<b>Denomination</b>	<b>Number of respondents</b>	<b>Percentage of respondents</b>
Anglican	6	12%
Antioch Bible Church	1	2%
Apostolic faith church	1	2%
Baptist/Reformed Baptist	5	10%
Christian Union	1	2%
Church of Nations International	1	2%
Independent	10	20%
Jehovah Witness	1	2%
Lutheran	1	2%
Methodist	2	4%
Moravian	3	6%
Nazarene Church	1	2%
New Testament Church	1	2%
Pentecostal	4	8%
Roman Catholic	4	8%
Salvation Army	1	2%
Seventh Day Adventist	3	6%
Wesleyan	3	6%
Total:	49	100%

#### Roles of survey respondents within their FBOs

Survey respondents defined the following as their roles within their FBOs.

**Table 2: Roles of survey respondents**

<b>Role</b>	<b>Number of respondents</b>	<b>Percentage of respondents</b>
Pastor/ Reverend	34	69%
Church president	4	8%
Leader	3	6%
Elder	2	4%
Curate	1	2%
Deacon	1	2%
Assistant Pastor	1	2%
People's warden	1	2%
Unspecified	2	4%
Total	49	100%

#### FBO Affiliations

Most respondents said their FBOs were affiliated with an umbrella group. Of the 31 respondents who identified their FBO's umbrella group, the following groups were identified.

**Table 3: Umbrella group membership of FBOs in the survey**

	Number of respondents	Percentage of respondents
Umbrella group		
Caribbean Christian Council	8	26%
United Evangelical Association	5	16%
Evangelical Association	5	16%
Antigua Christian Council	2	6%
Caribbean Conference of Churches	2	6%
Pentecostal assembly	2	6%
Independent Churches Association	2	6%
Apostolic Faith Mission	1	3%
Bethel Baptist	1	3%

Caribbean Union Conference of Seventh Day Adventists	1	3%
WCC	1	3%
Wisconsin Evangelical Lutheran Synod	1	3%
Total	31	100%

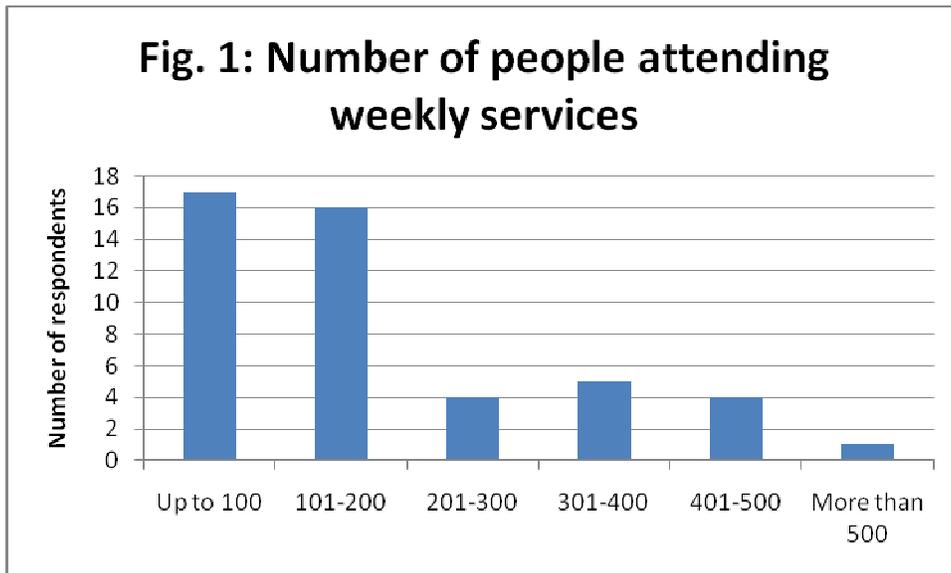
Note that the affiliations above were stated by the respondents. Some of those stated affiliations and umbrella groups could not be confirmed by the study research team through an Internet search when preparing this report, and may be local terms used by the respondents to refer to other official umbrella groups with similar names.

The structure of different FBOs included in the sample varied. Interviewees described a range of structures for their FBOs, including hierarchical, independent within a network of other similar churches and autonomous with decisions subject to vote by individual church membership. Interviewees reported a range between 1 and 31 in the number of churches in Antigua and Barbuda within the same denomination. According to the denomination, FBOs were organised geographically into circuits, districts, or parishes. The highest decision making body for most FBOs interviewed tended to be regional bodies although a few FBOs referred to a looser arrangement in which decisions were made through a participatory, less hierarchical process. At least two churches ministered to Spanish speakers through a Spanish-speaking minister either in the past or at the time of the study.

Most churches were able to support at least one full time office staff member, with one FBO employing as many as ten. These were mainly administrative positions in the FBOs and included bookkeepers, secretaries and bookstore attendants. One FBO mentioned full-time workers who included teachers in their schools and day care facilities and cleaners.

#### Size of Congregation

The size of FBO congregations was reported to vary. Survey respondents reported the data presented in Fig. 1. This shows that more than 70% of the 47 respondents to this question reported congregation sizes of up to 200 people. Only one person reported that their congregation exceeded 500 people. Interviewees in the qualitative research said congregations ranged in size from 15 to 2000 congregants.



According to all interviewees, the number of female members of FBOs was larger than the number of male members. The percentage of female members was said to vary from 60% to 85%. Levels of education were said to vary. Some FBO representatives noted a relatively high percentage of members with graduate level or college education while others had members who were predominantly high school graduates. Participants in three interviews reported the percentage of youth aged 18-30 to be in a range of 25-40% of the congregation while 4 reported between 60-75% of the congregation to be within this age group.

However, young people, especially teenagers, were reported to be increasingly difficult to retain within many FBOs, as noted in the following statement by an interviewee:

Young adults....that is a problem for the church.....you find that that's the set that drops out for a while and so I really think that we are having a problem in trying to make what we are saying real and relevant to them, and that's something we need to pay attention to and try to understand the dynamics of what's happening within their lives and to see how best we can have a relationship with them

Factors associated with declining membership among youth were said to include needing to work on Sundays, entertainment distractions such as the media, Internet and sports (outside the church), lack of parental control and guidance and church messages becoming unattractive to youths as they become young adults. Strategies suggested to retain youth included the use of music and new media as well as efforts to address youth-focussed issues:

So I think the answer might lie within programmes specifically geared to the issues that they encounter at that stage in life and their thrust would be employment, family issues, relationship issues you know those sort of stuff there and if that.....specifically oriented programme thrust was there it would help them to negotiate all this stuff. I think they probably would find that God is more meaningful through that, to all of that.

## 4.2 HEALTH AND WELFARE ACTIVITIES AT FBOS

Of the 49 FBOs surveyed, the majority (n=47, 94%) said that they currently provide health-related programmes or activities. Of those with health programmes, 32 said they had one programme, 7 said they had two programmes and 8 said they had three programmes. About half (n=25) of these programmes targeted the entire community. Some others targeted the congregation as a whole (n=14). Four targeted youth specifically.

All FBOs had procedures in place to care for the sick and needy, consistent with concepts of Christian charity. Some helped “poverty stricken” families and the elderly with food items or other basic necessities. Some FBOs had their own schools, day-care programmes or, more rarely, clinics.

Activities included health talks, seminars, workshops and fairs that were supported by doctors and nurses from the FBO or from the Ministry of Health in Antigua and Barbuda. These health-related activities, initiated by the FBOs, were implemented in a variety of ways. One FBO leader reported conducting a radio programme talk show, where callers were invited to discuss and pose questions regarding health related issues. In some FBOs, these were regularly scheduled activities (such as an annual health fair) while in others they took place on a more sporadic basis in response to requests and perceived needs as they arose.

Health issues have also been reportedly discussed from the pulpit, occasionally setting aside a special time during the church service when health matters will be covered. These sessions focus on chronic non-communicable diseases, dental and eye care and sometimes HIV.

The welfare of youth was an important focus of activity of some FBOs. A wide variety of activities were mentioned, including retreats, Bible study, camps, dances, music, drama and sports groups.

The frequency with which health promotion activities occurs varies between FBOs. One interviewee stated that within his FBO there are no formal health promotion programmes, but the FBO often invites professional guest speakers to address health matters with its congregation. Another noted that health promotion activities are needs-driven according to issues that are raised by church members. In contrast, some FBOs host health promotion events regularly, with one reportedly supporting a national health fair that is open to the Antiguan public at large.

## 4.3 HIV-RELATED ACTIVITIES AT FBOS

According to the quantitative survey, 71% of FBO respondents reported that they had HIV-related programmes. Table 4 gives the type of programme for the 48 respondents who replied to this question.

Table 4: HIV-related programmes reported by survey respondents

Programmes	Number of respondents	Percentage of respondents
Education for prevention	32	26%
Substance abuse	12	16%

Spiritual/ bereavement counselling for HIV-affected individuals and their families	8	16%
Referral for HIV testing	6	6%

Note: Some respondents reported more than one programme by their FBO.

The initiative to invite a guest speaker (such as a doctor, nurse or researcher) was the most commonly cited approach to address the issue of HIV and AIDS. Occasionally, PLHIV would be invited to talk to the congregation. These events would often be arranged in collaboration with the NAS, the Ministry of Health or HHHN. One doctor, known in Antigua and Barbuda for HIV care and support, was mentioned in 5 of the qualitative interviews as having visited many of the churches in the country to educate entire congregations and individuals about HIV. One FBO held a month of HIV-related activities every December, starting with World AIDS Day, and including teachings around HIV awareness, prevention, S&D, and testing, in collaboration with HHHN in Antigua.

In 3 interviews, it was mentioned that their Church leaders have attended training and workshops on HIV held by the CCC, the NAS and the Ministry of Health. Workshops have included sessions on ways FBOs can support PLHIV to “manage their own situation and enable them to feel as though they are still a part of a community”, including via the provision of palliative care. One FBO had been involved in a Red Cross initiative to train youth in HIV peer education. Other activities have targeted men such as including HIV among issues covered in a designated Men’s Health Week. A food drive for PLHIV is another example of a health- related initiative that was reported by one FBO representative.

One interviewee had been involved in a CCC project on HIV 4-5 years prior to the current study, funded by the Canadian International Development Agency (CIDA). This included seminars, lectures, role play, and question and answers on HIV prevention among men and youth. Activities covered S&D, testing, prevention, and watching what he called a ‘basic HIV 101’ video. The leader noted that there has been less HIV-related activity more recently since “[they] have used up the grant.”

One interviewee noted that HIV is included in the confirmation programme that occurs during Sunday school. This curriculum for Sunday school includes HIV, drug abuse and sexual activities among youth. Educational activities and competitions with HIV themes are also used to promote HIV awareness. One such programme is called the HIV/AIDS Liturgical Arts Competition. Other HIV initiatives for youth were integrated into programmes such as sports, summer camps, youth ministries or confirmation classes.

No FBOs represented in semi-structured interview participants had an established voluntary counselling and testing (VCT) programme. However, one of these FBOs had members trained in VCT. Only one of these FBOs had a specific support programme for PLHIV, consisting of a food drive twice yearly.

Some HIV activities were conducted by some FBOs on an ad hoc basis, in response to needs that might arise among congregants. These FBOs did not have an explicit HIV programme and HIV-related activities were sporadic:

Unless I know that we have an HIV situation in the parish, then the parish is not going to really... respond to it. It will acknowledge, it may do something for a while, but it would fade for a while after that.

HIV as an issue tended to be “lumped in,” as one interviewee stated, with other health care concerns for the following reasons:

- Competing priorities for church resources
- The view that it is part of the larger social issues already dealt with by the church
- Lack of recognition of the need among congregants
- Real or imagined stigma among congregants.

At the time of the interviews, no FBOs had an HIV ministry, although 71% of survey respondents thought it was very important to establish or further develop an HIV ministry or programme. One interviewee said that his FBO was putting an HIV ministry in place. One FBO had had an HIV ministry in the past, which included a hotline response to provide educational counselling, mainly geared towards young people. Lack of sustained finance for this appeared to be the reason that the ministry was no longer functioning. Though very few FBOs had a dedicated HIV ministry, most had HIV activities or programmes in place as indicated above.

#### **4.4 MESSAGES AROUND HIV PREVENTION**

HIV prevention messages delivered by FBOs include 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. FBOs reconciled standard HIV prevention messages about abstinence, being faithful and using condoms (the so-called ABC of HIV prevention) with Biblical teachings about sexual relations, whereby sex is only considered acceptable between married, heterosexual couples. Sex work, homosexual sex and sex outside a marital union are considered immoral and irresponsible behaviours. Accordingly, interviewees used terms such as “communal responsibility” and “moral behaviour” to refer to the approach they sought to promote in HIV prevention activities, while HIV infection was said to be the result of “reckless behaviour”, “promiscuity” and “immorality”. In 7 of the 8 semi-structured interviews it was said that people can only be truly empowered to prevent HIV transmission through abstinence before marriage and fidelity in marriage. Two FBO representatives expressed these to be the only relevant safe(r) sex teachings that were endorsed within their church.

Messages reiterated by FBO participants in relation to HIV and HIV risk expressed the importance of chastity and reserving sexuality for the context of marriage. Interviewees used terms expressing values that are expected to be upheld, including decency, commitment to one’s spouse, social responsibility, fidelity, maintaining sexual fidelity, human dignity and morality. In some FBOs, HIV prevention messages are not usually expressed during church services, but rather during private counselling or ‘rap’ sessions with youth.

Messages have been relayed during leadership conferences, workshops, and health fairs that are extended to the wider community.

Targeted messages toward youth are more often brought up during forums such as summer camps, Sunday school, and confirmation classes. Delivering appropriate messages toward youth appears to be a challenge for some FBOs. One participant noted a desire to use “scare tactics” toward youth in presenting HIV related messages. This interviewee noted the following methods that were used among youth.

We talk about how it's contracted, we talk about the whole concept of the stigma of AIDS and, and you know the whole concept that persons are naturally shunned, we speak about the care. Sometimes you have to use a little scare tactics for the young people because they not listening you know. Sometimes you have to startle them a little bit so we go to whatever level we have to. I think for me everybody thinks that HIV and AIDS is something that will happen to somebody else, so although the information is being fed... it's not a priority really for them, they just sort of listen but they don't see themselves as the one that could [be infected].

With regard to youth, interviewees expressed concern about negative influences on sexual behaviour associated with access to media and the Internet. One participant suggested parents should monitor what their children view on television and the internet. This was suggested to be a good way to protect young people from becoming HIV positive. In addition, youth are encouraged to keep the company of certain types of friends.

Again you can come back to the whole abstinence, faithfulness you know, and guarding against promiscuity, the, the kind of persons you would associate with you know and particularly young people, the kind of a company the kind of friends. You guard against what you view on your television. I know the internet right now you know ... Just recently I, I went and turn on my computer and I was reaching from one page to the other then all of a sudden, I just see this nude movie... So, the internet, one has to be very careful and parents have to really monitor that as well and ... you have to guard against what you watch on the television. So the messages of that nature...

An interviewee explained that messages on HIV awareness and prevention are transmitted to all age groups in this FBO through videos and pamphlets available through NAP that provide basic HIV information on transmission and preventative measures that include the use of contraceptives. One participant noted that during the health fairs, there is often the possibility of the presence of audience members who are not affiliated with the FBO, and as a result, he acknowledges that messages that are appropriate should be tailored to both members and non members of the FBO regarding condom use and HIV prevention.

Opinions regarding condom use varied. Some completely disapproved their use, as they were considered to be an invitation to extra-marital sex and promiscuity. Some only approved condom use as a means of birth control for married couples. For instance, one interviewee said, “Condom use and the discussion of that practice is left to the husband and wife, and that type of discussion is not seen as one that the church can have any sort of bearing.” Others thought that condom use could be approved in specific circumstances, such as when a spouse had been unfaithful, when one or both spouses were HIV positive, or among people who could not exercise sufficient “self-control” to abstain or be faithful.

There was a level of acceptance among some respondents that condoms were important to prevent HIV transmission, as expressed in the following three quotes from interviewees.

We are a strong advocate for abstinence at the same time we don't bury your head in the sand but we say if you not committed to this abstinence thing that we talking about.... and you feel you cannot really [silence], whatever, you protect yourself otherwise.

You need to be the one to take protection into your own hands and we can protect our self ... by using a condom... Because you're not being faithful and you playing fool out there. Use your head and be wise!

Whatever it takes to prevent the spread of STDs and AIDS and HIV and all of that ... If you know you are not given to abstinence don't live carelessly because in the end you are not responsible just to yourself.

In short, no-one approved condom use unconditionally.

#### **4.5 ATTITUDES TO VULNERABLE POPULATIONS**

Sex work, including transactional sex, and homosexual behaviour were considered wrong, sexually immoral and unacceptable. Some interviewees adopted the attitude of "Love the sinner but not the sin", explaining that SW and MSM could be accepted into the church, since, "Every man has a soul and every soul is important to God. Hence we must be able to welcome them [and] allow God to deal with them in the process." However, they would be counselled to change their lifestyles to conform to church teaching. These lifestyles were seen as incompatible with Christianity: "We don't believe in what is called gay for Christ....We don't believe that you're gay for Christ. If you're gay, you're gay. If you're for Christ, you're for Christ, not together."

Four interviewees expressed the desire to understand the motivation behind involvement in sex work so that they could alleviate the circumstances that led to this activity. Some FBOs were said to impose penalties on church members known to persist with sex work despite having counselled to stop. These could include public denouncement of the person with subsequent cessation of the ability of the person to partake in church ceremonies.

With the exception of one, all interviewees stated that MSM could be accepted into the church once they were not overt in displaying their sexual orientation: "People are just accepted for who they are, unless the person was really being blunt and, you know, push it in your face." In contrast, one FBO representative pointed to evidence of an increased acceptance of homosexuality in the news as

Evidence of deteriorating morality you know on mankind in general. We see it as maybe the sign of the end of times.... We see it as tolerance becoming overwhelmed, overboard with this thing... People become so tolerant .... that they begin to allow a certain type of lifestyle which is described in the Bible as an abomination... Most of us think it's an abomination.

The assumption made by churchgoers appeared to be that homosexuality is a choice, a "leaning" and can be changed by a spiritual conversion similar to the choice to use drugs or to smoke. Therefore changing the behaviour was possible:

There will be a time you will no longer be gay, but you're just a Christian man or a Christian woman... Just like if I used to smoke and the Lord help me to quit smoking? I say, no, I used to smoke a lot but now I'm no more a smoker. I used to dope, take my dope a lot, but I'm not into it anymore, or I used to sell myself but I'm not doing it anymore because the Lord changed me, just like the woman Christ met at the well. She used to be a prostitute and Christ changed her and she did not remain a prostitute, she become a preacher.

Some FBOs made reference to differences between denominations and within some denominations globally regarding the possibility of church leadership by homosexual men. It was said that churches in Antigua and Barbuda would generally oppose this. FBOs mentioned that teachings on homosexuality are carried out in church, through forums such as debates, panel discussions, retreats, youth gatherings and official position papers on the subject. No interviewees thought that an openly gay man could become a spiritual leader in Antigua and Barbuda. However, three interviewees said that if the person was not overt in his sexual orientation or had renounced homosexual sex he could be considered as a leader.

For most of the interviewees, gay, lesbian, bisexual or transgender (GLBT) members of their FBOs were either not known or were known only by rumour and supposition. One interviewee indicated that there were no GLBT members in their FBO but that GLBT periodically visit the FBO and are welcomed. Another interviewee said that during a church retreat "we had one or two young ladies who proclaimed boldly that they were lesbians." The impression given by this participant, however, was that this was not acceptable for the church. In contrast, one respondent claimed that GLBT persons are treated "moderately", are "not ostracised", are "accepted with some measure of concern", and are "accepted". He further noted they are "not driven away" and "there is no level of hostility to them that would be marked".

Single motherhood was noted to be something that occurred in almost all the FBOs. While having children outside of wedlock is considered a sinful behaviour, participants noted that single mothers are generally accepted in the FBOs. Single motherhood was considered a "public issue," one that was the responsibility of the pastor and sometimes the congregation to be alert to and to address.

Well it is clearly taught in this church that pregnancy is not a sin right, it's not among the commandments 'though shall not get pregnant'... [However] thou shall not commit adultery and fornication, those are sins... Alright that person needs to acknowledge their sin and... give assurance to the congregation that there is genuine repentance and what course of action you are going to take to avoid such activity in the future.... Many people have been restored to fellowships who have gotten involved in this...

The procedure in dealing with single mothers was sometimes punitive. In most FBOs it included counselling about the ethical issues involved in being a single parent. In some FBOs sanctions were applied such as demotions from positions of influence and authority and "dis-fellowship" where members are no longer accepted as active members of the church. A few FBOs qualified this statement by noting that the sanctions depended on the individual circumstances, for instance whether the single mother became pregnant more than once. Three FBO representatives mentioned the need to minister to the needs of single parents through programmes aimed at single parents or through support from the congregation.

## 4.6 ATTITUDES TO PLHIV

Interviewees reported that they had an accepting and inclusive attitude to PLHIV. This was largely based on the notion that, as stated by an interviewee, “all sins are forgivable, and all persons should be treated with God’s love.” An interviewee affirmed:

They're human beings and there's a certain degree of respect that is afforded every human being and more than that as a child of God, certainly. There's a duty, an onus placed on everybody, every [believer] to respond, in God's love to persons, who are infected or living with HIV and AIDS.

Two interviewees knew of HIV positive members in their congregations, and two more had hosted talks at their church by PLHIV. Fear and S&D against PLHIV were said to vary between church members. Some “condemned” PLHIV based on assumption of past immoral behaviour:

I think in church people are really concerned about behaviour, if this person didn't do this thing they wouldn't have had AIDS and so you may be judged in a sense..... In church you are taught not to condemn though it happens all the time in churches.... Church people can be self-righteous sometimes, and so you're going to have a wide range of people in the church with a different educational background a different tolerance for certain things.

One interviewee regarded HIV as a “judgement” from God, but said that redemption was possible: “The proliferation of the disease and the virus is in itself judgement [but] in the midst of judgement, there is grace and mercy for those who desire.”

One mentioned a Bible passage which seems to advocate a major role for redeemed sinners within FBOs and which he paraphrases:

If a person is truly repentant of their sins, placed their faith in the lord Jesus Christ and is scripturally Baptised, have rejected that life of sin, have qualified themselves for the ministry we won't have a problem with that. After all the apostle Paul was a known murderer and he became an apostle.

Another interviewee put the idea of acceptance of PLHIV less formally: “They [i.e. PLHIV] shouldn't be judge you know. Yes, they may have messed up, but I don't think we need to make that an issue.”

Some said the treatment of an HIV+ positive person by churchgoers may depend on beliefs about the way in which s/he was infected with the virus. One interviewee said that some infected persons may be “innocent”, such as a wife who contracts the virus from sex with her husband, as contrasted with someone who was infected through a homosexual encounter, who, by implication, would be considered “guilty”. A similar distinction between “innocent” and “guilty” PLHIV appears in the following quote:

If I'm tested to be positive but it is known that I...became positive because of a contaminated needle or something like that, and people know that, they would be more inclined to accept me than if they know I have been running around for example.

Some interviewees knew PLHIV who were part of or attended the FBO from time to time. Nevertheless, the number of PLHIV who had openly disclosed their status within the FBOs was either very limited or non-existent. One interviewee cited an instance in which a pastor of another denomination openly displayed a lack of acceptance of a PLHIV:

I have heard other stories of..., somebody being invited to speak about their situation, youth group and so on... and they did and they spoke about everything and at the end the Pastor even refuse to shake the hands of the person.

This may be the same incident recounted in more detail by another interviewee:

In one of my visits to an organisation of persons living with HIV and AIDS...the gentleman shared with me that, its not in my church, ... the leader of one of the prominent churches, top, top of the church was being introduced to him and he put out his hand to shake his hand. He refused and he just kept doing that and he just put his hands behind his back... I felt so badly when he told me that ... I personally felt bad for him, because, as I, as I said to them, and they stayed very quiet ... I said we talk a lot about HIV and AIDS but are we really ready to roll up our sleeves and deal with these persons? ... We can talk from the pulpit and we, we can talk from the altar and just talk but until we are ready to get down and deal with them and care, you know, what their needs are and all of that...

Whether the message of inclusion and acceptance is adopted by congregants varied among FBOs, some of whom cited previous instances of S&D against HIV positive persons within the congregation. Membership or spiritual leadership by PLHIV may therefore be problematic since not all FBO members were equally accepting of them.

You going to get the normal reaction if the person has full blown AIDS and showing visible signs and stuff like that. You'll get that withdrawal from some persons, but if they are just HIV positive and it is known, similarly you would have some but you would have others who would not shrink away and would embrace you.

#### **4.7 STIGMA AND DISCRIMINATION**

Interviewees reported various levels of S&D in FBOs. Some participants expressed never having heard of a case of S&D against an HIV positive person, whereas one stated, "it may be subtle". One interviewee noted, "But I've seen this happen to a homosexual person... as they may think that the person may be connected with AIDS to some degree." One interviewee noted that S&D persist within his FBO because there are misconceptions and misunderstandings about HIV and AIDS among persons in the congregation. Another participant suggested that some members of his congregation "would not have anything to do with persons who are thus afflicted". Another noted that in the past, before he became pastor of his congregation, levels of S&D were very high. He said that he had to do "a lot of un-teaching", which has allowed members to become more open-minded.

Another leader expressed great difficulty in determining the levels of S&D in his congregation, but noted that it certainly exists, despite discussion, education, training, and preaching. He gave examples of scenarios where parents have prevented their children from attending Sunday school or playing with children who are thought to be HIV positive. He also gave an example of persons who have refused to sing in the church choir due to the presence of a PLHIV. Others have refused "to sit next to the person, talk to the person".

The research uncovered several themes associated with HIV S&D. These were associated with:

- Moral judgements regarding vulnerable populations
- Fear of transmission via casual contact with a PLHIV
- Lack of confidentiality of personal information, including HIV status

The survey also involved measurements of HIV-related stigma according to a validated scale.

#### **4.7.1 Stigma and Moral Judgements**

Interviewees expressed the view that HIV may be associated with sinful behaviour. In the opinion of one interviewee, stigma was in fact appropriate as a spur to moral activity if it focussed on sins:

When a church historically and Biblically defines homosexuality as a sin we are not unhappy with such activities being stigmatised. We [the church] want all sin to be stigmatised – theft, murder, adultery, whatever....So I think it goes too far when they talk about removal of stigma.... Shame is an important motivator for moral activity. To make a case for the removal of shame you are going to lose a lot of conservative members of the church.

The difficulty here may be in making sure that the shame attaches only to the behaviour (“sin”) and not the person (“sinner”), as the same interviewee seemed to acknowledge when he said that he wanted “stigma to be moved in, so long as people who choose a lifestyle are not harmed or have their civil rights removed.”

Moral judgements were also apparent when interviewees discussed the possibility of FBO involvement in HIV counselling and testing. One spiritual leader mentioned that if a congregant approached him and expressed the need for an HIV test, he would want to know why the congregant felt the need to be tested. Counselling seemed to be carried out more from a moral standpoint than a public health one:

If somebody come to me and say them want to get [tested], I would think the person is sexually active. If the person is a member of my church I probably would want to counsel the person in that regard, you know, cause people don't, generally want, well most cases people don't test for HIV unless they have, you know, unless they, they are active or, they had a lifestyle that could be, you know, that could be dangerous, use needles or something like that, that kind of stuff, so I suppose it will initiate some kind of counselling.

#### **4.7.2 Fear of Casual Contact with PLHIV**

A further contributor to S&D is fear concerning the possibility of infection via casual contact.

People are not very comfortable with the fact that people are saying that HIV cannot be caught this particular way. They're not quite sure whether the doctors or the specialists really have the story down right or whether they're trying to hide the real truth about AIDS. There are people who disbelieve that AIDS can't be caught by, you know, just shaking hands, being in somebody's presence, so people are very afraid of the whole idea of AIDS, so that misconceptions of how it can be passed on sometimes warp people's mind.

Perhaps consistent with this kind of fear and mistrust, one interviewee reported an instance where a church bus was utilised, and there were members of the FBO who refused to sit on the bus while the PLHIV was present on it. The condition of the PLHIV may have already progressed to AIDS at that time as the interviewee said that the person died shortly thereafter.

These fears persisted despite the fact that the majority of participants in the qualitative interviews described the level of knowledge among congregants as ranging from 'Moderate' to 'Very High' (only one interviewee described it as 'Poor'). Interviewees however, did not seem to always be able to distinguish between HIV and AIDS, and in most cases referred to PLHIV as 'patients'. Overall knowledge levels were said to reflect those existing among the general population. There appears to be room for improvement in knowledge regarding HIV and the use of appropriate, inoffensive terminology. However, as noted above, there is evidence that some people continue not to believe information they have been given because of fear. Likewise, during interviews there was the recurrent notion that knowledge has not transferred to behaviour change especially when it comes to interaction with PLHIV. "I think people might intellectually know what it's all about... but when somebody with the AIDS show up, then it would change, people behaviour would basically change."

One interviewee drew attention to the fact that there may be prior cultural beliefs that condition what people think about HIV:

They have their prior beliefs and it's very difficult. To change your prior beliefs, it's a lot of cultural misinformation. Because even though you give them the facts they still say 'well you can say so but I believe something else.'

Another said that people persist in the belief that HIV will not affect them in their communities.

Interviewees emphasised the need for more education for congregants, since myths and misconceptions about modes of HIV transmission may be feeding the fear some congregants have towards PLHIV.

AIDS is a very new thing in a sense, it's a whole different ball game but if they are convinced that people with AIDS are safe to be around, then, I think, that the job would be done.

#### **4.7.3 Lack of Confidentiality of Personal Information**

In discussing HIV counselling and testing, interviewees drew attention to the possible lack of confidentiality that may arise in providing these in an FBO setting. FBOs were regarded as close-knit communities where personal information was often shared between congregants, some of whom did not keep the information secret. Because of the perceived lack of confidentiality and because of the stigma that may exist among congregants, people may not seek HIV testing at the FBOS or would not come forward to spiritual leaders to seek access to testing: "Confidentiality is going to be a really big issue you know so that people would give us the trust and [come] see us..."

One participant expressed awareness of issues pertaining to post-testing. Some individuals diagnosed HIV positive have been abandoned and evicted when their results became known. Testing for HIV may be frightening because of these potential consequences.

#### 4.7.4 Measurement of HIV-related Stigma

The survey included responses to validated scales to measure perceived levels of S&D among church congregations. Table 2 shows that average scores according to these scales. Fig. 2 ranks the statements from those that elicited responses indicating the highest level of stigma to those indicating the lowest.

**Table 2: Survey respondent reports of stigma and discrimination-related perceptions of members of their congregation.**

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

Statement	Average score
In your congregation, how many mothers would not want someone with HIV to hold their new baby?	2.0
In your congregation, how many mothers would not want an HIV infected person to feed their children?	2.2
In your congregation, how many people would not share dishes or glasses with someone who has HIV?	2.2
In your congregation, how many people would not want an HIV infected person cooking for them?	2.2
In your congregation, how many people avoid visiting the homes of people with HIV?	1.1
In your congregation, how many people think that HIV-infected people have brought shame on their families?	1.5
In your congregation, how many people think that if you have HIV you have done wrong behaviours?	2.0
In your congregation, how many people think people with HIV are paying for their karma or sins?	1.5
In your congregation, how many people think that people with HIV should feel guilty about it?	1.3
In your congregation, how many people think that a person with HIV is disgusting?	1.1

options:

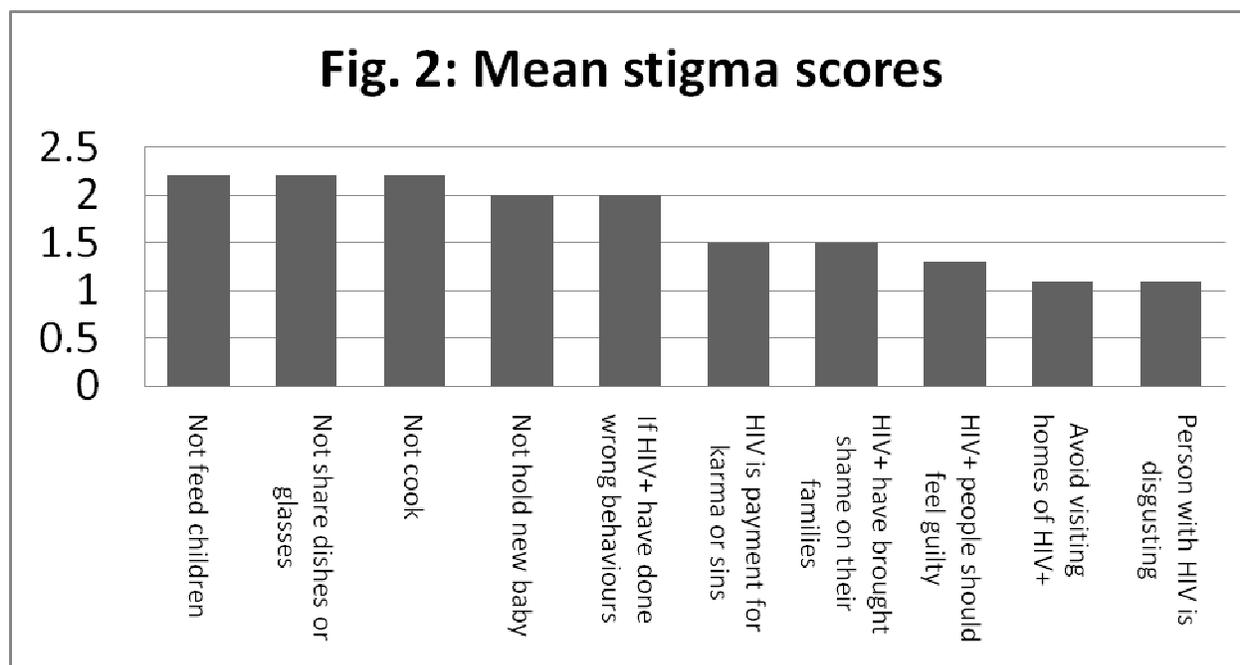
= No one

= 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 levels of stigma were associated with fears about sharing food and drink, e.g. not wanting a PLHIV to feed one’s children, to eat food cooked by a PLHIV or to share dishes or glasses with someone with HIV. Responses to the scale also indicated that some people think that if a person has HIV they have “done wrong behaviours.” Attitudes indicating extreme rejection of PLHIV, such as that people would avoid visiting the homes of PLHIV or that PLHIV are disgusting, were thought to exist among very few members of FBOs.

These results appear quite consistent with the results from qualitative research on S&D reported above. The findings of highest levels of stigma associated with sharing food and drink are consistent with interviewee accounts of persistent fear of casual contact with PLHIV. There is evidence that some people associate HIV with “wrong behaviour” or sin. Nevertheless, there appears to be a level of acceptance of PLHIV since very few people were thought to have extremely rejecting attitudes towards PLHIV.

#### 4.8 FUTURE PROGRAMMES

Most respondents (n=35, 71%) thought it was very important to establish or further develop an HIV and AIDS ministry or programme. This is illustrated in the following quote from an interviewee:

We really need to start paying attention to this whole thing. Not just from the point of view of praying for somebody, but really looking at it from a practical standpoint. More questions of prevention as well as, as well as you know, support and health care.

Some people who have AIDS basically need moral support, 'cause moral support might really assist the persons livelihood you know, how they feel their well being.

Interviewees were generally willing to assist in improving accurate knowledge about HIV so that PLHIV would feel more welcome in FBOs. It was mentioned that individuals in FBOs need more education on HIV, its means of transmission and treatment. Interviewees expressed a desire for more outreach programmes for and with PLHIV. Talks by PLHIV were thought by one interviewee to offer cautionary tales to prevent "mistakes":

There are a few persons who are willing to go around and talk to people and say, you know, I'm HIV and this is my life and you'd do well not to make the same mistake...

Another participant believed that primary school children should be targeted, because programmes currently target teenagers, and he thinks that at that point, it is too late to address the HIV problem because children are already aware about sex and that also it is too late to address S&D towards PLHIV.

We feel they too small to know these issues, but they are aware of it. They watch TVs and they see kisses, they see touching, they see petting. All kind of things they see, hence they ask question, hence if they can answer these questions therefore we need to bring training earlier to them so they can be aware and of course when a child get it very early they get it, they really get it. We have to target them when they are so innocent in the mind, we have to sew that seed so that it can germinate there, then they will know, of course they will also help playing a role at the fight against stigma discrimination.

A further major area of interest was in counselling and testing. One interviewee noted that there are programmes in place in his FBO that have the potential to develop assistance around HIV testing, such as a buddy programme, "where you have someone who journeys with you". There were calls for increased personnel and other resources for some aspects of counselling and testing. At the same time, interviewees recognised the challenges posed by possible lack of confidentiality that may deter people from coming forward for testing.

Two participants stated that at their FBOs there are members trained in palliative care who are open and interested in developing a palliative care programme. The conduct of such a programme would depend on the provision of a venue, commitment of pastors, funding and additional resource persons.

Interviewees stated they were open to distributing materials to promote safer behaviour with respect to HIV, but the contents would have to be vetted by the FBO for conformity to the religious belief system. One interviewee stated that the FBO leadership would need to be convinced that these materials contained "nothing at all that encourages the increase in sexual activity." Condom promotion in public forums was not regarded as a suitable approach to HIV prevention by FBOs.

Two interviewees expressed interest in involvement in programmes to assist SW. Reaching SW was considered by one interviewee to require special skills and training that his FBO does not presently possess. It takes a special type of orientation, special type of training, and you just can't send anybody to reach prostitutes, you just can't send anybody to reach somebody who is a drunkard, so we begin to look at these kind of, these areas and be able to train people especially to deal with these specialised areas.

## 5.0 Discussion

This study provides a preliminary assessment of the current and potential engagement of FBOs in Antigua and Barbuda in HIV programming. Contextual data was generated by semi-structured interviews, while the survey generated basic information on a broad range of FBOs. However, there are some study limitations: The report focuses only on Christian FBOs. It therefore presents salient issues for the majority of people in Antigua and Barbuda who are of Christian faith, but does not cover the concerns of people from other faiths such as Hinduism or Islam. The report also 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 Antigua and Barbuda 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. The findings indicate that greater involvement of FBOs in HIV programming holds the potential to extend the reach of HIV interventions. This is particularly the case among women, their most frequent attendees, and among young people in some denominations. Most FBOs in Antigua and Barbuda appear to be involved in HIV activities to some extent. Interviewees expressed support for the greater involvement of their FBOs, noting that this was consistent with Christian teaching regarding compassion and support for fellow human beings in need.

While interviewees expressed that they did not discriminate against PLHIV, some also noted the view shared by many in their FBOs that HIV was usually associated with sinful behaviour. Stigma was said to result both from judgements regarding the (supposed) behaviour that lead a PLHIV to be infected and from fear of infection via casual contact. Measurements on the stigma scale showed that church congregations continue to harbour fears about casual contact with PLHIV, particularly regarding sharing food and drink with them. There were also concerns expressed about the levels of confidentiality that may make it difficult for PLHIV to disclose their status within FBOs. The church leaders interviewed appeared willing and enthusiastic about helping PLHIV, but these attitudes and lack of confidentiality must be addressed in order to make the social environment more welcoming to PLHIV. Our research indicated genuine concern on the part of most interviewees about stigma and discrimination, with most wishing to extend love to PLHIV, noting that they are not different from other "sinners" in need of redemption. At the same time, some of the language used by interviewees (for instance referring to AIDS patients rather than PLHIV) suggested the need for further sensitisation and training for them to be able to fulfil the potential to assist. The association of HIV with "sin" may present a barrier to eradicating S&D in church congregations.

As regards MSM and SW, interviewees expressed the notion of “love the sinner and not the sin”, making it clear that if they attended church they would have to “repent their sins” and cease having homosexual or paid sex. While there is some scope for FBOs to refer MSM or SW to other services on the basis of compassion, FBOs’ ability to provide the range of prevention and care services needed by these vulnerable populations is constrained. 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 SW and/or MSM.

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 Antigua and Barbuda. While there are weaknesses in the epidemiological surveillance system in this country as in other parts of the Caribbean, available data suggest that HIV prevalence among the general population 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 SW. Our findings indicate that the role of FBOs in supporting key populations and in condom promotion may be 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.

This study focuses on the potential for involvement in HIV initiatives by FBOs and there are needs for further research in other related areas. Issues of sexual behaviour among church congregations and intervention methods to prevent HIV among them were not addressed by the current study and are worthy of further investigation, using methodologies involving participation from lay members of churches. Clandestine sex between men, resulting in part from societal homophobia, has been noted to put Caribbean men and their (male and female) partners at risk of HIV, but this issue was not included in our study. Similarly, transactional sex is common in the Caribbean, given prevailing norms that males are responsible for the economic maintenance of their sexual partners (41). Further research may be undertaken on the views of church leaders and congregations on clandestine sex between men and transactional sex, how common they are among church members and ways to develop interventions to address associated risks of HIV. Multiple concurrent heterosexual partnerships by men are also common in the Caribbean, to the extent of being an accepted norm. The potential and interest of FBOs in moderating this behaviour should be explored.

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 NAS, CHAA and other agencies, will augur well in increasing the impact of HIV prevention and care programmes in Antigua and Barbuda. Working with FBOs holds the promise to:

- Improve HIV care and support
- Change social attitudes in the interest of reducing the impact of HIV and reduce S&D against PLHIV
- Increase knowledge on HIV and STIs
- Uphold the value of compassion.

## 6.0 Recommendations

### 6.1 STIMULATING FBO INVOLVEMENT IN PROGRAMMING

FBO leaders who are already active and committed with regard to HIV should seek to mobilise their peers to become similarly involved. A meeting of FBOs may be arranged to 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. People in leadership positions in some FBOs may not wish for involvement, or involvement may be opposed by a significant number of church members. 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 this FBO network 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.

### 6.2 CAPACITY DEVELOPMENT FOR FBOS

Given, on the one hand, the interest expressed by FBOs to expand their programming, and on the other, the finding that there may be fairly high levels of S&D, it is recommended that training curricula be developed or adapted for church leaders and church members. The following are areas considered useful to include in any such curricula:

- Basic HIV and AIDS knowledge including epidemiology, prevalence, transmission myths and prevention methods
- Human sexuality and other sexual and reproductive health related 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)
- 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 challenge stigma and discrimination among FBOs in Antigua and Barbuda should be explored. Our findings suggest the need to address two areas relating to HIV stigma:

The belief that HIV is associated with sinful behaviour has resulted in stigma and discrimination against people thought to be engaging in this behaviour rather than focussed attention on the behaviour and its social influences.

Beliefs that HIV can be transmitted through casual contact.

Addressing S&D is not just a moral challenge but one that may assist in preventing HIV, since being part of a supportive community can build the self-esteem and respect that people need to look after their own health and that of others.

The NAS is encouraged to build a strong and collaborative referrals system between FBOs and other agencies involved in HIV programming. FBOs should be provided, for example, with a list of HIV support groups, NGOs providing support to key populations including MSM and SW, counselling and testing sites and health care providers. This list should be updated regularly. The NAS can assist in making contact between FBOs and the provider organisations. This will enable FBOs to make referrals for services that they are unable to provide themselves.

### **6.3 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.

### **6.4 MESSAGES FOR CHURCH CONGREGATIONS REGARDING STIGMA AND DISCRIMINATION**

The appropriate methods for relaying messages regarding acceptance of PLHIV should be explored. In some FBOs, messages from the pulpit may be effective and could, for instance, provide Biblical illustrations of instances when Jesus embraced people who were sick or had been involved in sinful activity. Messages could emphasise forgiveness, mercy and unconditional love.

The messages from the pulpit can be reinforced through other avenues and forums that allow for more detailed discussion. This might include visits to FBOs by persons who are HIV positive and feedback sessions. Discussions might also be held during meetings of groups within the church such as women's group, men's groups and youth meetings, Sunday school and confirmation classes. HIV prevention messages may also be included in one-to-one counselling sessions.

While congregants reflect the values of the general population in Antigua and Barbuda regarding fear of HIV, FBOs could provide the catalyst and the leadership to overcome the dichotomy between Christian values of love and compassion and existing stigma among FBOs and congregants towards PLHIV and other key populations.

### **6.5 YOUTH**

Our research indicated that some FBOs have predominantly young people as members of their congregations. In others, young people constitute a smaller but still substantial proportion of members. Working with young people via FBOs may be a way to reach substantial numbers of them. There are vibrant church programmes for youth, but many of these may not explicitly have an HIV focus. 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, summer camps, theatre or dances and socials that allow mingling in a relaxed atmosphere. They may also focus on developing communications skills and family life.

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 youth sexuality.

## **6.6 GENDER AND RELATIONSHIP ISSUES**

Interviewees reported that up to 75% of their congregants are women, and Caribbean epidemiological evidence suggests rising HIV incidence among women. Working via FBOs may be a way to include substantial numbers of women in HIV prevention activities. 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 churchgoing 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>2</sup> 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 extension and possible further adaptation of this intervention to suit churchgoing women may be explored.

The possibility of including HIV education as part of pre-marital counselling should be discussed with FBOs. This education may include options for counselling and testing, reproductive health and power issues in relationships.

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 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.

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<sup>2</sup>Caribbean HIV & AIDS Alliance and University of California, San Francisco (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.

## References

1. Central Intelligence Agency (CIA). CIA World Factbook: Antigua and Barbuda. [Online]. 2009. [cited 2009 Nov 2]. Available from URL: <https://www.cia.gov/library/publications/the-world-factbook/geos/ac.html>
2. U.S. Department of State: Bureau of Western Hemisphere Affairs. Background Note: Antigua and Barbuda. [Online]. 2009 Nov [cited 2009 Nov 2]. Available from URL: <http://www.state.gov/r/pa/ei/bgn/2336.htm>
3. UNAIDS. Keeping Score: AIDS Responses in the Caribbean: a consolidated analysis based on Caribbean reports submitted to the United Nations General Assembly Special Session on HIV and AIDS, 2006. [Online]. 2006. [cited 2009 Jun 30]. Available from URL: [http://data.unaids.org/pub/Report/2007/20070605\\_keeping\\_score\\_caribbean\\_ungass\\_2006\\_en.pdf](http://data.unaids.org/pub/Report/2007/20070605_keeping_score_caribbean_ungass_2006_en.pdf). p.14.
4. UNAIDS. AIDS Epidemic Update. 2009. Joint United Nations Programme on HIV/AIDS (UNAIDS) and World Health Organization (WHO).
5. Caribbean Conference of Churches. Guidelines for Caribbean Faith-Based Organisations in Developing Policies and Action Plans to Deal with HIV/AIDS. February 2007.
6. Genrich G, Brathwaite BA. Response of religious groups to HIV/AIDS as a sexually transmitted infection in Trinidad. BMC Public Health. [Online]. 2005 Nov 16. [cited 2009 June 23]. Available from URL: <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1310629>
7. Aggleton P, Parker R, Maluwa M. Stigma, Discrimination and HIV/AIDS in Latin America and the Caribbean. Inter-American Development Bank. [Online]. 2003 Feb. [cited 2009 Jul 27]. Available from URL: [http://www.iadb.org/sds/doc/SOC130Stigma\\_and\\_AIDS.pdf](http://www.iadb.org/sds/doc/SOC130Stigma_and_AIDS.pdf)
8. UNAIDS. Keeping Score. p.8, 9.
9. UNGASS 2008 Country Progress Report Antigua and Barbuda, Reporting Period: January 2006 – December 2007. [Online]. 2008. [cited 2009 Oct 15]. Available from URL: [http://data.unaids.org/pub/Report/2008/antigua\\_2008\\_country\\_progress\\_report\\_en.pdf](http://data.unaids.org/pub/Report/2008/antigua_2008_country_progress_report_en.pdf). p. 5.
10. CRF Consulting. Strategic Plan for the National Response to HIV/AIDS Antigua/Barbuda 2002-2005. [Online]. 2001. [cited 2009 Oct 15]. Available from URL: [http://hivaidsclearinghouse.unesco.org/search/resources/HIV%20AIDS\\_strategic%20plan\\_Antigua%20Barbuda.pdf](http://hivaidsclearinghouse.unesco.org/search/resources/HIV%20AIDS_strategic%20plan_Antigua%20Barbuda.pdf)
11. UNGASS 2008 Country Progress Report Antigua and Barbuda. p. 10.
12. UNGASS 2008 Country Progress Report Antigua and Barbuda. p. 17.
13. UNGASS 2008 Country Progress Report Antigua and Barbuda. p. 5, 6.
14. UNGASS 2008 Country Progress Report Antigua and Barbuda. p. 23.

15. Stewart RJ. Religion in the Anglophone Caribbean: Historical Overview. In: Pulis JW, editor. Religion, Diaspora, and Cultural Identity. The Netherlands: Gordon and Breach Publishers; 1999. p. 14.
16. Hunte K. Protestantism and Slavery in the British Caribbean. In: Lampe A, editor. Christianity in the Caribbean: essays on church history. Jamaica: University of West Indies Press; 2001. p. 96.
17. Hunte K. p. 104.
18. Hunte K. p. 106.
19. Stewart RJ. p. 16.
20. Hunte K. p. 100.
21. Hunte K. p. 102,103.
22. Stewart RJ. p. 16.
23. Olmos MF Paravisini-Gebert L. Creole Religions of the Caribbean: An Introduction from Vodou and Santeria to Obeah and Espiritismo. New York: New York University Press; 2003. p. 156,157.
24. Hunte. p.108.
25. Parry JH, Sherlock P, Maingot A. A short history of the West Indies. Fourth Edition. Oxford: Macmillan Education; 1987. p. 219,220.
26. Hunte. p.109.
27. Hunte. p.116.
28. Stewart RJ. p.27,28.
29. Stewart RJ. p.28.
30. Austin-Broos DJ. Pentecostalism in Jamaica. In: Pulis JW, editor. Religion, Diaspora and Cultural Identity. The Netherlands: Gordon and Breach Publishers; 1999. p. 217.
31. Austin-Broos DJ. p.219.
32. Declaration of Commitment: Champions for Change II. 23 November 2005. [Online.] 2005. [cited 2009 June 24] Available from URL: [http://pancap.org/index2.php?option=com\\_content&do\\_pdf=1&id=138](http://pancap.org/index2.php?option=com_content&do_pdf=1&id=138)
33. Caribbean Conference of Churches, *ibid*.
34. Caribbean HIV&AIDS Alliance. Caribbean HIV&AIDS Alliance Annual report – year 2 Eastern Caribbean Community Action Project October 2008 – September 2009; 2009. p.39

35. Caribbean HIV&AIDS Alliance. Final Report: A Workshop in Behaviour Change Communication for Leaders in Faith Based Organisations. 2008. Caribbean HIV&AIDS Alliance, Trinidad and Tobago.
36. Government of Antigua and Barbuda. The Constitution of Antigua and Barbuda. Available from URL: [http://www.ab.gov.ag/gov\\_v2/shared/constitution.html](http://www.ab.gov.ag/gov_v2/shared/constitution.html)
37. World Council of Churches. Member Churches: Antigua Christian Council. [Online]. 2009. [cited 2009 Nov 2] Available from URL: <http://www.oikoumene.org/gr/member-churches/regions/caribbean/antigua-and-barbuda/acc.html>
38. US Department of State. International Religious Freedom Report 2009 – Antigua and Barbuda. [Online]. 2009. [cited 2009 Nov 2] Available from URL: <http://www.state.gov/g/drl/rls/irf/2009/127375.htm>
39. Balm in Gilead. Survey. [Online]. 2003 [cited 2008 Mar 8]; Available from URL: [http://www.balmingilead.org/survey\\_2003/survey2.asp?ID=5](http://www.balmingilead.org/survey_2003/survey2.asp?ID=5)
40. Steward WT, Herek GM, Ramakrishna J, Bharat S, Chandy S, Wrubel J, Ekstrand ML . [HIV-related stigma: adapting a theoretical framework for use in India](#). Soc Sci Med. 2008 Oct;67(8):1225-35.
41. Bombereau G, Allen CF. Social and cultural factors driving the HIV epidemic in the Caribbean: a literature review. Caribbean Health Research Council, Trinidad and Tobago, 2008. Available at URL: [www.chrc-caribbean.org/LiteratureReviews.php](http://www.chrc-caribbean.org/LiteratureReviews.php)

# Appendices

## APPENDIX 1: CONSENT FORMS

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 surveys 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.

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## 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 programmes 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 Programmes in the FBO

Does your movement/ FBO have any kind of health promotion/disease prevention programmes? 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 programme 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/programme? 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 programmes 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 programmes does your movement/FBO have for young adults (under 30 years old)?

Please describe these programmes for me.

OR IF THEY DO NOT HAVE ANY

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

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

Please describe the different types of young adults from your movement that such a programme 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 programmes in your movement?  
[Probe for barriers to other kinds of HIV programming other than prevention as well]

What kinds of programmes 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  
question on health promotion programmes. 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  
programmes):

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 \_\_\_\_

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

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

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 programme 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 programme 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 PLHIV 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?



# Full Time Staff	Position/Title
# Part Time Staff	

**ABOUT HEALTH-RELATED PROGRAMMES:**

Does your group currently provide any health-related programmes or activities? (These are programmes 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 programmes and areas of health? What are the target population/s for these programmes?

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

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

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

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/PROGRAMMES 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) programmes 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/programmes?

No

Yes

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

In fulfilling your church's mission, how important is it for you to establish, or further develop an HIV/AIDS ministry/programme 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 programmes 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 programmes 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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## APPENDIX 4: MATRIX FOR ANALYSIS OF DATA FROM QUALITATIVE INTERVIEWS

FBO Study

Name:

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 programmes			
Partnerships			
Grant Monies			

If not, why not?			
HIV/AIDS ministry/ program			
Response from congregants to HIV 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			
Programmes for people who are HIV-positive			
Palliative care (home based programmes)			
FBO needs to run/expand these activities?			

Location:

More Detailed Responses:

Youth

Retention of youth in FBO

Current Programmes

Future Programmes

FBO Messages

HIV testing

HIV awareness and prevention

Sex work

Homosexuality

Treating PLHIV within FBO

FBO Views

HIV testing

HIV awareness and prevention

Sex work

Homosexuality

Treating PLHIV 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 programmes in the FBO

HIV prevention programmes in other FBOs

HIV prevention programmes in Antigua and Barbuda

## Stigma and Discrimination

Levels of stigma and discrimination in the FBO

Levels of stigma and discrimination on Antigua and Barbuda

Ways to combat stigma

## Leadership and Inclusion

Possibility of PLHIV leader in FBO

Possibility of GLBT leader in FBO

Influential members

## Other Notes

## CHAA COUNTRY OFFICES



### **Antigua and Barbuda**

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### **Barbados**

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Barbados  
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### **Jamaica**

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### **St Kitts and Nevis**

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

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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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