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THE ROLE OF FAITH-BASED ORGANISATIONS IN HIV PREVENTION AND SERVICES

A Situational Analysis in St. Kitts and Nevis



WITH THE SUPPORT OF



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

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

CHAA is a regional NGO and recently became a linking organisation of IHAA. CHAA works specifically to mobilise vulnerable communities to carry out HIV prevention and education activities, counselling and testing and promoting access to care and support with three key populations: men who have sex with men (MSM), sex workers (SW) and people living with HIV (PLHIV).

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

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

List of acronyms

AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral therapy
BBSS	Biological/ Behavioural Surveillance Surveys
CAREC	Caribbean Epidemiology Centre
CCC	Caribbean Conference of Churches
CDC	US Centers for Disease Control and Prevention
CHAA	Caribbean HIV&AIDS Alliance
FBO	Faith-based organisation
GLBT	Gay, lesbian, bisexual or transgender
HIV	Human Immunodeficiency Virus
IHAA	International HIV/AIDS Alliance
IRB	Institutional Review Board
MSM	Men who have sex with men
NGO	Non-Governmental Organisation
NAS	National AIDS Secretariat
PHSC	Protection of Human Subjects Committee
PLHIV	People living with HIV
PLWA	People living with AIDS
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SISTA	Sisters Informing Sisters on Topics about AIDS
SKN	St. Kitts and Nevis
SW	Sex worker
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
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

The research team for this study consisted of Dr. Janet Myers, Principal Researcher (UCSF); Andre Maiorana, Co-Investigator/Qualitative Analyst (UCSF); Dr. Gaelle Bombereau-Mulot, Evaluation Director (CHAA); Rosemary Lall, Senior Research Officer (CHAA) and Nadine Kassie, Research Officer (CHAA).

The Caribbean HIV&AIDS Alliance and the University of California at San Francisco would like to express our sincere gratitude to all those individuals and organisations who contributed to the successful planning and execution of this study. Special thanks to the staff of the Ministry of Health and the National AIDS Secretariat for their guidance during the process and for freely providing us with requested information.

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Finally, special thanks are extended to USAID for providing the funding to support this much needed situational assessment.

Background

Faith-based organisations (FBOs) play an important role within Caribbean societies and religious leaders have considerable influence. Many FBOs are already engaged at various levels in HIV prevention and services or have acknowledged their potential leadership role in the response to HIV and AIDS, including engaging in HIV prevention and 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 (SKN) 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:

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

Methods

The qualitative and quantitative data collection methods used in SKN 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 SKN, ten 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. Fifty FBO representatives participated in the survey in SKN. Secondary data from published reports available from government and online sources provided context for the design of the instruments and for the findings from the interviews and surveys.

Participants were asked about:

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

Results

Participant descriptions and demographics

Description of FBOs

Fifteen denominations were represented in this study with churches, varying in size from 30 to 400 congregants. Most FBOs were affiliated with an umbrella group. The greatest number said they were affiliated with the Caribbean Council of Churches (n=14).

Respondent Characteristics

Interviewees in the qualitative component of the study (the semi-structured interviews) identified themselves as archdeacon, pastor, administrator or overseer, nurse, captain, school superintendent, member of a health committee, head of women's group, counsellor, youth leader, or communications coordinator.

FBO Congregations

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

Willingness and capacity of FBOs to participate in HIV prevention activities

HIV as a Priority among FBOs

While almost all (48 out of 50) respondents to the quantitative surveys answered that HIV as an issue was very important for their FBOs, the level of priority given to HIV as an issue among FBOs represented in the qualitative interviews varied. Some FBOs are engaged in counselling and testing, care and support but on an informal and small-scale basis. One FBO demonstrated a high level of interest in HIV by putting up a welcome banner in the church advertising voluntary counselling and testing and mentioning HIV in their visitors' brochure. In contrast, another interviewee saw little programming relating to HIV in his FBO, though the National AIDS Secretariat (NAS) had involved that FBO in workshops.

Health and HIV services by FBOs

HIV services by NGOs usually form part of a broader package of social and health care provided by FBOs as part of their pastoral mission. HIV-related services often focussed on education, counselling and testing or palliative care for PLHIV, with some referring people to other services to meet these needs. Home visits and other forms of care were part of the ordinary work of FBOs in tending to the sick and needy and not part of a specialised HIV programme. Some educational activities were conducted in collaboration with the NAS. Some FBOs were involved in a multi-denominational programme for youth entitled Abstinence 'Til Marriage (ATM).

Messages around HIV and AIDS

Explicit HIV prevention messages delivered by FBOs are abstinence for those who are unmarried and fidelity for those who are married, non-discrimination towards PLHIV and, in some cases, condom use for married couples. Distribution of safer sex literature, promoting condom use or doing condom demonstrations were not considered viable messages within most FBOs. Some interviewees thought it important to provide access to condoms (e.g. via referral) in acknowledgement of the gulf between church teachings and the behaviour of some congregants. Interviewees said that FBOs were supportive

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

FBOs are interested in providing more prevention and other HIV-related programmes, particularly services for PLHIV and anti-stigma sensitisation among congregants. Some FBOs are already engaged in HIV testing, mainly through referrals to health facilities and also by providing pre-and post-test counselling. Some services to PLHIV have already been provided, mostly on an informal basis, in the form of care in end of life situations.

Stigma related to HIV

Participants in the qualitative interviews stated that FBOs, according to doctrine and philosophy, do not discriminate against PLHIV and encourage congregations not to be judgemental. The level of leadership amongst FBOs to combat stigma however varied. Some interviewees acknowledged the need for stronger messages coming from FBO leaders including pastors to help sensitise congregants about stigma and discrimination.

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, 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."

Most participants agreed that there is still the attitude that people living with HIV should be ostracised, punished and that it is their fault they have been infected, since HIV is associated with socially unacceptable behaviour such as having multiple partners or homosexual sex. Interviewees said that PLHIV may be welcomed in church in a general sense, but some congregants may express some reservations and have difficulty reaching out or relating to someone living with HIV. This may be associated with attitudes that HIV can only happen to "other people" who have been involved in socially unacceptable behaviour.

According to respondents, there is a need to advocate for increased acceptance and inclusion of PLHIV within FBOs.

Barriers to implementing HIV prevention interventions through FBOs

The promotion of abstinence and fidelity as primary HIV prevention messages was seen by some as a limitation when confronted with the reality of people being sexually active. It posed particular challenges when it came to talking to women whose husbands had sex outside the marital relationship. Respondents acknowledged gaps between religious teachings and behaviours of some congregants, e.g. sex before marriage, multiple partnership.

A few participants noted that the inability to teach contraception and talk about condom use prevented FBOs from being involved in some sorts of HIV prevention. In general, sex work including transactional sex and homosexuality were considered wrong, sexually immoral and unacceptable. This limits the ability of most FBOs to engage in work with key populations such as sex workers (SW) and men who have sex with men (MSM). Some interviewees adopted the attitude of, "Love the sinner and not the sin", explaining that MSM and SW could be accepted into the church, but they would be counselled to change their lifestyles to conform to church teaching.

These groups may thus be better served by other agencies willing to provide services without judging

behaviour, and some FBO members may be willing to refer them to these agencies. In the context of low general population HIV prevalence in SKN, the most pressing needs may be to provide effective prevention services for populations at higher risk, such as sex workers and MSM. Our data suggests that FBO ability to respond adequately to these needs is highly constrained. However, FBOs can operate in a complementary fashion to programmes that can provide support to key populations, through referral and through cultivation of a more supportive environment for PLHIV. Working with their most numerous members, women and young people, holds the promise to change social attitudes in the interest of reducing the impact of HIV in SKN as a whole, increasing knowledge and upholding the value of compassion.

Leaders of FBOs were said to fear a negative response from some congregants if they talk more openly about sex or condom use. Some respondents perceived that talking about condoms or demonstrating condom use will encourage people to have sex and that it will contravene religious doctrine.

As regards care and support, research participants indicated the willingness of FBOs to provide services to PLHIV. However, PLHIV do not seem to be willing to disclose their status and seek services at FBOs for fear of stigma and discrimination, and breach of confidentiality. The number of PLHIV who had openly disclosed their status within FBOs was said to be very limited or, in some cases, non-existent.

There are limitations in the reach and capacity of FBOs to conduct HIV programmes. While FBOs do some HIV work there may not be a uniform policy within the denomination not just in-country but also regionally and some people within different denominations may be uncomfortable confronting the issue or see it as part of the FBO's role to talk about HIV prevention. Respondents cited resource constraints including few skilled people to write project proposals and seek funding.

Facilitators to implementing HIV prevention interventions through FBOs

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

There are already some partnerships and collaborations between the NAS and faith-based umbrella organisations such as the Caribbean Council of Churches, the St. Kitts Christian Council and the St. Kitts Evangelical Association.

Recommendations

Stimulating FBO involvement in programming

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

provided in terms of capacity building and HIV programming. This may include support to the formation of a network of FBOs whose leaders are willing to participate in HIV programming.

Capacity development for FBOs

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 SKN should be explored.

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

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 with a list of for example HIV support groups, NGOs providing support to key populations including MSM and sex workers, 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.

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 or dances and socials that allow mingling in a relaxed atmosphere. They may also focus on developing communications skills and family life. Theatre initiatives for HIV education with youth may be pursued.

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

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

The feasibility of implementing evidence-based interventions for HIV prevention among church-going women should be explored. In SKN, CHAA is currently working with women in industrial estates to adapt an evidence-based intervention called SISTA¹. 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 church-going 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 partnership and promoting condom use may be particularly suitable for male audiences.

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

Conclusions

Relating to key populations in general:

This study provides a preliminary assessment of the current and potential engagement of FBOs in SKN 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:

1. The report focuses only on Christian FBOs. It therefore presents some salient issues for the majority of people in SKN who are of Christian faith, but does not cover the concerns of people from other faiths such as Hinduism or Islam.
2. 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.
3. 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 SKN as a whole.
4. 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.
5. 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 messages and programmes must be tailored to the ability and willingness of individual FBOs to engage further in HIV prevention. They may, for instance, be most willing to promote abstinence and fidelity as HIV prevention messages and counselling and palliative care as support strategies for PLHIV. It may be difficult to engage them in activities involving condom promotion and work with sex workers and men who have sex with men. A balance is needed between doctrinal teachings and the needs of sexually active or HIV positive congregants. The reach of FBOs among women and young people is considerable and further assessments and collaborative work with FBOs are needed to develop HIV programmes with FBOs that are appropriate to these populations.

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

1. Introduction

Faith-based organisations (FBOs) play an important role within Caribbean societies and religious leaders have considerable influence. Adherence to religious teaching remains a cultural norm within significant sections of the Caribbean population even though behaviours do not always reflect their influence. The importance of religious bodies in mobilising the response to HIV and AIDS in the Caribbean is demonstrated by the emphasis which continues to be placed on FBOs in regional and national strategic plans. Many FBOs are already engaged to some extent in HIV prevention and services or have acknowledged their potential leadership role in the response to HIV and AIDS, including engaging in HIV prevention 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)/Caribbean HIV&AIDS Alliance (CHAA) to conduct the Eastern Caribbean Community Action Project. This included an assessment of FBOs in four Eastern Caribbean countries, as follows:

1. Antigua and Barbuda
2. Barbados
3. St. Kitts and Nevis (SKN)
4. 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 SKN. 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.

The twin island Federation of SKN is part of the Leeward Islands in the Eastern Caribbean with an estimated population, at the end of 2006, of 49,000 inhabitants. At that time, the crude birth rate in SKN was 13.2 per 1,000 population and the annual population growth rate was 0.5 percent while the net migration rate was -3.51 migrants/1,000 population (1).

Having gained its independence from the United Kingdom in 1983, the island nation remains a member of the Commonwealth of Nations. The official language is English, the capital is Basseterre, and the majority of persons are of African origin, with a few who are of British, Portuguese, and Lebanese 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. (Source <http://www.avert.org/caribbean.htm>).

The main form of HIV transmission in the Caribbean is through sexual intercourse (4). Although in the region HIV was first seen in homosexual men, it has become a largely heterosexual epidemic, fuelled by unprotected sex, multiple partnering, transactional sex and existing laws against sex work and homosexuality, which help to perpetuate stigma and discrimination resulting in clandestine high risk taking 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.

Stigma and discrimination 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. HIV and AIDS stigma has religious and societal origins and acts to reinforce already existing discriminatory views towards vulnerable population segments, such as women, homosexuals, bi-sexuals, sex workers 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 St Kitts and Nevis

According to the country's National Advisory Council on HIV and AIDS, the first case of HIV and AIDS in SKN was reported in 1984. At the end of 2006, a total of 270 cases had been reported to the Ministry of Health. This gives a cumulative incidence rate of 551 per 100,000 population. Sixty-one percent of the cumulative reported cases fall into the 20-49 age range (9). The main form of transmission is through unprotected sex, especially amongst those with concurrent partners (10).

The SKN government established a National Strategic Plan for HIV and AIDS in 2008, the goals being to reduce the spread of HIV infection, and reduce the impact of HIV and AIDS on individuals, family and the community. The strategic areas of focus in this multi-sectoral approach are:

1. Prevention;
2. Care, treatment and support;
3. Advocacy, policy development and legislation;
4. Generating and using strategic information; and
5. National programme coordination and management (11)

The vision of the government is to “prevent and control the spread of HIV and AIDS, promote care for those who are infected and affected, and reduce the personal, social and economic impact of the epidemic” (12). Up to this point, the Ministry of Health and the Ministry of Education have taken the lead in the effort to address the epidemic. Activities have been held in the workplace, schools and in the prison (13).

The national strategic plan has identified men who have sex with men (MSM), sex workers (SW) and youth as populations most at risk for HIV. The 2006 UNAIDS report, however, stated that there are very few programmes that exist for targeted prevention interventions for MSM and SW (14), who are the subjects of substantial stigma and discrimination (15).

The SKN National Advisory Council on HIV and AIDS has acknowledged that reducing the stigma of HIV and AIDS in the general community is one of the main challenges in order to prevent the epidemic from being driven underground (15).

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 (16). 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” (17). 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 (18). 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 (19).

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 (20). 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 (21). 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 (22). The “nonconformist” churches may have had a “far more profound influence on religion in the West Indies than the Anglicans” (23). 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 (24).

2.3.2 Post Emancipation

The emancipation of the slaves in the West Indies occurred in 1834 as voted by the British Parliament. A year later, the same Parliament proposed a grant to educate the formerly enslaved people, and this was made available to the Church of England and other denominations. This represented an acknowledgement from the colonial government of the presence of the various Christian groups in the region, not just the established church (25). 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 (26).

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 (27). 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 (28).

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 (29). The arrival of apocalyptic, fundamentalist, and Pentecostal churches brought another wave of religious influence to the Caribbean (30). For example, Pentecostalism was introduced predominately from churches on the North American eastern seaboard in the early 1900s (31). 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 (32).

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, founded in 1973, serves as an implementing agency that promotes development and sustainability through various programmatic initiatives of churches in the Caribbean. Its work in 34 territories of the region has fostered mutual relationships between ecumenical organisations on a territorial, regional and international level. The CCC has gained financial support from the Canadian International Development Agency (CIDA). CCC's 34 member organisations have successfully collaborated and established initiatives that have benefited the Caribbean. CCC is a member of the Pan Caribbean Partnership Against HIV/AIDS (PANCAP). Its role is to serve the churches in the cause of unity, renewal and joint action (<http://www.oikoumene.org/gr/member-churches/regions/caribbean/ccc.html>).

PANCAP 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" (33).

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. SKN was one of the 14 target countries for the project (34). 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 four Eastern Caribbean countries with regard to HIV prevention, care and support.

2.5 FBOs in St. Kitts and Nevis

The prevalence of Protestant FBOs in SKN is a reflection of the shared history of British colonialism that occurred in many of the Caribbean countries. A key indicator of its influence is evident in the number of Protestant FBOs that still exist and function today.

St. Kitts has had a long-standing history of colonisation and was the first British colony of the Caribbean. Historical records note that the first Anglican priest arrived as early as 1634. Methodist missionaries did not arrive on the island until a century later, and began work there in 1784. Thereafter, the Anglican Slave Conversion Society, later known as the Christian Faith Society, began its ministry in 1785 in St. Kitts, and in 1805 in Nevis. Other formal institutions such as the Seventh Day Adventists, and the Southern Baptist Convention are indicated to have established ministry from around 1850.

Although the current constitution of St. Kitts and Nevis guarantees religious freedom, and there is a general sense of openness and tolerance toward all faiths among its nationals, an overwhelming majority of the population practise some form of Christianity – which is the dominant religion in SKN. According to the International Religious Freedom Report, the Anglican faith is the official denomination (35). An estimated one third of the population are members. The rest of the populace reportedly belongs to other denominations such as Roman Catholic, Methodist, Moravian, Seventh Day Adventist, and Jehovah’s Witnesses. An old Jewish cemetery that exists on the island of Nevis is a reminder of Nevis’ former Jewish community that no longer exists there. A small community of the Church of Jesus Christ of Latter-day Saints (Mormons) also thrives in SKN. Other religions such as Muslim, Rastafarian and the Bahai Faith are considered minority religions. More recently, there has been an increased following of Evangelical Christian groups in SKN.

Currently, the St. Kitts Christian Council includes the Anglican, Catholic, Methodist, and other traditional Christian religious groups (UNHCR 2009). The council recently initiated activities to foster greater communal understanding among the various Christian affiliations that exist on the island, including the St. Kitts Evangelical Association.

2.6 FBO Response to HIV in St Kitts and Nevis

Given that most people in SKN are devoutly religious (36), HIV activities conducted by FBOs have the potential to reach a substantial proportion of the population. In 2007, MEASURE Evaluation, IHAA and CHAA conducted a Situational Assessment in SKN which examined barriers to accessing services for vulnerable populations in this country and provided recommendations for planning the national response to HIV and AIDS.



This study was a key step in the Ministry of Health’s revision of its current strategic plan by generating data, not previously available, on populations who are key to the national response. Christian clergy, although not considered to be an at risk group, were interviewed as part of that study to gain a further understanding of the potential needs of vulnerable groups with regards to HIV prevention activities and services. One of the findings was that the Christian clergy “expressed their desire of being more involved in activities related to care of PLHIV. The clergy recognised, however, that PLHIV would not come forward for fear of being judged”.

It was said that perhaps the message that the church should be a “domain of reconciliation and compassion” was not being emphasised enough to PLHIV. While some FBOs are actively involved in the promotion of abstinence, through programmes teaching personal development and life skills among the youth, the report suggested the need to sensitise the clergy and their congregants through education as an initial step in the engagement of the church leaders in the response to HIV and AIDS (37). The research reported here looks in greater depth at the potential for involving FBOs in the HIV response.

3. Study Methods

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

Participants were asked about:

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

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 were reviewed and approved by the Institutional Review Board (IRB) at UCSF and by the Chief Medical Officer of SKN.

Qualitative Interviews

Ten indepth interviews were conducted with a diversity of FBOs of different denominations. A semi-structured guide (Appendix 2) was used for the discussion with participants in the interviews. Upon initiation of this study, discussions were held with the Ministry of Health who indicated that there are two major FBO umbrella organisations in SKN. These are the St. Kitts Evangelical Association and the St. Kitts Christian Council. 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 SKN. The determining characteristic of the nominees were that they be:

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

A survey was conducted with representatives of 50 FBOs, using a standardised questionnaire completed by the interviewer (Appendix 3). The questionnaire was adapted from another instrument developed by the organisation Balm in Gilead in the US (38) as well as stigma scales validated through other research (39). The instrument included questions about the organisation; estimated number of parishioners; health and HIV-related services currently offered by the denomination; their willingness and capacity to implement HIV related programmes; barriers and facilitators to doing that kind of work and finally stigma levels. Data collection lasted approximately 20 minutes with each respondent.

Sampling

Only representatives of Christian FBOs were included in the selection of participants in the study. The research therefore presents some salient issues for the majority of people in SKN who are of Christian faith, but does not cover the concerns of people from other faiths such as Hinduism or Islam.

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 St. Kitts 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. Findings based on qualitative data are described as from “interviewees” or “participants” whereas data described from surveys is described as from “respondents.”

Qualitative Interviews

Four researchers at CHAA and UCSF, including the three staff that 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 used to 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, the four analysts worked together to compare the ten 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, 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.

The findings have been organised to describe the characteristics of study participants and FBOs included in the study, the priority accorded to HIV among FBOs, the health and HIV services they provide, perceived knowledge of HIV among congregants, FBO views regarding HIV and sexual behaviour, stigma and discrimination and FBO messages around HIV. 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

The denominations represented in the qualitative sample were Anglican, Catholic, Methodist, Seventh Day Adventist, Baptist, Independent Baptist, Salvation Army, Wesleyan Holiness and Moravian. As noted in the methods section, the interview with the tenth participant, a Rastafarian representative, was excluded from the analysis presented in this report as it was found that the Rastafarians do not define themselves as an FBO but as a movement, with different issues being raised from those among Christian organisations.

Denomination of FBOs Represented in the Survey Sample

Table 1 provides an overview of the denominations represented in the survey sample. This sample contained greatest numbers of Anglicans, Baptists, Methodists and Seventh Day Adventists. The denominations of Church of God and Wesleyan Holiness were also well represented. The remaining respondents were from a variety of denominations.

Table 1: Denominations of Churches of Which Respondents were Members

Denomination	N	%
Anglican	6	12%
Apostolic faith church	1	2%
Baptist	6	12%
Catholic	2	4%
Church of God	5	10%
Church of God of Prophecy	4	8%
Evangelical	2	4%
Jehovah Witness	1	2%
Methodist	6	12%
Moravian	3	6%
Pentecostal	1	2%
Salvation Army	1	2%
Seven Day Adventist	6	12%
Wesleyan	1	2%
Wesleyan Holiness	5	10%
Total	50	100%

Survey Respondent Characteristics

Among survey respondents, almost half identified themselves as pastors or reverends (n=24 or 48%). The second largest group was church members (n=10). The rest of the respondents represented a variety of positions within their FBO. There were five youth leaders, four directors or coordinators, three administrative workers, and the remaining four classified themselves as a “major,” women’s leader, usher and counsellor.

Interviewee Characteristics

Interviewees in the qualitative component of the study identified as archdeacon, pastor, administrator or overseer, nurse, captain, school superintendent, member of a health committee, head of women’s group, counsellor, youth leader, or communications coordinator. Some interviewees reported more than one role within their FBO. One interview was conducted with two persons and one interview was conducted with three persons in different roles within their FBOs.

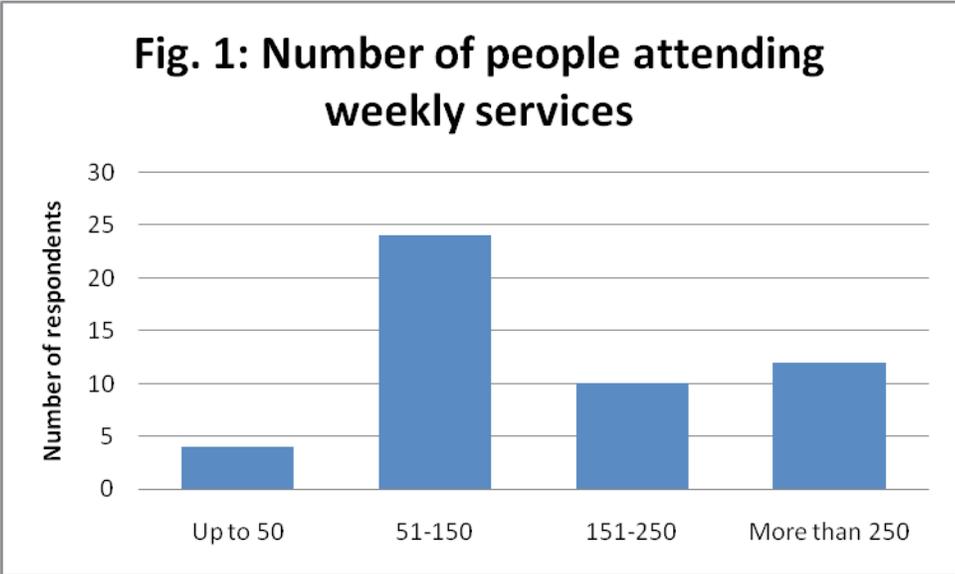
FBO Affiliations

Most FBOs were affiliated with an umbrella group. Of the forty respondents who identified their FBO’s umbrella group, the greatest number said they were affiliated with the Caribbean Council of Churches (n=14 or 35%). Nine others (23%) said they were affiliated with the Caribbean Christian Council. Six (15%) were associated with the Evangelical Association. Three (8%) were affiliated with the Caribbean Fellowship. Two (5%) were Baptist Conference members or Evangelical Society members. One each (3%) was Baptist Council, CGP International, and Church of God International. Note that the respondents stated the affiliations above. 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 respective FBOs ranging from a hierarchical quasi-military structure to a fellowship. The number of churches in St. Kitts within the same denomination ranged between 1 and 40. According to the denomination, FBOs were organised, for example, into circuits, districts, or parishes.

There was also diversity in the number of lay or religious persons working within the FBOs as pastors, emotional counsellors and teachers or other positions in charge of administering different programmes. Some FBOs had paid staff, while some relied on a combination of paid staff and volunteers. In some cases, persons were not paid staff within the FBO but had a job outside the FBO.

Size and characteristics of congregations

The size of the FBOs in the sample varied. Main religious services were said by interviewees to be attended by between 30 and 400 congregants. Data from the survey (Fig. 1) showed that most weekly services were attended by less than 150 people.



In at least one FBO, as reported by an interviewee, there has been a considerable decline in the last few years in the number of congregants attending services. Approximately 75% of the members of most FBOs were said to be women. In one FBO, the percentage of men was said to be only 10%. Most congregants were reported to have completed high school, vocational school or have some high school preparation.

Most interviewees reported youth i.e. those between 18 to 30 years of age as approximately 25% of their membership. Only two participants reported a much higher percent of youth within their FBOs. Young adults, particularly young men, were reported to be increasingly difficult to retain within many FBOs, although interviewees reported that some of them may return to the denomination later in life, when in their 30s or older.

Children attend FBOs with their parents but as they become teenagers, they may not go on to participate in programmes for youth available at the FBOs. Instead, they may become occasional visitors or stop attending altogether due to peer pressure and interest in other activities. An interviewee stated:

Just by virtue of being a [name of the denomination] it puts a number of young people in major conflict with their friends and other people who they would most likely interact with and so these would have been some of the challenges and so the issue would then be now for us to build alternative programmes within the church that can be equally attractive...

Another participant stated that as children turn into adolescents,

The church may appear to become less relevant and attractive for them because it is not evolving or using effective techniques to retain their attention at that critical stage in their life when they are searching it just doesn't seem like a place to find what they are looking for.

He added, however, that the solution is not to “move to a new paradigm” since this will only cause confusion and that young people will return when they are ready “if they fundamentally believe that you are preaching the truth.”

In a few cases, the reported percentage of youth between 18 and 30 years old attending FBOs was much higher, up to 60% of the congregants. Several reasons were given by one interviewee regarding the high retention of youth in the FBO to which he belonged. First, he said that there was acceptance of some aspects of youth's lifestyles, which were previously considered to be antagonistic to church doctrine such as partying and wearing certain kinds of clothes. Second, he said his FBO offers many youth- focused activities: “Kids get the attention they need, we do not just preach the Word of God to them, we develop programmes that they would be interested in.” Finally, he mentioned that his pastor is very patient and shows interest in the youth.

Some interviewees acknowledged with a sense of resignation that many of the women who attend the FBOs are young single mothers, despite the fact that churches generally put great emphasis on the nuclear family as ideal. Consistent with data from other sources, they reported that these women may have limited formal education and skills, and may engage in transactional sex in exchange for goods or money with casual, serial or concurrent sexual partners.

Most interviewees were not aware of gay, lesbian, bi-sexual, and transgender (GLBT) members at their FBOs. A few of the interviewees stated that it was rumoured or suspected that some of the congregants may be GLBT because of their mannerisms or the fact that they were not married. The term “do not ask, do not tell” was mentioned by a participant as applying to her FBO. Only one participant stated there were a few men within her FBO at different degrees of openness about their homosexuality. The interviewee said that these men were not rejected by church members, even though there were some members who used local derogatory terms to refer to them. The same participant stated that one of those gay men was a regular attendee, very open about his sexual orientation and critical of the FBO, but still very well accepted within the church.

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.

4.2 HIV as a priority among FBOs

While almost all (48 out of 50) respondents to the quantitative surveys answered that HIV was a very important issue for their FBOs, the priority given to HIV as an issue among FBOs represented in the qualitative interviews appeared to vary.

For some interviewees, HIV constituted a priority and a national health issue to be addressed by their FBOs. One participant stated,

It is a priority. Yes it is. We're very concerned about it. It becomes a priority when it is one of the biggest hazards, the biggest hazard, of having sexual intercourse before marriage.... We're trying to say, "you're young, you got school to go to, stay away from sex until you're ready for an adult relationship."

In another FBO, HIV was included in their visitor's brochure and there were plans to mention it on their website, which was under development. At this church, a welcome banner in the church advertised voluntary counselling and testing (VCT).

In contrast, an interviewee believed that HIV was not a major priority for his FBO, despite efforts by the National AIDS Secretariat (NAS) to include FBOs in programming,

The church can do much, much more... Maybe because of fear, or, I don't know maybe they feel the church... like it doesn't have any knowledge about the opportunities... well, because I have gone to workshops with the HIV and AIDS secretariat where the church is represented, pastors are there from the various churches and denominations, so it's not lack of knowledge, but maybe the church's agenda or focus is not on that... Most of the time there is not much being done.

Regarding the priority given to HIV as an issue among congregants, a participant stated that,

"We are just getting into awareness of the magnitude of AIDS. In the region and certainly in St. Kitts, the idea is not thoroughly popularised. I don't think every church member is.... that it registers that this is something we need to address and address right now."

HIV was said to be more of a priority within an FBO when, or if, congregants or their immediate family were affected directly by HIV. An HIV prevention activity or service may become operational because there are church officers or doctors or nurses within the congregation advocating for those programmes.

4.3 Health-Related activities at FBOs

HIV services by NGOs usually form part of a broader package of social and health care provided by FBOs as part of their pastoral mission. Here we describe features of health-related activities by FBOs, while HIV activities are described in the following section.

Of the 50 FBOs surveyed, the majority (n=42, 84%) said that they currently provide health-related programmes or activities. Of those with health programmes, 16 said they had one programme, 19 said they had 2 programmes and 7 said they had 3 programmes. About half of these programmes targeted the entire congregation. Another quarter targeted youth.

According to their size, how they define their mission and the financial and human resources available to them, FBOs offer different services to the community. These were said to include food distribution or helping "poverty-stricken" families or the elderly with basic needs. Some FBOs had their own schools, day care programmes, or even clinics. Some FBOs had also set up youth and/or health ministries.

Active involvement in health promotion varied. Some provided health education and health screening programmes and counselling periodically or irregularly at the FBO or at events such as health fairs. Usually these fairs were organised in collaboration with the Ministry of Health and/or the International University of Nursing (IUON). Programmes included talks on aging, prostate cancer, breast cancer, reproductive health and testing for diabetes and hypertension. Health and fitness classes were held in at least one FBO.

Programmes for youth were said to include:

- Academic activities and assistance to students with homework
- Skills training programmes such as cake making or apprenticeships in various job areas,
- Sports activities
- Summer camps, and
- Supervised social activities that may include music and dancing

A few FBOs conducted outreach to youth who do not attend church. The holistic development of youth, attending to both social and spiritual needs, was said to be encouraged through those programmes. Teenage pregnancy was often discussed, although most FBOs did not have specific programmes for youth that addressed sexuality and relationships. The goal of youth abstinence was discussed in youth groups, in Bible studies or from the pulpit.

4.4 HIV Services provided by FBOs

Almost two-thirds (n=31) of the FBOs surveyed reported that they had HIV-related programmes. The most frequently mentioned types of HIV-related programmes focused on education and prevention (29%). Many also provided services for HIV-affected individuals or their families. Fourteen percent of programmes provided spiritual counselling for HIV-affected individuals.

Interviewees said that FBOs provide HIV-related presentations or educational talks with support or involvement of the NAS or other health personnel. Talks are sometimes scheduled to coincide with certain dates such as World AIDS Day. HIV as an issue affecting the country is also mentioned from the pulpit and included in programmes or activities as part of the youth, women, and/or men's departments or ministries.

A multi-denominational programme for youth called, "Abstinence 'Til Marriage" (ATM) teaches abstinence as a goal and a way of life until marriage and as guaranteed protection against HIV. This has been in place for three years. ATM focuses on group activities and developing priorities other than sex among youth. ATM tries to help youth counteract peer pressure to become sexually active by instilling pride in youth in deciding to abstain from sex until marriage. The programme also aims to combat the materialism that was said to be creeping into the society and resulting in transactional sex. Interviewees said that ATM programmes are primarily aimed at congregants although they may also attract a small number of youth not attached to the FBOs.

FBOs referred congregants for HIV testing when requested or when HIV risk was identified through talks with the church pastor or counsellors. A few FBOs provided HIV pre and post-test counselling and delivered results themselves through staff trained and certified in Counselling and Testing, although the testing itself was conducted in a clinical setting.

Interviewees said that housing and palliative services were provided to PLHIV because these services were part of a church's core mission, which was to assist the sick and needy. Some FBOs were already providing or interested in providing home-based care with the support of the Caribbean Conference of Churches. However, according to some interviewees, identifying PLHIV in need of those services was a challenge due to the fear of disclosure.

Some support services for PLHIV, such as home visits, were not part of a formal HIV programme but part of the ordinary life of the FBO. They included praying, providing meals, and financial and logistical assistance for PLHIV who are sick or dying. Particularly if a PLHIV or a PLWA is bed-ridden or close to death, his or her status as a needy or sick individual was said to supersede any doubts about the morality of previous sexual behaviours.

4.5 Knowledge and Attitudes regarding HIV among Congregants

The level of HIV knowledge among congregants was described by an interviewee as being similar to that among the general population. It was considered to be between moderate to relatively high, with some interviewees considering that there was too much exposure to HIV-related information through the media. This was consistent with participants' opinions that lots has been done in St Kitts in the last three years by the government, including AIDS awareness media campaigns, promotion of HIV testing, and HIV education in the schools. However, other findings from this study suggest that there is room for improvement in knowledge about, for instance, risks of HIV transmission via casual contact (see section 4.7).

Despite this exposure to information, participants stated that HIV knowledge has not transferred to behaviour change. Some interviewees worried that people may not perceive HIV as something that may concern or touch them, but always as someone else's problem. One participant stated that persons, particularly youth, are in denial because they feel HIV cannot happen to them,

They tell themselves it can't happen. It's like we are in hurricane season and they say there's no hurricane. That is how we behave...we never know a hurricane is coming until it's across the sea. You won't find us board[ing] up our houses...we don't do [any]thing. We always believe it happens to somebody else and not us.

Among some of the congregants, there is still the need to address the misconception that HIV is a homosexual disease. As a participant put it,

I don't think it has reached home as yet to the rank and file of our membership that it's something to be talked about, to learn about, to address and to avoid discrimination and help reduce the stigma. There is still a hurdle over which we have to pass.

Interviewees emphasised the need for more education to dispel myths and misconceptions about casual transmission of HIV, which may contribute to stigma and fear towards PLHIV. Another interviewee referred to congregants' behaviours, including sex, and observed that Christians may not always be true to their beliefs and that issues are not addressed honestly,

People hide things and push things under the cover...we live a lie, I'm afraid. Our Sunday behaviour is different from Monday...Sunday is different from Monday to Saturday, you see. ...Because Christians are not always true to their vocation and commitment.

Several interviewees observed that persons still consider having HIV as a death sentence or at least that it leads to social ostracism. They therefore prefer not to know their HIV status. People are more likely to get tested if instructed by their doctors or if they suspect that a past or current partner may be HIV positive. People are unlikely to get tested for HIV if they look healthy. If their partners got tested they do not see the need to get tested themselves.

4.6 FBO Views on Behaviour

As noted, interviewees observed that HIV was often regarded by congregants as associated with the socially deviant behaviour of a minority rather than posing a risk to them. One participant observed that this point of view was unrealistic.

The whole face of AIDS has changed. We now know that it's no longer a homosexual disease, you see. At the time when our knowledge of it was so limited, it was just felt, here is God condemning all homosexuals to damnation. Today heterosexuals are very much in the whole fray as well.

Views on PLHIV

All interviewees stated that they would accept and include PLHIV within their FBOs. They also saw the need for FBOs to advocate for PLHIV. However, they generally did not portray congregants to be as accepting. Congregants' opinions and perceptions were said to range from fear of infection via casual contact with PLHIV to compassion towards PLHIV (see section in stigma and discrimination).

Views regarding sex

Interviewees said that many congregants are not comfortable talking about sex. This limits the scope of potential conversations about HIV and AIDS as well as the willingness of the FBOs to address HIV. A few participants stated that it is always the same persons who will attend HIV informational talks and getting other people to attend can be challenging: "We are only speaking to the converted, so even if you have a seminar, it's the same people over and over."

Another participant observed that many parents do not live up to their responsibility of providing guidance to children and teenagers. For example, some parents do not support sex education in school, "because they feel that this would be an opening for the children to be engaging in sex." Similarly, another participant elaborated that some parents thought that talking to their children about sex would be like "opening up Pandora's box", effectively encouraging them to have sex.

Views regarding MSM and sex workers

In contrast with interviewees' apparently welcoming attitude to PLHIV, their attitudes to sex workers and MSM were generally less accepting. In general, sex between men and sex work were considered wrong, sexually immoral and unacceptable sexual deviations.

Referring to sex work and sex between men, interviewees repeatedly used some variation of the statement, "God loves the sinner but not the sin." This view reflects the general condemnation of sexual behaviour other than that occurring between a married man and woman because it is wrong and "against God's teachings" and forbidden by the Bible or Scriptures. The implicit paradox in that statement may deter persons whose behaviours are not accepted from attending FBOs. But, at least in theory, this view allows the church to embrace the person and permit them to join the fellowship in order to "win a soul" and "let them find their way to God."

Sexuality issues are openly discussed or addressed to varying degrees by FBOs. In some FBOs, homosexuality and sex work are mentioned while referring to passages in the Bible (concerning Sodom and Gomorrah or Romans: 1), talked about incidentally, or excluded from discussions.

It was said that MSM or sex workers could avoid stigma and discrimination if they kept their sexual orientation or behaviours secret, or "in the closet". As illustrated by the following quote, some FBOs prefer to continue to ignore the issues:

We feel that too often they are too ostentatious about it. And...it's all gay pride and this sort of thing. We feel that if they had continued to allow it to remain where it was, in the closet, then you know, perhaps, it might be a little more acceptable, palatable, what have you. Something you could have lived with as we did over the years. We suspected we knew people but now they are... they're in marches and this and that.

There was no evidence, however, that MSM in St. Kitts were “out of the closet” and involved in the sorts of open advocacy activities this respondent spoke about.

It appears that MSM and sex workers can only comfortably be involved in FBOs if they are silent about their sexual activities or offer a public show of repentance for them. If a man in the FBO acknowledged his homosexuality, he would need to abstain from sex to be accepted by the church. “If someone understands that they are homosexual... we don't expect them to act out on it. In other words, it's a celibate lifestyle.” This implies that there is little room for GLBT to be members of an FBO and still be sexually active with partners of their same sex. The only possibility if such sexual activity does take place was to keep it a secret. “[If] you say you have changed your life, as long as you don't portray it in the church, it's not part of our problems.”

Only one interviewee expressed the personal belief that there is a place for legal/civil unions between persons of the same sex independent from the church. Another participant stated that among FBOs there is a “passion against homosexuality,” particularly against gay men, and that in St. Kitts “We are a very homophobic people and the church is just a microcosm of the society.” Someone else acknowledged that homosexuality and sex work were part of “the great divide” where FBOs in St. Kitts might preach against them but regionally or internationally their denominations may preach a more accepting message.

At least for some FBOs, decisions and policies regarding some behaviours which are condemned or considered reprehensible cannot be revised or adjusted without altering faith or doctrine. FBO representatives generally adopted a socially conservative attitude on sexual matters, refusing to be swayed by cultural trends,

We call it the three-legged stool. That is the basis of our faith. Scripture, tradition, reason. On the impact from the United States and elsewhere, they have put culture into it....They have also put experience. Well, we can live with experience because Blacks have experienced a lot of subjugation over the years. But certainly not culture, because culture changes. See, what's culturally proper today was culturally improper one hundred years ago. And...maybe different a hundred years to come. See you cannot allow culture to dictate how you're going to view this.... And because of the cultural impact, you know? Sex and so on, the Sixties, Sex Revolution, free for all, and so on. That has now sort of spilt over into this attitude towards homosexuality.

According to Christian doctrine, sex work is sinful, and most participants agreed that congregants would be against decriminalising prostitution. One interviewee acknowledged the economic connotations of sex work and indicated that FBOs should help find alternative sources of income for people selling sex. At the same time, that interviewee observed that sex work is illegal and as such it also needs to be considered a crime. Referring to sex work, a participant stated,

I'm afraid to talk openly in church about prostitution. It's something that... is always regarded with a certain amount of disapproval....I don't talk much about sex in church, I'm afraid. Except as sort of a scant illustration or what have you, depending upon if it emerges, even in a Bible study situation or what have you, you know? But sex is still taboo...

Another participant acknowledged that sex work is not talked about much in his denomination because, “they move from the premise that it doesn’t happen and the thinking is, ‘All I have to do is let those people know...it is hellfire, brimstone and damnation and they need to stop it.’”

The view at some FBOs is that spiritual guidance would allow congregants in general and youth in particular to avoid certain behaviours. An interviewee explained that the focus of his FBO was first and foremost to address spiritual needs and to rely on the youth’s spiritual connection to God to guide them through all other influences and temptations. As realistically observed by that interviewee, however, people may not always act in accordance with their FBO’s beliefs. In that regard, she felt that the fact that congregants hold a double standard may be playing a part in the spread of HIV, noting,

Religion is playing a kind of awkward part in the spread of it. Persons are not acknowledging that they are involved and in the false pretence of suggesting that you are upholding your faith, you are actually involved because of the secrecy and so on.

4.7 Stigma and Discrimination amongst Congregants

Participants in qualitative interviews stated that FBOs, according to doctrine and philosophy, do not discriminate against PLHIV and encourage the congregations not to be judgemental. The level of leadership amongst FBOs to combat stigma, however, varied. In some cases, interviewees acknowledged the need for stronger messages coming from FBO leaders, including pastors, to help sensitise congregants about stigma and discrimination.

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

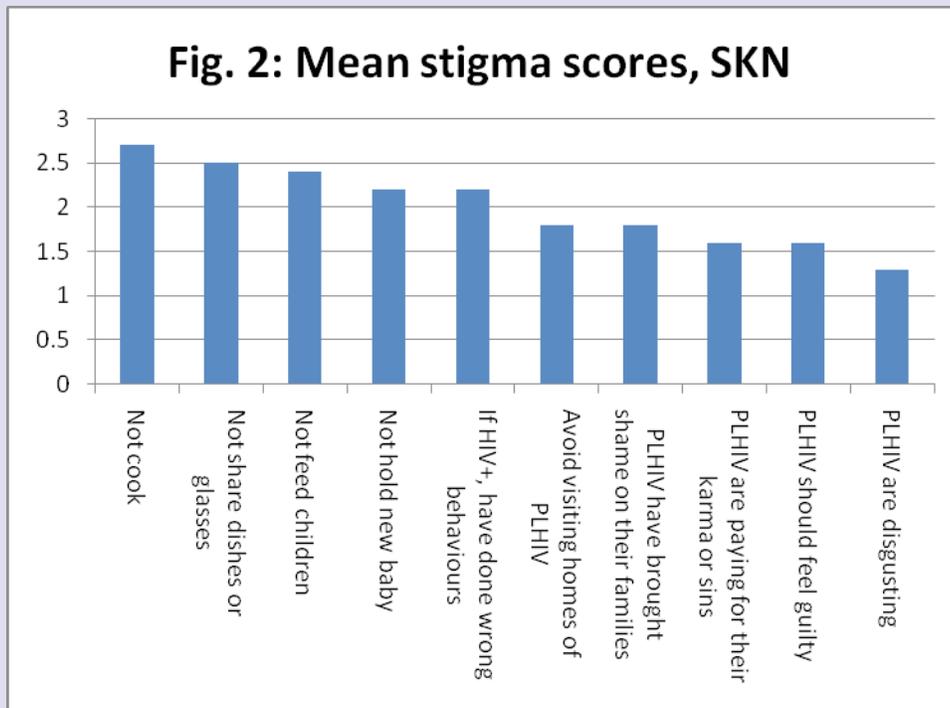
When asked how many people in the congregation would not want a person living with HIV cooking for them, the collective average, or mean, was 2.7, indicating a perceived high level of stigmatisation. Other food-related questions, whether the sharing of dishes or glasses with a PLHIV or allowing an HIV positive person to feed a child, also rated highly on the stigma scale, recording a mean of 2.5 and 2.4 respectively. Of note, also, is that the statement, “In your congregation, how many people think that if you have HIV you have done wrong behaviours?” yielded an average score of 2.2.

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

Statement	Average Score
In your congregation, how many mothers would <u>not</u> want someone with HIV to hold their new baby?	2.2
In your congregation, how many mothers would <u>not</u> want an HIV infected person to feed their children?	2.4
In your congregation, how many people would <u>not</u> share dishes or glasses with someone who has HIV?	2.5
In your congregation, how many people would <u>not</u> want an HIV infected person cooking for them?	2.7
In your congregation, how many people avoid visiting the homes of people with HIV?	1.8
In your congregation, how many people think that HIV-infected people have brought shame on their families?	1.8
In your congregation, how many people think that if you have HIV you have done wrong behaviours?	2.2
In your congregation, how many people think people with HIV are paying for their karma or sins?	1.6
In your congregation, how many people think that people with HIV should feel guilty about it?	1.6
In your congregation, how many people think that a person with HIV is disgusting?	1.3

NOTE: * The scale of 0 to 3 was used to quantify the responses which represent the following options:
 = No one
 = Very few people
 = Some people
 = Most people.

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



In qualitative interviews, participants stated that stigma and discrimination still exist among FBO members together with misperceptions and myths regarding HIV transmission. They observed that stigma and discrimination among congregants might reflect the same strong stigma present in the general society. Most participants agreed that there is still the attitude that HIV-positive people should be ostracised or punished and that it is their fault they have been infected, since HIV is associated with promiscuity. One participant stated that for the wider denomination, not just in his FBO, “...there is still the idea that if you have AIDS it’s a curse from God” as if AIDS were people’s choice and a consequence of their perceived “sinful” behaviours.

One interviewee stated the following regarding stigma within his FBO and SKN in general:

We know that stigma and discrimination is very high within the society and although the church has a policy that speaks to the equality and respect of all persons, it doesn’t preclude persons from exhibiting behaviours that are not necessarily in keeping with the church’s philosophy and of course there is work that needs to be done because stigma and discrimination is one of the big issues that we have had to confront as a nation.

One participant, however, believed that congregants might accept someone HIV positive, “I think most will because the ignorance has been dissipated a lot. They know better that you can’t catch the disease by fellowshiping with the person.”

PLHIV may be welcomed in church in a general sense, but interviewees said that some congregants might express some reservations and have difficulty reaching out or relating to someone living with HIV. One interviewee said,

“I still think that once it is known that people have HIV and AIDS, people are going to discriminate against them...and they’re going to be stigmatised...and that may happen even by people who don’t know their status...I mean those who discriminate against PLWA may be the very ones who don’t have...any knowledge of what their own status is.”

Based on an interviewee’s experiences, congregants would relate to PLHIV from a distance by bringing food, or asking about their health. They would not, however, visit the PLHIV since they would be afraid of being seen by others and of contracting HIV through casual contact. Another participant observed that, “If you tell them you can’t just get HIV just like that [through casual contact], they still not going to take the chance.” Another participant thought that some congregants would not want to receive Communion from the same common cup if they knew someone had HIV.

Some congregants may be judgemental towards PLHIV, who would be subjected to being a topic of gossip, rather than being welcomed like any other member. A participant thought that PLHIV need to be silent about their status because HIV is associated with homosexuality and FBO members would assume the person was homosexual before coming into the FBO. There was also the idea that some PLHIV, especially children and wives of men with other partners, could be considered by congregants as innocent victims and obtain sympathy and strong support from FBO members.

A participant recalled an instance in which a woman whom people knew was HIV+ joined the women’s group while the FBO was preparing its anniversary celebrations. While a couple of the women did not want her to be part of the group, the interviewee took the opportunity to work with the women, “...to help them understand that OK while that might be the case this is how you handle it....Are you gonna treat her how you think other people should treat her or are you gonna treat her the way you would want people to treat you if that was you?”

One interviewee had observed the bad experiences of the very limited number of PLHIV he knew who had chosen to publicly disclose their status. He said he would therefore ask “Are you sure?” if a PLHIV came to him to ask his advice about disclosing his or her status. He would want to be sure they are prepared to deal with the ramifications of disclosing their status because of the potential societal stigma. This participant’s statement, while well intended and meant to protect, seems also to reflect a certain pessimism or fatalism about whether public disclosure of a positive HIV status could be received any differently. The statement also seems to reflect an attitude that forecloses the possibility that the FBO will work with the congregation to encourage more accepting behaviour towards PLHIV.

4.8 Messages around HIV and AIDS

The main HIV-related prevention messages delivered by all FBOs were said to be abstinence before marriage and fidelity in marriage. These were the only consistent prevention messages among all FBOs. Others mentioned messages regarding the importance of HIV testing, non-discrimination towards PLHIV and, in some cases, condom use. Other messages delivered by FBOs implicitly or explicitly related to HIV and HIV risk emphasised love, “love thy neighbour,” compassion, repentance and lifestyle changes, forgiveness, and commitment to Christian values.

As noted above, this tended to result in the provision of care and support to PLHIV but also in the requirement to cease sexual activity not approved by the church. A participant considered that the need for respect of oneself and others would be another HIV prevention-related message that should be delivered by FBOs, particularly the need for men to respect women and consider them as their equal in sexual situations. However, it was unclear whether such messages were in fact transmitted by FBOs.

In some instances, HIV prevention messages were only included in the context of other activities or services offered by the FBO, such as specific programmes for youth or women. At one FBO HIV was considered a high priority, so messages on HIV awareness and prevention were presented at special activities called “mission service” and through regular bulletins produced by the parishes. These included information on the HIV situation in the country, statistics on the number of persons infected, and other messages on changing lifestyles and against stigma and discrimination.

Interviewees said that FBOs were supportive of congregants learning about HIV transmission and risk in order to protect themselves and as a way of dispelling myths regarding HIV and combating discrimination against PLHIV. However, distribution of safer sex literature, promoting condom use and doing condom demonstrations were not considered viable within the FBOs. Interviewees said that these methods would be controversial or not appropriate for every congregant. In general, the perception among FBO interviewees was that promoting safer sex messages would go against the message of abstinence and encourage congregants to have sex. However, some FBOs stated that in one to one counselling sessions with individuals who may be in risky situations or in youth forums, they would emphasise the need to adopt safety precautions and may even refer the individual to agencies that teach about safer sex or distribute condoms, such as the Family Planning Association.

Membership attitudes to sex and condoms

Several interviewees stated that since HIV is sexually transmitted they could not talk about or approach the issue in church because sex is a taboo subject. They stated that if FBO leaders were to endorse condom use, congregants might think or even complain that the FBO was promoting sexual activity among the faithful. Distributing safer sex literature may have the implication of condoning “fornication,” and subscribing to indiscriminate sex. Another participant stated that there would be resistance within his FBO if they promoted condom use because of the concern that they may be “promoting promiscuity.” In response to being asked if they talk about condoms, he said,

“In a church setting, there are certain conversations you wouldn’t necessarily bring up. You don’t want people to perceive you as a pervert, by bringing up a particular conversation... People have to be in a certain circle with you to bring up that. I just can’t walk into a group of young people and just start talking about sex.”

Some interviewees expressed the need to be careful that their messages would not offend anyone, being concerned about losing members or even the support of an entire family. These comments seem to indicate that some FBOs, afraid of what some congregants may say, are unable to mention different prevention options and provide congregants with the choice to decide which prevention messages work for them.

Prevention within marriage

Some FBOs would not broadly promote condom use but would recommend condoms for contraceptive purposes for married couples, knowing that condoms can also prevent HIV transmission. Some interviewees had no objection to condom use within marriage; instead, condom use was left to individuals when the two partners agreed to it.

Those instances when condom use within marriage would be acceptable included when a couple already had many children and could not financially afford to have any more, or when one of the partners was having sex outside the relationship and his or her spouse needed to protect him or herself. In the case of at least one FBO, condoms were distributed to couples within marriage or about to be married.

Some FBOs did not agree with using birth control methods, so even within marriage the use of condoms was not an option. A challenge mentioned by one participant, related to women whose husbands were having sex outside their marriage and were not members of the FBO. She pondered, "What should we tell those faithful wives who may be at risk for HIV through their husbands?" as the FBO did not talk about condom use.

Prevention outside of marriage

Referring to their stance against condom use one interviewee stated, "Now, people might say we are sort of burying our heads in the sand but that is where our stance is." One FBO that distributed condoms to married couples did not distribute them to single persons. A few FBOs distributed condoms to single persons not widely, but on a one-to-one basis.

An interviewee referred to "fidelity, abstinence, and then reality." He stated that the FBO needs to help youth understand the value of abstinence but agreed that those not prepared to abstain should find a way of protecting themselves. He explained that he refers to condom use when talking to congregants, but moderates the message by emphasising that no sex is the safest sex, "so that you are not accused of promoting condom use over abstinence, which many people would consider is purely what the Bible teaches." He believed in ABC (Abstinence, Be faithful and Condom Use), and thought that all three messages would need to be promoted if his FBO were to run a programme on prevention. "I do not believe that as a pastor it prohibits me from speaking about condom use...I'm not going to give you the condom but I'm gonna tell you the condom is there." Another participant echoed the same thought and explained that even if abstinence is preached, "I must say there are times when the reality strikes and you have to look at it from another perspective." The same participant stated that faced with the reality of young single women becoming pregnant, she personally would provide people with all the options, including condom use. She thought the pastor at her FBO would agree with that. Another participant believed that the church needs to promote some other means besides abstinence, to arm people with the necessary knowledge.

Another interviewee stated that his FBO would talk about condoms when a single person refused to be abstinent: "If you are going to be stupid, be careful and use condoms." Another participant, referring to the need to use condoms for people having sex, stated, "I would rather know I have a living child than to know I have a child with the HIV."

Different perspectives or voices within the same denomination seemed to exist with regard to the boundaries of the abstinence message. Some participants expressed being somewhat at a loss when confronted with the boundaries of the abstinence message in real life situations to protect the lives of the congregants, particularly of women, and prevent HIV. This may be a difficult topic to discuss within some denominations.

HIV Counselling and Testing

In reference to HIV testing, FBOs had different positions and there were degrees to which FBO leaders were proactive about promoting or referring congregants to get tested. People may be encouraged to get tested under the message that knowledge is power and learning one's HIV status would empower them

to make informed choices. To people not getting married or who are sexually active, an interviewee would explain that HIV test results are good for general documentation purposes such as insurance policies. HIV testing may be encouraged in the context of pre-marital programmes or counselling engaged couples as an avenue for partners to look at their sexual history, get tested, and examine their future if one or both parties were positive. For one participant, HIV testing for couples, perhaps even mandatory testing before getting married, together with reproductive health would promote healthier families and a healthier society.

Another interviewee stressed that a post-test counselling session with a congregant would be an opportunity to tell the person to change his/her behaviour and if HIV positive, to help the person seek care and normalise living with HIV. A third participant suggested the use of direct messages, such as caring for oneself in order to protect posterity and satisfy God's plan, "Because if you know that you are at risk; you still expose yourself, then you're ruining opportunities for posterity that will be dependent on you for care." A few FBOs offered HIV-related counselling at their premises.

Messages for Sex Workers and GLBT

The messages for sex workers were said to be to encourage them to live dignified lives and to seek other forms of employment instead of sex work. Similarly, GLBT would be encouraged by FBOs to change their lifestyle, "live a respectful life and get back to God's ideal."

Messages for People Living with HIV and AIDS

Messages regarding PLHIV emphasised compassion, empathy, non-stigmatising attitudes, and to help the persons living with HIV and AIDS to continue living as productive members of society. As one of the interviewees stated that messages would state that,

...all people are created and made in the image of God. And that all people should be treated alike... and having AIDS is not a death sentence. So that it is something you can live with and have a fairly respectable quality of life...and therefore we ought not to stigmatise people who are suffering or living with AIDS. "

As head of his FBO, a participant believed that pastors must lead by example. Because of that, he had PLHIV speak to the church and had embraced them physically to show his support of them and perhaps, more implicitly, that he was not afraid of infection. He stated that, "There must be the underpinning of love and support for these individuals...must be the underpinning that comes from the Bible because... whenever these things happen people think if there is one place I should get compassion is from the church."

4.9 Future Programmes

According to interviewees, despite some challenging attitudes, FBOs are generally supportive of developing further programming related to HIV. Most participants stated that the Ministry of Health is actively promoting AIDS awareness in St. Kitts and Nevis. However, two participants commented that not all aspects of the awareness messages were acceptable to the church.

Some AIDS awareness messages were perceived to progress "too fast, too far as the church is concerned..." since the Ministry of Health message of condom use may not be accepted by the FBOs. Interviewees proposed that future programmes should include education about HIV in the context of general health for congregants, those at risk for HIV, and PLHIV.

FBO HIV programmes, however, would need to fit within the boundaries of the FBO's beliefs and for the most part exclude explicit discussions of safer sex and condom use. As one participant said when asked about the possibility of developing group discussions on safer sex topics, "[We] can't do it. Only safest, which is abstinence." Another participant expressed the belief that distribution of safer sex literature would be "suspect, because if we are preaching abstinence then I cannot say safer sex." Another interviewee thought that even if condoms were distributed, people would prefer to get them somewhere else, outside the FBO.

Interviewees also noted that FBOs should provide programmes for youth, single parents and teenage mothers that include parenting skills. One participant firmly believed that programmes like these would make a great impact in a country such as St. Kitts and Nevis with a small population. These programmes would more indirectly but holistically address health needs, including HIV prevention, by helping develop youth as individuals. Garnering the support of private companies, schools, and community leaders to implement these programmes would be crucial for their success. Future prevention education programmes for youth should include activities that distract them from sexual risk-taking by promoting different activities such as hobbies. These would keep youth busy while developing self-esteem and a sense of empowerment that would potentially contribute to developing better decision-making skills including those related to sexual behaviour. One participant states the need for youth programmes that are fun, inclusive, interesting and meaningful to their lives.

We need to fill our young people's lives with things that can help them postpone sex. Because sex will always be an attraction for young people, but if they have a life that is filled to overflowing with meaningful, yes, meaningful things, they can postpone sex until they are adults.... The young people have their urges and we need to acknowledge that they are quite normal but that they can be deferred.

With regard to HIV testing, a few interviewees were of the opinion that they could host and provide the space for testing. This testing could still be conducted by someone external to the FBO, as a way of keeping it at arm's length from the FBO. One participant stated that pre-test counselling could be done through her FBO to determine risk and the need to be referred for testing. However, she thought it would be challenging to promote testing at the FBO as people may perceive that taking a test provided evidence to other FBO members that they were sexually active. Furthermore, potential participants in testing via FBOs may fear breaches of confidentiality.

Interviewees expressed their willingness to develop programmes for PLHIV such as support groups or organising exhibits of different crafts or other things made by PLHIV for fundraising purposes. A participant, however, doubted whether some congregants would wish to become involved in palliative care because, "there are people who just feel they're gonna get it [HIV] if they do that." Acceptance from the denomination would be needed to conduct these programmes, and the participant also expressed concern that PLHIV may be reluctant to get involved because of stigma.

None of the FBOs interviewed had an AIDS ministry in place. However, 46 of the 50 FBO representatives included in the survey expressed the wish to develop an AIDS ministry. In the qualitative interviews, some participants also expressed the desire to have one. However, concerns were raised regarding confidentiality of services and the possible need for these services to be presented as associated with health in general and not just HIV, in order to make them feasible and acceptable by the congregations.

5. Discussion

FBOs are a powerful societal force in the Caribbean and in SKN in particular. Our findings confirm 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, though the number of young people appears to be declining among some FBOs. Interviewees expressed support for the greater involvement of their FBOs, noting in many instances that this was consistent with Christian teaching regarding compassion and support for fellow human beings in need. They were particularly supportive of ideas involving greater ministry to PLHIV, increasing skills among FBOs to improve counselling, testing, care and support and provision of home-based and palliative care.

While interviewees expressed that they did not discriminate against PLHIV, they said that some of their congregations might not be so sympathetic. This was borne out in results on the stigma scale that indicated that congregations might exhibit stigmatising attitudes and behaviours in certain areas, such as preparation and sharing of food and drink. 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 must also be addressed in order to make the social environment more welcoming to PLHIV.

As regards MSM and sex workers, 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 sex workers 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.

Regarding HIV prevention, a variety of views were expressed. Many respondents indicated their support for the “A and B” of the “ABC” approach to HIV prevention, namely “Abstain and Be Faithful”. These were widely seen as consistent with Christian teaching regarding abstinence before marriage and fidelity in marriage. The third element, “Condomise”, met with mixed reactions. Some expressed the view that promoting condoms would encourage behaviours inconsistent with Church teaching, such as multiple partnerships.

Some saw dangers in providing greater access to condoms among young people since it appeared inconsistent with the message of abstinence until marriage. Others felt it was important for FBOs to provide access to condoms either directly or via referral, in acknowledgement of the fact that people do not always conform with the teachings of the church. They were more supportive of condom use among married couples than among people who were unmarried, including young people.

From these points of view, FBOs might be more comfortably involved in HIV prevention interventions that involve promotion of abstinence and fidelity than in those that promote condom use. Some churches have become involved in an abstinence-only initiative called Abstinence ‘Til Marriage. However, it should also be recognised that there is very little scientific evidence to demonstrate the efficacy of abstinence-only prevention programmes (40).

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 SKN. While there are weaknesses in the epidemiological surveillance system in SKN 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 severely limited. In that sense FBO programmes may not make a highly significant contribution to HIV prevention. However, FBOs can operate in a complementary fashion to programmes that can provide support to key populations, through referral and through cultivation of a more supportive environment for PLHIV. Working with their most numerous members, women and young people, holds the promise to change social attitudes in the interest of reducing the impact of HIV in SKN as a whole, increasing knowledge and upholding the value of compassion.

6. Limitations

- This study provides an assessment of the current and potential engagement of FBOs in SKN in HIV programming. Contextual data was generated by semi-structured interviews, while the survey generated basic information on a broad range of FBOs. Following are some limitations of the study:
- The report focuses only on Christian FBOs. It therefore presents some salient issues for the majority of people in SKN 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 SKN as a whole.
- The use of qualitative methods to generate much of the data on FBO representatives' views and attitudes is appropriate for understanding a situation through the voices and perceptions of participants at a specific location at one point in time, but this approach limits generalising the results.
- The respondents were generally in leadership positions within their FBOs and their views and perceptions may not accurately reflect those of the general FBO membership. While the methods are appropriate for the aim of reflecting the involvement of FBOs in HIV programming, further studies with broader representation from church congregations would be necessary to reflect the behaviour and attitudes of the general membership.

7. Recommendations

Stimulating FBO involvement in programming

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

Capacity development for FBOs

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 SKN should be explored.

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

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 with a list of, for example, HIV support groups, NGOs providing support to key populations including MSM and sex workers, 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.

It should be recognised that some FBOs may not have the capacity or willingness to provide a broad package of services regarding HIV, and may prefer to include HIV as one component in programmes for health and social support. Possible existing programmes that can be used as vehicles for HIV and AIDS programmes include prison outreach, spiritual counselling, food distribution, clinics, youth and/or health ministries including health screening programmes and counselling, health fairs, and health and fitness classes. It may be useful for the NAS to work with FBOs to identify some FBO members with interest and existing skills in HIV service provision, and seek to build skills and support the work of these people. The NAS may also assist in sourcing technical support to strengthen skills for writing project proposals and mobilising resources.

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 or dances and socials that allow mingling in a relaxed atmosphere. They may also focus on developing communications skills and family life. Theatre initiatives for HIV education with youth may be pursued.

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. They may also be trained in developing parental communication skills among members of their congregations around topics of sex and sexuality within the boundaries of what is acceptable for the church.

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

The feasibility of implementing evidence-based interventions for HIV prevention among church-going women should be explored. In SKN, CHAA is currently working with women in industrial estates to adapt an evidence-based intervention called SISTA (41). 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 church-going 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 discussing 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 better to consider their responsibilities with regard to their own vulnerabilities and to prevention of HIV transmission to their partners. Messages regarding the risks of multiple partnerships and promoting condom use may be particularly suitable for male audiences.

Care and support for PLHIV

Some FBOs were already providing or were interested in providing home-based care, as part of the church's core mission. The confidentiality issue associated with identifying PLHIV in need of those services may be addressed within the context of the training curriculum for church leaders and the general church membership. This should be one component of supporting FBOs to expand services in this area. The other would include capacity building around other elements of providing quality home-based care, such as provision of care; continuum of care; education; supplies and equipment; staffing; financing and sustainability (42).

Monitoring and evaluation

This research has revealed that Caribbean FBOs are already involved to varying degrees in HIV activities, and may benefit from and be assisted in making their interventions more systematic. There is very little information on the degree of success in interventions by FBOs in responding to HIV, and therefore little opportunity for ongoing learning from experience. As activities and interventions move forward, there is a need for the establishment of monitoring and evaluation systems that include:

- Recording and disseminating information on activities undertaken and services available
- Developing indicators of progress based on the strategic objectives of each FBO's HIV programme(s)
- Collection of qualitative data on processes and on satisfaction of key stakeholders

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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?

- The survey will take about 20 minutes to complete.
- At the end of the surveys you will be thanked for your time.

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.

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 In Surveys

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 the Strategic information Unit at the Caribbean HIV&AIDS Alliance in Trinidad at (868) 623-9714. Collect calls will be accepted at this number.

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

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

CONSENT

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

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

Appendix 2: Interview Guide

Interview #

Country:

Name of FBO or Faith Based Movement :

Denomination:

FBO Address:

Town/Area of Island:

FBO Telephone:

Fax:

Email:

Pastor or Contact Person:

Introduction

Thanks for agreeing to talk with me today. As you know, many people, especially young people, are at high risk for HIV. Although many different HIV prevention 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

- 1) Does your movement/ FBO have any kind of health promotion/disease prevention programs? If so, please describe. If not, why not?
 - Does your movement/FBO partner with any private/public health promotion agencies? If so, please describe
- 2) 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?
- 3) How big a priority is HIV and AIDS for your movement/FBO? Please explain.
- 4) Does your movement/FBO have an HIV and 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]
- 5) What would you say is the level of knowledge about HIV and other STDs in your movement/FBO? Is it low, moderate, or high?
- 6) What type of messages about HIV and 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?
- 7) How much is being done about HIV and AIDS outside your movement/FBO in your country
Probe, Other FBOs, NGOs, Ministry of Health
- 8) How does your movement view sex work? (probe for teachings, doctrines, etc). Is that something that is mentioned/discussed at all?

- a. In what forums do these ideas get communicated?
 - b. What do your members/congregants believe about sex work?
 - c. How do you think your movement's/FBO's teachings about this topic differ from other FBOs, if at all?
- 9) How does your movement view homosexuality? (probe for teachings, doctrines, etc). Is that something that is mentioned/discussed at all?
- a. In what forums do these ideas get communicated?
 - b. What do your members/congregants believe about homosexuality?
 - c. How do you think your movements/FBOs teachings about this topic differ from other FBOs, if at all?
 - d. Does your church have any laws/policy/guidelines on GLBT?
- 10) 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

- 11) If your movement were to run a programme for young adults, what do you think would be needed?
- 12) Who do you think would come/often come to those programmes?
- a. Please describe the different types of young adults from your movement that such a programme would likely miss?
 - b. What strategies do you think would be effective in reaching out to them?
- 13) 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]
- 14) What kinds of programmes do you think your movement would be willing to run?
- a. How likely would your movement/FBO be to support the following types of activities or events (Probe: Ask about the ones they did not mention as well as any mentioned as part of the earlier qu on health promotion programs. Also, what would their willingness be dependent on? Also, In terms of capacity what help would they need to be able to run/expand these programs):
 - Distribution of safer sex and HIV-related literature ____
 - Social activities or parties for young adults ____
 - Small discussion groups on safer sex topics ____
 - Condom distribution ____
 - Counselling and testing for HIV ____

- Small discussion group for young adults ___
- Programmes for people who are HIV-positive___
- Palliative care (home based programmes)___

- 15) 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]
- 16) 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?
- 17) 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?
- 18) 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?
- 19) How many members/congregants do you think accept an HIV positive person into fellowship?
- 20) 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?
- 21) Would a PLHIV be a spiritual/religious leader in your church/movement?
- 22) Would someone who is openly GLBT be a spiritual/religious leader in your church/movement?
- 23) Are there members/congregants who are more respected or influential among your members?
How likely are they to influence beliefs among your members/congregants?
- 24) What makes them be more influential? Their profession, personality, beliefs, financial situation?

Appendix 3: Survey Questionnaire

Faith-Based Organisation Survey

CHAA/UCSF

Final: October 7, 2008

Survey #:

Date of Survey:

Country:

Name of FBO:

Denomination:

Town/Area of Island:

FBO Telephone:

Email:

Pastor or Contact Person:

Record sex of the respondent: 1. Male

2. Female

NOTE: The terms “church” and “organisation” can be used interchangeably, depending on what works best. Use the term “movement” for the Rastafarian community.

About the Organisation:

What is your role within your organisation?

Does your denomination hold regular spiritual/religious services?

IF YES: What is the average attendance at these spiritual/religious services?

Type of Service	How often	#of People attending

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

Are there any paid staff working within your organisation

No

Yes (If yes, how many?)

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 and AIDS Education and Prevention
		HIV Testing Services (directly on site)
		HIV and 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 and 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 Programme
		Outreach services
		Employment of PLHIV
		Advocacy for Employment for PLWH
		Advocacy for Legislation supporting PLWH
		Palliative care (such as home based care
		Other (please specify)

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

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

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

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

Skip to Q 14:

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

No

Yes

Comments: _____

In fulfilling your church's mission, how important is it for you to establish, or further develop an HIV/AIDS ministry/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	Sometimes	Frequently
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 template for analysis of data from qualitative interviews

UCSF/CHAA FBO Study

Name: _____

Location: _____

Profile of FBO	Yes	No	Comments
Role of Interviewee			
Structure of FBO			
Independent			
Bi-vocational spiritual leaders			
Full-time paid leaders			
Hierarchy, Decision-Making/Leaders/groups within FBO			
Central admin office			
Full-time staff in office			
Services			
FBO Hall			
Member Profile			
# of attendees			
% of: men/women			
Age			
GLBT members			
Education			
Current Health Promotion			
Health Promotion programs			
Partnerships			
Grant Monies If not, why not?			
HIV/AIDS ministry/ program			
Response from congregants to HIV activities			
Potential Health Promotion			
A need for HIV/AIDS awareness program			
Support for the following activities/events:			
<i>Distribution of safer sex literature</i>			
<i>Distribution of HIV-related literature</i>			
<i>Social activities/ parties for young adults</i>			
<i>Small discussion groups on safer sex topics</i>			
<i>Condom distribution</i>			
<i>Testing for HIV</i>			
<i>Counselling for HIV</i>			
<i>Small discussion group for young adults</i>			
<i>Programmes for people who are HIV-positive</i>			
<i>Palliative care (home based programs)</i>			
FBO needs to run/expand these activities?			

More Detailed Responses:

Youth

Retention of youth in FBO
Current Programs
Future Programs

FBO Messages

HIV testing
HIV awareness and prevention
Sex work
Homosexuality
Treating 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 St Kitts

Stigma and Discrimination

Levels of stigma and discrimination in the FBO
Levels of stigma and discrimination on St Kitts
Ways to combat stigma

Leadership and Inclusion

Possibility of PLHIV leader in FBO
Possibility of GLBT leader in FBO
Influential members



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.

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