Faith-Based Organizations: Contributions to HIV Prevention

By Edward C. Green, Ph.D.

Harvard Center for Population and Development Studies

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Contents

Acronyms and Abbreviations

ABC	**A**bstain, **B**e faithful or use a **C**ondom (approach to HIV/AIDS prevention)
AIDS	acquired immunodeficiency syndrome
CORE	Communities Responding to the HIV/AIDS Epidemic
CHUSA	Church Human Services AIDS Prevention Program (Uganda)
DHS	Demographic and Health Survey
FBO	faith-based organization
HIV	human immunodeficiency virus
IMAU	Islamic Medical Association of Uganda
KABP	knowledge, attitudes, beliefs and practices (survey)
NHCP	Jamaican National HIV/AIDS Control Program
STD	sexually transmitted disease
STI	sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNEV	National Evangelic University (Dominican Republic)
USAID	U.S. Agency for International Development
WHO/GPA	World Health Organization/Global Programme on AIDS

Foreword

In the developing world, faith-based organizations (FBOs) are the major providers of care and support services to people living with HIV/AIDS. FBOs are uniquely positioned to spread HIV/AIDS education and prevention messages through their extensive networks that reach even the most remote villages. As the U.S. Agency for International Development (USAID) expands its work in care and support for people living with HIV/AIDS, FBOs and other community-based organizations can be essential partners in providing counseling, home care, clinical services, and advanced treatment.

USAID has a history of working with FBOs, such as Catholic Relief Services and World Vision, primarily through humanitarian response activities. USAID and The Synergy Project—managed by TvT Global Health and Development Strategies, a division of Social & Scientific Systems, Inc.—have been exploring how FBOs can expand their roles in the global campaign to fight HIV/AIDS. At a meeting convened by USAID and The Synergy Project in September 2000, FBO representatives had an opportunity to exchange ideas on this subject.

Since that meeting, USAID launched the Communities Responding to the HIV/AIDS Epidemic (CORE) Initiative. The CORE Initiative mission is to support an inspired, effective, and inclusive response to the causes and consequences of HIV/AIDS by strengthening the capacity of community and faith-based groups worldwide. The main approach is to leverage existing efforts, while catalyzing and encouraging new efforts through diverse and innovative partnerships in the areas of community-based prevention, stigma reduction, and care and support to people living with HIV/AIDS and their families.

Leading this initiative is CARE International in partnership with the World Council of Churches; the International Center for Research on Women; the International HIV/AIDS Alliance; and the Johns Hopkins Bloomberg School of Public Health Center for Communication Programs. With a global network of partners, the CORE Initiative provides state-of-the-art technical support and organizational development to community- and faith-based organizations and other USAID partners to design, implement, and evaluate comprehensive community HIV/AIDS programming.

This report provides examples of FBOs that are making a difference in afflicted communities. As nations seek ways to beat back HIV and AIDS, FBOs can provide instructive lessons for us all.

FBOs, as defined by USAID, are groups of individuals who have come together voluntarily around a stated spiritual or belief system that informs and guides their work together. FBOs range from small, grassroots organizations with simple structure and limited personnel to large, global institutions with highly sophisticated bureaucracies, wide networks, substantial financial resources, and significant human resources. For purposes of this discussion, the term FBO refers to organizations of varying sizes and bureaucratic complexity.

Introduction

During the early years of the HIV/AIDS pandemic, many people who worked in HIV prevention believed religious leaders and organizations were intrinsically antagonistic to what they were trying to accomplish. In the minds of many people, the stereotypic religious leader was a conservative moralist who disapproved of any form of sexual behavior outside of marriage, to say nothing of nonstandard sexual practices. It was also believed or known that religious leaders disapproved of condom use (considered the best way to prevent to HIV infection), and organized religion was seen as an impediment to sex education in schools. A UNAIDS report explained the conflict this way:

> Perhaps the greatest obstacle to AIDS prevention activities in many countries has been opposition, or even just the fear of opposition, from religious authorities. The tendency for religious leaders to prescribe abstinence and mutual monogamy in the face of overwhelming evidence that these behaviors are not always the norm has been seen in almost every corner of the world. The fear of offending powerful religious constituencies has created gridlock in some national governments, and for good reason. Conservative lobbies have shown that they can obstruct everything from family life education to condom promotion if they choose (Pisani 1999,12).

At an early international AIDS conference, the issue of religious involvement in HIV prevention was explained:

> Religious taboos on sexual education have been harassing AIDS prevention throughout Latin America. The confrontation between the condom and abstinence or fidelity has snapped closed any possibility for negotiating joint strategies. It has polarized political stances that clash public opinion and counterattack official efforts for AIDS prevention (Farill et al. 1992).

Such generalizations about religious institutions impeding efforts to prevent HIV and sexually transmitted infections often ignore that many FBOs have been working patiently, compassionately, and effectively for years in AIDS mitigation and prevention. This is true of large, internationally recognized religious groups and smaller ones as well. Specifically, FBOs have been providing care, support, and counseling for people living with HIV/AIDS, including care for AIDS orphans, income-generation projects for people living with HIV/AIDS and their dependents, and a variety of HIV prevention activities.

Workshops and seminars have been conducted for leaders of Buddhist, Christian, Hindu, Muslim, and other faith groups, and these efforts often have resulted in programs aimed at followers of the religion as well as others in local communities. These efforts demonstrate the ability of FBOs to bring AIDS support and education to communities not being reached by government campaigns, often using creative educational approaches (e.g., Campolino and Adams 1992; Farill et al. 1992; Ariyaratne 1998; Kagimu et al. 1998; Roesin 1998). Part of the challenge now is for health workers to overcome their own biases against working with FBOs.

> "… activists in HIV prevention need to purge themselves of their own prejudices and negative attitude towards religious institutions and engage them as partners in breaking the silence" (Iwere, Ojidoh, and Okide 2000, 1).

FBOs can make a considerable contribution to HIV/AIDS mitigation, prevention, and care activities. Although the introductory note in MAP International's *Religious-Based Initiatives* refers specifically to Christian churches in Latin America, it describes the potential role of religious organizations in the fight against HIV/AIDS generally:

> Religious-based initiatives are pivotal to the success of prevention and care efforts in Latin America as well as globally. Churches are found in nearly all communities in the region and wield a significant level of cultural, political, social, educational and economic influence. The Church can be viewed as the largest, most stable and most extensively dispersed non-governmental organization in any country. Churches are respected within communities and most have existing resources, structures and systems upon which to build. They possess the human, physical, technical and financial resources needed to support and implement small and large-scale initiatives. They can undertake these actions in a very cost-effective manner, due to their ability to leverage volunteer and other resources with minimal effort. Unfortunately, the resources, capabilities and potential of the Church are considerably neglected or untapped, and it has not been considered part of the solution and/or a driving force in the fight against HIV/AIDS (MAP International 1997).

Indeed, FBOs are often the only genuine nongovernmental organizations in many rural parts of poor countries, or at a minimum, they are the strongest and most influential. FBOs are able to mobilize people and resources, and to reach rural or isolated areas because of their organizational networks. FBOs tend to have a good understanding of local social and cultural patterns, and larger ones may have strong, expansive infrastructures. Many FBOs have long worked in health care and educa-

tion, and many have established thousands of faith-based hospitals and schools in sub-Saharan Africa. In all parts of the world, FBOs often have the power to mobilize large numbers of volunteers to contribute to causes they consider worthy. In addition, FBOs stress and support faith, idealism, and compassion, which are powerful and sustaining motivators for employees and volunteers who work with sick and dying individuals under extremely difficult conditions.

FBOs can be influential in policy debates concerning the legal, ethical, and moral issues surrounding AIDS and human rights (Lazzarini 1998), and in the debate over the introduction of education about sex, reproductive health, AIDS, and sexually transmitted infections in schools. In many developing countries, FBOs provide a substantial proportion of primary and secondary education.

A major debate is currently underway in the United States over the Bush Administration's announced intention to support faith-based initiatives, with the focus of debate being almost exclusively domestic rather than international. Underlying the debate is a fear that government support of FBOs might undermine the separation of church and state. In fact, USAID has been supporting FBOs in both humanitarian and development efforts for decades, with basically positive results. USAID supported these organizations on the basis of their demonstrated capacity to plan and implement services to high technical and ethical standards—not because they are FBOs. Some examples include the following:

- Catholic Relief Services has implemented HIV/AIDS programs since 1989, with an emphasis on care and support for people living with HIV/AIDS. In Zimbabwe, the group has assisted the diocese of Mutare to establish AIDS committees in every parish. Groups of community volunteers visit and care for the sick, perform AIDS preventive education dramas, and engage in income-generating activities. In an area where 25 percent of the adult population is HIV-positive, this program has greatly improved the quality of life for people living with HIV/AIDS, assured dying parents their children will be cared for, and brought support and comfort to families and communities afflicted by AIDS.

- Catholic Relief Services established the first HIV anonymous testing and counseling service in Egypt. Together with Caritas Egypt, Catholic Relief Services opened an HIV/AIDS counseling center in Cairo in 1995; its drop-in service focuses on youth, women, injecting drug users, street children, and sex workers. The center collaborates with the Ministry of Social Affairs to train hundreds of youth and women peer educators in HIV/AIDS and sexually transmitted infection awareness. Catholic Relief Services also established a care facility in New Delhi, India, for recovering drug users who are HIV-positive—a model now being replicated by the government of India at three additional sites.

- World Vision is currently implementing innovative HIV prevention strategies in Asia among high-risk groups such as sex workers, truck drivers, migrant workers, fishermen, and injecting drug users. The group promotes a variety of prevention modalities, such as condom promotion and distribution, syndromic management of sexually transmitted infections, and behavior change. Some of its programs are regional and are focused on cross-border populations, and some are active in non-USAID presence countries, such as Burma. World Vision also works with AIDS orphans and people living with HIV/AIDS in a variety of care and support programs.

- The Salvation Army provides relief supplies, education and prevention programs, HIV counseling and testing services, and spiritual support for infected and affected communities throughout Africa.

FBO HIV/AIDS Activities

FBOs have initiated, supported, and organized a range of HIV/AIDS activities, both with and without U.S. Government funds. Examples of these activities include the following:

- Counseling support groups for people living with HIV/AIDS and their families

- Support groups for educating local communities about HIV/AIDS

- Peer educator programs aimed at prevention of HIV and sexually transmitted infections

- Income-generation and vocational training programs for people living with HIV/AIDS and their dependents

- Care and support programs for children orphaned by AIDS

- Voluntary counseling and testing services

- Alternative employment or income-generation opportunities for girls and women who are vulnerable to or trapped in the sex-trafficking trade
- Hospice care
- Drama or music groups to raise awareness about HIV/AIDS, and to mitigate stigma
- Other methods of fighting against stigma associated with HIV infection within local communities

Fear and stigma are major obstacles to AIDS prevention and care initiatives, and faith-based groups can be important in reducing the stigma that is too often associated with HIV/AIDS. Just as open and frank discussion about AIDS by the highest government authorities helped to reduce stigma in Senegal and Uganda, faith-based leaders have similar authority and influence.

For example, the Christian Church Association of Lesotho implemented a project, the objectives of which were "to prepare communities for accepting and supporting all people with HIV and AIDS," and to promote "destigmatization of STD/HIV/AIDS patient care" (Barton et al. 1997, 8). Catholic Relief Services, which works with partners on more than 80 HIV/AIDS projects in more than 30 countries, has facilitated awareness workshops with clergy in several countries in order to "demystify and destigmatize HIV/AIDS" (Stecker 2003). The Adventist Development and Relief Agency held workshops for clergy, in part to "sensitize church leaders and reduce fear/denial/stigma associated with HIV/AIDS" (Adventist Development and Relief Agency 2002). Reverend Gideon Byamugisha, who for many years was the HIV/AIDS coordinator for the Church of Uganda (Anglican), has organized and led many workshops, conferences, and seminars on "breaking the silence" about AIDS and to promote acceptance of HIV-positive people as part of the community of faith. He continues to do so across Africa and elsewhere in his current role as the Church Liaison of World Vision International's Hope Initiative. As a final example, the Kip & K'Noodle Project of the Global Initiative on AIDS in Africa, a religious-oriented nongovernmental organization, uses drama in Cameroon to "change the way people think and react to HIV/AIDS, replacing stigma with love and compassion" (Marshall 2003).

Indigenous or "traditional" healers also qualify as faith-based groups in many parts of the world, because both the healers and their clients believe that spiritual forces underlie all or most indigenous therapy and healing. But the contribution that traditional healers make to AIDS mitigation will not be considered here because this subject has already been reviewed (cf. Green 1994; King 2000 for summaries), and because of the present need to clarify the role of internationally recognized religious groups.

FBOs in HIV Prevention: Country Examples

FBOs provide a large proportion of care and support services for people living with HIV/AIDS and their families and communities, especially in poor countries with high HIV infection rates. In general, FBOs have received relatively little international support for either their care and treatment work or for their prevention activities. For the most part, FBOs have been relatively less involved in HIV prevention. However, in a few countries, their involvement in government efforts to prevent the transmission of HIV appears to have had a significant impact. This paper examines the experience of those countries, and examines the role religious organizations have had in the success of these countries to stabilize HIV seroprevalence rates.

Uganda

Uganda is the standout among countries that have effectively responded to HIV/AIDS under the guidance of national leadership in both the political and religious realms. Uganda has experienced the most significant decline in HIV prevalence of any country in the world. National HIV infection rates declined from around 21 percent to just over 6 percent among pregnant women between 1991 and 2000, according to sentinel surveillance at some 15 sites (Stoneburner and Low-Beer 2000a,b; Uganda Ministry of Health 2000b).

Has FBO involvement contributed significantly to the stabilization of HIV prevalence through changes in sexual behavior in Uganda? Although interpretations have varied regarding the most effective measures in bringing about this decline, recent studies show that "... changes in age of sexual debut, casual and commercial sex trends, partner reduction, and condom use all appear to have played key roles in the continuing declines" (Hogle 2002). However, it appears that condom use became a contributory factor only by the mid-1990s, a few years after HIV incidence and prevalence had begun to decline (Hogle 2002; Bessinger and Akwara 2003; Green et al. 2003).

Beginning in 1986, in concert with President Museveni's official pronouncements and the frank discussion of the

HIV/AIDS epidemic initiated by the Government of Uganda, the major Ugandan religious leaders, including those in the Roman Catholic, Anglican, and later, Muslim faiths, became significantly involved in HIV prevention by working with the Ministry of Health to employ funds from the World Health Organization Global Program on AIDS (WHO/GPA). In 1992, USAID allocated funds for FBOs to work in prevention. From the beginning of their participation, the FBOs focused on the ABC approach (i.e., promotion of abstinence and fidelity, with use of condoms as a last resort, in response to failure or inappropriateness of the first elements of HIV/AIDS prevention) (Hogle 2002).

Many Uganda-based studies show that fewer partners and delay of sexual debut among youth appear to be more common behavioral changes than increased condom use (Asiimwe-Okiror et al. 1997; Barton 1997, 2; Green 1998; Kilian et al. 1999; UNAIDS 1998, 1999a; Sittirai 2001; Hogle 2002; Stoneburner and Low-Beer 2000a,b; Bessinger and Akwara 2003; Green et al. 2003).

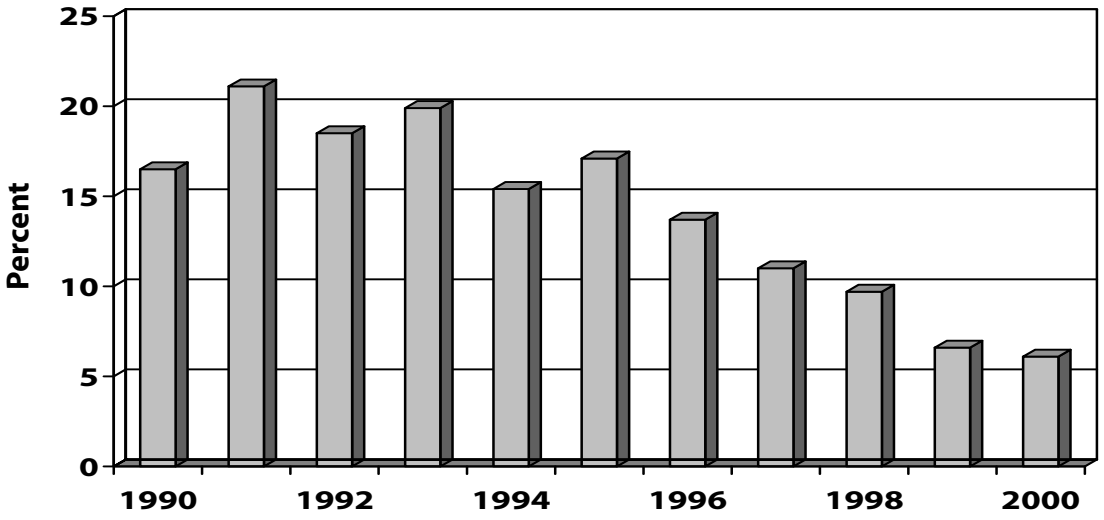
According to WHO/GPA surveys, the proportion of young men aged 15–24 who reported having premarital sex decreased from 60 percent in 1989 to 23 percent in 1995. For women in the same age group, the decline was from 53 percent to 16 percent. By 1997, there was a two-year delay in the onset of sexual intercourse among youths aged 15–24 years (Asiimwe-Okiror et al. 1997).

In all age groups, 41 percent of men had more than one sex partner in 1989; this figure declined to 21 percent by 1995. For women, the figure declined from 23 percent to 9 percent. Furthermore, the proportion of men who reported having three or more sex partners fell from 15 percent to 3 percent between 1989 and 1995 (Bessinger and Akwara 2003). A significant decline in commercial sex can also be observed by comparing the 1989 WHO/GPA survey and the Uganda 2000 Demographic and Health Survey. In 1989, 25 percent of men aged 15–49 and 33 percent of men aged 15–24 reported engaging in commercial sex in the previous year (Ankrah 1993). In 2000, only 1.6 percent of men aged 15–49 reported paying for sex in the previous year (Macro International 2001). Although differences exist in sampling between the 1989 WHO survey and later Demographic and Health Surveys, we can conclude that there was a highly significant decrease in commercial sex reported by Ugandan men.

Delay of sexual debut is not the only response to abstinence promotion, or for that matter, to fear of AIDS. In his review of behavior change evidence in Uganda, Barton (1997, 4) notes, "Nationally, in the reproductive (and sexually active) age range of 15–50, about 7 percent of women and 10 percent of men report that they have adopted complete and sustained abstinence for HIV protection." The Uganda 2000 Demographic and Health Survey shows that 72 percent of unmarried women and 65 percent of unmarried men reported no sexual partner in the previous year (Macro International 2001).

Uganda's experience in sexual behavior change activities is not unique. A recent United Nations report

National HIV Prevalence Rates, Uganda 1990–2000



Sources: Stoneburner and Low-Beer 2000a; Uganda Ministry of Health 2000b

(United Nations 2002, IX) summarized what has been learned from Demographic and Health Survey data; these findings were bulleted in the report's executive summary:

- In all countries surveyed, a large majority of men, ranging from 60 percent to 90 percent, reported that they had changed their behavior to avoid AIDS. In contrast, in only half the countries have a majority of female respondents made a behavioral change.

- Among those respondents, whether male or female, who did change their behavior, the most frequently cited change had entailed confining sexual activity to one partner.

- Only a small percentage of respondents began using condoms to prevent HIV transmission. Fewer than 8 percent of women in all countries surveyed report that they have changed their behavior by using condoms. Among married women, the percentages are particularly low. Figures are usually higher for men, ranging between 15 percent and 25 percent in most countries

Behavioral studies by WHO/GPA found the same trends a few years earlier: "Over half of all men in every country surveyed by WHO/GPA … reported having changed their sexual behavior in response to the HIV/AIDS epidemic. Reduction of partners (was) the most frequently reported measure. There is often frequent mention of abstinence, or young people delaying first sexual experience" (Cohen and Trussell 1996, 149).

AIDS-Related Behavior Change in Uganda

- Increase in the age of sexual debut by adolescents
- Reduction in the number of nonregular partners
- Increase in condom use, especially in urban areas after 1993

By 1991, when national HIV prevalence peaked, the proportion of men in Uganda who had ever used a condom was usually in the range of 5 percent to 10 percent, depending on the study and the area where the survey was taken (Barton 1997, 17–20). By 1997, some five years after the HIV seroprevalence decline began, "...an overall estimate based on all of the different studies might be a condom experience level of about 20 to 25 percent in the current sexually active population, which is up considerably from the level of 3 percent found in 1987" (Barton 1997, 17).

By 1998, between 39 percent and 55 percent of Ugandans in two major urban areas reported ever having used a condom (UNAIDS 1998, 10). Condom-use rates, however, have almost always been considerably higher in urban areas than in rural areas of Uganda. Rakai District, a mostly rural area that has been the site of intense AIDS-related study, as well as preventive interventions, has experienced just as significant a decline in HIV seroprevalence as any district in Uganda. By 1998, however, male condom use had reached only 17 percent (Lutalo et al. 2000; cf. Stoneburner and Carballo 1997).

The "ever-use" figures come from a UNAIDS-sponsored review of more than 300 studies. Note that the proportion of men who were using condoms on a more consistent basis would have been lower than the ever-use rate; and that women reported lower condom use rates than men, no matter how the condom question was phrased. When the Uganda Demographic and Health Survey queried about condom use during last intercourse with any type of partner—a measure of consistent use—it found that about 6 percent of men and women (averaged together) aged 15–49 reported condom use in 1995, and this figure rose to only 8 percent in 2000. In light of this evidence, and considering when HIV incidence and prevalence began to decline in Uganda, it seems unlikely that condom use contributed significantly to the onset of decline in rates of HIV and other sexually transmitted infections, even if increased condom use in subsequent years helped this process (Hogle 2002). It appears that condoms were not widely available until after 1993, and they were available primarily in urban areas (Stoneburner and Carballo 1997).

Did sexual behavior changes—particularly increased age at sexual debut and declines in the number of sexual partners—result from the work of FBOs in Uganda? In 1992, USAID allocated funds for three major religious groups in Uganda: Anglican, Catholic, and Muslim. Each developed an AIDS prevention project and each received roughly $350,000 from USAID. The FBOs said at first that they wished to promote "fidelity" and "abstinence" rather than condoms. At the time, many people working in AIDS prevention believed that fidelity and abstinence promotion would lead to few if any measurable results. Nevertheless, USAID made the grants and asked only that the FBOs not criticize condom promotion by other groups. The groups agreed to and adhered to this. In the months to follow there were few if any problems over condoms; in fact, before long, two of the projects began some condom promotion activities.

One of these projects was the Church Human Services AIDS Prevention Program (CHUSA), implemented through the Anglican Church of Uganda in five of its 27 dioceses. Both clergy and laity made pastoral home visits and conducted peer education, and CHUSA distributed sample sermons and other awareness materials, along with free condoms. In CHUSA's first 18 months, 863 leaders and 5,702 community-health educators were trained, and 1.2 million condoms were distributed (Ruteikara et al. 1996). But more striking was the impact on sexual behavior. A USAID-funded evaluation of sexual behavior change among those reached by CHUSA was conducted in 1995. It found that the proportion of men reporting two or more sexual partners declined from 86 percent to 29 percent, and of women from 75 percent to 7 percent (Lyons 1996, 8–9). Ever-use of condoms rose from 9 percent to 12 percent in the same period.

FBOs operate many primary and secondary schools in Uganda, and a large AIDS-prevention educational component has been offered in both religious and government schools. The *delay sex until marriage* message was emphasized in both types of schools. Moreover, religious groups run many of the health care facilities, and some AIDS education occurs in these facilities along with treatment, care, and support activities.

A substantial number of religious leaders and groups have been involved in Uganda's Ministry of Health HIV/AIDS prevention activities. In 1998, a World Bank evaluator estimated that between 1995 and 1998, approximately 6,750 religious leaders were scheduled to receive training on HIV/AIDS and would ask what they could do to help prevent it (Green 1998). As behavior has continued to change and HIV infection has continued to decline, the number of religious leaders and groups involved in Ministry of Health HIV/AIDS prevention activities (funded by the World Bank Sexually Transmitted Infection Project) has expanded. As a result, there is now a high level of involvement by religious organizations and leaders in these activities. Ugandan analysts give much credit to their faith-based institutions in fighting AIDS (Kagimu et al. 1998; Alwano-Edyegu and Marum 1999; Kaleeba et al. 2000; Okware et al. 2001).

Combined evidence suggests that religious organizations and other opinion leaders in Uganda (e.g., political leaders, school authorities, and traditional healers) who advocated abstinence and fidelity have had a significant effect on the overall decline in the HIV infection rate. It is noteworthy that disagreements over the role of condoms have not interfered with FBO involvement. For example, the Anglican and Muslim USAID-funded

The Islamic Medical Association of Uganda (IMAU) has taken the lead in educating Muslim religious leaders about HIV/AIDS and in mobilizing their support in response to the HIV epidemic.

Between 1992 and 1997, IMAU implemented the Family AIDS Education and Prevention Through Imams (FAEPTI) project, which covered 11 of Uganda's 45 districts. In each district, five-day training workshops were organized for imams, their assistants, and volunteers known as Family AIDS Workers. Imams from 850 mosques in the 11 districts participated in the workshops, and 6,800 community volunteers (one-half of whom were women) were trained.

Workshop participants studied topics such as basic facts about HIV/AIDS, sexually transmitted infections, behavior change, safer sex, and principles of communication and counseling. In the first year, after objections from Islamic leaders, the topic of condoms was omitted from the workshop curriculum. After further dialogue, the Islamic leaders agreed that education about the responsible use of condoms, within Islamic teachings, was acceptable, and the topic of condoms was reinstated.

A follow-up survey found significant increases in knowledge about HIV/AIDS in the project areas. Community members in the project areas also reported fewer sexual partners and increased condom use.

In Uganda's capital, Kampala, IMAU took a different approach. There, the project trained not only religious leaders from local mosques, but also members of Christian churches and of local government councils. The project also developed an AIDS education program for youth at Muslim schools. The Madrasa AIDS Education and Prevention project started in 1995 with 350 schools in the districts of Mpigi and Kamuli.

These three programs were funded by USAID, UNDP, and UNICEF and, in 1998, were featured in a case study booklet titled *AIDS Education Through Imams: A Spiritually Motivated Effort in Uganda*, published by UNAIDS in its Best Practice Collection.

Source: Kaleeba et al. 2000; Kagimu et al. 1998.

projects promoted condoms as part of a comprehensive prevention strategy, while keeping primary emphasis on abstinence and mutual fidelity (Kaleeba et al. 2000). AIDS prevention programs in Uganda and elsewhere have found that when religious leaders gain experience in prevention and have contact with public health partners, the issue of condoms becomes desensitized to the point that some clergy direct those requesting condoms to an appropriate source.

Senegal

Senegal was one of the first countries in Africa to acknowledge HIV/AIDS and to begin implementing significant HIV/AIDS prevention and control programs. According to the U.S. Bureau of the Census, like Uganda, "Senegal has been a success story, as the government has managed to keep the epidemic from getting out of control" (U.S. Bureau of the Census 2000a, 1). According to UNAIDS, Senegal currently has one of the lowest HIV seroprevalence rates in sub-Saharan Africa, and it appears to be stable, at 1 percent or less of the general population (U.S. Bureau of the Census 2000a).

Sittirai (2001, 12) attributes Senegal's ability to keep the infection rate low first to the relatively late age of sexual debut, and then to a reduction in the number of partners. In 2001, a Ministry of Health study conducted by Family Health International (FHI) with funding from USAID and the U.S. Centers for Disease Control and Prevention, found that of women in Dakar who had never married, only 4.1 percent of a random sample were having sex (Hygea/FHI 2001, 31). Of that 4.1 percent, more than half reported having just one partner (Hygea/FHI 2001, 35). According to the Senegal Demographic and Health Surveys, the average age of sexual debut among young Senegalese women aged 15 to 24 rose from 17.5 in 1992/93 to 18.8 in 1997 (Macro International and Government of Senegal 1994, 1997). This suggests that those at whom the delay message is targeted have in fact been responding to it. Age of sexual debut for young women is particularly important because of women's greater social, economic, and perhaps biological vulnerability to HIV infection.

Sittirai (2001, 12) also credits increased condom use and "apparently quite effective" sexually transmitted infection control efforts in the control of HIV prevalence. A UNAIDS study found significant declines in rates of sexually transmitted disease among women between 1991 and 1996: rates for chlamydia fell from 11.7 percent to 6.1 percent; those for gonorrhea fell from 2.9 percent to 0.9 percent; and those for syphilis fell from 7.5 percent to 4.4 percent (Sittirai 2001, 12).

A UNAIDS assessment of Senegal's response to AIDS called attention to a number of elements that influenced the nation's success in addressing HIV/AIDS (Sitterai 2001). Politicians in Senegal were quick to address the epidemic, once HIV/AIDS cases appeared in the second half of the 1980s. President Abdou Diouf acknowledged the presence of AIDS and began to implement a vigorous national AIDS prevention and control program in 1987. Unlike Uganda, Senegal had only a few cases of HIV at the time.

> During the first stages of the AIDS epidemic the majority of religious (leaders) condemned those infected with the virus, calling the illness a divine curse. This attitude made AIDS shameful and a positive diagnosis difficult. Religion systematically condemned certain modes of prevention as well as certain individual and group behavior (Diouf et al. 2000).

This perspective changed quickly, however, in a nation where 93 percent of the population is Muslim. In dialogue with the government, Muslim FBOs became involved in HIV/AIDS prevention early in the epidemic. A conservative Muslim organization, Jamra, approached the national AIDS program in 1989 to discuss prevention strategies (UNAIDS 1999b, 12). Following initial disagreement over whether FBOs should promote condoms, the Senegalese government conducted a survey of Christian and Muslim leaders to better define a role for them in HIV/AIDS mitigation. The survey found that religious leaders needed and wanted more information about HIV/AIDS, so that they in turn could educate their respective religious communities. In response,

> ... educational materials were designed to meet the needs of religious leaders. They focused in part on testimonials from people living with AIDS—the human face of the epidemic, often hidden where prevalence remains low. Training sessions about HIV were organized for Imams and teachers of Arabic, and brochures were produced to help them disseminate information. AIDS became a regular topic in Friday sermons in mosques throughout Senegal, and senior religious figures addressed the issue on television and radio (UNAIDS 1999b, 12).

A Catholic organization, SIDA Service, became involved in prevention as well as in counseling and psychosocial support. In 1996, a meeting on AIDS prevention was held for Christian leaders. Every bishop in Senegal attended, and a consensus was reached that AIDS prevention was an important national priority (UNAIDS 1999a, 13). The following year, Senegal hosted the First

International Colloquium on AIDS and Religion, in Dakar, which was attended by approximately 250 persons from 33 countries, including Buddhist, Christian, and Muslim religious leaders, and health ministers from five African countries (Ladame 1998). The effect on Senegalese religious leaders of all faiths seems to have been to empower them "to act freely in the promotion of prevention strategies" (Diouf et al. 2000).

In 2001, an article in the *Los Angeles Times* described the role of FBOs and religious leaders in Senegal:

> Conservative Islamic leaders are supporting AIDS prevention activities. Imams have started making AIDS a regular topic in Friday sermons throughout Senegal, where more than 90% of the population is Muslim. While the religious leaders insist that they encourage abstinence over the use of condoms, they acknowledge the importance of dispelling myths about the disease, such as the common theory that AIDS is a curse or a punishment by God (Simmons 2001).

In addition to the contribution of FBOs, many other levels of Senegalese society joined in the discussion, and by 1995, 200 nongovernmental organizations were active in the response, as were women's groups with about a half-million members. HIV prevention was included when sex education was introduced in schools, and parallel efforts reached out to young people who were not in school (Sittirai 2001).

Some may argue that sexual behavior in Senegal is conservative, and that preexisting norms and values rather than the effect of interventions are what has kept infection rates low. This interpretation, however, does not explain why HIV infection rates have risen in countries near Senegal that have similar marital and sexual practices and religious profiles. Further, the argument cannot be made in Senegal that behavioral change, followed by seroprevalence stability or decline, was caused by fear resulting from seeing so much death everywhere, because national HIV prevalence never exceeded about 1 percent. In fact, evidence suggests that Senegalese, despite their very low HIV infection rates, have come to feel personally at risk for HIV infection probably due to effective AIDS education. The Demographic and Health Survey asked women about their personal "perception of risk of AIDS." The highest proportion of (continental) African women feeling that their risk of contracting AIDS is "great" is found, paradoxically, in Senegal (39 percent, as early as 1992) (from the DHS/MEASURE Web site; http://www.measuredhs.com/, accessed November 25, 2002).

Senegal and Uganda stand out as countries where the governments boldly and strongly supported HIV/AIDS prevention efforts at a relatively early stage. There is wide agreement that this support has made a major difference and has allowed prevention programs to have maximum effect. Perhaps one of the factors inhibiting such a government response elsewhere in Africa and in other parts of the world is fear of a negative reaction from religious authorities. This argues for involving religious leaders and FBOs at the national level as early as possible in the fight against HIV/AIDS.

There is also evidence of a decline in HIV prevalence among younger cohorts in Zambia, as well as patterns of decline in premarital and multipartner sexual activity among youth (Bessinger and Akwara 2003; Green et al. 2003). Anecdotal evidence suggests that Christian FBOs are influential in Zambia, and that many have been involved in AIDS prevention. There is a need for research to confirm this.

Jamaica

Risk factors in Jamaica should predict relatively high HIV infection rates: an early age of sexual debut (median age of 14 for boys and girls); multiple sexual partners; a robust sex industry linked with tourism; lack of male circumcision; presence of chancroid; age disparity between partners (a pattern of older men having transactional or coerced sex with younger girls); relatively high levels of alcohol and drug use; and related factors such as poverty, labor emigration, male absenteeism, violence, homophobia, and major stigma associated with AIDS (Figueroa et al. 1998; AmaraSingham et al. 2000). Yet Jamaica has low seroprevalence by regional standards (1.2 percent or lower among the general population in 2001, down from 2 percent in 1996). This relatively low rate is apparently due to two factors: 1) programs of sexually transmitted infection case-finding and syndromic management, resulting in declining infection rates for virtually all sexually transmitted infections; and 2) behavior change communication programs that have resulted in high rates of condom use, reduction in sexual partners, and a slight rise in the median age of sexual debut.

From the early stages of the epidemic in Jamaica, religious leaders and churches have been involved in two main areas of Jamaica's National HIV/AIDS Control Program (NHCP): 1) care and counseling; and 2) behavior change and communication. The NHCP has targeted church organizations and congregations for awareness and prevention programs. Considerable numbers of

clergy have been involved in the National AIDS Committee (or subcommittees), or in local AIDS committees (or subcommittees), sometimes as chairpersons.

As in Uganda, FBOs in Jamaica have been especially interested in promoting "fidelity." Fidelity can result in a reduction of the number of nonregular partners, if not in monogamy and abstinence, which can result in a delay in the age of first sexual experience. Fidelity was promoted through HIV/AIDS education among congregations of major churches (Anglican, Baptist, Methodist, and Roman Catholic), often using community peer educators, and through similar programs in schools (AmaraSingham et al. 2000). Some school officials have allowed condoms to be discussed and shown in schools, and others have not; but it seems that no one opposed HIV/AIDS education that emphasized abstinence and fidelity messages. The focus of USAID's HIV/AIDS program in Jamaica has been on youth.

Has promotion of fidelity and abstinence resulted in behavioral change? The causal variables have yet to be sorted out, but the recent national population-based knowledge, attitudes, beliefs, and practices (KABP) survey of Jamaicans aged 15–49 shows that there has been a significant decline in the proportion of the population reporting two or more sexual partners in the previous 12 months (Table 2).

The proportion of both men and women who reported two or more partners for the previous three-month period declined sharply in 2000, compared with 1996 (although the question in 1996 was phrased in terms of two or more partners "currently"). There was a decrease among all age groups except for women aged 15–19 (4.5 percent in 2000 versus 3.8 percent in 1996). However, the general trend is encouraging. In fact, if the question had been phrased in 1996 in the same way that it was phrased in 2000, the numbers for 1996 might have been even higher, making the 1996–2000 differences even greater (Table 2).

The median age of sexual debut rose from 13 to 14 for boys between 1996 and 2000; it remained 14 for girls, according to the 2000 national KABP survey (Hope Enterprises 2001). Evidence from a recent qualitative study states that some young people believe that 15 or 16 is the earliest that Jamaicans should begin to have sexual intercourse (Chevannes and Gayle 2000, 76). A focus group of "suburban" boys (i.e., those from higher-income families, and with different beliefs, values, and behaviors) indicated that FBOs could do even more to focus behavior change communication. The same study showed that boys who delayed the age at which they first had intercourse tended to be "raised in a Christian home," which suggests the influence of religion in the delay of sexual debut (Chevannes and Gayle 2000, 25).[1]

Table 1
Mean Number of Partners: Jamaica KABP Survey 2000

	Age 15–19	Age 20–24	Age 30–39	Age 40–49
Men				
Mean number of partners in 12 months	2.80	3.54	2.68	1.396
Mean number of partners in 3 months	1.15	1.57	1.59	0.98
Women				
Mean number of partners in 12 months	1.19	1.15	1.08	0.77
Mean number of partners in 3 months	0.90	0.83	0.89	0.68

Source: Hope Enterprises 2001.

[1] Survey research elsewhere has also shown this relationship. For example, a study of university students in the Philippines found that 83 percent of the students were sexually abstinent, and that abstinence depends on "degree of religiosity," in this case, mostly Catholicism (Sy et al. 1996).

A great deal of community-based, face-to-face HIV/AIDS education, in addition to mass media awareness-promotion occurred in Jamaica, as it did in Uganda:

> A significant increase in participation in HIV/AIDS intervention, including face-to-face intervention was recorded (from 27 percent in 1996 to 35 percent in 2000). Notably, here was the citing of "community" intervention (15.7 percent) for the first time in a KABP survey. This undoubtedly is a reflection of the increased emphasis on face-to-face intervention in the communities. In fact, this is second to intervention in schools (48 percent), as the next most important source of intervention and is the most important source for men 20 years and over (Hope Enterprises 2001, 7).

Although face-to-face education is probably a more effective motivator of behavior change, this type of direct intervention reached 35 percent of the population, whereas mass media reached 83 percent of the population (Hope Enterprises 2001, 7).

Community peer educators interviewed by a recent USAID evaluation team reported that "mainstream" Jamaican churches (e.g., Anglican) have been particularly cooperative in participating in HIV/AIDS education efforts (AmaraSingham et al. 2000). Some churches resisted HIV/AIDS education efforts at first, but attitudes changed when church members started becoming infected. The result has been that relations between FBOs and national AIDS efforts in Jamaica have been excellent for many years.

The evaluation team did not find direct evidence of any clergy or religious organizations that oppose the work of Jamaica's National HIV/AIDS Control Program. Occasional allegations have been made that fundamentalist or Pentecostal churches criticized condom promotion, but no first-hand evidence of this has emerged. To the contrary, individual clergy and FBOs virtually everywhere were cited as being helpful, not only in providing care, support, and counseling for people living with HIV/AIDS, but also in aiding HIV prevention efforts. Even the former manager of the government's condom social marketing program, Althea Bailey, was able to promote condoms among church groups on several occasions, and she found no church opposition to any of the program's condom promotion efforts (Bailey 2000). As elsewhere, however, Jamaican FBOs have preferred to promote fidelity and abstinence rather than condom use.

A small survey was conducted in greater Kingston in June 1999, to assess the level of participation of churches in HIV prevention in Jamaica.[2] Findings included:

Table 2
Incidence of Multiple Partnerships: Jamaica KABP Survey 2000

Percentage of respondents reporting two or more partners

	Age 15–19	Age 20–24	Age 30–39	Age 40–49
Men				
	(n = 196)	(n = 337)	(n = 88)	(n = 48)
2000 survey	24.0%	31.8%	26.1%	12.8%
1996 survey	36.8%	36.9%	32.3%	13.6%
Women				
	(n = 132)	(n = 306)	(n = 113)	(n = 44)
2000 survey	4.5%	5.2%	7.1%	2.3%
1996 survey	3.8%	7.0%	9.3%	6.8%

Source: Hope Enterprises 2001.

[2] Information provided by Dr. Y. Gebre, director of the HIV/AIDS program in the Jamaica Ministry of Health, who requested and oversaw the survey, via e-mail to E.C. Green, Ph.D., July 1999.

- 9.5 percent of churches had a special HIV/AIDS ministry or special service on HIV/AIDS
- 19.5 percent of religious leaders had participated in HIV/AIDS programs:
  - 50 percent participated in support programs
  - 50 percent participated in education programs
  - 33 percent participated in counseling programs
- 98 percent of religious leaders expressed future plans to participate in HIV prevention:
  - 9.5 percent said they would participate in advocacy
  - 33 percent said they would participate in education
  - 19.5 percent said they would participate in counseling
  - 9.5 percent said they would participate in care
  - 14.3 percent said they would participate in support groups

Given the wide-ranging role that FBOs have played in HIV prevention and their occasional support for condom distribution, it is surprising that at the International AIDS Conference in Durban in 2000, the only paper presented on the role of FBOs in mitigating AIDS in Jamaica overlooked all positive contributions that FBOs have made. Instead, some churches were criticized for being anti-condom and for forbidding Christian burial of those suspected of having died of AIDS (Gunter and Hue, 2000).

It is clear that condoms play an important part in Jamaica's success, and FBOs have been relatively receptive to condom education and promotion. More than 90 percent of sex workers regularly use condoms with clients, as do 77 percent of men. Between 57 percent and 79 percent of women (depending on age group) reported using a condom during their last sexual encounter with a nonregular partner. Condom use among regular partners in Jamaica is high by international standards. The percentage of men who used a condom in their last sexual encounter increased from 47 percent in 1996 to 52 percent in 2000 (Market Research Services 1999; Hope Enterprises 2001).

Moreover, Jamaica has an excellent sexually transmitted infection control program that includes syndromic management, plus an effective program of contact tracing and HIV counseling and testing. Each of the 13 parishes has centers for treating sexually transmitted infections, and health workers are trained in syndromic management. As an apparent result, prevalence and incidence (where data for the latter are available) of most sexually transmitted infections have declined markedly for several years. Sexually transmitted infections, particularly of the ulcerative type, are facilitating factors in HIV transmission, and falling rates of these infections contribute to stabilizing HIV infection rates.

In sum, Jamaica's experience with engaging FBOs in HIV prevention has been unusual among developing countries. Evidence (although it is by no means definitive evidence) suggests that approaches to behavioral change favored by FBOs (i.e., promotion of fidelity and delay of sexual debut) have had some effect on behavior, as have condom promotion and syndromic management of sexually transmitted infections. Jamaica's experience with FBOs deserves to be further studied for what it can teach the world.

Dominican Republic

HIV seroprevalence and rates of sexually transmitted infections have stabilized in the Dominican Republic. Sentinel surveillance data from rural and urban antenatal clinics between 1991 and 1998 suggest that HIV prevalence in the general population is about 2 percent to 2.5 percent. The official figure used by UNAIDS in 2001 was 2.8 percent, yet a sero-survey component of the 2002 Demographic and Health Survey found that national prevalence was 0.96 percent among women and 0.88 percent among men. For young men aged 15–19, prevalence was 0.3 percent. For young women aged 15–19, HIV prevalence was 0.4 percent (Macro International 2002).

Positive behavior change has been observed in relatively high rates of condom use, and in a reduction in the number of extramarital partners or consensual union. A random sample survey of 1,400 urban, sexually active Dominican men was conducted in 1998 to measure changes in their sexual behaviors. The survey was prompted by results from the 1996 Demographic and Health Survey, which found that 84.8 percent of a national random sample of Dominican men claimed that they had changed their behavior in some way because of their fear of or concern over HIV/AIDS.

The proportion of respondents reporting behavior change, such as practicing monogamy or reducing their number of sexual partners, was about triple the proportion of those who reported condom use (Green and Conde 2000), with 79 percent of respondents claiming to had changed their behavior because of HIV/AIDS. A majority (52.2 percent) said they had become monogamous or reduced the number of sexual partners they had. This was followed by condom adoption (14.6 percent), having sexual relations only with a person they know (13.9 percent), avoiding relations with "prostitutes" (9.0 percent), or abstinence (1.6 percent) (Green and Conde 2000; OMSA 2000). As with the 1996 Demographic and Health Survey findings, most responses were classifiable as a behavior change other than condom adoption. The 1996 survey found that women who had never married (and were therefore predominantly young) were highly likely to report sexual abstinence or delay. Thus findings from the 1996 and 1998 surveys are comparable.

The Dominican Republic stands out among four countries in Latin America and the Caribbean (Table 3) as having the lowest rate of women who did not report a change in behavior. And among women who had never been married, fully 61 percent reported a behavioral change in the form of sexual abstinence or delay, compared with much smaller percentages in the other three countries in which the survey was conducted. This suggests that something is occurring in the Dominican Republic that is not occurring to the same degree in the other three countries for which comparable data exist.

In the mid-1980s, the Dominican Republic's National Sexually Transmitted Infection and AIDS Control Program made efforts to preempt church opposition to condom promotion efforts by explaining to Roman Catholic Church leaders the life-saving mission of its HIV prevention campaign (Green and Conde 1988). Religious groups have been involved in AIDS prevention since the early years of the national response to AIDS. For example, since the early 1990s, ProSolidaridad, an interfaith group comprised of many Christian churches, has trained youth leaders and others in local communities as AIDS prevention educators. One report shows that "2500 Christian pastors and religious and non-religious youth leaders have been trained as STI-HIV/AIDS educators and have started to achieve prevention interventions in Nagua and other provinces" (UNEV n.d.). These community-based educators receive training from ProSolidaridad, and they sometimes work through youth clubs. Face-to-face preventive education efforts are complemented by television and radio broadcasts.

There has been some conflict between the Roman Catholic Church and mainstream AIDS prevention groups over the role of condoms. One AIDS expert with links to both camps feels that to the extent that the conflict has been public, its effect has not been entirely negative, noting that the debate has served to "increase the perceived threat of disease in *risky* (non-marital) sex... reinforcing sexual abstinence (postponement of sex initiation in girls, faithful monogamy in married men)" (deMoya 2003).

Table 3
Behavior Change to Avoid AIDS Among Never-Married Women

	Behavior Change by Women			
	Began using condoms	**Restricted sex to one partner**	**Delayed first sex or stopped sex**	**Did not change behavior**
Colombia, 1995	10%	10%	8%	78%
Dominican Republic, 1996	1%	3%	61%	34%*
Guatemala, 1995	1%	2%	9%	81%
Haiti, 1994–95	3%	5%	16%	73%

*The figure had dropped to 21% by 1998 (Green and Conde 2000).
Adapted from Gardner, et al. (1999).

This is only one example of some of the prevention work that has taken place in the Dominican Republic, and it is distinct from work in care and support for people living with HIV/AIDS and their families. It is difficult to quantify the amount of prevention that has occurred in the Dominican Republic through ProSolidaridad, the Roman Catholic Church, and other FBOs. Programs that emphasize abstinence and fidelity tend not to be favored by mainstream medical and AIDS professionals, and so they may be given little attention. This may change as evidence accumulates to show that balanced "ABC" approaches are needed, especially in countries where the epidemic is generalized (U.S. Agency for International Development 2002). FBO prevention programs also tend to work with local funds, rather than to use funds from foreign donors. This means that programs are seldom subjected to rigorous external evaluation of impact, because these processes can be expensive. FBO activities need to be documented, and evaluation research of the activities still needs to be done in the Dominican Republic and in other countries. One of many FBO topics in the Dominican Republic that could benefit from research is the role of syncretistic Afro-Caribbean religions in AIDS prevention and treatment (Ureña et al. 1998).

FBOs As Behavior Change Agents

FBOs can influence behavioral change to promote AIDS prevention through a variety of methods, ranging from the relatively passive (e.g., inviting or allowing AIDS educators to address congregations) to the more active (e.g., using the prestige and moral authority of the religion to advocate behavior such as fidelity or abstinence). Long-term, qualitative research in KwaZulu Natal, South Africa, attempted to establish whether membership in any religious group affected sexual behavior, using as a measure the degree of extramarital and premarital sex found in the population. The researcher found that Pentecostals had the lowest level of extramarital and premarital sex, and that levels were much lower than those of mainstream Christian churches, i.e., Protestant, Anglican, and Roman Catholic—the same groups that seem to have so profoundly influenced extramarital and premarital sex in Uganda and Jamaica. The researcher notes:

> Indoctrination against all types of extra- and pre-marital sex is persistent, and is fortified with eschatological incentives and disincentives. Religious experience is subjectively intense; levels of participation in lively, expressive worship are high. Church members are highly socialized, meeting almost daily for prayer, Bible study, music practice or social events; interaction between men and women is overseen and monitored by senior members. Finally, there is the real risk of exclusion (from participation, or even membership) where a breach of the sexual code is suspected or proved. Mainline Christianity may feature these elements, but in much smaller doses. (Garner 1999)

Such interpretation of the mechanisms and antecedents of behavioral change must be considered speculative until confirmed by psychosocial research with adequate comparison groups. Although the KwaZulu Natal research was ethnographic, based on a small sample[3], and not representative of FBOs in general, the author's analysis of the mechanisms that reinforce abstinence and monogamy in the Pentecostal community suggests how and why FBOs might influence behavior.

What Is Meant by Behavior Change?

Behavior change is a term much used in AIDS prevention circles, and it is often used to mean reduction in risk of transmitting or acquiring a sexually transmitted infection by adopting condom use. One can make the argument that for a man who has had unprotected sex with multiple sexual partners for years, beginning to use condoms is indeed a change in behavior. But examined another way, condoms are really a risk- or harm-reduction solution for people who do not change their high-risk, multiple-partner behavior. John Richens of the University of London has proposed the term *primary behavior change* to distinguish more fundamental changes such as abstinence or delay and having fewer partners, from that of condom use. He formerly used "risk prevention" as distinct from "risk reduction" (Richens et al. 2000; cf. Garner 2000).

What can we say about primary behavior change? We can say from the evidence that primary behavior change occurs frequently as a response to direct perceptions of the threat of HIV/AIDS, as well as to interventions to promote primary behavior change. Summaries of responses to behavioral change questions show that

3 Research was based on "a year's ethnographic research, which included a survey of 334 households; 78 in depth interviews; and between 10 and 20 visits to churches of each of the theological types" (Garner 1999, 10).

respondents most often cite fidelity to a single partner or delayed age of first sex as responses, depending on respondents' age (those aged 15–19 are "delayers") (Cohen and Trussell 1996, 149; Gardner, Blackburn, and Upadhyay 1999; United Nations 2002, IX). The UNAIDS multicenter study in four African cities found that a lower number of lifetime sexual partners and a higher age of sexual debut were associated with lower levels of HIV prevalence—in fact, no other variation in behavior, including condom use, was significantly associated with HIV prevalence—especially after controlling for biological factors (Auvert and Ferry 2002). In addition, studies that have modeled the impact of different interventions on HIV infection rates in East Africa suggest that a reduction in the number of partners can have a great effect in averting HIV infection. The effect is greater than either condom use or treatment for sexually transmitted infections (Robinson et al. 1995; Bernstein et al. 1998; Auvert and Ferry 2002).

Where Demographic and Health Survey data exist from the same African country for more than one year and report age of sexual debut, sexually activity before marriage, and multiple partners, the behavioral trend is most often in the direction of less risk, even if the change is marginal (Mahy and Gupta 2002, 17).

One cannot help wonder whether there would be even more primary behavior change if these outcomes had been more rigorously promoted in secular as well as faith-based programs. We seem to find more primary behavior change in the few countries that have actively promoted behavior change (especially Jamaica, Senegal, and Uganda), and it seems that FBOs (along with schools and some other groups) have a "natural" ability to promote primary behavior change because abstinence and marital fidelity are central to the values of virtually all religions. There is growing evidence that promotion of behavior change is needed—along with condom use and treatment of sexually transmitted infections—to significantly reduce HIV infection levels. At a USAID-sponsored ABC Experts Technical Meeting in 2002, attendees concluded that a clear need exists for a balance of A, B, and C interventions. Furthermore:

> partner reduction emerges as probably the most important element of ABC, at least in generalized epidemics. Delayed sexual debut as part of "A" is also very important, especially for young women, as is targeted condom promotion for sex workers and people engaging in casual sexual encounters (U.S. Agency for International Development 2002,13).

FBO Contributions to HIV Prevention

Experience shows that national leadership and open discussion about HIV/AIDS are key factors in attaining stable or declining national HIV seroprevalence rates, but so is the involvement of religious leaders and FBOs in HIV prevention. In countries where religion is important, faith-based involvement may prove to be as necessary as condom social marketing, treatment for sexually transmitted infections, voluntary counseling and testing, and other state-of-the-art interventions in HIV prevention efforts. This is especially true in highly religious countries and in those in which FBOs comprise a major part of the nongovernmental sector. It makes little sense to mobilize only secular resources in such countries. Careful analysis is needed to determine the role that FBOs played in countries where national HIV infection rates have stabilized or decreased, and a comparison needs to be made with countries where this has not occurred. Qualitative studies and survey research are needed that include response categories that actively investigate the perceived roles of all aspects of religion.

In light of the apparent contribution of FBOs to positive behavior change, and possibly to a reduction in HIV and other sexually transmitted infection rates in countries such as Jamaica and Uganda, steps should be taken to overcome any conflict or antagonism between a faith-based approach and a secular, public health approach. Much can be gained by supporting religious organizations to implement their "comparative advantage," i.e., promoting what they call fidelity and abstinence. And that is precisely what most of these organizations want to emphasize. Forcing FBOs to work in condom promotion risks alienating them from AIDS prevention efforts, and thereby losing the great potential they bring to such efforts.

Is There a Downside to FBO Participation?

Is there a downside to FBO participation in HIV/AIDS mitigation, or to donor support of such efforts? Since President George Bush announced his faith-based initiative as a cornerstone of the new Administration's approach to delivery of social and humanitarian services in late 2000, debate about the pros and cons of faith-based initiatives has prevailed in various news media. These issues are worth considering because they might arise in discussions about FBO participation in HIV/AIDS activities.

Some who work in public health criticize a "moral" approach to HIV prevention on the grounds that such an approach is judgmental, that it relates to the values of particular groups, and therefore has no place in public health. The answer to this can be found in the present report: Consider the evidence that promotion of "fidelity" can result in partner reduction and promotion of "abstinence" can result in delay of sexual debut.

There is a counter argument that sexual behavior, especially when it involves coercion, rape, and seduction of minors, concerns itself with morals or at least ethics. Issues involving questions of right and wrong may well require an ethical answer. Noted sociologist Amitai Etzioni argued in a *USA Today* article in 2000 that AIDS prevention has become unduly "medicalized" when, in fact, it is largely a behavioral issue. He notes that in nations where fundamental behavioral change is advocated, such as in Senegal and Uganda, infection rates have "dropped drastically."

Some critics of FBO involvement in AIDS point to examples of religious faith healers who raise "false hope" by claiming to be able to cure or improve cases of AIDS through prayer or the laying on of hands. But anyone can claim miraculous AIDS cures: physicians, traditional healers, nutritionists, as well as religious faith healers. This does not mean that all faith-based groups should be excluded from working with donor funds in HIV/AIDS mitigation. Of course donor funds should not go to anyone making unsubstantiated claims. Yet some groups of people living with HIV/AIDS might even argue that the mere hope of recovery can help keep people alive who would otherwise die; indeed, it has been documented that depression and helplessness stress the immune system.

Another possible problem arises in the issues of separation of church and state. Clearly USAID cannot proselytize or support religious activity, but it can fund—and frequently has funded—FBOs to deliver health interventions. USAID has been funding FBOs such as World Vision, the Salvation Army, and Catholic Relief Services, awarding contracts on the basis of technical competence and experience in carrying out similar projects. In USAID's view, FBOs are a type of private voluntary organization that USAID funds because they bring experience, their own funds, and a record of achievement to international health and other sectors of development.

There is some concern that USAID and other donor agencies have different purposes and goals from religious-based groups, and that at least the smaller FBOs (with fewer financial resources) might become excessively influenced by USAID. However, this has not yet happened in USAID's support of FBOs. In fact, the technical assistance that private voluntary organizations acquire as a USAID grantee generally helps them become more effective in doing what they already do.

Other FBO-related policy issues are widely debated in the U.S. media. They focus largely on the potential role of FBOs in delivering social and health services in the United States, rather than in developing countries. But they are worth considering because they could arise in the context of international health. Among the points sometimes made:

- Public support for FBOs could lead to the government's favoring some FBOs (such as conservative, Christian ones) and discriminating against others (such as Muslim, animist or liberal, activist ones). Or the government might discriminate against FBOs that support policies that are out of favor with the current administration (such as contraception and choice in abortion). This raises serious constitutional issues of separation of church and state. It might also raise the possibility of lawsuits against branches of government.
- Public support for FBOs could lead to government interference with or creeping control of religious institutions. FBOs that rely on government funds would become less independent and more creatures of the changing policies of the government of the day. FBOs would also have to comply with U.S. (or other government) labor laws in hiring and adhere to other personnel policies that may be quite different from their current practices.
- FBOs would probably hire extra staff to carry out new or additional social services. Yet with the irregularities and uncertainties of government funding, FBOs would have to do just as much laying off of staff and new hiring. Some FBOs have used this as a reason not to become involved in the first place.
- Public support for FBOs could lead to a corresponding shift away from current government support of nonreligious private voluntary organizations, such as Pathfinder International, CARE, or Save the Children (to use examples from international health programs).

Over the past two decades, if we have learned nothing else, it is that our efforts to bring an end to HIV/AIDS will continue to be fraught with difficulties and seemingly insurmountable challenges. Partnerships between international government agencies and FBOs will have to confront their share of such difficulties, but the rewards of such collaborations have the potential to be great.

Conclusion

Although FBOs have been encouraged to play a stronger role in HIV prevention in the last several years, a conflict remains in many countries between taking a medical or "realistic" approach to AIDS prevention (and to behavior change specifically), and taking a religious or "moral" approach. The popular press and some AIDS literature pit medically enlightened progressives who recognize human behavior as it actually is against religious conservatives who moralize about how behavior ought to be. The former emphasize condom use and the treatment of sexually transmitted infections, whereas the latter emphasize abstinence and fidelity.

Many resource-poor countries have endorsed the so-called ABC approach to prevention (i.e., **A**bstain, **B**e faithful, or use **C**ondoms), in practice, however, most donor resources and programs go straight to the C option in one form or another, with remaining resources dedicated for treatment of sexually transmitted infections. Indeed, little effort has been invested to develop impact indicators to measure A or B practices. Measures of program effectiveness have focused on condom use and testing for sexually transmitted infections. As a result, there is a relative paucity of published data to document primary behavior change results, and even fewer data to link these results with program services or inputs. Moreover, there have been few rigorous evaluations of FBO programs. Existing evaluation results have not been much discussed or well disseminated. It is difficult and costly to measure separately the independent effects of various programs operating simultaneously and aimed at the same behavioral responses.

> Religious organizations ought to be given support to implement their "comparative advantage," i.e., promoting what they call fidelity and abstinence. And that is precisely what most of these organizations want to emphasize. Forcing FBOs to work in condom promotion risks alienating them from AIDS prevention efforts, and thereby losing the great potential they bring to such efforts.

Experiences in the Dominican Republic, Jamaica, and Uganda have shown that FBOs should not be forced to promote condoms. This component of HIV prevention already receives the lion's share of AIDS prevention resources. FBOs should be given support to do what they prefer to do, and what they do best: Promote what they call fidelity and abstinence.

FBOs provide a large proportion of care and support for people living with HIV/AIDS, their families, and communities, especially in poor countries where HIV infection rates are high. Yet relatively few international resources have been used to support either care and treatment or prevention activities by FBOs. The contribution of FBOs in providing care and treatment is relatively well recognized. This paper has illustrated the ways in which FBOs can contribute significantly to HIV prevention efforts. Because most religious organizations are not currently involved in prevention, they remain an untapped potential in the global fight against AIDS. The experience and evidence suggest that this resource should be further mined.

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