



Strange bedfellows: The Catholic Church and Brazilian National AIDS Program in the response to HIV/AIDS in Brazil

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ARTICLE INFO

Article history:

Available online 27 January 2011

Keywords:

Brazil
Religion
HIV
Institutional ethnography
Catholic Church

ABSTRACT

The HIV epidemic has raised important tensions in the relationship between Church and State in many parts of Latin America where government policies frequently negotiate secularity with religious belief and doctrine. Brazil represents a unique country in the region due to the presence of a national religious response to HIV/AIDS articulated through the formal structures of the Catholic Church. As part of an institutional ethnography on religion and HIV/AIDS in Brazil, we conducted an extended, multi-site ethnography from October 2005 through March of 2009 to explore the relationship between the Catholic Church and the Brazilian National AIDS Program. This case study links a national, macro-level response of governmental and religious institutions with the enactment of these politics and dogmas on a local level. Shared values in solidarity and citizenship, similar organizational structures, and complex interests in forming mutually beneficial alliances were the factors that emerged as the bases for the strong partnership between the two institutions. Dichotomies of Church and State and micro and macro forces were often blurred as social actors responded to the epidemic while also upholding the ideologies of the institutions they represented. We argue that the relationship between the Catholic Church and the National AIDS Program was formalized in networks mediated through personal relationships and political opportunity structures that provided incentives for both institutions to collaborate.

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Introduction

Religious organizations play key roles globally in relation to population health by providing front-line access to primary and terminal care, advocating for health and social welfare resources and influencing national public health and social policies (DeHaven, Hunter, Wilder, Walton, & Berry, 2004, pp. 1030–1036). The scientific analysis of religious responses to population health needs has thus far focused on identifying the barriers between religious policies and health promotion (Agadjanian & Sen, 2007; McGirk, 2008), and documenting religious approaches to public health interventions (Duan, Fox, Derose, & Carson, 2000; Sanders, 1997). It has described the effects of religion on health, especially in terms of psychosocial processes such as coping (Prado et al.,

2004; Simoni & Ortiz, 2003), yet often not analyzed why religious institutions become involved in public health policy and practice. Religious responses to HIV/AIDS provides an ideal scenario for examining institutional religious involvement in health precisely because of the controversies that the HIV epidemic has brought to the forefront of social debates.

The majority of literature on the involvement of religious institutions in responding to HIV/AIDS has focused on Africa (Agadjanian, 2005; Byamugisha, Steinitz, Williams, & Zondi, 2002; Maman, Cathcart, Burkhard, Omba, & Behets, 2009; Watt, Maman, Jacobson, Laiser, & John, 2009). Less attention has been paid to Latin America, despite the fact that the region has one of the strongest organized religious movements worldwide. Latin American has long-standing and complex ties between the State and the Catholic Church existing in nearly all the countries of the region. The very nature of the HIV epidemic has raised important new tensions in the relationship between Church and State in many parts of the region where policies and actions of governmental prevention and control programs, steeped as they are in a secular public health framework, frequently collide with key elements of religious belief and doctrine (Smallman, 2007).

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However, such contentious relationships have not always been the case. Brazil for example, nominally the world's largest Catholic country with over 125 million people (73% of the population) reporting being Catholic (IBGE, 2000), has an apparent national religious response to the epidemic articulated through the formal structures of the Catholic Church (Transferetti, 2005). The country is also unique for its widely recognized National AIDS Program (NAP) which has arguably produced the largest and broadest response to HIV/AIDS of any country in the developing world through a rights-based, solidarity approach to HIV prevention, treatment and care (Berkman, Garcia, Munoz-Laboy, Paiva, & Parker, 2005; Nunn, 2009; Okie, 2006). Building on the current literature regarding the Brazilian response to HIV/AIDS (Berkman et al., 2005; Grangeiro, Silva, & Teixeira, 2009; Nunn, 2009; Parker, 2009), this article presents original qualitative data from a five-year, multi-site ethnography designed to understand the social processes and contextual factors that structured institutional religious responses to HIV/AIDS over the past three decades (Seffner et al., 2008). We combine a historical analysis with contemporary, local experience, to suggest that the values of solidarity and citizenship, similar organizational structures, and interest in forming opportunistic alliances have formed the basis for the complicated, but strong, partnership between the two institutions. By linking the issues to a theoretical framework of interorganizational relations (IOR) theory (Alter & Hage, 1993), we seek to explore how this distinct history may advance our theoretical understanding of the ways in which partnerships are formed and sustained between religious, public health, and government institutions. Understanding the multilevel social processes involved may contribute to facilitating more fruitful partnerships between religious institutions and HIV prevention programs in other settings.

Background

The HIV epidemic is concentrated in Brazil, with the prevalence rate in the general population reported at 0.61% (Ministry of Health, 2010). While the largest number of cases continues to be among men, since 1998 there has been an increase in the number of AIDS cases among young women and young men who have sex with men (MSM) (Ministry of Health, 2010). The highest prevalence rates of HIV infection however have remain concentrated among MSM, female sex workers and injection drug users (estimated at 13.6%, 6.2%, and 23.1% respectively in a recent meta-analysis) (Malta et al., 2010). While AIDS cases have been reported in all of Brazil's five regions, the largest number of AIDS cases is concentrated in the Southeast (59% of the AIDS cases), followed by the South (19%) and Northeast (12%) (Ministry of Health, 2010). The Ministry of Health's response is multilevel, implemented through national, state, and municipal HIV/AIDS programs that support local projects with civil society organizations representing vulnerable population groups such as gays, transvestites, female sex workers and people living with HIV, and nationwide projects implemented through networks of organizations (including the Church).

Researchers have documented the fundamental role that civil society and non-governmental organizations played in structuring the country's response, tracing it to the historical processes associated with the period of redemocratization in Brazil (Grangeiro et al., 2009; Le Loup et al., 2009; Parker, 2009). In the mid-1970s to the mid-1980s, the country passed through a period of opening in civil society after decades of dictatorship that resulted in redemocratization. Several social movements came together in solidarity for reform in a wide range of sectors, including the health care system, eventually leading to the inclusion of principles of civil society participation, universality, decentralization, integral care,

prevention, and treatment of illness in the Constitution of 1988 and the foundation of the universal health care system (Sistema Único de Saúde – SUS). Thus, when the first cases of AIDS were reported in the early 1980s, Brazil was in the midst of a nationwide political discussion over the country's future in which social movements and opposition leaders articulated a vision of political solidarity and an economically, socially and politically democratic Brazil (Parker, Bastos, Galvão, & Pedrosa, 1994). This facilitated a connection between the national AIDS movement and other social movements, such as the gay rights movement and the sanitary reform movement (Parker, 2009). During this same period, Brazil developed its own multifaceted National AIDS Program, and state level, and a few local level, governments developed their own HIV/AIDS programs as well.

Some of the most important grassroots-based movements active in confronting the country's dictatorship in the 1970s and early 1980s were the Catholic Ecclesiastic Base Communities (CEBs – acronym in Portuguese) (Azevedo, 2004; Burdick, 1993). CEBs have religious values based on Liberation Theology; they emphasize grassroots involvement, individual self-esteem building, emancipation, and the people's ownership of social problems and solutions (Burdick, 1993). Thus far however, little attention has been paid to their role in building Brazil's response to the epidemic (Galvão, 1997; Parker, 2003). The research that does exist has focused on the macro level – on the Catholic institutional response as articulated through the National Council of Bishops (CNBB – acronym in Portuguese), the central source of official positions and bureaucratic power of the Catholic Church in Brazil (Transferetti, 2005). The official Catholic response to the epidemic, however, has not translated into a monolithic discourse throughout the Church hierarchy, specifically with regard to HIV prevention (Rios, de Aquino, Muñoz-Laboy, Oliveira, & Parker, 2008). The discourse suggests that a multilevel perspective (van der Geest, Speckmann, & Streefland, 1990) to data collection and analysis is necessary to understand the institutional dynamics and social processes that have structured the Church's response.

Furthermore, research has tended to focus on how each institution responded separately, without conducting analysis of social and cultural processes that facilitated the formation of networks between them. IOR theory (Alter & Hage, 1993) has been used in public health to explore how diverse networks and coalitions are formed among organizational partners to confront a variety of community health issues (Butterfoss, 2007). IOR theory draws on stage theory (Lewin, 1951) and elucidates a three stage continuum to explain the formation of collaborative institutional relationships over time: exchange or obligational networks, action or promotional networks, and systemic networks (Alter & Hage, 1993). In this study, we are particularly interested in understanding how two institutions with distinct, and at times, conflicting, ideological and organizational objectives came to be partners in the response to HIV/AIDS in Brazil, moving along a three stage continuum from informal exchange networks to systemic networks over time (Alter & Hage, 1993).

Methodology

Data presented here were collected from October 2005 through March of 2009 by Brazilian research teams in the five field sites of São Paulo, Rio de Janeiro, Porto Alegre, Brasília, and Recife. The Columbia University Institutional Review Board (IRB) approved this study, and the study protocol was translated into Portuguese and approved by the Committee of Research Ethics of the State University of Rio de Janeiro (CEP/UERJ) and by the Brazilian National Research Ethics Commission (CONEP). Interview respondents were read and asked to sign an informed consent form to participate.

We selected metropolises where the Catholic Church and Catholic NGOs have played a major role in shaping the dialog with NAP, in addition to choosing cities that reflect the diversity of the Church's response; in São Paulo, Recife, and Porto Alegre, there has been a long tradition of the Church having progressive Bishops who were sympathetic to issues of human rights and social justice whereas in Rio de Janeiro, the Bishop was much more conservative. The HIV epidemic is also highly prevalent in each city and they are located in four, out of the five, macro regions of the country. The use of multi-site ethnography (Marcus, 1995), with a multilevel perspective, focused on horizontal and vertical linkages between and within institutions (van der Geest et al., 1990) allowed us to gain insight into broader processes at the national level, and similarities and differences in how these patterns affected the local level.

Our methodological approach builds on Michael Burawoy's "extended case method" (Burawoy, 1991) in addition to the ethnographic framework used primarily in sociology and anthropology that begins by looking at specific experiences, behaviors, and practices and then works outward to draw conclusions about the codes, systems, and structures by which experiences are governed (Quinlan, 2009; Smith, 2005). Specifically, we relied on the following methods described in detail below: Archival research; Participant observation; In-depth and key informant interviews.

The reflexive science expounded by Burawoy is complementary to the interpretative nature of institutional ethnography (Smith, 2005). One of the methodological contributions of this paper is its emphasis on the intersubjective relationships that represent micro processes that occur on the ground; these micro forces are result of and also affect broader political and economic structures. We argue that this bidirectional relation between the micro and the macro can be used to reconcile some of the differences between the interpretive and reflexive paradigms for the ethnographic study of multilevel institutional forces. The extended case method provides a historical context for the interaction between institutions as they evolved within and between each other.

Archival research

Archival research was conducted through an analysis of academic journal articles, mass media articles, organizational and institutional reports and newsletters, the Brazilian NAP and governmental documentation to assess changes in the ways religious organizations have addressed HIV/AIDS-related issues over time (historical variations) and space (geographical and regional differences). Archival research was especially useful in identifying key informants with historical knowledge of the Catholic responses to AIDS in Brazil. All archival data was cataloged and stored at the local Brazilian partner institution by a trained archivist.

Participant observation

Participant observation (Bernard, 1994) was conducted at Catholic religious institutions, events and non-governmental organizations to gain first-hand knowledge of organizations in action and to witness how differently positioned actors (e.g., paid staff, volunteers, clients) perceive their own organizations. As is customary in ethnographic fieldwork, participant observation activities progressed through a series of stages and activities beginning with a broad mapping of the religious institutions and sites to closely examine organizational institutional dynamics and select institutions for extended ethnographic field observation. Ethnographers in each research site were trained to pay particular attention to the extent to which the religious groups were connected to the efforts of other religious, state, national, activist, and/

or social service efforts. Ethnographers attended local and regional religious seminars and religious ceremonies to observe whether and how dialog about HIV/AIDS was incorporated into interventions. Participant observation was also conducted in the national headquarters of the CNBB, where we observed how discourses played out into action on a national level. Participant observations were recorded in field notes.

Qualitative interviews, sampling and recruitment

Qualitative interviews (Bernard, 1994) were conducted with a total of 57 Catholic religious leaders across four of the field sites, including 16 in Rio de Janeiro, 8 in São Paulo, 15 in Porto Alegre and 18 in Recife. These research participants included 17 priests, 11 lay leaders, and 29 Catholic NGO leaders. Priests and lay leaders were recruited through a snowball technique, where priests led us to other priests and lay leaders that were willing to participate in this type of research. Catholic NGO leaders were selected based on the results of the religious institution mapping conducted during participant observation, and selected based on their time with the organization, involvement with HIV prevention and care activities, and leadership role within the organization.

Interviews with religious leaders focused on the individual's knowledge of the local and national history of the role of religious organizations in building the social response to the epidemic. The areas of interrogation in the category of religious leader included (1) religious belief systems as they relate to HIV/AIDS; (2) organizational structure and the internal organization of ecclesiastical power; (3) relations with the external world; (4) the construction of risk; (5) the construction of illness, care and treatment.

In the fifth research site, Brasília, we recruited and successfully interviewed fourteen former and current members of the Brazilian NAP, selected due to their extensive experience working in partnership with the Catholic Church. The participants from the NAP were asked a set of questions that covered (1) demographic data; (2) views on drug use, abortion, homosexuality, teenage pregnancy; (2) personal and professional trajectory in their responses to HIV/AIDS; and (3) how and in what way the NAP has worked with religious organizations.

Analytical strategy and data management

All interviews were audiotape-recorded and transcribed. Field notes were transcribed and analyzed in Portuguese and narrative data were coded using an open coding technique. All data, including interview and participant observation transcripts were kept securely at our principle local partner institution in Brazil. To organize the analysis of institutional change over time, we followed what Burawoy calls the four "moments" of the extended case method (Burawoy, 1991). The first moment is the participation of the observer in the community, which in this case is akin to our early stages of participant observation. The second moment is the extension of this participation over time and space to determine, through the observation of a succession of social events, the processes that govern an organization's functioning. Over time, and as the number of organizations and events observed increased, ethnographers identified themes such as "solidarity", "citizenship", "inclusion and care", "partnership", "capillarity", "strategy", and "reciprocity" within the interviews and organizational discourses. With this awareness of social processes in hand, the research team investigated the relationship between "micro processes" and "macro forces," which constitutes the third moment of case study analysis, aimed at understanding how forces beyond the community, such as political and economic developments, structure its functioning. In the final moment of analysis, the case study brings

observations from the field to bear on theoretical formulations, building generalizations and principles.

Results

In our analysis below, we focus on the basis upon which the institutional partnership between the NAP and the Catholic Church developed and was maintained over the course of the past three decades, noting differences between the study locations where appropriate. We identify three recurrent themes: (1) shared values of solidarity and structural understanding of HIV/AIDS; (2) similarities in backgrounds in terms of political history and organizational structures; and (3) the timely formation of mutually beneficial alliances. The most positive aspects of the relationship have revolved around treatment and care for people living with HIV. Prevention, on the other hand, has been a point of contention between the two institutions. Throughout our findings, we discuss how social actors blurred the lines between the dichotomies of Church and State and micro and macro forces in their efforts to confront the epidemic while both upholding, and at times challenging, the ideologies of the institutions they represent. Below we will elaborate on these tensions, and in the discussion, suggest the theoretical and programmatic implications of our findings.

Solidarity and structural understandings of HIV/AIDS

The earliest responses of the Church officials to the HIV epidemic were characterized by an extreme moral conservatism that contributed to an initial climate of stigma and discrimination. However, by the late 1980s, the Church's traditional concern with solidarity in the face of human suffering had begun to incorporate questions related to HIV/AIDS and people with AIDS into a range of concrete actions including the development of hospices and home care programs aimed at providing support for individuals suffering the effects of HIV. As one of the Catholic priests interviewed in Recife shared:

...the Church finds itself faced with AIDS. [With] the reality of the person that needs treatment, of the person that needs affection, of the person that needs to be included and not excluded... The Church places itself before an infected person that needs to be seen with mercy, with the same care that God wants us to have for any person. *Catholic priest*

Mercy and charity in the face of suffering were themes that ran throughout the interviews with NAP officials, Catholic clergy and religious organization leaders in all of the study locations. The Church was one of the first places people in need went, especially during the early years of the epidemic, both because of its important role in the community and because the Brazilian health care system had not yet been able to mobilize a response to the epidemic.

Since the beginning of the epidemic the government itself recognizes that these [religious] institutions end up providing a response that the government didn't have, especially if we look at the first support homes, they end up having a response of taking people in that the State didn't give. *NAP official*

A number of NAP officials emphasized the importance of the Church's response to those who had been ignored by other sectors of society. In the early years of the epidemic, there was an urgent need to respond to people facing a fatal disease, and the Catholic Church had more autonomy to respond at the local level than the universal health care system (which at this point was still centralized). As there was no anti-retroviral treatment, what

people most needed was care and spiritual guidance, which the Catholic Church often provided through an approach of inclusion and care by establishing half-way homes for people, Catholic and from other religious traditions, that were HIV positive and had nowhere else to go.

The importance placed on solidarity and a structural understanding of HIV/AIDS facilitated a partnership on two levels. First, the Catholic Church also held addressing poverty as one of the main tenets of social action in Brazil. Second, the solidarity approach, grounded in an understanding of HIV/AIDS as an outcome of structural violence, facilitated the development of multisector alliances between diverse groups of AIDS activists, academics, religious leaders, and health officials. As one of the AIDS Program officials interviewed stated:

We do not discriminate at the time of financing a project. We have a historical principle of respecting human rights, diversity, and it is through this viewpoint that we established a partnership with Church...The government has the obligation of talking and establishing a partnership with God and the Devil. ...I remember one day that is emblematic...that I was here at the [National AIDS] Program and in the same day, there was a meeting with the CNBB and in the other, [the director of the NAP] and producers of porn films to discuss the use of condoms in films with pornographic content. This gives a dimension to me, this story is emblematic of the dimension of the public we have to reach, it's fantastic. *NAP official*

For the NAP, solidarity extended beyond care and inclusion for those who were HIV positive to the formation of institutional partnerships with a diverse group of constituents. Within these partnerships, solidarity took clear priority over ideology, yet while for the NAP this meant being able to reach more people through prevention, for the Church, differences in ideological approaches and disconnects with the Vatican discourse were more problematic. Some officials interviewed at the NAP recognized this, and felt that collaboration with religious groups carried an inherent risk:

Do we run risks? We do, because you can have a collateral effect in constituting movements in moments when you have, for example, a very conservative change in a diocese, of work lost – all of that effort lost. What do you have with local ecclesial authority of a diocese when it changes direction: that work that you constructed on the next day may disappear to the degree that that authority can exert a position with the effect of dismounting the project's course. *NAP official*

The recognition of the agency and authority that certain dioceses held over the construction of their response to the epidemic created on one hand possibilities for fruitful partnerships between the institutions and on the other, a certain level of insecurity with regards to the possibility of a new diocese coming into power and adhering more strictly to Church doctrine. Hence timing, combined with the relative autonomy that the CNBB organizational structure allowed local church leadership, was critical to formalizing the relationship between the two institutions at historical moments when it was seen as mutually beneficial, and politically possible, for both.

Similar organizational structures

The degree, and manner, to which the Church responded in each study site frequently centered upon on the position of the local ecclesiastic leaders and the agency with which each diocese was able to articulate a response to HIV and AIDS with some degree of independence. A more focused discussion on how the religious and governmental bureaucratic structures manage discourses and

policies thus allows for a better understanding of how the Church has condemned and/or silenced prevention campaigns that promote condom use and respect diversity in sexualities on a macro level, while often times being more flexible in discourse and action at the micro level. This analysis shows some negotiation between politics and agency at the roots of these political institutions as they function on the local level and raises important issues for cross-cutting and comparative analyses of how the organs of the Church and other networks have dealt with issues related to prevention, treatment and care.

Hierarchically organized 'Pastorals' are segments of the organized Catholic Church that took on the bureaucratically structured social work as the grassroots mobilizations against the dictatorship in the 1970s–1980s decreased. As a Catholic priest from São Paulo stated:

A Pastoralist is he who puts his hands in the dough, he who stays with the people, next to the people. And the Canonist is he who stays linked to canonic laws. *Catholic priest*

The word "pastoral," was transformed from an adjective describing an action into a noun describing a dynamic and multi-level institutional structure. The decentralized nature of the Pastorals allows the CNBB to maintain a watchful eye on the branches of its structures by exerting symbolic power, *ex post* repudiation, and discursive silencing. This decentralization has applied to policy and dogmatic orientation as well as implementation. In other words, although local Pastorals respond to regional Pastorals, which respond to national Pastorals within a particular line of social actions – the Pastoral's distance from the "top" and "official discourse" impacts the implementation of the Church's policy on the local level, giving elbowroom for some priests to develop approaches to HIV treatment, care, and to some extent even prevention, that may contradict the structure of the international institution of the Holy See.

The clearest examples of this can be seen in comparing the local responses between the four of the study sites. In São Paulo, Recife, and Porto Alegre, there has been a long tradition of the Church having progressive Bishops who were sympathetic to liberation theology, political rights and the struggle against poverty that facilitated a more solidarity based approach to AIDS. The position of the Church in Sao Paulo was so distinct from other states that those interviewed mentioned HIV positive priests from all over Brazil coming to São Paulo in the beginning of the epidemic where many of them died of AIDS. Dom Paulo Evaristo Arns, the archdiocese of São Paulo from 1970 to 1996, and a political activist widely respected for fighting against inequality and human rights, worked closely with the state AIDS Program from the beginning of its foundation in the early 1980s.

In contrast, in the city Rio de Janeiro (different from the periphery where there was more progressive ecclesiastic leadership), Bishop Dom Eugênio Sales initially articulated highly stigmatizing commentaries through the media toward people with AIDS, associating the disease to sinful sexual debauchery and homosexuality (Sales, 1985, 1991). As the epidemiological tendencies of the epidemic shifted and began to affect women and children more expressively in the late 1990s and early 2002, his discourse also shifted to the central role these population groups played to the maintenance of family values (Sales, 2002) and conservative notions of sexuality education (Sales, 1994).

The extent to which the decentralization of the NAP over the past decade has had a positive effect on prevention actions at the local level is debatable. Whereas on the social level, health professionals know the community-related health barriers and facilitators best, on a programmatic level, health programs and local NGOs are often weak because of lack of human resources

and money for infrastructure, especially in poor communities where the state has difficulties reaching the population. This is precisely why the NAP, in its route to greater decentralization has involved grassroots networks of the Catholic Church and its Pastorals on the local level, as they are more apt to collaborate with public health prevention, treatment and care.

Due to their institutional structures and the distinct forms that decentralization has taken in each, activists from the AIDS movement have tended to be incorporated into the NAP, whereas those more active in AIDS work in the Church have stayed at the local level. The movement of social actors from local activism to political structures with national reach blurred the lines between the micro forces of local politics and the macro forces of institutional ideologies of the government and Church. For the Pastorals, the distance between the local and national level favored partnerships and more progressive policies for HIV care and prevention actions. For NAP officials with activist histories on the local level, movement into the NAP at times meant being able to expand their experiences and relationships on the local level onto a national scale. As the section below will explore, this overlapping of spheres and histories is one of the factors that led to the creation of mutually beneficial alliances between the two institutions.

Creating "Official" networks and political alliances

In the interviews, the institutional relationship between the NAP and Church was traced back to 1998 when HIV positive priests distanced from the Church due to their HIV status contacted the Civil Society and Human Rights (SCDH) department of NAP. SCDH was created in 1997 as one of the six departments of the NAP with the goal of facilitating a direct link between the government and PLHIV to strengthen NAP's actions focused on human rights, AIDS, and social inclusion. The first director of SCDH was a well-respected doctor, university professor, and activist involved in founding one of the most important NGOs of PLHIV in Niteroi (a suburb of Rio de Janeiro), *Grupo pela Vida*. In 1998, an HIV positive friar sought out the director of SCDH and the CNBB with the idea of developing prevention activities articulated through the structures of the Catholic Church. The director of SCDH brought the idea to the then Minister of Health, Jose Serra, a 2010 presidential candidate and former political exile with a long history linked to the progressive Catholic Church. A series of confidential meetings were held between the CNBB and Ministry of Health, and in 1999, a technical and scientific commission was created within the Health Pastoral to discuss AIDS and come up with the "official position" of the Church within the National Forum for AIDS-related NGOs. As the then director of SCDH stated with regard to how the initial meetings between the institutions unfolded, "The discussions were very good...it was hunger with a desire to eat together." The relationship between the Church and the Ministry of Health was formalized in 2000 when religious representatives, AIDS activists, and public health workers founded the AIDS Pastoral.

The AIDS Pastoral is a national network with regional with local branches of Pastorals that tap into community networks to promote HIV prevention and care activities. Since its beginning, the Pastoral placed importance on capacity-building and training community peer educators to work on care and prevention. It created an official guide for community agents that combines spiritual stories of the "Good Samaritan" with striking photographs of sexually transmitted infections, instructing community agents to "capacitate, study, comprehend, with naturalness, everything that refers to the human and understand the implications that a disease brings" (Pastoral de DST/AIDS, 2005:68). The juxtaposition of "Good Samaritan" stories, with photographs of diseases and emphasis on understanding shows that beyond treating the

epidemic as a biomedical problem, the AIDS Pastoral has understood the epidemic to be a social *and* religious problem. This was especially true in its attempt to work with other civil society organizations and the government on the de-stigmatization of living with HIV (Pastoral de DST/AIDS, 2005).

The expansion of the Pastoral's work to other countries in Latin America is the outcome of a relationship formed between a member of the NAP's Center for International Cooperation (CICT) and members of a Catholic NGO in Porto Alegre. CICT was founded in 2004 with the goal of facilitating South–South partnerships to strengthen and expand national responses to HIV in other developing countries. Similar to many of the technical officers in the NAP, the CICT official who facilitated the international expansion of the AIDS Pastoral was recruited to CICT from her role as the director of the Municipal HIV/AIDS Program in Porto Alegre. In the late 1980s and early 1990s, she developed a close relationship with a Catholic NGO that established a reference center to link PLHIV with local public health hospitals and train peer educators in the city's poorest communities. The NGO's work was perceived as being important because it was able to, in her words, “access a population that only they were able to reach”, at a time when the epidemic was expanding among the poor. She supported the NGO during her tenure as the municipal director with financial and technical resources, and after joining the CICT in 2004, continued to advocate on their behalf, promoting international meetings between the organization's leaders and religious leaders from other countries who also worked in AIDS. Whereas the Church's image of “washing the feet of the poor” (in the words of the NAP official from CICT) has facilitated, and incentivized, their relationship with NAP and expansion of the AIDS Pastoral work in Brazil and elsewhere, a national coordinator from the Youth Pastoral claims that the Roman Catholic Church washes its hands “like Pontius Pilate,” allowing for some of the most controversial issues (such as condom distribution) to be dealt with in a clandestine fashion at the base or grassroots level without disturbing (or voicing) its “official” alignment with the Holy See.

Moments of tension: condoms and compromises

The most positive aspects of the relationship between the NAP and Catholic Church have revolved around treatment and care for people living with HIV. Prevention, however, has been a point of contention between the two institutions since condom use took a lead role in NAP prevention efforts. While the NAP is well recognized for its solidarity with social movements of vulnerable population groups, the solidarity-based approach of the Church toward people with HIV has largely stopped when issues around sexuality become involved. NAP officials referred to this as one of their most delicate negotiations with the Church hierarchy but have maintained their stance that condoms must be included in prevention programs:

They [the Church] have to understand that the families do what they call sins, and they have to include the question of condoms, and other methods...there is a negotiation. The National [AIDS] Program does not want to say that “they have to use condoms,” but it has to be put out there that there are relations outside of marriage, and that for these relations to be safe, they have to be protected. *NAP official*

Prevention is one of the clearest places where discourse and action, even within the Church leadership, diverge. During the first meeting of the Bishops Council's National Seminar on AIDS in 2000, in which the Ministry of Health also participated, Dom Paulo Evaristo Arns claimed that when faced with death, condom use was a “lesser evil” (a claim he had already made publicly five years

earlier in the *Folha de São Paulo* [see Cavallari & Couto, 1995]). This, in turn, set off a series of ideological conflicts within the Church. More conservative Archbishops, such as Dom Frei José Cardoso Sobrinho in Recife, argued that the justifications for the “lesser evil” argument support decadence.

The NAP largely attempted to stay out of these debates, but on some occasions, it has directly confronted the Church. One particular instance was in 2003 when the NAP produced a short television spot in partnership with non-governmental organizations entitled “It's a sin not to use it.” The spot criticized the Catholic Church's position on prevention. The CNBB was so offended that it suspended its partnership with the NAP immediately, and eventually Brazilian President Lula became involved in an attempt to reconcile the two institutions. The dissemination of the video was prohibited on national television, and in response, the NAP wrote a public letter defending the video and its position:

The National Sexually Transmitted Diseases and AIDS Program of the Ministry of Health publicly defends the right to disseminate the video, “It's a sin not to use it”, that non-governmental organizations involved in the control of the epidemic made in response to the Church's position against condom use. We are in a democratic country, democracy that part of the Church itself helped to construct... The Brazilian government does not discuss the dogmas and individual and moral values of abstinence and conjugal fidelity. Nonetheless, we emphasize that these strategies are inadequate in terms of a public health policy to prevent HIV and other Sexually Transmitted Diseases (Globo, 2008).

The letter ends by recognizing the important contributions of the Church in the fight against HIV and AIDS in Brazil. While not undermining the political importance of the Church, NAP refused to back down from its primary obligation to prevent HIV and respect the diversity of the groups most affected by the epidemic in Brazil. NAP has currently adopted a stance of avoiding situations that could be contentious to facilitate the partnership with the AIDS Pastoral. For example, during the Pope Benedict's visit in 2007, NAP leadership decided it would be to its advantage to not attend the Pope's visit to a Catholic home for PLHIV – as the related publicity might simply create more problems rather than add to a dialog between the two institutions.³

Discussion

Three factors contributed to the articulation of a national religious response to HIV/AIDS articulated through the formal structure of the Catholic Church. First, shared values surrounding solidarity, a structural understanding of HIV/AIDS, and the rights of PLHIV to a full and healthy life formed the ideological basis on which the partnership between the Catholic Church and the NAP was formed. Second, organizational structures with spaces for responses and agency at the local level in both the Catholic Church and the NAP created a complementary institutional framework through which each could implement a local response. Third, mutually beneficial alliances and social networks between the two institutions made collaborative efforts strategic and effective at disseminating discourses nationally and responding to constituents locally. The institutional relationship is not without problems, yet the fundamental consensus between the institutions on care and

³ As we were finishing work on this article, Pope Benedict XVI announced what may be an important shift in his position with regards to condom use (Donadio & Goodstein, 2010), however it is still unclear how these recent declarations will be interpreted and put into practice.

treatment has allowed for differences regarding condom use and prevention to be negotiated over time.

Social actors situated within complex political, historical and social processes took advantage of changes in political opportunity structures (Tarrow, 1998) to formalize multilevel “systemic networks” (Alter & Hage, 1993) between the institutions. The networks evolved out of “exchange or obligational networks” developed between the Church and sanitary reform movement in the early in the 1980s. The transition period out of the dictatorship in Brazil opened up opportunities for participation for both the sanitary reform movement and grassroots organizing of the CEBs. The shift in the government contributed to a political environment of solidarity and a pervasive belief in the rights of the Brazilian population to health. These ideologies were imbued in the organizational structures created during this time, specifically in the Democratic Constitution in 1988 and the NAP in 1986, and were maintained throughout the processes of decentralization and bureaucratization that affected both institutions throughout the 1990s and 2000s. Informal networks between the institutions characterized the relationship until the 1990s when they began to work together on a local level in states such as Rio Grande do Sul through “promotional networks.” Influential allies on the local level eventually moved into the institutional structure of the Ministry of Health and were critical in establishing the mutually beneficial alliances and “systemic networks” that led to the creation of the AIDS Pastoral, and the expansion of the Pastoral’s work into other Latin American countries.

The existence of systemic networks between government and religious institutions is what makes the Brazil case study unique from other contexts where the role of faith-based, non-governmental organizations in providing responses to HIV/AIDS has been more prominent (Agadjanian & Sen, 2007; Chambre, 2001; DeHaven et al., 2004; Francis & Liverpool, 2009). As their name denotes, faith-based approaches have tended to focus on how adherence to certain faiths and religious doctrines can help solve ‘social problems,’ such as teen pregnancy and HIV (Chambre, 2001; Francis & Liverpool, 2009). Such approaches also act primarily on a local level. For example, in their literature review of faith-based public health strategies, DeHaven et al. (2004) found that the program scope of the majority (60.4%) of organizations included in the meta-analysis was limited to local congregations.

While the response articulated through the Catholic Church in Brazil differs from other countries, it is important to highlight that it is also distinct from, and influenced by, the institutional responses of other religions studied as part of this larger research project. Due to the structure of the funding mechanisms of NAP, collaboration is directed toward national networks, such as the Pastorals or the National Network for Afro-Brazilian Religions. The Evangelical churches in Brazil, while growing at an incredibly fast rate, are not linked by a national network, making it structurally difficult for NAP to work with them on an institutional level (Garcia & Parker, 2010). The CNBB organizational structure also facilitated the autonomy necessary for Catholics at the grassroots level to promote a positive image of itself at a time when Evangelical Protestants were challenging the hegemony of the Church (Birman & Leite, 2000). On an ideological level, the Afro-Brazilian religious traditions have been more open than the Catholic Church when it comes to issues surrounding sexuality and prevention whereas the Evangelical pastors interviewed tended to refer to nonheterosexual desires and behaviors as pathologies needing to be cured, and adopted prevention discourses more similar to those adopted by the more conservative wings of the Catholic Church (Garcia, Muñoz Laboy, de Almeida, & Parker, 2009).

There are several limitations related to the political nature of the case study and those interviewed that should be considered.

Interviews conducted with NAP officials should be interpreted as being framed within their official governmental stance. It is difficult to discern the differences in discourses and negotiations that may occur in private spaces. Similarly, the events observed through participant observation (in particular the capacity-building events) may not reveal all of the tensions in meanings and codes behind the discourses of both the AIDS Pastoral and the NAP. In addition, taboos related to sexuality and prevention made it difficult to access clergy members in Recife and Rio de Janeiro. This depended on the openness of the diocese to the research process. Some officials at the corresponding Archdiocese requested the interview instrument days prior to the interview for review. In these cases, lay leaders, such as Pastoral coordinators, were indicated by the Archdiocese as the most “appropriate” for the interview. We conjecture that the inclusion of issues related to homosexuality, condoms, and abortion made it difficult for priests to position themselves through recorded discourse. In some cases, this strategic silence may have been a mechanism to disguise their actions on the ground. The representation of priests and lay leaders is thus a convenience sample, and the incorporation of extensive archival research was included in an attempt to balance some of these limitations.

To address some of these concerns, future research should consider comparing Catholic leaders already involved in HIV work and those that stayed away from the topic. Additionally, exploring the impact of the Catholic Church in smaller and more remote municipalities in Brazil may provide useful insights for understanding how the responses are structured by economic, social, and cultural factors. Indeed, one of the most important lessons learned from this research is the need to examine the role of historical processes and social actors involved in constructing religious responses to the HIV epidemic, with a particular focus on the overlaps, and disconnects, between religious dogmas, organizational structures and larger political processes. Along these lines, a comparative study of the Catholic Church’s involvement in HIV prevention in other Latin America countries may illuminate how distinct political and economic forces in each country impact the Church’s response. Finally, on a programmatic level, our findings suggest that the Catholic Church would benefit from formally reconciling Church discourse with action on a local level. Interventions to reduce these hierarchical differences should be sensitive to the history and logic of their formation and direct their attention to social actors that challenge secularity by operating at the border between Church and State. Such an approach may facilitate more productive and effective work, particularly surrounding prevention and care for people living with HIV.

Acknowledgements

This article is based on data collected from the research study titled Religious Responses to HIV/AIDS in Brazil, a project sponsored by the Eugene Kennedy Shiver U.S. National Institute of Child Health and Human Development (grant number R01 HD050118-05; principal investigator, Richard G. Parker). This national study was conducted in four sites, at the following institutions and by their respective coordinators: Rio de Janeiro (Associação Brasileira Interdisciplinar de AIDS/ABIA—Veriano Terto Jr.); São Paulo (Universidade de São Paulo/USP—Vera Paiva); Porto Alegre (Universidade Federal do Rio Grande do Sul/UFRGS—Fernando Seffner); and Recife (Universidade Federal de Pernambuco/UFPE—Luís Felipe Rios). Additional information about the project can be obtained via e-mail from religiao@abiids.org.br or at <http://www.abiids.org.br>, the Associação Brasileira Interdisciplinar de AIDS (ABIA) website.

Jonathan Garcia was supported by F31 HD055153-02 from the Eugene Kennedy Shiver U.S. National Institute of Child Health and Human Development and by T32MH020031 from the National

Institute of Mental Health. The content is solely the responsibility of the authors and does not necessarily represent the official views of the NICHD, NIMH or the NIH. Support from the scientists at the Center for Interdisciplinary Research on AIDS at Yale University and the Center for Gender, Sexuality and Health was very valuable in revisions.

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