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Vulnerable salvation: Evangelical Protestant leaders and institutions, drug use and HIV and AIDS in the urban periphery of Rio de Janeiro

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Abstract

This analysis focuses on the evangelical Protestant responses to drug use and HIV prevention, treatment and care in the urban periphery of Rio de Janeiro. We question how religious institutions, and the positions of pastors, create or reduce various elements of societal illness and vulnerability. We aim to show that the views of pastors may symbolise a form of social regulation that may have a meaningful social impact on drug use and HIV and AIDS. The interviews of 23 evangelical religious leaders were collected using a theoretical sample and analysed through a grounded theory approach. Two case studies of evangelical drug rehabilitation centres are derived from five qualitative interviews. Evangelical drug rehabilitation centres generally reflect pastors' discourses of reintegration into social networks including marriage, family, and employment. We found important differences in the discourses and practices in private versus state-funded rehabilitation centres that may reveal ways social and programmatic vulnerabilities may affect the efficacy of public health interventions.

Keywords

Evangelical Protestant religion; drug use; HIV and AIDS; vulnerability; Brazil

Introduction

The proliferation of evangelical, especially Pentecostal, religions has been a worldwide phenomenon (Hunt 2000)¹. Globalising religious groups have not only formed transnational linkages, but also they have focused on establishing deep roots on the local level with distinct cultural interpretations (Hunt 2000). The health disparities in developing countries have presented challenges to the “wealth and health” gospel. In low- and middle-income countries and regions, a number of scholars have documented the importance of evangelical religious groups in strategizing to mitigate problems linked with HIV and drug use, which

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¹In Brazil, there has been a growth of evangelical religions (from 9% in 1991 to 15% in 2000) and a diminishing number of Catholics (from 83% in 1991 to 73% in 2000), according to census data (IBGE 2000). These groups include historical protestant churches, such as Baptists, Presbyterians and Lutherans. Pentecostal groups include groups such as the Assembly of God, the Quadrangular Church, the Universal Church of the Kingdom of God, and numerous churches and missions with unique names and followings.

have affected populations that are socio-economically and culturally marginalised (Hansen 2004, Todd et al. 2007).

Religious leaders and institutions could mould perceptions about HIV-related vulnerabilities (Smith 2004, Adogame, 2007, Eriksson et al. 2009) and drug use (Deng et al. 2007, Todd et al. 2007, Sanchez and Nappo 2008). Religious institutions, especially the rapidly proliferating evangelical groups, have high levels of community influence in impoverished and culturally marginalised communities in Rio de Janeiro that are considered to be the most vulnerable to HIV (Garcia et al. 2009). They may play an integral role in improving health indicators and social cohesion. Religions offer options for participation in the social world (Chesnut 2003). Religious organisations have stepped in to solve such “pathogens of poverty” (Chesnut 1997). In fact the “pathogens of poverty” can be termed the “pathogens of inequality” if we consider the role of racism, gender inequality, unemployment, discrimination based on sexual orientation, etc., in these areas. The role of evangelical religious institutions has been interpreted as a response to the societal illness and structural violence suffered by poor and marginalised women and men (Chesnut 2003, Burklick 1993).

Drug use and HIV have been considered societal illnesses. In Brazil, a total 22.7% of reported cases of AIDS were due to intravenous drug use (IDU) in 1997, decreasing to 7.2% by 2008 (Brazilian Ministry of Health 2008). In a multisite epidemiological study conducted in ten Brazilian cities (Rio de Janeiro, Manaus, Recife, Salvador, Belo Horizonte, Santos, Curitiba, Itajaí, Campo Grande and Brasília), Bastos (2009) found that the prevalence among drug users was 5.9%, much higher than the national prevalence of 0.7% in the general population. The decrease in cocaine injection has given way to a rise in the use of crack, which is associated with higher levels of sexual risk behaviours (Pechansky et al. 2006, Azevedo et al. 2007). Drug use, ranging from crack (Azevedo et al. 2007), to marijuana and alcohol, is still a major concern for curbing the AIDS epidemic in Brazil (Garcia and Siqueira 2005, Pechansky et al. 2006). The synergistic epidemic of drugs use and HIV is exacerbated by other societal problems, primarily due to *vulnerabilities* related to poverty, race, and sexuality, which tear at the social fabric. In the last decade, the Ministry of Health and the National Secretariat against Drugs (SENAD) has proposed the involvement and regulation of religious groups involved in drug rehabilitation (Garcia and Siqueira 2005).

The concept of vulnerability brings together individual, social, and programmatic elements of the processes such as the policy negotiation, the production of knowledge, and the invention of technologies for socio-cultural and structural health interventions (Ayles 1996, Paim and Filho 1998, Ayles et al. 2003, Ayles et al. 2006). The social vulnerability framework has been used mostly in HIV research to counterbalance behavioural approaches, which are said to attribute shame and blame to individuals that engage in risky behaviours (Delor and Hubert 2000). Social ties can reinforce a variety of norms and behaviours, such as the conceptualisations of health and illness (Kawachi and Berkman 2000). Vulnerability can denote a *process* where personal agency is shaped and limited by a dominant culture.

Programmatic vulnerability relates to the processes of governance and intervention that shape individual agency and social structures. The WHO defined programmatic vulnerability as having three fundamental components, “information and education, health and social services, and non-discrimination” (Mann and Tarantola 1996, p. 441). Some argue that in places where the state is weak, informal institutions act as substitutes in the provision of social goods (Isham et al. 2002). These social and political stakeholders affect the “availability and accessibility of key program elements, the quality and content of each element, and the process through which the elements are designed, implemented, and

evaluated” (Mann and Tarantola 1996, p.442). Both structures (programmes) and individuals (service recipients) can be affected by programmatic vulnerability.

Where the health system and the state have failed to reach large portions of the population, evangelical religious institutions and leaders have played a significant role in providing drug-related health services in Brazil (Sanchez and Nappo 2008). This paper uses the concepts of social and programmatic vulnerability to analyse the ways evangelical communities and institutions can address issues related to drug use and HIV. Whereas attempting to decrease drug and alcohol use may reduce vulnerability, claims that physical illness can be cured through spiritual rituals add a level of concern for HIV- and AIDS-related community interventions. First, the discourses of evangelical religious leaders are presented to uncover some elements of how religious leaders may frame vulnerabilities related to drug use and HIV. Then, two case studies of evangelical rehabilitation centres present an institutional perspective, contrasting ideological and pragmatic approaches that may depend on institutional relationships with the state.

Methods

Research site and social context

This study was conducted in the *Baixada Fluminense*, the urban periphery of Rio de Janeiro, between December 2006 and March 2009 as part of a larger study on the religious responses to HIV and AIDS in Brazil.² The living conditions of the *Baixada Fluminense* are historically marked by the high levels of poverty, attributed in part to geographic confinement and segregation due to urbanization (CIDE 2005, Garcia et al. 2009). According to Chesnut (1997), “huge labor surplus, even in the context of economic growth, ensures that salaries will not rise” (p. 15). Much of this population survives in precarious housing conditions and poorly functioning sanitation (CIDE, 2005).

Moreover, the relationship between poor health and life expectancy in urban poor Rio de Janeiro and areas with highest proportion of residents of poor communities and shantytowns suggest an environmental element of social disorganization, emphasising the importance of social cohesion as a resource (Szwarcwald et al. 2000). The more comprehensive analyses of health disparities are not simply measured by “hospital health” but by “environments in which people live” showing that “the residential environment cannot be simply considered as a compositional effect but rather as a contextual effect” (Szwarcwald et al. 2000, p. 534).

The absence of the state creates an ideal situation for the “parallel governance” by drug traffickers. According to Soares (1996), the parallel power of drug trafficking leads to a lack of transparency and to corruption in the penal system—leaving 90% of criminal cases open without a search for the identity of the assassins. The *Baixada Fluminense* is the area in metropolitan Rio with the some of the highest rates of violence, in comparison to other cities in the Brazil (HRW 2009). In fact, in these municipalities there is less than one police officer for 1000 people (CIDE 2005). Many deaths are caused by extermination by the police—officially justified as armed confrontations with local militia forces (Cano 1999). According to Marcelo Freixo, from the Centre for Global Justice, what is necessary is “security as a citizen,” including “rights to housing, to employment, to health, [and] to education,” which Freixo claims do not truly exist in metropolitan Rio de Janeiro (Martins 2004, Nadanovsky et al. 2009).

²The study was approved by the Columbia University Institutional Review Board (IRB), the Committee of Research Ethics of the State University of Rio de Janeiro (CEP/UERJ), as well as by the Brazilian National Research Ethics Commission (CONEP).

Sample selection and recruitment

We began sampling based the Brazilian Interdisciplinary AIDS Association's (ABIA) network of AIDS-related NGOs. From this sample we identified two evangelical AIDS-related faith-based organisations (FBOs). We recruited six religious leaders from these two NGOs. From these two FBOs, we were referred to drug rehabilitation centres run by evangelical pastors. We recruited five religious leaders from these centres. We continued our snowball sampling approach to expand our network of recruitment by asking the religious leaders who had agreed to participate in the study to indicate other leaders. Using this sampling technique, we recruited another 12 religious leaders from evangelical communities. Another 11 religious leaders were recruited through other evangelical FBOs and weak ties to ABIA. Our total sample included 23 evangelical religious leaders as shown on Figure 1. Generally, the trend shows that there are clusters of recruitment centred on the involvement of faith-based organisations. These organisations were inter-denominational evangelical, but Pentecostals tended to recruit other Pentecostals. Both drug rehabilitation centres (DRC) were associated with Pentecostal FBO₁ and FBO₂, and the state-funded DRC₂ tended to be located in a denser network than DRC₁.

The limitations of this study include the fact that only religious leaders were interviewed. Future studies should integrate an analysis of drug users with those of leaders. Interviewing drug users and people with HIV and AIDS bring out important elements of individual risk, but our attempt was to focus on the institutions (and leaders as proxies for institutional codes) in order to capture social and programmatic dimensions of vulnerability. Although the case studies cannot be generalised to represent all drug rehabilitation centres, this approach points to essential factors influenced by organisational structures, funding, and ideology.

Interviewing process and key questions

Qualitative interviews were conducted with evangelical pastors within the context of understanding their individual and institutional responses to AIDS, which included a component about drug use and HIV. The project's interview guide included open-ended and semi-structured questions. A research assistant with a background in HIV and social work conducted the interviews. Her knowledge of the religious field was crucial in order to form rapport with study participants, especially when asking sensitive questions regarding sexuality and drug use in their communities.

The first set of questions was regarding the individual religious leaders' perceptions and responses to the AIDS epidemic. Religious leaders were asked questions on (1) demographic data (age, marital status, monthly earnings); (2) questions about their religious communities (size, social work, gender, social problems); (3) their views on issues related to HIV and AIDS (including a history of their encounter with the epidemic, as well as their views on prevention, treatment and care for HIV and AIDS); and (4) questions on sexual and reproductive health (views on homosexuality, abortion, teenage pregnancy, fidelity, marriage).

The second set of questions was directed towards understanding the institutional responses of the religious group or FBO led by the religious leader. Institutional questions were used to construct case studies. These included (1) a historical trajectory of the institution including its funding and structure; (2) activities, related or unrelated to AIDS; (3) description of persons that use the services of the institution; (4) issues related to ideologies and the mission of the institution; (5) issues focused on the intersection between drug use and HIV risk (harm reduction, rehabilitation, abstinence, drug trafficking in their communities); and (6) articulation with civil society and the state.

Data Analysis

Data were managed and kept securely at the Brazilian Interdisciplinary AIDS Association (ABIA). The data was analysed using grounded theory (Glaser and Strauss 1967) through a selective coding technique. The authors open coded and verified observations using a qualitative codebook that was constructed manually. Then a spreadsheet in Microsoft Excel was used to compute data for all religious leaders. Key themes that were repeated in interviews were considered to have greater validity, and these were chosen for analysis in this article. Answers to open-ended or semi-structured questions related to drug use as it intersects with HIV vulnerabilities were of particular importance for this analysis. This intersection was the basis for selective coding into categories related to social vulnerabilities and programmatic vulnerabilities. Using discourse analysis, we aimed to contextualise the narratives of the religious leaders.

Results

Discourses of pastors

Drug trafficking urban poor Rio sets the backdrop for the involvement of evangelical churches on HIV. Through decades, pastors in the *Baixada* have witnessed how youth are susceptible to working in the drug economy because “even for those who do have the option of going to school and work, drug trafficking is a great subsidy that will get them money quickly,” explained the coordinator of evangelical AIDS NGO. This data reverts back to the expectations that poor neighbourhoods in geographically marginalised regions suffer from particular vulnerabilities.

“We know it should not be practiced, our society should seriously invest in combating drug trafficking and violence, but I am in favour of dialogue with these [drug gang] groups. I am also in favour of justice. But what is missing really is figuring out why it is all happening in poor communities on hillsides.”
(Presbyterian pastor for 11 years, congregation with 100 members)

We observed that the co-existence of religious institutions within drug-ruled communities is characterised by negotiation (“dialogue”) in observation of territorialism. Religious organisations may need to support (or not contradict) drug trafficking governance in order to survive, although they are “in favour of justice.” The negotiation necessary to work (or to conduct research) in poor areas with limited access to formal health care services is complicated and can be controlled by the legitimacy of religious organisations. These complex relations within civil society in places where there is an absence of the state create programmatic vulnerabilities that may be addressed through local community institutions, such as churches.

From the discourses of pastors, we found that drug use and the rehabilitation from addiction were key elements of evangelical cures for social problems, which could be interpreted as attempt to cure vulnerability. Drug use was universally attributed to the manifestation of evil and in some cases demonic possession. All pastors used religious ideological discourses to regulate (or “dominate” as argued by Bourdieu, 1979) social interaction, at the same time that these discourses are strategic tools for welcoming those afflicted by the pathogens of inequality into the religion. While all churches welcomed drug users, there are elements of stigmatisation involved in the social processes of religious indoctrination.

“People who are dependent on drugs sometimes seek help.... So the Bible is rule that turns to practice. These [drug users] are immoral. It is our desire to rehabilitate them from the vice to spiritually.” (Pentecostal pastor for 7 years, congregation with 400 members)

The ways of addressing vulnerability are not limited to adherence to the Scriptures, but they depend on the social interactions that occur in churches and on the effect that the family may have in providing social support. In this vein, another pastor makes a link between several social areas in which his church's *programmes* interact with its surrounding community, alluding to alcoholism, marriage and HIV.

“Our church's structure has programs for alcoholics, for marriage...because of poverty. [Our work] is called the Ministry of Family, of couples; we act in this area. And, working with HIV, we could recuperate the community.” (Baptist pastor for 4 years, congregation with 260 members)

Churches have programmes directed towards increasing social cohesion according to their ideologies. The greatest emphasis was on reincorporation into society, especially into the family and into work. One pastor emphasises the importance of the incorporation into the family and home for leading a healthy life.

“It is important that he enter into the path of a normal life, transformed. I have witnessed it. The family who thought there was no other way, and today is in the church in the path of the Lord, and I praise God for that. Now my worry is with their families. Why? The family always saw the things that they did wrong, the crimes they committed. We preach the Gospel and that to the Lord Jesus Christ will help the person recuperate and return home.” (Presbyterian pastor for 6 years, congregation with 140 members)

Table 1 summarises our findings based on selective coding, which map out how community formation and views of pastors regarding drug use and HIV may affect vulnerabilities. The table also shows solutions proposed for these problems that emerged most commonly in the interview narratives.

On another level, all pastors except for one thought abstinence and rehabilitation (not harm reduction) were the only ways to cure addiction and reincorporate people into society. The following pastor had to negotiate her actions and her discourses.

“My prevention is a bit radical, but it does not treat society as if it had no knowledge. I am in favour of the government in syringe exchange because there is a greater risk in injection drug users. I am in favour of government subsidies that do not view this as risk.... If I went on the pulpit of my church and preached that, they would say I was not as pastor.... In truth, I live a paradox. I live a constant war because I preach socialization and rehabilitation.” (Ministry of Jesus, Pentecostal pastor for 8 years, congregation with 1300 members, leader at faith-based organization leader for AIDS services)

The pastor acts differently behind the pulpit than she does at her faith-based organisation. Her views at the pulpit may increase social vulnerability. Her work at the FBO may be considered an intervention that decreases programmatic vulnerability by providing services in marginalised populations that are hard to reach by the state. While this pastor shows openness to curbing transmission through injection drug use, there is still some lack of knowledge related to the risks of HIV infection associated with other drugs, such as crack cocaine.

Case study results

There may be a positive effect and reduction of social vulnerability through social integration. The idea of spiritual cures for social ills (including drug use and HIV) and the rejection of condoms by pastors may increase vulnerability within rehabilitation communities. The question remains of how these private or state-funded initiatives can

affect programmatic vulnerability if we consider the state's outsourcing of social services to civil society organisations. The contrast between one centre that is funded privately by the community and another that is state-funded provides important insights about vulnerabilities addressed by contrasting institutional types and their approaches.

Case 1: Community and privately funded rehabilitation centre

The work with the spiritual and physical rehabilitation of men was inspired by a preacher who carried out a more “institutionalised” version of the interviewee's first project. The pastor we interviewed organised and founded a halfway house, which received extremely negative responses from his neighbours. They created a legal petition to expel him from the community because he lived with vagabonds. He was surprised with the community's reaction considering that “most of them were evangelical,” and had to pause his work until he moved to another municipality. There he constructed—this time with donations and volunteer manual labour from neighbours—his first shelter, which also developed with contributions from evangelical churches in its environs.

After two decades, the centre offers services such as housing, feeding and establishing personal hygiene for male drug users. The facility now houses 41 men. The funding comes from the evangelical churches, community donations, and assistance from some private companies (“with hearts moved by God”). There is no funding from the state, which “makes the work difficult but God keeps them from scarcity,” according to the pastor. The funding structure, as well as the mission of the institution determines the way the institution is organised, allowing for a small salaried staff of six social workers. The coordinator of the group acts as “disciplinary figure” to the interned.

During the period of recuperation, which lasts approximately nine months, there is a continued effort to reincorporate the person into his own family, if he has one. He becomes a volunteer at the institution if no family network is found. Those who do not wish to participate in religious activities are expelled from the facility, indicating the strong emphasis on indoctrination—for “they must obey the leaders; if they do not obey the leaders it is not possible to carry out the work of recuperation,” claims the pastor. The discipline given through work is part of the process of reintegration into society and communities, and it includes providing basic rights for these men through legal registration, identity cards, the equivalent social security number, and a work card.

Moreover, the “majority of the men interned at this facility are HIV positive, but they are not open about it,” according to the pastor. In most cases only the staff knows, while in other cases it is visible that they are living with AIDS but do not want to admit it. One problem that created programmatic vulnerability was the delay in the HIV testing process because of the inefficiency of the health care system. It took six months to attain HIV test results. Due to the lack of facilities in the *Baixada Fluminense*, this process is slower, displaying a great concern for programmatic vulnerability. The fact that there are few facilities also creates greater external and auto-stigma because people are afraid of being seen by others in their own communities.

The pastor talked about an HIV positive man at the institution that had been involved in drug trafficking. The man believed that “he did not have to take medications, but God would cure him.” And “when his viral load was undetectable, and he recuperated from drug use, it was a miracle.” The pastor “respects” when the HIV positive person “truly believes and places his faith on spiritual cure.”

“We understand by the Bible that he who believes receives victory in Christ. We had an HIV positive man who needed treatment; God would cure him. In the Bible

there is a text in which a blind man screamed ‘Jesus have mercy on me,’ and in this plea, he wanted Jesus to cure him. When Jesus came closer to him, he asked, ‘what is it you want? I will do it.’ If the blind man asked to see, it is because he believed, so Jesus automatically cured him. So that happens today when the person confides, beliefs entirely that God can cure him. This was the case of this young man. Eventually, when he wanted to get married, he no longer needed to go to the doctor for treatment.” (Pentecostal pastor and missionary, 20 years of service)

The organisation works with “physical, moral and spiritual recuperation” and not with harm reduction, according to “the work of God as written in the Bible.” The pastor believes that the way to prevent transmission of HIV is through what he calls the “pact.” In what seems to be a contract, God stipulates, first, that abstinence should be practiced before marriage, and, second, that fidelity during marriage will protect the man and the woman from such diseases. Condoms are for those who break this pact, immediately attributing sin to their use.

Case 2: State-funded rehabilitation centre

This institution began over two decades ago as a drug rehabilitation community linked directly with an evangelical church. After the pastor founded the community, it was soon established as a state-funded clinic for drug dependency, with support from evangelical politicians. The pastor interviewed asserts the reason that this community was chosen for public funding was because “the community has *know-how* in dealing with chemical dependence.” The structure of this entity and its areas of action are all related to treating facets of drug abstinence and rehabilitation. The NGO is directly related a church in leadership and networks. The president is a pastor, and his wife and daughter are co-directors of the facility. All of the staff of the NGO belongs to evangelical churches.

The organisation has approximately 90 workers, including doctors, psychiatrists, psychologists, social workers, and nurses, among others, to provide “bio-psycho-social” attendance. There are 190 persons receiving services, 170 men and 20 women. In the interview, the pastor suggests that gender disparities may be due to the fact that men have “tended to not adhere to treatment as well as women,” and that the involvement of men in drug trafficking draws men closer to drug use. He offers an alternative explanation: “the religiosity of women and adherence to belief systems that pronounce a cure is different than that of men,” arguably making women less vulnerable.

“Not staying merely on the spiritual issues, we offer a fusion of the biotechnical and the spiritual, psychological. Before, the most [frequently] used drug was marijuana, it was the most offensive, but today it is cocaine and actually crack, a drug that destroys the capacity of thinking in the human. The NGO needed to be dynamic with such changes, not just focusing on the spiritual, providing incentives for the person to study psychology.... This is why we consider the technical and the spiritual, so that we can meet peoples' needs; it's not just a question of prayer. You need the point of view of medicine, and the social also. There should be a bio-psycho-social and spiritual approach. This wider view of the behaviour of the individual has been occurring since the foundation of the organization.”
(Coordinator of NGO)

In order to enter the facility, financed by the state, the subject goes through a triage with medical professionals that evaluate the condition of the drug user. Activities include: cleaning, individual consultation/treatment, talks, group meetings, twelve-step groups, and leisurely activities. Religious services are central but optional to avoid breaking the separation between church and state. As the pastor explains:

“We have, Wednesday at fourteen hours, Sundays from ten to eleven in the morning, but service is not an obligation, it's optional. It's important because it is a government project, which calls itself laical (laughs); you have respect.”
(Coordinator of NGO)

The organisation had some lectures on HIV and AIDS. The main topics of conversation were (1) marriage and coping with AIDS, (2) employment and AIDS-related discrimination, and (3) how to maintain social bonds when infected with HIV. The NGO does not work with HIV prevention through the distribution or promotion of condom use. When the pastor was asked whether the NGO supported condom use, there was a prolonged silence, and then he responded:

“It's not that the rehabilitation centre is in favour of the condom, but it's a double-edged sword. The NGO is in favour of sex as it was written in the Bible, of fidelity, after marriage.” (Coordinator of NGO)

However, in this institution, AIDS is not seen as a punishment from God. Instead:

Today this church is trying more and more to act without prejudice, through *information*. The church cannot stay restricted to the question of religion, as Jesus had a broader understanding of the human being, of human necessities. So for Him the leper did not shock him, [nor did] a prostitute. He gave them value, cured, and gave them words of hope and incentives. And today the church needs that—not to point at people. (Coordinator of NGO)

The ideas of access to information and linkages to other health services address important aspects of programmatic vulnerabilities encountered by institutions that treat drug users. The state could be passing-off responsibility for public drug rehabilitation to this centre because of its “know-how,” but the clear social norms against condom use create higher levels of vulnerability.

In comparing both case studies, there seems to be a stronger focus on spiritual cures in the privately funded centre, although the state-funded centre also supports spiritual cures for drug use and HIV if the person chooses to be saved. In both cases there is strong emphasis on religious participation, an entirely evangelical staff, and the possibility of spiritual cures. The state-funded institution integrates a “bio-psycho-spiritual” approach to treatment through methods such as twelve-step programmes, which comparatively lower vulnerabilities related to alienation. The scale of the state-funded centre is greater (41 members in case one versus 190 members in case two). There is also a difference in target populations. In privately funded first case, only men are served, mostly homeless, while case two 10.5% of those served are women. The emphasis on abstinence and marriage, as well as the symbolic prohibition of condoms creates a set of vulnerabilities. By comparing these two cases, it seems that state funding provides staff and infrastructure, as well as stricter guidelines, which make treatment closer to a biomedical model. Overall, we can say that state funding decreases programmatic vulnerability, but is it the duty of the state to provide these services directly or should these services be outsourced to religious groups?

Discussion and conclusions

This paper argued that values reinforced by social integration and inculcated religious ideology might be both barriers and facilitators to the pursuit of better health practices, particularly in addressing drug use and HIV. The frameworks of social and programmatic vulnerabilities developed early in the epidemic by Mann and Tarantola (1996) are employed to understand the quality of these health services, as they are mediated by discursive and programmatic intervention.

The framework of “vulnerability” has been used frequently in HIV and AIDS research, but it has seldom been applied to drug use (Ayres et al. 2003). The paper offers an argument that religious institutions have a greater opening in places where the state has limited access to health, as was also indicated by studies such as Sanchez and Nappo (2008). This was true in poor, geographically marginalised communities in the peri-urban Rio de Janeiro, where drug cartels have power to negotiate the actions of local institutions. The interactions and legitimacy of religious institutions may mitigate violence in the governance of these communities.

We first looked at the evangelical communities through the discourses of the evangelical pastors. We highlighted the importance of religious institutions in these communities and implications of vulnerabilities associated with the “pathogens of poverty” (Chesnut 1997) or rather the pathogens of inequality. We found that the evangelical discourses regarding drug use and HIV there may be increased social and programmatic vulnerability by advocating spiritual cures and not accepting harm reduction in some cases. Religious institutions and leaders reinforce community values and morals. These may be ideologically and symbolic domination (Bourdieu 1979) driven by scriptures, the social agendas of religious leaders, as well as by the needs of the community.

Notwithstanding, the focus on reintegration into communities, marriage, families, and employment may decrease vulnerability by establishing valuable social ties to institutions and networks—increasing social cohesion in places where societal illnesses such as drug use and HIV may affect social disintegration. Social integration and cohesion can be important in shaping the levels of agency of individuals as well as the structures and institutions in extremely marginalised populations.

The idea that religious institutions can garner support from the state was an important finding. From our discourse analysis and case studies, there are several questions for further research that emerge. Should the state pass some responsibility for the reduction of drug use and HIV infection to religious organisations, considering their possible use of ideological indoctrination? Can institutions, such as FBOs and drug rehabilitation centres run by evangelical religious leaders, reduce the vulnerabilities stigma associate with HIV and AIDS if there is greater state and public health collaboration? In part, the state has been efficient at “delegating” responsibility to civil society in providing such services, even incentivising the growth of civil society networks. When not shaped by the public commitment and control that state affiliation tends to promote, as shown in the case studies, religious moralist and dogmatic discourses and practices may increase the vulnerability of drug users by disregarding human rights, increasing stigmatisation, inhibiting condom use, etc. Analysing the local impacts of a global phenomenon provides a window into the complexities in the responses of civil society and the state to drug use and HIV, especially in countries where the intervention of the state may be limited by economic scarcity and socio-cultural marginalisation.

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Figure 1. Sampling and associations among ABIA, FBOS, and religious leaders

- DRC (Drug Rehabilitation Centre)
- FBO (Faith-based Organization)
- ABIA (Brazilian Interdisciplinary AIDS Association)

Table 1
Tiers of vulnerability and evangelical approaches to societal illness

Vulnerability	Societal Illness	Approaches/Solutions
Individual	<ul style="list-style-type: none"> • Overindulgence • Libertinism • Youth 	<ul style="list-style-type: none"> • Abstinence • Spirituality/religious cures • Psycho-spiritual treatment
Social	<ul style="list-style-type: none"> • Disintegration of values • Straying from community 	<ul style="list-style-type: none"> • Marriage • Integration into family • Employment
Programmatic	<ul style="list-style-type: none"> • Lack of information • Absence of state • Drug economy 	<ul style="list-style-type: none"> • Church activities • FBO participation • Drug rehabilitation centre

Table 2
Comparison of drug rehabilitation centres, according to sources of funding

	Community and Private Funding	State funding
<i>Composition</i>	41 Men	170 Men and 20 Women
<i>Highest target population</i>	Homeless men	Youth
<i>Religious association</i>	One evangelical church	Interdenominational evangelical churches
<i>Methods for HIV Prevention</i>	Abstinence and Fidelity in Marriage, not condoms	Abstinence and Fidelity in Marriage, preferably not condoms
<i>Treatment and care for drug use and AIDS</i>	Spiritual cures, rehabilitation, social integration	Spiritual cures, rehabilitation, social integration, biomedical and psychological treatment