Combating HIV and AIDS Related Stigma, Denial and Discrimination

A TRAINING GUIDE FOR RELIGIOUS LEADERS
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Thanks as well go to Mr. Tsegaye Chernet, Ms. Jane Gaithuma, and Ms. Zebib Kavuma in the African Council of Religious Leaders/Religions for Peace office in Nairobi for guiding the development and editing of this manual; to Dr. Francis Kuria of the Inter-religious Council of Kenya for extensive review and editing; and to Rev. Canon Gideon Byamugisha for preparing the initial draft of this manual and for his tireless dedication and leadership in reducing stigma throughout Africa and globally for those living with and affected by HIV and AIDS.

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Religions for Peace—the world’s largest and most representative multi-religious coalition—advances common action among the world’s religious communities for peace. Religions for Peace works to transform violent conflict, advance human development, promote just and harmonious societies, and protect the earth. The global Religions for Peace network comprises a World Council of senior religious leaders from all regions of the world; more than seventy national and four regional inter-religious bodies; and the Global Women of Faith Network and Global Youth Network.

One area of multi-religious cooperation that has been a long-standing priority is the well being of children and families. In 2000, in an effort to respond to the devastating impact of HIV and AIDS was having on families and children in Africa, Religions for Peace entered into a partnership with four other organisations—Plan International, Save the Children Alliance, Society for Women and AIDS in Africa (SWAA) and CARE international, later joined by World Vision International and Network of African People Living with HIV and AIDS (NAP+), to form the “Hope for African Children Initiative” (HACI) whose mandate is to expand community based responses to the impact of HIV and AIDS on orphans and other vulnerable children (OVC) in Africa.

Within HACI, Religions for Peace has had a particular mandate to strengthen advocacy among religious communities, on a pan-Africa scale, to address challenges related to the AIDS pandemic that often deprive children of basic social services and even the support of their extended families, such as stigma and discrimination, abuse and sexual exploitation among other issues. HIV and AIDS advocacy helps drive a more effective response globally, regionally and nationally.

This training guide is meant to strengthen the commitment and skills of religious leaders to combat HIV and AIDS related stigma and discrimination in religious communities and in the broader society at both national and community levels. Active engagement of PLWHA is seen as paramount in defeating HIV related stigma, and this handbook suggests various ways in which religious leaders can work hand in hand with PLWHA to combat it. Empowered and motivated families, congregations and communities will stimulate development, planning and programming for practical local interventions by addressing issues of stigma and discrimination to improve HIV prevention, care, treatment and support.

This engagement will in turn build religious community ownership in regard to HIV and AIDS by showing that stigma and discrimination do exist and how the religious leaders, congregations, communities and their institutions can make a difference in combating it.
Introduction

1.1 GOALS AND OBJECTIVES

This training guide contains a training manual and handbook on HIV and AIDS related Stigma, Denial and Discrimination (SDD) for religious leaders, which provide leaders and facilitators a comprehensive information pack on the twin issues of HIV and AIDS and SDD.

The purpose of the training is to equip religious leaders with the information, skills and other tools necessary to:

- Enhance knowledge and understanding on HIV and AIDS related stigma, denial, and discrimination;
- Strengthen their commitment as agents of change for increased HIV prevention, AIDS care, treatment and impact mitigation and for reduction of the stigma and discrimination associated with HIV and AIDS in congregations, communities and nations.

The manual provides the training guidelines and process while the handbook section provides the background and factual information. Religious leaders and lay trainers who are well versed in the background information on HIV and AIDS and SDD may not need to refer extensively to the handbook. However, those versed in training methodologies and have their own curricula and training schemes can use the information in the handbook to include a module on SDD in their own training schedules.

Training Objectives

The training will allow a process of:

- Sharing and learning information and experiences related to HIV and AIDS related stigma, denial, and discrimination (SDD);
- Identifying and addressing myths, misconceptions, inappropriate attitudes, policies and actions which tend to perpetuate and enhance HIV and AIDS related SDD;
- Appreciating and utilizing accurate information, appropriate attitudes and communication/programming skills for:
  - Preaching and practicing love and compassion for those infected and affected by HIV and AIDS;
  - Formulating and implementing effective training programs for increased HIV prevention, AIDS care, treatment and impact mitigation at a congregation and community level; and
- Increasing advocacy initiatives for accelerated HIV prevention, AIDS care, treatment and impact mitigation.

Specific Learning Objectives

At the end of the course, religious leaders will be able to:

- Demonstrate their understanding of HIV infection and related concepts
- Discuss modes of HIV transmission and methods of prevention
- Rebut myths and misconceptions of HIV and AIDS
- Describe HIV and AIDS related stigma, denial and discrimination
- Discuss major sources and manifestations of SDD
- Understand and apply effective interventions for combating SDD at various levels
- Demonstrate understanding of effective promotion of the Greater Involvement of People Living with HIV and AIDS (GIPA) principles.

1.2 RELIGIOUS LEADERS AS KEY PLAYERS IN REDUCING STIGMA

Religious leaders must be key targets in the fight for reduction of SDD, because of the roles they play in the communities they serve. Their roles are unique and touch on all spheres of life. At their best, religious leaders perform the following functions:

- They instruct, guide, encourage, correct, mediate and care for members of their faith communities through all aspects of life, including death.
- They plan and lead worship, prayer and other related ceremonies of a given faith community
- They interpret doctrines, rituals, beliefs, and codes of conduct in light of new findings, new experiences, and unforeseen circumstances and/or problems.
- They act as representatives of their religious institutions in the community
- They teach people about various life issues including
  - How to seek out what is right, good, lawful and
safe and  
• How to avoid what is wrong, bad, unlawful and unsafe  
• They encourage growth, learning and action in religious thought, belief and practice  
• They promote good health and well-being of the people in their individual lives, families, local communities, nations, and in the global community

Religious leaders have moral authority in the community. They play a major role in determining the direction taken by the community. They are considered to be role models and their actions and deeds are regarded highly.

Religious leaders have a unique catalytic role to play in addressing stigma, denial and discrimination within communities. They can influence a community’s response. Religion is full of hope for humanity, especially for the ones who are suffering in the community. This can be translated into action to support those infected and affected by HIV and AIDS.

In carrying out all these roles; not only are religious leaders well placed to address HIV and AIDS related stigma, denial, and discrimination but they also have the mandate and the responsibility to overcome these issues in the following ways:

a) Stigma kills and makes people suffer unnecessarily; religious leaders need to fight it;

b) Denial, inaction and misaction make already bad situations worse; religious leaders need to confront them;

c) Discrimination leads to rejection, suffering, misery and low quality of life; religious leaders must work to discourage and eliminate it; and,

d) Stigma, denial, and discrimination attack both the glory and the promises of God and can lead to sickness, death and disruption that could have been prevented or delayed; religious leaders are called on to defeat them.

1.3 PREPARATIONS FOR TRAINING

a) Understanding the Process
This training guide for accelerating the reduction of HIV and AIDS related stigma, denial and discrimination relies strongly on allowing God to work with and through people, by cognitive (what to know), affective (what to be), and psycho-motor (what to do) processes.

The training approach used in this course is highly interactive and participatory. The participants will have many opportunities to work in small groups applying principals of adult training/learning methods. This course will be based on the assumption that people participate in training courses because:

• They are interested in the topic
• They wish to improve their knowledge and/or skills and thus their job performance
• They desire to be actively involved in course activities.

A facilitator, therefore, needs to understand how to guide these processes.

A variety of methods can be used to realize the goal and objectives of the training workshop. These include but are not limited to:

• Telling and listening to peoples’ and communities’ experiences in relation to AIDS related stigma and discrimination
• Guided discussion and brainstorming
• Group activities
• Exploratory and discovery exercises
• Video shows
• Mini Lecture/Discussion

These learning processes will challenge participants on both their attitudes and knowledge, while exposing them to the needs, realities, and opportunities related to defeating HIV and AIDS related SDD.

The facilitator has the opportunity to change people’s lives, attitudes and views but this opportunity can be gained or lost in the preparatory stage. Hence, the need for good preparation as this will play an important role in achieving the desired goals.

b) Know the Audience, the Venue and Resource Requirements
The ideal size of a group should be between 15 and 25 participants. The facilitator should be aware of the following characteristics:

• Age range
• Past experience, especially in HIV and AIDS knowledge
• Whether or not they have attended any previous workshops or conferences on HIV and AIDS
• Level of education or training both in general and religious education
• Most suitable or preferred language of instruction
• Expectations for learning in the workshop
• Expected roles and responsibilities after the training as a result of the information, skills and attitudes they gained from the workshop

The facilitator might also take the following suggestions into consideration during the planning process:
• Identify other players that the religious leaders can team up or collaborate with during their work
• Consider other additional people they might need to work with to lead and conduct the training effectively and with more impact
• Consider and prepare equipment, materials and other resources needed for training and establish who will be providing them before and during the training such as an overhead projector, LCD video machines etc
• Consider seating arrangement and select a suitable arrangement based on the size of room available
• Identify the person who will record the proceedings and other course work and provide the workshop report
• Design a way of introduction that will enable the participants realize that the facilitators are knowledgeable and experienced people and they can trust them

Whether one has just a few minutes, a few hours or a few days to help religious leaders appreciate the importance of accelerating the defeat of HIV and AIDS related SDD, this section will help the facilitator to put together an optimal program.

The secret, however, is to be well versed with the topics and issues related to HIV and AIDS so that you know when to say what and with whom. If you have a few minutes or hours; stick to the basics. The sample timetable in this manual is based on a 4-day program (residential). You can make it ½ day, 2 days, or run it in non-consecutive days depending on the time and resources available.

The ideal however is to count the time needed for each session and to see how best to deliver a part or a whole of this program.

**c) Ideas for Encouraging Participation**

It is one thing to bring religious leaders together but it is another thing to get them involved and participating fully in the training and learning process. It is important to ensure active engagement of participants at all times of the training process.

Involve the participants in establishing workshop norms such as:
— Time keeping
— Punctuality
— Respecting each other’s religious views and opinions about HIV and AIDS
— Putting mobile phones off or in a silent mode
— Allowing time to relax outside the training program

The facilitator can introduce icebreakers, breathers and other energizing techniques:
• Use energizers when people look sleepy or tired or use them to create a natural break between activities and sessions
• Choose activities that are appropriate for the local context and for the group and in which everyone can participate; be sensitive to the needs and circumstances of the group, e.g. people with physical disabilities
• Ensure that there is enough space and that the floor is clear
• Use activities that encourage team building
• Keep energizers short and move on to the next activity.

### 1.4 Sample Training Schedule

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<th>Day 3</th>
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<td>8:00–8:30am</td>
<td>Registration/Logistics</td>
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<tr>
<td>8:30–10:00am</td>
<td>Session 1</td>
<td>Session 6</td>
<td>Session 11</td>
<td>Session 14 continued</td>
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<tr>
<td>10:00–10:30am</td>
<td>Tea Break</td>
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<td>Tea Break</td>
<td>Tea Break</td>
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<tr>
<td>10:30–1:00pm</td>
<td>Session 2 &amp; 3</td>
<td>Session 6 continued, 7 &amp; 8</td>
<td>Session 12 &amp; 13</td>
<td>Post-course assessment/evaluation and closing</td>
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<tr>
<td>1:00–2:00pm</td>
<td>Lunch Break</td>
<td>Lunch Break</td>
<td>Lunch Break</td>
<td>Lunch Break</td>
</tr>
<tr>
<td>2:00–5:00pm</td>
<td>Session 4 &amp; 5</td>
<td>Session 9 &amp; 10</td>
<td>Session 13 continued &amp; 14</td>
<td>Departure</td>
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Module 1: Introduction

SESSION 1: WELCOME AND OVERVIEW

Time: 90 minutes

Session Objective:
To welcome the participants and provide an overview of the training course

Methodology:
• Small group discussion
• Open discussion
• Self-assessment

Activities:
1. Conduct official opening ceremony for the workshop Welcome remarks by representative of the organization sponsoring the course, an outside guest, and/or the lead facilitator
2. Facilitate introduction of participants Participants divide into pairs, interview each other and then introduce each other sharing their partner’s name, faith/denomination, position, and any unique characteristics.
3. Provide course overview Review course goal, objective and the time schedule, discuss all the materials to be used in the course e.g. participants handbook, reference materials.
4. Identify participants expectations Ask participants to share their expectations of the course and record responses on the flip chart. Attach the flip chart page on the wall for reference.
5. Assess participants pre-course knowledge and attitudes Distribute the pre-course assessment tool, read the instruction together with participants and ask them to complete the questionnaire

Materials/equipment needed:
— Overhead projector/projection screens
— Flip chart with markers
— Masking tape
— Pre-course assessment tool (Annex 1)
— Material from section 1.1 in Handbook

SESSION 2: RATIONALE FOR INVOLVING RELIGIOUS LEADERS

Time: 60 minutes

Session Objective:
To understand the important role of religious leaders in addressing stigma and discrimination

Methodology:
• Group work
• Brainstorming

Activities:
1. Discuss who a religious leader is and their roles in society Facilitator asks participants to work in groups of three and discuss who a religious leader is and to write down their responses
2. Explain the rationale for targeting religious leaders in HIV/AIDS and SDD Facilitator asks the same groups of three to discuss the rationale for involving religious leaders and to write down their responses
3. Discuss in plenary the responses of the small groups to the two questions

Materials/equipment needed:
— Overhead projector/projection screens
— Flip chart with markers
— Material from section 1.2 in the Handbook
Module 2: Understanding HIV and AIDS

SESSION 3: INTRODUCING HIV AND AIDS

Time: 90 minutes

Session Objective:
To improve knowledge and understanding of basic facts related to HIV and AIDS

Methodology:
• Brainstorming
• Interactive lecture
• Group discussion

Activities:
1. **Discuss basic facts about HIV** Participants brainstorm the meaning of Human Immune Deficiency Virus (HIV) in the plenary. Facilitator writes all responses on the newsprint and provides input from the basic science of HIV, including its relationship to the CD4 cells and body’s immune system.

2. **Describe HIV infection process** Input from the facilitator highlighting the phases of infection:
   • Phase 1: Entry stage and window period stage
   • Phase 2: Conversion stage: symptomatic stage
   • Phase 3: AIDS related illness stage

3. **Discuss definition of AIDS and differentiation between a person living with HIV and a person with AIDS** Facilitator asks the participants to brainstorm the two aspects and writes down the responses. Facilitator can then provide input and explain any gaps arising from the participants’ responses.

4. **Discuss the progression of the disease** Facilitator guides a small group exercise and presentation on major and minor signs and symptoms related to progression from HIV to AIDS. The facilitator can also highlight major signs in children.

5. **Discuss treatment options for AIDS in the absence of a cure or vaccine** Facilitator can highlight the role of antiretroviral (ARV) drugs, treatment of opportunistic infections, and importance of good nutrition.

6. **Discuss HIV and AIDS situation by region, gender and age categories** In small groups, participants can share the situation in their respective communities. Facilitator can give an update of the AIDS situation and impact based on UNAIDS current global report.

Materials/equipment needed:
— Overhead projector/projection screens
— Flip chart with markers
— Slides/handouts based on material from sections 2.1-2.3 in the Handbook
— Current national/regional data on HIV and AIDS situation (from UNAIDS and other sources)

SESSION 4: MYTHS AND MISCONCEPTIONS OF HIV AND AIDS

Time: 30 Minutes

Session Objective:
To identify and dispel common myths about HIV and AIDS in Africa

Methodology:
• Open discussion
• Group exercise

Activities:
1. **Discuss common myths and misconceptions** Allow each participant to fill out the exercise. Facilitator then invites participants to share their views on common myths and misconceptions about AIDS and the perceptions of HIV and AIDS that they hear from members of their faith communities. Facilitator can provide input that addresses/breaks down common myths in Africa.

Materials/equipment needed:
— Overhead projector/projection screens
— Flip chart with markers
— Myths and Misconceptions Exercise (Annex 2)
— Material from section 2.4 in the Handbook
SESSION 5: MODES OF HIV TRANSMISSION

Time: 90 Minutes

Session Objective:
To understand and be able to describe ways in which HIV is transmitted

Methodology:
• Self-assessment
• Interactive lecture

Activities:
1. Facilitator has participants complete individual quiz on ways that HIV is and is not spread (based on material in section 2.5 of the Handbook)
2. Facilitator leads interactive discussion about the major ways HIV is spread, including:
   • Sexual contact
   • Blood transfusion
   • Mother-To-Child Transmission (MTCT)
   • Piercing instruments and procedures e.g. injections.

Materials/equipment needed:
— Overhead projector/projection screens
— Flip chart with markers
— Slides/handouts with material from section 2.5 of Handbook

SESSION 6: MODES OF HIV PREVENTION

Time: 120 Minutes

Session Objective:
To understand and be able to describe how to prevent transmission of HIV

Methodology:
• Self-assessment
• Group work
• Interactive lecture

Activities:
1. **Conduct personal risk assessment exercise**
   Share the hand out on the exercise; explain its purpose and that participants’ responses will remain confidential. Have participants score their responses

2. **Facilitator leads discussion based on the following questions:**
   • How do you feel after completing the exercise
   • What have you learned from the exercise

3. **Discuss the various methods of prevention of HIV.** Divide participants into 4 groups, with each group focusing on one of the major modes of transmission of HIV. Groups can report their key points back to the plenary. Have each group explore how to promote prevention through each of the following technical elements:
   • Risk reduction
   • Information and education
   • Community dialogue
   • Advocacy

   The facilitator can mention other key elements in HIV prevention including:
   • Control and management of sexually transmitted infections (STI)
   • Promotion of voluntary counseling and testing (VCT)
   • Blood safety
   • Infection control

   **Facilitator’s Note:** It may be necessary highlight distinctions between Information Education and Communication (IEC) and Behavior Change Communication (BCC), and the respective importance of each to HIV prevention strategies

4. **Introduce concept of Voluntary Counseling and Testing (VCT) and its role in prevention**
   Facilitator can provide basic information in a mini lecture, with discussion following that can include some of the ethical issues related to VCT, including attitudes and practice in religious communities related to HIV testing before marriage

5. **Discuss the role of stigma reduction in minimizing HIV spread**
   Conduct brainstorming exercise on the relationship between reducing stigma and HIV prevention
SESSION 7: WOMEN AND HIV AND AIDS

Time: 60 minutes

Session Objective:
To improve understanding on the impact of HIV on women and to identify ways to address violence against women.

Methodology:
- Interactive lecture
- Group Work

Activities:
1. **Provide overview of Women & HIV AND AIDS**
   - Facilitator presents some of the key gender dimensions of HIV and AIDS

2. **Discuss gender roles in society**
   - Facilitator divides participants into small groups to examine the types of gender roles that exist and how they shape attitudes in the response to HIV and AIDS in terms of:
     - Empowerment
     - Community leadership
     - Care giving and access to treatment
     - Stigma and discrimination

3. **Discuss links between gender based violence and HIV**
   - Facilitator introduces key points about gender based violence and asks the same small groups to identify linkages between GBV and HIV and to develop 1-2 recommendations on how religious leaders can address this problem.

Materials/equipment needed:
- Overhead projector/projection screens
- Flip chart with markers
- Slides/handouts with material from section 2.6 in the Handbook
Module 3: Combating HIV and AIDS Related Stigma, Denial and Discrimination

**SESSION 8: UNDERSTANDING THE TERMS**

**Time:** 60 Minutes

**Session Objective:**
To understand basic concept of stigma and discrimination and be able to use key terms

**Methodology:**
Interactive lecture

**Activities:**
1. **Facilitator introduces key terminology and conducts discussion with participants** Participants are encouraged to share examples of how they have seen the different concepts in real life situations

**Materials/equipment needed:**
- Overhead projector/projection screens
- Flip chart with markers
- Slides/handouts with material from sections 3.1–3.2 of Handbook

**SESSION 9: SOURCES AND MANIFESTATIONS OF STIGMA AND DISCRIMINATION**

**Time:** 90 Minutes

**Session Objective:**
To understand what creates SDD and how it presents itself in individuals and communities

**Methodology:**
- Interactive lecture
- Plenary discussion
- Group work

**Activities:**
1. **Discuss sources of stigma** Facilitator leads group discussion about what causes HIV-related stigma; can provide information from chapter 3.3 of Handbook on religious beliefs that contribute to stigma

  2. **Discuss external and internal manifestations of stigma** Facilitator divides participants into small groups and asks each group to identify 3 external manifestations and 3 internal manifestations of SDD. After 20–30 minutes, groups report back. Trainer then shares 1–2 case studies with the full group and asks them to identify the manifestations of SDD present in the cases.

**Materials/equipment needed:**
- Overhead projector/projection screens
- Flip chart with markers
- “Manifestations of Stigma” table (Annex 4)
- Slides/handouts with material from sections 3.3–3.4 of Handbook

**SESSION 10: THE ROLE OF RELIGIOUS LEADERS IN COMBATING STIGMA AND DISCRIMINATION**

**Time:** 60 Minutes

**Session Objective:**
To understand the important roles of religious leaders in combating all forms of stigma and discrimination

**Methodology:**
- Group work
- Plenary discussion

**Activities:**
1. **Discuss the different roles religious leaders can play in combating SDD** In small groups ask the participants to discuss how they can combat SDD in their different functions as religious leaders, including the following:
   - Leaders of religious organizations
   - Teachers/scholars
   - Leaders of worship
   - Pastoral/counseling duties
   - Community leaders
   - Advocates with government

Participants are encouraged to share practical examples of combating SDD in their own work
environments. Groups can write ideas on flip charts and share in the plenary

Materials/equipment needed:
- Flip chart with markers
- Material from section 3.5 of the Handbook

Session 11: Interventions to Combat SDD at the Individual and Family Level

Time: 90 minutes

Session Objective:
To identify and understand effective ways to address how stigma affects individuals and families

Methodology:
- Group work
- Role Play
- Interactive lecture

Activities:
1. Discuss the needs of an HIV positive person
   Facilitator divides participants into small groups and asks them to put themselves in the position of someone who just found out he/she is HIV-positive and to list their needs in the following areas:
   - Moral/spiritual support
   - Psychological support
   - Psychosocial support
   - Physical support/self care
   Participants present their group work in the plenary

2. Demonstrate key aspects of “living positively”
   Facilitator introduces the following elements of positive living for those who have HIV or AIDS. After the introduction, participants should divide into groups of four to role play ways in which a religious leader can promote a positive attitude for an individual living with HIV or AIDS.
   - Making plans for the future
   - Telling those who matter about HIV status
   - Avoiding alcohol, drugs, tobacco and other harmful substances
   - Practicing daily hygiene
   - Maintaining adequate rest and exercise
   - Monitoring general health and controlling infections
   - Seeing spiritual and other counseling

   • Devising healthy eating habits
   Facilitator also addresses the importance of HIV-negative caregivers and associates to practice positive living and to develop their own coping mechanisms

3. Discuss interventions for combating SDD at family level
   Facilitator has participants work in small groups and gives them the following discussion areas:
   - Caring for family members who are HIV-positive
   - Coping with societal stigma and discrimination
   - Addressing HIV and AIDS with children and adolescents
   - Encouraging participation in religious and community events

   After small groups report on their discussions, Facilitator leads a plenary discussion on issues of testing and counseling with adolescents and young people, including the following:
   - Questions as to whether adolescents should go for testing
   - Factors which hinder young people from accessing VCT services
   - Perceptions related to pre-marital testing
   - Approaches and skills for counseling adolescents and young people

Materials/equipment needed:
- Overhead projector/projection screens
- Flip chart with markers
- Slides/handouts with material from sections 3.6-3.7 of Handbook

Session 12: Interventions to Combat SDD at Congregational/Community Level

Time: 90 minutes

Session Objective:
To identify and understand concrete steps religious leaders can take to combat SDD in their congregations and local communities

Methodology:
- Interactive Lecture
- Group Work

Religions for Peace • Combating HIV and AIDS Related Stigma, Denial and Discrimination
Activities:

1. **Discuss how to combat SDD in congregations and at the community level** Facilitator conducts an interactive lecture on types of local interventions that help combat stigma using the following discussion points:
   - Integrate HIV and AIDS education and training in worship, prayer and other congregational activities.
   - Conduct personal HIV and AIDS risk assessment interventions.
   - Encourage Voluntary Counseling and Testing and establishment of VCT centers in the local community; consider contributing to testing costs.
   - Initiate Post HIV Test Clubs (support groups) for HIV and AIDS awareness, education and positive living.
   - Initiate homecare teams at congregational level to support HIV positive members to access treatment and adhere to ART regimens.
   - Involve HIV positive members in leadership, worship and program development.

2. **Conduct exercise on planning interventions** Facilitator has participants break into small groups and assigns each group one of the following topics and asks them to develop guidelines/recommendations on how religious leaders should take action:
   - Supporting HIV awareness, education and training in the congregation.
   - Supporting establishment of VCT centers in the community.
   - Supporting establishment of post-test clubs/PLWHA support groups in the congregation and/or community.
   - Supporting establishment of psycho-social and spiritual support and counseling services in the congregation and/or community.

**Materials/equipment needed:**
- Overhead projector/projection screens
- Flip chart with markers
- Slides/handouts with material from section 3.8 of Handbook
SESSION 13: INTERVENTIONS TO COMBAT SDD AT INSTITUTIONAL LEVEL

Time: 120 minutes

Session Objective:
To identify and understand actions religious leaders can take to promote stigma reduction in religious and national institutions

Methodology:
• Interactive lecture
• Group work

Activities:
1. **Discuss the need for behavior change in religious institutions** Facilitator illustrates the behavior change model based on the following outline and conducts an open discussion among participants
   - Whose behavior needs to change?
   - Behavioral analysis
   - Key factors influencing behavior
   - Activities to foster change

2. **Introduce concept and principles of GIPA (greater involvement of people living with HIV and AIDS)** Facilitator leads discussion outlining key policy recommendations and asks participants to reflect on how well their own institutions are fulfilling these principles and what actions they need to take to achieve greater involvement

3. Discuss how religious leaders can engage their religious institutions in interventions such as:
   - Focusing on a result-oriented action against HIV and AIDS related stigma, denial and discrimination in religious communities
   - Developing policies in religious institutions for combating SDD
   - Strengthening national and local community movement of religious leaders and communities against SDD
   - Developing practical ways to measure progress of religious leaders and communities in reducing SDD

4. **Develop an approach for combating SDD at the institutional level** Participants divide into small groups and answer the ten questions in the action-planning handout based on the situation in their religious organization. Groups can share ideas in the plenary and these will be the basis for the action plans participants develop in the next session.

5. **Discuss policy action at national level** Facilitator leads discussion on ways that religious leaders can be engaged in policy advocacy at the national level to reduce stigma in the society

Materials/equipment needed:
— Overhead projector/projection screens
— Flip chart with markers
— Action planning handout
— Slides/handouts with material from section 3.9 of the Handbook

SESSION 14: ACTION PLANS AND FINALIZING THE COURSE

Time: 3 hours

Session Objective:
To develop action plans as a guide for participants to implement SDD reduction activities in their organizations and communities

Methodology:
• Individual/group work
• Plenary presentation

Activities:
1. **Prepare action plans** Facilitator introduces the concept of action planning and the planning form; participants then use the form to develop action plans, either as individuals or in previously determined groups

2. **Present and review action plans** Participants share their action plans and the group has opportunity to ask questions and make suggestions

3. **Conduct course summary and evaluation** Participants fill out post-training assessment and evaluation forms. Trainer facilitates brief discussion with participants about how their knowledge and attitudes have changed during the workshop

4. **Hold closing ceremony** Organizers, facilitator, and/or outside guest make closing remarks
Annexes
Annex 1: Pre and Post-Training Assessment Tool

Tick the correct answer

1. A Religious leader is a person who mainly:
   a) Advocates for change of the constitution in a community.
   b) Acts as a representative of a religious organization in the community
   c) Plans and leads worship and other related ceremonies of a given faith.

2. Statements about HIV and AIDS (mark those that are true)
   a) Once you have AIDS you cannot live beyond 3 years.
   b) Morally upright/faithful people can get HIV infection and unfaithful/immoral people can escape HIV infection
   c) All children of HIV positive parents must be HIV positive
   d) People who look well and fat can be HIV positive while those who look thin and sickly may not be
   e) Mosquito and other insect bites cannot cause HIV
   f) Faithful people cannot get HIV

3. Complete the following sentences.
   HIV Window period is:
   HIV Incubation period means:
   HIV and AIDS Clinical stage means:

4. Values and attitudes assessment. Tick whether you agree or disagree with the following statements:

<table>
<thead>
<tr>
<th>Number</th>
<th>Statement</th>
<th>Agree</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>AIDS is a curse from God</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Faithfully married men or women cannot get HIV and AIDS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>In order to control HIV effectively; people with HIV and AIDS should be separated from the rest of the community</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>I cannot get HIV</td>
<td></td>
<td></td>
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<tr>
<td>5.</td>
<td>Condoms encourage immorality and therefore should not be talked about</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>If a women wants to use a condom, but the man does not, the woman has a right to refuse sex with the man</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>It is not proper for religious leaders to talk about safe sex. This should be left to health professionals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>I would feel uncomfortable eating from the same bowl with someone who is HIV positive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>If a person gets HIV, he or she cannot live for more than 5 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>A very moral religious person who is God fearing cannot get HIV and AIDS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>Young people are refusing to change their behavior. If they get HIV and AIDS, it is their fault because they have free will to choose what is right from what is wrong</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>Teaching young people about safe sexual behavior encourages them to experiment with sex. They should not be taught about these issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>If a person goes for an HIV test, it is evidence that s/he has been involved in sinful behavior and fears that s/he might be HIV positive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>A religious leader who becomes HIV positive should not be allowed to continue preaching</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Annex 2: Myths and Misconceptions Exercise

- HIV and AIDS is a curse
- HIV and AIDS is a punishment for sin
- AIDS only affects prostitutes, truck drivers, homosexuals and immoral people
- Once you have AIDS you cannot live beyond three years
- All children of HIV positive parents must be HIV positive
- Faithful people cannot get HIV
- HIV is caused by witchcraft
- AIDS can be cured by having sex with virgins
- Virgins cannot get HIV and AIDS
- People who look healthy and are fat cannot be HIV positive
- People who are thin or sickly must be living with HIV and AIDS
- All HIV positive people are infectious through casual contact
- All those HIV positive people who have been prayed for and healed from HIV and AIDS no longer have HIV in their blood, semen, vaginal fluids or breast milk
- Currently there are many cures of HIV and AIDS
- A circumcised male cannot get HIV
- If a child is born negative, it means the parents are free of HIV

Methodology
- Each participant is given 2 cards: one written on “True” and another written on “False” (it is helpful if the cards are different colors).
- The facilitator reads a series of statements (these can be found in the box on the left of the page).
- For each of the statements participants are asked to give their opinions by raising one of their cards; the facilitator records the number of “true” and “false” answers for each statement.
- Participants are reminded that there is no “wrong” or “right” answer and that each is entitled to their opinions so long as they are prepared to defend them.
- The facilitator then goes through the statements in turn noting the total number of “True” and “False” answers for each statement and asking participants to share why they answered the way they did.
- Before revealing what is really the “accurate and appropriate” response, the facilitator can call on those participants who have responded to a statement with “inaccurate information” or “inappropriate attitudes” to defend their position, followed by others who have responded more accurately so that in the discussion both appropriate attitudinal changes and cross-fertilization of accurate ideas happen without forcing them on the participants.
- At the end participants are asked what they liked most about the exercises and what new knowledge they have gained from the exercises.

Annex 3: Personal Risk Assessment Exercise

Aim
1. To remind the participants that any one who lacks accurate information, appropriate attitudes, services and a supportive environment for self-protection could be at risk of HIV infection irrespective of their religious beliefs, values, practices and spiritual status.
2. To increase an appreciation among participants on the need for and value of undergoing periodic HIV testing.
3. To increase understanding among participants that there is no need of pointing fingers at people who are known or believed to be HIV positive since the one pointing the finger could also be at risk.
4. To help participants understand that the causes of HIV vulnerability are more than what people commonly think about (i.e. unlawful/promiscuous/adulterous sex)
Objectives
By the end of the exercise participants should be able to:
• Approximate their own level of risk to HIV infection
• Decide whether they need to take an HIV test or not
• Appreciate that ‘pointing fingers’ and stigmatizing people is not an accurate attitude
• Understand what religious leaders can do to help people learn more about the risks of contracting HIV

Methodology
1. The exercise has 11 questions which can be reduced or increased depending on the social, economic, cultural, and political environment of the participants
2. The exercise has rules:
   • It is strictly confidential and none of the participants should see what the other one is writing on his/her paper.
   • After the scoring exercise; participants should destroy all evidence of their scores.
   • For Questions 1 – 8; a “YES” answer scores ‘10’ and a “NO” answer scores ‘0’
   • For Questions 9 -11; a "YES" answer Scores ‘O’ and a "NO" answer scores “10”
   • Questions must be answered in all honesty and sincerity since this is a “personal risk assessment exercise” that no one else will ever come to know of what came out of it apart from the participant
   • While answering these questions, participants should take into account the time HIV and AIDS were first talked about in their country and the length of the incubation period (10-15 years), where one can be HIV positive without showing any signs or symptoms.
   • Participants should use “loose” paper that can easily be destroyed without damaging their notes or files.

Questions
Remembering the time HIV and AIDS was first identified in your country, looking back in your past life, and remembering the length of the incubation period:
1. Have you ever had sex?
2. Have you ever had sexual intercourse with someone (whether your spouse or not) who had already had sex with someone else?
3. Have you had sexual intercourse with more than one sexual partner?
4. Have you separated from your sexual partner (because of studies, work, travel, or disagreement) and then later resumed sexual relationship after some time?
5. Have you or your sexual partner ever-received blood transfusion?
6. Have you or your sexual partner ever shared skin piercing or skin cutting instruments with others?
7. Have you or your sexual partner ever injected drugs or received injections from non-professionals administering injections who may not have cared to sterilize their instruments?
8. Have you ever had a Sexually Transmitted Disease?
9. Were you a virgin when you married and if you are not married are you a virgin now?
10. Was your sexual partner a virgin when you first had sex with her or him?
11. Have you been using condoms correctly and consistently every time you have sex?

Total up your scores for the 11 questions.

The lowest score you can get in this exercise is “O” and the highest is “110”.

A total score of “O” means you are not at risk of HIV infection. Celebrate your “O” and endeavor to keep it “Zero”.

A total score of “10” and above means you could be at risk of HIV infection and later develop AIDS. The higher the score, the greater the risk. Only taking an HIV test can tell for sure

Final Questions to participants after the Exercise
• How do you feel after doing this exercise?
• What do you learn from this exercise?
• Do you have any questions regarding this exercise?
### Annex 4: Manifestations of Stigma at Different Levels

<table>
<thead>
<tr>
<th>National/Global Level</th>
<th>Institutional Level</th>
<th>Congregational/Community Level</th>
<th>Family Level</th>
<th>Individual Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refusal to put in place appropriate policies and programs for preventing HIV and AIDS.</td>
<td>Denial of employment, promotion.</td>
<td>Labeling HIV positive people as sinners, loose, immoral, lacking self-control.</td>
<td>Denial of food and shelter.</td>
<td>Self Stigma: • Self Stigma</td>
</tr>
<tr>
<td>Failure to enact and enforce HIV non-discriminatory laws and policies.</td>
<td>Denial of medical care services.</td>
<td>Denying HIV positive people leadership within Church/Mosque/ Temple/Village Community.</td>
<td>Isolation &amp; solitary confinement.</td>
<td>• Depression</td>
</tr>
<tr>
<td>Failure by some of the international community to respond appropriately because of the misconception that Africans are incurably promiscuous.</td>
<td>Denial from work and employment.</td>
<td>Isolation &amp; rejection of infected spouse/child.</td>
<td>Divorce.</td>
<td>• Depression</td>
</tr>
<tr>
<td>Refusal to put in place appropriate policies and programs and to allocate enough funding for medical treatment or HIV prevention because of perception that people who are positive deliberately get HIV and that their care is a bottomless pit.</td>
<td>Dismissal from work and employment.</td>
<td>Rejection of infected spouse/child.</td>
<td>Exclusion from learning &amp; working institutions.</td>
<td>• Depression</td>
</tr>
<tr>
<td>Failure by some of the international community to respond appropriately because of the misconception that Africans are incurably promiscuous.</td>
<td>Unkind treatment by colleagues through whispering, pointing fingers and outright isolation.</td>
<td>Being denied marriage.</td>
<td>Being denied or denial of treatment.</td>
<td>• Depression</td>
</tr>
</tbody>
</table>

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**Religions for Peace** • **Combating HIV and AIDS Related Stigma, Denial and Discrimination**
Module 1: Introduction

1.1 TRAINING COURSE OVERVIEW

In planning the opening session of a training workshop, the facilitator will need to ensure that this session sets an overview of the goals of the workshop, creates a positive environment among the participants, and clarifies expectations about what people want to achieve. The following exercises can be useful elements in the opening session.

Theological Reflection

Invite a local religious leader or scholar to present a personal theological reflection on the relationship between religion, people’s health and well-being, and HIV and AIDS.

This activity can help remind participants of the religious obligation and responsibility they have in promoting people’s health and well-being, and the importance of giving faith priority in all they do. They can relate their own spirituality and faith with what is going on around them with regard to HIV and AIDS.

Some possible themes that could be addressed in the reflection are:

- Members and leaders of different faith communities are called by God to affirm a life of hope, health, and well-being in the midst of HIV and AIDS.
- Religious doctrines call us to embody and proclaim hope, and to celebrate life and healing in the midst of suffering.
- It is an affront to God’s glory and promises that many people are suffering and grieving silently while many more are dying from preventable, manageable, and treatable illnesses and conditions.
- Religious and moral barriers have prevented religious communities from responding with compassion: “We love the Law rather than practice the Law of love.”
- As long as one member of God’s family is humiliated, fearful, anxious, rejected, and discriminated against, our collective human quality is reduced.
- God has no other hands than ours. If the sick are to be healed, it is the religious leaders’ hands and hearts that will heal them. If the lonely, the frightened, and the stigmatized are to be comforted, it is the leaders’ duty to embrace and comfort them.

Training Program Overview

The facilitator should introduce the participants to the goals, objectives, and expected outcomes of the training and introduce the agenda and timetable for comments and suggestions.

The facilitator can also provide a quick overview of some of the key questions and issues that will be addressed, such as:

- Why defeat HIV and AIDS-related stigma, denial, and discrimination (SDD)?
- What is the unique role of religious leaders in that process?
- What do we hope to see as a result of our work and effort?

Exercise for Expectations and Group Norms

The facilitator can use this time to get important background facts regarding his or her own work, education, leadership responsibilities, HIV status, previous training/experience on HIV and AIDS, and find out why participants prioritized coming to the training workshop and what they expect to get out of it. This helps clarify with the group what is possible to accomplish during the workshop.

The facilitator explains what is to be done with self-introductions and expectations and then models the process by starting with his or her own introduction and expectations.

1.2 THE ROLE AND CONTRIBUTION OF FAITH-BASED ORGANIZATIONS

Faith-based organizations (FBOs) play an important role in responding to HIV and AIDS. In Africa, church-supported hospitals and clinics were among the first to care for people who fell ill with AIDS. FBOs have a key role to play in advocacy, prevention, treatment, care, and support.

In Southeast Asia, Buddhist monks and nuns in Cambodia, Thailand, and Vietnam provide care and
support for people living with HIV and AIDS while engaging in prevention work. Caritas Internationalis has for many years conducted theological reflections on HIV and AIDS, while many national Caritas organizations provide care and support for people living with HIV and AIDS (PLWHA) and orphans. In Africa, for example, FBOs, including the All-Africa Conference of Churches, the Organization of African Institute Churches (OAIC), the Islamic Medical Association of Uganda, the Church of the Province of Southern Africa (Anglican), and the Inter-religious Council Uganda, have successfully sought grants to support strategic planning and program activities through their various religious networks. Elsewhere, the Latin American Episcopal Conference works with UNICEF’s regional office to arrange HIV and AIDS workshops and training courses for pastoral workers in parishes across the region.

Diverse religious communities complement their strengths in solving practical problems, such as engaging churches and mosques together in efforts to reach children affected by HIV and AIDS. Multi-religious cooperation can also facilitate the formation of public partnerships, helping religious people not only to cooperate among themselves, but also to work together with the best of the international, governmental, and civil society agencies to solve humanity’s problems.

At the local level, FBOs:
- are able to reach communities
- have widespread service outlets
- their leaders have an authority that, in many respects, exceeds that of governments
- their leaders can attend to ethical and moral issues, and are well placed to address HIV and AIDS

**Module 2: Understanding HIV and AIDS**

### 2.1 FACTS ABOUT HIV AND AIDS

HIV stands for *human immunodeficiency virus*. It is the virus that causes acquired immune-deficiency syndrome (AIDS), which belongs to the class of viruses called retroviruses because of the way they replicate inside a host cell. The human immunodeficiency virus is weak and fragile, so it is quickly killed by exposure to water or even air and therefore cannot survive outside a living host.

The virus can enter a person’s body through the mucous membranes such as the inner lining of the vagina, the inside of eyelids, or through abrasions, sores, cuts, or wounds on the skin. It can also be injected directly into the bloodstream through needles and other surgical instruments.

Once inside the person’s body, the virus attaches itself to specific cells found in blood called CD4 cells or T-helper cells. The CD4 cells are part of the white blood cells in the body that monitor the severity of the infection for each HIV-positive individual. The cell membranes (lining) of these CD4 cells have specific receptor sites, which the virus can attach to. Once inside the host cell, the virus sheds its outer coating and releases its genetic material into the host cell’s nucleus. The nucleus controls and initiates cell replication, consequently becoming part of the host cell’s genes, and replicates together with the host cell. It can remain inactive inside the carrier’s body from five to 10 years, where it remains dormant but within the genes.

The CD4 cells are responsible for initiating an immune response by ingesting (“eating”) germs such as other viruses, bacteria, fungi, the body’s own diseased cells (e.g., cancer cells), and other parasites that enter the blood. They transport these germs to disease-fighting sites, especially the lymph nodes. At these sites, the body produces molecules called antibodies (antibody for one), which attach themselves to similar germs, especially in the bloodstream, and thus fight off infections.
When one is infected with the virus, the infection can be detected by testing for these antibodies within the blood. Other tests to detect the presence of antibodies in saliva and urine are also available, but are not commonly used. The presence of the antibodies indicates that the virus is present in an individual, whether in a dormant stage but replicating, or actively replicating and killing the host cells.

The trigger for the onset of rapid viral replication is not medically known, but is precipitated by certain factors, including nutritional status, health, and the presence of other infections. Once the genetic material replicates, it commandeers the cell’s internal mechanism so that the host cell produces the outer coating of the virus. In this way, millions of new viruses are produced inside the carrier’s host cell. As they increase inside, the cell swells and eventually bursts, killing itself and releasing the viruses into the bloodstream where they can attach to and invade new CD4 cells and repeat the cycle exponentially. Figure 1 illustrates this process.

Figure 1: Stages of HIV Development

Virus enters body through mucous membrane or by being injected directly into the bloodstream.

Virus attaches and invades CD4 or T-helper cells.

Virus replicates in the CD4 cell.

CD4 cell swells, bursts, and dies.

Virus is released into the bloodstream.

Body reacts to virus by releasing antibodies, which can then be detected by the HIV test.

Measuring a person’s viral load tests for the presence and density of viruses, which is important in determining treatment with antiretroviral drugs. However, not everyone who has the virus has AIDS. With proper care, management, and healthy living, an infected person can live with HIV for a long time without any signs of AIDS. For example, there are people in Africa and around the world who have been living with HIV for over 20 years.

By infecting and killing the CD4 cells, the virus reduces the body’s ability to defend itself against infection and some forms of cancer because there are not enough CD4 cells to ingest and carry other disease-causing germs to the lymph nodes, so that the body can mount an immune response by producing antibodies against those germs. We thus refer to it as a lowered immune response or an immunodeficiency.

The diseases that occur when the body’s immune system is lowered are called “opportunistic infections” because they take the opportunity provided by the weakened immune system to attack the body.

Normally in a healthy person, the body can stop many infections, especially from bacteria and fungi, by either eliminating them or keeping the germs in very low concentration. It also routinely removes dead and damaged cells from the body through the immune system. However, a person with an HIV infection loses this ability. Germs can enter the body, or those that can survive in low concentrations on the skin and within the gastrointestinal tract multiply in large numbers so as to cause disease. Examples of such opportunistic infections include common colds, pneumonia, diarrhea, skin rashes, gum disease, etc.

At first little damage is done, but over time, large numbers of virus are produced and they destroy the immune system until it is completely compromised and the person succumbs to a variety of infections. Antiretroviral therapy treats the infections or stops the virus from replicating in order to give the body time to produce new CD4 cells and mount an immune response.

To illustrate what actually happens, a healthy person has 1,000 CD4 cells per microliter of blood. Over time, as HIV damages the immune system, the person’s CD4 count goes down. A person with a CD4 count lower than 200 cells per microliter should seek medical attention for antiretroviral treatment. When a person’s
immune system is completely compromised, the body cannot defend itself against many types of infections and some forms of cancer. At this stage, the person has AIDS or an HIV-related illness.

Finally, one of the challenging characteristics of HIV is its ability to mutate; it changes its genetic makeup, especially the gene responsible for determining the virus’ outer coating. When the virus does this, it can evade the antibodies that the body produces to kill it. Therefore, vaccination as a control mechanism against HIV has so far been difficult because any vaccine produced to date has not been effective as the virus produces a new outer coating that deceives the guarding antibodies.

2.2 THE PHASES AND STAGES OF HIV

There are three major phases in the progression of HIV infection in the human body. Each phase has two stages.

Phase 1

During Phase 1, the HIV is present in the blood, but laboratory tests cannot detect it for up to six months. This phase is divided into two stages:

Entry stage: This is when the virus enters the body.

Window period stage: This is when the HIV is multiplying in the body, but cannot be detected by the normal tests done during a visit to a voluntary counseling and testing (VCT) site. However, other specialized tests can be used to detect the virus. This stage, which is very infectious, lasts approximately three months. Therefore, one initial test is usually not enough to confirm if one is HIV-negative, especially if the person has been exposed to the virus through sexual intercourse or other methods of infection. One is advised to repeat the test after three months and to avoid risky behaviors during this period. In newborn babies, the mother’s antibodies are present in the infant’s blood so it is not possible to test for HIV using the normal serological tests that detect the antibodies. Instead, tests that detect the virus can be done. The maternal antibodies persist for 18 months, after which tests can be done to detect if the child’s body has produced its own antibodies.

Phase 2

During this phase, the HIV is in the blood and laboratory tests can detect its presence. It has no signs or symptoms for two months to several years. The time varies from person to person. This HIV-positive (HIV+) stage includes:

The sero-conversion stage: This means that the virus is present in large enough quantities to produce an immune response that laboratory tests can detect in the blood. This is the period when a person goes from being HIV-negative to HIV-positive. Young children and the elderly go through sero-conversion faster because they have less robust immune systems.

The asymptomatic sero-positive stage: This means that the virus is in the body in large quantities, but the person infected shows no signs and is not aware of the infection unless tested. The person is in good health. HIV can live almost silently in the system for many years without causing obvious signs of damage. During this time, the person looks and feels healthy and will not know that she or he is living with HIV unless given an HIV test. Even though the person may look healthy, he or she can spread HIV during this healthy stage.

Phase 3

During this phase the HIV is in the blood, laboratory tests can detect the virus, and the person shows signs and symptoms of acquired immune-deficiency syndrome. This is a condition in which the person infected with HIV develops signs of repeated and often prolonged illnesses resulting from the immune system’s reduced ability to defend itself against disease. This phase includes:

The AIDS-related illness stage: Infected people show signs and symptoms such as diarrhea, weight loss, weakness and fatigue, loss of appetite, fever, night sweats, etc., but are still capable of taking care of themselves.

The full-blown AIDS stage: People show more pronounced and more frequent signs and symptoms of AIDS and often become too weak to care for themselves. This is the advanced stage of AIDS.

Advanced AIDS-related diseases sometimes occur when the CD4 cell count is below 200 cells per microliter, while others have signs of two minor and two major opportunistic diseases. Some people with a CD4 cell count of less than 200 cells per microliter may not have signs of AIDS. The following are the most common serious illnesses:
• Respiratory infections such as pneumonia, tuberculosis, and bronchitis manifested with persistent cough, fever, and chest pain
• Bowel infection causing ongoing diarrhea
• Infection of the brain causing headaches, fits, and other neurological conditions
• Cancers, such as the uncommon Kaposi’s sarcoma, which causes brownish marks on the skin or in the membranes (e.g., mouth, eyelid, nose, intestines)
• Lymphoma (swollen lymph glands)
• Severe fatigue and weakness
• Occasional mental impairment (e.g., memory loss, low concentration)

Other conditions are:
• Wasting of the body tissue and severe weight loss
• Blindness caused by damage to the retina
• Meningitis
• Numbness or pins and needles in the hands and feet

When the immune system is damaged, the person becomes ill with a number of signs and symptoms. Eventually these become more severe and the person may develop a range of opportunistic infections and terminal illnesses.

People who are infected should be encouraged and made aware that many of these opportunistic infections can be treated with relevant drugs. The viral load can also be reduced through antiretroviral therapy. If no drugs are given, the immune system becomes very weak and the person may die from one or several opportunistic illnesses.

2.3 SIGNS AND SYMPTOMS OF AIDS

Often a clinical officer has to reach a diagnosis of AIDS without any laboratory support. The World Health Organization, in a workshop at Bangui, Central African Republic, defined diagnostic criteria for Africa. It groups the signs and symptoms of AIDS into two categories, depending on the frequency and seriousness:
• Major signs and symptoms
• Minor signs and symptoms

According to the Bangui criteria, AIDS in an adult can be defined by the presence of at least two major signs associated with at least one minor sign. In children, AIDS can be defined by the presence of at least two major signs and two minor signs.

Major Signs and Symptoms in Adults

The three major signs and symptoms of AIDS in adults are:
• Rapid loss of more than 10 percent of body weight without any apparent reason
• Chronic diarrhea that lasts longer than one month and does not respond to treatment
• Prolonged fever that lasts longer than one month and does not respond to treatment

Major Signs and Symptoms in Children

There are also major symptoms of AIDS that are specific to children:
• Weight loss or abnormally slow growth
• Chronic diarrhea for more than a month
• Prolonged fever for more than a month

Minor Signs and Symptoms in Adults and Children

AIDS also has some minor symptoms, such as:
• Persistent dry cough for more than a month
• Generalized itchy skin
• Recurrent multiple blisters that are filled with fluid and are painful; the pain persists even after the blister disappears (Herpes zoster)
• Chronic white coating of the mouth, tongue, and throat (thrush)
• Generalized swollen glands that are painless unless there is an active infection
• In children, repeated common infections (ear, throat)
• In children, confirmed maternal HIV infection
2.4 MYTHS AND MISCONCEPTIONS ABOUT HIV AND AIDS

Religious leaders need to first understand the nature and impact of the virus in order to help fight ignorance about HIV and AIDS and teach others of its dangers. People who are already infected need care and support, so teaching is very important in the response to AIDS in case people fall prey to various rumors, myths, and misconceptions, which may cost them their lives.

Some of the most common myths in the African culture are:

**Virgin cure:** There is a popular belief that having sex with a virgin or a child can cure HIV and AIDS. This is not true as it may lead to spreading the virus to the virgin or the child.

**Traditional Cures:** Others believe that eating raw eggs or the African potato, and visiting witchdoctors can cure HIV and AIDS. Some even claim that not having sex for a year can cure HIV and AIDS. None of this is true. Currently there is no medical cure for HIV and AIDS, and some of the rituals performed by witchdoctors involving blood exchange may reinfect HIV-positive people, which means that they can contract the virus again, thereby increasing the rate at which the immune system is being weakened, leading to an earlier death.

**God’s punishment:** Some people believe that HIV and AIDS is God’s punishment for the wicked, and that those who have it must have been immoral. This is false. HIV and AIDS is a disease like any other and is incurable. People can contract HIV through blood transfusion; infants can be infected at birth or from their mothers while breast-feeding; and others can contract it by being raped. Therefore, it does not mean that people are bad or immoral if they contract HIV.

**Insects transmit HIV:** People fear contracting HIV and AIDS from mosquito bites, donating blood, or using hair-cutting tools. Others are afraid that they will contract HIV when HIV-positive people sneeze, spit, or breathe near them. Sharing food, housing, toilets, cutlery, plates, cups, taps, wells, blankets, sheets, bicycles, swimming and talking, touching, laughing, kissing, hugging or holding hands cannot lead to contraction of HIV.

**People over 50 years of age cannot get HIV:** This is equally false. Anyone can get HIV regardless of his or her wealth, sex, age, or skin color. Usually people over 50 tend to become less sexually active, which greatly reduces their chance of contracting HIV, but that does not mean that they cannot contract it.

**Sexual partners who are both HIV-positive do not need to practice prevention:** This has come to be believed by many. However, people who have HIV and AIDS can be reinfected. They also stand a risk of contracting new strains.

**Slim people have HIV and fat people cannot contract it:** Though AIDS may later lead to weight loss, it does not mean that people who are slim have HIV. People may be slim due to stress, genetics, poor diet, or a desire to be slender. Being fat or healthy does not mean that one does not have HIV and AIDS as anyone can contract it. An HIV test is the only way to know for certain if one is HIV-positive.

**Birth-control pills and putting on two condoms protects one from contracting HIV:** Birth-control pills prevent conception, not HIV. Condoms are 97 percent safe when used correctly. Using two condoms is dangerous as they can easily burst or tear due to friction and hence increase the chance of contracting HIV.

“I feel better after the treatment I was given; I am cured”: People with HIV and AIDS may feel better after treatment or after taking antiretroviral drugs. This does not mean that they have been cured as HIV is incurable, but they can learn to live as healthily as possible.

**Washing the genitals protects one from HIV:** Many believe that washing their genitals with soap, bleach, or methylated spirits before or after sexual intercourse will protect them from getting HIV. A few also think that drinking insecticides or methylated spirits will cure them of HIV and AIDS. All these methods do not prevent or cure HIV. In fact, they are harmful, fatal, and should be avoided. HIV lives in the body cells and bloodstream of HIV-positive people.

The following points can assist the facilitator in guiding discussion with participants about myths and misconceptions:

1. There is no theological or spiritual truth to back the myth that AIDS is a curse or punishment from God. If HIV is a curse, then all other currently incurable diseases are also curses from God.
2. Anyone who lacks accurate information, appropriate attitudes, skills, and services for self-protection is at risk of HIV regardless of his or her spiritual or moral beliefs and practices.

3. Morally upright/faithful people can get HIV and unfaithful/immoral people can escape HIV infections. It depends on whether or not they have the right information, appropriate attitudes, skills, and services for self-protection.

4. HIV cannot be caused by witchcraft.

5. Having sex with virgins cannot cure HIV and AIDS.

6. Virgins can get HIV and AIDS from other routes of infection other than sex if they lack accurate information, appropriate attitudes, skills, and services for self-protection.

7. Not all children born of HIV-positive parents are HIV-positive. Sixty to 70 percent are HIV-negative, and programs for prevention of mother-to-child transmission are increasing these percentages.

8. An HIV-positive person can live for over 15 years with adequate care, treatment, nutrition, and self-acceptance. AIDS progression can now be reversed with modern treatment and many opportunistic infections are treatable.

9. People who look healthy and fat can be HIV-positive, while those who look thin and sickly may not be.

10. Not all people with HIV are actively infectious. Those who have taken antiretroviral treatments correctly and consistently to achieve undetectable viral load levels are much less likely to transmit HIV through sex, although it is always good practice to take precautionary measures when having sex.

2.5 Modes of HIV Transmission and Prevention

HIV Transmission
HIV is found in bodily fluids such as blood (including menstrual blood), breast milk, vaginal fluid, and semen. HIV is most concentrated in the blood, semen, and vaginal fluid. A person can be infected only if one of these HIV-infected fluids enters the body and bloodstream. The virus cannot be transmitted through intact skin.

HIV is spread through three main modes of transmission linked to exposure to the body fluids of infected individuals. The most common means of HIV transmission are sexual contact, blood contact, and mother-to-child transmission.

Sexual Contact
Having unprotected sexual intercourse with a person living with HIV is the most common mode of HIV transmission. The frequency of exposure, the presence of cuts and sores on sexual organs, and the amount of virus in the semen or vaginal fluid are all contributing factors in HIV transmission through unprotected sex. Sexually transmitted infections (such as cancroid and syphilis) that cause sores are an important predisposing factor. Studies have shown that proper treatment of opportunistic infections reduces the chances of infection. One does not have to be engaged in unacceptable, unlawful, or morally inappropriate behavior to be infected through sexual contact.

Blood Contact
HIV is transmitted when a person is exposed to HIV-contaminated blood through blood transfusions, injections, body cuts, and other skin-piercing procedures. (A spouse, best friend, family member, or respected community leader may transmit HIV to another person in this way.) One does not have to be engaged in unacceptable, unlawful, or morally inappropriate behavior to be infected through contaminated blood. The most common ways are through:

- injections and sharing needles, intravenous drugs, or injury from contaminated needles or other sharp objects
- contaminated skin-piercing instruments, such as scalpels, needles, razor blades, tattoo needles, and circumcision instruments
• transfusions using infected blood or blood products or transplant of an infected organ; this is minimized if health personnel follow protocols for prevention of HIV infection through blood
• infected blood contact with broken skin through cuts or lesions

**Mother-to-Child Transmission (MTCT)**

A mother can pass the virus to her infant during pregnancy, delivery, or breast-feeding.

There are some factors that increase the chance of mother-to-child transmission during pregnancy and childbirth, such as the mother’s malnutrition and any infections she may have. During childbirth, other factors include complications with labor and the use of sharp objects that cause injury to the child.

Religious leaders can contribute to prevention of MTCT by encouraging expectant mothers to attend postnatal clinics and ensure hospital delivery.

Research has shown that HIV is not passed in the following ways:
- Shaking hands
- Insect bites
- Sharing cups, plates, and other household utensils
- Social kissing and hugging
- Sharing toilet and bathroom facilities
- Sleeping in the same room as an infected person

**HIV Prevention**

Despite some substantial efforts in HIV-prevention activities, there has not been a significant reduction in the spread and impact of HIV transmission. There is a lack of adequate and effective preventive care and support or palliative care services for the thousands of families affected by AIDS. Some of the major contributing factors to the continued spread of HIV include social/cultural practices such as early sexual debut; wife inheritance; male and female genital cutting, which intends to initiate youth into adulthood; and an active sexual life with multiple partners. Religious leaders are well placed to mitigate the impact of HIV and AIDS through these cultural factors by encouraging alternative cultural rites.

There are four technical elements that should be part of any effective HIV-prevention strategy:

1. **Risk Reduction**

Changing individual and community behaviors is key to HIV prevention. HIV spread can be prevented, slowed, and even reversed in developing and developed countries by implementing specific harm and risk-reduction strategies such as using safe surgical procedures, safe blood transfusion, reducing prison congestion to control drug abuse, and establishing needle-exchange programs. Gender-based violence also contributes to the AIDS epidemic as issues of rape, alcoholism, sexual abuse and violence, sex trafficking, and female genital cutting/mutilation also need to be addressed.

Effective prevention also requires individuals to adopt safer behaviors. This can be achieved through systematic behavior-change communication (BCC) methodology, which teaches role models and community behavior influencers (innovators) some positive behaviors and relays messages reinforced with strong communication outreach in the community.

2. **Information and Education**

Information and education in visual and other media formats provide individuals with the basic facts and the social context for HIV and AIDS, which may lead to motivating positive behavior change.

IEC campaigns should be tailored to address different stages of the epidemic, since population subgroups (target audiences) may be at different stages in the behavior-change continuum. Target audiences must be segmented into different groups, with targeted campaigns developed for each group. Faith groups can be segregated in different ways according to location or different ages for participation; different prayer groups for men and women; or faith associations, among others.

3. **Community Dialogue**

Dialogue among community groups stimulates discussions on the factors that contribute to the spread of HIV and AIDS, such as high-risk behaviors and the cultural environment. As a result, such dialogue contributes to information for prevention, care, and support services for affected and infected people.

HIV-prevention interventions aim to change individual behavior, although community and societal-level interventions have been developed to change norms and behaviors at the group level. It is critical to support and promote BCC at both the individual and group level.
levels. An effective prevention program should engage the community in addressing all possible causes of transmission and how to deal with them most effectively.

4. Advocacy

Advocacy efforts help ensure that policy makers and key opinion leaders stay informed about the epidemic and follow through on the promises they have made. Advocacy takes place at national and community levels. Experience has shown that while HIV risk grows quickly in a community or country, attitudes favoring prevention and preventive behaviors are likely to lag far behind. Mass media play an important role in promoting attitude changes and popularizing safer behaviors. When behaviors lag behind knowledge, religious leaders can work through the mass media to stimulate dialogue about risk behaviors and risk settings particular to a community.

Additional Approaches for Effective HIV Prevention

Voluntary Counseling and Testing (VCT)

Voluntary counseling and testing (VCT) for HIV is internationally recognized as an effective and pivotal strategy for prevention and care. VCT is an effective and cost-effective strategy for facilitating behavior change. It is also an important entry point for care and support. VCT is thus a valuable component of comprehensive HIV and AIDS programs. Religious leaders have a role to play in ensuring that their congregants and communities have access to VCT services.

The major barrier to VCT is fear of stigma; women in particular can face violence and loss of shelter, food, and relationships. It is particularly important to ensure and maintain confidentiality at all times when dealing with both men and women. Counseling itself is labor-intensive and requires training and supervision to ensure its effectiveness.

Voluntary HIV counseling and testing are key components of prevention and care programs. In prevention, VCT helps people learn the modes of HIV transmission, practice safer sex, get an HIV test, and, depending on the result, take steps to avoid becoming infected or infecting others. Within care programs, people can be directed toward relevant care and support services, such as treatment for tuberculosis and sexually transmitted infections, family planning, and, where indicated, treatment for opportunistic infections, antiretroviral treatment, and prevention of mother-to-child transmission. In addition, broader access to VCT may lead to greater openness about HIV and AIDS and less stigma and discrimination.

It is important to note that antiretroviral therapy (ART) drugs are increasingly available, and religious leaders should promote community awareness and preparedness for ART. Once people are aware that treatment for HIV is available, they are likely to go to VCT centers, which promotes self-disclosure and reduces denial. The greater the number of people living with HIV and AIDS in a community, the less stigma and discrimination the community will experience. In Sub-Saharan Africa, evidence and experience have shown that rapidly increasing the availability of antiretroviral therapy leads to greater uptake of HIV testing. Kenya, for example, saw a dramatic increase in testing and uptake of ARV in 2000–2004.

Managing Sexually Transmitted Infections (STIs)

There is a direct relationship between sexually transmitted infections (STIs) and HIV.

• The behavior that puts a person at risk of contracting STIs puts the same person at risk of contracting HIV infection.
• STIs that result in open/broken skin (e.g., sores, ulcerations, or inflamed/red and tender skin) make it easier for HIV transmission.
• A person who has a weakened immune system due to HIV infection has a higher risk of contracting STIs.
  • People who are HIV-positive have reduced immunity, which makes it difficult to treat STIs effectively.
  • Pregnant mothers who are HIV-positive and suffer from another STI increase the chances of transmitting the virus to their unborn babies during delivery.

Supporting Discordant Couples

Since HIV is frequently spread through heterosexual contact, it was wrongly assumed in the past that if one partner in a couple is infected, then the other partner is automatically infected. However, evidence has shown otherwise. In most of Sub-Saharan Africa, nearly a quarter of all couples in which one partner is HIV-positive, the other is HIV-negative. In such a relationship, the infected partner has not transmitted the virus to his or her partner despite a normal intimate sexual relationship. A couple in which one partner is
HIV-positive and the other HIV-negative is called a discordant couple.

That is why both partners are encouraged to go for testing. If one partner is HIV-positive, appropriate advice is given on how to protect the uninfected partner so that he or she can remain HIV-negative.

**Greater Involvement of People Living with HIV and AIDS in Prevention**

Prevention strategies are more effective when they meaningfully involve people living with HIV and AIDS in their design, implementation, and evaluation. The principle of greater involvement of people living with HIV and AIDS (GIPA) in the AIDS effort was formally recognized at the 1994 Paris AIDS summit when 42 countries agreed that ensuring the full involvement of people living with HIV and AIDS at national, regional, and global levels will stimulate the creation of supportive political, legal, and social development. (See Section 3.9 of the Handbook for more information on GIPA.)

**Stigma Reduction**

Stigma is a critical issue to address when developing BCC campaigns and other prevention activities. Stigma is defined as a mark of shame or discredit on a person or group. With regard to AIDS, stigma affects people living with HIV and AIDS and other sectors of the community touched by the epidemic.

Stigma often presumes a negative behavior on the part of those affected and is manifested in different ways, from ignoring the needs of a person or group to psychologically or physically harming the stigmatized. Because of stigma, those living with HIV are more likely to fear disclosing their status or being tested for HIV. As a result, they are at more risk of transmitting the virus to partners.

Stigma reduction attempts to influence the social response through communications regarding prevention and care. Through a BCC campaign or other prevention efforts, religious communities should address stigma and provide compassion and humane treatment for people living with HIV and AIDS. This approach helps to create an environment in which people are less fearful of being tested and are more likely to accept their HIV status. It is very important to involve people living with HIV openly in these anti-stigma and BCC campaigns.

To reduce stigma, religious leaders need to understand HIV and AIDS, and the fact that the disease is not a consequence of a sin, in order for them to reduce and eventually eliminate the stigma and discrimination associated with the disease in their congregations and communities.

**KEY IMPLEMENTATION QUESTIONS FOR STIGMA REDUCTION**

- In what ways is stigma hindering effective prevention and care interventions?
- What role can BCC, VCT, and other prevention and care interventions play in alleviating the impact of stigma?
- What existing legal, political, human rights, and policy contexts are related to stigma?
- Are policies in place to enhance and protect the rights of people living with HIV and AIDS?
- Has high-profile disclosure occurred within the country?
- Does the hospital and health care setting play a role in perpetuating stigma?
- What role do the religious leaders play to reduce stigma, denial, and discrimination?

**HIV Treatment**

There is still no cure or vaccine for HIV despite researchers’ efforts worldwide. An HIV infection may last a lifetime. However, many of the symptoms and conditions related to HIV infection, and the progression of HIV itself, are manageable with antiretroviral (ARV) drugs, which slow down the replication of the virus through different ways. ARV drugs greatly increase the life expectancy of people with HIV. They are currently cheaper than they were a few years ago, and several government and nongovernmental organizations are offering ARVs at minimal or no cost. All people living with HIV and AIDS should be encouraged to go for medical assessment to determine their level of need of the ARVs.

The use of ARVs, good nutrition, and a healthy lifestyle has contributed to improved quality of life for many people living with HIV and AIDS. Today there are many people living with HIV and going about their business like anyone else in the community.

This is one of the reasons why religious leaders and other actors in the community should promote healthy living and advocate for access to VCT and ARVs among individuals, families, congregations, and the community at large.
ARVs improve the quality and quantity of life. They are also a factor in HIV prevention by reducing the viral load to undetectable levels and by aiding the prevention of mother-to-child transmission. However, they do not cure HIV or AIDS. They prolong life and make one healthier by reducing the replication of the virus and may delay or reverse the onset of AIDS. However, the person remains HIV-positive and needs to continue with the treatment. The HIV virus can become resistant to ARVs, so it is important to undergo a periodic CD4 count and viral-load tests to check progress and any occurring side effects with the ARVs.

Health care professionals consider three things before starting ARV therapy:
- The viral load
- The CD4 cell count
- The presence of any symptoms

### 2.6 WOMEN AND HIV AND AIDS

According to the UNAIDS 2007 epidemic report, about 33.2 million people were living with HIV globally by 2007. Among them, the adult population was 30.8 million, of whom 15.4 million were women and 2.5 million were children under 15 years. In 2007, among the people who were newly infected with HIV, 2.1 million were adults and 420,000 were children under 15 years. AIDS-related deaths were about 330,000 for children under 15 years and 1.7 million for adults.

In Sub-Saharan Africa, almost 61 percent of adults living with HIV in 2007 were women, while in the Caribbean that percentage was 43 percent (compared with 37 percent in 2001). The proportions of women living with HIV in Latin America, Asia, and Eastern Europe are slowly growing as HIV is transmitted to the female partners of men who are likely to have been infected through injection drug use or during unprotected paid sex or sex with other men. In Eastern Europe and Central Asia, it is estimated that women accounted for 26 percent of adults with HIV in 2007 (compared with 23 percent in 2001), while in Asia the proportion reached 29 percent in 2007 (compared with 26 percent in 2001).

The following are key issues regarding HIV and AIDS and gender:
- Social expectations about the behavior of women and men reinforce gender inequalities and exacerbate the epidemic.
- Gender violence is linked to HIV transmission through rape and reduces the ability of women and vulnerable men to discuss sex with their partners.
- Unequal rights to property mean that women may be forced out of their homes when widowed or diagnosed with HIV. This increases their vulnerability to illness and sex work.
- The burden of caring for the sick falls mainly on women, increasing their domestic responsibilities and reinforcing stereotypes about gender roles.
- Unequal access to treatment means that fewer women than men are treated for HIV and AIDS-related illnesses, directly increasing the impact of the epidemic on women.
- Unequal access to appropriate prevention information for many women increases their vulnerability to HIV. Groups targeted by specific prevention interventions risk being stigmatized in the larger population.

**The Link between HIV and Violence against Women**

Studies have shown that high levels of the violence perpetrated against women are compounded by HIV and AIDS. This link occurs as follows:
- Assaults, battery, and the rape of children, especially girls, occur frequently and perpetuate the spread of HIV through rape or by promoting intrafamilial fear that might prevent disclosure by a HIV-positive partner to an HIV-negative partner or prevent negotiation for safe sex. Some situations such as conflict, migration, and sex work can aggravate the impact of violence on HIV-positive women.
- Society’s tolerance of violence against women prevents them from discussing the issue, leaving or confronting an abusive situation, or seeking help. Stigma and discrimination associated with HIV heightens such tolerance.
- Women may fear leaving an abusive relationship because of the children’s safety and security if they do not have child-custody rights.
- Women are often the first in the household to discover their status through postnatal testing. This can lead to blame, violence, or rejection by partners or in-laws, family, friends, and community.
- Exposure to reinfection by a partner’s refusal to wear condoms, or the violation of a woman’s reproductive rights can endanger her life due to HIV-related complications.
- Internalized stigma and discrimination may mean that people living with HIV and AIDS feel...
ashamed of themselves and of their status, which can undermine their confidence to leave or confront an abusive relationship.

- Myths and misconceptions and attitudes about HIV promote violence against women. For example, the belief that having sex with a virgin can cure you has led to increased rape of young girls.

Vulnerability to Gender-Based Violence and HIV and AIDS

In everyday usage, the word “vulnerable” means being liable to injury or hurt feelings, and open to successful attack. The implication is that one who is vulnerable can easily be injured, hurt, or attacked. Vulnerable populations are, therefore, those that can easily be attacked by some danger. In the context of gender-based violence (GBV) and HIV and AIDS, vulnerable populations are in some disadvantaged situation and are therefore easily manipulated, forced, or coerced into sexual activities that expose them to the risk of HIV infection. Basically, they are groups of people who are taken advantage of by those they trust or those who are authorized by society, religion, or the state to protect them. These groups include:

- Refugees fleeing their countries as a result of civil strife or war
- People displaced by natural disasters, ethnic cleansing, or civil strife
- Trafficked and/or migrant girls and women
- Children
- Women and girls living in conflict settings
- Girls and women who have to undergo harmful traditional practices such as female genital cutting, child marriages, widow inheritance, or payment of dowry
- Commercial sex workers

GBV and HIV and AIDS are among the serious social, cultural, and economic problems facing humanity today. They therefore need concerted effort to solve them. Religious leaders and peoples of faith know that to overcome major threats to humanity like HIV and AIDS, it is necessary to work together. This can be achieved through multi-religious cooperation at the local, national, regional, and international levels. To combat the effects of GBV and HIV and AIDS, therefore, a multi-religious approach is the best option because religious leaders and people of faith sometimes operate even where local governments are unable to reach.

The comparative advantage of faith communities, therefore, lies in the fact that:

- Faith-based institutions have a wide reach, and operate in circumstances where government institutions are absent or weak. They can therefore be used to assist survivors of GBV who cannot be reached by government officials.
- The international community trusts faith-based organizations more than many national governments, which lack transparency and accountability. Funds to combat the effects of GBV and HIV and AIDS can therefore be channeled through them.
- Faith-based organizations are better placed to offer shelter to vulnerable groups and survivors of GBV since it is easier for them to receive funding than most other nongovernmental organizations (NGOs) and community-based organizations (CBOs).
Module 3: Combating HIV and AIDS Related Stigma, Denial and Discrimination

3.1 INTRODUCTION

HIV and AIDS-related stigma and discrimination are shaped by a combination of several co-occurring behavioral patterns; while not unique to HIV and AIDS, they have had probably the greatest impact in stigmatizing the syndrome. Unfortunately, the behavior patterns have a profound effect on the preventive strategies for HIV infection and the reversal and mitigation of HIV and AIDS and AIDS-related impacts.

The stigma and resultant shame related to HIV and AIDS cause families and communities to deny their existence within their midst. This, within the religious context, is usually a wall of silence around the disease and continuously and persistently excluding those infected and affected from participating fully in worship and other activities within the faith community. This discrimination may be extended to spouses, children, and other family members of the infected and the affected person.

As the community continues to deny the problem and discriminate against those infected, affected, and their families, it misses opportunities to take remedial action. By these actions, the religious leader, congregation, or community make people fearful about being tested for their status. People are afraid that when they are tested with positive results, they would face similar seclusion, persecution, and discrimination. The fear of shame and stigma thus causes inaction.

If an individual is infected but has not been tested, then she or he can unknowingly spread the disease to uninfected people. This is the most serious consequence of the stigma and shame associated with HIV and AIDS. By failing to test, the HIV infection chain cannot be broken.

Those who have tested positive might choose to remain silent because of similar fears. They fail to seek information and services to help them live healthily in mind and body, and eventually are more likely to develop full-blown AIDS. This results in physical, financial, and emotional strain, and eventually social debilitation. At this stage, many individuals and families are driven by desperation to seek witchdoctors and other quacks, take vengeful actions, or, in a few cases, commit suicide. Others decide to live in denial.

Attention needs to be focused on stigma, denial, discrimination, shame, inaction, and mis-action as most of the negative behavioral patterns are associated with these elements.

In the past, programs dealing with HIV and AIDS failed to have meaningful impact as they did not address issues of stigma, denial, and discrimination. In a few instances when attempts were made to tackle these issues, developing interventions was difficult as SDD was too rooted in the culture and behaviors of specific communities and was thus context-specific. However, studies in various communities have shown that these behavior patterns have striking resemblance regardless of the communities practicing them.

3.2 DEFINITIONS

Stigma

Silence kills, stigma kills. We should not want those living with HIV to be the modern equivalent of the biblical leper who had to carry a bell and shout saying, “I am unclean.”

—Archbishop Desmond Tutu

According to UNAIDS, HIV-related stigma is “the process of devaluation” of people either living with or associated with HIV and AIDS. This stigma is derived from the historical and contemporary association of HIV and AIDS with what society considers socially unacceptable behavior and the fact that it leads to an incurable, unalterable, severe, and degenerative condition that may result in physical disfigurement or death (Nzioka 2000).

The Religions for Peace manual on Advocacy and Media Relations for Religious Leaders gives this definition: “Stigma is discrediting a person on the basis of his or her belonging to a particular group or on the basis of possessing certain characteristics such as color, the way the person talks, the way the person walks, etc. It is a mark and a token of disgrace.”
Religions for Peace • Combating HIV and AIDS Related Stigma, Denial and Discrimination

In previous years, and in the religious context, HIV was stigmatized because it was transmitted sexually and because of perceptions that those living with the virus were sinners and were thus paying the wages of sin or leading immoral lives.

Stigma is also reinforced by fear driven by a perception of risk or the threat of infection with an incurable or potentially fatal disease. Epidemics that present an overt threat to the values of a community are likely to evoke stigma. Stigma is used to “enhance or secure social structuring, safety and solidarity or reinforce societal or community values by excluding divergent or deviant individuals”

Fear of contagion is not reduced by general knowledge of how HIV is transmitted. As shown by studies in several countries and testimonials by people living with HIV and AIDS, even health workers who are quite knowledgeable about the modes of transmission routinely exhibit fear and irrational behavior and stigmatize people living with HIV and AIDS. Only in-depth knowledge and appreciation of how HIV is not transmitted and the vulnerability of the HIV virus in the open environment have been shown to reduce this fear.

Although most often stigma is directed at individuals, families, communities, tribes, or even districts/ counties, countries and regions can also be stigmatized. For example, Sub-Saharan Africa is often described by the Western media as a region where HIV is “rampant” or “runaway,” which perpetuates a misconception and labels a significant population as immoral, lacking in self-control, or ignorant.

Stigma reinforces and strengthens existing prejudices and social stereotypes. Thus, women, orphans, and certain nationalities and social classes will face increased prejudice, which often leads to increased inequalities and the spread of HIV infection within these targeted groups.

Shame

Shame is the internalization of guilt by an individual or family for bringing themselves or their communities into disrepute. Shame is a powerful social tool used to force members to conform to societal values and norms. Being shamed or losing face is the degradation of an individual in the eyes of society for failing to meet the acceptable standard of behavior within that society.

Within many societies in Africa, the loss of face associated with shame is a powerful determinant of behavior. Public naming and shaming of individuals practically makes them pariahs within their communities.

The same is true within the context of HIV and AIDS. Individuals and communities are shamed, lose face, and coerced to feel bad for being infected and affected.

CASE SCENARIO

Mary was a prominent member of a congregation in Mombasa, the coastal town of Kenya. A deeply religious woman, Mary was often in the church office and could be seen helping the pastor with visitors, organizing church functions, singing in the choir, and many other activities. Mary’s husband was also a Christian and worked in Nairobi, the capital city west of Mombasa. Mary was a housewife. In early 2002, Mary’s husband developed a nasty cough. After unsuccessful treatment and continued deterioration of his health, which led to admission to hospital, he was tested and found to be living with HIV. He resigned from his job and went home to Mombasa to disclose his HIV-positive status to his wife. He also visited the pastor and discussed the problem with him. The pastor advised him to be quiet about the situation and promised to pray for him. The following Sunday, the pastor made an impassioned speech, denouncing immorality and warning the congregation that those who failed to take heed would face death from AIDS. Mary’s husband died about a month later. The death of her husband was a big blow to Mary, but the worst was yet to come. First, the pastor refused to preside over the funeral. Instead, he sent a junior church official. Later he told Mary that she should not come to the church offices. Soon other congregational members were shunning her, refusing to greet and hug her as they used to. Eventually, Mary was forced to change to another church as the members were hostile to her and did not wish to associate with her. Mary has also been tested and found to be HIV-positive. She has, however, managed to overcome social rejection and is living positively with the virus.

This is a true story as told by a lady during a satellite session hosted by HACI during the ICASA conference in Nairobi in 2003. Mary is not her true name.
Community perceptions of sexual immorality, “loose” behavior, making questionable decisions, lack of self-control, prostitution, and other behaviors that do not conform with societal norms are seen as causes of being infected or affected. Shame is especially gendered. Women are more likely to have or be forced to feel ashamed for failing their husbands, children, families, or community even though not all HIV infections are caused by an individual’s failure.

Such individuals or families are made to feel that they have failed their communities and should “pay penance” by excluding themselves; not expecting or demanding social respect, dignity, and acceptance; or by doing more than other members of society. In faith communities, they exclude themselves from their congregations by not worshiping, praying, tithing, or being more pious than other members of the same congregation.

Denial

Denial is the failure to acknowledge or face reality. In the context of HIV and AIDS, denial means that an individual, family, institution, community, or nation refuses to acknowledge the presence and threat of HIV and AIDS within their lives and interactions. In some areas, denial and silence regarding HIV have been the norm for years. People do not want to admit that a fatal disease spread by behaviors branded as immoral could be rampaging through their community or country.2

Until the mid- to late 1990s, denial of the global nature of the pandemic was still evident. Such an individual or group in denial would convince themselves that the infection could not infect or affect them since they were good, pious, faithful to their spouses, lived in a good neighborhood, etc.

At the individual level, self-pity is the driving force of denial. At the family and community level, denial is driven by cultural, ethnic, racial, and class considerations. Within faith communities, some faiths have higher levels of denial than others. Many religious leaders may deny the existence of the disease within their congregation for fear that high prevalence rates may indicate them of failure to uphold the morals of their congregation or their faith community.

This denial of the presence and threat of HIV and AIDS is responsible for low uptake of HIV and AIDS-related services, including prevention, Voluntary counseling and testing, treatment, care, and support services. Many faith congregations’ failure to commence HIV and AIDS-related activities within their institutions is due to the lack of volunteers, which is often driven by the denial that the condition is an important factor among the congregation.

Congregational responses may be muted or lack integration with other services and activities as a community or religious leader may not want to appear too keen on HIV-related issues. Indeed, religious leaders have feared that congregants will desert congregations if they see increased HIV and AIDS-related activities. This may indirectly increase denial.

Discrimination

Discrimination is the unjustifiable differential action taken by individuals toward others, their families, communities, tribes, races, or nations because of their race, gender, age, religion, socioeconomic status, or health condition. Such actions are intended to demean, deride, or subjugate the individuals concerned.

According to UNAIDS, discrimination is different treatment of individuals who, within a particular culture or setting, have certain attributes that others define as discreditable and unworthy. It is thus the progression from stigma, which marks that person with an undesirable attribute, to giving them differential treatment.

In relation to HIV and AIDS, discrimination is additionally spurred by the false notion that people living with HIV and AIDS are waiting to die and therefore have no need for education, jobs, skills upgrading, good medical care, property, good clothes, entertainment, friends, marriage, or otherwise live normal lives.

Several groups are at risk of being discriminated against since they have a lower social status due to historical or cultural practices. These vulnerable groups include women (especially widows), children, the physically or mentally challenged, and the poor. Children are especially at risk of discrimination by association when they are discriminated against because their parents are living with HIV. Due to inadequate knowledge of HIV and AIDS, it is erroneously assumed, even by well-educated people, that such a child is automatically HIV-positive.

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Discrimination is not only confined to those who are ignorant of the transmission of the disease. For example, some years ago it was routine for hospitals to have separate isolation wards and beds for HIV-positive patients, which ingrained people’s fear of those living with HIV and AIDS even though medical personnel knew that casual contact would not spread the disease. In religious communities people have been denied participation in rituals, such as communion.

The majority of people, especially couples, have not gone for an HIV test because if one or both partners were HIV-positive, it would create a marital problem that they would not know how to deal with. In other words, many would prefer to be ignorant than have to come to terms with the reality.

The paralyzing fear of finding out one’s HIV status leads to inaction. However, in other instances, inaction can be due to inadequate knowledge or inappropriate attitudes.

Others are afraid of taking preventive measures because others might think they were infected or lacking in morals. Some people have not been tested and therefore do not know their HIV status. Although they may suspect that their spouse may be unfaithful, they may not use a condom for fear that they may be thought to be HIV-positive.

The inaction of one or both partners may lead to infection as the HIV-positive party may infect the spouse who is HIV-negative.

A prenatal HIV test could avoid mother-to-child transmission. An HIV-positive mother’s failure to be tested may lead to infection of her breast-fed baby.

Some mothers who, having had a prenatal test and found they were HIV-positive, fail to disclose it to their spouses for fear of rocking the marital boat. The child is consequently infected at delivery or subsequently through breast-feeding.

**Mis-action**

Many cases have been reported of individuals developing depression and suicidal tendencies on learning they are HIV-positive. Taking the wrong action on discovering that one is HIV-positive is called “mis-action.”

Within the religious context, one of the most common mis-actions is faith healing. The infected person fails to seek medical services and waits for faith healing. In the intervening period, many people living with HIV and AIDS who were leading healthy lifestyles, sometimes with the assistance of antiretroviral drugs, might neglect their medication before consulting with their health care providers, believing that the virus has been completely eliminated from their bodies. Indeed, many who have sought God’s intervention in dealing with HIV and AIDS think it shows a lack of faith in God to be tested after being prayed for.

**CASE SCENARIO**

Jane (a pseudonym), a mother, was a teacher in a private school in Kibera, a large slum on the southern outskirts of Nairobi. Her five-year-old daughter was a pupil in the same school. When her husband died after a long illness, she decided to take an HIV test and tested HIV-positive. Fortunately, her daughter tested HIV-negative.

Jane joined a support group for people living with HIV and AIDS in her neighborhood. When her employer noticed her fraternizing with the group, she questioned her about her status. Jane revealed to her employer that she was HIV-positive. Her employer immediately fired her even though she was a good teacher and had never fallen ill. Two weeks later, the former employer called her and asked her not to bring her child to school as she was a risk to other children even though the child was HIV-negative.

This is a true story as told by a participant during a preparatory workshop in the development of this manual in 2004 in Nairobi, Kenya. The young girl was discriminated against by the school because her mother was living with HIV. Given that the mother had also lost her job and her source of livelihood, her daughter was in danger of not continuing with her education, thus exacerbating her vulnerability.

**Inaction**

Inaction is failing to go for an HIV test, join a group for people living with HIV and AIDS, or take out life insurance, which would require a mandatory HIV test as the ultimate fear would be discovering that one is HIV-positive.
Some of the mis-actions may include raping and molesting children in the erroneous belief that having sex with a virgin or child can cure HIV infection.

Mis-action has had the following unfortunate results:

- **Increasing fear of infection:** This hastens stigma, shame, denial, and discrimination.
- **Death:** Many HIV-positive people progress rapidly to full-blown AIDS and death because of mis-action.
- **Inaccurate and disempowering language about HIV and AIDS and those living with it:** Such language in reference to people living with HIV and AIDS reinforces stigma, shame, denial, and discrimination among those living with the virus.
- **Perpetuating false information, doctrines, and theologies:** Wrong or inaccurate information about the disease perpetuates myths about witchcraft and curses. Among faith communities, it may lead to incorrect doctrines stating that AIDS is God’s punishment for wrong or immoral behavior, or a false theology of disempowerment based on quotation of Holy Scriptures out of context. Instead, a theology of empowerment should be offered.
- **Exploitation of people living with HIV and AIDS is a major consequence of mis-action:** In many countries, individuals and even organizations have exploited the ignorance and anxiety of people living with HIV and AIDS to announce new discoveries and treatments for the virus, and then charge exorbitant fees for them. Many people anxious to be cured have spent life savings and family resources to purchase such treatments. This kind of exploitation occurs as national governments responsible for authorizing the sale and distribution of drugs and licensing of other treatments turn a blind eye as the people living with the virus are taken advantage of.

Previously it was not considered possible to have large-scale antiretroviral treatment in Africa as the population was largely illiterate and therefore could not adhere to the stringent treatment schedule of the combined therapy. That belief and inaction on the part of international agencies delayed crucial funding programs for antiretroviral drugs for several years, leading to untimely death and suffering of hundreds of people living with HIV and AIDS who might have been helped.

In conclusion, stigma, denial, and discrimination cause individuals, communities, congregations, and nations to remain ignorant, powerless, oppressed, silent, and vulnerable. This continues to undermine and frustrate interventions for increased HIV prevention, AIDS care, treatment, and impact mitigation at all levels.
3.3 SOURCES OF STIGMA, DENIAL, AND DISCRIMINATION

A clear understanding of the sources of stigma, denial, and discrimination is important to the development of appropriate strategies and plans to combat the menace. These sources include:

Fear of Casual Infection
This fear is caused by lack of in-depth understanding about how HIV is transmitted and its subsequent progression to AIDS. It is sometimes referred to as medical stigma as it results from epidemics such as leprosy, plague, influenza, cholera, and dysentery, which are spread primarily by contact or inhalation.

This fear is rooted in the belief that casual contact, sharing utensils, or living with a person with HIV will automatically give the virus to an uninfected person. This fear leads people to avoid shaking hands with an infected person or hugging him or her, or designating certain utensils for the exclusive use of the infected person, and eventually housing an HIV-positive person in a separate room in the house.

Remarkably, even health professionals can fear infection from casual contact, and subsequently often avoid contacting and treating people living with HIV and AIDS.

Fear of Immediate Death
When a disease is mysterious, painful, and causes unexplainable deaths, a society will stigmatize any person suffering from it. HIV and AIDS was initially perceived to be a mysterious disease, and those infected died in an undignified way, which perpetuated stigma. According to Cogan and Herek (1998), the fact that AIDS is incurable and leads to disfigurement before death made the disease more mysterious and stigmatized.

Billboards along major highways and market centers with depictions of severely emaciated individuals on the point of death, accompanied by the universal danger sign of a skull and crossbones, reinforced the perception that HIV leads to an inevitable early, painful, and undignified death.

Connection with Poverty and Immorality
There is a perception that all HIV infections are caused by illegitimate and immoral sexual contact, and that people living with HIV or AIDS are immoral and sinful.

As well, there is a perception that infected women are sexually active or engaged in commercial sex.

Certain types of stigma are directed at certain classes of people, especially poor women, who are perceived to be sexually immoral and involved in the commercial sex trade. This is a generalization about all poor people based on the actions of a few.

The attribution of immorality is devastating, especially for political and religious leaders who are expected to have higher morals than the general public. However,
prominent personalities like sports celebrities or media icons living with HIV and AIDS are not subjected to social condemnation. For example, legendary tennis player Arthur Ashe, who died of the virus, was idolized.

**Uncritical Use of Holy Scriptures**

In many circumstances, religious leaders have inadvertently, or sometimes intentionally, caused stigma and discrimination through the uncritical quotation of holy texts and scripture in ways that have associated HIV and AIDS, and those affected by it, with scenarios, behaviors and attitudes from the ancient historical worldviews reflected in those texts. The result is often perceptions of sinfulness and blame for illness that is seen as a punishment for wrongdoing.

**Lack of Awareness of Stigmatizing Attitudes, Actions, and Language**

Many people who stigmatize those living with HIV and AIDS are often unaware that they are doing so. They say and do things in good faith without realizing the negative consequences of their words, messages, and actions. (See box at right.)

### 3.4 Manifestations of Stigma, Denial, and Discrimination

**External Manifestation**

**Avoidance**

This is the most common and subtle form of stigma. People avoid shaking hands, sharing a seat in church, using the same utensils, and eventually living in the same house with an infected person. This avoidance results in loneliness and great mental anguish for those infected, especially when the people avoiding them are close family members, friends, colleagues, or members of the same congregation.

**Isolation**

One is regarded as an outcast and is isolated and rejected by close family members. This causes those living with HIV and AIDS to withdraw from the rest of the community. Prominent personalities will isolate themselves or move to different residences to avoid stigma, shame, and discrimination.

**Discrimination**

People living with HIV and AIDS face different types of discriminatory treatment when their status is known. Many have been denied jobs or were dismissed from employment. Others have been denied promotion, skills upgrading, education opportunities, insurance policies, medical cover, hospital beds, etc., once people realize they have HIV or AIDS. Young HIV-positive children are routinely denied school either by relatives or the school authorities. A good example was a child from Nyumbani, a children’s home in Nairobi, who was denied enrollment in school for being HIV-positive. The home’s administration had to obtain a court order for the child to be admitted when the school authorities refused to heed a government directive to enroll the child in the school.

Within families, people living with HIV and AIDS have been denied food, inheritance, and even medical treatment. Within congregations, the most common discrimination is a religious leader’s refusal to officiate
a marriage ceremony where the bride or bridegroom has HIV or AIDS. An infected person might also be denied leadership and responsibility within the religious institution.

**Moral Judgment**
Finding someone to be morally deficient justifies the consequential stigma and discrimination directed toward him or her. Moral judgment allocates blame and helps those discriminating to distinguish between themselves as holy people and those infected, who are regarded as unholy, sinful, and deserving of the “punishment.” Religious institutions and leaders are sometimes faced with the dilemma of using appropriate nonjudgmental language when preparing messages for their congregations.

**Stigma by Association**
A person is stigmatized because someone related to them has HIV and AIDS. The perception is that through casual contact, an associated person could also be infected, so he or she should be avoided. Stigma by association causes friends and relatives to avoid the infected individual in the hope that they themselves will escape social stigma.

**Marginalization**
This differs slightly from discrimination as it is not overt but perceptible. It usually occurs in the workplace and is caused by the notion that people living with HIV and AIDS will die soon, so no investment should be made in their future. Such investment is viewed as an unnecessary drain since the person will not be there to utilize any new skills gained. People living with HIV and AIDS are also among the first to be considered for retrenchment and other cost-cutting measures within organizations. Within the faith communities, they will not be considered for leadership regardless of their commitment.

**Abuse**
Many people living with HIV and AIDS have been verbally or physically abused by their spouses, families, and sometimes coworkers. Women and children are especially affected, with many widows being thrown out of their homes and physically assaulted by their in-laws when their husbands die of a disease suspected to be HIV and AIDS-related.

Children are taunted by other children in schools or playgrounds because their parents or other relatives are known to be HIV-positive. Children living alone or with sick parents are constantly abused and exploited by close relatives and neighbors because of their vulnerability.

There have been cases where women are physically abused by their spouses for insisting on safe sex. The women may have reason to believe that their husbands have more than one sexual partner and are assaulted for refusing to be exposed or infected with the virus or for implying that their partners are infected.

**Internal Manifestation**

**Self-Exclusion**
A person living with HIV and AIDS resolves to exclude himself or herself from others. For example, an HIV-positive person might resign so as not to be in the same work environment as healthy employees.

Many infected people will not seek services or jobs for fear that they will be forcefully tested and stigmatized.

**Overcompensation**
This can be positive or negative.

- **Positive compensation**: This arises when the individual who, after realizing that she or he has HIV or AIDS, tends to overreact by being overly good to those around them so that they will not suspect that the person is sick.

- **Negative compensation**: Due to an HIV-positive status, the individual may neglect his or her health.

**CASE STUDY**
At a recent funeral in central Kenya, a pastor decided that it was time to discuss the cause of death of the person being buried, a young man who had died of AIDS. This was meant to open up debate on HIV and AIDS and educate the community about the many deaths from the disease in that area. He lambasted a young woman whose husband had died earlier. His cause of death was not disclosed, but the pastor concluded that the person being buried, who was a younger brother of the woman’s late husband, had been infected by the same woman, who had now “murdered” two people. He meant this to be a warning to area residents not to covet their dead relatives’ wives. However, those present did not understand the message that way. Needless to say, that night the woman’s house was torched and she was banished from the homestead.
family, and other responsibilities. Many infected people have turned to alcohol out of desperation and despair.

Revenge
A person living with HIV may seek to take revenge for his or her situation by trying to intentionally infect others with HIV through sexual liaisons with multiple partners or even through rape and violence. Usually such behavior is due to deep-rooted personal self-hatred that gets directed towards others, often by those persons who felt they had been infected through no fault or action of their own and who have not gotten any support and thus feel helpless and resentful.

Self-Rejection
Due to the behavior of those living around them, those living with HIV and AIDS reject their situation, lose hope, and give up on life. Once HIV-positive people know their status, they become unproductive or supposedly die faster. They have inadequate knowledge about the progression of the virus and are unaware that one can lead a long and rewarding life even though one is infected.

CASE SCENARIO

AFRICA: Religious leaders urged to drop “holier than thou” attitude to HIV

NAIROBI, 20 June 2007 (PlusNews)—Understanding and support, not moral judgment, is what HIV-positive people need from their religious leaders; this was the message from a recent meeting of the International Network of Religious Leaders living with or personally affected by HIV and AIDS (INERELA+) in the Kenyan capital, Nairobi.

“The attitude taken by most religious leaders towards those infected by HIV is one of condemnation: that the reward for sin is calamity and death,” Sheikh Ali Banda, from the Islamic Centre in Lusaka, Zambia, told IRIN/PlusNews. “This should not be the attitude, because when one has lost hope, one turns to the mosque or church for consolation.”

Banda, whose older brother died from an AIDS-related illness, said ignorance was the main reason for such attitudes. “It is important for religious leaders to have HIV awareness, so that the information trickles down to the congregation,” he said. “We should not judge people by the calamities that have befallen them, but teach them how HIV is spread so they can avoid infection.”

Although religious institutions in Africa have been integral in providing care and support to communities affected by AIDS, particularly in the area of setting up home-based care programmes, their impact on raising awareness about the pandemic has often been limited to preaching abstinence and faithfulness, with some describing the AIDS pandemic as divine retribution for pre- and extra-marital sex.

Uganda’s Canon Gideon Byamugisha, former chair of INERELA+’s African chapter, said the network was advocating a shift from condemnatory prevention messages, which only served to increase stigma, to a focus on improving HIV awareness.

“The message we would like to get across is that HIV is preventable, while AIDS is manageable,” he said. “People must know their status, because those who are positive think they are negative, while those who are negative are afraid they could be positive.”

Byamugisha disclosed his HIV-positive status shortly after being diagnosed in 1992. He noted that religious leaders living with HIV were especially subject to stigma, due to the position they occupied in society.

“People wonder how church leaders get HIV... sometimes you never know how you got infected—maybe through injections, blood transfusion or sex in marriage,” he said. “It is not important to know how someone got infected, but to know how one can continue to live positively,” he said.

The organization has dubbed its approach to HIV control “SAVE”: Safer practices to prevent infection and for the care of infected persons; Access and availability to treatment and nutrition; Voluntary counselling and testing; and Empowerment with knowledge and skills.

Report can be found online at: http://www.plusnews.org/reportaspx?ReportId=72844
In extreme cases, self-rejection may result in suicidal tendencies stemming from severe depression accompanied by a lack of self-worth and hope. Religious leaders have a duty to counsel and encourage those who are HIV-positive not to judge or reject themselves by committing suicide.

**Fear of Disclosure**
During a workshop held in Nairobi in 2004 to discuss how people living with HIV and AIDS could combat HIV-related stigma, a young man disclosed his HIV-positive status. He knew about his positive status in 1998, but had not disclosed it to his parents and relatives for fear of the repercussions even though he had attended many counseling sessions. Although he was a trained counselor, he disclosed the news to everyone except his close relatives.

This fear of the consequences of disclosure prompts many HIV-positive individuals not to disclose their status. It is a defense mechanism against having to confront and deal with any unpleasant issues that may arise if they reveal their status.

### 3.5 THE ROLE OF RELIGIOUS LEADERS IN COMBATING STIGMA

For the churches, the most powerful contribution they can make in combating HIV transmission is the eradication of stigma and discrimination. Given the extreme urgency of the situation and the conviction that the churches have a distinctive role to play in the response to the epidemic, what is needed is a rethinking of our mission, and the transformation of our structures and ways of working.  

Religious leaders are important opinion shapers within their communities at the local, national, and international levels. The public have enormous trust and confidence in them. They are listened to and their opinions sought, not only by their congregants and people of similar faith, but also by other leaders and the general public. By giving credence to certain actions, opinions, or words, they legitimize them in the eyes of their community members.

Religious leaders influence their congregations, communities, and the greater public in how they judge and accept certain actions and opinions. They influence society in deciding what is good and acceptable or bad and unacceptable. This has great influence in shaping normative behavior.

Religious leaders and their congregations control important mediums of communication within their communities and to the wider public. Religious leaders at high echelons in their faith communities have networks through which information is shared and knowledge is passed, and new doctrines and conduct are approved or disapproved. It is through this faith community network that a culture is developed.

Thus, when religious leaders combine the trust and confidence they enjoy with the legitimization and authentication of certain actions and opinions, and with the power to communicate and share such actions, opinions, and words both within and beyond their faith community networks, they become truly transformative.

This transformational power is critical in addressing HIV and AIDS-related stigma and discrimination. Religious leaders have a role to play in eradicating stigma and discrimination within families, communities, and the national arena. Once this transformational power is harnessed, it can be an effective mechanism to defeat stigma, denial, and discrimination.

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3*AIDS-Related Stigma: Thinking outside the Box. EAA and WCC, 2005.*
3.6 INTERVENTIONS TO COMBAT SDD AT THE INDIVIDUAL LEVEL

The Role of People Living with HIV and AIDS in Reducing Stigma, Denial, and Discrimination: Living Positively

Positive living is a combination of several factors that people can use; both a positive mental attitude and a healthy physical lifestyle can boost their immune system. Positive living is doing everything to help the immune system cope with the HIV virus in order to live well and have a more productive life. The basic points for positive living are highlighted below.

Make Plans for Life
Being HIV-positive should not mean giving up on life. Although there are adjustments to be made and practical matters to be dealt with, people living with HIV and AIDS should be helped to deal with them as soon as possible while they are still well enough to do so. They should be encouraged to keep on working as long as possible.

They should not give up things they enjoy doing or cancel dreams and aspirations. Loneliness should not be a factor; it is still possible to meet a loving and supportive partner.

Inform Family and Friends about One’s HIV Status
This may be difficult, but hiding this kind of information has a negative impact on both physical and mental health. It can hurt those who care about them if they feel that they cannot trust them with such information. It would help family, friends, and coworkers to understand when one is not well or is sometimes unable to be as productive as usual.

Those who hide their illness from others and try to carry the burden alone have less resistance to disease and die much faster than those who confide in friends and loved ones.

Avoid Tobacco, Drugs, Alcohol, and Other Harmful Substances
Tobacco harms the lungs and prevents the absorption of nutrients such as vitamin C. Alcohol, caffeine, or black Ceylon tea can strain the liver. These are also stimulants and can cause insomnia. Illegal drugs damage the organs, including the brain. Both drugs and alcohol can lead one to have unsafe sexual encounters.

Moderation is very important. The occasional cigarette, glass of wine, or beer may do little harm, but it is important not to strain the body’s ability to function.

Maintain Daily Hygiene
Everyone should bathe with soap and clean water every day. People living with HIV and AIDS should add a little salt, household bleach, or antiseptic to the water to kill bacteria on the skin. Brushing teeth after every meal, washing hair at least once a week, and keeping the nails clean and trimmed regularly all contribute to good hygiene.

Clothes and bedding should be washed regularly. Hygiene not only avoids infection, but a person who looks neat and smells clean feels good about himself or herself and is more likely to socialize and stay in contact with friends and family.

Get Rest and Exercise
People living with HIV and AIDS should avoid being idle if they are still able to be active. Exercise tones the muscles and keeps them strong. It is good for the heart, ensuring that the blood has a constant supply of oxygen for circulation to the brain and the body. Stretching, bending, and massages are good ways to keep the circulation going even when walking or more vigorous exercise is not possible.

Anyone who has regular exercise and who has enough fresh air, oxygen, and rest is able to be positive and enjoy life. Even if they are seriously ill, they will also be able to cope better with responsibilities.

Avoid Infections
An ill person is susceptible to bacterial or other infections as the immune system is weakened and cannot defend the body well. Those with HIV or AIDS are particularly vulnerable.

People living with HIV and AIDS should avoid situations in which they could get infected by others who are sick with a cold, a cough, or flu. They should stay away from animal and chicken enclosures, rubbish heaps, and any place where bacteria may be present and present a risk of infection.

HIV-positive people should abstain from sex or use protective measures to avoid infection with STIs or reinfection with a different strain of the HIV virus. Reinfecction, STIs, and pregnancy will all weaken the immune system and hasten the progress of AIDS. They
should also avoid being pregnant unless they are under strict medical supervision.

Seeking prompt treatment for STIs and other infections, including TB, is strongly encouraged so that greater health risks are minimized.

Monitor General Health
Visiting the clinic or hospital regularly for checkups, including weight monitoring, is a good routine. A doctor or health worker can identify health problems early and ensure that the correct treatment is given. Medicines should be taken as prescribed, otherwise the they may not work properly or may prove harmful.

Pregnant women should visit clinics regularly to ensure that they receive the best possible care. Children with HIV or AIDS need regular medical attention as they have special needs.

Seek Spiritual and Other Counseling
Counseling and other psychosocial support is critical for the person living with or affected by HIV. It assists in developing a positive attitude, living positively with the infection, or taking care of those within the immediate family who are infected.

The infected and affected are encouraged to have a personal relationship with a priest, imam, or a spiritual person who can support them in dealing with the realities of HIV and AIDS. It is especially important to seek spiritual nourishment within the faith community. This may not always take place in a formal setting, such as with a priest or trained counselor; sometimes just having a good friend to talk to or laugh with can be uplifting.

Avoid those who are negative, treat others badly, or make one feel bad about oneself. Negative or depressing situations can suppress the immune system.

Herbs have been used in all cultures for their nutritional and medicinal value and to make food more appetizing. For instance, garlic and onions are delicious and are natural antibiotics.

Share with Families and Children: Memory Books
In many countries, memory books have become an important way of opening channels of communication within families about HIV and AIDS, and helping HIV-positive mothers tell their children about their HIV status. Terminally ill parents and their children work together to compile the memory book, which is often an album containing photos, written anecdotes, and other family memorabilia.

In Uganda the use of memory books was pioneered by The AIDS Support Organization (TASO) in the early 1990s. Since 1998, the National Association of Women Living with AIDS has promoted this approach on a wider scale. The association found that HIV-infected mothers had great difficulty communicating with their children about their ill health, and that memory books were good ways for the women to introduce the idea of HIV to their children and discuss its impact.

The book serves as a reminder to children of their roots so they do not lose their sense of belonging. It also promotes HIV prevention as the children see and understand the ordeal the parent goes through and would want to avoid that experience.

Living with People Living with HIV and AIDS
An important part of living positively is that patients should be involved in daily life as much as possible and be encouraged to join activities. They should be active and useful and not feel they are a burden on others. Unless there are specific needs, meals should be suitable for the whole family, with no special diets for the person living with the virus.
Although they may be quite frail, people living with AIDS can help with entertaining small children and doing some of the daily chores such as mending, sweeping, gardening, etc.

People need to take care of themselves and boost their immune systems; they can be susceptible to colds and other infections, which they can spread to the patient. It may be tempting to skip meals or daily hygiene simply because there is so much to do. Many people may neglect themselves because they feel guilty about taking care of their own needs.

Living positively means taking care of the whole person, giving attention to both the physical and the mental. In addition to healthy eating, exercise and rest, and avoiding infection, people should make sure that they do not neglect friendships and doing the things they enjoy.

Spiritual comfort and counseling is just as important for volunteers and caregivers as it is for those living with HIV and AIDS, who should find someone they can talk to, join or form a support group, or join a choir. Try to set aside time each day for prayer.

Remember: Positive living is important for everybody affected by HIV and AIDS and not just for those who have the virus. Caregivers and family members should also practice living positively. This is important for keeping the mind and the body strong enough to cope with responsibilities of caring for someone with the virus and for life’s other demands.

The Role of Religious Leaders in Combating Stigma, Denial, and Discrimination at the Individual Level

According to Ogden and Nyblade (2005) religious leaders can minimize stigma through the following:

- By showing compassion, acceptance, and encouragement through the use of holy texts and religious teachings and interpretations
- By encouraging their congregations to show love, acceptance, accommodation, and empathy to people living with HIV and AIDS, and interpreting holy texts in appropriate ways to avoid condemnation
- By involving people living with HIV and AIDS in sensitizing the congregation and the community by engaging them in activities that attract the entire congregation
- By counseling people living with HIV and AIDS through support groups to instill love and compassion
- By using inclusive language as opposed to condemning language; religious leaders should try to avoid discriminatory words

3.7 INTERVENTIONS TO COMBAT SDD AT THE FAMILY LEVEL

The role of religious leaders is to encourage self-assessment and suggest that family members, especially youth, seek counseling services.

Religious leaders need to contact families who are affected or have a person living with HIV and AIDS. They should encourage peer counseling at the family level, be aware of appropriate community resources, and, when appropriate, make referrals.

Religious leaders have a role to play in developing skills and offering counseling and psychosocial support to the infected and affected families within their congregations.

They need to seek out and encourage children whose parents are sick and hospitalized. The children need an adult to relate to and share their problems with. Children with sick, dying, or dead parents are often confused, deprived, and traumatized. They need special care and attention that religious leaders are able to give.

Religious leaders should be available to talk to family members/clients. The role of religious leaders is to promote stigma reduction at the family level and encourage family members to support those infected or affected.

Specific interventions at the family level include:

- Home visits: Religious leaders need to visit and share with family members who are infected or affected. Home visits provide forums for sharing, spiritual nourishment, encouragement, and assessment of the family needs. A religious leader visiting an affected family breaks the isolation the family may experience. They encourage other congregational members and neighbors to visit the family, thus eliminating whatever stigma the family was experiencing.
- Involving the affected in religious events:
Involving the infected and affected in the worship services and rituals signals to the community that these people are fully involved in the life of the congregation and should not be discriminated against. This includes offering them all the sacraments, officiating at their weddings and funerals, and allowing their election or promotion to any congregational roles.

3.8 INTERVENTIONS TO COMBAT SDD AT THE CONGREGATIONAL AND COMMUNITY LEVEL

Religious leaders have many opportunities for combating stigma, denial, and discrimination at the congregational and community level. However, they need to first recognize the various manifestations of SDD within their congregations.

It is at the congregational and community levels where people other than immediate family members come into contact with infected or affected individuals. It is at this level that the most stigmatizing language and attitudes are developed and used extensively, where gossip and rumors on the health status of individuals are discussed and moral judgment is passed. Religious leaders who are alert to this will be able to reduce the stigma in congregations and communities and thus pave the way for effective programs for HIV prevention; AIDS care, treatment, and support; and impact mitigation.

The best interventions are those developed by members of the congregation, especially those living with HIV. The following are examples of specific interventions that can be implemented at the congregational or community levels. They are only guidelines so the religious leaders and their congregations should amend them to fit their circumstances and needs.

Supporting HIV Education and Training

Information to raise awareness and educate about HIV can be integrated in worship, prayer, and other congregational activities. It should be aimed at increasing the congregants’ knowledge about issues concerning HIV and AIDS. Although sermons can be used as avenues for such education, special educational hymns and songs at worship services can also be used. As well, songs aimed at tackling SDD and its manifestations can be composed and presented during worship so that their messages are ingrained in the mindset of the congregation.

In addition, some congregations have developed specific liturgical services for HIV and AIDS. Such worship can be dedicated during specific worship days—for example, Fridays for Muslims, and Saturday and Sunday services for different Christian denominations. Religious leaders can also have special AIDS education sessions for different segments of the congregation—men, women, youth, and children. Such special sessions should be participatory and also involve multimedia accessories, which heighten interest in the subject. For example, where electricity is available, the use of documentaries with an AIDS theme and a way forward for those living with HIV and AIDS could be shown.

Religious leaders need to keep up to date with correct and accurate information on HIV and AIDS to avoid inaccurate, misleading, and erroneous information from worsening stigma, denial, and discrimination.
A religious leader could also appoint someone from the congregation to deal with HIV and AIDS and help the congregation understand the illness and therefore eliminate SDD.

Supporting Voluntary Counseling and Testing (VCT)
Supporting establishment of VCT centers and mechanisms within congregations and local communities is an effective intervention against SDD. Being tested for HIV is an important first step toward many of the interventions against HIV. The presence of VCT centers, along with religious leaders’ encouragement for people to be tested, gives members of a congregation the opportunity to find out their health status and hence protect themselves from infection, reinfection, or spreading the disease.

The congregation and community should contribute in various ways to the running of the VCT center. Nurturing and developing counselors from among the membership of the congregation will assist in developing confidence in the VCT and ensuring its sustainability.

Religious leaders should avoid the temptation to make HIV testing a compulsory requirement for receiving any service or sacrament within their congregation as it may be counterproductive and worsen stigma.

Religious leaders can spend time at the VCT, encouraging those who come for testing. They can launch the VCT by being the first to be tested. They should also ensure that the pre- and post-test counseling services are properly delivered, and that those who test as HIV-positive get into a program immediately to help them cope with the reality.

Supporting Establishment of Post-test Clubs
Post-test clubs (PTC) are for all community members who have undergone an HIV test, not just for those who are HIV-positive. They assist those who are HIV-positive to gain confidence and encourage them to disclose their status to their families. They also encourage healthy and responsible sexual behavior and can facilitate the establishment of support groups for people living with HIV and AIDS.

To start a PTC, the religious leader needs:
- a well-trained and committed volunteer counselor
- a room with seats or a clear field where members can sit in private
- a core group of three to five congregational members who have undergone the test

The leader and counselor should set a date for an initial meeting and announce it to the congregation two weeks prior to the meeting. They should set an agenda for the inaugural meeting. The religious leader should attend the inaugural meeting to ensure it starts well and to offer encouragement to the participants.

Supporting the Establishment of Support Groups for People Living with HIV and AIDS
These are support groups for people who are infected and affected by HIV and AIDS, including spouses and family members who are living with those who have the virus or full-blown AIDS. Religious leaders can help with the start-up of a group by attending their sessions, providing space within the congregation or worship location, supporting with materials and other resources required by the group, and ensuring that the group is linked to other services such as the local health center.

The congregation should be encouraged to pray for and support people living with HIV and AIDS through this group. HIV-positive members should be encouraged to participate fully in all congregational activities and be considered for any training, leadership, and other opportunities that may arise within the congregation.

Members of the support group should play key roles in HIV awareness and education activities and any other special liturgical and worship services where HIV and AIDS is taught or discussed.

The congregation should support group members, their respective spouses, and family members who are living with HIV to access treatment for opportunistic infections and antiretroviral therapy by establishing treatment funds and adherence support groups.

Supporting Establishment of Psychosocial and Spiritual Support and Counseling Centers
Finding out that one is HIV-positive may cause psychosocial and emotional distress. The congregation is well placed to offer psychosocial support and comfort to the HIV-positive person and his or her family. Many HIV-positive people require case management to be able to cope with the medical expenses, loss of income, and productivity, as well as the financial burdens their caregivers face.

Spiritual and emotional support is important in helping infected individuals. The majority of people living with HIV and AIDS seek spiritual support at some point.
during their illness. Support from religious institutions and clergy can help them face the reality of dying and death.

Spiritual support can be given during support group meetings or individually. Spiritual support helps participants tap into spiritual resources in order to live happy and healthy lives.

Religious leaders can provide psychosocial care by:
- attending post-test club and other support group meetings for people living with HIV and AIDS, and giving messages of hope and compassion
- visiting the sick, praying with them, and giving them compassionate care
- helping those who are dying to make peace with the world and with God
- facilitating transitional arrangements with the family

3.9 INTERVENTIONS TO COMBAT SDD AT THE INSTITUTIONAL LEVEL

Promoting Behavior Change in Religious Institutions

To change attitudes and behavior that foster stigma and discrimination at the institutional level, a behavior change model is required. Frequently there are two simultaneous but contradictory attitudes operating in religious communities: caring and compassion for people living with HIV and AIDS and their families, on the one hand, and judgment and condemnation of behavior on the other.

The following questions provide a model for analyzing current behavior and developing strategies to change behavior in ways that reduce stigma and discrimination:
- Identifying whose behavior needs to change:
  Who are the key individuals or groups in the congregation or community whose behavior needs to change?
- Behavioral analysis: What is their current behavior? What is the ideal? If the ideal is not feasible, which practical behavior changes should be encouraged?
- Key factors: Which key factors influence current behavior and make it easier or more difficult for them to change their behavior?
- Activities: Which specific activities can be implemented that will address these key factors and help achieve behavior change?

Introducing and Implementing the Greater Involvement of People Living with HIV and AIDS (GIPA)

People living with HIV have directly experienced the factors that make individuals and communities vulnerable to HIV infection and, once infected, the HIV-related illnesses and strategies for managing them. Their involvement in program development and implementation and policy making will improve the relevance, acceptability, and effectiveness of programs. Measuring the involvement of people living with HIV in policy is not an easy or exact science. However, experiences have shown that when communities are proactively involved in ensuring their own well-being, success is more likely. GIPA seeks to ensure that people living with HIV are equal partners and breaks down simplistic (and false) assumptions of service providers (those living without HIV) and service receivers (those living with HIV).

The engagement of people living with HIV is all the more urgent as countries scale up their national AIDS responses to achieve the goal of universal access to prevention, treatment, care, and support services.

The benefits of GIPA are wide-ranging. At the individual level, involvement can improve self-esteem and boost morale, decrease isolation and depression, and improve health through access to better information about care and prevention. Within organizations, the participation of people living with HIV can change perceptions, as well as provide valuable experiences and knowledge. At the community and social levels, public involvement of people living with HIV can break down fear and prejudice by showing the faces of those living with HIV and demonstrating that they are productive members of, and contributors to, society.

Policy Position

No single agency can provide for all the needs of people living with HIV, so partnerships among actors are needed. To enable the active engagement of those living with HIV, religious communities and other actors need to ensure that people living with HIV have the space and the practical support for their increased and meaningful involvement.

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Governments, international agencies, and civil society must:
• set, implement, and monitor minimum targets for the participation of people living with HIV, including women, young people, and marginalized populations, in decision-making bodies; selection processes should be inclusive, transparent, and democratic.
• involve people living with HIV in developing funding priorities and in the choice, design, implementation, monitoring, and evaluation of HIV programs from their inception.

In addition, UNAIDS recommends the following actions for religious communities and other civil society organizations:
• Make the concept of HIV mainstream within organizations, including the development and implementation of specific HIV workplace policies.
• Create procedures for implementing GIPA at all levels in the workplace, including recruitment of skilled people living with HIV to boards and senior management.
• Commit and devote financial resources to organizational development, including leadership, management and governance, and capacity building of organizations and networks of people living with HIV.
• Work in partnership with other nongovernmental and government organizations and networks of people living with HIV in advocacy, service delivery, and other relevant actions.

Religious leaders can also encourage governments and international agencies to take action to achieve GIPA in the following ways:

**Actions for governments**
• Include GIPA in the National AIDS Plan; undertake a baseline survey for measuring GIPA and stigma and discrimination; and include GIPA within the national monitoring and evaluation system. Enable people living with HIV to claim their rights and meet their responsibilities by creating a supportive legal and policy environment that also protects them from discrimination and violence.
• Support the creation and strengthening of organizations of people living with HIV in addressing infrastructure, governance, management, resource mobilization, accountability, and staff’s skill-building needs.
• Strengthen the capacity of people living with HIV who volunteer for leadership in public speaking and communication skills, in organizing and conducting policy advocacy, dialogue and negotiation, in program design, and in monitoring and evaluation at the international, regional, national, and local levels.
• Ensure psychosocial support for those living with HIV who, in revealing their status, may experience discrimination against themselves or their dependants. Promote better understanding of HIV-related vulnerabilities and the needs of people living with HIV in the community and the workplace.

**Actions for international partners**
• Prioritize initiatives, supported by enhanced, predictable, and continued funding, to build and sustain the capacity of organizations and networks in line with their self-identified needs.
• Promote efforts to fulfill the rights of people living with HIV, particularly women, young people, and vulnerable populations.
• Ensure that people living with HIV are included in the design of ethical research for new prevention technologies and the development of treatments.

**Ideas for Policy Action at the National Level**
Religious leaders also have influence in public life, so they can be effective advocates at the national level for reducing stigma and discrimination in society at large. Some of the actions that leaders can take include:
• enlisting political support in combating SDD through national forums.
• encouraging high-profile individuals to serve as leaders and role models.
• supporting legislation that protects the rights of people living with HIV.
• advocating for national efforts to scale up antiretroviral treatment.
• advocating for greater funding of PMTCT services.
• mobilizing efforts to connect national advocacy with the global movement against SDD.
• advocating for laws and regulations that protect people against HIV and AIDS-related stigma and discrimination in places of work, residence, education, worship, entertainment, and business.
• establishing mechanisms for increasing visibility and involvement of people living with HIV and AIDS in the development, strategic planning, and implementation of national HIV and AIDS policies.
Analysis and Planning to Reduce Stigma in Religious Institutions

Religious leaders who make a commitment to reduce stigma in their institutions need to develop a very concrete approach to identifying policies, attitudes and practices that perpetuate stigma and a plan for changing the institution’s policies and practices to ensure that stigma and discrimination are eliminated. The ten steps shown in Table 1 below can serve as an effective tool for both identifying the problems that need to be addressed and for outlining an action plan.

Table 1: 10 Steps for Moving to Action

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
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<tbody>
<tr>
<td>1.</td>
<td>Where are you now? (Situational Analysis) This helps you look at what is happening at the moment regarding stigma. You can ask, “How have things been in the past?” and “How are they now?” “Where is the SDD in the community or workplace?”</td>
</tr>
<tr>
<td>2.</td>
<td>Where do you want to be? (Vision) How would things look if you could really make a difference? Make a vision of the future with reduced stigma.</td>
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<tr>
<td>3.</td>
<td>How will you get there? (Activities) What kind of activities can you do to reduce stigma? Brainstorm all your ideas and practical actions to solve the problems.</td>
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<tr>
<td>4.</td>
<td>Where will you start? (Prioritize) What are the most feasible actions to start doing? What is the most important action?</td>
</tr>
<tr>
<td>5.</td>
<td>What do you need? (Resources) Identify any resources, skills, or training that will help with your action and any partners who can help. Do not think you cannot do something because you lack funds.</td>
</tr>
<tr>
<td>6.</td>
<td>What might get in the way? (Obstacles) Identify any obstacles that might prevent your action from being successful. Make plans or strategies on how to overcome these obstacles.</td>
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<tr>
<td>7.</td>
<td>How will you know that you are successful? (Indicators) Decide how you will measure your success. Identify indicators or signs that will show you stigma is decreasing. (Are more people talking more openly about testing HIV-positive? Are more people openly declaring their status?)</td>
</tr>
<tr>
<td>8.</td>
<td>Action Start the activities you have planned. Assign tasks to specific people.</td>
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<tr>
<td>9.</td>
<td>Monitoring Check how you are doing and whether anything is changing.</td>
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<tr>
<td>10.</td>
<td>Replan Make changes to your plans based on what you learned from the monitoring.</td>
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3.10 ACTION PLANNING AND MEASURING PROGRESS

There are several ways of developing an action plan. However, the most important thing is to ensure that realistic plans are made and that the necessary preparation is done before the implementation date.

During the training, the facilitator explains that action-plan worksheets have been developed to guide the action-planning process. Refer the participants to the Action-Plan Worksheet in their handouts. Point out that this is a step-by-step plan to help them implement SDD-reduction activities within the next six months as part of their individual and organizational activities. The activities identified should require minimal resources and be accommodated within existing work plans.

Measuring Progress
It is important for religious communities to measure results in their efforts to eliminate HIV and AIDS-related stigma, denial, and discrimination in the family, congregation, and community. This can be done by acquiring the following information:

- The number of people who start seeking and utilizing HIV-prevention information, services, and openly requesting for AIDS treatment (antiretroviral therapy)
- The number of people trained, including religious leaders, to be advocates against stigma and discrimination
- The number of people who start declaring their HIV status openly and freely
- The increase in the number of people who believe
that AIDS is like any other disease
• The increase in equal treatment in homes and clinics for people living with HIV and AIDS
• The number of institutions that develop policies and guidelines that are sensitive to the rights and needs of people living with HIV and AIDS; supportive of prevention, care, and treatment services; and effective in ending stigma and discrimination

These and other indicators will help religious organizations monitor and evaluate whether their actions are having real impact on eliminating stigma, denial, and discrimination within their communities and society at large.

Table 2: A Sample Action Plan

<table>
<thead>
<tr>
<th>Activity</th>
<th>Date</th>
<th>Duration</th>
<th>Resource Required</th>
<th>Expected Outputs</th>
<th>Expected Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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What each of the above means:

**Activity**: This means the actions that will be planned upon completion of training by each religious leader.

**Date**: This is the actual point in time set for each activity or action planned.

**Duration**: This is the exact length of time or interval or period that each activity planned will take.

**Resource required**: This means material, funds, or even expertise needed to complete each activity.

**Expected outputs**: These are likely or possible returns or yields that are realized immediately after the particular activity is undertaken.

**Expected outcomes**: These are likely or possible results or consequences that are realized after some time elapses (longer term) following the activities.
References


Engender Health. Reducing Stigma and Discrimination Related to HIV and AIDS. Training for Health Care Workers. 2004


Stover, J. STI, 80 (Suppl. 1). 2004.


ADDITIONAL RESOURCE LINKS

CARE, www.care.org

Ecumenical Advocacy Alliance, www.e-alliance.ch


Hope for African Children Initiative, www.hopeforafricanchildren.org

Religions for Peace, www.religionsforpeace.org


United Nations Joint Programme on HIV and AIDS (UNAIDS), www.unaids.org

World AIDS Campaign, www.worldaidscampaign.org