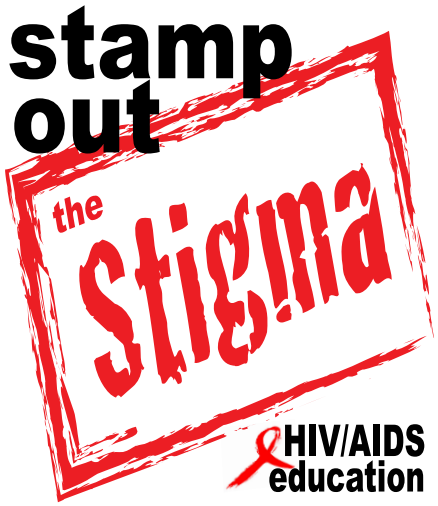
2013 Indiana Annual Conference
(Updated in 2019)

Let us…



a train-the-trainer seminar for clergy and ministry leaders

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Original Presenters:

Rev. Lisa Marchal, Senior Global Grassroots Associate, RESULTS – lmarchal@results.org, 317.529.5182

Nate Rush, Executive Director, The Bethlehem House – nrush@thebethlehemhouse.org, 317.920.1519

RESULTS is committed to creating the political will to end hunger and the worst aspects of poverty.

www.results.org

The Bethlehem House's mission is to provide, in a compassionate environment, the services that will assist and support those individuals adversely affected by substance abuse, HIV, and other related psychosocial issues.

www.thebethlehemhouse.org

Disclaimer: This seminar seeks to give a general overview of the HIV/AIDS and stigma and does NOT substitute for expert medical knowledge, preventive care, diagnosis, advice, or other treatment by healthcare providers.

Stigma is a word that originally means a "sign," "point', or "branding mark." It is also defined as a *badge of shame,* a physical mark of infamy, or disgrace. Stigma is a sign of social unacceptability and its symptom of shame. It is synonymous with disgrace, dishonor, and humiliation. This word lies at the roots of the HIV & AIDS pandemic, whether the individual involved lives in sub-Saharan Africa, Southeast Asia, mainland Europe, the United State, or Indianapolis.

There are many reasons why people living with HIV and their families experience the shame, humiliation and rejection associated with stigmatization. In some instances, the discrimination is intentional, but there are ample examples of stigmatizing that is unintentional. In either case, however, the impact on the victims is devastating.

Religious leaders are key participants in the fight for reduction of HIV & AIDS stigma as they have the ability to proactively engage their congregations in making the church community one that is responsive, supportive and affirming. Pastors and church ministry leaders can instruct, guide, encourage and care for the faith communities informing and engage them in the effort to stamp out stigma. The impact can be felt not only in their church congregations, but also in the communities of which their members are a part.

Inspired and instigated by the INUMC AIDS Advocacy Team, this to train-the- trainer seminar seeks to provide a toolkit of resources to help eradicate stigma associated with HIV & AIDS within the faith community. The seminar will hopefully equip clergy and those who have leadership positions within the church to more comfortably engage those they serve in a creative learning process to stamp out stigma.

INTRODUCTION

Goals and Objectives of this Toolkit are to help our congregations and faith groups to do the following:

- Understand the roots of stigma
- Enhance their knowledge of HIV & AIDS and stigma, denial, and discrimination
- Identify both covert and overt manifestations of stigma
- Raise awareness of the impact of stigma on individuals and families
- Provide a Christ-centered model of inclusiveness
- Strengthen their ability to be compassionate reactively and proactively, helping to reduce stigma and discrimination associated with HIV & AIDS in their congregations and their communities
- Utilize available tools to advocate for the end of the AIDS pandemic

Why Faith Leaders are Key

Religious leaders have a significant impact on their communities and congregations. They speak both practically and prophetically within congregations to influence theological reflection around real-world issues. Through their leadership, clergy and laity alike can effectively raise the issue of HIV and AIDS within and around their congregation, helping congregations confront stigma and discrimination and effectively begin transforming their church culture so as to live into a new way of being Christ's people in the midst of the continuing AIDS pandemic.

Many people suffering from AIDS and not killed by the disease itself are killed by the stigma surrounding everybody who has HIV/AIDS. **– Nelson Mandela**

WHAT IS HIV?

- **H -- Human** – This particular virus can only infect human beings.
- **I -- Immunodeficiency** – HIV weakens your immune system by destroying important cells that fight disease and infection. A "deficient" immune system can't protect you.
- **V -- Virus** – A virus can only reproduce itself by taking over a cell in the body of its host. HIV is a lot like other viruses, but there is an important difference; over time, your immune system can clear most viruses out of your body. That isn't the case with HIV. The human immune system can't seem to get rid of it. Scientists are still trying to figure out why.

We know that HIV can hide for long periods of time in the cells of your body and that it attacks a key part of your immune system - your T-cells or CD4 cells. Your body has to have these cells to fight infections and disease, but HIV invades them, uses them to make more copies of itself, and then destroys them.

Over time, HIV can destroy so many of your CD4 cells that your body can't fight infections and disease anymore. When that happens, HIV infection can lead to AIDS.

WHAT IS AIDS?

- **A -- Acquired** – AIDS is not an inherited condition.
- **I -- Immuno –** Your body's immune system includes all the organs and cells that work to fight off infection or disease.
- **D – Deficiency** – You get AIDS when your immune system is "deficient" or not working the way it should.
- **S – Syndrome** – A syndrome is a collection of symptoms and signs of disease. AIDS is a syndrome rather than a single disease because it is a complex illness with a wide range of complications and symptoms.

AIDS is the final stage of HIV infection. People at this stage have badly damaged immune systems which puts them at risk for opportunistic infections (OIs). People infected with HIV generally develop AIDS several years after becoming infected with HIV. People are diagnosed with AIDS if they have one or more specific OIs, certain cancers, or a very low number of CD4 cells. People with AIDS usually die of illness such as TB, pneumonia, or septicemia. If you have AIDS, you need medical intervention and treatment to prevent death.

HOW DO YOU ACQUIRE HIV?

HIV is found in specific human body fluids. If any of those fluids enter your body, you can become infected with HIV.

HIV lives and reproduces in blood and other body fluids. We know that the following fluids can contain high levels of HIV:

- Blood
- Semen
- Pre-seminal fluid
- Breast milk
- Vaginal fluids
- Rectal mucous

HIV attacks the body's immune system and weakens the capacity of the body to fight off many different illnesses, but it also affects people psychologically, socially, and spiritually. Knowing that one is HIV-positive can lead to hopelessness and spiritual crisis.

> "AIDS attacks the body; prejudice attacks the spirit. One is caused by a virus. One is caused by ignorance. Both can kill."
>
> - New Zealand AIDS Foundation

HIV IN THE UNITED STATES AT A GLANCE

Source: Division of HIV/AIDS Prevention; National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention; Centers for Disease Control and Prevention

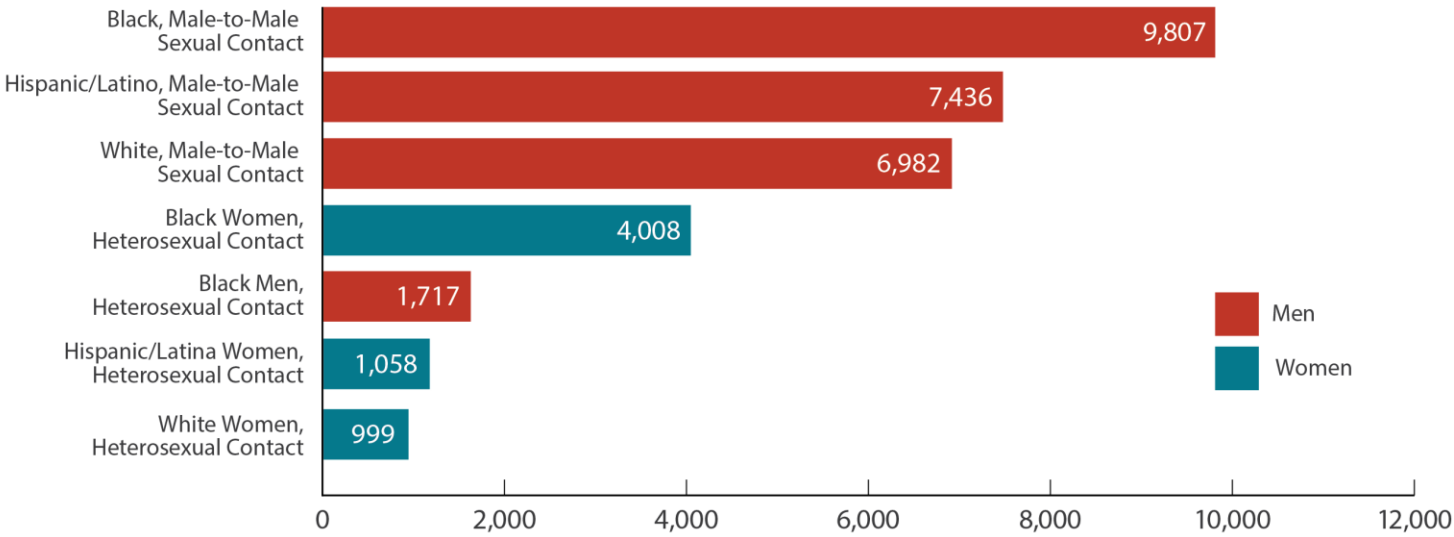
Fast Facts

- The annual number of new HIV diagnoses[a] has remained stable in recent years in the United States (US) and dependent areas.[b] However, annual new diagnoses have increased among some groups.
- In 2017, 38,739 people received an HIV diagnosis in the US. The annual number of new HIV diagnoses remained stable between 2012 and 2016.
- Gay and bisexual men[c] are the population most affected by HIV. In 2017, gay and bisexual men accounted for 66% (25,748) of all HIV diagnoses and 82% of diagnoses among males.[d]
- By race, blacks/African Americans face the most severe burden of HIV.

[a] *HIV diagnoses* refers to the number of people who received a diagnosis of HIV during a given time period, not when the people were infected.
[b] Unless otherwise noted, the term *United States* (US) includes the 50 states, the District of Columbia, and the 6 dependent areas of American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the US Virgin Islands.
[c] The term *male-to-male sexual contact* is used in CDC surveillance systems. It indicates a behavior that transmits HIV infection, not how individuals self-identify in terms of their sexuality. This fact sheet uses the term *gay and bisexual men*.
[d] Does not include gay and bisexual men who reported injection drug use. CDC's HIV surveillance fact sheet provides more information about how CDC classifies the transmission category for HIV cases.

- In the 50 states and the District of Columbia:
    - An estimated 1,122,900 adults and adolescents were living with HIV at the end of 2015. Of those, 162,500 (15%) had not received a diagnosis.
    - Young people were the most likely to be unaware of their infection. Among people aged 13-24 with HIV, an estimated 51% didn't know.
- In the United States, 1,008,929 people were living with diagnosed HIV infection in 2016.
- In 2016, there were 15,807 deaths among people with diagnosed HIV in the United States. These deaths may be due to any cause.

New HIV Diagnoses in the US and Dependent Areas for the Most-Affected Subpopulations, 2017



Subpopulations representing 2% or less of all people who received an HIV diagnosis in 2017 are not represented in this chart.

Source: CDC. Diagnoses of HIV infection in the United States and dependent areas, 2017. *HIV Surveillance Report* 2018;29.

By Risk Group in the United States

Gay and Bisexual Men.

Gay and bisexual men[a] are the population most affected by HIV in the United States. In 2016, gay and bisexual men accounted for 67% of the 40,324 new HIV diagnoses[b] in the United States and 6 dependent areas.[c] Approximately 492,000 sexually active gay and bisexual men are at high risk for HIV.

[a] The term *male-to-male sexual contact* is used in CDC surveillance systems. It indicates a behavior that transmits HIV infection, not how individuals self-identify in terms of their sexuality. This fact sheet uses the term *gay and bisexual men*.
[b] The numbers reported in this fact sheet include infections attributed to male-to-male sexual contact only, not those attributed to male-to-male sexual contact *and* injection drug use (men who reported both risk factors).
[c] American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the US Virgin Islands.

Injection Drug Users

The risk for getting HIV is very high if an HIV-negative person uses needles, syringes, or other injection equipment that someone with HIV has used. Estimated annual HIV infections among people who inject drugs (PWID) declined 32% from 2010 to 2014 in the United States.[d] However, injection drug use in nonurban areas has created prevention challenges and has placed new populations at risk for HIV.

[d] Unless otherwise noted, all numbers include infections attributed to injection drug use and those attributed to male-to-male sexual contact and injection drug use.

Blacks/African Americans

Blacks/African Americans[e] account for a higher proportion of new HIV diagnoses[f] and people living with HIV, compared to other races/ethnicities. In 2017, blacks/African Americans accounted for 13% of the US population[g] but 43% (16,694) of the 38,739 new HIV diagnoses in the United States and dependent areas.[h]

[e] *Black* refers to people having origins in any of the black racial groups of Africa, including immigrants from the Caribbean, and South and Latin America. *African American* is a term often used for Americans of African descent with ancestry in North America. Individuals may self-identify as either, both, or choose another identity altogether. This fact sheet uses*African American*, unless referencing surveillance data.
[f] *HIV diagnoses* refers to the number of people who received an HIV diagnosis during a given time period, not when the people got HIV infection.
[g] The US Census Bureau's population estimates include the 50 states, the District of Columbia, and Puerto Rico.
[h] Unless otherwise noted, the term *United States* (US) includes the 50 states, the District of Columbia, and the 6 dependent areas of American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the US Virgin Islands.

Hispanics/Latinos in America

HIV continues to be a serious threat to the health of Hispanic/Latino[i] communities. In 2016, Hispanics/Latinos accounted for 26% (10,292) of the 40,324 new HIV diagnoses in the United States and 6 dependent areas.[j]

[i] Hispanics/Latinos can be of any race.
[j] American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the US Virgin Islands.

UNDERSTANDING HIV/AIDS STIGMA

The main causes of stigma relate to incomplete knowledge, fears of death and disease, sexual norms and a lack of recognition of the existence of stigma. Insufficient and inaccurate knowledge combines with fears of death and disease to perpetuate beliefs in casual transmission and, thereby, avoidance of those with HIV. The knowledge that HIV can be transmitted sexually combines with an association of HIV with socially "improper" sex, such that people with HIV are stigmatized for their perceived immoral behavior. Finally, people often do not recognize that their words or actions are stigmatizing.

Socio-economic status, age, and gender all influence the experience of stigma. The poor are blamed less for their infection than the rich, yet they face greater stigma because they have fewer resources to hide an HIV-positive status. Youth are blamed for spreading HIV through what is perceived as their highly risky sexual behavior. While both men and women are stigmatized for breaking sexual norms, gender-based power results in women being blamed more easily. At the same time, the consequences of HIV infection, disclosure, stigma and the burden of care are higher for women than for men.

People living with HIV/AIDS face physical and social isolation from family, friends and community; gossip, name-calling and voyeurism; and a loss of rights, decision-making power and access to resources and livelihoods. People with HIV internalize these experiences and consequently feel guilty, ashamed and inferior. They may, as a result, isolate themselves and lose hope. Individuals associated with people living with HIV - especially family members, friends and caregivers - face many of these same experiences in the form of secondary stigma.

People living with HIV and AIDS and their families develop various strategies to cope with stigma. Decisions around disclosure depend on whether or not disclosing would help to cope (through care) or make the situation worse (through added stigma). Some cope by participating in networks of people living with HIV and actively working in the field of HIV or by confronting stigma in their communities. Others look for alternative explanations for HIV besides sexual transmission and seek comfort, often turning to religion to do so.

Stigma impedes various programmatic efforts. Testing, disclosure, prevention and care and support for people with HIV are advocated, but are impeded by stigma. Testing and disclosure are recognized as difficult because of stigma, and prevention is hampered.

STIGMA TOWARDS FAMILIES

- Isolation and rejection towards families suspected to have HIV
- Name-calling, finger pointing, gossip, rumors, backbiting, jealousy
- Rumors about HIV and AIDS used as a weapon to denounce families
- Suspicion/speculation about other people based on observed symptoms
- Stigma triggered by visits/food provided by home-based care workers
- Shame or loss of family honor – "You have discredited/shamed our family."
- Snooping – people visit to see the condition of the person living with HIV
- Not allowing children to play with neighbor's children

STIGMA WITHIN THE FAMILY

- Separation of personal household items like utensils
- Burning or discarding of clothing and other things used by person(s) living with HIV
- Physical isolation (i.e., being forced to sleep alone or in a separate room)
- Minimum physical contact
- Being hidden from neighbors
- Being treated as a burden
- Minimized input regarding family decision-making
- Judging, blaming, condemning – made to feel she/he has disgraced the family
- Family members not being honest about their feelings toward the individual(s) living with HIV
- Partners/spouses of person(s) living with HIV assumed to be HIV-positive

STIGMA AND COMMUNITIES

- Evictions
- Halted visits, but continued concern about being criticized for not visiting
- No exchange of food, gifts, or time for outings
- Fear of infection through sharing or using household items owned by a person living with HIV
- Fear of stigmatization through association
- Fear of children being infected through contact with the HIV-affected family

> *"Stigma remains the single most important barrier to public action. It is a main reason why too many people are afraid to see a doctor to determine whether they have the disease, or to seek treatment if so. It helps make AIDS the silent killer, because people fear the social disgrace of speaking about it, or taking easily available precautions. Stigma is a chief reason why the AIDS epidemic continues to devastate societies around the world."*
>
> *– UN Secretary General Ban Ki-moon*

STIGMATIZATION AS EXPERIENCED IN SCRIPTURE – TWO STORIES

The Woman Subject to Bleeding

Mark 5:24-34 (Background reading: Leviticus 15:25-26)
Story also found in Matthew 9:20-26

> *A large crowd followed and pressed around him. And a woman was there who was subject to bleeding for twelve years. She had suffered a great deal under the care of many doctors and had spent all that she had, yet instead of getting better she grew worse. When she heard about Jesus, she came up behind him in the crowd and touched his cloak, because she thought, "If I just touch his clothes I will be healed." Immediately her bleeding stopped and she felt in her body that she was free of her suffering. (NIV)*

Question

Enter into the heart of this woman. What fears might she be experiencing as she makes plans to touch the hem of the garment of Jesus?

Story Continues:

> *At once Jesus realized that power had gone out of him. He turned around and in the crowd he asked, "Who touched my clothes? "You see people crowding against you," his disciples answered, yet you asked, "Who touched me? But Jesus kept looking around to see who had done it. The woman knowing what had happened to her came at his feet trembling with fear, told him the whole truth. He said to her. He said to her, "Daughter, your faith has healed you. Go in peace and be freed of your suffering." (NIV)*

More Questions

1. What does the fact the woman was fearful when she was discovered tell us?
2. How do you think some in the crowd may have felt, including the disciples?
3. How would you characterize her interaction with Jesus? How was it transformative?
4. Do you see any similarity in this story and HIV & AIDS? What are they?

The Healing of the Leper
Mark 9:20-26 (Background reading: Leviticus 14)
Story also found in Matthew 1:40-43

> *A man with leprosy came to him and begged on his knees, "If you are willing, you can make me clean." Filled with compassion, Jesus reached out and touched the man. "I am willing," he said. "Be clean." Immediately the leprosy left him and he was cured. Jesus sent him away at once with a strong warning. See that you don't tell this to anyone. But go show yourself to the priest and offer the sacrifices that Moses commanded for your cleansing, as a testimony to them. "Instead he began to talk freely, spreading the news. As a result, Jesus could no longer enter a town openly but stayed outside in lonely places. Yet the people still came to him from everywhere. (NIV)*

Questions

1. The man with leprosy felt confident that Jesus could heal him but there is something in his heart that suggests that Jesus might not be willing. He also gets on his knees and begs. What do you suspect he might be thinking?

2. The text states very emphatically that this man was strongly advised to tell no one but shows himself to the priest and offers the sacrifice that Moses commanded. Why was he so advised?

3. What may have been the reason for touching the man afflicted with leprosy?

4. The man did not follow Jesus' instructions. What were the consequences? Why?

5. What were the responses of the people, and why do you think they responded differently to Jesus?

For Personal Thought and Reflection

- How does this story parallel the story of HIV & AIDS and how is it different?
- Where do you find yourself in this story?
- Do you know the steps you can take to make your story parallel the story of Jesus?
- What was the driving force that moved Jesus to action?
- What would it take for you to move into action?

Other texts that might be studied:

- **John 9:2-7**

  His disciples asked him, "Rabbi, who sinned, this man or his parents, that he was born blind?" "Neither this man nor his parents sinned," said Jesus, "but this happened so that the works of God might be displayed in him. As long as it is day, we must do the works of him who sent me. Night is coming, when no one can work. While I am in the world, I am the light of the world." After saying this, he spit on the ground, made some mud with the saliva, and put it on the man's eyes. "Go," he told him, "wash in the Pool of Siloam" (this word means "Sent"). So the man went and washed, and came home seeing. (NIV)

Others that you would add:

REFLECTION ON EXPERIENCES WITH STIGMA

- What personal experiences have you had with HIV/AIDS?
- What fears are present for you/your community around the issue of HIV/AIDS?
- How did those experiences affect you and your family?
- What did you learn?
- What is the current situation in your church regarding HIV stigma?
- What forms of stigma are common in the community, and what are some of the background factors??
- In your community/congregation, is there secrecy and silence around sexuality and HIV? Do people find it difficult to talk?
- Is denial about HIV & AIDS an issue to discuss? What is your role in making that discussion happen?
- Are HIV & AIDS-affected households the target for insults, exclusion and discrimination?
- Is there a sense of fear, fatalism or hopelessness within your community regarding HIV & AIDS?
- How well is your community informed?

CHANGING ATTITUDES AND BEHAVIOR

SUPPORT FOR PEOPLE LIVING WITH HIV/AIDS (PLHAs) AND THEIR LOVED ONES

- Encourage PLHAs to talk openly about their feelings, and listen
- Don't be party to isolating PLHAs. Talk, meet, and make PLHAs feel wanted and included
- Encourage PLHAs to maintain good self-care and medical care
- Create an emergency fund
- Help PLHAs connect with others for the sharing of feelings and experiences
- Arrange childcare and transportation support
- Organize the sharing of "caring work" among family and friends
- Help facilitate problem-solving and conflict resolution

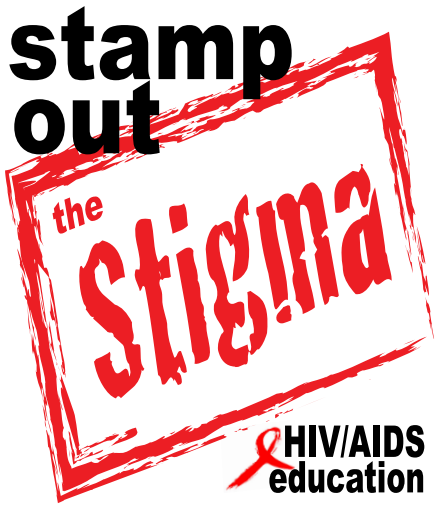
Source: Ethiopian Toolkit Workshop, May 2003

WHAT YOU CAN DO AS A LEADER

- Watch your own language and avoid stigmatizing words
- Provide a caring ear and support family members who are living with people with HIV
- Visit and support people living with HIV and their families in their homes and neighborhood
- Encourage people living with HIV to use available services and refer them to others who can help.
- Use informal conversations as opportunities to raise and talk about stigma
- Use real stories which put stigma into a practical context: Stories of poor treatment of people living with HIV resulting in depression; stories of good treatment and its life-giving nature
- Challenge stigmatizing words in a compassionate way
- Encourage people to talk openly about their fears and concerns about HIV and AIDS
- Correct myths and misconceptions about HIV and AIDS
- Promote the idea of a friendly, supportive ear
- Encourage the sharing of stories by people living with HIV or their families about their experience of living with the disease
- Utilize the arts (drama, visual art, music) – either its creation or by attending a show/exhibition – as a catalyst for discussion
- Convene community meetings or study circles to discuss what has been learned from the above methods and make decisions about what the community wants to do next
- Conduct training workshops on stigma for community and peer group leaders

Make sure that people who want to make a difference are given an opportunity to state their commitment to challenge stigma publicly. Action starts with commitment and powerful commitment ensures that obstacles are challenged and overcome. The commitment of leaders serves as a role model and encouragement for others. Whenever possible, find examples of how one person's commitment led to action which made a difference in a community.

Let us…



a train-the-trainer seminar for clergy and ministry leaders

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Affirming a Future with Hope:

HIV & Substance Abuse Prevention for

Communities of Faith
"20 Faith-based Activities for HIV Prevention"

1. Adopt the use of a denominationally produced curriculum on sexuality and health
2. Add HIV prevention education to an existing health ministry
3. Sponsor a semi-annual health fair which includes HIV testing
4. Sponsor the ministerial staff's attendance at a Red Cross HIV/AIDS Instructor Training
5. Set up a short course to help parents sharpen communication skills for talking with teens about sexuality, sex, and drug use
6. Sponsor a youth retreat with opportunities to practice faith sharing, healthy eating, fitness, academic skills, decision making and goal setting
7. Create comfortable opportunities for youth to facilitate dialogue on topics such as human sexuality
8. Establish a basketball or baseball program with a peer mentoring component for HIV and substance abuse prevent
9. Create an attractive pamphlet of Bible verses to encourage and comfort persons facing HIV/AIDS or other illnesses
10. Display free HIV/AIDS and substance abuse information and resources in a central location
11. Use your CVLI license to screen films such as "New Jack City" and "And the Band Played On" and facilitate discussion of cultural patterns related to sexuality, substance abuse, and HIV/AIDS
12. Create and perform an HIV or drug prevention dance or rap using gospel music
13. Establish a ministry to supply clothing, bedding, and toiletries for persons and families who are living with HIV/Aids
14. Hold a benefit gospel concert, use the proceeds support prevention programs

What else?

As followers of Christ, we have a loving role we can play in challenging stigma and discrimination. We can all educate others and advocate for new attitudes and practices.

Be a Role Model
Think about the words you use and how you treat people living with HIV.

Share What You Have Learned
Set up a workshop in your own faith community. Get others talking about stigma and how to change it.

Challenge Stigma When You See it in Your Congregations, Churches and Communities
Speak out, name the problem, and let people know that stigma hurts.

Act Against Stigma as a Group
Each group can look at stigma in their own situation and agree on one or two practical things they can do to bring about change.

Saying "Stigma is Wrong or Bad" is Not Enough
Help people move to action. Agree on what needs to be done, develop a plan, and then do it.

Think Big. Start Small. Act Now.