Faith and Stigma on the Fast Track

A Framework for Taking Action

March 2016

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Summary

UNAIDS has set ambitious Fast Track targets for the year 2020 on the way toward elimination of HIV as a public health threat by the year 2030:

- 90% of people living with HIV know their status
- 90% of those are on treatment
- 90% of those have suppressed viral load

It is universally agreed that the societal stigma associated with HIV and AIDS must be significantly reduced in order to meet these Fast Track targets.

Local faith communities have a significant effect on stigma because of their influence on the attitudes of their members. Some faith communities reinforce stigma, either actively through judgmental messaging and exclusion or passively by ignoring the issue. Other faith communities reduce stigma through inclusive messages, education, advocacy, and support and encouragement for people living with HIV. Reducing overall societal stigma will require action by local faith communities, and reaching the 90-90-90 targets will require a lot of action.

We propose the following targets for reduction of stigma in faith communities by the year 2020:

- Less than 10% of the population worship regularly at faith communities that actively strengthen stigma.
- At least 50% of the population worship regularly at faith communities that are free of stigma toward members and families.
- At least 25% of the population worship regularly at faith communities that reach out non-judgmentally to marginalized populations.

Stigma Load, a quantitative measure of stigma reduction in faith communities, can be used to measure progress toward these targets. Stigma Load is based on a list of ten characteristics of a stigma-free faith community combined with criteria for rating each characteristic on a six-point Likert scale. Particular Stigma Load ratings correspond to the three targets for 2020.

There is a Cascade of Stigma Reduction in faith communities that is similar to the Cascade of Treatment for PLHIV. The cascade for faith communities has the following four stages:

- Stigma Evaluation – The faith community knows whether or not it is free of stigma.
- Stigma Action – The faith community is actively transforming itself to reduce stigma.
- Weakened Stigma Load – The faith community is free of stigma toward members and families.
- Suppressed Stigma Load – The faith community is free of stigma toward marginalized populations.

Different interventions are appropriate at different stages in the cascade.

The Cascade of Stigma Reduction can be used to establish targets, similar to the 90-90-90 Fast Track targets. As an example, we project that over four hundred thousand faith communities in sub-Saharan Africa must actively address stigma before 2020, which will require a significant scaling up of existing initiatives.

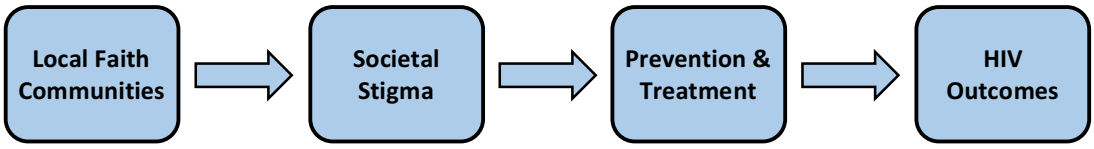
Implementing this framework will require work in the following four areas:

- Establishing a baseline about how many faith communities are already free of stigma
- Committing to ambitious targets and motivating faith communities to address stigma
- Making training, materials, and support widely available to local faith communities
- Conducting scientific studies of the relationship between faith communities and stigma

This work must begin immediately if we are to meet the UNAIDS Fast Track targets in 2020.

The Effect of Local Faith Communities on the Stigma of HIV and AIDS

The framework for action described in this paper is based on the assumption that the actions of local faith leaders, as well as the attitudes and behavior of members of local faith communities, have a significant effect on the stigma felt by people living with HIV and by members of key populations at risk of becoming infected with HIV in regions where faith is a significant part of community life. In turn, this societal stigma has a significant effect on access to and effectiveness of prevention and treatment, which in turn have a significant effect on HIV outcomes. This chain of effects is illustrated in the following diagram:



This framework for action is primarily focused on the first step in the chain, that is, the effect that local faith communities have on societal stigma. There are already a variety of measures and action programs that address other aspects of societal stigma and the rest of the chain of effects. For example, the *People Living with HIV Stigma Index* is a measure of perceived societal stigma, and the *Global AIDS Response Progress Report* includes data about societal stigma. Recently, the US Department of State began reporting directly on the Stigma of HIV and AIDS in its annual *Human Rights Report*. Discriminatory laws and policies are other indicators of societal stigma. And, of course, there are numerous mechanisms for tracking access to prevention and treatment, as well as HIV outcomes. The framework described in this paper is not intended to directly address those later elements in the chain of effects, although we believe that the actions taken within this framework will indirectly affect those steps by having a significant direct beneficial effect on societal stigma.

The effect of local faith communities on stigma is often characterized as negative: stigma is strengthened or reinforced, either actively through overt actions such as judgmental messages and exclusion, or passively by simply ignoring the issue. However, local faith communities can also have a very positive effect in reducing or eliminating stigma through inclusive messages, education, advocacy, and support and encouragement for people living with HIV.

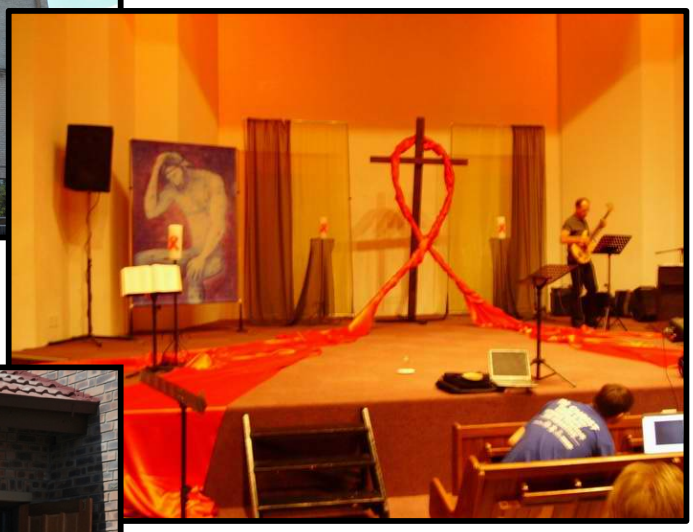
These effects, both negative and positive, go beyond the boundaries of the local faith communities. Faith leaders are often influential in the wider community, and members have frequent contact with their neighbors and friends. Thus, progress toward the elimination of stigma in individual faith communities also drives stigma elimination in the broader society.

However, there are many other factors that may increase societal stigma, including cultural, historical, and political forces, as well as fear and ignorance on the part of individuals. There are also many other factors that may reduce societal stigma, such as community activism and advocacy. Those other factors, in both directions, create the context in which local faith communities take action and the context on which those actions have an effect.

Stigma-Free Faith Communities

Although faith communities are often perceived as reinforcing or strengthening the stigma associated with HIV and AIDS, there are in fact a large number of faith communities that have actively and openly sought to reduce stigma by spreading inclusive messages, by providing care and support, by encouraging testing, and by actively advocating on behalf of people living with HIV.

The pictures below illustrate the activities of these faith communities:



Measuring Societal Progress in Reducing Stigma in Faith Communities

In our experience, local faith communities generally fit into one of the following six categories with respect to the stigma associated with HIV and AIDS:

- Actively Harmful – The actions of the faith community frequently include judgmental messaging or overt rejection of people living with HIV and of marginalized populations.
- Silently Neutral – The faith community does not recognize that stigma is an issue that has an effect on the HIV epidemic.
- Aware but Inactive – The faith community recognizes that stigma is an issue, but does not take much action to reduce it.
- Actively Transforming – The faith community is actively working to reduce stigma, a transformation process that may take several years.
- Free of Internal Stigma – The faith community has transformed itself sufficiently that stigma against members and their families has effectively been eliminated.
- Free of External Stigma – The faith community reaches out non-judgmentally to marginalized populations.

Note the distinction between two types of stigma, Internal Stigma toward members and families and External Stigma toward marginalized populations. Although elimination of External Stigma represents more complete stigma reduction, we believe it is nonetheless important to look at Internal Stigma as well when evaluating the progress of faith communities in reducing the stigma associated with HIV. Internal Stigma focuses on members and families, including, for example, stigma affecting women, children, and young people. Reducing Internal Stigma would require dealing with issues such as gender inequality, gender-based violence, and extramarital sex. External Stigma is broader, including stigma affecting other key populations at risk of HIV infection, such as men who have sex with men, sex workers, and injection drug users. However, it is much more difficult for a faith community to eliminate External Stigma, because it involves greater personal, cultural, and even theological change on the part of faith community leaders and members. Elimination of Internal Stigma represents an important and useful intermediate step for a faith community on its way toward elimination of External Stigma.

While all six categories may have some effect on the societal stigma of HIV and AIDS, the first and the last two have the greatest effect, as suggested in the following diagram:

Based on this framework, we suggest the use of three measures of progress on stigma reduction in faith communities that can be applied at the community, national, or regional level. For each of these measures, we also propose specific targets to be achieved by the year 2020 in regions where HIV prevalence is high:

- Less than 10% of the population worship regularly at faith communities that are Actively Harmful.
- At least 50% of the population worship regularly at faith communities that are Free of Internal Stigma.
- At least 25% of the population worship regularly at faith communities that are Free of External Stigma.

We readily admit that these proposed targets are both aspirational and speculative. We do not know whether it would even be possible to reach these targets by 2020, nor do we know that reaching these targets would have a sufficient effect on societal stigma to enable the 90-90-90 Fast Track targets to be reached. As discussed below, we would welcome research that would help validate these measures and refine these targets. But until that research has been done, we suggest using these targets as place holders to guide our work and to track our progress on reducing stigma in faith communities.

Note also that these targets are only relevant if a significant percentage of the population worship regularly at faith communities. If less than half of the population worship at faith communities, then obviously even the Internal Stigma target cannot be met.

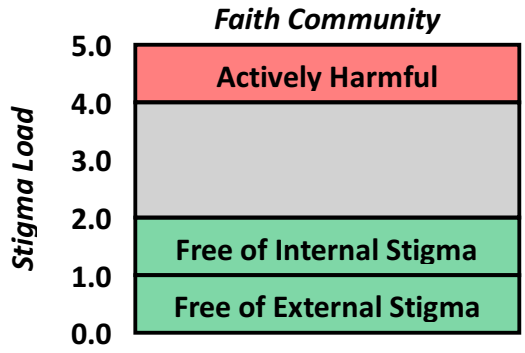
Measuring Stigma Reduction in a Faith Community

Measuring progress toward our proposed 2020 stigma reduction targets requires evaluating local faith communities and classifying them into the six categories identified in the previous section. For this purpose, we propose a quantitative measure we refer to as "Stigma Load." Stigma Load is based on the list of ten characteristics of a stigma-free faith community described in the *Stigma-Free Faith Communities* guidebook. For each characteristic, we use a six-point Likert scale to rate the characteristic for the faith community.

5	The faith community takes actions that strengthen or increase stigma
4	The faith community does nothing, ignoring HIV and AIDS
3	The faith community recognizes the need to take action
2	The faith community occasionally takes limited action
1	The faith community regularly takes effective action
0	The faith community reaches out to marginalized populations

The six points on the Likert scale correspond generally to the six faith community categories identified in the previous section but are focused on a single characteristic, rather than on the faith community as a whole. In fact, most faith communities will vary in their ratings across the characteristics. Specific criteria for each characteristic are given in an appendix.

The Stigma Load for a faith community is the average rating over all ten characteristics. Specific ranges of Stigma Load correspond to the faith community categories described earlier:



Based on Stigma Load, we propose the following as working definitions of the 2020 targets:

- Less than 10% of the population worship regularly at faith communities with a Stigma Load greater than 4.0.
- At least 50% of the population worship regularly at faith communities with a Stigma Load less than 2.0.
- At least 25% of the population worship regularly at faith communities with a Stigma Load less than 1.0.

Data about Stigma Load would ideally be produced through formal studies. However, self-evaluation based on the ten characteristics is a component of the *Stigma-Free Faith Community* methodology, so data about Stigma Load are natural by-products which can be used in an informal monitoring mechanism.

A Cascade of Stigma Reduction in Faith Communities

It isn't easy for a faith community to reduce its Stigma Load to 2.0 or 1.0. It requires deliberate and focused action over a sustained period of time. The first step is simply to recognize the need to take action against stigma. Often, faith communities are not aware of the stigmatizing effect that their attitudes and behaviors have on people living with HIV. Often, faith communities are driven by fear or ignorance. Often, faith communities have difficulty with the cultural and theological issues that must be confronted when dealing with stigma. But sometimes, faith communities recognize that HIV and AIDS are significant issues that they must deal with. They may be motivated by speakers or workshops, by surveys or interactions with members of key populations, or simply by their faith.

Whatever the motivation, taking action begins with self-evaluation. What are the strengths and weaknesses of the faith community with respect to stigma? The six-point Stigma Load evaluation scale detailed in the appendix can be a useful tool in this regard. Once weaknesses have been identified, the faith community can undertake specific actions to address those weaknesses. Once those actions have been taken, the faith community must self-evaluate again, to ensure that progress has been made and to identify any further weaknesses that need to be addressed. Depending on the starting point, a faith community may require several evaluation-action cycles to substantially reduce Stigma Load, a process which may take several years. The *Stigma-Free Faith Community* guidebook can help local faith leaders during this transformation.

The process of transforming a faith community can be described as a Cascade of Stigma Reduction that is somewhat analogous to the Cascade of Treatment for people living with HIV. For a faith community, the cascade has the following four stages:

- Stigma Evaluation – Determine whether or not the faith community is free of stigma.
- Stigma Action – For faith communities that are not free of stigma, undertake a series of actions to turn the weaknesses into strengths.
- Weakened Stigma Load – The faith community's actions have substantially reduced stigma against members and families.
- Suppressed Stigma Load – The faith community's actions have continued long enough to substantially reduce stigma against marginalized populations.

Quantitatively, Weakened Stigma Load corresponds to a value of Stigma Load below 2.0, and Suppressed Stigma Load corresponds to a value below 1.0.

Interventions for Stages in the Cascade

The best interventions for a faith community obviously depend on its current situation and its stage in the Cascade for Stigma Reduction. A variety of interventions is given in the table below:

Cascade Stage	Objectives	Interventions
Stigma Evaluation	• The faith community will be motivated to look at stigma as an issue. • The faith community will know its stigma status.	• Advocacy by national and international faith leaders • Communication at national levels between faith leaders and people living with HIV, for example, using the *Framework for Dialogue* developed by EAA, GNP+, INERELA+, and UNAIDS • Workshops and training sessions, for example, the *Churches, Channels of Hope* program from CABSA or the *SAVE Toolkit* from INERELA+ • Self-evaluation by faith communities, for example, using the Stigma Load criteria • Societal stigma surveys, such as the *People Living with HIV Stigma Index* • Formal studies of Stigma Load on a national or regional level
Stigma Action	• The faith community will take actions to change its stigma weaknesses into strengths. • The faith community will persevere until stigma is substantially reduced.	• Workshops and training sessions, for example, the *Churches, Channels of Hope* program or the *SAVE Toolkit* • Communication at local levels between faith leaders and people living with HIV, for example, using the *Framework for Dialogue* • Self-evaluation on a regular basis by faith communities, for example, using the Stigma Load criteria to identify strengths and weaknesses • Self-driven local interventions, such as those suggested in the *Stigma-Free Faith Communities* guidebook, listed in an appendix • Formal programs to measure Stigma Load in affected communities

Weakened Stigma Load	• Faith community members will know their status and will adhere to treatment. • The faith community will continue to take action to reduce stigma against marginalized populations.	• Regular ongoing self-evaluation and self-driven interventions by local faith communities • Monitoring of HIV outcomes for faith community members and families • Formal programs to measure Stigma Load and societal stigma in affected communities
Suppressed Stigma Load	• Members, families, and marginalized populations will all see the faith community as a place of hope for people living with HIV. • The faith community will continue to advocate for the human rights of all people living with HIV and key populations at high risk of HIV infection.	• Communication at local levels between faith leaders and marginalized populations, for example, using the *Framework for Dialogue* • Formal programs to measure societal stigma and HIV outcomes in affected communities • National and international forums for advocacy

Setting Fast Track Targets for the Cascade of Stigma Reduction in Faith Communities

UNAIDS has set ambitious Fast Track targets for the year 2020, based on the Cascade of Treatment for people living with HIV:

- 90% of people living with HIV know their status
- 90% of those are on treatment
- 90% of those have suppressed viral load

Similarly, we can also express targets for the Cascade of Stigma Reduction for faith communities. However, there is one key difference: whereas the first stage in the Fast Track targets applies only to people living with HIV, the first stage in the Cascade of Stigma Reduction applies to all faith communities. Also, the entire framework is only useful if a significant percentage of the population worships in faith communities. We will assume that 80% of the population worship regularly at local faith communities.

The 2020 targets for the Cascade of Stigma Reduction are as follows:

Cascade Stage	Description	Assumption	Target
Membership	What percentage of the population worships regularly in local faith communities?	80%	
Stigma Evaluation	Of these, what percentage worship at faith communities that know their stigma status?		80%
Stigma Action	Of these, what percentage worship at faith communities that are taking action to reduce stigma?		90%
Weakened Stigma Load	Of these, what percentage worship at faith communities that have substantially reduced stigma against members and families?		90%
Suppressed Stigma Load	Of these, what percentage worship at faith communities that have substantially reduced stigma against marginalized populations		50%

These targets in the Cascade of Stigma Reduction would enable us to meet the second and third overall stigma reduction targets proposed earlier: that half of the population worships at faith communities that are Free of Internal Stigma, and that half of those worship at faith communities that are Free of External Stigma. These cascade targets do not directly address the other 2020 target: that less than 10% of the population worship at faith communities that are Actively Harmful. However, the combination of the Membership assumption and the Stigma Action target imply that less than 16% of the population worship at faith communities that do not know their stigma status. Presumably, not all of those faith communities are Actively Harmful.

The numbers in the cascade suggest the challenge we have before us. What would it take for 80% of the faith communities in affected regions to seriously evaluate themselves against the Stigma Load criteria? Of those who are not free of stigma, what would it take for 90% of them to commit to taking action? Of those who commit to taking action, will 90% persevere through a year or two of activity in order to significantly weaken or suppress their Stigma Load?

Scaling Up for the Fast Track

As an example, we will consider a group of eighteen countries in sub-Saharan Africa.[1] The total population of those countries is about 600 million people. About 95% of the population are members of either Christian or Muslim faith communities.[2] There is considerable variation in the size of these faith communities (e.g., Roman Catholic faith communities have considerably larger average membership than other Christian faith communities). The overall average is about 600 members. Thus, there are about 950 thousand faith communities in those eighteen countries.

Presumably not all of the members attend regularly. For this example, we will assume that 80% of the population are regular attendees. Further, let us assume as a starting point that the following percentages of the Cascade of Stigma Reduction stages have already been met:

- 25% of the population worship at faith communities that already know their stigma status
- 20% of the population worship at faith communities that have begun taking specific action against stigma
- 15% of the population worship at faith communities that are already free of stigma toward members and families
- 5% of the population worship at faith communities that are already free of stigma toward marginalized populations

Note that these numbers are guesswork, selected purely for the purposes of this example. There is no data to support them. As described below, a baseline survey to gather such data would be very helpful.

The following table summarizes the situation in this example, comparing the starting point to the targets:

Cascade Stage	**Starting Point**		**Targets**		**Difference**
Population		600 M		600 M	
Membership	80%	480 M	80%	480 M	
Stigma Evaluation	25%	120 M	80%	384 M	264 M
Stigma Action	80%	96 M	90%	346 M	250 M
Weakened Stigma Load	75%	72 M	90%	311 M	239 M
Suppressed Stigma Load	33%	24 M	50%	155 M	131 M

The "Difference" column shows the difference between the starting point and the Cascade of Stigma Reduction targets. For example, 264 million additional people would need to worship at faith communities that know their stigma status.

[1] Angola, Botswana, Burundi, Democratic Republic of Congo, Kenya, Lesotho, Madagascar, Malawi, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Swaziland, Tanzania, Uganda, Zambia, Zimbabwe,

[2] Exact data about religious affiliation are notoriously difficult to get. Except where otherwise indicated, all data for this example are based on the World Religion Database and the World Christian Database, with some rounding to simplify the explanation.

Based on an average membership of 600 people in a faith community, reaching the cascade targets would require active work by over four hundred thousand faith communities in the eighteen countries:

- 440 thousand faith communities would need to learn their stigma status.
- 417 thousand faith communities would need to take deliberate actions to reduce stigma.
- 398 thousand faith communities would need to persevere for a year or two to reduce their Stigma Load below 2.0.
- 218 thousand faith communities would need to persevere even longer to reduce their Stigma Load below 1.0.

That would be, indeed, a lot of action by a lot of faith communities.

Implementing the Framework

The example suggests that there is a lot of work that must be done in local faith communities if we are to reduce stigma sufficiently to reach the 90-90-90 Fast Track targets established by UNAIDS. This work can be characterized in the following four areas:

- **Establish a baseline**
  - Conduct surveys of faith communities in high prevalence regions to determine the degree to which faith communities are already free of stigma. The starting point for the example, namely that 25% of the faith communities are already aware of their stigma status, is pure guesswork. Is the reality much worse or much better? If it is much better, then perhaps stigma in faith communities is not as great an issue as many of us think. If the reality is much worse, then we have a much greater task ahead of us.
- **Start strongly**
  - Commit to targets. Ambitious targets will only be reached if religious organizations make serious commitments to achieving the targets and implement mechanisms for measuring progress. Conventional wisdom in organizational change is that targets and measurement are fundamental to success. There is no reason to think that organizational change in faith communities would be any different.
  - Focus on motivation. Often, the hardest step in transforming a faith community involves recognizing the need for transformation, which is the goal of the first stage in the Cascade of Stigma Reduction. As illustrated in the table earlier, there are a variety of interventions that may successfully motivate local faith communities to address stigma, and we should pursue all of them aggressively to motivate as many faith communities as possible.
- **Provide support to local faith communities**
  - Training and materials for local faith leaders are critical. In recent years, this has often taken the form of workshops for religious leaders. A baseline survey would indicate how successful this has been. If it has been successful, then we may only need to scale up the work to reach the targets for 2020. But if the baseline survey shows that relatively few local faith communities have successfully addressed stigma, then we will need to find new, more cost effective and scalable ways to provide training and materials for a large number of local faith communities.
- **Conduct scientific studies**
  - Validate the repeatability and utility of the working definitions of Stigma Load. This is important for ensuring that data related to faith community progress is reliable.
  - Determine the relationship between stigma in local faith communities and stigma in nearby settings, such as health clinics. Information about this relationship is important for determining whether the proposed overall targets are the right targets. If there is little correlation between measures of stigma in faith communities and nearby health clinics, then the influence of faith communities on societal attitudes and behavior is perhaps less than many of us believe. On the other hand, if there is a very high correlation, then we can use the data to set effective overall targets.
  - Determine the relationship between stigma in local faith communities and stigma as perceived by people living with HIV in the wider community, for example, using the

People Living with HIV Stigma Index. If there is a high correlation, then we can be confident that faith communities do, indeed, affect stigma in the wider community.

- Determine the relationship between stigma in faith communities and specific HIV outcomes, such as adherence to treatment. Although the focus of this framework is on indirect effects on HIV outcomes, there are some situations in which the effect can be both direct and significant.
- Determine the effectiveness of specific faith community actions in improving the ratings of specific stigma characteristics. The question here is whether similar stigma reduction actions in different faith communities have similar effects. If so, then we can take a consistent, methodical approach in reaching the hundreds of thousands of faith communities where the stigma of HIV and AIDS is still a significant factor.

If we are to reach the UNAIDS 90-90-90 Fast Track targets in the year 2020, then we must begin this work immediately.

Appendix I: Stigma Load

Stigma Load is a measure of HIV-related stigma in a faith community. The measure is based on a list of ten characteristics of a faith community that is free of stigma. Each characteristic is rated as a strength or a weakness of the faith community using a Likert scale ranging from 5 (the faith community is very weak with respect to the characteristic) to 0 (the faith community is very strong with respect to the characteristic). The Stigma Load of a faith community is defined to be the average rating of the ten characteristics.

The ten characteristics and the specific criteria for each point on the Likert scale are given below:

1. **A stigma-free faith community talks openly about HIV and AIDS, as well as related issues such as sexual behavior and gender inequality.**

5	Leaders discourage discussion of such topics and deny that HIV and AIDS are significant issues for the members.
4	Leaders neither promote nor discourage discussion of such topics.
3	Leaders acknowledge the importance of discussing such topics.
2	Such topics are discussed in small gatherings.
1	Such topics are discussed regularly in large gatherings such as worship services.
0	Leaders promote interaction and discussions with marginalized populations.

2. **A stigma-free faith community consistently and repeatedly gives messages of compassion, not judgment, toward people living with HIV.**

5	Leaders give judgmental messages about people with HIV and other marginalized populations.
4	Leaders do not refer to people living with HIV in large gatherings.
3	Leaders acknowledge the need to treat people living with HIV with compassion.
2	Leaders occasionally give messages of compassion toward people living with HIV.
1	Leaders regularly give messages of compassion and inclusion about people living with HIV.
0	Leaders give messages of inclusion about marginalized populations.

3. A stigma-free faith community describes HIV and AIDS as medical conditions, not punishment for immoral behavior.

5	Leaders say that HIV and AIDS are punishment for immoral behavior.
4	HIV and AIDS are not discussed in large gatherings.
3	Leaders acknowledge that HIV and AIDS are medical conditions.
2	Leaders give messages describing HIV and AIDS as medical conditions.
1	Most members recognize that HIV and AIDS are medical conditions.
0	Most members recognize the medical needs of marginalized populations.

4. A stigma-free faith community provides basic facts about HIV and AIDS, including methods of transmission, treatment, and prevention.

5	Leaders give messages with false information about HIV and AIDS.
4	HIV and AIDS are not discussed in large gatherings.
3	Leaders encourage members to get accurate information about HIV and AIDS.
2	Leaders gives messages that dispel myths and cover the basic facts about HIV and AIDS.
1	Most members know the basic facts about HIV and AIDS.
0	Leaders and members encourage marginalized populations to know the basic facts about HIV and AIDS.

5. A stigma-free faith community encourages all members to engage fully in the life of the faith community, regardless of HIV status.

5	Leaders and members discourage people living with HIV from participating in faith community activities.
4	Leaders do not discuss the rights of people living with HIV to participate in faith community activities.
3	Leaders give messages about the rights of people living with HIV to participate in faith community activities.
2	Leaders and members actively encourage people living with HIV to participate in faith community activities.
1	HIV-positive members do not feel barriers to full participation in the life of the faith community.
0	Marginalized populations are encouraged to participate in faith community activities at all levels.

6. A stigma-free faith community focuses on providing care and support to people living with HIV, rather than on how they became infected.

5	Leaders say that people living with HIV should repent before asking for help.
4	The needs of people living with HIV are not discussed in faith community gatherings.
3	Leaders give messages acknowledging the role of the faith community in helping people living with HIV
2	The faith community helps people living with HIV find care and support from other organizations.
1	The faith community has active on-going initiatives to provide care and support for people living with HIV.
0	Support initiatives reach out to marginalized populations.

7. A stigma-free faith community encourages positive living through education and support groups for people living with HIV.

5	Leaders say that people living with HIV do not need to take ARVs if their faith is strong enough.
4	The needs of people living with HIV are not discussed in faith community gatherings.
3	Leaders give messages about the importance of adhering to treatment.
2	HIV-positive members are actively encouraged to adhere to their treatment plans.
1	Most HIV-positive members adhere to their treatment plans.
0	Leaders and members encourage marginalized populations to seek and accept treatment.

8. A stigma-free faith community actively encourages testing for all members and facilitates access to voluntary counseling and testing.

5	Leaders say there is no need to be tested, since HIV and AIDS are not issues for true believers.
4	Leaders do not discuss HIV testing.
3	Leaders give messages encouraging all members to get tested for HIV.
2	The faith community occasionally participates in testing campaigns.
1	The faith community regularly conducts testing campaigns.
0	The faith community facilitates access to VCT for marginalized populations.

9. A stigma-free faith community affirms the responsibility of all members to know their HIV status and to refrain from behavior that risks transmission of HIV.

5	Leaders say that HIV infection is the result of immoral choices.
4	Leaders do not discuss personal responsibility with respect to HIV.
3	Leaders give messages about personal responsibility.
2	Leaders and members openly talk about which behaviors are safe and which are not safe.
1	Most members know their HIV status and refrain from behavior that is not safe.
0	Leaders and members encourage marginalized populations to know which behaviors are safe and which are not safe.

10. A stigma-free faith community works proactively with other organizations to address HIV and AIDS issues in the wider community.

5	Leaders say there is no need to engage with the wider community to address HIV and AIDS.
4	The faith community does not engage with other HIV and AIDS organizations in the community.
3	Leaders give messages encouraging members to engage with other HIV and AIDS organizations in the community.
2	The faith community occasionally participates in HIV and AIDS activities with other organizations in the community.
1	The faith community actively engages with other community organizations to provide services to people living with HIV.
0	Leaders and members actively advocate for the human rights of marginalized populations.

Appendix II: Self-Driven Local Interventions

The *Stigma-Free Faith Communities* guidebook describes ten actions that can help faith communities transform themselves and reduce the stigma of HIV and AIDS. The faith community selects which actions to perform based on a self-evaluation of its strengths and weaknesses.

A. Preach and teach about overcoming the stigma of HIV and AIDS.

Worship services, teaching sessions, and other faith community gatherings are important platforms to present and reinforce messages about stigma. Success will depend on repeated and consistent use of sermons and other teaching opportunities – at least once a month.

B. Present personal testimonies by people who are HIV-positive or personally affected by HIV.

Personal testimonies put a human face on the disease and can change the focus from theoretical dogma to the complexities of life for real people.

C. Conduct educational sessions.

Early in the transformation process, there is a great need for factual information about HIV and AIDS. This can be provided during worship services or by having separate training sessions focused on facts.

D. Provide educational resources.

It is helpful to provide educational material such as books or pamphlets. Two topics are especially important: (1) basic facts about HIV and AIDS; (2) guidelines for positive living.

E. Conduct discussion sessions on specific topics.

Discussion sessions encourage interaction among members of the faith community. This is helpful for topics involving both facts and opinions, such as sexual norms or gender issues. For some topics, separate sessions for men, women, and youth are best. For other topics, mixed groups might be better.

F. Provide testing and counseling facilities at the same time as worship services and other faith community activities.

It is important for all members of the faith community to be tested. The availability of testing facilities in conjunction with worship services and other faith community activities helps significantly. It is important for the results to be kept confidential and to have trained counselors available.

G. Organize support or self-help groups.

Support groups can help people living with HIV to cope with their condition. It is sometimes best to have separate support groups for men, women, and youth, or it may be best to have a mixed group. Support groups meet regularly for discussion about relevant topics, such as positive living and adherence to treatment plans. They are also a natural way to provide logistical help (e.g., travel to clinics). Finally, they can serve as a work team for income-generating activities. Working together in support groups also forms stronger bonds with the faith community as a whole.

H. Test faith community leaders publicly.

It can be very effective for the leaders of the faith community to be tested publicly for HIV. Such actions demonstrate that we are all in this together, that there is no "Us Against Them." The results should be kept confidential. If a faith leader is HIV-positive, he or she may later choose to be open about their status, perhaps as a personal testimony during worship, but it need not be disclosed immediately after testing.

I. Publicly display the commitment to ending stigma.

Prominently displayed posters, signs and banners are visible signs of commitment to eliminating the stigma of HIV and AIDS.

J. Conduct awareness activities with other community organizations.

Important activities with the wider community include educational campaigns, testing days, and recognition of World AIDS Day on December 1.

Resources

People Living with HIV Stigma Index

The *People Living with HIV Stigma Index* provides a tool that measures and detects changing trends in relation to stigma and discrimination experienced by people living with HIV.

www.stigmaindex.org

Framework for Dialogue

The *Framework for Dialogue* is a tool for developing joint actions and ongoing discussions between religious leaders, faith-based organizations and networks of people living with HIV at national level.

www.frameworkfordialogue.net

Churches, Channels of Hope

Churches, Channels of Hope is a comprehensive program for HIV competence in Christian Communities.

www.cabsa.org.za/content/churches-channels-hope

Christian AIDS Resource and Information Service

The *Christian AIDS Resource and Information Service* (CARIS) offers quality, reliable and accessible information and resources to empower Christian initiatives in the fight against HIV and AIDS.

www.cabsa.org.za/content/caris-introduction

Stigma-Free Faith Communities

Stigma-Free Faith Communities is a methodology for transforming faith communities to eliminate the stigma of HIV and AIDS. The guidebook is available in over a dozen languages.

www.empactstigmafree.org

SAVE Toolkit

The *SAVE Toolkit* systematically tackles the stigma, shame, denial, discrimination, inaction and misaction around HIV and AIDS, and comprehensively gives information related to HIV and methods of HIV transmission and how to mitigate these.

www.inerela.org/resources/resourcessave-toolkit-second-edition