Faith-Based Anti-Stigma Initiative towards Healing HIV/AIDS – Project (FAITHH)

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PROTOCOL SUMMARY

Title: Faith-Based Anti-Stigma Initiative towards Healing HIV/AIDS – Project (FAITHH)

Goal:
To demonstrate that an HIV/AIDS (H/A) anti-stigma curriculum helps to reduce H/A stigma, improve HIV knowledge, and strengthen support for persons living with HIV/AIDS (PLWHA) in African-American (AA) faith-based communities in rural Alabama.

We aim to accomplish this goal through two objectives:

1. To describe: 1) the baseline HIV/AIDS stigma, knowledge, experiences of a sample of church pastors in rural Alabama, and 2) the spiritual needs, well-being and possible HIV-related stigma experiences of a sample of PLWHAs living in rural Alabama (for possible tailoring of the HIV/AIDS anti-stigma intervention).

2. To assess the baseline and post-intervention impact of an educational curriculum on H/A stigma, knowledge, attitudes and activities among church members in three study arms which will compare: 1) an H/A anti-stigma curriculum, 2) a standard H/A curriculum, 3) written H/A educational materials displayed at churches (Figure 1).

Design: We propose a randomized trial design based on a transformative model that uses the HIV/AIDS Stigma, Fear, Denial (SFD) theoretical framework (Figure 2). This framework has been previously described in the literature. (Foster, 2007) Twelve AA churches in rural Alabama will be selected purposively and a multi-method data collection approach used. Semi-structured qualitative interviews as well as brief survey data will be collected from AA Pastors, and self-administered survey data will be collected from congregation members. Random assignment will occur to one of the three arms of the study: (1) delivery of an anti-stigma faith-based curriculum to be adapted for use in rural Alabama from curriculum developed by the Christian Council of Ghana for use in Ghana churches, (2) delivery of a standard H/A curriculum currently used in the United States, and (3) placement of written H/A educational materials at churches with no curriculum. This Ghana anti-stigma curriculum is based upon the socio-ecological model, which considers the complex nature of the church community and provides a framework for intervening at multiple levels of influence on health behaviors and practices. We hypothesize that transformative outcomes such as decreased H/A stigma and increased H/A prevention activities in churches will be associated with exposure to the anti-stigma faith-based curriculum (after tailoring based on local AL feedback).
Study Duration: The study will take place over four years.

Year 1: Develop recruitment materials for pastors, congregation members and PLWHAs. Construct & finalize interview guide for pastors. Identify appropriate instruments of measure for internalized stigma, individual and community stigma, and spiritual and religious practices and spiritual well-being, and HIV/AIDS knowledge. Apply for IRB approval from the University of Alabama. Obtain CDC project determination. Set up project website. Have a PI meeting with Christian Council of Ghana (CCOG) members to plan teleconference and training sessions for anti-stigma curriculum. This curriculum is the only available faith-based, anti-stigma curriculum developed in an African cultural context. Because of the historical, cultural similarities
between some African and African American faith groups (Eke, et al., 2010), this curriculum is being used in an effort to adapt for rural, southern faith populations.

**Years 2-3:** Recruit pastors (as leaders of their congregations), congregational members, and PLWHA into the study. Conduct pre-training interviews with pastors and complete PLWHA surveys. Analyze interview and survey data from pastors and PLWHA to ensure the Ghanaian developed anti-stigma curriculum may be appropriately tailored/adapted for rural, southern target populations. Also review data to inform material development and ongoing study strategies for Project FAITHH. Recruit church liaisons and congregational members into the study. Complete the train-the-trainer sessions with (CCOG) and the Anti-Stigma Training Team (ASTT) and conduct baseline (pre-intervention) surveys with congregational members. Deliver the standard H/A curriculum with 4 churches (80 congregational members). Deliver the anti-stigma curriculum to another 4 churches (80 congregational members), and place H/A educational pamphlets at 4 churches who are a part of the no curriculum group (See Figure 3). The study team will also develop and submit abstracts and manuscripts based on the study conceptual and theoretical frameworks, process findings and lessons learned, and PLWHA data (i.e., early abstracts/manuscripts).

**Year 4:** Complete post-intervention (training) activities including in-depth interviews with participating pastors and church members. Clean, organize, and analyze interview and survey data. Disseminate research findings to local faith institutions, community-based organizations (CBOs) and AIDS Service Organizations (ASOs). Develop and submit abstracts and manuscripts to the public health community through scientific meetings and peer-reviewed journals.

**RESEARCH TEAM**

<table>
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<tr>
<th>Name</th>
<th>Degree</th>
<th>Role</th>
<th>Institution</th>
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<tr>
<td>Pamela Payne Foster</td>
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<tr>
<td>Susan Gaskins</td>
<td>RN, DSN</td>
<td>Senior Investigator</td>
<td>UASON</td>
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<tr>
<td>Jason M. Parton</td>
<td>PhD</td>
<td>Biostatistician</td>
<td>UACOB</td>
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<tr>
<td>Rev. Willie Smith</td>
<td></td>
<td>Ministerial Liaison</td>
<td>Salem CC</td>
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<td>Rev. John Meeks</td>
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<td>Ministerial Liaison</td>
<td>New Hope/Friendship BC</td>
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<td>Rev. Chris Spencer</td>
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<td>Ministerial Liaison</td>
<td>St. Matthew/Watson MBC</td>
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<td>Rev. Sam Gordon, III</td>
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<td>Ministerial Liaison</td>
<td>Macedonia CME</td>
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<tr>
<td>Myra Vickery</td>
<td></td>
<td>Graduate Research Assistant</td>
<td>UASOM-Tuscaloosa.</td>
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**Investigators Biographies**

**Pamela Payne Foster, MD, MPH**, Principal Investigator, is an Assistant Professor in Community and Rural Medicine at the University Of Alabama School Of Medicine - Tuscaloosa campus. Dr. Foster also serves as Deputy Director of the Institute for Rural Health Research at the institution. Dr. Foster has already begun to establish herself as a researcher in the area of stigma in rural African Americans in Alabama. Her specific areas of research include: generalized characterization of community-based stigma in rural African Americans, characterization in older HIV+ African Americans in Alabama, characterization of disclosure issues in rural African American men infected with HIV and faith-based approaches to HIV/AIDS prevention. Dr. Foster has also been involved in local and state HIV/AIDS advocacy and planning.

**Susan Gaskins, RN, DSN, FAAN**, Senior Investigator, is a Professor of Nursing at the Capstone College of Nursing at the University of Alabama. She has been working in the area of HIV/AIDS for most of her research career. She has served as PI on several grants and has recently completed a National Institute of Health (NIH) grant, which studied the impact of AIDS disclosure on rural African American men. She has also been involved in HIV/AIDS advocacy and research at the national, state and local levels.

**Dr. Jason M. Parton**, Consultant, is a Biostatistician working at the University of Alabama, College of Business. He also has an adjunct faculty affiliation with the Institute for Rural Health Research. Dr. Parton will assist with methodology and evaluation design, implementation and statistical analysis.

The other integral members of the team include four ministers who will serve as important liaisons between the investigators and the churches being recruited into the study. All of them have extensive pastoral experience as well as interest in health disparities. **Reverend Willie Smith** is Pastor of Salem Christian Church in Letohatchie, Alabama, Disciples of Christ Church. He has been involved with HIV/AIDS Street Ministry in the Montgomery, Alabama area where he actively seeks persons to educate and test for HIV. He works in this capacity through his nonprofit, Emergency Relief Ministries (ERM) Outreach Ministries. **Reverend John Meeks** is the former State President of the New Era Progressive Baptist Conference in Alabama. He also serves as the National Advisor in HIV/AIDS to the National Baptist Progressive President, Reverend Thurmond. He also serves as the Pastor of the New Hope Missionary Baptist Church in Greenville, Alabama and Friendship Baptist Church in Georgiana, Alabama. **Reverend Chris Spencer** is the Assistant Director of the Center for Community Based Partnerships at the University of Alabama where he is responsible for facilitating community engagement with faculty and staff at the university. He is also a Community Associate with the Black Belt Community Foundation and facilitator of organizing pastors in the West Alabama area. In a recent presentation given by Dr. Foster on health disparities, the group discussed HIV/AIDS as a possible focus of concern for the group. Reverend Spencer is also the Pastor of St. Matthew-Watson Missionary Baptist
Church in Boligee, Alabama. **Reverend Sam Gordon, III** is Pastor of Bethlehem Christian Methodist Episcopal (CME) Church in Prattville, Alabama (Autauga County). He was formerly Director of the Birmingham Area Interfaith Sponsoring Committee, a coalition of churches conducting social justice projects including health. Currently he serves as the Regional Coordinator for Social Justice Issues for over 200 CME churches in Alabama and Florida. Although all four pastors serve small churches (N<100) each of them have relationships with other pastors and congregations within their spheres of ministry, including denominational, ministerial and community affiliations. These relationships create a larger sphere for potential recruitment of pastors and congregation members into the study.

A graduate research assistant (GRA) will be hired to assist the investigators in presentations, training, interviews and data collection and analysis.

**Dr. Madeline Sutton**

Dr. Madeline Sutton will act as our CDC scientific mentor and provide technical support only. She will not directly engage with study participants, nor have access to identifiable data. Therefore, CDC is considered not engaged in this study. However, any adverse events will be reported to Dr. Sutton within 48 hours using deidentified data.

## STUDY SITES

The proposed research will occur in a variety of settings, including the University Of Alabama School Of Medicine at the Tuscaloosa branch campus, the Capstone College of Nursing, various meetings of the Alabama Consumer Advisory Board, and AA rural churches in Alabama.

**University of Alabama School of Medicine, Tuscaloosa**

The University Of Alabama School Of Medicine’s main campus is housed in Birmingham with two branch campuses primarily concerned with rural primary care in the state. The site where the PI is located (Tuscaloosa) is one of the branch campuses and will house many of the planning meetings for the project. This site will also be the location where the videoconferencing between the ASTT and the CCOG will take place. This site will also be responsible for conducting all data storage and data analysis in the PI’s locked UASOM-Tuscaloosa office space and accessible to only the PI and GRA. The PI’s office is HIPAA-compliant and equipped to provide confidentiality safeguards. See Ethics Integrity section-page 37.

**Capstone College of Nursing**

The Senior Investigator of the study is housed at this site on the campus of University of Alabama. This location has several meeting rooms and teleconferencing equipment and will be used as a back-up site if room is not available at The University of Alabama School of Medicine site.
Community Sites
We will recruit and conduct the study in rural area sites, such as churches, ASO offices, and individual homes. See Methodology section for information on determination of rurality.

LIST OF ABBREVIATIONS AND ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AA</td>
<td>African American</td>
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<tr>
<td>AASTTT</td>
<td>Alabama Anti-stigma Training Team</td>
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<tr>
<td>ASO</td>
<td>AIDS Service Organization</td>
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<tr>
<td>AST</td>
<td>Anti-stigma Training</td>
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<td>AL</td>
<td>Alabama</td>
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<tr>
<td>ACAB</td>
<td>Alabama Consumer Advisory Board</td>
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<tr>
<td>CBO</td>
<td>Community Based Organizations</td>
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<td>CCOG</td>
<td>Christian Council of Ghana</td>
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<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
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<tr>
<td>CME</td>
<td>Christian Methodist Episcopal</td>
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<tr>
<td>DOC</td>
<td>Disciples of Christ</td>
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<tr>
<td>GIPA</td>
<td>Greater Involvement of People Living with HIV/AIDS</td>
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<td>CBR</td>
<td>Community Based Research</td>
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<td>H/A</td>
<td>HIV/AIDS</td>
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<tr>
<td>IRB</td>
<td>Institutional Review Board</td>
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<td>IRHR</td>
<td>Institute for Rural Health Research</td>
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<tr>
<td>MSM</td>
<td>Men Having Sex with Men</td>
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<tr>
<td>PLWHA</td>
<td>People living with HIV/AIDS</td>
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<tr>
<td>PLHIV</td>
<td>People living with HIV</td>
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<tr>
<td>PWID</td>
<td>People who inject drugs</td>
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<td>Abbreviation</td>
<td>Description</td>
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<tr>
<td>SFD</td>
<td>Stigma, Fear, and Denial</td>
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<td>UASOM</td>
<td>University of Alabama School of Medicine</td>
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<td>UACOB</td>
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<td>UACON</td>
<td>University Of Alabama College of Nursing</td>
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INTRODUCTION

BACKGROUND & SIGNIFICANCE

HIV/AIDS in African Americans living in the Rural South

African Americans (AAs) are disproportionately affected by HIV/AIDS as they account for higher proportions of HIV infections in all stages of the disease (CDC, 2011). In 2009, AA represented only 14% of the total U.S. population but comprised 44% of all new HIV infections. AA men accounted for 70% of all new infections among AAs and have a rate of infection that is $6\frac{1}{2}$ times higher than that of white men. The majority of new HIV infections are in men who have sex with men (MSM); new infections among young (aged 13-29) MSM increased by 48% from 2006-2009. In addition, the rate of new infections in AA women is 15 times higher than in white women, and 85% of transmission is through heterosexual sex. HIV was also the ninth leading cause of death for all AAs at the end of 2008 and the third leading cause of death for all AAs aged 35-44. (CDC, 2011)

The Deep South as geographically consists of Louisiana, Alabama, Mississippi, Georgia and South Carolina, and portions of Texas, Arkansas, Tennessee, and Florida (Pierce, 1974). This region has the highest percentage of AAs in the country and carries a disproportionate burden of HIV/AIDS (Southern AIDS Coalition, 2008). Additionally, higher percentage of new AIDS cases in people who live in non-metropolitan areas are reported by southern states than any other region in the country (Southern AIDS Coalition, 2008). Sixty-five percent of all rural AIDS cases are in the South. In Alabama, AA account for 69% of new HIV cases yet they comprise only 26% of the state’s population (Alabama Department of Public Health, 2011). Alabama also has the 11th highest HIV infection rate in the country (CDC, 2009), and it has the 8th highest AIDS related death rate (Hannaa et al, in press).

Factors related to life in the Deep South, particularly for AAs, are vital to understanding the dynamics of the HIV/AIDS epidemic, including racism, lack of trust and suspicion, religious beliefs, homophobia, and poverty. (Foster, 2007; Jemmot, Jemmot & Hutchinson, 2001). Rural residents are more likely to lack access to health care and health care insurance, and are less likely to practice primary prevention measures. Culture in rural areas is more conservative than in urban ones, valuing self-reliance (Bushy, 2000) and religiosity (Rural Center for AIDS/STD Prevention, 2005), but including a negative view of homosexuality, resulting in men fearing to be labeled as homosexual (Kennamer, Honnold, Bradford, & Hendricks, 2000). Religiosity is also associated with negative attitudes toward individuals with HIV/AIDS and is a major barrier to both acceptance and adoption of prevention messages and interventions in rural areas, especially in many AA communities (Foster, 2007). In addition, there is an ongoing cultural distrust of the medical community, stemming in part from the infamous Tuskegee Syphilis Study conducted in the early 1900’s.
Homophobia is one of the most significant barriers to successful implementation of evidence-based HIV programs by AA communities. There are strong negative attitudes toward MSM, especially in churches. Heckman (2006) identified rural AA with HIV as an overlooked population in need of culturally contextualized interventions to improve their quality of life and period of survival. Considering the disproportionate infection rate among AAs, it is critical that theory-based, culturally sensitive and methodologically sound studies be conducted to develop interventions to decrease the incidence of HIV infection and to improve the lives of people who are infected.

**HIV/AIDS Related Stigma**

People living with HIV/AIDS (PLWHA) have faced stigma since the beginning of the pandemic. HIV/AIDS has evolved from an acute, fatal disease to a chronic, treatable one. However, stigma continues to be a problem and possibly accounts for reluctance to seek testing or treatment for HIV. Additionally, stigma makes it less likely that PLWHAs will disclose their status with others (Southern AIDS Coalition, 2008). Disclosure is recognized as a first step in obtaining care and social support, and is an expectation by partners engaging in high-risk behaviors in reducing the likelihood of transmitting the virus to others. (Simoni & Pantelone, 2005).

Early in the epidemic, stigma was identified as a barrier to HIV/AIDS prevention and treatment. Herek (1999) described H/A stigma as negative feelings and behaviors towards HIV infected persons as well as groups and communities characterized by high rates of HIV-infection (e.g., MSMS, people who inject drugs (PWID) and heterosexual women). Stigmatized groups include homosexual men, PWID, persons with multiple sexual partners and persons involved in exchange sex. The literature has shown that perceptions that may further contribute to H/A stigma, include: a) transmission occurs because of voluntary and immoral behaviors, b) transmission is perceived to be fatal, c) transmission is infectious and non-preventable, and d) the disease is physically apparent to others. Stigmatization may lead to feelings of shame, guilt, self-loathing and depression, which can result in low self-esteem and decreased social interactions (Emlet, 2007; Galvan, Davis, Banks and Bean, 2008). PLWHA have reported rejections by family and friends as well as losing their jobs or housing (Herek, 1999). As previously stated, stigma is also a barrier to testing which is the gateway to treatment and prevention (Mahajan et al., 2008) and has been identified as a contributing factor the to the expansion of the epidemic (Visser, Kershaw, Makin & Forsyth, 2008).

H/A-related stigma has been reported to be more pronounced in the Deep South, where the epidemic has disproportionately affected AAs. (Southern Manifesto Update, 2008; Foster PH, 2007) The reasons for increased stigma may be related to several issues including: 1) social conservatism appears to be more pronounced in the South compared with the rest of the nation (Lichtenstein, et.al, 2005); and 2) prominence of the church in the South as denoted by term “Bible Belt” promotes sexual prohibitions (Visser et. al, 2008). The increased H/A-related stigma may actually be fueling the increased incidence rates in the South. For example, MSMs may be less likely to disclose their sexual behaviors because of stigma and may become involved with women and men who are unaware of the risk posed to them by their partners' MSM behaviors. (Lichtenstein, 2003)
Reducing HIV/AIDS Stigma. Because of the negative health outcomes related to stigma, HIV/AIDS programs, service providers, and communities have focused efforts to reduce stigma. Strategies and interventions to reduce H/A stigma have been identified, developed and recommended for implementation in both developed and developing countries. Heijnders and van der Meij (2006) reviewed pertinent literature and identified numerous strategies and five levels of intervention to reduce stigma: 1) intrapersonal, 2) interpersonal, 3) organizational/institutional, 4) community, and 5) governmental/structural. Strategies at the intrapersonal level are targeted at behavioral change and include individual counseling, cognitive behavioral therapy (CBT), self-help, advocacy and support groups. For individual counseling to be effective in reducing stigma, the intervention needs to include an intense stress prevention component. Modifying the environment is the aim of interpersonal interventions that focus on strengthening social support and networks. Care for PLWHAs is provided by family members, community volunteers and health care providers, so these people are educated about HIV/AIDS. At the organizational/institutional level, strategies target stigma-related aspects of an organization. One typical-strategy is a training program to increase knowledge about HIV/AIDS as well as the impact that stigma has on the lives of PLWHAs. New policies can be developed within an organization that will address likely areas of stigma, such as voluntary counseling and testing services. Increasing knowledge that provides facts that counter myths or false knowledge on which stigma is based is the aim of community-level interventions. A variety of strategies can be used to present the educational content. Other reviews have reported that educational interventions are not sufficient to change attitudes or effect behavior. Rather, education needs to be combined with other approaches, such as personal contact and skills building (Brown, Macintyre, & Truijillo, 2003). Another community level intervention strategy is contact or interactions between the public and PLWA to humanize the stigmatized population (Anderson, 2004). This contact can be direct or indirect. An example of an indirect contact would be an influential or well-known people disclosing their HIV/AIDS, like Magic Johnson or Elizabeth Glazer. Brown and colleagues (2003) described contact as one of the best approaches to reduce stigma, but emphasized that it must be accompanied by education to be effective. Advocacy programs go beyond education and work towards ensuring support, commitment and recognition from policy and decision makers. Legal and policy interventions aim to enforce the protection of the rights of people with HIV/AIDS at the governmental and structural level.

Education is the common thread in interventions to reduce H/A stigma. Heijnders and van der Meij (2006) argue that interventions must empower PLWHAs to take an active role in developing relevant stigma-reduction programs in their communities. It is important that outcomes be assessed to determine effective strategies for different populations.

In 2010, Sengupta and colleagues conducted a literature review of interventions to reduce H/A stigma. Their work focused on the quality of the studies and the use of evidence-based interventions. Measures used to evaluate stigma reduction in the interventions were found to be disparate or inadequate. It is important to use a previously validated scale to measure stigma pre-intervention and compare post-intervention scores. Even when H/A reduction interventions demonstrate statistical
significance, they also need to have public health significance. Improved health outcomes include increased testing, access to care and treatment, new and improved policies, and improved social support. None of the reviewed studies addressed these outcomes.

Although H/A curricula targeting faith-based AA and African communities have emerged (i.e., Balm in Gilead, Gospel Against AIDS, Affirming a Future with Hope: HIV & Substance Abuse Prevention for AA Communities of Faith- Interdenominational Theological Center), there has not been rigorous evaluation on whether these programs decrease stigma. (Martin, P, et. al., 2003) Additionally, there has been a lack of anti-stigma interventions, which have been rigorously tested in U.S. populations, particularly faith-based AA communities. (UNAIDS, 2002) There are interventions that have been implemented in the international arena including this study’s proposed anti-stigma curriculum developed by the Christian Council of Ghana. Although the Christian Council of Ghana’s curriculum was evaluated for program delivery effectiveness, it was not evaluated for effectiveness in decreasing individual or community HIV/AIDS related stigma. In addition to need for more rigorous evaluation, there are also recommendations and guidelines to develop a successful program that include having a comprehensive approach that empowers PLWHA and addresses stigma across the care continuum (prevention to care) (Osborne, 2004). Internationally the importance of Greater Involvement of People Living with HIV/AIDS (GIPA) in all stages of community-based research and projects (CBR) is recognized. This local involvement is critical for not only community support and culturally appropriate interventions, but for sustained, relevant outcomes.

Faith-Based Approaches to HIV/AIDS

Among AA, faith-based institutions have substantiated themselves as a foundational support for community not only for its spiritual, but also educational, political, and economic support and for the AA faith-based leader as an influential leader in the community, often seen as reliable sources of information (Billingsley, 1991; Billingsley, 1992, Martin, 2003). Recently churches have become involved in battling health disparities, particularly in the area of cancer, diabetes, and cardiovascular prevention (Becker et al., 2001; Oexmann et al., 2001; Sutherland et al., 1992). However, the Black Church has not embraced HIV/AIDS as readily because of the difficult and complex issues attached to risk behaviors such as substance abuse, premarital sex, adultery, promiscuity, and homosexuality (Fullilove et al., 2007; Smith et al., 2005; Eke et al., ). Other barriers to churches’ involvement to addressing HIV/AIDS include the controversy regarding the use of condoms, and that HIV/AIDS is viewed as the direct result of sin in some religious communities (Mechael, 2004). Despite these complexities, the increasing disparity of HIV/AIDS in the AA community has demanded engagement of faith based leaders as partners in the epidemic. For example, in 2006, the Centers for Disease Control (CDC) convened a meeting for Black faith-based leaders to elicit their help in increasing awareness of the disease in their communities and support for prevention activities such as HIV testing (CDC, 2006).

A literature review shows a paucity of information on HIV/AIDS faith-based strategies. Featured in some of the literature is the Balm in Gilead, a national nonprofit
organization, has convened faith based leaders in the AA community to build the capacity of this unique target group to conduct HIV/AIDS prevention (Balm in Gilead, 2013). Additionally, strategies such as the Week of Prayer for HIV/AIDS have been a way to increase awareness among faith leaders in the AA community. Other coalition models of state and regional coalition building among AA faith leaders have begun to impact faith based strategies in HIV/AIDS prevention. For example, Project FAITH (Fostering AIDS Initiatives that Heal), was established in January 2006 to reduce stigma of HIV among AA faith-based organizations in South Carolina. During the first year, Project FAITH funded 22 churches (who applied for funding and had low HIV stigma at baseline; selection bias) to provide HIV-related programs and services to their congregations and surrounding communities (Lindley et al., 2010). However, there was no randomized trial study of an intervention. Our study borrows that acronym with an extra H as Project FAITHH and will go a step further by testing a faith-based anti-stigma intervention in rural faith-based settings using a randomized trial format.

**End point:** The proposed research will examine an HIV/AIDS anti-stigma training, which has been developed in Ghana. As there are no other US-developed anti-stigma faith interventions, and African and African American faith culture often share historical context, this study presents an opportunity to test and adapt this anti-stigma intervention for use in rural, southern faith settings. We believe that we will see decreases in individual and community stigma through use of this anti-stigma curriculum compared with controls. If effective, this curriculum could be further adapted for use in US rural southern churches as an HIV/AIDS stigma-reduction strategy, which may ultimately serve to help increase awareness, sensitivity and support for persons living with or at risk for HIV/AIDS.

**The Conceptual Model for Project FAITHH**

The Principal Investigator (PI) of this study developed a conceptual framework for addressing H/A stigma, fear, and denial (SFD) among AAs in rural Alabama (Foster 2007). In this framework, SFD are targeted and potentially decreased through community empowerment, cultural competence skill development and social action addressed at all levels of prevention: primary, secondary, and tertiary. Inclusion of community empowerment, cultural competency, and social action components make the model more comprehensive and specific to rural AA communities than standard H/A interventions. (See Figure 2 for a pictorial schematic of framework).
Figure 2. Stigma, Fear and Denial Framework of Prevention in African Americans in the Rural Deep South (Foster 2007)

**PREVENTION ENGINE** – To eliminate misinformation, myths, and distrust associated with HIV/AIDS via education and training interventions

1. Community empowerment
2. Cultural competence skill development
3. Social action

- = Stigma
□ = Fear
● = Denial
STUDY OBJECTIVES

Study Objectives

Goal:

To demonstrate that an HIV/AIDS (H/A) anti-stigma curriculum helps to reduce H/A stigma, improve HIV knowledge, and strengthen support for persons living with HIV/AIDS (PLWHA) in African-American (AA) faith-based communities in rural Alabama.

We aim to accomplish this goal through two objectives:

1. To describe: 1) the baseline HIV/AIDS stigma, knowledge, experiences of a sample of church pastors in rural Alabama, and 2) the spiritual needs, well-being and possible HIV-related stigma experiences of a sample of PLWHAs living in rural Alabama (for possible tailoring of the HIV/AIDS anti-stigma intervention).

2. To assess the baseline and post-intervention impact of an educational curriculum on H/A stigma, knowledge, attitudes and activities among church members in three study arms which will compare: 1) an H/A anti-stigma curriculum, 2) a standard H/A curriculum, 3) written H/A educational materials displayed at churches (Figure 1).

Study Hypotheses

**Hypothesis 1:** Individuals receiving the anti-stigma H/A curriculum will have significantly lower measurable individual and community H/A stigma compared with the control groups who do not receive the anti-stigma training. Individuals receiving the anti-stigma H/A or standard H/A curriculum will have higher H/A knowledge compared with individuals who do not receive any curriculum, but have written H/A materials displayed at their church.

**Hypothesis 2:** Churches that receive the anti-stigma H/A curriculum will have increased H/A prevention activities compared with churches that do not receive the anti-stigma H/A curriculum.
Figure of Overall Study Design for Project FAITHH

Study I
(Baseline assessments/pre-initiative)

Enroll and collect baseline qualitative and quantitative data:
- Pastors (n=12)
- PLWHA (n=40)
- Congregation members, including opinion leaders (n=240)

Study II
(Randomized trial of stigma reduction intervention)

Group 1
Receives stigma-reduction intervention training (8 sessions)

Group 2
Receives standard HIV/AIDS curriculum

Group 3
No training; educational materials left at church

Study III
(Post-initiative phase)

Collect post-initiative quantitative and qualitative assessments from participants:
- Pastors (n=12)
- Congregation members (n=240)
STUDY DESIGN

Overview of Project FAITHH (Faith-based Anti-stigma Initiative Towards Health and Healing)

This research project will conduct a randomized trial of an HIV/AIDS anti-stigma intervention. Enrollment will include 12 rural AA churches (pastors), 240 church members, including opinion leaders within those 12 churches, and 50 PLWHAs not necessarily affiliated with the churches. The research project is divided into three studies.

Study I

Goal
The goal of this study is to collect baseline data from
- 12 pastors
- 50 PLWA
- 20 congregational members or affiliated members (nearby churches) from each of the 12 churches (240 persons total).

Objectives:
1. To recruit 12 pastors from rural Alabama.
2. To interview 12 pastors from rural Alabama about their H/A knowledge and prevention activities as well as attitudes about H/A stigma.
3. To survey 50 PLWA about their spirituality and wellness as well as any experiences with H/A stigma. (One time assessment)
4. To survey 240 church opinion leaders from the 12 rural churches in Alabama about their H/A knowledge, individual and congregational H/A stigma.

Design
During this phase, the Research team will conduct in-depth interviews with pastors (n=12) to assess H/A stigma and knowledge. In PLWHAs, experiences of stigma, religious and spiritual behaviors, and wellness will be assessed. The feedback from the 12 pastors and 50 PLWA is vital to help tailor/adapt the anti-stigma curriculum (developed in Ghana) for use in rural, southern faith settings. In addition, engaging the 12 church leaders is a vital step before directly engaging the congregation members, including opinion leaders, in the larger randomized trial. Congregational members will be assessed for individual and community stigma. During this phase, two Ministerial Liaisons will be selected to become Lead Trainers and with the Investigators will lead delivery of the anti-stigma curriculum. The Christian Council of Ghana will train the Alabama Anti-Stigma Training Team on the Ghana curriculum.

Recruitment: Pastors
Recruitment of Pastors will involve several strategies. One strategy for recruitment of pastors into the study will occur informally by all members of the research team, particularly the Ministerial Liaisons, through their denominational or other affiliations (such as Ministerial Alliances). Each Ministerial Liaison will use contact lists and recruitment materials such as letters and fliers (See Appendix 14 for sample recruitment letters) to invite potential participants to be in the study. Each liaison will be responsible for recruiting three pastors/churches within their denomination/affiliation sphere to meet the 12 church requirements for participation. If Ministerial Liaisons cannot meet their recruitment expectations, we will also conduct targeted recruitment in this population through: a) networks such as denominational groups or leadership, b) mass marketing strategies using media, c) direct recruitment in churches. Snowball strategy will also be used to recruit by asking successfully recruited pastors for the names and contact information of their peers.

The inclusion/screen and enrollment criteria for the pastors in this study are:

- Senior Pastor (defined as head pastor of church)
- At least 19 years of age
- Self-Identified as AA
- Serving a predominately AA rural Alabama congregation (membership at least 80% AA).

An eligibility checklist for study participants is included in Appendix 22. An exclusion criterion for congregational participation would be if any congregations received formal HIV/AIDS training. Study Investigators will map the geographical locations of churches as well as list their denominational status, and will determine a final list of churches to include in the study, which allows variability. Additional information used in the selection of the final 12 churches and pastors selected for the study will include gender and age of pastors, interest in H/A prevention and experiences in H/A prevention in order to select a variety of interest levels and experiences as well as to balance some selection bias. The pastors will receive detailed information about their role in the study and written informed consent will be obtained in person by the study investigators. Additionally, during this session, the Investigators will fully explain the role of their congregational participants in the study. Pastors will be asked to assist with recruitment of their congregation members, particularly church leadership such as deacons, ministers, youth groups and auxiliaries.

Recruitment: PLWHAs

Fifty PLWHAs will be recruited through multiple strategies, including use of AIDS-related networks including ASOs, Alabama Consumer Advisory Board (ACAB) where the research staff have previous affiliations and relationships with persons affiliated with PLWHAs. Agency staff will serve as intermediaries for recruitment of study participants. The directors and case managers at the ASOs will identify potential participants. Using the procedures the PI has used in previous research with these agencies, staff will approach the potential participants and confidentially provide them with written information about the study through a PLWHA recruitment letter. (Appendix 16)
Interested PLWHAs who call a research team member will have a one-on-one session scheduled to complete the written surveys. Additionally, PLWHAs who are recruited through fliers posted at ASOs and H/A clinics as well as announcements at H/A related meetings will be given the Investigative team phone number in order for a member of the investigative team to screen interested persons for study eligibility, and then schedule all eligible participants for a session to complete surveys one-on-one. See Appendix 15 & 16 for sample letters and sample fliers to recruit PLWHAs.

**PLWHA inclusion, screening and enrollment criteria will include:**

- HIV diagnosis for at least 6 months (self-report)
- At least 19 years of age
- Self-Identifies as AA
- Lives in rural Alabama. Rural is defined by the US Census Bureau and other federal agencies as non-metropolitan areas with county size (population < 50,000)
- Able to speak and understand English

An inclusion criteria checklist for study participants is included in Appendix 22.

**Recruitment: Church Members, including Opinion Leaders**

There are two main strategies for recruitment of 240 church members, including opinion leaders into the study: 1) suggestions by the Pastor of church leadership to participate in the study (i.e., Deacons, Elders, Church Department Heads or Chairs, Ministers of Music, etc.); or 2) Ministerial Liaisons will recruit participants through congregational and group presentations as well as information in the church bulletin. Each Pastor will also designate either the First Lady or other church leader such as Elder or Deacon of the congregation to act as the Church Liaison to the study in order to assist the Research Team with coordination of training sessions. (See Appendix 12 for recruitment letters for Church Liaisons and Appendix 13 & 14 for sample recruitment fliers and letters).

**The inclusion, screening, and enrollment criteria for Church Liaisons and Church Opinion Leaders will include:**

- Confirmed Church Leadership role by Pastor
- At least 19 years of age
- Self-Identifies as AA
- Willing to participate in a 8 week study course (incentives provided)
- Able to speak and understand English

An eligibility checklist for study participants is included in Appendix 22. The Ministerial Liaisons will work with the Church Liaisons to set up an interest meeting with all potential church congregation participants to be given an overview of project. At that
time, the Research staff will determine all members who meet inclusion criteria and obtain informed consent.

If deemed eligible for the study, each church will be randomly assigned by the statistical consultant to one of the three groups (4 churches x 3 group assignments = 12 churches total). Each of the 3 groups (1-intervention, 2-standard curriculum, 3-written materials only) will contain 80 church members for a total of 20 congregational participants across four churches. An envelope method will be used to randomize churches into the study groups, which will involve placement of names/pastors of all 12 churches into an envelope and selection systematically of churches/pastors into one of three arms of the study.

Data Collection
Both qualitative and quantitative data will be collected in order to test our three hypotheses. Qualitative data from the pastors will be collected via in-depth interviews (Appendix 4) and transcribed verbatim. NVivo will be used for qualitative data analyses.

We will collect quantitative data from pastors, PLWHAs, and from congregational members. Quantitative data will include: a) demographic surveys (Appendix 5 & 6) of 12 pastors, 50 PLWHAs and 240 congregational members; b) spiritual practices and well-being and internalized stigma surveys from 50 PLWA; c) HIV knowledge, individual stigma and community stigma in 240 congregational member’s pre-and-post initiative Please see the Appendices 5-11 for specific data collection tools; these survey items will be entered into the computer tablets for ACASI data collection.

Pastors:
A member of the Research team will meet individually with each pastor to electronically (self-administered) and collect demographic information and measure HIV/AIDS knowledge. In-depth interviews will be conducted to assess the pastor’s attitudes and knowledge about stigma, and the presence of standard HIV/AIDS-related primary prevention activities in their churches such as HIV/AIDS education and testing.

Demographic Assessment (Appendix 5): The demographic tool used for the Pastors was adapted from a previous study conducted by the Investigative team. The tool asks basic demographic information such as age, income status, living arrangements and employment status and additional target group specific questions (e.g., denomination and leadership role for Pastors.

HIV/AIDS Knowledge Test (Appendix 11): HIV/AIDS knowledge will be assessed using an HIV/AIDS Knowledge Test developed by UNAIDS/WHO and adapted for this study. We revised questions 1 and 2 to reflect more of a national and regional approach to HIV/AIDS knowledge compared to questions, which reflected more of a global approach to H/A knowledge. The tool has been well established and adapted to meet the needs of various populations and is listed as a UNAIDS resource tool.

Pastor In-Depth Interview Guide (Appendix 4): This series of eight questions are based on previous research experience (Foster, 2007). Questions will also be asked to
assess H/A activities such as testing and education conducted by their congregations. Additionally, we want to know the H/A prevention behaviors of the Pastors, so we ask a question about their own HIV testing behaviors. We also desire to know the Pastors perceptions of their congregation’s attitudes or stigma attitudes about PLWHA, so we ask questions about the number of PLWHA in their congregations. The interview will last between 60 and 90 minutes.

PLWHAs:

Face-to-face meetings will be arranged at a place chosen by the study participant. Data collection will include demographics, any stigma experiences (Appendix 8), and religious and spiritual well-being. (Appendix 7)

**Demographic Assessment (Appendix 6):** Demographic tools used in this study, were tailored to PLWHAs. This tool was adapted from previous studies conducted by the Investigative team. The tool collects generic demographic information such as age, income status, living arrangements and employment status as well as target group specific questions (e.g., length of HIV status for PLWHAs).

**Internalized Stigma Measure (Appendix 8):** We are using an internalized stigma tool developed by Visser et al., which is part of a series of parallel tools, which measure internalized, individual and community stigma. These tools have been tested rigorously in subpopulations in South Africa where their internal consistency was acceptable at 0.70 for internalized stigma and evidence of their validity was supported in several ways including the findings that people who were more knowledgeable about HIV and people that know someone with HIV have lower levels of stigma scores using the scales similar to previously reported research. (Visser et. al, 2008) Additionally, the demonstration that for HIV positives there are significant associations between internalized stigma and measures of self-esteem, depression and social support provides some evidence supporting the validity of the internalized stigma scale. (Visser et. al, 2008) We are testing these tools for the first time in our unique rural AA population. The tools are a 17-item questionnaire framed as positive and negative statements and are related, but differ in vantage point of questions from either the point of view of an HIV+ person, from an individual’s viewpoint, or from a community member’s viewpoint. Respondents answer using either of two responses: agree or disagree. The higher the agreement score, the greater the stigma (except for three questions which are the reverse).

**Practices and Well-Being (Appendix 7):** The Brief Multidimensional Measure of Religiousness/Spirituality has four broad scales: behavioral, social, psychological and physiological as mechanisms of religion/spirituality. It also covers a variety of domains including daily spiritual experiences, meaning, value, beliefs, forgiveness, private religious practices, religious/spiritual coping, religious support, religious/spiritual history and preference, commitment, and organizational religiousness. The measure has been tested for reliability and validation. Reliability of nine items ranged from moderately good (0.64) to excellent (0.91). Three types of validity were measured: content, discriminant, and convergent. Several of the questions have been found to be good
measures in other health research. (Idler, et. al., 2003) We will also add two questions, which measure negative religious/spiritual coping: 1) I wonder whether God has abandoned me; and 2) I feel God is punishing me for my sins or lack of spirituality. See Appendix 7 for sample spiritual/religious practices and spiritual well-being Scale as well as additional negative coping questions.

Church Members, including Opinion Leaders

Church Liaisons will schedule meetings for the Research team to meet with potential congregational participants to describe the study and obtain written informed consent for the study. At this meeting, data collection will be obtained electronically by the Research team will include 1) demographic data (Appendix 5), 2) H/A knowledge (UNAIDS/WHO HIV/AIDS Knowledge Test- (Appendix 11)), and 3) individual and community stigma. We will assess both individual and community stigma using tools developed by Visser and colleagues. (See Appendix # 9 & 10 for the individual and community stigma measures). After completion of assessments, a time will be determined for each church to receive the assigned training.

Demographic Assessment (Appendix 5): Demographic tools used in this study were tailored to congregational members. This tool was adapted from previous studies conducted by the Investigative team. The tool collects generic demographic information such as age, income status, living arrangements and employment status as well as target group specific question (e.g. denomination, leadership role in church, etc.)

Trainings

The PI will correspond with the Christian Council of Ghana to plan the length and number of training sessions that they will provide to the Alabama Anti-stigma Training Team (AASTT). The AASTT will include the Investigators, (2), one Graduate Research Associate, four Ministerial Liaisons, and 4-5 volunteers of UA faculty and staff working on the project. One role of the AASTT will be to receive the AST from the CCOG. After the training, there will be a debriefing session with the AASTT in order to adapt portions of the training received from the CCOG to fit the culture of rural African American Alabama churches and congregation members. The adapted curriculum will be pilot tested in one rural church pastored by one of the Ministerial Liaisons by 20 congregational leaders to assess practicality and functionality of the forms and information.

The other role of the AASST will be to assist with delivery of the anti-stigma curriculum during Phase II of the study. The two Investigators and two Ministerial Liaisons selected as Leader Trainers will lead the AASST in delivery of the anti-stigma training to the congregational study participants.
Study II

Goal
To compare H/A knowledge and stigma in three sets of church members, including opinion leaders in rural Alabama.

Objectives
1. To recruit 240 church members, including opinion leaders in 12 rural Alabama churches.
2. After randomization, to: 1) conduct an 8-week training of an adapted anti-stigma intervention in 4 churches, with 80 church members, including opinion leaders 2) conduct an 8-week training of standard H/A education in 4 churches with 80 church members, including opinion leaders, and 3) display H/A educational pamphlets in 4 churches.

Design
During this phase we will conduct a randomized trial with three groups of congregational members: one group will receive an 8-week anti-stigma curriculum and training, one arm will receive 8-weeks of currently practiced or standard H/A training, and another group will not receive any training, but will receive H/A educational materials such as pamphlets and fact sheets displayed at their church (Figure 3).

Figure 3. Project FAITHH:
Randomization at the church level
(n=12 churches and 240 church members)
Implementation

A stratified methodology of randomization will be used in this study to achieve between group comparability and variability of certain factors such as geographical location in state, denomination and level of HIV/AIDS prevention experience-low vs. high. Our biostatistics team member (Dr. Jason Parton) will serve to facilitate this role to prevent the primary investigative team from being involved in the process to preserve objectivity. After stratification of churches, the 12 churches will be randomized using an envelope assignment method. This method involves placement of 12 pastors/churches on individual sheets of paper into an envelope and selection of churches into one of the three arms of study. The dose effect should be equal in the two groups that receive trainings based on fact that both the time and amount of sessions is equal (1.5-2 hour sessions over 8 weeks.)

Two Lead Trainers will lead the anti-stigma training sessions. These group sessions will be held over an eight-week period within overlapped time to allow the AASTT to cover training for all four churches in this research arm. Therefore, a group of 2-3 members of the research team will deliver the eight-week anti-stigma training to a group of 20 congregational members at the 4 churches assigned to receive the anti-stigma training. After completion of training and assessments for all four churches of this research arm have been completed, then the next training cycle of the standard H/A curriculum will begin, with training occurring at overlapping times. After completion of the training and assessments of the four churches of this research groups, we will obtain pre-assessments from the four churches in the next research group, which will not receive any training but will have H/A educational materials placed at their church. After eight weeks, we will collect post-assessments and end Phase II of the study. We anticipate that all church congregational members in the study will complete Phase II after 20 weeks. See Appendix 20 for sample timeline of training initiative of congregational members of Phase II of the study.

Anti-Stigma Curriculum:

The anti-stigma curriculum (based on the socio-ecological model) developed by CCOG will be used in this study. We will use feedback obtained from the rural AA pastors and PLWHAs in AL to ensure it is adapted for future use with rural, southern African American faith-based populations. To our knowledge, the CCOG curriculum is the first faith-based anti-stigma curriculum developed to address HIV/AIDS. More details about the curriculum are located on the website: http://www.waccglobal.org/en/programmes/programmes-and-projects-2006-2012/hiv-and-aids-communication-and-stigma.html. This program supports communication strategies that are gender sensitive to change stigmatizing and discriminatory behavior that may contributes to the spread of HIV.

Objectives of the CCOG intervention:

1. Promote and communicate better understanding and greater awareness of HIV and AIDS and their stigmatizing and discriminatory effects among people of influence.
2. Train church and community leaders, youth leaders, women’s groups and human rights activists in communication skills and strategies to reduce stigma, discrimination and denial.
3. Equip persons living with or affected by HIV and AIDS with communication skills and train them to develop strategies and tools to address stigma and discrimination, including self-stigmatization.
4. Empower grassroots groups and individuals to communicate “success” stories on how people are reducing stigma and discrimination.

The training manual (See Appendix 18) is divided into seven sessions lasting about 2-3 hours each. They include:

Session One: Naming the Problem  
Session Two: More Understanding, Less Fear; Session Three: HIV Transmission  
Session Four: Impact of HIV Infection on Families  
Session Five: Sex, Morality, Shame, and Blame  
Session Six: Stigma and Religion  
Session Seven: Coping with Stigma

The curriculum manual also includes use of a variety of tools used to engage participants including presentations, discussions, experience sharing, tableaux, role-play, Brainstorming, rotational brainstorming, pictures, energizers, small groups, buzz groups, card storming, working with feelings.

**HIV/AIDS Standard Curriculum:**

We will also use a variety of materials for an 8-week training of the H/A standard education group. Material and curriculum covered will come from established materials from the Alabama Department of Public Health, materials from ASOs in Alabama, CDC, Project SAVED—a CDC Capacity Building Project and slides, videos, and information known to the Investigators. See the Appendix 19 for schedule for the suggested topics during that eight-week period for the standard HIV/AIDS curriculum. Topic areas include history and epidemiology of the disease in the US, risk behaviors associated with the disease, transmission patterns and treatment, testing and diagnosis. Additionally, see the Appendix section for sample curriculum.

**Study III**

**Goal**

To collect post-initiative assessments in order to assess a decrease stigma in church opinion leaders and increase H/A knowledge and H/A prevention activities in pastors and church leaders.

**Objectives**
1. To measure and compare H/A knowledge and stigma in church members, including opinion leaders pre/post initiative between the three groups.
2. To assess and compare the 12 churches’ H/A prevention activities, including engagement with PLWHAs.

**Design**
The last phase of the study will include post-initiative phase of the study, where all post-assessments of pastors and congregational members will be conducted.

**Data Collection**
Both qualitative and quantitative data will be collected in order to test our hypotheses. Qualitative data from the pastors will be collected via in-depth interviews (Appendix 4) and transcribed verbatim. Pastors will be assessed through in-depth interviews to determine whether there are any changes in H/A prevention activities conducted at churches or any changes in interactions with PLWHAs after the initiative. NVivo will be used for qualitative data analyses.

We will collect quantitative data from pastors and congregational members post intervention. Quantitative data will include: a) demographic surveys (Appendix 5 & 6) of 12 pastors, and 240 congregational members; b) HIV knowledge, individual stigma and community stigma in 240 congregational member’s pre-and-post initiative Please see the Appendices 5-11 for specific data collection tools; these survey items will be entered into the computer tablets for ACASI data collection.

The table below summarizes the data collection according to phases and information assessed for each subpopulation of the study.

<table>
<thead>
<tr>
<th>Study</th>
<th>Data collection mode</th>
<th>Target population</th>
<th>Sample Size</th>
<th>Variables/Topics</th>
</tr>
</thead>
</table>
| I     | Pre-Initiative Qualitative & quantitative | Pastors          | 12          | Qualitative interviews:  
H/A attitudes and activities and interaction with PLWHAs (Appendix 4)  
Quantitative surveys: Demographic, HIV Knowledge Test (Appendix 5 and Appendix 11) |
| I     | Pre-Initiative Quantitative | PLWHA            | 50          | Surveys: Demographic, Spiritual Practice/Spiritual Well-being, Internalized Stigma (Appendix 6, Appendix 7, and Appendix 8) |
I  Pre-Initiative Quantitative | Congregation members | 240 | Surveys: Demographic, Individual stigma, Community stigma, H/A knowledge (Appendix 5, Appendix 9, Appendix 10, and Appendix 11) 

III Post-Initiative Qualitative and Quantitative | Pastors | 12 | Qualitative interviews: H/A activities and interaction with PLWHAs (Appendix 4) 

III Post-Initiative Quantitative | Congregation members | 240 | Surveys: Individual stigma, Community stigma, H/A knowledge (Appendix 9, Appendix 10, and Appendix 11) 

**Study Site**

This study will be conducted in rural Alabama and will involve recruitment of three AA subpopulations in pastors, PLWHAs, and congregational members. According to the Alabama Rural Health Association, there are rural areas in all 67 counties in the state, therefore, all counties will be considered for recruitment based on Rural-Urban Commuting Areas (RUCA) codes for rurality. (Office of Primary Care and Rural Health, 2012) See methods section for definition of rurality).

**Sampling:**

The target sample size for PLWHA (n=50) is based on efforts to reach saturation with a target sample that has a small, limited population in rural Tuscaloosa, AL. A power analysis was conducted to determine adequate sample size needed in order to split church participants into 3 study arms (pages 33-34 of protocol). These analyses were used to determine the selection of 12 pastors and 12 churches to recruit 20 persons from each church, for a total of 240 church members, including opinion leaders as study participants. This power analysis was conducted by a PhD biostatistician affiliated with the study in Alabama and reviewed by a PhD mathematical statistician employed by the Epi Branch in DHAP/CDC.

In interviews with Ministerial Liaisons, many rural AA congregations in Alabama have less than 100 members; therefore, recruitment of 20 members from the same congregation may be difficult. Additionally, in sessions with Ministerial Liaisons, many Pastors serve two churches or have affiliation with neighboring churches within their denomination. Therefore, we may combine two churches of near location or pastored by one minister (i.e., same town or county) into one church subset. Additionally, we may also employ oversampling of 25 church congregation members/ church in order to
guarantee our total congregational number of 240 participants who complete the 8-week trainings, and pre/post assessments.

The primary sampling strategy that will be used in recruiting participants in the three target groups will be a combination of *purposive and convenience sampling*. The sampling for the twelve Pastors will be purposive in nature meaning that Pastors will be selected for in-depth interviews (qualitative study) who are in our target population and have affiliation with the four Ministerial Liaisons. Pastors who participate will also need to agree to inform church members about the study and the presence of the research team. The rest of the study, which is quantitative in nature, will employ convenience sampling.

After Pastors are recruited, we will ask them to assist by informing the church about the study. Additionally, because the Investigators have prior experience through statewide H/A networks recruiting PLWHAs, they will use these networks to recruit ACAB leadership either will assist us in recruiting PLWA directly at ACAB meetings or will refer potential participants. Lastly, the Investigative team will also be able to recruit all three subpopulations into the study using: 1) a *snowball strategy* to recruit additional contacts of recruited members; for example, each pastor recruited will be asked to recommend another potential pastor for recruitment, 2) each PLWA will be asked to recruit another PLWA into the study; and 3) *direct recruitment* through advertisements in the community and within organizations such as churches and ASOs. Each of these strategies will be implemented to ensure that the sample is representative. A proposed and convenience sampling frame for participants is summarized below.

<table>
<thead>
<tr>
<th></th>
<th>Pastors</th>
<th>PLWA</th>
<th>Congregants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liaisons/Investigators</td>
<td>9</td>
<td>40</td>
<td>180</td>
</tr>
<tr>
<td>Media recruitment</td>
<td>0</td>
<td>10</td>
<td>25</td>
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<tr>
<td>Snowball</td>
<td>3</td>
<td>10</td>
<td>35</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td>50</td>
<td>240</td>
</tr>
</tbody>
</table>

**General Screening & Consent Process**

After determining eligibility, written consent will be obtained face-to-face. The Investigative Team will hand out written consent forms to participants, which they will read, fill out, and sign. The Investigative team will assist any participant who has difficulty in reading and filling out forms. If any participant has difficulty reading, a member of the research team will assist the participant by reading the consent form to them. Each population recruited into study will have their own unique consent form (Appendices 1-3).

After consent, participants will be asked to respond to all demographic and survey/measurement items using a computer tablet equipped with ACASI. If needed,
the Investigative Team will be available to assist participants in their input of data into the computer tablets.

**Incentives to be provided**

All study participants will receive a token of appreciation for taking part in the study. PLWHAs will receive $50 after completion of the survey. Pastors will receive $25 at the end of each assessment for a potential total of $50 at the end of the study. All congregational study participants will receive $25 after completion of all their written assessments. Additionally, those congregational study participants who are in the anti-stigma curriculum arm or the standard H/A curriculum arm will receive $10 for each session that they attend for a maximum of $80. Therefore, congregational members who are in either the anti-stigma or standard HIV/AIDS curriculum intervention groups can receive a total incentive amount of $130. Congregational members in the no intervention arm can receive a total incentive amount of $50.

**Privacy**

To ensure privacy and anonymity, all study participants will be given a unique identification number, which will be tied to contact information in order to ensure follow-up for completion of all assessments. This will also allow the research team to match up concordant pre-post surveys between individuals. Pastor in-depth interviews will be conducted in a face-to-face meeting in a private setting at the choice of the pastor. PLWHA surveys will be conducted by a member of the Research Team in a face-to-face meeting in a location selected by the study participant. Consent for congregational study participants for all three groups of the study will be conducted in a group setting before the first session of the training. It will be emphasized to study participants that they may withdraw from the study at any time.

**General Methodological approach**

This study will use a confirmatory approach to test the stated hypotheses. The current proposed study adds to the research literature by describing the effectiveness of an anti-stigma curriculum or intervention, which has been used in African churches in Ghana and will be adapted for use in AA churches in rural Alabama.

Qualitative data will also be used to provide greater depth to the findings and to better contextualize findings. After all congregational members receive their training, and then the post initiative phase of the study or Phase III will include all post assessments including pastor interviews and congregational assessments.

**Study procedures**

After participants are recruited from the three-targeted populations, rurality for this study will be defined by the Office of Rural Health Policy (ORHP) criteria. ORHP accepts all non-metro counties as defined by the US Census Bureau as rural as county population size < 50,000 and uses an additional method of determining rurality called the Rural-Urban Commuting Area (RUCA) codes. Like the Metropolitan Statistical Areas (MSA)
designated by the White House Office of Management and Budget, these are based on Census data which is used to assign a code to each Census Tract. Tracts inside Metropolitan counties with the codes 4-10 are considered rural. While use of the RUCA codes has allowed identification of rural census tracts in Metropolitan counties, among the more than 60,000 tracts in the U.S., there are some that are extremely large and where use of RUCA codes alone fails to account for distance to services and sparse population. In response to these concerns, ORHP has designated 132 large area census tracts with RUCA codes 2 or 3 as rural. These tracts are at least 400 square miles in area with a population density of no more than 35 people. The ORHP definition includes about 20% of the population and 91% of the area of the USA. (HRSA, 2013)

Study Variables:

The study variables will be used to assess participants’ exposures to distal and proximal factors that influence H/A stigma in AA rural congregational members in Alabama.

Dependent/Outcome Variables

The dependent variables in this study include the *H/A stigma and knowledge of the congregational members and Pastors* and stigma this variable will be measured by an adapted H/A knowledge test by UNAIDS/WHO. See Appendix 11. The UNAIDS/WHO test measures very basic, general, and standard HIV/AIDS information including the topics of epidemiology, transmission and prevention. Because the test is a global one, we added two questions related to disparities in H/A in African Americans and in the Southern United States. The test responses include multiple choice, true or false, or free style answers. The validity and reliability will be assessed in this study.

Independent Variables

The independent variables in this study are both training sessions including the anti-stigma curriculum and training as well as the standard H/A education and training sessions and the display of H/A educational materials at churches.

Moderator Variables

Based on previous studies, one factor that may have a protective factor on H/A stigma, are those participants who are “reverse migrants” or who have lived in larger metropolitan areas outside of the Deep South for an extended amount of time. We will assess this factor in the demographic tools.

Covariates & Secondary Variables

Several other demographic and health related variables will be measured in this study including demographic and health related variables such as age, education level, marital status, employment status, income, and HIV-testing history.

Data collection instruments for the PLWHA survey and congregational member survey are located in the Appendix section- Data Collection Tools. All quantitative measures were selected based on their reliability and validity, their use in previous research
studies, and most importantly, their applicability and relevance to our targeted study participants.

**Analysis plan for qualitative data**

All of the qualitative data for this study will come from the in-depth interviews conducted with the twelve pastors participating in this study. The pastors will be asked to describe their church’s involvement in H/A prevention as well as their own and their churches attitudes about H/A stigma, and the interaction between church and PLWHAs. The interviews will be transcribed verbatim from the audio tapes onto computer files and then be erased. No name identifiers will be used during the recordings or in the transcripts. NVivo, a computer software program, designed to assist in qualitative data management and analysis will be used to assist in coding, developing categories, themes and retrieving coded data. Following grounded theory methodology, a constant comparative method of joint coding and analysis will be used to analyze the data. Open and axial coding will be used to develop themes.

**Analysis plan for quantitative data**

Quantitative data will be used to test the study hypotheses. Quantitative data, which directly tests Hypothesis 1, will come from our convenience sample of the 240 congregational members recruited into the study to participate in the anti-stigma curriculum and training where we hope to demonstrate decreased individual and community stigma among participants. Data collected from the pastors will directly test Hypothesis 2 to demonstrate an increase in the number of H/A prevention activities that their church conducts after the anti-stigma training compared to churches where they only received traditional H/A education. We predict that the change in the stigma study participants will have an effect on the leadership and will spur movement from the congregation to develop at least one HIV prevention activity such as education or testing. The time between the three phases of the study is approximately 3 years, which should allow enough time for congregations to make a change or increase in H/A prevention activities.

Quantitative data analysis will occur through use of a computer software program quantitative review systems (QRS). A variety of descriptive statistical analyses will be conducted to achieve the study aims with congregational members and PLWHAs, including the measurement of frequencies and percentages, and measurement of central tendency and dispersion. Study factors will be summarized using basic descriptive statistics such as measures of central tendency and standard deviations. Exploratory graphical techniques such as stem-and-leaf diagrams and normal probability plots will be computed to examine the distribution properties and display outliers. Where necessary and appropriate, non-parametric models and/or data transformations, including the elimination of outliers, will be considered for variables with problematic characteristics.

**Research Question 1**
Are there statistically significant changes in the average scores of H/A stigma after the implementation of the anti-stigma H/A curriculum compared with individuals who received standard H/A education and no H/A education?

This study design will measure participants at pre and post implementation phases of the study. A repeated measures ANOVA will evaluate how participants' H/A stigma scores (dependent variable) differ pre and post measurement phase by type of curriculum implemented (independent variable). The univariate repeated measures ANOVA model will be fitted as follows:

\[ y_{ijk} = \mu + \alpha_i + b_{ij} + \gamma_k + (\alpha\gamma)_{ik} + e_{ijk} \]

Where:

- \( y_{ijk} \) is the stigma measurement at measurement phase \( k \) on the \( jth \) subject assigned to curriculum \( i \),
- \( \mu + \alpha_i + \gamma_k + (\alpha\gamma)_{ik} \) is the mean stigma score for curriculum \( i \) at measurement phase \( k \),
- \( b_{ij} \) is the random effect associated with subject \( j \) in curriculum \( l \),
- \( e_{ijk} \) is the random error associated with the \( jth \) subject assigned to curriculum \( i \) at measurement phase \( k \).

**Power Analysis**

We conducted power analysis on Hypothesis 1 in which repeated measures design with 1 between factor and 1 within factor has 3 groups with 80 subjects each for a total of 240 subjects. Each subject is measured 2 times. This design achieves 90% power to test factor B (curriculum) if a Geisser-Greenhouse Corrected F Test is used with a 5% significance level and the actual effect standard deviation is 0.20 (an effect size of 0.23), achieves 100% power to test factor W (measurement phase) if a Geisser-Greenhouse Corrected F Test is used with a 5% significance level and the actual effect standard deviation is 0.20 (an effect size of 0.40), and achieves 100% power to test the BW (curriculum/measurement phase) interaction if a Geisser-Greenhouse Corrected F Test is used with a 5% significance level and the actual effect standard deviation is 0.20 (an effect size of 0.40). The figure below illustrates the power analysis.
Study timeline:

Year 1
- Hiring of GRA
- Finalize recruitment materials
- Construct and finalize interview guide for Pastors
- Identify appropriate survey tools
- Set up study Website

Year 2
• Obtain UA IRB approval
• Complete CDC internal project determination process
• Train research staff in in-depth interviewing, data collection for Pastors- Recruit PLWHAs, conduct written surveys electronically
• Begin to analyze both PLWHA and Pastor data
• Recruit 12 Pastors and conduct Pastor in-depth interviews+ Pastor demo+ H/A knowledge test
• Conduct Train-the-Trainer session between GCOC and ASTT (Alabama) via teleconferencing sessions, have debriefing session with ASTT to adapt curriculum
• Conduct pilot testing of curriculum with one rural AA church (pastored by one of the Ministerial Liaisons)
• Recruit 240 congregational members – assign 80 to receive either anti-stigma training, 80 to receive standard H/A education and 80 to receive no HIV/AIDS education.
• Conduct pre-initiative surveys with all 240 congregational members: (Demographics, H/A knowledge test, and individual and community stigma tools)
• Conduct sessions with 80 congregational members who will receive anti-stigma training – 8 weeks
• Conduct sessions with 80 congregational members who will receive standard H/A training- 8 weeks
• Conduct sessions with 80 congregational members who will receive no HIV/AIDs education

Year 3

• Conduct post- initiative in-depth interviews with Pastors
• Conduct post-initiative surveys with all 240 intervention congregational members (Demographics, H/A knowledge test, and individual and community stigma tests)- completed in 20 weeks
• Develop and submit conference abstracts and manuscripts based on preliminary data

Year 4

• Clean and organize and quantitative data.
• Conduct quantitative data analysis
• Develop and submit abstracts and manuscripts based on study findings
• Disseminate results to local and national CBOs and ASOs

Post Data collection management

Qualitative data from the transcribed in-depth interviews will be stored in a NVivo database. Additionally, a transcriptionist will store transcribed pastor interviews on the University shared drive where the PI can retrieve the data, and interviews/data will be
stored on a non-internet connected, password-protected, laptop computer in a locked office assessable only by the research staff. After adding transcripts into NVivo, the audio tapes will be destroyed. Privacy of Pastors will be protected since only a participant ID will be associated with transcripts. The NVivo program will reside on the PI’s computer located in her office. The PI will be notified when a pastor interview is completed and transcribed and stored on the PI’s computer in the NVivo program, which is password, protected with access only to the PI. In order to ensure proper back up of all files that contact data, data on the computer will be saved on an external file managed by the University to archive data in order to be shared by the PI and Senior Investigator on a regular basis (weekly).

Quantitative data from the pastors, PLWHA, and congregational surveys will be self-administered electronically by participants through use of computer tablets, locked, and stored in both the PI and Senior Researcher’s offices. No names and only coded identifiers will be used. All electronic data will be managed using the Quality Review System (QRS) which is password protected.

Study website

A study website will be developed through the college website for the purpose of recruiting Pastors and congregational members as well as PLWHA so it will be public and able to be accessed by the public. Pastors and congregational members can use the website to request follow-up call if interested in participating in the study.

Quality control/assurance

Several measures have been/will be taken to ensure the quality of the data that is collected. First, because all quantitative data will be collected via self-administration, we will have at least one member of the Core Research team (PI, Senior Investigator, or GRA) will be available to assist participants in administering the surveys as well as check each survey after completion to guarantee that all entries are completed correctly and completely. The team will meet regularly to discuss the recruitment and retention progress and challenges. We have planned for some of these issues by providing small incentives (i.e., pads, pens, bible covers, etc.) throughout the eight-week training sessions, including reminders through emails, telephone calls, mailings, and church bulletin reminders.

Additionally, before analysis, minor data cleaning and creation of composite variables will be performed on survey data if needed to ensure that variables are coded similarly across the dataset and that differences between missing data and valid skips are detectable.

Bias in data collection, measurement and analysis

We expect minimal measurement error from the study, because most of the measures selected for this study have been shown to be both reliable and valid in prior studies (Visser, 2008). Likewise, the demographic tools are similar to tools used in previous
studies and have been shown to be effective. However, we do recognize that selection bias may be a challenge in this study. This is a study proposed in rural, southern areas with churches that often have less than 100 congregants. Still, these small, rural churches are important partners for HIV prevention and anti-stigma efforts. In order to correct for some of this bias, we are recruiting a diverse group of Pastors into the study (i.e., gender, denomination, geographic area, age, experience in HIV/AIDS prevention) in order to balance the type of church opinion leaders which will be recruited. This approach may not eliminate all possible selection bias in this study.

Intermediate data reviews

Data will be collected in stages according to the study phases and analyzed as close to each data collection phase as possible to minimize potential loss of data and facilitate early detection and correction of errors. In addition, a tracking log will be maintained to document participant compliance by curriculum arm and number of curriculum sessions completed.

ETHICS & RESEARCH INTEGRITY

Handling Adverse Events

We anticipate minimal risk for adverse events. Any adverse events that occur during the conduct of the study will be reported within 24-hours to the PI and a report will be filed with the UA IRB and the CDC Program Office within 48 hours of the incident. If participants’ report any psychological distress during the course of the study, they will be referred to the appropriate agency or provider using a standardized referral process (See Appendix 21 for sample referral protocol). At the end of the study, we would also like to connect interested PLWHAs with participating churches and connect interested churches with ASOs and CBOs who conduct HIV prevention. In addition, in the unlikely event of an emergency (i.e., health issue, violent behavior, etc.) during a session, the research staff will immediately call for assistance and follow emergency procedures at each church or agency location. (See Appendix 21)

Training of study personnel

All study personnel are required to take a mandatory computerized HIPAA (Health Information Portability and Accountability), Conflict of Interest and IRB training administered at the University of Alabama (online training). You may access the links for specific trainings on the University of Alabama Office of Sponsored Programs website (http://www.osp.ua.edu). All research members will also be trained in data collection and interviewing techniques as well as completion of ethics training which covers two years.

All certificates of completion for all research team members are on file in both the PIs office as well as the Senior Investigators’ office.

Privacy of Study Data
Privacy

Quantitative data will be collected electronically and de-identified with a code number unique to each participant before analysis. Names of individuals and as well as town or church names will be de-identified using initials of names including middle initial. This same code number will be used to match pre-post data (i.e., H/A knowledge tests, in-depth interviews, stigma tools). All data will be stored on secure, password-protected servers operated by the University Of Alabama. All survey data from participants will be stored on a password-protected laptop that is solely dedicated to data management for the project and not connected to the Internet. This laptop will be stored in a locked file cabinet in the locked PIs office.

Other safeguards are in place for the offices of the PI include: 1) All data will be kept in a separate locked file (paper copy) or encrypted and password protected (electronic copy) for 3 years after the completion of the study. Only the PI will have access to this file; 2) In reports or publications, results will only use group data, or fictitious names will be used to protect the confidentiality of the participants; 3) password-protected computers; 4) screensavers on computers automatically initiate after 20 minutes of nonuse; 5) all computers are located in positions and angled so that casual observers cannot read computer screens; 6) all computers contain the most current virus and security software and receive regular updates of this software; 7) all data will be placed on an external hard drive on a weekly basis. In all cases, data will only be accessible by the PI and a Project Coordinator.

Digital recordings of the qualitative interviews will be labeled with a code number and not the participant’s name. Only a code number will appear on data records and computer files. The digital recordings will be stored on a computer in the PIs office. Professional transcribers will transcribe recordings. All references to names of the church names or individual names or town names will be removed from interview transcripts to protect the confidentiality of participants.

Data and safety monitoring plan

Data and safety for participants in this study are considered to be of minimal risk. See the Handling of adverse events section for specifics on the reporting of any events where data is leaked or personal information is compromised.

Potential Risks

Minimal risks to study participants (Pastors, congregational members, and PLWHAs) are expected including potential embarrassment or discomfort in participation in the interviews, training sessions or in completing surveys because of the sensitive nature of HIV/AIDS. However, this should be minimized by ensuring study participants that they are encouraged to say or report what is comfortable for them. If a study participant is uncomfortable or does not wish to proceed with completing the study, they may withdraw at any time.
The other risk in this study is breach of confidentiality. To ensure confidentiality, no names or identifiers will be used in study results. Confidentiality in the study will also be ensured by locking all data collection records, including audio recordings and transcripts, in the PI’s office at The University of Alabama. All forms and papers will use identification numbers rather than names. The list with the participants’ names and identification numbers will be kept in a separate locked file (paper copy) or encrypted and password protected (electronic copy). Only the PI and the rest of the research team will have access to this file. In reports or publications, results will only use group data, or fictitious names will be used.

**Potential Benefits**

Public health benefits to the field of HIV/AIDS prevention are expected with this study. Potential benefits from the study may include a reduction in H/A stigma in rural AA congregations, which can lead to increased support, and involvement in H/A education and programs in the community. It is the view of the proposing investigators that these activities will also enhance primary prevention efforts in this population. Additionally, the study has the potential to enhance congregational acceptance and outreach to PLWHA resulting in support and facilitation of their spirituality/religious practices and support.

**DISSEMINATION PLAN**

**Disseminating results to public**

**Community-based organizations**

If during the course of the study, we find that stigma is significantly different among our training groups, we may consider offering the anti-stigma training to the group that does not receive it, after the study, if it is desired. The research team will plan and implement a final meeting/community forum/conference will be held to report and disseminate pertinent findings to the community participants, and stakeholders including researchers, PLWHA, rural Pastors and churches, and ASOs and CBOs in rural Alabama and the South. This meeting will also serve as a venue through which stakeholders and invited potential funders can give feedback on the study and on potential follow up interventions and studies.

**Scholarly journals and conferences**

It is anticipated that several publications and presentations will result from the study. In the second, third, and fourth years of the study the research team will work to develop conceptual, methodological, and empirical papers that can be published in scholarly journals focusing on topics related to HIV/AIDS, public health, minority health, and faith-based journals. Additionally, the team will develop abstracts for submission to several conferences, including the annual CDC HIV Prevention Conference, the International Conference on AIDS and other AIDS/faith-based conferences.
Consent Forms
Appendix 1. The University of Alabama
Informed Consent to Participate in Research - Pastors
Flesch-Kincaid Reading Level=7.8

You are being asked to be in a research study. The study is called "Faith-Based Anti-Stigma Initiative Towards Healing HIV/AIDS – Project (FAITHH)." The University of Alabama in Tuscaloosa is conducting the study. This study is funded by the Centers for Disease Control and Prevention (CDC). No members of the CDC will be involved in collecting data for this study.

In this study, we will interview 12 pastors from 12 different rural churches in Alabama serving mostly an African-American congregation. It is up to you if you want be part of the study. To help you decide if you want to join the study we will tell you about:

1. why the study is being done
2. what will happen if you join the study
3. what the possible risks of the study are
4. what the possible benefits of the study are
5. your rights as a person in the study

What is this study trying to learn?
The purpose of the study is to test a program on reducing HIV/AIDS stigma in rural Black churches in Alabama.

What will be done with the information from the study?
This information will help us plan HIV-related services and programs for Black communities in rural Alabama.

Why am I being asked to do in this study?
You are being asked to be in this study because you are a Black pastor of a church located in rural Alabama. We believe that your experiences may help researchers in HIV/AIDS prevention.

What do I have to do if I am in this study?
If you are in the study, a member of the research team will interview you twice during the study period, which could extend within a one-year period. The interview will be completed in a private location of your choice. Each interview session will have two parts: an in-depth interview and brief survey.

In the in-depth interview, you will be asked questions that you can answer in detail. The interview will be like a conversation but you will do most of the talking. The open-interview will take about 90 minutes to complete and will be audio recorded. We record your answers so that we do not miss anything that you say. You will be asked questions that do not have right or wrong answers. We will ask you questions about:

- Yours and your church’s views on HIV/AIDS;
- Church activities with persons infected with HIV/AIDS; and
- Church HIV/AIDS prevention activities
In the brief survey, we will ask you questions about yourself, such as your age and highest level of education obtained. In addition, we will ask you questions about HIV/AIDS such as:

- Groups and persons at greatest risk for infection
- Behaviors that increase risk of infection
- Symptoms associated with infection

The survey part of the interview session will take about another 30 minutes to complete. This makes the entire interview session about 120 minutes in length.

Are there risks (dangers) to me from being in this study?
Some questions may make you feel uncomfortable or uncomfortable.

Is there any gain to me from being in this study?
There may be no direct benefit to you. However, you may feel good that your information may be useful in helping person deal with HIV/AIDS. It also enables more persons affected by HIV to turn to faith settings for support.

What is my other choice to being in this study?
You can choose not to take part in the study.

What costs are there?
There is no cost to you for being in this study.

What type of incentives are provided
We will give you $25 for each interview session that you complete to a possible total of $50.

How will my privacy be protected?
We will keep all your private facts and what you tell us in the interview private. Your signed consent form will be kept in a secure, locked office that can only be accessed by the study team.

A unique number code will be used to identify your interview. A unique number code will also be used to identify your church. Your name or your church’s name will not appear on the recording of the interview or in any records. We will listen to the audio recording and type out what you say. After that, we will destroy the recording after completion of the project (2016). Only the people doing this study will be able to listen to your audio recording or see the typed notes.

Information you give use will be combined with information from other interviews. Your interview will not be presented alone. No names will be used in sharing study results with communities and researchers. All summaries on this study will state only that the people and faith-based communities are from rural Alabama. We may use your actual words to help make a specific point. In this instance, we may use “fake” names or provide minor details like your age range.

Assurances
The decision to be in this study is up to you. If you do not join, you will not lose any services that you can get apart from this study. You may change your mind about being in the study at any
time. If you decide to join the study, you can choose not to answer any question or stop at any time. In that case, too, you will not lose any services that you can get apart from this study.

**You are invited and encouraged to ask questions about the study now.** If you have questions later on, you can call Drs. Foster and Gaskins at (205) 348-5148 or (205) 348-1027. If you have questions about your rights as a person in a research study, you may contact Ms. Tanta Myles, The University of Alabama Research Compliance Officer at (205) 348-8461 or the toll-free number (1-877-820-3066).

You may also ask questions, make a suggestion, or file complaints through the IRB Outreach Website at [http://osp.ua.edu/site/PRCO_Welcome.html](http://osp.ua.edu/site/PRCO_Welcome.html). After you complete the study, you are free to complete the University of Alabama survey for research participants that is on the website. You may also email us at participantoutreach@bama.ua.edu.

I understand what I am being asked to do. I agree to be in this study.

_______________________________________________________________
Signature or Mark of Participant in Study Date

_______________________________________________________________
Signature of Investigator Date
Appendix 2. The University of Alabama
Informed Consent to Participate in Research- Congregational Members
Flesh-Kincaid Reading Level= 7.8

You are being asked to be in a research study. The study is called "Faith-Based Anti-Stigma Initiative Towards Healing HIV/AIDS – Project (FAITHH) ". The University of Alabama in Tuscaloosa is conducting the study. This study is funded by the Centers for Disease Control and Prevention (CDC). You will not have contact with anyone from the CDC during this study.

In this study, we will interview 240 congregational members from 12 different rural churches in Alabama serving mostly an African-American congregation. It is up to you if you want to be part of the study. To help you decide if you want to join the study we will tell you about:

1. why the study is being done
2. what will happen if you join the study
3. what the possible risks of the study are
4. what the possible benefits of the study are
5. your rights as a person in the study

What is this study trying to learn?
The purpose of the study is to test a program to decrease HIV/AIDS stigma in rural Black churches in Alabama.

What will be done with the information from the study?
This information will help us plan HIV-related services and programs for Black communities in rural Alabama.

Why am I being asked to be in this study?
You are being asked to be in this study because you are a member of Black church located in rural Alabama. We believe that your experiences may help researchers in HIV/AIDS prevention.

What do I have to do if I am in this study?
If you are in the study, a member of the research team will conduct a series of classes over an eight-week period, which you may be selected to take. Some people asked to be in the study may not be selected to take classes. Those selected to take the class will be expected to take 8 classes. The classes will occur once a week and will last about 2-3 hours. They will be held at a location decided by church leadership. All who are in study will be asked a series of questions at two times during the study which may be separated by approximately six months. The survey questions will be collected by a member of the Research Team electronically and will include some basic information about yourself. Surveys will include questions about HIV/AIDS attitudes and behaviors.

Are there risks (dangers) to me from being in this study?
One possible risk is that you may find some of the activities uncomfortable. You do not have to be part of any activities which makes you uncomfortable. This is your right as someone in a research study.

Are there any gains to me from being in this study?
No direct gain can be promised to you. However, you may feel good about knowing that the study may be useful in helping other Blacks deal with HIV. The information may also allow more persons affected by HIV to feel comfortable sharing information in faith settings.

What is my other choice to being in this study?
This is not a medical treatment study. Your alternative is not to be in the study. You are free to join the study or not. If you do not join, you will not lose any services that you expect to get apart from this study. If you decide to join the study, you are also free to drop out later for any reason. In that case, you also will not lose any services that you may expect apart from this study.

You may refuse to answer any question or simply not talk about a matter that you do not wish to discuss.

How will my privacy be protected?
Several things will be done to protect your privacy. Your name will not be used in the study except on the signed consent form. The consent form will be kept in a separate, locked drawer. No one else will know where it is or see it.

You will receive a unique code number, which will help us collect your information and keep it private.

During classes, we will ask all participants not to share anything that is said outside of class. As an added protection, we will not use the specific names and locations of the churches and the counties where they live.

What costs are there?
There is no cost to you for being in this study.

What type of incentives are provided?
You will receive $10 for each class you complete and $50 after completion of all surveys, which will be collected electronically by the Research Team to thank you for your time. We will also offer shirts, hats, and certificate to thank you for being in the study. If you change your mind about being in the study, you must complete at least one class to receive payment. If you change your mind about being in the study, you will not be viewed negatively.

Assurances
The decision to be in this study is up to you. You may change your mind about being in the study at any time.

You are invited and encouraged to ask questions about the study now. If you have questions later on, you can call Drs. Foster and Gaskins at (205) 348-5148 or (205) 348-1027. If you have questions about your rights as a person in a study, you may contact Ms. Tanta Myles, The University of Alabama Research Compliance Officer at (205) 348-8461 or the toll-free number (1-877-820-3066). You may also ask questions, make a suggestion, or file
complaints and concerns through the IRB Outreach Website at http://osp.ua.edu/site/PRCO_Welcome.html. You may also email the office at participantoutreach@bama.ua.edu.

I understand what I am being asked to do. I agree to be in this study.

_______________________________________________________________
Signature or Mark of Participant in Study               Date

________________________________________________________________
Signature of Investigator                                      Date
Appendix 3. The University of Alabama Informed Consent to Participate in Research- Study – Persons Living With HIV/AIDS (PLWHA)  
Flesch-Kincaid Reading Level= 7.8

You are being asked to be in a research study. The study is called " Faith-Based Anti-Stigma Initiative Towards Healing HIV/AIDS – Project (FAITHH) ". The University of Alabama in Tuscaloosa is conducting the study. This study is funded by the Centers for Disease Control and Prevention (CDC). You will not have contact with anyone from the CDC during this study.

In this study, we will interview 50 African American PLWHAs from rural Alabama. It is up to you if you want be part of the study. To help you decide if you want to join the study we will tell you about:

1. why the study is being done
2. what will happen if you join the study
3. what the possible risks of the study are
4. what the possible benefits of the study are
5. your rights as a person in the study

What is this study trying to learn?  
The purpose of the study is to test a program to decrease HIV/AIDS stigma in rural Black churches in Alabama.

What will be done with the information from the study?  
This information will help us plan HIV-related services and programs for Black communities in rural Alabama.

Why am I being asked to be in this study?  
You are being asked to be in this study because you are a Black person living with HIV/AIDS in rural Alabama. We believe that your experiences may help researchers in HIV/AIDS prevention.

What do I have to do if I am in this study?  
If you decide to be in this study, a member or our research team will ask you a series of questions, which they will collect electronically. Survey questions will include your ties with Black churches in rural Alabama, your spiritual and religious practices, and well-being and stigma. General personal demographic questions will also be asked.

Are there risks (dangers) to me from being in this study?  
One risk of this study for you is word getting out about your diagnosis. We plan to do several things to keep this from happening. (See privacy section) Another danger of the study is that you may find some of the questions uncomfortable to answer. You are not expected to answer any questions, which make you uncomfortable. This is your right as someone in a research study.

Are there any gains to me from being in this study?
No direct gains can be promised to you. However, it is possible that you will feel good about knowing that your experiences may be useful in helping Black churches deal with HIV/AIDS stigma. You will receive $50 after you complete the surveys to thank you for your time.

What is my other choice to being in this study?
This is not a medical treatment study. Your alternative is not to be in the study. You are free to join the study or not. If you do not join, you will not lose any services that you expect to get apart from this study. If you decide to join the study, you are also free to drop out later for any reason. In that case, you also will not lose any services that you may expect apart from this study.

You may refuse to answer any question or simply not talk about a matter that you do not wish to discuss.

How will my privacy be protected?
Several things will be done to protect your privacy. Your name will not be used in the study except on the signed consent form. The consent form will be kept in a separate, locked drawer. No one else will know where it is or see it.

You will receive a unique number, which will help us collect your information. There will be no way for the person who handles the data to know who you are.

If you are filling out this survey at an HIV/AIDS meeting, all participants will complete forms in a separate and private room away from other meeting participants. Lastly, we will not use any names of specific residences when we report our findings.

What costs are there?
There are no costs for being in this study?

Assurances
The decision to be in this study is up to you. You may change your mind about being in the study at any time.

You are invited and encouraged to ask question about the study now. If you have questions later, you can call Dr. Foster at (205) 348-5148 and Dr. Gaskins at (205) 348-1027. If you have questions about your rights as a person in a research study, you may call Ms. Tanta Myles, The University of Alabama Research Compliance Officer at (205)-348-8461 or toll-free at 1-877-820-3066. You may also ask questions, make a suggestion, or file complaints and concerns through the IRB Outreach Website at http://osp.ua.edu/site/PRCO_Welcome.html. You may also email us at participantoutreach@bama.ua.edu.

I understand what I am being asked to do. I agree to be in this study.

_______________________________________________________________
Signature or Mark of Participant in Study                      Date

_______________________________________________________________
Signature of Investigator                                     Date
Survey Tools and Measures
Appendix 4. Sample Interview Guides for Pastor Interviews- Pre-Assessment

**Personal:**

1. How did you learn about HIV/AIDS? (i.e., radio, class, seminar, other)
2. Tell me about any HIV/AIDS education that you have received?
3. Please tell me about your personal experiences with HIV testing.
4. How would you define stigma and discrimination of persons affected by H/A?
5. What are your thoughts on the way HIV/AIDS is being addressed currently in the African American community?
6. Explain why you are interested in having your congregation participate in this study? (What changes do you hope to gain from participation? Any benefits? Any risks?)

**Congregational/Community:**

7. Describe how HIV/AIDS has affected your church and community?
8. What groups of people in your church and community are most affected?
9. Has your congregation interacted with PLWHA? (Explain) If so, have they dealt with stigma or discrimination of PLWHA?
10. What type of HIV preventions services are conducted by your church? Who coordinates these activities?
11. What role could the Black Church play in addressing HIV/AIDS in the African American community?
12. What advice would you give the research team in conducting Project FAITHH at your church? (Prompts: target groups, times to meet, etc.)
Appendix 4. Sample Interview Guides for Pastor Interviews-Post-Assessment

Congregational:

1. Describe your church’s response to being in this study? increased H/A prevention activities and outreach including education and testing? Interaction with PLWHAs?
Appendix 5. Pastor and Congregation Demographic Survey

Select the answer that best describes you.

1. What is the month and year of your birth? ______________

2. Which age range are you in:
   - 19-30____
   - 31-39____
   - 40-50____
   - 51-65____
   - ≥66 ______


4. How long have you lived there? ______

5. Have you ever lived anywhere else: Y___ N___
   If yes, where__________
   How long? ________

6. What is your gender?
   Male_____ Female___

7. What is your ethnicity? Choose one:
   - Hispanic or Latino_____
   - Non-Hispanic or Latino ______

8. What is your race?
   - African American or Black____
   - Caucasian____
Asian/Pacific Islander____
Native American____
Other____

9. What is your religion/denomination?
   Baptist___
   AME____
   CME____
   Pentecostal____
   Other (please state_____________
   Epic

10. Which best describes your education level?
    Less that high school diploma____
    High school diploma or GED equivalent____
    Attended some college/trade school____
    College graduate____
    Graduate school_____

11. What is your current marital status?
    Single____
    Married____
    Living with partner____
    Separated____
    Divorced____
    Widowed____
    Other____

12. Do you hold a leadership role in the church? Y___N___
    If yes, title______________

13. Are you in full time ministry? Y____N____
    If no, what is your other occupation? ______________

14. Have you ever had a HIV test? Y____N____
Appendix 6. Demographic survey – PLWHA:

Tell Us About Yourself. Select the answer that best describes you.

1. What is the month and year of your birth? ______________

2. Which age range are you in:
   - 19-30____
   - 31-39____
   - 40-50____
   - 51-65____
   - ≥66____


4. How long have you lived there? __________

5. Have you ever lived anywhere else:   Y__N__
   - If yes, where________
   - How long? ________

6. What is your gender?
   - Male_____ Female_____ 

7. What is your ethnicity? Choose one:
   - Hispanic or Latino____
   - Non-Hispanic or Latino

8. What is your race?
   - African American or Black____
   - Caucasian____
   - Asian/Pacific Islander____
   - Native American____
   - Other____
9. Which best describes your highest educational level?

   Less than a high school diploma____
   High school or GED graduate_________
   Trade School________
   Some college? _________
   College graduate_____
   Graduate degree_____
   Other_____

10. Which best describes your current marital status?

    Single____
    Married____
    Partnered____
    Separated____
    Divorced____
    Widowed____
    Other_____

11. What are your living arrangements?

    Living alone____
    Living with Relatives____
    Living with spouse or partner____
    Living with spouse or partner and children____

12. What is your annual income?

    0-$10,000____
    $11,000-$20,000____
    $21,000-$40,000____
    $40,000-$60,000____
    Over $60,000____

13. Are you currently employed Y____N____

    If yes, what is your occupation? ______________

14. How long have you been HIV+?

    <1 year____
    1-5 years____
    5-10 years____
More than 10 years____

15. Are you currently receiving medical treatment for HIV?

Y_____N____
Appendix 7. Multidimensional Measurement of Religiousness/Spirituality for Research - Fetzer Institute, info@fetzer.org, 616-375-2000

Multidimensional Measurement of Religiousness/Spirituality for Use in Health Research

**Forgiveness**

Because of my religious or spiritual beliefs:

9. I have forgiven myself for things that I have done wrong:
   1. Always or almost always
   2. Often
   3. Seldom
   4. Never

10. I have forgiven those who hurt me:
    1. Always or almost always
    2. Often
    3. Seldom
    4. Never

11. I know that God forgives me:
    1. Always or almost always
    2. Often
    3. Seldom
    4. Never

**Private Religious Practices**

12. How often do you pray privately in places other than at church or synagogue?
    1. More than once a day
    2. Once a day
    3. A few times a week
    4. Once a week
    5. A few times a month
    6. Once a month
    7. Less than once a month
    8. Never

13. Within your religious or spiritual tradition, how often do you meditate?
    1. More than once a day
    2. Once a day
    3. A few times a week
    4. Once a week
    5. A few times a month
    6. Once a month
    7. Less than once a month
    8. Never

14. How often do you watch or listen to religious programs on TV or radio?
    1. More than once a day
    2. Once a day
    3. A few times a week
    4. Once a week
    5. A few times a month
    6. Once a month
    7. Less than once a month
    8. Never

15. How often do you read the Bible or other religious literature?
    1. More than once a day
    2. Once a day
    3. A few times a week
    4. Once a week
    5. A few times a month
    6. Once a month
    7. Less than once a month
    8. Never

16. How often are prayers or grace said before or after meals in your home?
    1. At all meals
    2. Once a day
    3. At least once a week
    4. Only on special occasions
    5. Never

**Religious and Spiritual Coping**

Think about how you try to understand and deal with major problems in your life. To what extent is each of the following involved in the way you cope?

17. I think about how my life is part of a larger spiritual force.
    1. A great deal
    2. Quite a bit
    3. Somewhat
    4. Not at all

18. I work together with God as partners.
    1. A great deal
    2. Quite a bit
    3. Somewhat
    4. Not at all
19. I look to God for strength, support, and guidance.
   1 - A great deal
   2 - Quite a bit
   3 - Somewhat
   4 - Not at all

20. I feel God is punishing me for my sins or lack of spirituality.
   1 - A great deal
   2 - Quite a bit
   3 - Somewhat
   4 - Not at all

21. I wonder whether God has abandoned me.
   1 - A great deal
   2 - Quite a bit
   3 - Somewhat
   4 - Not at all

22. I try to make sense of the situation and decide what to do without relying on God.
   1 - A great deal
   2 - Quite a bit
   3 - Somewhat
   4 - Not at all

23. To what extent is your religion involved in understanding or dealing with stressful situations in any way?
   1 - Very involved
   2 - Somewhat involved
   3 - Not very involved
   4 - Not involved at all

24. If you were ill, how much would the people in your congregation help you out?
   1 - A great deal
   2 - Some
   3 - A little
   4 - None

25. If you had a problem or were faced with a difficult situation, how much comfort would the people in your congregation be willing to give you?
   1 - A great deal
   2 - Some
   3 - A little
   4 - None

26. How often do the people in your congregation make too many demands on you?
   1 - Very often
   2 - Fairly often
   3 - Once in a while
   4 - Never

27. How often are the people in your congregation critical of you and the things you do?
   1 - Very often
   2 - Fairly often
   3 - Once in a while
   4 - Never

28. Did you ever have a religious or spiritual experience that changed your life?
   No
   Yes

IF YES: How old were you when this experience occurred?

29. Have you ever had a significant gain in your faith?
   No
   Yes

IF YES: How old were you when this occurred?

30. Have you ever had a significant loss in your faith?
   No
   Yes

IF YES: How old were you when this occurred?
Commitment

31. I try hard to carry my religious beliefs over into all my other dealings in life.
   1. Strongly agree
   2. Agree
   3. Disagree
   4. Strongly disagree

32. During the last year about how much was the average monthly contribution of your household to your congregation or to religious causes?

   $_________ OR $_________
   Contribution per year Contribution per month

33. In an average week, how many hours do you spend in activities on behalf of your church or activities that you do for religious or spiritual reasons?

Organizational Religiousness

34. How often do you go to religious services?
   1. More than once a week
   2. Every week or more often
   3. Once or twice a month
   4. Every month or so
   5. Once or twice a year
   6. Never

35. Besides religious services, how often do you take part in other activities at a place of worship?
   1. More than once a week
   2. Every week or more often
   3. Once or twice a month
   4. Every month or so
   5. Once or twice a year
   6. Never

Religious Preference

36. What is your current religious preference?

IF PROTESTANT ASK:
Which specific denomination is that?

(List of religious preference categories attached for advisory purposes. See Religious Preference section.)

Overall Self-Ranking

37. To what extent do you consider yourself a religious person?
   1. Very religious
   2. Moderately religious
   3. Slightly religious
   4. Not religious at all

38. To what extent do you consider yourself a spiritual person?
   1. Very spiritual
   2. Moderately spiritual
   3. Slightly spiritual
   4. Not spiritual at all

Appendix-Meaning

The working group did not feel it was appropriate at this time to include any "religious meaning" items in this measure, as no final decisions have been made regarding this domain. The following items are being considered for a Short Form.

1. The events in my life unfold according to a divine or greater plan.
   1. Strongly agree
   2. Agree
   3. Disagree
   4. Strongly disagree

2. I have a sense of mission or calling in my own life.
   1. Strongly agree
   2. Agree
   3. Disagree
   4. Strongly disagree
Additional Negative Coping questions:

| Negative Religious Coping | 1. I wonder whether God has abandoned me.  
|                          | 2. I feel God is punishing me for my sins or lack of spirituality |
Appendix 8 PLWA: Parallel HIV-Related Stigma Survey (Visser et Al., 2008) – Internalized stigma

Please indicate if you agree or disagree for each of the following statements:

1. Getting HIV is a punishment for bad behavior.
   Agree____ Disagree____

2. If I was in public or private transport and someone know I had HIV, they would not sit next to me.
   Agree____ Disagree____

3. I think my getting HIV was just a matter of bad luck.
   Agree____ Disagree____

4. I think less of myself because I have HIV.
   Agree____ Disagree____

5. My neighbors would not like me living next door if they knew I had HIV.
   Agree____ Disagree____

6. I would understand if people rejected my friendship because I am HIV+.
   Agree____ Disagree____

7. I feel it is completely safe for me to handle other people’s children. (reverse)
   Agree____ Disagree____

8. I have a lot to teach people about life through having HIV. (reverse)
   Agree____ Disagree____

9. Because of my HIV, people would not date me.
   Agree____ Disagree____

10. People are right to be afraid of me because I have HIV.
    Agree____ Disagree____

11. I feel that it is my fault that I got HIV.
    Agree____ Disagree____

12. Although I have HIV, I am a person who deserves as much as respect as anyone else.
Agree____Disagree____

13. Most employers would not employ me because I am HIV+

Agree____Disagree____

14. If I drank water from a tap and people knew I had HIV, they would not drink from the same tap.

Agree____Disagree____

15. I must have done something wrong to deserve getting HIV.

Agree____Disagree____

16. I feel ashamed that I have HIV.

Agree____Disagree____

17. When people know I have HIV, I feel uncomfortable around them.

Agree____Disagree____
Appendix 9. Congregation Member: Parallel HIV-Related Stigma Survey

(Visser et Al., 2008) – Individual Level Measurement

Please check agree or disagree to the following questions

1. I think getting HIV is a punishment for bad behavior.
   
   Agree____ Disagree____

2. If I was in public or private transport, I would not like to sit next to someone with HIV.
   
   Agree____ Disagree____

3. Having HIV is just a matter of bad luck.
   
   Agree____ Disagree____

4. I think less of someone because they have HIV.
   
   Agree____ Disagree____

5. I would like someone with HIV to be living next door.
   
   Agree____ Disagree____

6. I would not like to be friends with someone with HIV.
   
   Agree____ Disagree____

7. It is safe for a person with HIV to look after somebody else’s children. (reverse)
   
   Agree____ Disagree____

8. People with HIV can teach us a lot about life. (reverse)
   
   Agree____ Disagree____

9. I would not date a person if I know that he/she had HIV.
   
   Agree____ Disagree____

10. I feel afraid to be around people with HIV.
    
    Agree____ Disagree____

11. People with HIV/AIDS have only themselves to blame.
    
    Agree____ Disagree____

12. People with HIV deserve as much respect as anyone else. (reverse)
13. I would not employ someone with HIV.

   Agree____Disagree_____

14. I would not drink from a tap if a person with HIV had just drunk from it.

   Agree____Disagree_____

15. If you have HIV, you must have done something wrong to deserve it.

   Agree____Disagree_____

16. People with HIV should be ashamed of themselves.

   Agree____Disagree_____

17. I feel uncomfortable around people with HIV.

   Agree____Disagree_____
Appendix 10. Congregation Member: Parallel HIV-Related Stigma Survey

(Visser et al., 2008) – Congregational/Community Level Measurement

Please check agree or disagree to the following questions:

1. Most people think getting HIV is a punishment for bad behavior.
   Agree____ Disagree____

2. Most people would not like to sit next to someone with HIV in public or private transportation.
   Agree____ Disagree____

3. Most people think that having HIV is just a matter of bad luck.
   Agree____ Disagree____

4. Most people think less of someone because they have HIV.
   Agree____ Disagree____

5. Most people would not like someone with HIV to be living next door.
   Agree____ Disagree____

6. Most people would reject the friendship of someone with HIV.
   Agree____ Disagree____

7. Most people feel that it is safe for a person with HIV to look after somebody else’s children.
   Agree____ Disagree____

8. Most people think that people with HIV can teach us a life about life. (reverse)
   Agree____ Disagree____

9. Most people are afraid to date a person if they know that he/she had HIV.
   Agree____ Disagree____

10. Most people are afraid to be around people with HIV.
    Agree____ Disagree____

11. Most people feel that if you have HIV/AIDS it is your own fault.
    Agree_______ Disagree____

12. Most people feel that people with HIV deserve as much respect as anyone else. (reverse)
13. Most employers would not hire someone with HIV to work for them.
   Agree_____Disagree_____

14. Most people would not drink from a tap if a person with HIV had just drunk from it.
   Agree_____Disagree_____

15. Most people believe that if you have HIV you must have done something wrong to deserve it.
   Agree_____Disagree_____

16. Most people believe that someone with HIV should be ashamed of themselves.
   Agree_____Disagree_____

18. Most people feel uncomfortable around people with HIV.
   Agree_____Disagree_____
Appendix 11. HIV and AIDS knowledge test- with and without answers

(Adapted from UNAIDS/WHO) All questions same except Questions 1 & 2)

PART 1.

1. Which ethnic/racial group makes up the largest group living with HIV/AIDS?
   A. Latinos
   B. Asian/Pacific Islander
   C. White
   D. African American

2. In what region of the U.S is the rate of new infections of HIV increasing the greatest?
   A. The South
   B. The Midwest
   C. The Northeast
   D. The West

3. What does the acronym HIV stand for?
   A. Hemo-insufficiency virus
   B. Human immunodeficiency virus
   C. Human immobilization virus

4. What does the acronym AIDS stand for?
   A. active immunological disease syndrome
   B. acquired immune deficiency syndrome
   C. acquired immunological derivative syndrome
   D. acquired immunodeficiency syndrome

5. What is the main means of HIV transmission worldwide?
   A. unprotected heterosexual sex
   B. homosexual sex
   C. intravenous drug use
   D. mother-to-child transmission

6. Spread of HIV by sexual transmission can be prevented by:
   A. abstinence
   B. practicing mutual monogamy with an uninfected partner
   C. correct use of condoms
   D. all of the above

7. Women are most likely to contract HIV through:
   A. unprotected heterosexual sex
   B. injecting drug use
   C. contaminated blood

8. HIV can be contracted from:
   A. condoms
   B. kissing
   C. mosquito bites
   D. drinking from the same glass as an infected person
E. sharing a spoon with a person living with HIV
F. sharing a toothbrush with someone who is living with HIV
G. all of the above
H. none of the above

9. Risk of contracting HIV is increased by:
   A. being infected with another sexually transmitted infection (STI)
   B. having poor nutrition
   C. having a cold

10. Pregnant women infected with HIV:
    A. can reduce chances of transmitting HIV to her unborn child by maintaining a low viral load and staying in good health
    B. can take medication to reduce the risk of mother-to-child transmission during childbirth
    C. all of the above

11. List the four main body fluids that, when infected, may transmit HIV.

12. List the four main ways HIV is transmitted.

PART 2: the answers to part 2 can be found below. For more explanations, please refer to the HIV and AIDS fact sheets and glossary that can be found in the resources section.

1. If a person has HIV, they will always develop AIDS.

2. HIV is present in blood, sexual fluids and sweat.

3. Abstaining from (not having) sexual intercourse is an effective way to avoid being infected with HIV.

4. When a person has AIDS, his or her body cannot easily defend itself from infections.

5. A person can get the same sexually transmitted infection more than once.

6. There is a cure for AIDS.

7. If a pregnant woman has HIV, there is a still a chance she will not pass it to her baby.

8. A person can get HIV infection from sharing needles used to inject drugs.

9. Many people with sexually transmitted infections, including HIV, do not have symptoms.

10. HIV can be easily spread by using someone's personal belongings, such as a toothbrush or a razor.

11. A person can look at someone and tell if he or she is infected with HIV or has AIDS.

12. It is possible to avoid becoming infected with HIV by having sexual intercourse only once a month.

13. A condom, when used properly, provides excellent protection against sexually transmitted infections, and can prevent transmission of HIV.

14. An effective vaccine is available to protect people from HIV infection.
15. A person can be infected with HIV for 10 or more years without developing AIDS.

16. You can get HIV by kissing someone who has it.

17. A person can be infected with HIV by giving blood in an approved health facility.

18. Ear-piercing and tattooing with unsterilized instruments are possible ways of becoming infected with HIV.

19. A person can get HIV by being bitten by a mosquito.

20. A person can avoid getting HIV by eating well and exercising regularly.
PART 1.

1. Which ethnic/racial group makes up the largest group living with HIV/AIDS?
   A. Latinos
   B. Asian/Pacific Islander
   C. White
   D. African American
   Answer: D. According to the Centers for Disease Control, Blacks continue to experience the most severe burden of HIV, compared to other races and ethnicities. Blacks represent approximately 14% of the U.S. population, but accounted for an estimated 44% of new HIV infections in 2009. Blacks accounted for 46% of people living with HIV infection in 2008.

2. In what region of the U.S is the rate of new infections of HIV increasing the greatest?
   A. The South
   B. The Midwest
   C. The Northeast
   D. The West
   Answer: A. According to a report of the Duke Center for Health Policy and Inequalities Research, The rate of new HIV infections per 100,000 population was the highest in the Southern US, indicating that this region had the greatest proportion of residents testing positive for HIV in 2009.

3. What does the acronym HIV stand for?
   A. Hemo-insufficiency virus
   B. Human immunodeficiency virus
   C. Human immobilization virus
   Answer: B. HIV stands for Human Immunodeficiency Virus. HIV is the virus that causes AIDS, this virus weakens the body’s immune system and which if untreated may result in AIDS.

4. What does the acronym AIDS stand for?
   A. active immunological disease syndrome
   B. acquired immune deficiency syndrome
   C. acquired immunological derivative syndrome
   D. acquired immunodeficiency syndrome
   Answer: B. AIDS stands for Acquired Immune Deficiency Syndrome. AIDS is a range of medical conditions that occurs when a person’s immune system is seriously weakened by HIV to the point where the person develops any number of diseases and cancers.

5. What is the main means of HIV transmission in the U.S.?
   A. unprotected heterosexual sex
   B. homosexual sex
   C. intravenous drug use
   D. mother-to-child transmission
   Answer: B. Though all of the answers above can transmit the virus, the most common means of transmission of HIV in the U.S. is through unprotected homosexual sex.

6. Spread of HIV by sexual transmission can be prevented by:
   A. abstinence
   B. practicing mutual monogamy with an uninfected partner
C. correct use of condoms
D. all of the above

Answer: D. Abstinence is the only 100% effective way to prevent HIV transmission, though proper use of condoms and staying faithful with your partner, (once you have both been tested for HIV) are also effective ways of preventing the transmission of HIV.

7. Women are most likely to contract HIV through:
   A. unprotected heterosexual sex
   B. injecting drug use
   C. contaminated blood

Answer: A. In many cultures, women are at a higher risk of contracting HIV through unprotected sex than men. This is due to physical reasons, but also due to the social factors that keep them submissive to men.

Biological reasons that make women more vulnerable to HIV infection through sexual intercourse include:
1. Women receive greater quantities of possibly infected fluids during a sexual encounter.
2. Women have a surface area of mucous membrane (portal of entry) that is greater in size than men's.
3. Very young women have more risk of infection during sex both because the cells in the vagina in underdeveloped women are more likely to receive the virus, and because tearing may cause bleeding which increases the risk of infection.
4. If a woman has been circumcised or uses natural substances to dry out her vagina, the smaller or drier area may rupture more easily during sex.

8. HIV can be contracted from:
   A. condoms
   B. kissing
   C. mosquito bites
   D. drinking from the same glass as an infected person
   E. sharing a spoon with a person living with HIV
   F. sharing a toothbrush with someone who is living with HIV
   G. all of the above
   H. none of the above

Answer: H. The HIV can only be transmitted by an infecting fluid and a portal of entry into the body. A portal of entry is the way that HIV enters the body. This is either through a cut, sore, or opening in the skin or through the soft tissue called mucous membrane, located in the vagina, the tip of the penis, the anus, the mouth, the eyes, or the nose.

HIV is not an airborne, water-borne or food-borne virus, and does not survive for very long outside the human body. Therefore, ordinary social contact such as kissing, shaking hands, coughing and sharing cutlery does not result in the virus being passed from one person to another.

There is no way to catch HIV by being near a person with HIV, or by sharing their cups or bathrooms, or by hugging them or kissing them when blood or a contaminated fluid is not present. There are no documented cases of HIV transmission through sharing toothbrushes. This practice could only present a risk if there was blood present on the toothbrush.

9. Risk of contracting HIV is increased by:
   A. being infected with another sexually transmitted infection (STI)
   B. having poor nutrition
   C. having a cold

Answer: A. In general, a genital sore or ulcer as in syphilis, cancroid, or herpes expands the portal of entry. Having a discharge, as in gonorrhea or chlamydia, means that more white blood cells are present. Since white blood cells are hosts for HIV, it means that more virus can be transmitted or received when the discharge is present. Quick and proper treatment of STDs and immediate referral of partners can be important strategies for HIV prevention. Often women do not have apparent symptoms of sexually transmitted diseases, so checkups and partner referrals are very important. But men, too, may occasionally not have symptoms, even of gonorrhea; so, it is important that the man seek treatment.
10. Pregnant women infected with HIV:
   A. can reduce chances of transmitting HIV to her unborn child by maintaining a low viral load and staying in good health
   B. can take medication to reduce the risk of mother-to-child transmission during childbirth
   C. all of the above
   **Answer:** C. An HIV-infected pregnant woman can pass the virus on to her unborn baby either before or during birth. HIV can also be passed on during breastfeeding. If a woman knows that she is infected with HIV, there are drugs she can take to greatly reduce the chances of her child becoming infected. Other ways to lower the risk include choosing to have a caesarean section delivery and not breastfeeding or breastfeeding for only the first six months of the child’s life.

11. List the four main body fluids that, when infected, may transmit HIV.
   1. Vaginal fluids
   2. Semen
   3. Breast milk
   4. Blood (using infected instruments for cutting, or sharing infected needles for drug use)

12. List the four main ways HIV is transmitted.
   1. Mother-to-child transmission
   2. Sharing needles for injections (drug use) or using contaminated instruments
   3. Blood transfusion
   4. Unprotected sexual intercourse

PART 2: the answers to part 2 can be found below. For more explanations, please refer to the HIV and AIDS fact sheets and glossary that can be found in the resources section.

1. If a person has HIV, they will always develop AIDS.
   **(False)**
2. HIV is present in blood, sexual fluids and sweat.
   **(False: not present in sweat.)**
3. Abstaining from (not having) sexual intercourse is an effective way to avoid being infected with HIV.
   **(True)**
4. When a person has AIDS, his or her body cannot easily defend itself from infections.
   **(True)**
5. A person can get the same sexually transmitted infection more than once.
   **(True)**
6. There is a cure for AIDS.
   **(False)**
7. If a pregnant woman has HIV, there is a still a chance she will not pass it to her baby.
   **(True)**
8. A person can get HIV infection from sharing needles used to inject drugs.
   **(True)**
9. Many people with sexually transmitted infections, including HIV, do not have symptoms.
   **(True)**
10. HIV can be easily spread by using someone’s personal belongings, such as a toothbrush or a razor.
    **(False)**
11. A person can look at someone and tell if he or she is infected with HIV or has AIDS.
    **(False)**
12. It is possible to avoid becoming infected with HIV by having sexual intercourse only once a month.
    **(False)**
13. A condom, when used properly, provides excellent protection against sexually transmitted infections, and can prevent transmission of HIV.
    **(True)**
14. An effective vaccine is available to protect people from HIV infection.  
   (False)
15. A person can be infected with HIV for 10 or more years without developing AIDS.  
   (True)
16. You can get HIV by kissing someone who has it.  
   (False)
17. A person can be infected with HIV by giving blood in an approved health facility.  
   (False)
18. Ear-piercing and tattooing with unsterilized instruments are possible ways of becoming infected with HIV.  
   (True)
19. A person can get HIV by being bitten by a mosquito.  
   (False)
20. A person can avoid getting HIV by eating well and exercising regularly.  
   (False)
Recruitment Tools
Appendix 12. Recruitment Letter – Church Liaisons

Dear Church Leader:

Thank you for agreeing to help me find people who might be interested in participating in a study titled “Project FAITHH”. I need to find at least 20 members from your congregation who meet these conditions:

- At least 19 years of age
- Predominately African American descent
- A member of your congregations for at least 3 months
- Mentally (cognitively) able to understand the study, give their informed consent to participate
- Willing to participate in an 8 week study course (incentive provided).

Please inform all interested persons that I would like to receive their contact information so that I can invite them to a church orientation session with all the participants from the congregation to more specifically explain the study to them, to have them sign informed consent forms, and to set up a group schedule for the eight study sessions, depending on which group they are assigned to. Or if they would prefer, they can contact me directly at 205-348-5148.

This study is approved by the University of Alabama Institutional Review Board.

Sincerely,

Pamela Payne Foster, MD, MPH
Appendix 13. Recruitment Flier for Congregation Members

Research Study for HIV/AIDS

Investigators: Dr. Pamela Payne-Foster, MD, MPH & Dr. Susan Gaskins, RN, DSN—The University of Alabama

The purpose of this study is to test different HIV/AIDS programs in rural African American churches in the South.

To be in the study you must be:

- African American
- Live in a rural area
- Over 18 years of age
- A member or affiliation with participating churches
- Able to speak English

You may be asked to attend an 8 week course in HIV/AIDS. Each class will last 1–2 hours. All participants will receive a minimum of $20 after completion written assessments. An additional $10/class can be accumulated for those assigned to classes for a total incentive of $100.

Please contact Dr. Foster at 205-348-5148 or 1-877-363-2247
Appendix 14. Congregation Recruiter Letter

Dear Congregational Members,

We are conducting a study to test informational sessions to see which ones work best in rural African American churches. The project is called Project FAITHH.

We would like to recruit church members to possibly take an 8-week course and complete several written surveys and knowledge tests. One church group will not take the courses but will receive HIV/AIDS educational written materials displayed at their church. Each church will be randomly assigned to one of three groups.

We will pay a small compensation of a range of $50-$130 for your time for all participants who complete the study. If you are interested in participating, please contact Dr. Pamela Payne Foster at 205-348-5148.

This study is approved by the Institutional Review Board at the University of Alabama.

Sincerely,

Pamela Payne Foster, MD, MPH
Appendix 15. Pastors Recruitment Letter

Dear Pastor:

HIV/AIDS is increasing in African American communities, particularly in the South and in rural areas. We are developing faith-based tools to better engage churches in the fight to decrease HIV/AIDS and stigma. Therefore, we are conducting a study titled “Faith-Based Anti-Stigma Initiative Towards Healing HIV/AIDS. (Project FAITHH)” The project will involve testing different informational sessions for African American congregations in rural Alabama.

The first phase of the study involves interviewing the pastor of potential congregations and the next phase involves assessing different curriculums on HIV/AIDS related stigma in rural AA church congregations. I would like to invite you and your congregation to participate in this study.

If you are interested, you may contact me directly at 205-348-5148 to set up an interview. This study is approved by the University of Alabama Institutional Review Board.

Sincerely,

Pamela Payne Foster, MD, MPH
The University of Alabama
Appendix 16. PLWHA Recruitment Letter

Dear PLWHA:

HIV/AIDS is increasing in African American communities, particularly in the South and in rural areas. Researchers are developing faith-based tools to better engage churches in the fight to decrease HIV/AIDS and stigma. Therefore, I am conducting a study titled “Faith-Based Anti-Stigma Intervention Towards Healing HIV/AIDS. (Project FAITHH)”

The project will involve testing an anti-stigma curriculum for African American congregations in rural Alabama. The other important goal of the study is to increase the number of AA rural congregations that are welcoming to HIV+ persons.

The first phase of the study involves completing several written surveys that assess your formal or informal affiliations with churches in rural Alabama as well as your spiritual/religious practices and well-being and your internalized stigma. Each participant will be paid $50 for their time. To be eligible for this study, you need to be:

- HIV+ for at least 6 months
- African American
- Live in rural Alabama

If you are interested and eligible, you may contact me directly at 205-348-5148 to set up an appointment. This study is approved by the University of Alabama Institutional Review Board.

Sincerely,

Pamela Payne Foster, MD, MPH

The University of Alabama
Research Study for HIV/AIDS

Investigators: Dr. Pamela Payne-Foster, MD, MPH and Dr. Susan Gaskins, RN, DSN—The University of Alabama

The purpose of this study is to better understand HIV/AIDS related stigma in the Black Church in the South.

To be in the study you must be:

- African American
- Live in a rural area
- >19 years of age
- Speak English
- HIV+ for at least 6 months

You will be asked to complete three short written surveys: demographic, spiritual practices and spiritual well-being, and internalized stigma. Compensation will be $30 after completion of surveys.

Please contact Dr. Foster at 205-348-5148 or 1-877-363-2247
Other
BACKGROUND

According to the current sentinel survey, Ghana has a prevalence rate of 1.9%. One of the problems associated with HIV and AIDS in Ghana is the high level of HIV related stigma. Interactions with Associations of Persons Living with HIV and AIDS indicated that stigmatization and discrimination against persons living with HIV and AIDS is very high in most communities. This situation directly affects the management of HIV and AIDS and reducing its spread. Stigma presents a significant barrier to accessing care and support services. In view of the fear of discrimination following disclosure of HIV status stigma prevents PLHIV from getting the needed attention from family members. It also functions as a barrier to people with HIV or AIDS disclosing their status and getting access to available support and care services, and to HIV prevention that encourages people to adopt safer behavior. If people are mocked or treated with hostility, they may feel uncared for and are therefore less likely to take steps to protect themselves. They may also infect others in retaliation to the stigma.

It is against this background that the Christian Council of Ghana (CCG) embarked on a project on Reducing HIV and AIDS Related Stigma and Discrimination among Vulnerable Groups in the Dangme West and Ga West in the Greater Accra Region and Manya Krobo in the Eastern Region. This manual is designed to equip partners with the necessary skills, knowledge and attitude to enable them effectively contribute to the reduction of stigma in the communities. Additional details about the curriculum can be located here: http://www.waccglobal.org/en/programmes/programmes-and-projects-2006-2012/hiv-and-aids-communication-and-stigma.html.
METHODOLOGY
The tools to be used in the training include:

Presentation:
Presentations are made on topics that are technical in nature and where accurate information is needed and for summarizing sessions.

Discussions:
The manual contains structured framework for group discussions, designed to elicit facts and varied perspectives of issues from the participants. It basically involves reflections on experiences, sharing with others, analyses of issues and planning for action together.

Experience sharing:
Participants are offered the opportunity to share real life stories on related topics. Experience sharing is a rich learning process for participants because participants get the opportunity to relate theories to practicality.

Tableaux:
Tableaux are representations of scenes by silent and motionless groups of people, which is a quick method of presenting a situation. It is also another form of presenting real life experience. Discussions that are generated by tableaux are a good learning experience for participants.

Role-Play:
A further step on drawing on the experiences of participants is the use of role-plays. Participants are encouraged to think of situations of their own choice relevant to the exercise in question and dramatize it. An exercise makes participants draw on similar situations in their environment.

Brainstorming:
This is a method of finding answers to problems in which all the members of a group think very quickly of as many ideas as they can. It promotes interaction among participants and allows them to arrive at best ideas.

Rotational brainstorming: is a method where participants break into groups, with each group given a starting topic, however after a few minutes group members rotate and also continue to respond to the questions of the other groups. This continues until each group gets to its starting point.

Pictures:
Pictorial presentation is another effective way of describing reality in a setting. It will be used to generate discussions during sessions.
**Energizers:**
Energizers are fun exercises to allow participants to relax their brains and body. There is however an element of learning in energizers, usually in a humorous way.

**Small Groups:**
Small groups are used to maximize participation in discussions. Some trainees feel shy in a large group but in a small group they find it easier to talk. Small groups can also be used to do “task group” work- different groups exploring different topics.

**Buzz Groups:**
Two people sitting beside each other- is a trainer’s secret weapon! This helps get instant participation. It is hard to remain silent in a group of two people.

**Card Storming:**
Participants, working individually or in pairs, write single point on every card and tape them on the wall, creating a quick brainstorm of ideas. Once everyone is finished, the cards are organized into categories and discussed.

**Working with Feelings:**
Many exercises in the Guide involve working with feelings. An important component in anti-stigma training involves working with attitudes towards, experiences of and beliefs about traditionally taboo subjects like sex and death. To do this, many exercises are designed to assist participants express the feelings which often lie behind these attitudes. As trainers, it is important to create a safe, non-threatening space where feelings, fears and taboos can be discussed and explored openly. The following tips must be considered.

- Setting clear ground rules and expectations around confidentiality, listening and support are essential
- Awareness of your own feelings and fears about the topics you are going to cover will also help you feel more confident during the exercise
- Participants are more likely to trust you if you can share your feelings openly and by doing this, you lead by example
- Remember that no feeling is wrong, but some participants may find it difficult to accept certain feelings
- Remember to always leave enough time for participants to share their feelings and help the group to create an atmosphere where participants know they will be listened to
- Offer participants “time out” if they need to take a break
- Feelings are a powerful tool – use them with the group to develop drama and role-plays, to build on stories, and as examples for the future
- If there are any exercises you do not feel comfortable leading, find a co-trainer who can help out
- If you have counseling skills, you are more likely to be confident in working with feelings
DURATION OF SESSIONS
The whole training program has been divided into sessions. Each session has a number of activities, which are geared at achieving the purposes of the session. Each session has been designed to cover a specific thematic area. Depending on the activities, each session shall take between 2 – 3 hours.

MATERIALS
• Felt pens
• Flip chart stand and papers
• Masking tapes
• Note books
• Pens
• Chalks
• Cardboards
• Pictures
• Facts Sheets
• Character descriptions on cards
SESSION ONE: NAMING THE PROBLEM
The chapter gets participants to name the problem and acknowledge that stigma exists and it manifests itself in many forums including rejecting, isolating etc. We are all involved in stigmatizing intentionally or unintentionally through our words and deeds. Acknowledge that we stigmatize PLHIV and we can really make a difference buy charging our thinking and action.

Objectives:
Help the participants identify stigma as a problem
Help participants connect to stigma on personal emotional level
Help people describe their own experience of stigma
Express different types or forms of stigma, causes and effects

Exercise 1: Naming Stigma through Pictures

Activities
Step 1: Put participants into groups using any technique.

Step 2: Each group first looks at the pictures on the wall and then picks one picture to discuss.

Step 3: The following three questions are asked to the groups.
What is happening in the picture in relation to stigma?
Why is it happening?
Does this happen in your community?

Examples

Picture One: Eviction
A family is being ejected from the home – maybe one is HIV positive, landlord does not want them in house.
He fears another tenant can get infected and he will be blamed.
It happens in my community – many people are ejected because of getting sick

Picture Two: Isolation in Bus
Passengers traveling on a bus have decided not to sit by a particular passenger because he looks lean and sick. The isolated passenger feels dejected because he has realized that no one wants to sit by him. This is happening because the passengers are not sure of what disease this man is carrying and therefore do not want to risk getting close to him.
This happens in our communities. I refused to sit by a passenger because he had an unpleasant odor.
Summary by Facilitator

A summary is given of some of the key words related to stigma or forms of stigma that participants are likely to identify through the pictures: *Hiding, rejection, exclusion, blame, violence, denial, disapproval, judgments, eviction, discrimination.*

**Exercise 2: Reflection on Our Experience of Being Stigmatized**

**Activities**

This is a follow-up exercise from the first one.

Step 1: Participants are asked to find a quiet space alone and think back to a time in their life when they felt lonely or isolated.

Step 2: After a few minutes, they share their experiences in pairs and then return to the large group for sharing and processing.

**Examples**

I come from a poor family. My father is a farmer and he worked hard so I could get to University. When I went to the college, I was just getting on with my studies, but I became aware that some people were laughing at my clothes and my shoes. They even shouted something out so that I felt ashamed.

The first time I went to the UK, I had dressed in my African dress, proud to be from Ghana. As we queued for the immigration, I saw that a lot of women were getting picked out of the line. Then I realized they were all African women. I myself was called and given a body search by a young woman. I felt humiliated: they treated me like a criminal.

I tested HIV positive and everyone was shocked, especially my family. They blamed me and questioned me – how could it be you?

Step 3: Based on the reflections, the participants are asked the following questions.

**How was the exercise?**

**What do we learn from it?**

**Examples**

- The old memories came back strong and fresh
- It was not easy to forget because I was hurt
- It is difficult trying to share that experience
- It is traumatizing
- Discrimination and stigma are all around us
- There is prejudice everywhere
- Some strong feelings make you an advocate to help others
- It makes me understand what others go through and makes me strong
- It makes one adjust to situations and helps others in similar positions
- It makes me more accommodating
- It makes me recognize problems and deal with them when they arrive
- We learn best when we experience it ourselves
We need to work on negative attitudes to make a positive impact

Summary by Facilitator
The facilitator summarizes the effects of stigma as portrayed by the participants. The exercise is purposed at making participants feel stigmatized and reveal how bad it is to stigmatize people no matter what the situation would be.

What is Stigma?
Literary means a mark or blemish on someone or something
A significantly discrediting attribute that reduces the bearer from a whole and usual person to a tainted, discounted one.
Examples woman with issue of blood, lepers in the Bible days

Types of Stigma
Self-stigma
Family stigma
Societal stigma

What is discrimination?
It is the negative reaction triggered by stigma
Treating a person or group differently (usually worse) from others.

Causes of Stigma and discrimination
Some people believe AIDS is a curse from God or witches
Believe that it can be acquired through the sharing of household items and touching of an infected person
Belief that healthy looking people cannot have HIV/AIDS
Religious or moral beliefs that HIV infection is a result of immorality and promiscuity
The fact that HIV is incurable

Effects of stigma and discrimination
Prevents people from seeking treatment
Prevents people from acknowledging HIV status
Discourages open discussion on the disease
Make HIV infected people shun away from health care services
Make infected and affected people feel guilty and ashamed
SESSION TWO: MORE UNDERSTANDING, LESS FEAR

HIV stigma is rooted in both fear and ignorance. Research has shown that everyone has information about HIV and AIDS but few people have enough information to overcome fears associated with HIV and its transmission. Most persons really have problems with distinguishing between real risk and imagined risk and this stigmatizing PLHIV. In the light of the above, this chapter will seeks to address the gaps in the knowledge of participants so that they get a clearer understanding and this limit the fear which final stigmatization.

More Understanding, Less Fear

Objectives:
Help participants articulate their fears about HIV and AIDS
Enable participants to relate their fears to their response to PLHIV
Establish that key cause of stigma is fear of casual transmission
Help people explore all the fears openly and provide clear information about how HIV is / is not transmitted

Exercise 1: Fears about HIV

Activities
Step 1: A card storm is used to get participants to discuss in pairs and write down points on cards on the different fears in the community about catching HIV through non-sexual (casual) contact and tape them on the wall and cluster common points for discussion.

Examples
・ Sharing office equipment
・ Sharing the same office
・ Sharing toilet facilities
・ Blood transfusion
・ Touching HIV positive person
・ Eating with an infected person
・ Eating food of an infected person
・ Kissing
・ Sharing hairdressing equipment (saloon and barbering)
・ Shaking hands with an infected person
・ Touching fluids of infected person e.g. tears, saliva and urine

Step 2: Participants are then asked to pick out the cards they believe do not pose any threat to HIV transmission. There will be a lot of discussions as participants will try to justify why some non-sexual contacts could aid in the transmission of HIV.
Step 3: Introduce Quality Quantity Route (QQR) of Transmission tool at this point. The QQR tool is a useful way of giving clear, unambiguous information about transmission.

**Quality**
The virus must be strong
HIV cannot survive outside the human body
It starts to die as soon as exposed to air
It does not live on the surface of the skin
The virus can only survive outside the body in a vacuum

**Quantity**
There must be enough quantity of the virus to pose any threat
Enough quantity is only found in the blood, semen, vaginal fluid and breast milk

**Route of Transmission**
The virus must get into your blood stream
Our body is a close system
Common sense and everyday hygiene

**Summary by Facilitator**
The facilitator reemphasizes that HIV related stigma is rooted in both fear and ignorance. It will be noted from the discussion that everyone has some information about HIV and AIDS but not all of us have enough information to overcome irrational fears associated with HIV and its transmission.
Every participant knows that HIV can be transmitted through sex, but not all are convinced that they are not at risk through non-sexual “casual contact.” As a result many people fail to distinguish real risks from imagined ones. This fear of casual contact will often lead to isolation and segregation of PLHIV – isolating them from others, giving them separate plates and cups and a separate room among other discriminatory acts.

**Exercise 2: Assessing Risk of HIV Infection**

**Activities**
Step 1: On separate full sheet of flipchart papers, write in big letters “HIGH RISK,” “LOW” RISK,” and “NO RISK.”

Step 2: Write each of the following points on index cards or on half sheets of A4 paper before starting the exercise and then mix them up:

**HIGH RISK**
- Vaginal sex without a condom
- Having sex with a sex worker without a condom
- Anal sex without a condom
- Many sexual partners without using condom
- Having sex when infected with an STI without a condom
- Having sex with a person infected with an STI without a Condom
- Having sex while drunk without a condom
- HIV infected person wanting to have a child
- Using Vaseline or hair oil to lubricate a condom
• Sharing needles with intravenous drug users
• A transfusion of untested blood

**LOW RISK**
• Oral sex without a condom
• Sex with a condom
• Sex for money with a condom
• Touching the blood of an injured person

**NO RISK**
• Abstinence
• Kissing, hugging, massaging and mutual masturbation
• Sex between mutually faithful, uninfected partners
• Sharing eating, drinking and cooking utensils with a person with HIV
• Donating blood
• Deep kissing with tongues
• Sharing a toothbrush or hairbrush with a person with HIV
• Being bitten by mosquitoes
• Touching a person with HIV
• Sharing a bathroom or latrine with a person with HIV
• Feeding a person with HIV
• Hugging a person with HIV

Step 3: Tape the flipchart papers of “HIGH RISK,” “LOW” RISK,” and “NO RISK” on separate places on the wall and ask the participants to pick up the mixed cards made at the Step 2 and stick under any category of “HIGH RISK,” “LOW” RISK,” or “NO RISK” with explanation of reasons why the card should go into the selected category.

**Notes for Facilitator**
Make sure that all the cards are in the right category and offer explanations for misplacements of the cards
SESSION THREE: HIV TRANSMISSION
A clear understanding of HIV transmission is very important since it helps to reduce the unnecessary fear which leads to stigmatization and discrimination against PLHIV. The session will help participants to assess their risk and also discuss how fast HIV can spread if it is not managed effectively.

TASO GAME
Objectives:
Assist participants to understand how quickly HIV can spread
Assist participants to reduce the perceived distance from PLHIV
Enable participants to realize that everyone is at risk of being infected with HIV

Exercise 1: The TASO GAME

Activities

Step 1: Mark slips of paper with “+” and “−” signs, 25% of “+” and 75% of “−” and fold them.

Step 2: Ask each participant to choose one of the folded pieces of paper. Emphasize that no one should look at their slips of paper until the end of the exercise.

Step 3: Ask the participants to move freely around the training area, stopping to greet friends.

Step 4: After each person has greeted four or five friends, stop the activity and ask everyone to look at their slip of paper.

Step 5: Ask all those who have “+” on their paper to come forward. Explain that this game is pretending that these people are HIV positive.

Step 6: Ask those who greeted any of those who came forward first to come forward also to join their friends. Explain that this game is pretending that these people are at risk of being infected with HIV.

Step 7: Look to see who is left. Explain that this game is pretending that the statuses of these people are unknown. They may have made friends with those infected before they had become infected; but in any case they are at risk.

Step 8: Finally ask the following questions according to this game.

- How many people were originally infected with HIV virus?
- How many are at risk of being infected?
- How many others are at risk of being infected?
- How many remain uninfected?
- What does this tell us about the spread of HIV in our community?
SESSION FOUR: IMPACT OF HIV INFECTION ON FAMILIES
The family is the basic unit of society, everyone belongs to a family. In our African context the extended family system may be useful or not in supporting PLHIV. Once a person is diagnosed positive, there is an impact on the family, this module will assist participants to assess the impact and help in minimizing stigma.

How HIV and AIDS Affect the Family
Objectives:
Enable participants to discuss more openly how HIV and AIDS affect families
Identify some of the critical issues related to living with, caring for and not stigmatizing PLHIV in family/home

Exercise 1: HIV and the Family
Activities
Step 1: Put the picture(s) on the wall or organize a role-play based on one of the themes in the picture.

Step 2: Discuss in small groups on the following questions.
  What is happening in this picture or role-play?
  What happens when the family finds that one family member has HIV?
  What are the immediate effects?
  What are the longer-term effects?
  What are the effects on the PLHIV?
  What are the families already doing to provide care and support for PLHIV?
  What is blocking families from helping PLHIV?
  What practical things can we do as families to support PLHIV?

Examples
Immediate effects on the family
  • Shock
  • Anger
  • Disappointment
  • Worry
  • Grief
  • Sorrow
  • Fear of caring for PLHIV
  • Fear of neighbors finding out and being stigmatized
  • Denial to accept results
  • Family inaction – don't know what to do
  • Hatred within family
  • Blaming

Longer term effects on the family
  • Conflicts within the family
• Divorce or separation
• Heavy burden on the caregivers leading to burnout
• Loss of income and money problems
• Children drop out of school and may become orphans
• Widows
• Sexual cleansing
• Property grabbing

Effects on PLHIV
• Loss of job, friends and self-confidence
• Become withdrawn and depressed – may resort to drinking
• Lots of worry
• Isolation and self-isolation

What are families doing already to provide care and support for PLHIV?
• Taking PLHIV for medical treatment
• Raising funds for medical treatment
• Getting help from faith groups
• Trying to provide nutritious food and informal counseling

What is blocking families from helping PLHIV?
• Lack of knowledge on how to care for PLHIV
• Fear of infection due to lack of knowledge about HIV transmission
• Blaming and judging attitudes
• Poverty
• Fatigue, burnout

What practical things can we do to support PLHIV family members?
• Encourage PLHIV to talk openly about their feelings and listen
• Do not decrease interactions – treat them as you treat other family members
• Chat and spend time with them
• Make them feel wanted
• Encourage them to identify and get treated for opportunistic infections
• Connect them with other PLHIV for sharing experiences and feelings
• Encourage PLHIV to practice safe sex to avoid getting re-infected

THE FLEET OF HOPE

[The original fleet of hope concept and materials were created and developed by Bernard Joinet, José Cantal Rivas & Theodore Mugolola]

Summary

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The spread of HIV/AIDS in Ghana is represented by a rising flood situation in which all sexually active persons are required to take action to prevent themselves from being attacked by the dangerous creatures in the water (HIV/AIDS and STIs). The available options are the boats of “Abstinence”, “Faithfulness” and Condom Use. Being on these boats prevents one from being attacked by the dangers of the rising flood.

In this interest game situation participants discuss the issues using the card characters and the Fleet of Hope Cloth.

**Objectives**

When this section is complete, participants will:
- Be able to describe what behaviors put someone at risk of HIV infection and which do not.
- Have identified key issues in their community around staying safe from HIV infection.
- Realize that HIV infection is also a key issue for married couples and long-term partners.
- Be able to recall the following Key Messages:

**Key Messages**

HIV infections are increasing everywhere in Ghana, like a rising flood. Anyone who goes into the floodwater risks being attacked by HIV and other STIs.
You can stay safe from HIV infection using Abstinence, mutual Faithfulness and/or Condoms. These are like three boats to escape the flood.
Always be on one of these ‘boats’, the boat of your character, your way of life.
If need be, switch to another boat.

**PREPARATION**

Before starting this exercise, sort out a selection of 15 to 25 card characters which the group you are training will recognize as being the sort of people they might find in their own community.

**ACTIVITY ONE**

**BEING ON THE BOAT OF SAFETY**

**STEP 1. Setting the scenario and discussing the key terms**

The facilitator creates the scenario by narrating the following:
*This is a story about a very serious flood and what helped the people in one particular community to deal with it. I will start the story then we will all join in directing and developing the story together. The waters of this flood have been rising for several years, flooding houses, villages, towns and whole countries.*

Lay the cloth with the boat on the ground or hang it up in front of the group.
This is the flood, and in this flood there are some dangerous creatures. 
Put the crocodile on the cloth. 
Some of these dangers you can see, but others lie hidden in the water. These include HIV and some other sexually transmitted infections (STIs) like gonorrhea. 
Initially many people do not notice the flood coming, and they do not know what caused it. Some people climb onto the roof their house, or move to higher ground to escape the flood. But the floodwaters keep rising. How can you escape from a flood? On a boat. There are three different boats available for people to escape the flood — called Abstinence, Faithfulness and Condom. 
Invoke participants in a discussion to clarify what is meant by these terms, and make use of local terms in common usage, which participants are familiar/comfortable with using. 
Each person in the community can choose which boat they want to get on, depending on their culture, religion, character, age and way of life. Different people climb onto each of the three boats, which stay close together so that it is possible to switch safely to another boat when someone wants to. 
Anyone not on the boats is swimming about in the floodwater, in danger of being attacked by one of the creatures in the water. Some do not notice the flood coming until it is too late. Others see the floodwaters coming, but it very hard to leave their way of life and change what they have been doing, and so the flood catches them. Some are trying hard climb back onto the boats. 

STEP 2. Being on the boats 
Hand out the card characters to participants. Give each participant a character which would NOT represent that individual. For example, if it is a mixed group, give male characters to women and female characters to men. Ask participants one at a time to talk about their character. 
Introduce your character. Give them a name. Talk about them as though they are someone you know. Tell us something about who they are, what they are like, and what they are doing today. Then put them on the boat they are actually on at the moment or in the water if that is where they are. Put them where you think they are now, not where you think they ought to be. 
Ask participants to explain why they have put them there, and facilitate discussion about the issues facing each character in relation to staying on a boat or getting on to another boat. Ask the group what support they could offer the character to overcome the issues/problems they are facing. 
Clarify that people can and often do change boats. Illustrate this with the card character that looks like a businessman: 
This businessman has a faithful relationship with his wife most of the time. Then he goes away on a business trip. He gets on the Abstinence boat, but after a week away, he meets a pretty woman. If he decides to have sex with her, he must get on the Condom boat, otherwise he will take a dive into the water. People often move boats when they get married. If you cannot face staying on the boat you are on, change boats. Just stay out of the water. 
Encourage participants to create relationships between the different card characters. The discussion can develop in many directions, addressing different issues through these „characters“. 

ACTIVITY THREE
HOW HIV CAN OR CANNOT BE SPREAD
This is an optional input, which could be used if participants are not all clear about the different ways that HIV can or cannot be spread.

STEP 1. What does or does not put people at risk of HIV infection
Take two card characters, one male and one female of similar age. Put them in the abstinence boat. Explain that they met each other recently, and the relationship between them is developing. Before meeting, they have had other sexual relationships.
Ask participants the following question:
If the following things happen, will these two people stay safely on their boat, or will they be in the water, at risk of HIV infection?
They share cutlery (totally safe)
They hold hands and hug each other (totally safe)
They kiss (totally safe, unless they both have bleeding sores on their mouths)
A mosquito bites both of them (totally safe – when a mosquito bites someone, it injects only saliva, not blood. The saliva can have the malaria parasite in it, but the HIV virus is only in the blood)
The woman is in an accident, and is given a blood transfusion at the hospital (should be safe, but if the blood has not been checked properly for HIV, might be in the blood)
The woman sneezes into the man’s face (totally safe)
They have sex using a condom (onto the condom boat – very safe (99%) if used properly all the time)
They promise each other that they will be faithful and committed to each other, and agree to have unprotected sex (risky – into the water – if either of them has ever had sex without a condom before, there is some risk that they may have HIV. They should have an HIV test before they can get on the Faithfulness boat.)
One of them has an STI, but they still have unprotected sex (very risky – into the water, maybe head first, so just their feet are left sticking out – this adds humor and impact)

Take the card character of the pregnant woman and/or the woman with a baby on her back.
Ask participants these questions:
If this woman is living with HIV, what about the baby/unborn child? (About one in three risk of the baby getting HIV.)
A traditional healer cuts tattoos on their bodies and does it for several other people one after the other using the same knife (very risky - into the water)

STEP 2. Discussion Questions
Using the following questions lead participant to carry out a final discussion of the issues of protection:
What local customs might spread HIV through blood?
What can you do to protect yourself if you go to a traditional healer, village health worker, health center or Hospital?
What can men and Women do to protect their future children from AIDS?
SESSION FIVE: SEX, MORALITY, SHAME AND BLAME

Exercise 2: Things people say about some groups of people

Activities
Rotational brainstorming is used to carry out this exercise that is purported at linking names calling to stigma.

Step 1: Participants are put into groups by the use of the „puzzle technique,” where they are to find the other parts of the puzzle to form a group.

Step 2: Everyone is given a group that they belong to e.g. street child, MSM, sex worker, person living with HIV, teenage girl, widow, etc. Participants stay in the same groups to start the rotational brainstorm.

Step 3: On each flip chart they write down all the things people say about that group – names, expressions, beliefs, etc.

Step 4: As a song starts, the groups switch flipcharts until all groups have written on all flipcharts.

Step 5: A member from each group reads out the names – saying: „This is what you say about us….“ After all the groups have read out the names tagged on them they are asked how they felt listening to the words used to describe them.

Examples

How did you feel in your group after listening to the names?
• Felt uncomfortable
• Disgraced
• Self pity
• Committing suicide
• So ashamed

Things people say about sex workers
• They are immoral
• Transmitters of HIV
• Prostitutes
• Dangerous
• They love money
• Uncultured
• Disgrace to families
• Bad
• Sinners
• Disrespectful
• Shameful
• Evil

Things people say about people living with HIV
• Hopeless
• Not live long
• Prostitutes
• Witches and wizards
• HIV carriers
• We should blame them
• Fornicators
• Deprived
• Disgraceful

**Things people say about street children**
• Burden to the nation
• At risk
• Need help
• Hopeless
• Stubborn
• Unfortunate
• Less privileged
• Criminals
• Bad children
• Wayward
• Thieves
• Vagabonds
• Bastards
• Disrespectful

**Things we say about teenage girls**
• Truants
• Armed rubbers
• Sex drive is high
• Prostitutes
• Husband snatchers
• Irresponsible
• Disrespectful
• Bad
• Vulnerable
• Exposed to risk
• Careless
Things people say about men having sex with men

- Taboo
- Shameless
- Abomination
- Evil
- Ill mannered
- Crazy
- Disgrace to the human race
- Useless
- For hell
- Outcast
- They bring curse to the land

Images and Consequences of PLWHAs

<table>
<thead>
<tr>
<th>Image</th>
<th>Consequence (Action as a Result of Image)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hopeless</td>
<td>Individual-</td>
</tr>
<tr>
<td></td>
<td>Family-</td>
</tr>
<tr>
<td></td>
<td>Community-</td>
</tr>
</tbody>
</table>

Summary by Facilitator

Emphasize that these groups of people are vulnerable and need help instead of rebuking them, which reinforces the stigma against them. Comment on the power of the words and the level of hurt behind them. State that these names give people a justification for stigmatizing some groups of people.

Session Six: Stigma and Religion

The church or the mosque is one place where people go for solace. PLHIVs must also have that right; however, some religious beliefs and practices bar PLHIV. Some parts of the Bible and other religious books are misinterpreted to the effect that PLHIVs are sinners and condemned to death. The good books, however, direct that all are one in the sight of God and this is inclusive of PLIVs. Many parts of the bible abhors stigma and discrimination

Stigma and Religion

Objectives:
Enable participants to explore some religious beliefs that fuel stigma
Establish that religion is one of the sources of stigma
Discuss negative attitudes against PLHIV by some religious leaders that perpetuate stigma by congregation members

Exercise 1: Religious practices that stigmatize PLHIV

Activities
Step 1: Begin the exercise with a "mock sermon," given by a participant who play the role of a religious leader. The sermon is supposed to be one that is judgmental. Organize the seating arrangement of participants to look like a group role-play with everyone in a church or a mosque.

Step 2: After the sermon, ask the participants to discuss the following question.

*What kind of messages came from the preacher?*

Step 3: Group participants according to their religious inclination and ask them to answer the following question.

*What are some forms of stigma that we see in some churches or mosques?*

Step 4: Discuss some of the positive messages that can be used from the Bible, al-Qur’an, or any other religious texts that can help fight stigma. And then give examples.

**Examples**

Jesus talks with a Samaritan woman-John 4:1-26
The woman caught in the act of adultery-John 8:7
Judge not so that you shall not be judged (Matthew 7: 1-2)
Love your neighbor as yourself (Matthew 22: 39)
Judging and condemning (Luke 6: 37)
SESSION SEVEN: COPING WITH STIGMA

When tackling stigma, it is important to include strategies for supporting PLHIV. PLHIV play crucial role in raising awareness about stigma. Combating stigma automatically links to human rights – fighting to maintain rights is a key element of anti-stigma activities. We can help to build self-esteem, assertiveness and advocacy skills as ways of coping with and challenging stigma.

Importance of Feeling Good

Objectives:
Assist participants to recognize the importance of emotional well-being of PLHIV to live long and productive lives
Identify how we can help PLHIV stay emotionally healthy
Identify ways that we can challenge stigma and assist PLHIV to cope with effects of stigma

Exercise 1: Importance of Feeling Good

Activities
Step 1: Ask participants to draw a picture, make a collage, write a poem, or make a song, and find a way to express „what makes you feel good."
Step 2: Ask them to share their works in pairs.
Step 3: The same pairs are asked to discuss the following questions.
   What do PLHIV need, to feel good about themselves?
   Why is „feeling good“ (emotional well-being) important for PLHIV to lead long lives?
   What might prevent PLHIV from feeling good?
Examples
   What do PLHIV need, to feel good about themselves?
   ・To be loved
   ・Cared for
   ・Listened to
   ・Given information about HIV and AIDS
   ・Nutritious food
   ・Involved in family decision making
   ・Access to proper medical services
   ・Legal protection to stop them from being fired from jobs
   ・Prayer and encouragement from spiritual leaders
   ・Considered to be productive, contributing to family like others
Why is feeling good important for PLHAs to a long life?
- If our mind feels good, so does our body
- Less likely to fall sick
- More likely to share problems

What might prevent PLHAs from feeling good?
Stigma – lack of attention, isolation, lack of care and support
Self-stigma – feeling guilty, Loss of friends, stigma by neighbors

Exercise 2: Stigma, Self-Stigma, and Self-Esteem

Activities
Step 1: Ask participants to act out the role-play below.

Story for Role Play
At the market, a PLHIV is refused service and shunned by the traders, who gossip about him being “promiscuous.” He returns home where he pours out his heart to his brother, talking about his frustration and feeling of rejection. He blames himself, saying he was “reckless and therefore deserves to be treated like this.”

Step 2: Ask the participants to discuss in pairs based on the following questions and then share the outcomes of the discussion.
What happened? Who is stigmatizing? Why?
How does the way he has been treated affect his emotional health?
What are the indicators of “self-stigma”?

Step 3: Facilitate a discussion among the participants on the following question.
How can we support PLHIV to cope with stigma?

Examples
Encourage PLHIV to talk openly with friends and family about their feelings and their situation and be listened to with empathy
Encourage PLHIV to get supportive counseling from family, friends, or health professionals
Encourage them to join a support group and share feelings and experiences with other PLHIV
Allow them to continue being productive by doing things that build confidence and self esteem
We can challenge stigma ourselves and show why it is wrong to judge PLHIV
Recognize that PLHIV have rights to have sex, get married, have children, have work, and have friends, and demand their rights
Summary by Facilitator
In summarizing the discussion, the facilitator emphasizes the following points:
Emotional health is an important part of positive living. Stigma may negatively affect PLHIV emotional health.
Stigma by other people can lead PLHIV to self-stigmatization
We can all play an important role in challenging stigma, and supporting PLHIV to cope with the effects of stigma.

Exercise 3: Stigma and Rights

Activities
This exercise helps to explore how rights can be violated if you are living with HIV. It also looks at how assertiveness skills can be developed to support people to fight for their rights.
Step 1: Ask participants to mention the rights of PLHIV that are infringed upon.

Examples
*What are some of the rights that can get disregarded if we are living with HIV?*
Freedom of association
Right to privacy
Right to health care
Right to family-belonging
Right to education
Right to earn a living/employment
Right to good information
Right to human dignity
Right to shelter
Right to parenthood (having children)
Right to sex
Right to marry

Assertiveness
Assertiveness skills can help PLHIV fight for their rights. Some PLHIV allow themselves to be treated as “victims” by remaining passive, allowing others to think for them and decide for them to keep their own feelings and ideas hidden. PLHIV need to be more assertive if they are to gain more control over their lives and defend their rights.

Why be assertive?
Increase your confidence
Stand up for your rights
Gain more respect from others
Improve your relationships
Gain more control over your life.

**Assertiveness Definition:**
Saying what you think, feel, and want in a clear and honest way that is good for yourself and others. It is not being aggressive or showing anger.

Step 2: Rights role-plays using assertiveness skills
Put participants into smaller groups and ask each group to prepare a short role-play to demonstrate how the rights of PLHIV are violated and how assertiveness skills can be used to maintain the rights.

**Examples**

**Right to Treatment**
PLHIV arrives at the hospital from a distant village. He/She joins long queue and got to consulting room late. He/She cannot pay for three months’ prescription and cost of drugs. He/She uses assertive skills and mother's interventions to convince the medical officer to give prescription for one month and return in a month's time to continue treatment.

**Skills Exhibited**
Bold about her status
Used another person to assert with her

**Right to Employment**
PLHIV enters interview hall. Because he/she honestly discloses his/her HIV status, he/she is rejected. He/She goes for another organization for an interview and gets employed because he/she demonstrates his/her competence. The first organization discriminated against staff member because of his/her HIV status.

**Skills exhibited**
Showing the panel his/her competence and skills despite the situation
Courageous in speaking out
Looking directly into the face of panel while speaking

**Right to Human Dignity**
Though he/she used to meet with the friends at a spot to discuss issues as daily habit, the friends abandon him/her when they discover his/her status.

**Skills Exhibited**
Confronted friends calmly
Taking control of self

Step 3: After all the role-plays, ask the participants the following question.

**What did we learn from these Role Plays?**

**Exercise 4: Using Advocacy to Challenge Stigma**
**Activities**
Step 1: Brainstorm among the participants on what advocacy is.
Examples

What is Advocacy?
Trying to identify a problem
Pushing the problem for people to understand
Designing deliberate action for policy change
Speaking and taking actions to achieve an objective
Lobbying people to understand your views
Processing to bring about change
Identifying issues you want to address
Speaking out to people on issues

Advocacy Definitions
An action directed at changing the policies, positions and programs of any type of institutions
The process to bring about change in the policies, laws and practices of influential individuals, groups and institutions

Step 2: Brainstorm among the participants on how to carry out effective advocacy.

Examples
1. Press Release: an outline of an anti-stigma campaign is developed, which raises several examples of people who were fired because of their HIV statues. It also provides clear details of how to find out more.
2. TV interview: A skillful interviewer who is well briefed to ask relevant questions conduct an interview with the representatives of an anti-stigma campaign who ensured that all the details are included
3. Presentation is made to a group of company directors by using a story about a fellow colleague who has been stigmatized at work and resulted in the loss of a big contract.
4. A drama group leads a powerful play about a member of staff being stigmatized, showing different attitudes from their board members and union members.
5. A presentation is made to introduce an anti-stigma campaign to a committee or network of NGOs by providing clear information so as to gain sufficient support from them.

**Notes for Facilitator**
Facilitator assists participants to develop an advocacy campaign strategy. For this, five (5) logical steps should be involved as follows.
1. Identifying and clarifying the issues
2. Establishing goals and objectives
3. Agreeing on targets, audiences and messages
4. Agreeing on tactics and tools
5. Gender proof your campaign
6. Monitoring and evaluation.

**Week 1: History of HIV/AIDS:** This session will focus on the history of HIV/AIDS, particularly in the United States, which groups were initially affected, an overview of the virology and pathology of the disease and its affects. This session will be supplemented with an introductory video highlighting the history of the disease.

**Week 2: HIV/AIDS in 2012:** This session will continue to build on general AIDS 101 and also discuss the changing epidemiology of the disease, particularly in African Americans in the South.

**Week 3: Testing for HIV:** This session will go into more detail about the virology of the disease as well as the importance of early testing. Examples of current available tests will also be discussed. We will also offer HIV testing during this session for any who have not been tested.

**Week 4: HIV/AIDS in Women and Children:** This session will focus on the unique needs of African American women and children as it pertains to HIV/AIDS prevention and treatment.

**Week 5: Stories from the Quilt:** This session will focus on the history of the AIDS quilt and focus on real life members of the African American community who have been affected. This session will be supplemented with videos, websites.

**Week 6: Treatment for HIV/AIDS:** This session will focus on the current available treatments for HIV/AIDS.

**Week 7: HIV/AIDS in Rural Areas:** This session will focus on the unique needs of persons infected and affected by the disease in the rural U.S., particularly in the rural Deep South.

**Week 8: Personal Perspectives:** This session will be organized by the ACAB and will feature PLWHAs for them to tell their stories.

Sample HIV/AIDS Training Materials
Appendix 20. Sample Timeline for Training

Group A. Anti-stigma Education

Week 1- Church 1A begins

Week 2- Church 1A-Week 2; Church 2A-Week 1

Week 3- Church 1A-Week 3; Church 2A- Week 2

Week 4- Church 1A-Week 4; Church 2A-Week 3; Church3A-Week 1

Week 5- Church 1A-Week 5; Church 2A-Week 4; Church 3A-Week 2

Week 6- Church 1A-Week 6; Church 2A-Week 5; Church 3A-Week 3; Church 4A- Week 1

Week 7- Church 1A-Week 7; Church 2A-Week 6; Church 3A- Week 4; Church 4A-Week 2

Week 8- Church 1A-Week 8; Church 2A-Week 7; Church 3A-Week 5; Church 4A-Week 3

Week 9- Church 2A-Week 8; Church 3A-Week 6; Church 4A-Week 4

Week 10- Church3A-Week 7; Church 4A-Week 5

Week 11- Church 3A-Week 8; Church 4A-Week 6

Week 12- Church 4A-Week 7

Week 13- Church 4A-Week 8

Group B: Standard H/A curriculum

Week 14- Church 1B-Week 1

Week 15- Church 1B-Week 2; Church 2B- Week 1

Week 16- Church 1B-Week 3; Church 2B-Week 2

Week 17- Church 1B-Week 4; Church 2B-Week 3; Church 3B-Week 1

Week 18- Church 1B-Week 5; Church 2B-Week 4; Church 3B-Week 2

Week 19- Church 1A-Week 6; Church 2B-Week 5; Church 3B-Week 3; Church 4B-Week 1

Group C: No Curriculum- No Training

Week 20- Church 1C, 2C, 3C, 4C
Appendix 21. Sample Referral Protocol for study participants in case of an emergency

If a study participant exhibits any of these symptoms, please refer to a local health professional:

- Severe Agitation
- Severe Anxiousness
- Serious health conditions, which preclude providing, consent or completing the study (i.e., seizures, dizziness, passing out, etc.)
- Intoxication
- Overt Mental disorders
- Exhibiting Violence Behaviors
- Severe stigmatization or negative experiences

For mental health emergencies, we will refer to the University of Alabama Medical Center’s Betty Shirley Clinic- Dr. Thaddeus Ulzen-Chair- 205-348-

For all medical emergencies, we will refer to the Emergency Room of nearest hospital using the Alabama Hospital Association website (www.alaha.org) which lists all hospitals by county.

Contact numbers/staff persons:
Pamela Payne Foster, 205-348-5148

Susan Gaskins, 205-348-1027
Appendix 22. Study Participant Eligibility Screener

Inclusion Criteria for Pastors:

- Are you a Senior Pastor?  Y___N___
- At least 19 years of age?  Y___N___
- Do you self-identify as AA?  Y___N___
- Are you currently serving a predominately AA rural Alabama congregation (membership at least 80% AA)?  Y___N___
- Are you willing to give informed consent to participate?  Y___N___

Exclusion/Criteria for Congregations

- Has your congregation had any formal HIV/AIDS training (i.e. courses, series of speakers)  Y__ N____

Inclusion/Screen in criteria for Church Liaisons and Congregational Members:

- Are you affiliated with participating church located in rural Alabama as designated by RUCA coding?  Y____N____
- Are at least 19 years of age?  Y____N____
- Do you self-identify as AA?  Y__ N____
- Are you able to give informed consent to participate?  Y____N____

Inclusion/Screen in criteria for PLWHA:

- HIV diagnosis for at least 6 months to have some baseline length of stability in diagnosis  Y____N____
- At least 19 years of age  Y____N____
- Self-identified as AA  Y____N____
• Lives in rural Alabama as designated by RUCA codes
  Y_____N_____
• Able to understand and speak English
  Y_____N_____

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Appendix 23. References


Alabama Department of Public Health-Office of Primary Care and Rural Health. Assessed from website: www.adph.org/ruralhealth/


Centers for Disease Prevention. Executive Summary- Consultation on Faith and HIV Prevention. February 13-14, 2006, Atlanta, GA.


