

ONE
CONVERSATION
Community Forums on HIV/AIDS

HIV/AIDS Ministry Toolkit



FOREWORD

Deloris Dockrey, *Director of Community Organizing*

“My people perish from a lack of knowledge”

—Hosea 4:6

One Conversation is a public education, HIV prevention, and community action campaign. It was conceived and implemented by the late Riki Jacobs, Executive Director of Hyacinth from 1993 to 2009, and Rev. Warren Dennis, Director of Metro-Urban Ministry at New Brunswick Theological Seminary. Hyacinth's current Executive Director, Kathy Ahearn-O'Brien, continues to prioritize **One Conversation's** goal to raise awareness of HIV in communities disproportionately impacted by HIV/AIDS. For example, African Americans make up 13% of the population in the United States, but represent almost 50% of all HIV/AIDS cases. **One Conversation** raises new voices in the debate around HIV in the community. Since the first forum was hosted in 2005, we have presented educational forums in more than 50 churches, primarily in the greater Newark area.

In addition to forums, the program provides sessions to train church champions (clergy and lay leaders) to build and expand HIV/AIDS ministries in their churches. These activities have reached more than 1,000 individuals, including more than 400 in Essex County. The campaign also reached more than 1,000 individuals in 14 settings, including student organizations and vocational schools. I am also very proud of our Youth Project for young people ages 11–19 years.

Because of the complexity of the AIDS crisis, it became clear early on that church leaders needed a toolkit to provide information on HIV/AIDS and how it impacts their communities. We provide information that addresses fear, stigma, and homophobia and that may help build or strengthen HIV/AIDS ministries. It is my hope that this toolkit will increase knowledge, and help to bring an end to the fear and stigma, and eventually, to AIDS itself.

Covenant Statement

We believe that God created all human beings in God's likeness, and therefore all of God's children should be entitled to love, compassion, kindness and forgiveness.

We believe that all persons are deserving of the love and kindness God so richly provides to us all.

We are the agents of God's love and compassion and are committed to providing ministry, spiritual and medical, to those with HIV/AIDS.

—Clergy Advisory Board

ACKNOWLEDGEMENTS

We thank all of the individuals who have collaborated to produce the One Conversation HIV/AIDS Ministry Toolkit.

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1.1 Introduction

HIV does not discriminate, but Black Americans are much more likely than Whites to become infected. It is time for our pastors and congregations to take an active role to bring an end to this disease in our communities.

After 30 years, HIV is a modern epidemic nearly brought to its knees by a collaboration of the best resources that science, industry, government, and community have to offer. Thirty years ago, HIV was a virtually incurable disease that brought a horrible death to people in the prime years of their lives. It was a new disease doctors knew virtually nothing about. Today, after three decades of advocacy and medical breakthroughs, we are poised to write the final chapter.

We have learned a great deal about the HIV virus. We understand how it spreads, mutates in the body, and hides from the immune system. This knowledge has allowed us to develop interventions that prevent the spread of the virus through behavioral change and barriers to transmission, as well as how to interrupt and slow its life cycle, thus halting disease progression. We have changed HIV infection from a death sentence to a manageable condition. We also know that when viral replication is controlled, so is the risk of unintended transmission. There is much to celebrate and be proud of.

Yet we are falling short. The end of the epidemic is in sight, yet it remains out of reach. In the United States today, 20% of people living with HIV remain undiagnosed, and these individuals are responsible for up to 70% of new infections. Furthermore, of those people living with HIV who know their status, 50% are without care. As a result, these individuals are destined to come into care late and very sick. They are also the most likely to die from AIDS. These delays in diagnosis and access to care are due to multiple factors, including lack of insurance, untreated mental health and addiction, inaccurate health perception, low health literacy, and, of course, stigma and fear that remain the albatross around the neck of the epidemic. As a community we will not be able to end the spread of the virus if we are not able to reduce stigma, fear, and misinformation around HIV. We need to educate our community on how HIV is transmitted, how HIV can be prevented, and how HIV is managed and treated.

Paula Toynton

Hyacinth AIDS Foundation

1.2 Purpose

The One Conversation HIV/AIDS Ministry Toolkit was developed to help establish HIV/AIDS ministries amongst churches in New Jersey. African Americans are disproportionately affected by HIV/AIDS and for many people, the Church is the center of their social network and community. The Toolkit opens conversations, not just about HIV/AIDS but sexuality in general. Sex is viewed as a taboo subject within religious institutions, and discussions about sexual practices are discouraged, leaving people searching for guidance with nowhere to turn.

One Conversation, a public education, HIV prevention and community action program, was developed to raise awareness and encourage action to address the social crisis caused by the HIV/AIDS epidemic in New Jersey. The One Conversation HIV/AIDS Ministry Toolkit includes an informed conversation about the difficult issues surrounding the AIDS crisis. The Toolkit answers many questions about transmission, prevention, and management of the disease. The Toolkit will discuss what has inhibited an effective community response to the epidemic and the social justice issues that contribute to an environment that allows the epidemic to flourish. The Toolkit discusses what the community can do to bring the epidemic to an end.

There are already many churches that have mobilized and joined the fight against the epidemic. The participating clergy advisors provide personal accounts of their own experiences working with people living with HIV/AIDS, as well as liturgical resources to provide spiritual guidance on this journey.

2.1 The HIV/AIDS Landscape

The HIV/AIDS Timeline

- 1981 June 5—The Centers for Disease Control issues a warning about a relatively rare form of pneumonia among a small group of gay men later determined to be AIDS. This marks the beginning of the AIDS epidemic.
- 1982 The CDC officially establishes the term Acquired Immune Deficiency Syndrome. The disease refers to four “high-risk” groups: injection drug users (IDUs), gay men, Haitians, and hemophiliacs.
- 1983 The U.S. Public Health Service issues recommendations for preventing transmission through contact with blood and transfusions. The National Association of People Living with AIDS (NAPWA) and the National AIDS Network (NAN) are formed.
- 1984 The virus that causes AIDS is isolated and named the Human Immunodeficiency Virus (HIV).
- 1985 The first International AIDS Conference is held in Atlanta. Community-based organizations are created to serve people with AIDS around the country.
- 1987 AZT, the first antiretroviral drug for AIDS, is approved by the FDA. The AIDS Coalition To Unleash Power (ACT UP) is established in New York. President Reagan delivers his first AIDS-specific address.
- 1988 The World Health Organization (WHO) declares the first World AIDS Day on December 1.
- 1990 Ryan White dies at 18. The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act is passed to improve the quality and availability of care for people with AIDS. The FDA approves AZT for pediatric AIDS.
- 1991 The red ribbon becomes a worldwide symbol of AIDS awareness.
- 1995 The first protease inhibitor is approved by the FDA. Viral load proves a significant indicator of HIV disease progression.
- 1996 The International AIDS Conference introduces a radical new treatment paradigm: HAART (Highly Active Antiretroviral Therapy) and the use of viral load tests.
- 1997 For the first time, the CDC reports a decrease in AIDS deaths (by 40%) in the U.S.

- 1998 Health and Human Services Secretary Donna Shalala announces that needle exchange programs decrease the spread of HIV/AIDS and do not lead to increased drug use. The Minority AIDS Initiative is created after African American leaders declare a “state of emergency.”
- 2000 The Young Men’s Survey Study shows an alarming rise in risk behaviors and new infections in young men who have sex with men (MSM) of color. The Millennium Development Goals are announced, including the goal of reversal of the spread of HIV/AIDS.
- 2001 Officials note the spread of drug-resistant strains of HIV.
- 2002 U.S. FDA approves OraQuick rapid test.
- 2003 New Jersey still does not have syringe access or exchange programs.
- 2004 UNAIDS launches the Global Coalition on Women and AIDS to raise awareness of the epidemic’s impact on women and girls worldwide.
- 2007 New Jersey allows syringe exchange in the 6 highest-prevalence cities.
- 2008 New HIV incidence reports show that the epidemic is worse in the United States than previously thought.
- 2010 National AIDS Strategy signed by President Barack Obama.
- 2011 **June 5 marks 30 years since the first AIDS case was reported.** CDC announces the High-Impact HIV Prevention approach that includes addressing social determinants of the epidemic.
- 2012 The 19th International AIDS Conference held in Washington, D.C. This is the first time in 22 years that the conference is in the United States.

Timeline from the Kaiser Family Foundation
Source: Kaiser Family Foundation

Surveillance



United States

- Since the beginning of the epidemic, 1.7 million people have been diagnosed with HIV
- 1.2 million people currently live with HIV/AIDS
- 615,000 people have died
- 56,000 Americans become infected with HIV every year
- Every 9 ½ minutes, someone in the United States is infected with HIV
- 1 out of 5 people are unaware that they are HIV positive
- The 20% of people who do not know they are HIV positive account for 40-70% of all new infections
- MSM remain the group most severely affected by HIV
- 31% of all new infections are through heterosexual contact
- Women account for 27% of all new infections
- Injection drug users represent 12% of new infections
- African Americans make up 13% of the U.S. population but 48% of all people living with HIV
- The rate of infection amongst Latino/Hispanic men is double that of White men
- The rate of infection amongst Latina/Hispanic women is 4 times that of White women



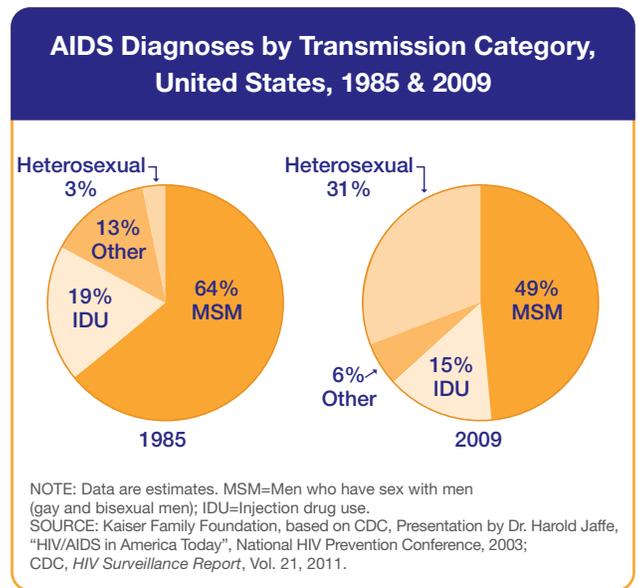
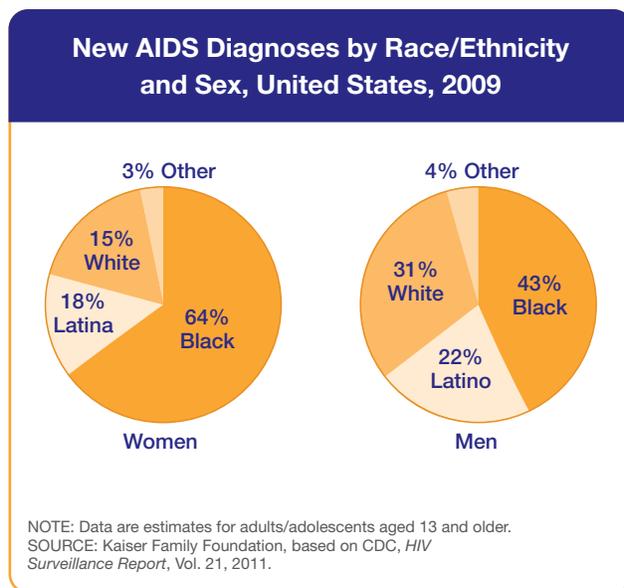
New Jersey

- As of December 2010, cumulative HIV/AIDS cases exceeded 75,000
- Minority populations account for 76% of cumulative cases
- 35,688 people are currently living with HIV or AIDS in New Jersey
- Injection drug use and sexual contact remain the major modes of exposure to HIV infection
- 3 out of 4 people living with HIV/AIDS are 40 years old or older
- Women make up 35% of people living with HIV/AIDS
- Of all the women living with HIV/AIDS, 59% are 20-49 years old
- African Americans make up 14% of New Jersey's population and 54% of New Jersey's residents living with HIV/AIDS
- African Americans have less access to appropriate healthcare and access the healthcare system less frequently than their White counterparts
- 64% of women living with HIV/AIDS were exposed through heterosexual transmission
- Essex County has the highest number of residents living with AIDS, approximately 9,644
- Of that number, 8,760 are located in Newark alone

How HIV/AIDS Affects Different Populations

Women and HIV

At some point in her life, 1 out of 32 African American women will be diagnosed with HIV. Women are faced with unique social obstacles in preventing and treating HIV/AIDS. Relationship dynamics play a role because often a woman is too afraid to ask her partner to wear a condom during sex. She fears her partner will be offended or assume that she is being unfaithful. The fear of losing their partner prevents women from protecting themselves. Another obstacle is lack of education. Some women become infected because they are unaware of their partner’s risk of contracting HIV, or they lack knowledge about the disease and do not believe that they are at any risk of contracting HIV themselves. Some women still believe that HIV is a “man’s disease” or that they are safe because they’re in a monogamous relationship. However, 31% of all new infections are through heterosexual contact. Women who have suffered abuse are more likely to turn to drugs, putting themselves at risk for infection as well. Injection drug users are more likely to engage in high-risk behavior such as having multiple sexual partners, sharing contaminated needles, and engaging in unprotected sex. Poverty is a systemic issue that contributes to women’s increased risk of becoming infected. Limited access to quality healthcare, exchanging sex for money, drugs, or personal needs, and higher levels of drug use are all factors that increase a woman’s chance of becoming infected with HIV.



Men and HIV

MSM represent 2% of the U.S. population, yet have the highest rates of HIV infection. From 2006 to 2009, HIV infections amongst African American gay and bisexual men increased 48% and accounted for 61% of all new infections (2009). Stigma and homophobia have an enormous impact on the sexual health of MSM, limiting many men's willingness to get tested and seek treatment and potentially isolating them from family and community support. The stigma that surrounds HIV/AIDS, especially amongst MSM, creates cultural barriers as well. Another obstacle men are faced with is incarceration. Although sexual activities are forbidden under prison rules, both consensual and non-consensual sex are common amongst inmates. Condoms are considered contraband and are not readily available, putting inmates at greater risk for infection. Due to the stigma surrounding homosexuality in many cultures, heterosexual men who had participated in sexual activities while incarcerated may not disclose to their partner at home, increasing the risk of infection. Like women, men who are injection drug users are at a higher risk of contracting HIV.

Children and HIV

Most children infected with HIV before the age of 13 are infected during pregnancy, childbirth, or breast-feeding, although treatment and prevention methods have reduced the risk of transmission through these modes to about 2%. Many children with HIV reach adolescence without issue; however, 20% will develop an opportunistic infection within the first year of their life. Children with HIV suffer common childhood infections such as recurrent colds, fever, and diarrhea more frequently and severely than uninfected children and are susceptible to the same opportunistic infections (OIs) as adults. Medication adherence may be a problem for children as well.

Youth and HIV

Young people in the U.S. are at risk for contracting HIV. The risk is especially high for young, gay African American MSM. In 2009, young adults ages 13-29 accounted for 39% of all new infections; 69% of that population was MSM. The medical community is faced with prevention challenges specific to young adults. According to the National Youth Risk Behavior Survey, many adolescents start having sex at young ages (46% in high school), sometimes before they can be properly educated about safer sex. Research has shown that a large percentage of young adults are not concerned with contracting HIV, which can translate into not taking measures to protect themselves from contracting the virus or getting tested. Normal adolescent behavior, such as risk taking, experimenting with independence, and having a sense of invulnerability, can be detrimental to infected youth. According to HIV Care For Youth, a DHHS-supported training program, the resentment of having to depend on healthcare providers and family may result in poor adherence and isolation. Some of the goals in treating young adults living with HIV are to identify and

address crises (homelessness, depression), promote adherence to treatment plans, support development of self-care, and reinforce and sustain safer sex behaviors. There are also resources available for parents to help care for their HIV-positive children. More resources are available at www.CDC.gov and www.hivcareforyouth.org.

HIV and Older Adults

HIV is increasingly affecting adults age 50 and over. With the help of antiretroviral therapy (ART), people are living longer and healthier lives. There is also an increase in new diagnoses among this population. There is an accepted assumption amongst the younger population that once a person reaches 50 years old, they are no longer sexually active. Healthcare providers are less likely to discuss safer sex practices and HIV/AIDS prevention with older adults. Likewise, older adults are less likely to open up about sexual practices and possible drug use with their healthcare providers. Some older adults also assume that once they are past childbearing years, there is no need to use protection. Both of these statements are untrue and have helped contribute to the increased infection rates amongst the older population. In 2005, people age 50+ accounted for 19% of new infections. Also contributing to the increase of HIV among older adults is the lack of knowledge about the disease. Younger populations learn about HIV/AIDS and other sexually transmitted infections (STIs) in school, where older adults did not have the same education regarding prevention and transmission. There are age-related risks as well. In women over 50, vaginal thinning or drying leads to tearing that makes it easier for the virus to be transmitted during sexual intercourse. There are also the expected health concerns such as a weaker immune system. This generation was already into adulthood when HIV/AIDS first came into the public arena, and the fear and stigma surrounding the disease are not easily forgotten. For more information regarding older adults and HIV, please visit www.CDC.gov or www.AIDS.gov.

Basic Facts

About the HIV Virus

- A virus is genetic material (RNA or DNA) wrapped in proteins or fatty acids
- HIV has two strands of RNA
- HIV attacks the body's white blood cells to replicate. This destroys the immune system and makes people more likely to get other infections. When a person becomes very sick from HIV because their immune system has been so damaged, they have developed AIDS
- One infected T cell makes 10,000,000 copies of the virus
- 2-10 billion copies are made daily
- To see a model of the virus life cycle, visit: http://www.aidsinfo.nih.gov/contentfiles/HIVLifeCycle_FS_en.pdf

Stages of HIV Infection

Window Period

- The 3-6 month time period during which antibodies develop
- HIV can be transmitted

Acute Initial Infection

- Some people may experience flu-like symptoms
- Usually lasts between 1-2 weeks
- Virus is extremely active during this time
- HIV can be transmitted

Chronic Asymptomatic Stage

- No signs or symptoms
- Average of 7-10 years
- Infected persons look and feel healthy
- HIV can be transmitted
- Virus is reproducing and attacking immune system
- Not enough damage has been done to cause illness

Chronic Symptomatic Stage

- Severe and persistent symptoms and illnesses began to appear, such as:
 - Swollen glands
 - Unexplained night sweats
 - Headaches, nasal congestion
 - Painful white lesions in mouth
 - Shortness of breath
 - Change in bowel habits
 - Muscle/joint pain
 - Opportunistic infections
 - Low-grade fevers (100-101 degrees)
 - Unwarranted fatigue
 - Sore throat
 - Cough
 - Abdominal pain
 - Change in skin
 - Gynecological changes
 - Early stage dementia

AIDS

- The immune system is severely impaired
- Public Health Services guidelines define AIDS as CD4 cell counts below 200
- Cannot fight off life-threatening diseases
- Opportunistic infections appear

Risk and Transmission

Transmission:

There are 3 modes of transmission of HIV.

- Unprotected sexual intercourse—This includes vaginal, anal, and oral sex. People who have unprotected sex are putting themselves at a greater risk of contracting HIV.
- Perinatal—It is possible for HIV to spread from mother to child during pregnancy, birth, and breast-feeding. During pregnancy, amniotic fluid can transmit the virus. During a vaginal birth, the baby is exposed to blood that could be carrying HIV. During breast-feeding, HIV is spread because breast milk contains immune cells.
- Contaminated injection equipment—Sharing contaminated needles is another way that HIV is spread, especially amongst injection drug users. The stigma surrounding drug use as well as the fear of getting caught leads people to share needles.

There are 4 bodily fluids through which HIV is spread; it is important to wear latex gloves when coming in contact with any of these fluids.

- Blood
- Semen
- Vaginal fluids
- Breast milk

These fluids contain immune cells, which are affected by HIV.

Other fluids that do NOT contain immune cells are:

- Sweat
- Feces
- Saliva
- Urine

Although HIV is not spread through these fluids, universal precautions should always be used, including wearing latex gloves. Other ways HIV is NOT spread are through:

- Hugging
- Casual kissing
- Sharing a drinking glass
- Using the same toilet as someone who is HIV positive
- Holding hands

Sexually Transmitted Diseases and HIV

People who have already been diagnosed with an STI are at greater risk of contracting HIV. STIs like herpes or syphilis can cause open sores, which makes it easier for HIV to enter the bloodstream. Inflammation due to genital ulcers increases the concentration of immune cells in genital secretions that serve as targets for HIV. The presence of an STI also appears to increase the ability of an HIV-infected person to transmit the virus to their partner. Studies have shown that there is a higher concentration of HIV in the genital secretions of people who are co-infected with an STI than of those who are not. The higher the concentration of HIV in the fluids, the more likely it is that HIV will be transmitted to a sexual partner. For more information, please visit www.AIDS.gov and www.CDC.gov.

HIV/AIDS Prevention

Here are some simple ways to prevent HIV transmission.

Avoid Unprotected Sexual Intercourse

HIV is spread through vaginal, anal, and oral sex with an infected person.

Prevention Intervention:

- Abstinence—Abstaining from any sexual contact is a sure-fire way to reduce the risk of contracting HIV. This includes oral sex, a method that many people do not consider sex. It is!
- Safer sex—Wearing a condom (male or female) every time a person has sex (including oral!) is one way to prevent contracting HIV. The latex or polyurethane material acts as a barrier through which HIV cannot penetrate.
- Abstaining from drugs and alcohol—Being drunk or high affects your ability to make healthy choices and lowers your inhibitions, leading you to take risks you are less likely to take when you are sober, such as having sex without a condom.

Avoid Blood-to-Blood Transmission

Prevention Intervention:

- Abstaining from injection drug use is one way to prevent blood-to-blood contact. Injection drug users represent about 41% of new HIV infections in New Jersey annually.
- Clean injection equipment—For those who continue to use injection drugs, using clean needles will prevent the transmission of HIV. Syringe exchange programs reduce transmission of HIV by 40%

among IDUs. In New Jersey, there are five needle exchange sites. On January 17, 2012, a law was enacted that allows people to purchase a limited number of syringes at pharmacies without a prescription. Both the program and the law allow easier access to clean needles.

Perinatal

Prevention Intervention:

- 01** Know your status—Perinatal transmission is the transmission of HIV from mother to child during pregnancy, during the birthing process, or after birth through breast-feeding. Pregnant women who know they are HIV positive can get into treatment to reduce the risk of transmission to their children.
- 02** Get into treatment—With the approval of the antiretroviral drug AZT for pregnant women, transmission from mother to child during pregnancy and delivery has decreased to about 2%.
- 03** Follow medical guidelines—CDC guidelines recommend that HIV-positive mothers not breast-feed their children. Because breast milk contains immune cells, there is a risk of transmitting the virus. Using formula is recommended as an alternative in order to prevent transmission.
- 04** In New Jersey, all pregnant women should be tested for HIV in the first and third trimester of their pregnancy. If her HIV status is unknown at the point of delivery, the mother must be offered an HIV test that she can opt out of; however, the newborn will be tested for HIV.

Sources: NJDOH, AIDS.gov, CDC, drugpolicy.org

Getting Tested

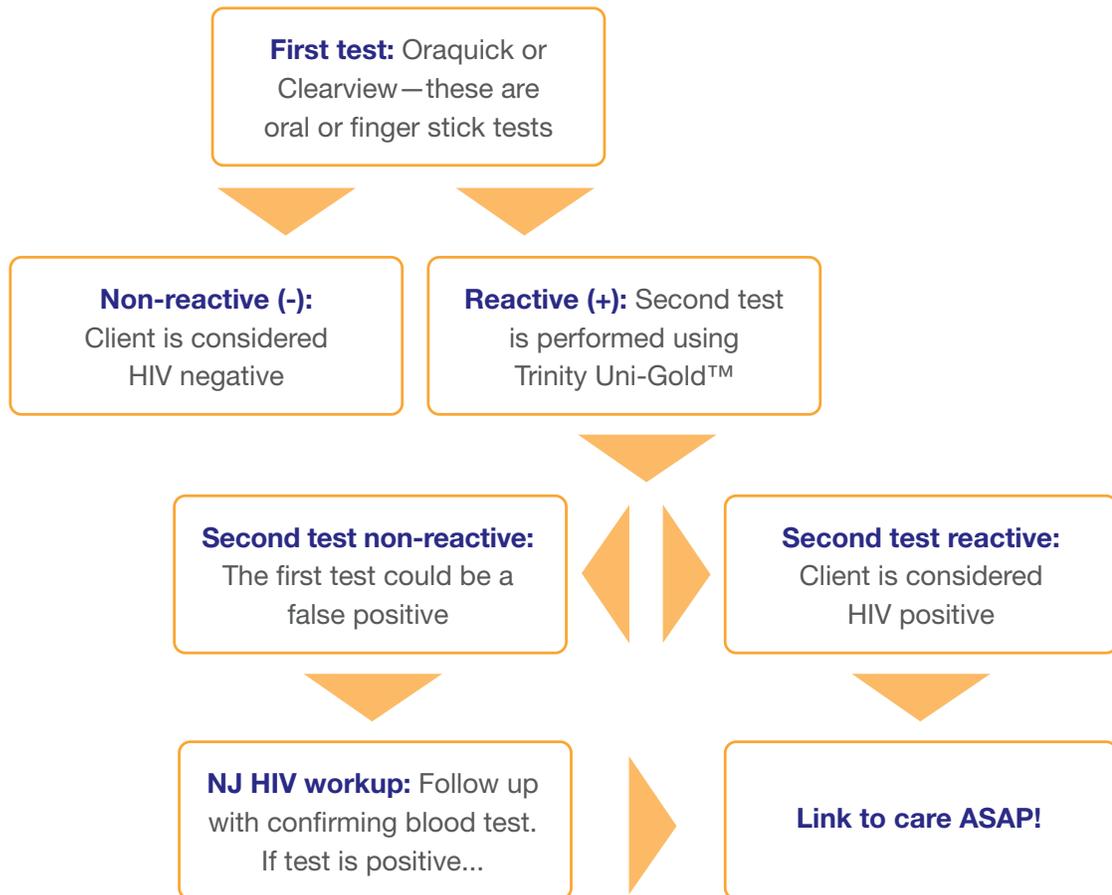
Know your status!

It is important for everyone to know their HIV status. People who are sexually active, especially those with multiple sex partners, should be tested regularly. In the United States, 20% of people who are unaware of their status are responsible for about 40-70% of all new infections annually. Receiving treatment sooner rather than later results in clinical benefits for the individual and a potentially enormous public health benefit by slowing the spread of infection. Knowing your status is the first step in ending the epidemic.

There are multiple tests available on the market today. New technology allows for rapid testing and quick results so patients can receive follow-up care and enter treatment as soon as possible. Counselors are available at testing sites to help newly infected patients deal with their diagnosis and begin to navigate the healthcare system.

Below is a diagram of the testing process to help you become familiar with NJ testing practices.

NJ Rapid Test



Medical Management of HIV

Tracking the Disease

The first step in any treatment program is to GET TESTED! If there is any chance of exposure, getting tested is the only way to obtain a diagnosis and begin treatment. Treatment of HIV includes medications, regular doctor visits and testing, finding a support system, and becoming an advocate.

Antiretroviral Therapy (ART)

ART is the treatment of HIV with medications offered in combination, usually from more than one drug class, in order to prevent drug resistance and improve the performance of the medication. These drugs cannot cure AIDS; however, they reduce the viral load (the amount of HIV in the bloodstream). With the help of ART, some people can get their viral load so low that it is undetectable. This does not mean that they are cured of the infection. Each antiretroviral drug has its own side effects, such as weight gain and liver and kidney problems. Some drugs are more easily tolerated than others. Discussing options with a healthcare provider is an important step in treating HIV.

Treating Opportunistic Infections

Infections that take advantage of weakness in the immune system are called opportunistic infections (OIs). OIs occur when the immune system is too weak to manage the germs carried in the body. A healthy immune system can control these bacteria, protozoa, fungi, and viruses. When the immune system is damaged by HIV/AIDS, these germs get out of control and cause health problems. The rates of OIs have fallen due to antiretroviral therapies; however, they are still a problem, especially for people who do not know they are infected. The most common OIs include:

- Candidiasis (thrush)—A fungal infection of the mouth, throat, or vagina
- Herpes simplex viruses—Oral (cold sores) or genital herpes are common but outbreaks are more frequent in people with HIV/AIDS
- Pneumocystis pneumonia—A fungal infection that can cause fatal pneumonia
- Toxoplasmosis—A fungal infection of the brain
- Tuberculosis—A bacterial infection that attacks the lungs and can cause meningitis

For each OI, there are specific drugs or combinations that seem to work best.

Complementary and Alternative Medicine (CAM)

CAM is a diverse group of medical and healthcare systems, practices, and products that are not presently considered to be part of conventional medicine (medicine practiced by holders of an MD and medical license). Complementary medicine is used together with conventional medicine, while alternative medicine is used in place of conventional medicine. The National Center of Complementary and Alternative Medicine, a component of the National Institutes of Health, has issued guidelines for practices that constitute CAM. Some practices include:

- Mind-body medicine
- Biologically based practices
- Manipulative and body-based practices
- Energy medicine

It is important for patients to decide what course of treatment they would like to try and discuss it with their healthcare providers. Some providers are open to CAM; some are conservative and believe that medication is the best course of action.

Become an Active Participant

Many patients do better when they take an active role in planning their own healthcare. They actively research treatment plans and current news about HIV/AIDS. These patients bring their own information to the healthcare provider and work as a team to determine the best course of treatment. Some advice to being an advocate for care includes:

- Make sure the provider has all the information he or she needs to give the best advice about treatment. This starts with medical records. Having a personal copy will help patients bring new doctors up to date with their progress.
- Patients must express their feelings about using medications and their illness. Some people don't mind taking a lot of pills while others prefer a more holistic approach to treatment.
- Honesty about lifestyle is critical as well. It's important that providers know a patient's eating, sleeping, and work habits. Sexual practices and drug use will also make a difference in healthcare. If a provider seems judgmental, the patient should be encouraged to seek someone they feel comfortable with.
- Providing emergency contacts and names of people in the client's support network is helpful to providers. If there is a medical emergency, providers can contact these people and vice versa. They are also the people who will support the client and help make medical decisions if he or she becomes ill and they will need to know proper directions for giving care.

Choosing a Healthcare Professional

Because HIV is a complex disease, people living with HIV need to find a health professional (this could be a doctor, nurse practitioner, or physician's assistant) with special training. Although knowledge and experience are critical, it is also important to choose a health professional who is likable. Patients need to feel comfortable because part of managing HIV is being open about sexual activity, drug use, and other aspects of a patient's personal life that they may not want to disclose. A healthcare professional is a partner in fighting the disease. He or she will be there for a long time, not only providing medical treatment but helping patients cope with the ups and downs of HIV/AIDS. It's key that patients find someone they are comfortable talking to.

Case Management

Case management is an umbrella term for coordinating HIV/AIDS care and support services. It includes collaboration between a person living with HIV/AIDS and their healthcare professional, support system, and consumer service agencies. There are multiple aspects to case management, all of which are vital to maintaining a long and healthy life.

Source: The Body (thebody.com)

In recent years, researchers have classified HIV as a chronic manageable disease and have stated that if people living with HIV are diagnosed early and linked to medical care they can live a normal life span. Among the most important scientific advances presented in the past year are the results of the HIV Prevention Trials Network (HPTN) 052 study. This randomized trial shows that HIV transmission can be reduced by up to 96% if HIV-positive people start ART early, and proves that treatment can effectively work as prevention. Thanks to this research, we can use this knowledge to our advantage—developing ingenious ways to prevent HIV transmission.

The following links provide more information on these advances:

Treatment as prevention and the findings from the HPTN 052 study:

NEJM article on HPTN 052: <http://www.nejm.org/doi/pdf/10.1056/NEJMoa1105243>

NIH on the famous HPTN 052 study that supports “treatment as prevention”:
<http://www.niaid.nih.gov/news/Qa/pages/hptn052qa.aspx>

CDC on high-impact HIV prevention: <http://www.cdc.gov/hiv/strategy/hihp/>

The effects of inflammation in people living with HIV/AIDS:

CROI 2012 studies on HIV and inflammation (NATAP report):
http://www.natap.org/2012/CROI/croi_69.htm

Tim Horn on HIV and aging:
http://www.aidsmeds.com/articles/hiv_aging_inflammation_2042_18256.shtml

Current guidelines for treatment of people living with HIV/AIDS:

DHHS link to imbed in your document: <http://www.aidsinfo.nih.gov/guidelines/>

Additional information on the HIV epidemic:

<http://www.kff.org/globalhealth/7124.cfm>

“We know a great deal about the HIV virus. We understand how it is spread, how it constantly mutates in the body, and how it hides from the immune system. This knowledge has allowed us to develop interventions that prevent the spread of the virus through behavioral change and barriers to transmission, as well as how to interrupt and slow its life cycle, thus halting disease progression. We have changed HIV infection from a death sentence to a manageable condition.”

—Paula Toynton

Abbreviations

This is a list of common acronyms used throughout the Toolkit with their definitions.

AIDS: Acquired immune deficiency syndrome

ART: Antiretroviral therapy

ARV: Antiretrovirals

CDC: Centers for Disease Control and Prevention

DHHS: Department of Health and Human Services

IDU: Injection drug user

MSM: Men who have sex with men

NIH: National Institutes of Health

NJDOH: New Jersey Department of Health (formerly NJDHSS, New Jersey Department of Health and Senior Services)

OI: Opportunistic infections

OSHA: Occupational Safety and Health Administration

PLWHA: People living with HIV/AIDS

WHO: World Health Organization

Myth vs. Truth

Although the HIV/AIDS epidemic has reached its thirtieth anniversary, there are still myths circulating about the disease. It's this misinformation that prevents HIV-positive people from reaching out to access care and propels the stigma surrounding HIV/AIDS. Below are a few common myths and the truth:

Myth: HIV is a curable disease.

Truth: There is no known cure for HIV. Proper care, including antiretroviral therapies, is allowing people to live longer.

Myth: You can tell someone has AIDS just by looking at them.

Truth: The symptoms of HIV are not always visible. HIV affects people indiscriminately, so there is no way to tell if someone is infected unless they disclose their status.

Myth: Someone who has HIV also has AIDS.

Truth: HIV is the virus that causes AIDS. A person with a diagnosis of HIV can live for several years before they are diagnosed with AIDS. They may never reach an AIDS diagnosis.

Myth: You can contract HIV from public toilets.

Truth: HIV cannot survive outside the body, so it is perfectly safe to use the same toilet as someone who is HIV positive. It's also safe to share saunas and hot tubs.

Myth: HIV is only a "gay disease."

Truth: HIV affects gay AND straight populations. In fact, there were 11,200 women infected with HIV in 2009, 64% of whom contracted through heterosexual contact.

Myth: I am not at risk because I am in a monogamous relationship.

Truth: If your partner is having unprotected sex with someone who is infected, you are at risk.

2.2 Voices of the Epidemic



The Story of George and Francis

George and Francis met as volunteers at church. They courted for 2 years and eventually married, in the same church. With their friends as witnesses, they celebrated their lives and what their life together would bring.

There was a time for both of them when neither could see a life of much happiness. George had been an injection drug user for many years. Now he was in recovery for 10 years and spoke often about the hope and strength he found when he came to the church community. Francis was widowed young with 2 children. For her, the people of the church were there to help her raise her children, who she was proud to say both went to college.

A year after their wedding, George developed a dry cough that wouldn't go away and got progressively worse. He was very tired all the time. One day while climbing the stairs in their house, he couldn't catch his breath. Francis called 911, and George was taken to the emergency room and diagnosed as HIV positive with PCP pneumonia.

George had AIDS. Francis took the test, and she too was positive. They both met with the medical case manager at the clinic and saw the infectious disease doctor. Francis still had a very healthy immune system and low viral count. She most likely was infected by George and had not been positive very long. George, on the other hand, had a very compromised immune system and high viral load. The doctor thought he most likely was infected when he was still shooting drugs, over 10 years ago.

The grief and shame of their diagnoses overwhelmed them. They were afraid to turn to their friends at church for fear of rejection. Believing that he would die, George became very depressed and did not care for his illness the way he could or should have. He died the following summer. Her friends at the church rallied around Francis to comfort her. She told them George had died of cancer.

After his death, her doctor talked about the importance of her treatment and the need for support. HIV/AIDS was only whispered about at church, so she turned to an HIV community support group. There she learned that HIV was not a death sentence. Francis discovered that she had choices and control over her care. This filled her with hope and faith. And as part of her journey she began a quest for spiritual healing. No longer ashamed, she sought justice and honor for the memory of her beloved George. And so she returned to her church asking for their support to start an AIDS ministry in his name. Eventually, she shared with them her own status. In doing so, she encouraged others to step forward and find the hope to speak and to heal their losses.

The story of George and Francis illustrates the losses of health, life, and relationships that come from not knowing the truth. It speaks to the unintended damage done to all by whispers and silence. But it also shouts of spiritual and physical opportunities that can be found in knowledge, friendship, faith, and hope.



Jay's Story

Jay is a proud father of 3 daughters and grandpa of 3 granddaughters. He has lived a life of service to both his church and community through his work with youth and as an advocate for Hyacinth's One Conversation initiative.

Growing up in the church, I suppressed things that I knew about myself because of what other people thought. I was told homosexuality was a sin regardless of what I felt, and through God it could be overcome. One of the main reasons I became an advocate is because so many people get that message and that is not the right message. God wants us to live life and love one another and I believe that God's concern is about our spirit. So I am far more spiritual than I am religious because my experience has taught me that religion can be bondage.

Growing up, you're taught what is right and what is wrong, but until you experience life you don't really understand. It took moving abroad for me to become really in tune with my spirit. I lived in Masawa, Japan, for 5 years where I worked with youth through the Boys and Girls Clubs of America, which taught me that you don't have to be in the church to do God's work.

Not long after I returned to the States, I was diagnosed with HIV. I began to spend more time within my community rather than in the church. In my struggle with being HIV positive, the church didn't offer support. Twenty years ago you could not have told me that I'd have a positive spirit and mind to be able to stand up before people and say "I am HIV positive." That's the message I feel needs to be put out there because there are so many people who suffer because they don't have that refuge, but the refuge is within you.

I believe there is so much that faith leaders can do to help get this message to our communities. I believe they can and should offer more support for people living with HIV. Their role is crucial to ending the epidemic. So many people turn to the church for support as I did my entire life, but the church needs to be equipped to help all of us, even those of us who are HIV positive.

“For God so loved the world, that he gave his only begotten Son, that whosoever believeth in him should not perish, but have everlasting life.”

— John 3:16

Jay's message demonstrates the need for the church to consider how it can be a refuge to everyone, not only those who fit a specific mold. His story highlights the need for an HIV ministry in every church that offers support to those who are often stigmatized and who are in their greatest time of need. He tells his story with passion and conviction that all souls are equally worthy of being saved and that God does not discern between gay and straight or on the basis of HIV status.



Cheryl's Story

Cheryl is retired from the department of corrections and currently volunteers at her church as an administrator. In the past, Cheryl established an HIV ministry called HOPE (Helping Other People Endure).

I first learned of my diagnosis in 1990, not long after my sister had learned she was positive. I still remember the day I went in for testing. It was rainy and dreary; I snuck into the hospital under the cloak of darkness. When I finally came in for the results and was told I had HIV, they said they tested it twice, and back then a diagnosis meant you had about 18 months to live. When you hear something like that you start preparing, so I joined a support group of about 12 others, including my sister, and began attending early intervention clinics.

From 1990 to 1994 it seemed like every other day I was dressed for a funeral. My sister's boyfriend died of AIDS in 1990, and so did every other member of my support group within the next 4 years. My husband passed in 1994, and 2 months later so did my baby sister; she was the last of our group to die, and I took over as caretaker of her son. I am the only one who is still alive, but HIV is not about dying anymore, it's about living.

Oftentimes the church can be such a place of stigma. When I first disclosed to adults, I could see their body language change. When we were asked to hug in church, people would go the other way. When you're sick with HIV, you really become sensitive to that. That is why I founded an HIV ministry called HOPE, because everyone has a right to have a relationship with Jesus, even if they have HIV/AIDS. I work to have congregants feel at ease and to let them know they belong in the church. Some people I know who are positive are afraid to tell anyone, even their own parents. When I disclosed my positive status to my pastor, I was scared that he would treat me differently, but he never did (and that isn't the case for everyone). His hugs never changed, nor did the way he talked to me; he only asked me how he could become better equipped to deal with this—and that is how I started HOPE ministry.

Through my experience I learned that we need to love people the way they are. We need to focus on what the church can do to help those who are positive and prevent new infections. This is the only way we will stop the progression of this disease.

“ I will praise thee; for I am fearfully and wonderfully made: marvelous are thy works; and that my soul knoweth right well. ”

—Psalms 139:14

Cheryl's story shows the prevalence of HIV/AIDS within our communities and throughout all walks of life. Her story highlights the stigma associated with HIV/AIDS within the church community and how establishing an HIV ministry can diminish this stigma. She has personal experience with how this ministry can help the infected have a relationship with God and how it can educate others to prevent the spread of new infections by involving leaders of the faith community and activating them to spread knowledge of the disease.



Jacquelyn's Story

Jacquelyn is a mother of 3 and currently works at a hospital doing counseling and testing. She also serves her church by running an HIV ministry, a position she has held and loved for the last 5 years.

Although I did not attend church often as a young girl, I grew up always believing in God, but it wasn't until later that I really formed a relationship with Him.

In my thirties I found myself in a bad situation. I was tied to a relationship with a person who was using drugs and I started using them too; that's what our relationship was based on. Once I realized this, I was able to end it, but it was difficult and I continued to abuse drugs.

I learned of my HIV status just after giving birth to my second child. I continued to struggle with my addiction for some time. I sought support through group homes and NA meetings, but something was always missing: people just weren't close enough. What the groups really lacked was spirituality, and thinking back on it, they needed to learn that we can't always do everything ourselves. We need to learn how to accept help, and that help comes from God.

After receiving an invitation from an acquaintance, I walked into church for the first time in many years and I felt a closeness that is hard to explain. I still remember that day when the pastor's wife sat with me and told me of their HIV ministry. Hearing this brought me overwhelming relief, to know that I could really be myself in this community.

As a person of faith, I believe that we need to realize God loves everyone and we should do the same.

My advice to all faith leaders is to ask yourself what you would do if someone very close to you became HIV positive, because it could happen to anyone. Whether it be starting prayer groups or educational groups for people who are not positive, it is important that faith leaders sit in and be a part of it. Through my personal experience of leading an HIV ministry, I see how crucial these groups can be.

“Trust in the Lord with all your heart and lean not on your own understanding.”

—Proverbs 3:15

Jacquelyn's story is a testament to the important role the church plays in the faith community and how influential faith leaders can be in helping those with HIV overcome hardship. Leaders of the faith community are in a position to reach so many who are infected with HIV as well as educate others in order to prevent new infections. By establishing HIV ministries we can help others find this same peace and be one step closer to bringing this epidemic to its conclusion.



Polly's Story

Polly was diagnosed with HIV in 2007 and has turned to her faith to help her overcome drug addiction and be at peace with her diagnosis. She has lost many friends and family to the disease and hopes that through her story she can prevent the loss of others and raise awareness of HIV/AIDS within our communities.

I was born a Baptist and spent the first 16 years of my life in a Baptist church, but I have attended many churches of different denominations. My faith in God has always been strong and helped me through many struggles. In the past, I battled with drug addiction for many years. There were times I was able to quit, but I was on and off again for many years, up until I learned of my diagnosis in 2007.

There is so much stigma surrounding HIV/AIDS, especially in the church. My brother, who was also positive, was diagnosed with HIV in 1999. We had made arrangements with our pastor to do his eulogy before he passed in 2000, but when the time came our pastor refused, when he learned my brother died from complications related to HIV/AIDS. It wasn't long after that my family and I sought out a new church.

While in an HIV/AIDS housing program at Imani Park, I attended a new church with a pastor who supported me. When I told her about my diagnosis, she wanted to establish an HIV ministry, and she never treated me differently or told anyone about my status. On graduation day from the program, I invited my pastor and her husband to tell him about my status. But when I disclosed to her husband, he was not supportive or educated about HIV. He told me he believed disease was retribution from God. It wasn't long after that my pastor passed away and he took over as head pastor. As I had many times before, I left the church, and I haven't attended regularly since.

So my question to faith leaders is, how are we going to deal with this disease that is affecting our communities? You all say you love God, but when you have an opportunity to help those with HIV, many leaders ignore the problem when there is so much they can do to help.

“Be still, and know that I am God: I will be exalted among the nations, I will be exalted in the earth.”

—Psalms 46:10

Polly's story shows how the church can foster an environment of stigma surrounding HIV/AIDS, causing some congregants to avoid attending. Although she is currently looking for a new church, Polly has left many because of the lack of education and outreach for HIV/AIDS as well as the mistreatment of her and others who are positive. By establishing an HIV ministry, faith leaders are in a position to reach so many by offering support and a place of refuge.

3.1 Liturgy

What Does Our Faith Say?

“Compassion is when you are aware of people’s pain and you are moved to help them or you suffer with them.”

—Reverend Jerry Sanders, Fountain Baptist Church

Fear and Stigma in the Church

by Reverend Gerald Bailey

“God has not given us the spirit of fear, but power, love, and a sound mind.”

—2 Timothy 1:7

During the early years when HIV was discovered and diagnosed, absolute fear and panic prevailed, not only in the general population, but also in the Church of God. The fear was that people infected with HIV could spread the virus with their breath or touch. That fear was understandable—even doctors, dentists, healthcare providers, morticians, and medical examiners turned their backs on HIV patients for fear of becoming infected.

Since the 80s, medical science has determined that HIV is spread by 4 bodily fluids: blood, semen (including pre-ejaculatory fluid), vaginal fluids, and breast milk. And that the mode of transmission is either sex (anal, vaginal, or oral), blood to blood, or perinatal (mother to child). Thus there’s no reason to worry unless people put themselves at risk from the above categories or choose to remain ignorant of HIV. One definition of fear is lack of knowledge. And one spiritual definition of fear is lack of faith.

Hence, we should neither fear nor perish, because we have the knowledge to keep ourselves safe. People living with HIV/AIDS (PLWHA) have embraced the reality that HIV is no longer a death sentence, that they are more than the HIV virus. Fear has also diminished because PLWHA know that if they take their medications, eat well, get their proper rest, and protect themselves from new infections, they can live a long and healthy life.

Today, the Church doesn't fear its members becoming infected as much as it fears being stigmatized as a Church or denomination whose members have HIV/AIDS.

I deliberately use the word "stigmatized" in the same way the world often labels those with HIV and ostracizes them and their families. Pastors and churches who have dared to embrace PLWHA and build aggressive HIV ministries have had to empower their congregations to fight their fear with faith and to encourage their church leaders, particularly, to open church doors wide to receive *all* who labor and are heavy laden (that they may receive their rest) among the people of God.

Modern-day fear of HIV/AIDS in the Church has more to do with the pastor's reluctance or anxiety over how to confront his/her congregation and its leaders to reach out and embrace "those people" who have the virus. The Church's profile in the community is highly valued. My experience has been that churches often avoid those very souls with whom Jesus would have sat down and broken bread. They are outcast because of their sexual orientation or because they are prostitutes, alcoholics, drug users, or former convicts. Not many pastors want their church to be known as "the HIV Church."

The question every pastor, church leader, or member should be afraid of today is not whether a member of their church is HIV positive. Instead, the most dreaded question is "when I was hungry, why didn't you feed me; when I was thirsty, why didn't you give me drink; when I was homeless, why didn't you help house me; when I was HIV positive, why didn't you minister to me?" (from Matthew 25:35).

God has not given us the spirit of fear, but a spirit to be more than conquerors, to weep with those that weep, help the fallen, the downtrodden, helpless, hopeless, the Samaritans, the unchurched, the lepers, the prisoners, the orphaned, the widowed, and even those with HIV.

“ I could deal with the children or the women who were infected, but not gays and lesbians. I was judgmental. In about a year, I was convicted. I realized that anybody could get HIV. I did crazy things in college. I was promiscuous and I realized it was the luck of the draw. I came to understand that God loves all people; there is no bias with Him. I slowly began to accept. As a minister, if you're in front of a person who is hurting, it is your responsibility to help them.”

—Reverend Gerald Bailey

About Change

by Reverend Gerald Bailey

We have heard over the years that Jesus “is the same yesterday, today, and forevermore.” Yet, how do we explain the following:

“These 12 Jesus sent forth and commanded them, saying, “Go not into the way of the Gentiles, and into any city of the Samaritans enter you not: But go rather to the lost sheep of the house of Israel.”

—Matthew 10:5-6

and

“But you shall receive power, after that the Holy Ghost is come upon you: and you shall be witnesses unto me both in Jerusalem, and in all Judaea, and in Samaria, and unto the uttermost part of the earth.”

—Acts 1:8

Did Jesus change? Remember that during the time of Christ, the Samaritans were hated among the Jews. They were considered to be traitors, unclean, and “inbreeders.” I don’t think Jesus changed, but I do think the human side of His heart changed about the Samaritans after 3 interactions He had with Samaritans:

One day, Jesus met a woman at a well. He told her about living water, about true worshippers, and all about herself. Some have said she was the first evangelist, for she left her water pot and told all the men about Jesus. And they came, witnessed Him for themselves, and believed Him to be the Christ, the Savior of the world.

She was from Samaria.

On another occasion, 10 lepers came to Jesus to be healed, saying, “Jesus, Master, have mercy on us.” And Jesus healed them and told them to go show themselves to the priests. The Bible says, “As they went, they were cleansed (healed).” Only one turned back and with a loud voice glorified God, falling at the feet of Jesus, thanking Him.

He was from Samaria.

Lastly, Jesus told a story about a man that was beaten and robbed on the Jericho Road and left to die. Both a priest and a Levite saw him and crossed the road to avoid any contact with this wounded, bleeding man. But one man saw him and had compassion, bound up his wounds, took him to an inn and took care of him, paying all expenses.

This man was also from Samaria.

No, Jesus did not change. But His heart and mind were changed toward the Samaritans because He personally experienced Samaritans.

When pastors and congregants get to know people living with HIV/AIDS, they find they are no different from themselves. They will find them to have made decisions and taken risks, some good, some bad, but they experienced life like anyone else. The difference is that people with HIV/AIDS, our modern-day Samaritans, were infected when many others took some of the same risks and made some of the same decisions, BUT BY THE GRACE OF GOD WERE NOT INFECTED.

“Providing Ministry for People Living With HIV/AIDS IS NOT AN OPTION!”

—Reverend Reginald T. Jackson, Pastor, St. Matthew A.M.E. Church

About Compassion

Bible quotes provided by Pastor Jerry Sanders, Fountain Baptist Church

“God is a God of Love, a God of Compassion.”

—Pastor Jerry Sanders

Job 6:14

“A despairing man should have the devotion of his friends, even though he forsakes the fear of the Almighty.”

Psalms 35:13-14

“Yet when they were ill, I put on sackcloth and humbled myself with fasting. When my prayers returned to me unanswered, I went about mourning as though for my friend or brother.”

Zechariah 7:9

“This is what the Lord Almighty says: ‘Administer true justice; **show mercy and compassion to one another.**’”

Exodus 22:27

“Because his cloak is the only covering he has for his body. What else will he sleep in? When he cries out to me, I will hear, for **I am compassionate.**”

Exodus 34:6-7

“And he passed in front of Moses, proclaiming, ‘**The Lord the Lord, the compassionate and gracious God**, slow to anger, abounding in love and faithfulness, maintaining love to thousands, and forgiving wickedness, rebellion and sin.’”

Matthew 15:32

“Jesus called his disciples to him and said, ‘**I have compassion** for these people; they have already been with me three days and have nothing to eat, I do not want to send them away hungry, or they may collapse on the way.’”

Matthew 22:37-39 (the Greatest Commandment)

“Love the Lord your God with all your heart and with all your soul and with all your mind...Love your neighbor as yourself.”

“Education and awareness are empowering. You can engage at a different level, no matter whom, no matter what the disease. Why should we feel a certain way when we are next to someone with HIV?”

—Pastor Antonio Porter

Mark 6:34

“When Jesus landed and saw a large crowd, **he had compassion on them**, because they were like sheep without a shepherd. So he began teaching them many things.”

Luke 7:13

“When the Lord saw her, his heart went out to her and he said, ‘Don’t cry.’”

“Compassion is when you are aware of people’s pain and you are moved to help them.”

—Pastor Jerry Sanders

Hebrews 4:15

“For we do not have a high priest who is unable to sympathize with our weaknesses, but we have one who has been tempted in every way, just as we are—yet was without sin.”

Romans 12:15

“Rejoice with those who rejoice; mourn with those who mourn.”

About Homophobia

by Reverend Gerald Bailey

When HIV came to the forefront in the U.S. and we heard that mostly white gay men were infected, churches were also infected with fear, discrimination, and prejudice. The fear was so rampant that those individuals were often shunned and sometimes even asked to leave their community of faith. The infected and affected made themselves invisible to escape rejection and stigmatization. Admittedly, I was one of those ministers who initially said, “Those people deserved what they got.” I once even believed that “HIV was God’s judgment on gays.” I cannot tell you how many times the Spirit of God beat me up and moved me to confess my “homophobia,” and moved me to pray for forgiveness and ask those I hurt to forgive me also.

Still, today, one of the greatest issues before the Church is how to heal its people of homophobia. Homophobia is defined as a fear of or discomfort around those who are not heterosexual and have same-sex partners. Homophobia has led to blatant and sometimes violent attacks on homosexuals. We must remember that homophobia is also an attack on love and compassion. Jesus’ commandment to “love one’s neighbor” wasn’t just limited to people like us. God’s love extends to all neighbors. Thus, God’s people must resist the temptation to interpret scripture and create doctrine that judges and writes people off who are different, HIV positive, or gay. The mean-spiritedness toward the hurting, desperate, lonely, and “different” forces them to look for acceptance in inappropriate and unhealthy environments and pushes the “different” to look for love in all the wrong places.

Young men and women are becoming infected, spreading the virus, and dying at alarming rates while many religious zealots and theologians write their judgmental, doctrinal treatises, justifying their hate for the Samaritan, the leper, the gay, the lesbian, the bisexual, the transgendered, and the brother or sister on the down low. Every 33 ½ minutes someone in the U.S. dies of AIDS. AIDS is still the leading cause of death for African Americans between the ages of 25 and 44.

“Love is universal;
judgment is not of God.”

—Reverend Gerald Bailey

Since the 80s, medical science has made many advances toward the healing of PLWHA with the discovery of several antiretroviral drugs. HIV is no longer a “death sentence.” The CDC has campaigned long and hard to prevent infection and spread of the virus. AIDS service organizations and support groups have sprung up throughout the U.S. The once rejected and dejected are getting help.

Today, the virus is undetectable in the blood of many patients who are on medication and are taking care of themselves, eating right, and getting their rest and exercise. So like polio, influenza, and so many other once incurable diseases, there will one day be a cure for HIV.

I pray that while science is working on a cure, the Spirit of God is working on His Church and its leaders to likewise be cured of homophobia. I pray that men and women of God will honestly “weep with all those that weep and rejoice with all those that rejoice,” and bear the burdens of the many different in our midst. God would have us do so out of genuine care and concern for all His children and to refuse to ever let a biblical interpretation or opinion prohibit us from meeting people where they are.

The Church should be able to love yet disagree where people live biblically or morally. Yet, like so many other things the Church struggles with, the homophobic Christian and the gay Christian both need God’s help so that lives might be saved, a safe place to worship fortified, and gifts and talents utilized in the body of Christ.

Prayer for the Persecuted

by Jerry McCathern,
Senior Director of Development, Hyacinth AIDS Foundation
Member, All Souls Unitarian Church, NYC, since 1987

Sometimes as people of faith we pass judgment on others and forget the Word of the Lord. Since the beginning of the AIDS epidemic over 30 years ago, many well-meaning ministers of all too many churches condemned people who contracted the HIV virus, oftentimes from the pulpit, shaming and rejecting those who needed our love the most. GLBT (gay, lesbian, bisexual, and transsexual) Christians have also suffered rejection and condemnation, resulting in estrangement from the Church and causing untold, undeserved suffering.

As a gay man of faith and an AIDS activist for over 25 years, I humbly offer this prayer for the persecuted, and pray that all ministers and lay leaders of all denominations will open their hearts and their doors to all in need, especially those who have been rejected by their own families and society in general.

Dear God in Heaven:

We are so thankful for the Beauty of the Earth, the Infinite Majesty of the Universe, and the Magnificence of Your Creation. We thank You, God, for the Gift of Life itself.

We pray today for those who suffer from illness, injury, war, incarceration, poverty and persecution. We ask that You bring Your infinite Love to all those in pain, to those tormented because they are a different color, or have a different religion, origin, sexual orientation, or language, or live with cancer, HIV or any other disease.

To all of these Jesus said: "Blessed are you when others revile you and persecute you and utter all kinds of evil against you falsely on my account." (Matthew 5:3)

And to those who would pass judgment on them He said: "Judge not, that you be not judged." (Matthew 7:1)

Help us remember that all people are created by You and are perfect in Your sight.

God bless us that we might love all our neighbors as ourselves, and whatever we wish others would do to us, we would do also to them.

In Jesus' name we pray. Amen.

Liturgical Resources

The Balm In Gilead develops educational and training programs specifically designed to meet the unique needs of African American and African congregations that strive to become community centers for health education and disease prevention.

<http://www.balmingilead.org/index.php/home-page.html>

Rev. Dr. James A Forbes, Jr., “Developing Sermons on HIV/AIDS,” The Balm In Gilead, Inc., 2005.

<http://www.nationalweekofprayerforthehealingofaids.org/downloads/2012%20Developing%20Sermons%20on%20HIV-AIDS.pdf>

“We Will Break the Silence: Liturgical Resources for the Healing of AIDS,” The Balm In Gilead, Inc., 2005.

[http://www.cnyhsa.com/content/files/we_will_break_the_silence_\(balm_in_gilead\).pdf](http://www.cnyhsa.com/content/files/we_will_break_the_silence_(balm_in_gilead).pdf)
(includes litanies, responsive readings, and prayers)

National Week of Prayers for the Healing of AIDS—Planning Guide.

<http://www.nationalweekofprayerforthehealingofaids.org/downloads/2012%20NWPHA%20Planning%20Guide%20Final%20.pdf>

Founded in 1909, the NAACP is the nation’s oldest and largest civil rights organization. From the ballot box to the classroom, the thousands of dedicated workers, organizers, leaders, and members who make up the NAACP continue to fight for social justice for all Americans.

“Sermon suggestions,” NAACP Day of Unity 2012.

<http://chicagofaithandhealth.org/archives/3357>

NAACP — The Black Church & HIV: The Social Justice Imperative.

http://naacp.3cdn.net/93e02bcd4b6cef2aad_pam6yxw29.pdf

The Christian Reformed World Relief Committee (CRWRC) is the relief and development arm of the Christian Reformed Church. CRWRC reaches out in God’s name to people, both in North America and around the world, who are struggling with poverty, hunger, disaster, and injustice to help them find lasting ways to improve their lives.

“Embrace AIDS: Resources.”

http://www.crwrc.org/pages/crwrc_aidsresources.cfm

(includes sample sermons, AIDS meditations, and suggested scriptures)

The Ecumenical Advocacy Alliance is an international network of churches and church-related organizations committed to campaigning together on common concerns. Current campaigns focus on HIV/AIDS and Food.

“HIV Prevention: A Global Theological Conversation.”

<http://www.e-alliance.ch/en/s/hivaids/publications/theological-conversation/>

“AIDS RELATED STIGMA: Thinking Outside the Box: The Theological Challenge.”

<http://www.e-alliance.ch/en/s/hivaids/stigma/aids-related-stigma-resource/>

“Theology/Ethics and HIV/AIDS.”

<http://www.e-alliance.ch/en/s/hivaids/>

The NYC Faith in Action Coalition is a city-wide partnership of individuals, faith organizations, and health and secular organizations who have a common interest to reduce and eliminate HIV/AIDS in New York City.

NYC Faith in Action for HIV/AIDS Prevention, Care and Education Coalition.

<http://www.nycfia.org/>

Reverend Mel White: “What the Bible says—and doesn’t say—about homosexuality.”

<http://www.soulforce.org/resources/what-the-bible-says-and-doesnt-say-about-homosexuality/>

VOICES OF THE EPIDEMIC

“Live as people who are free, not using your freedom as a cover-up for evil, but living as servants of God.”

—1 Peter 2:16

3.2 How to Incorporate HIV/AIDS Into Your Ministry

Ministry might be defined as: a personal commission from God that labors toward the reconciliation of others to Christ through the Gospel.

“Ministry, carrying forth Christ’s mission in the world, is fundamentally the task of the Church, the whole people of God, and is conferred on each Christian in baptism.”

—Fahlbusch’s (et al) *Encyclopedia of Christianity*

Ministry is personal, interpersonal, and centered upon the person and work of Christ.

Starting a Women's Ministry

by Reverend Brenita Mitchell

President and Founder, Healing Waters Global Inc.

“When a woman begins to be aware of the divine spark within, she will soon be faced with a decision whether to honor and trust it...She is so accustomed to looking outside herself for authority that the realization of God within is radical and shattering. It changes everything.”

Why a Women's HIV/AIDS Ministry?

Arguably, women are natural born social beings. They typically love to gather together and rarely need a reason to do so. They can be found shopping, calling each other to meet for breakfast, lunch, Sunday morning brunch and/or late-night dinner. They organize car pools to transport their children to and from school. They can be found gathering together at watering holes, soccer and cheerleading practice, after-school programs, and outside markets, parks, libraries, and church services and Bible studies. In addition, they can be found chatting together while getting manicures and pedicures and at community yard sales. They are great advocates and they take pleasure in supporting each other. Women will adjust their busy schedules to make room for listening to and sharing the most intimate and implausible details of their hot and often tragic romances. Moreover, they take great pride when they come together to boast about their children's grades and SAT scores, and in the spirit of sisterhood reach out to each other for prayer when faced with personal health and family crises. Lastly, as new moms and grandmothers they meet with great excitement as they share photos of their children's and grandchildren's births. To that end, no matter what context women find themselves in, most share a deeply sacred and special bond between them. Therefore, in light of the above reasons and more, it is imperative that churches, synagogues, and mosques develop an HIV/AIDS ministry just for them.

It is critical that such a ministry be a safe and intimate place where women can begin to listen to themselves and each other without judgment, share personal stories that have the power to heal and transform, support each other in community, discover their gifts, and get closer to their true selves and their God. “12 Steps to Starting a Successful Women's HIV/AIDS Ministry” is a program designed to do just that. The program will provide your organization with the necessary basic steps to jump-start a women's HIV/AIDS ministry. The 12 Steps to Starting a Successful Women's HIV/AIDS Ministry will be a significant guide to help empower women living with the disease to live a more loving, forgiving, fearless, purposeful, and deeply reflective spiritual life.

12 Steps to Starting a Women's Ministry

- 01** Pray (ask God to guide your steps).
- 02** Agree on a name for the ministry (you may also include a supporting scripture).
- 03** Develop a brief mission statement (establish your core values, purpose, and ministry vision. Set goals and agree on how often group meetings will take place).

Mission Statement example:

“The purpose of our Women’s Ministry is to meet the spiritual, physical, and emotional needs of women living with HIV/AIDS in church and within the community. This ministry is designed to encourage women of all ages, races, ethnicities, financial status and marital and parental status, and at any stage of their lives, to grow in their faith in Christ, to develop and strengthen intimate friendships with other women, and to provide opportunities to serve and reach our community for Christ.”
- 04** Make a plan for the first year, and be sure to consider the needs and priorities of the women in the group. Include social activities, such as field trips, recreational activities, movies, plays, dinner, dancing, musical and gospel concerts, planting a garden, etc.
- 05** Create a safe and trusting environment. Develop a Confidentiality Covenant (see attached Ministry Covenant Sample).
- 06** Write a Ministry Confession: optional (see Ministry Confession Samples A and B).
- 07** Organize a “kick off” program (i.e., a breakfast, cook-out, brunch, etc).
- 08** Provide food and refreshments during ministry meetings and change the locations for group meetings.
- 09** Start a Bible study with a focus on women in the Bible. Provide journals.
- 10** Start a group Book Club and invite other women inside and outside the church to attend.
- 11** Organize an annual overnight retreat with a guest speaker, choose an appropriate theme, and include activities that pamper the body, soul, and spirit.
- 12** Organize outreach programs so that women in the group have the opportunity to serve in the community and the world. For example, a program to raise funds to help train oppressed women with AIDS in Sub-Saharan Africa or to help to support babies in local hospitals born with HIV.

Optional: Assign members to write their Spiritual Autobiography.

Ministry Membership Covenant

(Please PRINT your name): _____

I understand that every attempt will be made to guard my anonymity and confidentiality in this group, but that it cannot be absolutely guaranteed in a group setting.

I realize that the group leader cannot control the actions of others in the group.

I realize that confidentiality is sometimes broken accidentally and without malice.

I understand that the group leader is morally or ethically obligated to break confidentiality when:

- I communicate an intention to kill myself.
- I communicate an intention to harm another person.
- I reveal ongoing sexual or physical abuse.

I have been warned about the consequences for communicating the above types of information: that reports will be made to the proper authorities, including the church leadership, the police, suicide units, and Child Protective Services, as well as to any potential victims.

I understand that the leader will make every effort to find additional help for me, if my needs prove to be too great for the resources of the group.

I realize that this is a support group and not a therapy group. I understand that the leader is qualified by “life experience” and not by professional training as a therapist. The facilitator’s role in the group is to create a safe climate where healing can occur, to support my personal journey, and to share her own experience, strength, and hope.

Signed: _____

Date: _____

Ministry Confession: Sample A

I know God created me, and God loves me.

I have faults and weakness, and I want to change. I believe God is working in my life. God is changing me bit-by-bit, and day-by-day. While God is working on me, I can still enjoy my life and myself.

Everyone has faults, so I am not a failure just because I am not perfect.

I am going to work with God to overcome my weaknesses, but I realize that I will always have something to deal with; therefore, I will not become discouraged when God convinces me of areas of my life that need improvement.

I want to make people happy and have them like me, but my sense of worth is not dependent upon what others think of me. God has already affirmed my value by Jesus' willingness to die for me.

I will not be controlled by what other people think, say, or do. Even if they totally reject me, I will survive. God has promised never to reject or condemn me as long as I keep believing (see John 6:29).

No matter how often I fail, I will not give up because God is with me to strengthen and sustain me. God has promised never to leave me or forsake me (see Hebrews 13:50).

I like myself. I do not like everything I do, and I want to change—but I refuse to reject myself.

I am right with God through Jesus Christ.

God has a good plan for my life. I am going to fulfill my destiny and be all I can be for God's glory. I have God-given gifts and talents, and I intend to use them to help others.

I am nothing, and yet I am everything! In myself I am nothing, and yet in Christ I am everything I need to be.

I can do everything God calls me to do, through God's Son Jesus Christ (see Philippians 4:13).

Ministry Confession: Sample B

Today, I release myself. I forgive myself anything I may have done that hurt others. I am free to shed a tear for the promises I made that were not kept and I apologize for not meeting my own expectations. Today, I recognize that my past does not dictate my future and I am now free to be who I always wished I could be. There is a light that shines within me. It radiates with love, peace, and wellness. It fills me with the perfect love that I was designed to experience. I am now free to go on my way loving others as I wish to be loved. If sadness follows me it is because I am allowing it to. There were no permanent mistakes; I am not a bad person. I desired to be loved and to love others. I am grateful for the chance to begin again. Peace of mind comes now! My family needs me to be the best I can be. I am perfect in Creation. I soar with the Angels. I am now my brightest me, beautifully and wonderfully made in this skin. My life is limitless and I forgive myself because I now know that I am awesome in Creation. I love myself. I have a purpose for being here, and I will see it!

Men's Ministry

by Reverend Antonio Porter

“Nothing can separate us from the love of God.”

—Romans 8:35-39

Definition: One might wonder how a men's ministry is any different from a woman's ministry, or for that matter, any kind of ministry. After all, it would seem that ministry, if done in service of the Lord, is all the same regardless of the gender, age, or race of the individual serving. Men's ministry is the active pursuit of men in order to connect them to God, His Word, and other men for the purpose of winning, growing, and training God's man in Christ.

This raises a question. How do we reproduce believers? Can a men's ministry enable a man to better understand his calling in life and how to achieve it? Can a men's ministry challenge a man to grow deeper in intellect, emotion, and spirit? Can a men's ministry teach men how to stay sexually pure? The answer to these questions is a resounding “Yes!”

The Focus: The first step in forming a vital men's ministry in the local church is to decide what you want to see happen in a man's life. Once this is determined, you will need to raise up leaders who will catch the vision and help you lead a potential small group of men into a deep relationship with the Lord. Men's ministry can focus on bringing men together and providing opportunities for them to explore a monthly outreach (hospital, nursing home, Meals on Wheels, or correctional facility), participate in an annual HIV/AIDS walk, explore a monthly men's fellowship (9 am-11 am), and explore a men's ministry month with 1 weekend having an HIV/AIDS focus.

In order to have a strong and balanced men's ministry, you will have to build a framework. Here are 6 biblically balanced benchmarks for a healthy ministry for men:

FILLING—God's man is a self-feeder. Consistently studying and applying God's Word independent of the church or small group is essential. To do this, a man must be taught how to study the Bible. We suggest building your framework to support a weekly meeting with the pastor or small-group leader to teach Bible interpretation skills (1 Peter 2:1-3; Psalms 1:1-3).

PRACTICING—God's man learns how to apply God's Word to all areas of life. It is essential to allowing room for accountability within the men's ministry for the purpose of consistency and obedience to God's Word (James 1:22-25; Ezekiel 33:30-32).

UNITING—God's man makes it a priority to connect with other men at least 2 times a month for the purpose of community, accountability, confession, and prayer (Galatians 6:1-3; James 5:16; Hebrews 10:23-24).

REACHING—God’s man gets involved in some form of men’s ministry based on his gifts and talents. God has called each of us to pour out to others what He has poured into us (1 Peter 4:10-11; Ephesians 4:11-13).

IMPACTING—God’s man invests time and resources into the lives of other men. We suggest one-on-one connection through shared activities, spiritual mentoring, and modeling (2 Timothy 2:22; Proverbs 27:17; Mark 3:13-14).

SHARING—God’s man learns to actively share his faith in order to lead others into a personal relationship with Jesus Christ (Acts 1:8; 1 Peter 3:15; Matthew 28:18-20).

HIV/AIDS References: The church must create a “safe space”—knowledge is power. The church can no longer avoid the subject of HIV/AIDS because the church is where people come to hear the truth. Silence is death! African Americans face the most severe burden of HIV of all racial/ethnic groups in the United States. Despite representing only 14% of the U.S. population in 2009, African Americans accounted for 44% of all new HIV infections in that year. Compared with members of other races and ethnicities, African Americans account for a higher proportion of HIV infections at all stages of disease—from new infections to death.

In 2009, Black men accounted for 70% of the estimated new HIV infections among all Blacks. The estimated rate of new HIV infection for Black men was more than six and a half times as high as that of White men, and two and a half times as high as that of Latino men or Black women.

In 2009, Black MSM represented an estimated 73% of new infections among all Black men, and 37% among all MSM. More new HIV infections occurred among young Black MSM (aged 13-29) than any other age and racial group of MSM. In addition, new HIV infections among young Black MSM increased by 48% from 2006-2009.

The church plays an important role in spiritual nourishing. It is the very place where one can immerse oneself in a community, feel a part of something, and connect to the spiritual strength of others.

Incorporating HIV/AIDS Awareness Into Your Youth Ministry

by Seminarian Joy Lynch

Focus on Education and Mission

Education is important in the fight against AIDS, even at an early age. Education should focus on empathy for individuals with HIV/AIDS and prevention of HIV/AIDS. Missions should focus on what the youth can do to help prevent the spread of HIV/AIDS and what they can do to support those who already have HIV/AIDS.

Education

You know your youth and know which forum would be the best forum for introducing this subject.

Make the forum and content age appropriate.

We recommend: For teens and pre-teens, 1 or more informal rap sessions; for 18-year-olds and older, 1 or more structured workshops.

For each age group, solicit empathy from the youth by asking a series of questions surrounding their response to individuals who are sick. You could consider this question and answer period your ice breaker for the session. Sample ice breaker questions are as follows:

- Do you know anyone who has diabetes or high blood pressure?
- If yes, have a discussion about juvenile diabetes, mentioning the fact that it is hereditary.
- If no, how do you feel when you're in their presence? Are you empathetic/sympathetic?
- How would you feel if you found out that your best friend had diabetes?
- Would you help this person if they needed your help? What would Jesus do?

You may want to remind participants that Jesus always supported those who were sick and outcast from society. He is an example to show us how to include those who are cast out of society today.

Do you love them any more or any less because they are sick?

Tip: Limit your ice breaker to 5 minutes and the overall discussion to an hour for teens and pre-teens and an hour and a half for those 18 and older.

Introduce the HIV/AIDS conversation—be age appropriate. The conversation should stress empathy for those who are living with HIV/AIDS, just as participants empathized with those who have diabetes or any other disease; and prevention of HIV/AIDS, i.e., risky behaviors vs. responsible behaviors. Include statistics that are specific to youth—local, U.S., and global statistics. During the conversation, let them talk about what's on their minds about the subject. Be sure to dispel any myths about HIV/AIDS that surface in the discussion. Emphasize that they must take responsibility for their own bodies and for their own behaviors because their “body is the temple of the Holy Spirit” (1 Corinthians 6:19) and does not belong to them. This is directed at both the male and the female. The more interactive the forum, the more the youth will be able to benefit from the information that they receive.

Informed Consent Agreement HIV/AIDS Training

I understand that participation in the HIV/AIDS training offered through the Youth Department involves discussion of sensitive information. I have carefully considered the sensitivity of the information and have given _____, my (son/daughter), my/our consent to participate in the training session(s) on _____.

This form must have both parent/guardian signatures:

Name (please sign and print): _____ **Date:** _____

Name (please sign and print): _____ **Date:** _____

Telephone number(s) (area code included): _____

Mission

You will need permission slips for this aspect of the training as well.

Invite teens and pre-teens to visit a **center/hospital** where youth with HIV/AIDS are being supported. The purpose of this visit is to underscore the reality of HIV/AIDS among those under 18 and to send a message that they are not invincible.

Invite those over 18 to help develop an HIV/AIDS ministry in your church. If you already have a ministry, invite them to actively participate in the church's ministry or volunteer at a home/agency that supports HIV/AIDS patients.

3.3 Advocacy

“The Spirit of the Lord is upon me, because he has anointed me to bring good news to the poor. He has sent me to proclaim release to the captives and recovery of sight to the blind, to let the oppressed go free, to proclaim the year of the Lord’s favor.”

—Luke 4:18-19

The Pastor As Advocate

by Reverend Gerald Bailey

Queen Esther was an excellent example of an advocate. Though she was compelled by her uncle Mordecai to petition the King for the lives of her people, she put it all on the line to do just that. I am sure you know the story. She came boldly before the throne of grace so that she could obtain mercy and find grace from her King to stop the potential genocide of the Jewish community throughout Persia. It was not her season or time to approach the King, and to do so could possibly mean her death; but her response has resounded throughout biblical history: “If I perish, I perish.”

Being an advocate is different from being a lobbyist. In most cases, advocates sacrifice and sometimes are sacrificed for their client, family member, friend, neighbor, or whomever they are serving. They are compelled and propelled by compassion. Advocates *suffer with* the sufferer. This is not an enviable position, but inescapable if you are doing real ministry, visiting the fatherless and widows in their affliction, and to keep oneself unspotted from the world (James 1:27).

I am convinced that all men and women of God, particularly pastors, are to serve, support, but also advocate—“stand in the gap”—for their people, especially those who cannot stand for themselves. Help me to understand why far too many pastors are not advocating “standing in the gap” for those in their congregation or community who are infected or affected by HIV/AIDS? Are they saying “if they perish, let them perish?”

I certainly hope not. Yet, in the spirit of Mordecai, I cry out to ministers, pastors, priests, and evangelists: Who knows whether or not God has called you for such a time as this to minister to the thousands in New Jersey who are infected with HIV, to develop an HIV/AIDS ministry, to reach

“If it pleases the King, let my life be given me—that is my petition—and the lives of my people—that is my request. For we have been sold, I and my people, to be destroyed, to be killed, and to be annihilated.”

—Esther 7:3-4

out to broken families who are hurting at the loss of one or both parents, a child, or a sibling. My cry is for men and women of God to ADVOCATE, break the silence, and petition for people living with HIV/AIDS, the least of the least among us.

Ministry spans the spectrum: feeding, clothing, housing, visiting, etc **ALL those** in need, but also speaking for and standing for **ALL those** whose cries for help have been strangled in their throats and now can hardly be heard.

You may be asking, how exactly does one advocate? Queen Esther was an excellent example of an advocate, but Jesus was the consummate advocate. He stood in the gap between heaven and earth for the **whole world** to have life and live more abundantly.

“But how exactly does one advocate?” you may ask. Again, Queen Esther shows us how: You dialogue with your Mordecai, your HIV-positive parishioner, friend, colleague, or family member, and listen to how you can help. In the Book of Esther, Mordecai “charged Esther to go in unto the King, to make supplication unto him, and to make request before him for her people” (Esther 4:8). We need you to be that strong voice that insists that justice and medical or counseling assistance will always be with us and there for us.

Sometimes people just need you to be there for emotional support or they need you to be that strong voice that insists on justice, medical or counseling assistance, or just basic necessities for them. Sometimes they need you to stand with them and for them.

After Esther went before the King, she invited him to a banquet, to come unto her. As advocate, sometimes the more prudent “advocacy” is to invite a public official, e.g., mayor, police chief, director of the health department, etc, to a public forum at the church or community center. The pastor is in the best position to request such a meeting because he/she

- a) represents voters, and
- b) speaks for a group of “concerned citizens.”

Though Queen Esther was a sterling example of an advocate, the sacred text also has numerous examples of advocates: Abraham (for Sodom), Moses (for the Hebrew slaves), Mordecai (for the Jewish Nation), Deborah (for Barak and the children of Israel), David (for King Saul), the Syrophenician Woman (for her daughter), Simon of Cyrene (for Jesus), and Jesus (for the adulterous woman and for an evil and adulterous world).

Finally, as God, Jehovah-Jireh, has promised to “always be with us and there for us,” pastors, ministers, and the body of Christ are compelled to be with and be there for those in need and commanded to provide (or procure) food, water, shelter, and clothes for those without. Moreover, all “believers” are admonished to visit those who are incarcerated and those who are sick and to pray for (advocate to) the Great Physician for their healing.

Grassroots Advocacy

by Reverend Martisha Dwyer

Advocacy is an act of public witness to the Gospel of Jesus Christ where the church speaks with and on behalf of others in need, articulating positions consistent with our faith. Advocacy focuses on the needs and the rights and interests of people.

Pray—Pray with intention for direction in this type of ministry. Invite people to come together in prayer and conversation to hear God individually and collectively around the topic of HIV/AIDS.

Begin—Small beginnings set a lasting foundation and give people the opportunity to find their place in outreach efforts and to envision greater efforts. Inventory your worship community and agencies in your local community for connections and partnerships. Utilize the assets of your congregation and community to bring awareness, education, practical assistance, and support to those who need it the most.

Educate—Designate a person to lead the educational component for the congregation. Include visits from a medical expert to avoid misconceptions or myths about HIV/AIDS. Presentations about HIV/AIDS done by your designee or task force can include local and national statistical and demographical data about infections, legislation, treatment, testing, and support.

Mission—Participate in a national and/or local initiative. If there is not one in your community, think about organizing one. Designate a sermon or a Sunday for HIV/AIDS awareness; include those living with HIV/AIDS on your Sunday morning prayer list; or attend a health fair where HIV/AIDS testing and education materials are available.

Build Relationships—Knowing the resources and having contact names and numbers is another way to support individuals and families living with HIV/AIDS. Ensure that the advertised resources are available and determine whether you can make a referral to agencies in your community. A referral coming from church leadership goes a long way toward building your contact list.

Public Policy Advocacy

by Sabrina Jenkins

Advocacy is the active promotion of a cause or principle. It is one of many possible ways to approach a problem and it involves actions that lead to an intended goal. It is the process of people participating in decision-making that affects their lives.

DEVELOPING A PLAN FOR ADVOCACY

Identify Policy Issues—Advocates must first identify the problem and attempt to get the target audience to recognize that the problem needs action.

Research the Issue—Advocates must have a thorough understanding of the issue and be knowledgeable about the subject matter.

Select an Advocacy Goal/Objective—The goal must be narrowed down to an advocacy objective. Goals and objectives can be long-term, short-term, or immediate.

Identify Your Audience—The key players who can resolve the issues must be identified. All advocacy efforts should be directed to the people with decision-making power, as well as the people who influence the decision makers such as staff, the media, and the public.

Constructing a Classical Argument:

- **Introduction** warms the audience up and announces a general theme or thesis for the argument.
- **Narration** summarizes any relevant background information the audience needs to know about the environment and circumstances that produced the argument.
- **Confirmation** lays out in a logical order (usually strongest to weakest) the claims that support the thesis, providing evidence for each claim.
- **Refutation and Concession** address anticipated opposing viewpoints to your argument without weakening it.
- **Summation** provides a strong conclusion, amplifies the force of the argument, and shows the audience that this solution is the best at meeting the circumstances.

Strengthen Your Personal Story—When used effectively, a PLWHA personal story and experience can be used as an effective advocacy tool. Gather stories from people impacted by the disease/issue and bring them to meetings.

Make Effective Presentations—Opportunities to talk to key leaders are often limited. Careful preparation of convincing arguments and presentations can turn a brief opportunity into successful advocacy.

Evaluate Advocacy Efforts—Being an effective advocate requires continuous feedback and evaluation of your efforts.

Ways to Advocate

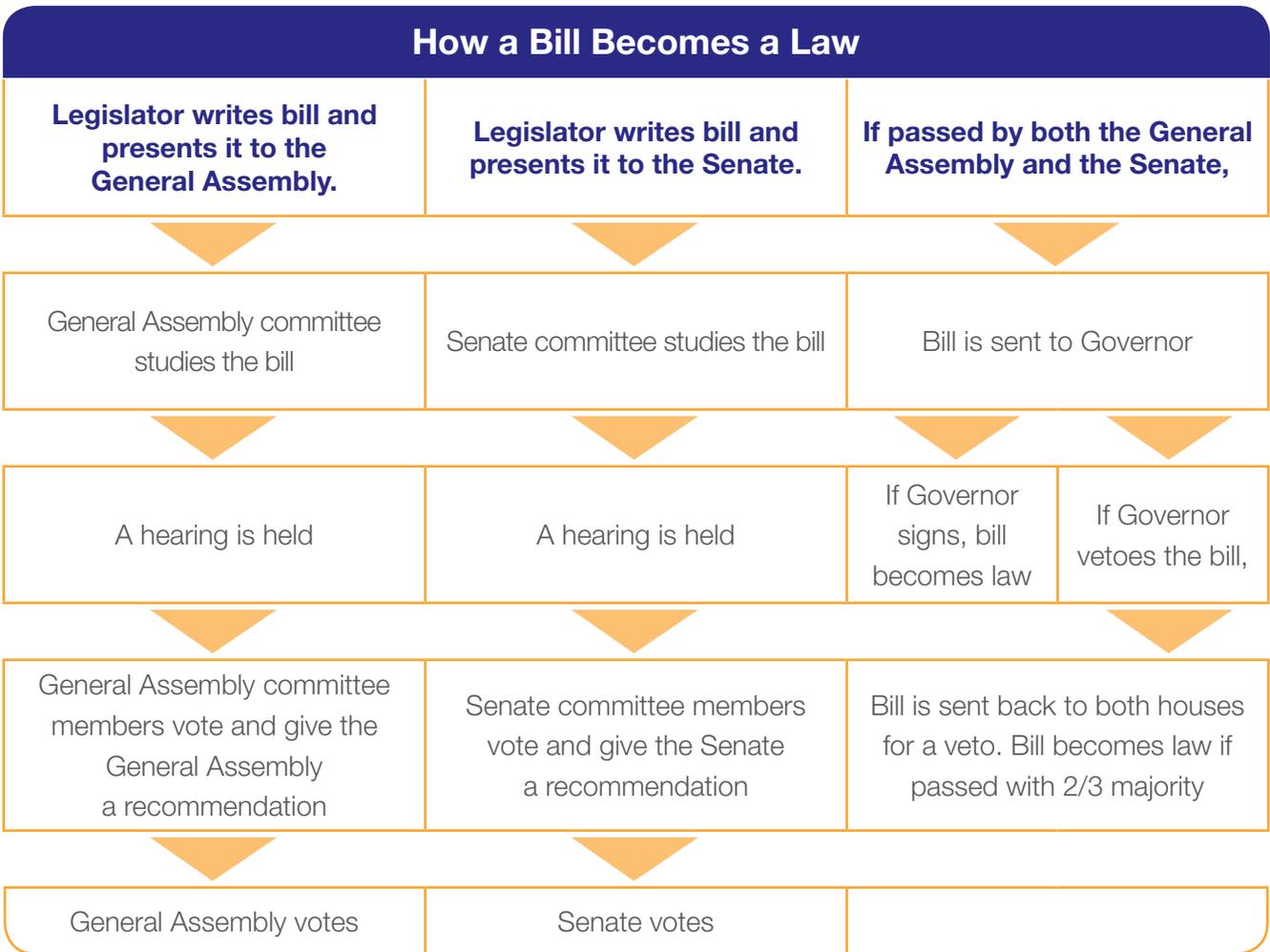
Attend a Hearing—Before the House or Senate can vote on legislation, it must be approved by Congressional committees and subcommittees.

Write a Letter—Letters to members of Congress are effective tools for voicing opinions and priorities about your cause. Some tips for letter writing: Keep the content focused and on one page, mention the bill number or title, and include your personal story when it is relevant; and consider a follow-up call to the legislative assistant within a week.

Visit the Office of Your Representative, Senate, or Legislator—Visiting the office of your Representative or Senator is the most important way to bring attention to your concerns.

Understanding New Jersey’s Government

The government of the State of New Jersey, like that of the United States, is divided into 3 branches: the legislative, the executive, and the judicial. The principal function of the **Legislative Branch** is to enact laws. The **Executive Branch** (the Governor and State agencies) carries out the programs established by law. The **Judicial Branch** (the Supreme Court and lower courts) punishes violators, settles controversies and disputes, and is the final authority on the meaning and constitutionality of laws.



3.4 Resources

“As a community we will not be able to get to zero, if we are not able to reduce stigma, fear, and misinformation around HIV. Stigma and discrimination continue to be the principal barriers to ending the epidemic. We need to educate our community on how HIV is transmitted, how HIV can be prevented and how HIV is managed and treated. Most importantly, we need to understand what we can do in our community to get to zero discrimination.”

—Deloris Dockrey, Director of Community Organizing,
Project Supervisor, Hyacinth AIDS Foundation

Using Social Media

Social media makes it possible for *anyone* to create, modify, and share material with others, using relatively simple tools that are often free or inexpensive. Social media requires a computer or mobile device with Internet access.

What is social networking?

Social networking sites are online communities that allow you to connect with, or provide resources to, clients, colleagues, family, and friends. Many social network sites, such as Facebook and Twitter, allow you to upload videos and photos, create a blog, post events, join groups, and send messages. The sites can be used to raise awareness within the community about HIV/AIDS ministries and reach people with important information about HIV/AIDS. Most public and private organizations have a social networking site.

Social media tools can help you:

- 01 CONNECT** people with information and services. This includes connecting individuals with healthcare providers and people living with HIV with one another. New media can also connect the families, friends, and caregivers of people living with HIV/AIDS to resources for their loved ones and themselves. Promoting community projects and events is another way new media can be useful.
- 02 COLLABORATE** with other people—including those within your organization or community. Reach out to established service organizations in New Jersey in order to construct a successful HIV/AIDS ministry.

03 CREATE new content, services, communities, and channels of communication that help you deliver information and services. Breakthroughs are happening every day in the fight against HIV/AIDS, whether it be the discovery of a new medication or the passage of a law. New media allow people to find and spread information to reach the masses. For those who are starting an HIV/AIDS ministry, new media will help you not only to provide the most current information to your congregations, but also to spread the word about upcoming events and policies and to gain support from community members.

Information provided by www.AIDS.gov

Fund-raising

Funding is an important part of developing any program. There is more than one aspect to raising money. Fund-raising may involve special events, collecting donations from individuals, or writing grants to obtain organization and government funds.

The **Association of Fundraising Professionals (AFP)** has an informative website that will provide you with many of the resources you'll need to fund a ministry and its programs. The AFP is a worldwide professional association dedicated to the advancing of philanthropy by enabling people and organizations to practice ethical and effective fund-raising. The association's core activities include education, training, mentoring, research, and advocacy. The website's "Resource Center" provides information about fund-raising policies, development plans, tax issues, and much more.

Grants

Writing a grant proposal is another way to secure funding for ministry programs. When developing a larger project, a private or government funded grant may ease financial burdens that may be imposed on congregations. The first step in writing a grant is to identify a need for funds, for example, an educational initiative within the congregation. The next step is to identify a donor, private or governmental. When beginning your project proposal, it's important to establish credibility by conducting research and setting achievable goals. Many grant writers use a process called SMART objectives. SMART means Specific, Measurable, Achievable, Relevant, and Time-framed. It is important to remember that funders will want to see results. Make sure the objectives of the program can be quantified by evaluation methods. Also, the objectives must be within the capabilities of the congregation and be likely to produce the desired results. In any transaction involving money, time is of the essence. Give benefactors a timeline for when you expect to complete your objectives.

Writing a Grant Proposal

01 Identify a fundable need

- What are the unmet needs of the community (for example, an HIV/AIDS ministry)?
- What is the impact of an unmet need on the community's health (lack of education, stigma, etc)?
- Policy trends in HIV/AIDS care. (What are some new laws that either grant access or bar access to health resources?)
- Funder's priorities. (What result does the funder want to see?)

02 Find a funder

- Find a funder that has a common interest in your project.
- Private funders: Chronicle of Philanthropy, Council of NJ Grant Makers, Foundation Center.
- Government funders: www.grants.gov

03 Develop a proposal

- Establish credibility by providing evidence-based research about the problem and how your project will help to solve it. Set achievable goals, create measurable objectives, and propose feasible evaluation methods.

04 SMART objectives

- Specific: What exactly are we going to do, with or for whom?
- Measurable: Is it measurable and can WE measure it?
- Achievable: Can we get it done in the proposed timeline, in this political climate, with this amount of money?
- Relevant: Will this objective lead to the desired result?
- Time-framed: When will we accomplish this objective?

05 Create a logic model

The logic model is a chart that has a few key elements. The chart will help you keep your thoughts organized as well as let you track your progress in writing your proposal. The key elements are:

- Inputs: The resources that will be used to accomplish project goals (for example, human, financial, etc).
- Activities: Actions performed with the resources to create change; processes, tools, events.
- Outputs: Quantifiable measures that directly result in activities.
- Outcomes: Short-term, intermediate-term results (1-3 years).
- Impact: Long-term, system-level changes (3-5 years).

06 Elements of a proposal

There are 6 elements of a grant proposal outline. Make sure you include all of them in order for your proposal to be a success.

- Proposal summary or abstract—A brief paragraph describing what your proposal is all about.
- Needs assessment—This is the research that shows the needs of a community (for example, your church) and how your project will meet those needs.
- Goal and objective—What goals you expect to accomplish in the short- and long-term and how you will meet them.
- Implementation plan—The actions taken to accomplish your goals, such as:
 - Methods
 - Evaluation
 - Staffing
- Organizational capacity.
- Budget and budget justification—How much will your project cost? How can you justify spending the money?

07 The cover letter

The cover letter summarizes the request of the proposal. It should be brief and to the point, demonstrating the urgency of raising funds and highlighting your organization's past success. The cover letter should address the individual by name, instead of a Sir or Madam. This element of the grant proposal is only needed when requesting funding from a private donor, not a government agency.

08 Writing for your reader

Neatness is key to writing a successful grant proposal. The physical appearance of the document should be clean and easy to read. Make sure all statistics and graphs are clearly labeled and cited or the grant proposal will lose credibility. Fonts, line spacing, and margins should be consistent throughout the document.

Not only is appearance important, but understanding your audience is key. The proposal must be easy for the audience to read and should be written in language that they understand. The document should appeal to the reader as well. For example, when requesting funds from a business, make sure you include positive results for the business. Write in an active voice and be careful not to make sentences too wordy. The proposal needs to be simple and easy to read.

Resource List

The Hyacinth Foundation provides client services in 8 regional offices as well as several statewide services that include client advocacy; hotline counseling for prevention, care, and treatment; service referrals; professional and community education workshops; and public policy advocacy. Below is the contact information for each site.

New Brunswick office

317 George Street, Suite 203
New Brunswick, NJ 08901
(732) 246-0204

Jersey City office

880 Bergen Avenue, 8th Floor
Jersey City, NJ 07304
(201) 432-1134

Drop-in Center:

492 Communipaw Avenue
Jersey City, NJ 07304
(201) 360-3910 or (800) 433-0254

Trenton office

701 Whittaker Avenue
Trenton, NJ 08601
(609) 396-8322

Hotline: (800) 433-0254

E-mail: info@hyacinth.org

Although Hyacinth is the oldest and largest AIDS service organization in New Jersey, there are a number of social service resources available statewide. For more information, please visit <http://hpcpsdi.rutgers.edu/>.

You can also visit www.AIDS.gov for a complete list of federal services.

Newark offices

408 Bloomfield Avenue, 2nd floor
Newark, NJ 07107
(973) 563-0300
Fax: (973) 643-8661

800 Broad Street
Newark, NJ 07102
(862) 772-7819

North Plainfield office

25 Craig Place
North Plainfield, NJ 07060
(908) 755-0021

Paterson office

100 Hamilton Plaza, Suite 421
Paterson, NJ 07505
(973) 278-7636

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