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Holistic Healing: Exploring Christian Churches' Unique Contributions to HIV-Related Stigma Reduction in Civil Society

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An abstract of
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Abstract

Holistic Healing: Exploring Christian Churches' Unique Contributions to HIV-Related Stigma Reduction in Civil Society

By Joseph Lawrence Davis

This thesis explores various frameworks and strategies used in efforts to reduce HIV-related stigma in Civil Society and Christian churches. This thesis also adopts a pragmatist perspective and employs a qualitative research strategy, focusing on a non-probability purposive sampling of publications and journals. The research questions addressed are: (1) What are the main/key conceptual frameworks that inform our understanding of HIV-related stigma in academia and more specifically in the context of public health? (2) What are the most salient impacts of stigma on those who are living with HIV? (3) What have been effective efforts to reduce stigma in the context of civil society and Christian churches, and to what extent do those efforts align with conceptual frameworks of stigma?

The study reveals that while the HIV-related stigma reduction frameworks developed in the social sciences, Civil Society, and Christian churches are more similar than different, Christian churches have a unique approach to reducing HIV-related stigma in that they focus on the spiritual dimensions of the lives of those who are affected by HIV. Sociologists and Civil Society tend to address the physical and psychological impacts of this stigma but do not necessarily address the spiritual needs of the people whom they are serving. The study suggests that the "3x3 Model" documented in the World Council of Churches (WCC) Case Study could be an ideal way to address HIV stigma as it takes a holistic approach to the lives of those who are living with and affected by the virus.

Furthermore, the study finds that the participating congregations of the WCC Case Study employed each element of the 3x3 Model to some capacity in their approach to creating programs and ministries that aim to reduce HIV-related stigma. The study concludes that building a culture in which those who are living with HIV feel cared for rather than judged is essential in reducing HIV-related stigma. With the 3x3 Model and the essential recommendations derived from the WCC Case Study, congregations who wish to begin and/or improve their efforts to reduce HIV-related stigma in their respective communities will have a widely applicable guide to assist them.

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CHAPTER 1: INTRODUCTION

1.1 Statement of Purpose

This thesis aims to identify successful strategies for reducing HIV-related stigma found in both Christian religious institutions and civil society. Drawing on academic literature and the five key themes identified in a case study of Christian congregations conducted by the Ecumenical HIV and AIDS Initiatives and Advocacy (EHAIA) Office and the Ecumenical Advocacy Alliance (EAA) of the World Council of Churches in partnership with The Interfaith Health Program (IHP) at Emory University, this thesis compares common frameworks and strategies used in anti-stigma initiatives. The case study investigated the ways Christian congregations carry out programs to support people with HIV and HIV-related challenges, with the goal of developing resources for faith communities to begin new HIV ministries or strengthen existing ones.

1.2 Significance

Reducing HIV-related stigma is essential to achieving global health goals and improving the lives of people living with HIV. The case study of Christian congregations conducted by EHAIA, EAA, and Emory's IHP provides valuable insights into effective approaches to supporting people living with HIV and reducing stigma in faith communities. By linking the findings of the case study to relevant literature reviews and public health implications, this thesis aims to strengthen the legitimacy of the study's findings, as well as examine the unique contributions that Christian congregations can offer to anti-stigma initiatives, providing insight into the potential impact of faith-based organizations in reducing HIV-related stigma. Overall, this thesis has the potential to inform efforts to reduce HIV-related stigma in both religious and civil society settings, ultimately contributing to improved health outcomes for people living with HIV.

CHAPTER 2: METHODS

2.1 Ontological and Epistemological Assumptions

This study adopts a pragmatist philosophical perspective, emphasizing the value of verifiable and interpretive findings. By exploring how HIV-related stigma is defined, experienced, and addressed in Civil Society and Christian churches, recognizing that such constructs are socially constructed and perpetuated by various factors such as cultural beliefs, social norms, etc. (Parker and Aggleton, 2003). By adopting this perspective, the study seeks to generate practical knowledge and insights that can be applied to address the issue of HIV-related stigma in these contexts. The study acknowledges that knowledge is socially constructed and shaped by the context in which it is produced. Therefore, the study seeks to explore how HIV-related stigma is defined, experienced, and addressed in the context of civil society and Christian churches. This thesis is taking on the assumption that stigma is not an inherent quality of HIV itself but rather is constructed through cultural beliefs and practices. This thesis is also posing that HIV-related stigma is perpetuated by social norms, media representations, and institutional policies, among other factors.

2.2 Approach

The approach of this study employs a qualitative research strategy, focusing on a non-probability purposive sampling of publications and journals. The study will address the following research questions:

1. What are the main/key conceptual frameworks that inform our understanding of HIV-related stigma?
2. What are the most salient impacts of stigma on those who are living with HIV?

3. What have been effective efforts to reduce stigma in the context of Civil Society and Christian churches?
4. To what extent do those efforts align with conceptual frameworks of stigma?

2.3 Data Collection

A literature Review was done using the main aspects of the Preferred Reporting Items for Systematic Reviews and Meta Analyses (PRIMA) framework. Search terms included "HIV stigma," "civil society," "stigma reduction," and "HIV ministry." The review was focused on publications from the last 20 years in medical, scientific, and sociological research. Additionally, the narrative data collected from interviews of clergy, lay people, and congregants from the World Council of Churches (WCC) Case Study were integrated to the analysis.

2.4 Data Analysis

The data collected in the WCC Case Study interviews were analyzed using reflexive thematic analysis. The analysis was inductive, allowing for emerging themes to be identified from the data. The themes were organized according to the research questions and sub-themes identified in the literature review.

CHAPTER 3: LITERATURE REVIEW

Stigma is a complex and multifaceted concept that has been studied across numerous disciplines, including sociology and psychology. Defined as a discrediting attribute that sets an individual apart from the norm, stigma has been observed across various social contexts, including that of disease. The stigma of disease is a powerful phenomenon that not only affects individuals but also has wider societal implications. One manifestation of this is the *stigma of the self*, where individuals who experience stigma may internalize negative societal attitudes towards their condition, leading to a negative self-image. *Societal stigma* can have far-reaching effects, including discrimination and marginalization of stigmatized individuals. This is particularly evident in the context of HIV, where people living with the virus are often subject to significant levels of stigmatization. HIV-related stigma can have significant negative impacts on individuals, including reduced access to healthcare, reduced quality of life, and increased risk behaviors. Given the substantial negative consequences of HIV-related stigma, efforts to reduce this stigma have been a focus of civil society and faith-based organizations, including Christian churches. This literature review will provide an overview of these different types of stigma and efforts to reduce HIV-related stigma in Civil Society and Christian churches.

Figure 1

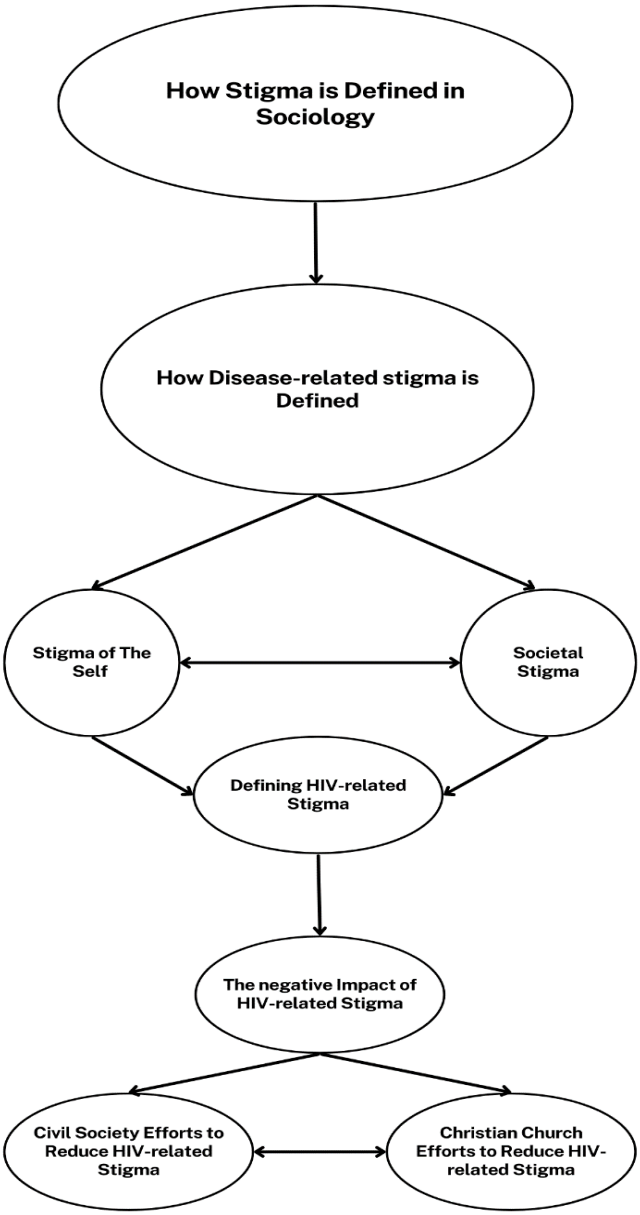


Figure 1 above is a visual depiction of the results of the literature review, which approached the definition of stigma from a generalized perspective regarding how stigma is defined in sociology, towards a narrower, more specific definition regarding the efforts Civil Society and Christian churches have made to reduce HIV-related stigma. The following literature

review will go into detail about how each “bubble” of this chart is integral in the analysis of the aims of this thesis.

3.1 Sociological Definition of Stigma

Goffman significantly influenced how stigma is understood and studied in sociology. He defined stigma as "an attribute that is deeply discrediting" (Goffman, 1963, p. 3). According to Goffman, stigma is a social construct that is imposed on individuals who possess certain attributes or characteristics that are deemed undesirable or unacceptable by society.

Goffman's work provides a comprehensive analysis of the different types of stigmas that exist in society, including physical deformities, mental illness, and criminal records. He identified three main types of stigma: physical, moral, and tribal. Physical stigma refers to a visible or physical characteristic that is stigmatized, such as a physical disability. Moral stigma is associated with characteristics that are perceived as immoral or shameful, such as a criminal record. Tribal stigma is linked to characteristics associated with a particular group, such as race or ethnicity.

Goffman's work on stigma is significant because it provided a theoretical framework for understanding the ways in which stigmatized individuals are treated by society. He described how individuals with stigmatized characteristics often face discrimination and exclusion, which can have significant negative effects on their lives. Goffman also explored the strategies that stigmatized individuals use to cope with the challenges of living with stigma, such as concealing their stigmatized characteristics or seeking social support from others who share their stigmatized status.

Medical Sociology Perspective

Link and Phelan (2001) state that social factors such as income, education, occupation, and social support are linked to health outcomes through access to resources, power, and status.

In their article Link and Phelan (2001) argue that social inequalities create disparities in health outcomes by influencing exposure, vulnerability, and response to disease. They contend that social factors are more fundamental than biological or behavioral factors in determining health outcomes and that interventions that address social inequalities are more likely to be effective in reducing health disparities.

Link and Phelan identify the following components of stigma; labeling, stereotyping and discrimination. Labeling refers to the process of attaching a particular attribute or characteristic to an individual or group. This label may be based on physical or behavioral differences, or on social categories such as race or gender. Once a label is attached, it can become the basis for social categorization and discrimination (Link & Phelan, 2001).

Stereotyping involves the creation of a standardized image or perception of a particular group. Stereotypes can be positive or negative and may be based on inaccurate or incomplete information. Stereotyping can lead to the formation of biases, which can influence attitudes and behaviors toward stigmatized groups (Link & Phelan, 2001).

Discrimination refers to the unequal treatment or exclusion of individuals or groups based on their perceived differences. Discrimination can take many forms, including social exclusion, denial of access to resources, and violence or harassment. Stigma can have negative consequences for individuals and groups, including lowered self-esteem, diminished social opportunities, and reduced access to resources and services (Link & Phelan, 2001).

In conclusion, Goffman's (1963) work on stigma has had a profound impact on the way that we understand and study the social phenomenon of stigma. By defining stigma as a social construct and identifying its different types, Goffman provided a theoretical framework for understanding how stigmatized individuals are treated by society and the negative effects that stigma can have

on their lives. Link and Phelan's (1995) article on social conditions as fundamental causes of disease further expands on the impact of stigma on health outcomes and, using the medical sociology and social epidemiology frameworks, highlights the importance of addressing social inequalities in reducing health disparities.

3.2 Stigma of Disease

Patrick Corrigan's 2014 book, *The Stigma of Disease and Disability: Understanding Causes and Overcoming Injustices*, defines 'Stigma of Disease' as a multifaceted phenomenon that goes beyond an individual's health and wellness issues (Corrigan, 2014). Corrigan highlights the two 'faces' of stigma, which are *Personal Harm* and *Public Phenomenon*. Personal harm refers to the impact of stigma on an individual's self-esteem and self-efficacy, while public phenomenon refers to how stigma impacts social opportunities, including institutional and structural phenomena that discriminate against those who are labeled as "ill" (Corrigan, 2014).

According to Corrigan (2014), stigma has a profound effect on an individual's right to equal opportunities including employment, housing, health care, relationships, faith-based communities, friends, communities, and legal protections. The effects of stigma vary across conditions and vary by disease and disability. For instance, HIV and other infectious diseases lead to stereotypes associated with fear of contagion and disgust, resulting in alienation and quarantine. In contrast, disability stigma manifests as benevolence stigma, where the person is seen as childlike and in need of an authority figure to guide them (Corrigan, 2014).

Corrigan (2014) argues that differences in prejudice result in different types of discriminatory responses. Therefore, it is crucial to understand the unique nature of each condition's stigma to develop appropriate interventions that address the specific effects of stigma for each group.

The work by Turan et al. (2017), “Framing Mechanisms Linking HIV-Related Stigma, Adherence to Treatment, and Health Outcomes”, aims to better understand the mechanisms through which HIV-related stigma affects the health of individuals living with HIV. HIV-related stigma has been recognized as a major barrier to HIV prevention and engagement in HIV care, as well as a driver of health disparities for people living with HIV. However, the mechanisms through which stigma affects health outcomes are not well understood. The conceptual framework presented in the article aims to fill this gap by identifying four dimensions of individual-level HIV-related stigma and proposing that these dimensions operate through multiple pathways to affect health outcomes.

The four dimensions of individual-level HIV-related stigma identified Turan et al.’s framework include perceived community stigma, experienced stigma, internalized stigma, and anticipated stigma. Perceived community stigma refers to an individual's perception of stigmatizing attitudes and behaviors in their community, while experienced stigma refers to the actual experiences of stigma and discrimination that individuals face. Internalized stigma refers to the internalization of stigmatizing attitudes and beliefs, while anticipated stigma refers to the fear of experiencing stigma and discrimination.

Turan et al.’s framework proposes that these dimensions of stigma operate through multiple pathways to affect health outcomes. For example, stigma can create barriers to engagement in HIV care and decrease adherence to treatment, leading to worse health outcomes. Stigma can also increase psychological distress and affect mental health, leading to negative health outcomes. Finally, stigma can activate biological stress pathways, leading to worse physical health outcomes.

The authors emphasize the importance of considering intersectional and structural stigmas in understanding the effects of HIV-related stigma. Intersectional stigma refers to the overlap of multiple stigmatized identities, such as being both HIV-positive and a member of a marginalized racial or ethnic group. Structural stigma refers to the broader societal factors that contribute to stigma and discrimination, such as laws and policies that criminalize HIV.

Overall, the conceptual framework presented in the article by Turan et al. (2017) provides a useful guide for future research and interventions aimed at addressing HIV-related stigma and improving HIV-related health outcomes. By highlighting the complex and multi-dimensional nature of HIV-related stigma, the framework emphasizes the need for comprehensive approaches that address stigma at multiple levels, including individual, interpersonal, and structural factors. The Stigma of Disease goes beyond an individual's health and wellness issues and has a profound impact on their access to equal opportunities in various domains of life. Understanding the unique nature of each condition's stigma is crucial to developing appropriate interventions that address the specific effects of stigma for each group. Addressing stigma at multiple levels, including individual, interpersonal, and structural factors, is essential to creating a more just and equitable society for individuals living with disease and disability.

3.3 Stigma of Self

In “On the Self-Stigma of Mental Illness: Stages, Disclosure, and Strategies for Change”, Patrick W. Corrigan and Deepa Rao discuss the concept of self-stigma and its impact on individuals with mental illness. Self-stigma refers to the internalization of negative attitudes and beliefs about one's mental illness, leading to shame and low self-esteem. Corrigan and Rao (2012) propose a model of the stages of self-stigma that individuals with mental illness may experience. The model includes four stages: awareness, agreement, adoption, and internalization.

The awareness stage involves recognizing that one's mental illness is stigmatized, and the agreement stage involves agreeing with the negative beliefs and attitudes about mental illness. The adoption stage involves taking on the negative beliefs and attitudes as one's own, and the internalization stage involves the negative beliefs becoming a core part of one's identity.

The authors also discuss the issue of disclosure of mental illness and the impact of self-stigma on disclosure decisions. Individuals with mental illness may fear the consequences of disclosing their illness, such as social rejection, discrimination, or negative career consequences. Self-stigma may also lead to a reluctance to seek treatment or support for mental health issues. To combat self-stigma, Corrigan and Rao (2012) suggest several strategies, including education about mental illness, advocacy for mental health rights, and contact with individuals with mental illness who are successfully managing their conditions. They also emphasize the importance of creating supportive environments that reduce the impact of stigma on individuals with mental illness.

Overall, Corrigan and Rao's (2012) article sheds light on the complex and pervasive issue of self-stigma among individuals with mental illness. Their model of the stages of self-stigma provides a useful framework for understanding the development of self-stigma and developing interventions to combat it. By promoting education, advocacy, and support, mental health professionals and advocates can work to reduce the negative impact of self-stigma on individuals with mental illness (Corrigan and Rao, 2012).

In conclusion, self-stigma refers to the internalized negative attitudes and beliefs that individuals hold about themselves as a result of their stigmatized identities. It can have a profound impact on their mental and physical health, social relationships, and overall quality of life. However, self-stigma is not an isolated phenomenon and is deeply connected to societal

stigma. The societal stigmatization of certain groups reinforces and perpetuates self-stigma, creating a vicious cycle that can be difficult to break. Therefore, addressing and combating societal stigma is crucial in reducing self-stigma and promoting well-being among stigmatized individuals.

3.4 Societal Stigma

Frost (2011) examined the ways in which social stigma impacts individuals who are stigmatized. Social stigma is a pervasive and damaging force in society, which can lead to a range of negative outcomes for the stigmatized individual.

Frost (2011) begins by defining social stigma as a process of labeling, stereotyping, and discriminating against individuals or groups on the basis of socially defined characteristics, such as race, gender, sexual orientation, or mental illness. He notes that social stigma is often tied to power imbalances, with dominant groups using stigma as a way to maintain their power and control over marginalized groups.

Frost (2011) then outlines the various ways in which social stigma can impact the lives of those who are stigmatized. He notes that social stigma can lead to social exclusion and discrimination, making it difficult for individuals to form relationships and access resources. Social stigma can also lead to internalized shame and self-blame, as well as increased levels of stress and anxiety.

To better understand the impact of social stigma, Frost (2011) identified three stages that stigmatized individuals may go through: anticipation, experience, and aftermath. In the anticipation stage, individuals may feel anxiety or fear about the potential for stigmatization, leading them to conceal their identity or avoid certain situations. In the experience stage, individuals may encounter stigmatizing behavior, which can lead to feelings of shame, anger, or

depression. In the aftermath stage, individuals may experience long-term consequences of the stigma, such as lowered self-esteem, reduced opportunities, or ongoing discrimination.

Despite the negative impact of social stigma, Frost (2011) identified several strategies that stigmatized individuals can use to cope with and resist stigma. These include seeking social support, engaging in activism and advocacy, and using humor or other forms of resistance to challenge stigma. Frost (2011) also noted that societal interventions, such as education campaigns and policy changes, can help to reduce social stigma and its harmful effects. Overall, Frost's article provides a comprehensive overview of the damaging impact of social stigma on stigmatized individuals, while also highlighting the ways in which individuals and society can work to challenge and resist stigma.

3.5 Defining Stigma in The Context of HIV

HIV and AIDS-related stigma and discrimination continue to be major barriers to the prevention and treatment of HIV. In their article, Richard Parker and Peter Aggleton (2003) present a conceptual framework for understanding the complex nature of HIV-related stigma and discrimination. They argue that HIV-related stigma and discrimination are rooted in social and cultural norms, beliefs, and practices that are shaped by historical, economic, and political factors. Parker and Aggleton (2003) contend that HIV-related stigma and discrimination are not only a consequence of the disease but also contribute to its spread by discouraging individuals from seeking HIV testing, treatment, and care.

The conceptual framework presented by Parker and Aggleton (2003) highlights the need to address the root causes of HIV-related stigma and discrimination through a comprehensive approach that involves changing social norms, beliefs, and practices. The framework emphasizes the importance of understanding the social, cultural, and political context in which HIV-related

stigma and discrimination occur and the need for multisectoral collaborations to address these issues. Therein, three main levels of stigma are identified by the framework: the individual, the interpersonal, and the structural. Individual-level stigma describes unfavorable attitudes and preconceptions that people may have about those who are HIV/AIDS positive. This could appear as prejudice, ignorance, and fear.

Interpersonal stigma refers to how individuals other act and behave negatively toward those who have HIV/AIDS. Included among these actions could be rejection, exclusion, and verbal or physical abuse. Families, friends, and communities may stigmatize those who are HIV/AIDS positive. Lack of social support and an increased risk of depression and anxiety can result from this. The institutional policies, laws, and cultural norms that support stigma and discrimination against people living with HIV/AIDS are referred to as structural stigma. This could include laws that make HIV transmission illegal as well as discriminatory healthcare and employment laws. It can be challenging to address structural-level stigma because it is frequently ingrained in social and cultural norms.

The authors of the article contend that all three levels of stigma must be addressed to effectively combat HIV-related stigma and discrimination. This means addressing individual attitudes and beliefs, challenging negative behaviors and actions toward PLWH, and changing institutional policies and cultural norms that reinforce stigma. Moreover, the authors advise promoting HIV/AIDS education and awareness programs to combat individual-level stigma. These programs can promote empathy and understanding for those who are living with HIV/AIDS while helping to dispel myths and misconceptions about HIV/AIDS. Parker and Aggleton (2003) advise putting anti-discrimination laws into place and encouraging social

inclusion for PLWH to combat interpersonal-level stigma. For PLWH this may entail starting support groups and peer networks as well as launching campaigns.

Florom-Smith and De Santis (2012) define HIV-related stigma as a social process that involves devaluation, rejection, and discrimination against people living with HIV (PLWH). This stigma arises from fear, ignorance, and misinformation about HIV transmission and treatment, as well as from negative attitudes and beliefs about people who are perceived to be "different" or "deviant."

The authors argue that HIV-related stigma can have negative consequences for PLWH, including psychological distress, social isolation, and reduced access to healthcare and other resources. Stigma can also contribute to the spread of HIV by discouraging people from getting tested and seeking treatment, or by forcing people underground where they engage in risky behaviors to avoid detection. Florom-Smith and De Santis (2012) also point out that HIV-related stigma can be directed not only at PLWH, but also at people who are perceived to be at risk for HIV, such as men who have sex with men, people who use drugs, and sex workers. This can lead to further marginalization of these groups and make it even harder for them to access HIV prevention and treatment services.

The authors suggest that reducing HIV-related stigma requires a multifaceted approach that involves education, advocacy, and social support. Education can help dispel myths and misconceptions about HIV and promote accurate information about transmission and treatment. Advocacy can help promote policies and programs that reduce stigma and discrimination against PLWH and other affected groups. Social support can help PLWH, and their families cope with the emotional and practical challenges of living with HIV and can help reduce the social isolation that often accompanies HIV-related stigma. Overall, Florom-Smith and De Santis

(2012) argue that reducing HIV-related stigma is critical to improving the lives of PLWH and preventing the further spread of HIV.

In summary, Parker and Aggleton's conceptual framework identifies the root causes of stigma and discrimination at individual, interpersonal, and structural levels, emphasizing the need for a comprehensive approach to addressing the issue. Florom-Smith and De Santis argue that reducing HIV-related stigma requires education, advocacy, and social support. However, societal stigma can have a detrimental impact on individuals who are stigmatized, leading to feelings of shame, low self-esteem, and social exclusion. Therefore, addressing and combating societal stigma is critical to promoting the well-being and dignity of all individuals. It is important to recognize that the fight against stigma and discrimination is ongoing, and that there is a need for continued efforts at all levels to achieve lasting change.

Societal stigma can have a profound and detrimental impact on individuals who are stigmatized. Stigmatized individuals may face discrimination, social exclusion, and negative attitudes from others, which can lead to feelings of shame, low self-esteem, and a sense of being devalued and marginalized. These negative experiences can also result in adverse mental health outcomes, such as depression, anxiety, and PTSD. Furthermore, societal stigma can create barriers to accessing healthcare, education, and employment opportunities, leading to further disadvantage and social exclusion. Therefore, addressing and combating societal stigma is crucial in promoting the well-being and dignity of all individuals, regardless of their stigmatized identities.

3.6 The Negative Impact of HIV-related Stigma

Vanable et al. (2006) aimed to explore the impact of HIV-related stigma on the health behaviors and psychological adjustment of HIV-positive men and women. The findings of this

study suggest that HIV-related stigma has a negative impact on the health behaviors and psychological adjustment of HIV-positive men and women. Specifically, HIV-related stigma was found to be associated with increased levels of depression, anxiety, and stress among HIV-positive individuals.

Vanable's study also provides important insights into the impact of HIV-related stigma on the lives of HIV-positive individuals. The need for interventions that address HIV-related stigma to improve the health and well-being of HIV-positive individuals. Furthermore, the study emphasizes the importance of developing strategies to reduce the stigma associated with HIV to improve the quality of life of people living with HIV (PLWH).

Several studies have explored the role of internalized and anticipated stigma in the impact of HIV-related stigma on health and psychosocial outcomes. Caroline Kingori (2019) examined the impact of internalized stigma on HIV prevention behaviors among HIV-infected individuals seeking HIV care in Kenya. The study is particularly significant in light of the high levels of stigma associated with HIV in Kenya, which can have serious consequences for both the mental and physical health of HIV-positive individuals, as well as for the success of HIV prevention efforts.

Kingori's study draws on a sample of 184 HIV-positive individuals who were receiving care at a large HIV treatment center in Kenya. The participants completed a survey assessing their levels of internalized stigma and their HIV prevention behaviors, including condom use and adherence to antiretroviral therapy (ART). The findings of the study indicated that internalized stigma is indeed a significant barrier to HIV prevention behaviors among HIV-infected individuals in Kenya. Specifically, participants who reported higher levels of internalized stigma

were less likely to report consistent condom use and were more likely to report poor adherence to ART.

Moreover, the study finds that internalized stigma may operate differently for men and women, with women experiencing higher levels of internalized stigma and being more affected by it than men. This is particularly concerning given that women in Kenya are disproportionately affected by HIV and are often subject to gender-based violence and discrimination that can further exacerbate the effects of internalized stigma.

Turan et al. (2017) examined the relationship between perceived community stigma and health and psychosocial outcomes among PLWH, as well as the mediating roles of internalized and anticipated HIV stigma in this relationship. The study recruited 703 PLWH from four HIV clinics in the southeastern United States and collected data through surveys and medical record reviews.

The results of the study showed that perceived community stigma was associated with increased depression, anxiety, and poorer quality of life among PLWH. Furthermore, perceived community stigma had a direct impact on PLWH's physical health outcomes, such as increased viral load and reduced CD4 count. These findings are consistent with previous research that has shown that stigma can negatively impact the health and well-being of PLWH. The study also found that internalized and anticipated HIV stigma partially mediated the effects of perceived community stigma on health and psychosocial outcomes among PLWH. Specifically, the impact of perceived community stigma on health outcomes was partially mediated by internalized and anticipated HIV stigma. Similarly, the impact of perceived community stigma on psychosocial outcomes was partially mediated by internalized and anticipated HIV stigma.

Van der Kooij (2020) found that stigma is associated with increased levels of depression, anxiety, and stress in PLWH, leading to a decreased quality of life. Moreover, stigma can also result in social isolation and a lack of support from family, friends, and healthcare providers, which can exacerbate mental health issues. Stigma can also impact the social and economic lives of PLWH, resulting in discrimination in the workplace and reduced.

A study by Stutterheim et al. (2011) found that specific stigma manifests in various social settings and has harmful effects on the mental health of individuals living with HIV. The authors also found a relationship between HIV-related stigma and psychological distress. In addition, HIV-positive individuals who disclose their status are more likely to experience stigma visibility, which has been linked to poorer health outcomes.

The impact of HIV-related stigma on treatment adherence has been widely researched, and a systematic review and meta-synthesis by Katz (2013), provides valuable insights into this area. The review analyzed 30 studies conducted between 2002 and 2016 and found that HIV-related stigma had a significant negative impact on treatment adherence, particularly among marginalized and vulnerable populations. The review identified various types of stigma, including internalized, anticipated, and enacted stigma, which was all associated with poorer treatment adherence.

The review highlighted the role of healthcare providers in reducing stigma and improving treatment adherence. Healthcare providers who demonstrated supportive attitudes and behaviors, such as showing empathy, providing education, and being non-judgmental, were found to promote treatment adherence. In contrast, healthcare providers who exhibited stigmatizing behaviors, such as using stigmatizing language or making assumptions about patients' behavior, were found to contribute to HIV-related stigma and decrease treatment adherence.

A study conducted in China by Li et al. (2016), explored the impact of HIV-related stigma on healthcare providers' attitudes and behavior toward patients living with HIV. The study utilized a cross-sectional survey design, and data were collected from 372 healthcare providers across China. The results revealed that HIV-related stigma among healthcare providers was prevalent, with 62.9% of respondents reporting discomfort in treating HIV-positive patients. Furthermore, 51.6% of respondents believed that HIV-positive patients were responsible for their infection and 35.5% believed that HIV-positive patients should be isolated.

These attitudes and beliefs towards HIV-positive patients can result in discriminatory behavior, lack of adherence to treatment, and low quality of care. Inadequate training and education on HIV-related stigma and discrimination may be contributing factors to these negative attitudes among healthcare providers. The authors recommended that healthcare providers receive regular training on HIV-related stigma and discrimination to improve the quality of care and eliminate discriminatory attitudes.

In a qualitative study by Gagnon (2015) examined the impact of HIV-related stigma on healthcare settings. Gagnon's study included in-depth interviews with healthcare professionals in Canada, and her findings revealed that stigma surrounding HIV can lead to negative attitudes and behaviors towards patients living with the virus. This, in turn, can result in poor healthcare outcomes, including delayed testing, lack of follow-up care, and decreased treatment adherence. Gagnon's (2015) study highlights the need for increased education and training for healthcare professionals to combat HIV-related stigma and improve the quality of care for people living with the virus.

Rintamaki et al. (2006) examined the relationship between social stigma and medication adherence in individuals living with HIV. The study utilized an online survey of 238 individuals

living with HIV, and the results indicated that those who reported greater concerns about stigma were more likely to have lower adherence to their HIV medication regimens. The study also found that those who experienced social support from family and friends were more likely to have better adherence. Additionally, the study emphasized the need for healthcare providers to address social stigma concerns when treating individuals living with HIV, and to encourage social support from family and friends.

Dong et al. (2012) found that Chinese healthcare providers were highly stigmatizing towards individuals living with HIV. This stigma manifested in discrimination against HIV-positive individuals, with some providers even refusing to provide care to them. Additionally, fear of contracting HIV in the workplace resulted in discriminatory behavior towards HIV-positive colleagues. Such discrimination can lead to poor health outcomes for HIV-positive individuals, including decreased access to healthcare and reluctance to disclose their status. The findings of this study highlight the need for continued efforts to address HIV-related stigma among healthcare providers in China.

The impact of HIV-related stigma on individuals varies depending on the phase of the illness trajectory. Stigma can lead to negative evaluations of self and behavior, reluctance to disclose HIV status, isolation, alienation, internalization of negative attitudes, and disempowerment. Healthcare professionals should be mindful of the potential impact of their actions and language, which can exacerbate or alleviate the stigma experienced by individuals living with HIV.

3.7 Existing Efforts to Reduce HIV Stigma in Civil Society

The following section aims to examine the current efforts to reduce HIV-related stigma within Civil Society. However, the majority of existing literature on this topic is focused on the

healthcare sector. This is because healthcare providers play a crucial role in reducing HIV-related stigma and discrimination, given that they are typically the first point of contact for people living with HIV who may experience stigma or discrimination.

Andersson (2015) conducted a study that examined stigma reduction interventions for PLWH to improve their health-related quality of life. The study highlighted the importance of social support in reducing stigma, and how the use of peer educators could be an effective tool to combat stigma. Andersson found that the use of peer educators resulted in a significant reduction in internalized stigma and increased social support, ultimately improving the overall quality of life for PLWH.

The Horizons Project (2003) developed a self-assessment tool, to aid hospitals and medical institutions in providing better care for PLWH. The checklist provides a framework for assessing the level of HIV-related stigma and discrimination within healthcare settings and offers suggestions for improvement. The checklist has been successfully implemented in a number of countries and has resulted in improved quality of care and reduced stigma and discrimination.

Nyblade et al. (2019) conducted a literature review to identify effective strategies for combating HIV-related stigma in healthcare settings. The review found that interventions involving both healthcare providers and PLWH were the most effective. The study highlighted the importance of training healthcare providers to provide non-judgmental care and address systemic issues that contribute to stigma and discrimination within healthcare settings.

Marshall et al. (2017) sought to examine the different tools and methods used to measure HIV-related stigma among healthcare providers. Through their analysis of 28 studies, the authors identified a wide range of stigma measurement tools, including both self-administered surveys and interviews. They also found that certain factors, such as level of training and years of

experience, could impact healthcare providers' attitudes toward HIV-related stigma. The authors concluded that while there is no one standardized measure for HIV-related stigma, it is important to consider the cultural context and the specific populations being surveyed when selecting measurement tools. Overall, this study highlights the need for ongoing efforts to assess and address HIV-related stigma among healthcare providers and the importance of tailoring interventions to the specific needs of different populations.

While there have been some efforts to address HIV-related stigma and discrimination in civil society, most research and interventions have focused on healthcare settings. Steward (2007) stressed how stigma is a significant problem for those living with HIV. The publication reviewed research on the impact of HIV-related stigma on health behaviors and psychosocial adjustment among HIV-positive individuals in India. Steward (2007) proposed a theoretical framework that can be used to develop interventions to address stigma, highlighting the need for a multi-level approach that takes into account individual, community, and societal factors. The publication emphasizes the importance of involving people living with HIV in the development and implementation of stigma reduction interventions. Additionally, addressing HIV-related stigma is critical to improving the lives of those living with HIV and reducing the spread of HIV in India (Steward, 2007).

Poteat et al. (2015) aimed to adapt the conceptual framework of syndemics to understand and address the HIV risk among transgender women sex workers. The syndemic framework posits that social and structural factors, such as stigma, discrimination, and violence, interact with biological factors, such as HIV and other sexually transmitted infections, to produce syndemic conditions that increase vulnerability to HIV. The framework also recognizes the importance of addressing multiple health disparities that exacerbate HIV risk and contribute to

poor health outcomes among transgender women sex workers. Additionally, Poteat et al. (2015) suggest that HIV prevention interventions must address the complex interplay of syndemic conditions and multiple health disparities to effectively reduce HIV risk and improve the health of transgender women sex workers.

Skinta (2014) proposed a new framework to address HIV-related stigma. The study focused on acceptance and compassion-based group therapy (ACBT) as a potential intervention to reduce HIV stigma. The framework is based on the principles of mindfulness, acceptance, and compassion and is designed to address HIV stigma at multiple levels, including intrapersonal, interpersonal, and institutional. The study highlights the need to address the emotional and psychological components of HIV stigma in addition to the social and structural aspects.

While there have been some efforts to address HIV-related stigma and discrimination in civil society, the majority of research and interventions have focused on healthcare settings. This is because healthcare settings are often where PLWH receive medical care and may experience stigma or discrimination from healthcare providers or other patients. As a result, many interventions have focused on training healthcare providers to provide non-discriminatory care, implementing policies to protect the rights of PLWH in healthcare settings, and empowering PLWH to advocate for their own rights and access to care.

3.8 Existing Efforts to Reduce HIV Stigma in Christian Churches

In the previous section, we discussed the efforts of health care systems and health practitioners in reducing HIV-related stigma. In the following section, we will focus on the role of Christian churches in this effort. Christian churches play a critical role in many communities, and as such, they can have a significant impact on reducing HIV-related stigma and discrimination. This section will explore the various ways in which Christian churches are

involved in HIV-related stigma reduction efforts. By exploring the role of Christian churches in reducing HIV-related stigma, we can gain a better understanding of the broader effort to combat the negative impact of HIV/AIDS on individuals and communities.

AIDS-related stigma remains a significant challenge in many parts of the world, including those with high rates of HIV/AIDS. Christianity, the world's largest and most widespread religion, has a vital role to play in reducing stigma and promoting compassion and understanding toward those living with HIV/AIDS through its Christian churches. Paterson (2015) emphasized the need for the church to think creatively and theologically about ways to address HIV-related stigma. This article highlights the importance of promoting acceptance, love, and empathy as core Christian values and developing new frameworks that emphasize inclusion and support for those affected by HIV/AIDS. Through innovative and compassionate approaches, the Christian church can help to break down stigma and contribute to a more inclusive and supportive society for people living with HIV/AIDS. Patterson also discusses an approach of compassionate and accepting theology. This approach is based on the belief that every individual, regardless of their status, is a beloved child of God and deserving of love, compassion, and dignity. Churches that adopt this approach provide support and care to those living with HIV/AIDS and reject negative attitudes and actions toward them.

By thinking outside the box and adopting compassionate and accepting theology, churches can help to create a world where every individual, regardless of their HIV status, is treated with love, respect, and dignity. Bradley's (2018) study, provided valuable insights into the development of a faith-based HIV stigma-reduction intervention in a rural area in the Southeastern community in the United States Southern community. The study utilized a community-based participatory research approach and involved collaboration between

researchers and community stakeholders. The development of the intervention involved community engagement, and pilot testing. The use of biblical principles and faith leaders as key components of the intervention was identified as effective in reducing HIV-related stigma in the community. The study highlights the importance of community engagement and collaboration in the development of effective stigma-reduction interventions and provides a model for future community-based participatory research in HIV stigma reduction.

Coleman et al. (2012) developed a framework for HIV/AIDS prevention programs in African American churches. The authors note that African American churches are important community institutions and can play a key role in HIV prevention efforts. However, the authors found that few prevention programs have been developed specifically for use in churches, and there is a need for a framework that can guide the development of effective programs.

Additionally, Coleman et al. (2012) conducted a literature review and consulted with experts in the field to develop a framework that includes five key components: leadership, membership, message, methods, and evaluation. The leadership component emphasizes the importance of having strong and committed church leaders who can provide support and guidance for prevention efforts. The membership component focuses on engaging the congregation in prevention activities and creating a sense of community around HIV prevention. The message component emphasizes the need for culturally appropriate messaging that is tailored to the needs of African American communities. The methods component includes a range of prevention activities, such as HIV testing, educational programs, and outreach efforts. Finally, the evaluation component emphasizes the importance of measuring the effectiveness of prevention programs and making improvements based on feedback.

According to Coleman et al. (2012), this framework can be used to guide the development of HIV prevention programs in a variety of church settings, and they provide examples of how each component can be implemented. They also note that further research is needed to test the effectiveness of this framework and to refine it over time. Overall, this article provides a useful guide for developing HIV prevention programs in African American churches, which can be an important strategy for addressing the disproportionate impact of HIV/AIDS in this community.

Kruger et al (2020) explored the experiences of spiritual leaders who participated in a comprehensive HIV stigma reduction intervention in South Africa. The study utilized a qualitative research design, and data was collected through individual interviews with spiritual leaders who participated in the intervention. The study findings indicate that the intervention was effective in increasing knowledge about HIV and reducing stigma among spiritual leaders. The spiritual leaders also reported improved attitudes towards people living with HIV, increased empathy and compassion, and a willingness to provide support to people living with HIV. This study highlights the importance of engaging spiritual leaders in HIV stigma reduction efforts and provides insights into the potential impact of comprehensive interventions in reducing HIV-related stigma.

Ruffin et al. (2019) conducted a pilot study to investigate the effects of a church-based intervention on HIV stigma reduction and HIV testing promotion among African Americans and Latinos. The study utilized a pre-and post-test design with a sample of 69 participants from three churches in a Midwestern city in the United States. The intervention consisted of a two-day workshop that aimed to provide information on HIV, reduce stigma, and promote HIV testing. The results of the study showed a significant reduction in HIV-related stigma and an

increase in HIV testing rates among participants. Specifically, the Latino Roman Catholic and Latino Pentecostal intervention churches both showed significant decreases in HIV stigma and mistrust from baseline to follow-up. The effect size changes were -0.16 and -0.15 for HIV stigma and mistrust respectively in the Latino Roman Catholic intervention church, and -0.38 and -0.56 for HIV stigma and mistrust respectively in the Latino Pentecostal intervention church. The Latino Pentecostal control church also showed a significant decrease in HIV mistrust during the study. However, the African American Baptist intervention church showed no significant change in HIV stigma and mistrust, while the African American control intervention church experienced a significant increase in HIV mistrust.

The findings of Ruffin et al.'s study suggest that a church-based intervention can be an effective strategy for reducing HIV stigma and promoting HIV testing among African American and Latino populations. These results are consistent with previous research that has highlighted the important role of churches in HIV prevention efforts among minority populations (Levin et al., 2017; Coleman et al., 2012). However, further research is needed to confirm these findings and to determine the long-term effects of church-based interventions on HIV prevention behaviors among diverse populations.

In conclusion, the Christian church has an important role to play in reducing HIV-related stigma. By adopting innovative and compassionate approaches and promoting acceptance, love, and empathy as core Christian values, churches can contribute to breaking down stigma and creating a more inclusive and supportive society for people living with HIV/AIDS. Community engagement and collaboration are crucial in developing effective faith-based HIV stigma-reduction interventions, and the development of frameworks such as the one proposed by Coleman et al. (2012) can guide the creation of effective HIV prevention programs in African

American churches. The findings from studies by Kruger et al. (2020) and Ruffin et al. (2019) provide insights into the potential impact of comprehensive interventions and church-based interventions in reducing HIV-related stigma and promoting HIV testing. Overall, the Christian church has the potential to be a powerful force in reducing HIV stigma and helping to create a world where every individual is treated with love, respect, and dignity.

3.9 Literature Review Summary

How is stigma defined in sociology?

- Eric Goffman: stigma is a social construct that is imposed on individuals who possess certain attributes or characteristics that are deemed undesirable or unacceptable by society.
- Stigma can be defined as a negative or discriminatory attitude or behavior towards individuals or groups based on their perceived or actual characteristics, such as race, gender, sexual orientation, or health status.
- Within sociology, stigma has been studied from various perspectives, including social psychology, medical sociology, and cultural anthropology.
- Researchers have identified different types of stigma, such as personal or social stigma, enacted or felt stigma, and visible or invisible stigma.

What is disease-related stigma?

- Disease-related stigma refers to the negative attitudes and discriminatory behaviors directed towards individuals or groups who are perceived to be affected by a particular disease or health condition.
- Disease-related stigma can manifest in various ways, including fear, avoidance, blame, and discrimination.

- Disease-related stigma can have significant consequences for the health and well-being of those affected, including social isolation, limited access to healthcare, and increased risk of depression and other mental health issues.

Interpersonal stigma and societal stigma:

- Interpersonal stigma refers to the stigmatizing attitudes and behaviors exhibited by individuals towards those who are affected by a particular disease or health condition.
- Societal stigma, on the other hand, refers to the broader cultural and structural factors that contribute to stigma at the societal level, such as discrimination in healthcare, employment, and housing.
- Both forms of stigma can have significant negative impacts on the health and well-being of individuals and communities affected by HIV/AIDS.

Defining HIV-related stigma:

- HIV-related stigma can be defined as the negative attitudes, beliefs, and behaviors directed towards individuals and communities affected by HIV/AIDS.
- HIV-related stigma can manifest in various ways, including fear, blame, discrimination, and social exclusion.
- HIV-related stigma can have significant negative impacts on the health and well-being of individuals and communities affected by HIV/AIDS, including limited access to healthcare, increased risk of depression and other mental health issues, and decreased quality of life.

Impact of HIV-related stigma:

- Research has shown that HIV-related stigma can have significant negative impacts on the health and well-being of individuals and communities affected by HIV/AIDS.

- HIV-related stigma can lead to social isolation, limited access to healthcare and social services, and increased risk of depression and other mental health issues.
- HIV-related stigma can also have broader public health implications, including decreased uptake of HIV testing, treatment, and prevention services.

Civil society efforts to reduce HIV-related stigma:

- Civil society organizations have played a significant role in addressing HIV-related stigma through various strategies and initiatives, such as community mobilization, advocacy, and education campaigns.
- These efforts have focused on promoting awareness and understanding of HIV/AIDS, challenging negative attitudes and beliefs, and promoting acceptance and inclusion of individuals and communities affected by HIV/AIDS.
- Civil society organizations have also been involved in providing social support, healthcare, and other services to individuals and communities affected by HIV/AIDS.

Christian Church efforts to reduce HIV-related stigma:

- The Christian Church has played an important role in addressing HIV-related stigma, including its efforts to provide spiritual and emotional support to individuals living with HIV/AIDS and their families.
- The Church has also been involved in advocacy and education campaigns aimed at promoting awareness and understanding of HIV/AIDS, challenging negative attitudes and beliefs, and promoting acceptance and inclusion of individuals and communities affected by HIV/AIDS.

- The Church has also been involved in providing healthcare and other services to individuals and communities affected by HIV/AIDS, and in partnering with civil society organizations and other stakeholders to strengthen the response to HIV/AIDS.

CHAPTER 4: RESULTS

4.1 Summary of The Six Themes Derived from the WCC Case Study

The following is a summary of the six main themes identified by the World Council of Churches (WCC) Case Study. The themes are: 1) Diverse Congregations Yield Diverse Responses, 2) Processes Congregations Went Through and Their Effects, 3) Impact of HIV on Congregations' HIV Programs on People Living With HIV, 4) Theme 3: Impact of HIV on Congregations' Understanding of Faith and Scripture, 5) Challenges and Surprises Collaborating with Marginalized Communities, and 6) Recommendations. The recommendations of the case study are key in that they provide a guide for creating effective HIV-related stigma reduction programs and ministries for Christian churches.

4.2 Theme 1: Diverse Congregations Yield Diverse Responses.

The WCC Case Study discusses six congregations located in Africa and Latin America that offer various services and programs for people living with or affected by HIV, as well as those in the broader community who are not members. These services and programs were grouped into four categories: direct services, education of the congregation about welcoming people living with HIV, holistic care, and public witness. Direct services include transportation, financial support, counseling, food and nutritional support, job training, educational support, and HIV testing. Education about welcoming people living with HIV includes building awareness and commitment to support those with HIV, prevention education, and elders and church leaders publicly supporting those with HIV. Holistic care includes physical, psychological, social, and spiritual support such as food and housing, medical treatment, counseling, pastoral care, social events, and home visitation. Public witness involves visible acts of solidarity, the prophetic role

of ministers, lay involvement, community worship, challenging stigma and discrimination, and advocacy for expanded access to HIV medications and more just policies.

Two important characteristics were identified in all congregations. Firstly, they expanded their response to HIV over time from an inward focus to caring for their members to building relationships with people living with or affected by HIV outside the church. Secondly, the congregations offered programs for people across the lifespan with diverse dimensions of human life, such as children, adolescents, young adults, senior adults, women, men, and members of the LGBTQ+ community.

The case study emphasizes the importance of diverse congregations in yielding diverse responses. The congregations studied had members from various backgrounds and walks of life, which enabled them to offer a range of services and programs. The paper suggests that congregations can play a vital role in responding to the HIV epidemic by providing direct services, education about welcoming people living with HIV, holistic care, and public witness.

In conclusion, results of the WCC Case Study highlight the importance of diverse congregations in providing support and care for people living with or affected by HIV. The congregations studied provided a range of services and programs that addressed the physical, psychological, social, and spiritual needs of people living with HIV across their lifespans. The WCC Case Study's report suggests that congregations can make a significant contribution to responding to the HIV epidemic by expanding their response over time, offering programs for people from diverse backgrounds and walks of life, as well as actively challenging stigma and discrimination.

4.3 Theme 2: Processes Congregations Went Through and Their Effects.

Faith communities play an essential role in responding to public health challenges. Through the leadership of clergy and formative events, congregations develop a compassionate and prophetic response to public health challenges like the HIV epidemic. These events were often catalysts that required congregations to decide whether to offer welcome and hospitality to people living with HIV or to close their doors and echo a message of judgment heard in some faith communities and in the broader community. Despite the controversy, congregations weathered these challenges through formal events to create dialogue, training initiatives, and clear articulation of why HIV ministries reflect and broaden the mission of the church. This resilience and commitment of these communities in the face of adversity is remarkable. The impact of HIV programs and ministries went beyond the congregation, challenging stigma and discrimination in the broader community. HIV services served as a model, demonstrating that a compassionate response to public health challenges is not only possible but necessary.

The development of HIV programs and ministries forced congregations to grapple with difficult theological questions, challenging their understanding of love, compassion, and justice. The development of HIV programs and ministries is transformative not only for the individuals served but also for faith communities themselves. They call on faith communities to live out their faith in tangible ways, to love and care for their neighbors, and to work towards a more just and compassionate society. It challenges faith communities to re-examine their own biases and prejudices and to confront the ways in which their own biases and prejudices may have contributed to the marginalization of people living with HIV.

The lessons from the processes that congregations went through and their effects on their HIV programs and ministries provide an important framework for faith communities and society

as a whole. It demonstrates the resilience and commitment of these communities in the face of adversity, and it challenges us to re-examine our own biases and prejudices. It calls on us to work towards a more just and compassionate society, where all individuals are welcomed and valued, regardless of their HIV status or any other factor. Ultimately, it is a call to live out our faith in tangible ways, to love and care for our neighbors, and to work towards a more just and compassionate world.

4.4 Theme 3: Impact of HIV on Congregations' Understanding of Faith and Scripture

Congregations have become more accepting of those living with HIV, and this has changed their theological beliefs in various ways. The analysis of case study interviews identified six subthemes that emerged from the analysis of the congregations' responses, including the value of community ministry, cultural context, ecumenical and inter-faith efforts, holistic ministry, social witness, and theological beliefs. Additionally, four subthemes emerged regarding the way that HIV ministries changed congregations' theological beliefs, including the importance of hospitality, the power of prophetic witness, the nature of the church, and God's ongoing revelation. Finally, our analysis noted that while many congregations have become more accepting of people living with HIV, ongoing tensions and struggles remain, and some members still discriminate against gay people.

During the interviews, participants identified various frameworks for interpreting Scripture, describing how they turned to Biblical narratives to help them accept all people and welcome those who were despised. After meeting people living with HIV, participants described using Biblical texts to champion love and reject judgment and to deepen their capacity for empowering empathy. Several participants made a general reference to various stories in the gospels in which Jesus healed those who were sick. Others saw relevance in the book of Job in

which suffering was not linked to sinfulness but was something endured by various people in life regardless of their own actions.

4.5 Theme 4: The Impact of HIV on Congregations' HIV Programs on People Living with HIV

The WCC Case Study investigated the impact of congregations' HIV programs on people living with HIV, specifically in relation to voluntary disclosure of HIV status and the presence of people living with HIV in leadership positions within the congregations. The analysis showed that while most congregations did offer programs of hospitality, welcome, and support for people living with HIV, voluntary disclosure of HIV status was not common. This was often due to the high levels of stigma associated with HIV, which made people reluctant to disclose their status. However, many of those who did disclose were met with a welcoming and supportive response from their congregation and often assumed leadership positions within the congregation. Findings revealed a difference in responses between those who disclosed their HIV status and those who did not. Those who disclosed often described a more complex mix of social support within their congregations, including experiences of stigmatization and isolation. This highlights that even in congregations that offer support programs, stigmatizing attitudes can still persist, which can make it difficult for people to disclose their status and receive support. It was also found that the presence of people living with HIV in leadership positions within congregations can help to reduce stigma associated with HIV. These individuals were often more integrated into the congregational community, had a wider social network, and were able to advocate for people living with HIV and work to reduce the stigma associated with the virus.

In conclusion, it was found that congregations' HIV programs can have a positive impact on people living with HIV, but there is still much work to be done to reduce stigma and promote

social inclusion and integration within faith communities. Stigmatizing attitudes can persist even in congregations that offer support programs, highlighting the need for ongoing education and advocacy efforts to promote a more inclusive and welcoming environment for people living with HIV. The presence of people living with HIV in leadership positions within congregations is an important factor in reducing stigma and promoting social integration and should be encouraged and supported.

4.6 Theme 5: Challenges and Surprises Working with Marginalized Communities

The case study on congregations offering care and support to people living with or affected by HIV has highlighted challenges and surprises when working with marginalized communities. Congregations that have committed to addressing HIV need to support members in the congregations and stand in solidarity with those in the broader community who may face rejection, stigma, and discrimination because of their HIV status. However, stigma and discrimination are contextual, varying from place to place in relation to several social-cultural, religious, and political factors. The contextuality of stigma is evident in the various attitudes towards LGBTQ+ communities, sex workers, drug users, and other marginalized groups in different congregations. Some congregations have a long history of welcoming members of LGBTQ+ communities and even have them in leadership positions, while others have deeply entrenched, stigmatizing attitudes toward them. The attitudes toward sex workers and drug users are also complex and vary based on cultural, social, and religious factors.

The congregations' efforts to address these issues are ongoing, and many are working to expand God's welcome to members of their communities who live on the margins despite their own stereotypes. This requires dismantling unexamined and unconscious assumptions and challenging their own way of seeing the world. Some congregations are expanding their efforts

to reach out to marginalized communities, including those who are displaced from their homes due to war or civil unrest or those seeking asylum.

In these efforts, the notion of accompaniment plays a significant role. The concept of accompaniment is grounded in the empathy made possible by a mutual, loving relationship, where there is no hierarchy of those with resources and expertise and those in need of resources or knowledge. The interviewees described how spiritual accompaniment was not possible if physical needs were overlooked.

Overall, the contextuality of stigma is evident in the various attitudes towards marginalized communities in different congregations. Still, the commitment to addressing their needs through accompaniment, empathy, and mutual relationships is a common element among all interviewed. These efforts are ongoing and require continuous work to dismantle unexamined assumptions and challenge cultural and religious stereotypes to expand God's welcome to all members of the community.

The study also revealed that congregations need community partnerships to provide comprehensive care and support. They must also work with other organizations to address the underlying social and economic factors contributing to HIV stigma and discrimination. Despite the challenges, congregations experienced surprises and unexpected outcomes in their work. The HIV programs helped to break down barriers between different groups in the community and strengthen the sense of community within their congregations. It also helped challenge their own assumptions and stereotypes about people living with or affected by HIV, and the people they worked with were resilient, resourceful, and creative, despite the many challenges they faced.

So, in working with marginalized communities, including people living with or affected by HIV, a commitment is required in order to build relationships, challenge stereotypes and

assumptions, and work with other organizations and groups in the community. While there are challenges, there are also rewards such as strengthened communities, increased understanding, and acceptance, and new insights into the nature of faith and service.

4.7 Theme 6: Recommendations

Recommendations, the final theme from the WCC Case Study, organizes suggestions and advice offered by participants into three categories: 1) core principles to ground an HIV program, 2) programmatic characteristics of a strong HIV program, and 3) logistical considerations to address. It suggests that congregations focus on the physical before jumping ahead to the spiritual, actively challenge stigma, mobilize resources, work with other faith communities as a team, and consider a "3x3 Model" (see definition below) to develop specific activities to address physical, psychological, and spiritual dimensions of HIV support.

1) Core principles to ground an HIV program

- Accompaniment is your mission-- share knowledge with empathy and fellowship—HIV programs should be grounded in the realization that churches are called to work alongside those living with or affected by HIV because of shared humanity. Congregations should not take on an attitude of pity for those living with HIV or an air of superiority of expertise; rather they seek to discern how to build mutual, loving relationships with those who find their way into the programs offered.
- All are created in the image of God—Modeling the principle of accompaniment is only possible when we remember that every human being reflects the divine. This means that the person we meet through an HIV program represents an opportunity to learn something new about the nature of God's grace and goodness in the world. HIV

programs should not be focused in helping “the needy” but in awareness of the shared richness of relationship.

- Build a culture where all are welcome—HIV ministries may require the congregation to confront unacknowledged prejudices and stereotypes. They may place the congregation into unfamiliar places that are initially uncomfortable. The commitment to step into such places must be built on a commitment to welcome all and to acknowledge that the capacity to offer such welcome is an ongoing process. Such an attitude leads to a recognition that there is no “us” and “them” because we are all affected by HIV. It also calls congregations to discern how to actively and publicly stand alongside those on the margins. Finally, it involves advocacy and public engagement to challenge discriminatory laws and policies that create inequities.
- Know each person's story—Ground your programs with the act of gratefully hearing and being changed by each person’s story because such stories reveal God at work. The specific activities and services of your HIV program are important but don’t set them above the importance of the stories of people’s lives.
- Pray for a change of heart and mind by grounding your approach in love—Be prepared to be changed by your HIV programs and be willing to acknowledge attitudes and judgments that become plainer as you extend hospitality to people living with HIV.

2) Programmatic characteristics of a strong HIV program

- Focus on the physical before jumping ahead to the spiritual.
- Create awareness in your congregation so that those who are not actively part of the HIV programs can learn and grow and support such efforts. Don’t only address HIV on special occasions such as World AIDS Day; make your HIV programs part of the

communication the members receive not only in worship but also in other church programs.

- Designate your HIV program as an important ministry of your congregation and devote the resources (financial, personnel, administrative) necessary to make it strong.
- Actively challenge stigma. Do not let stigmatizing attitudes or messages go by without addressing them, even if they come from those in the congregation.

3) Logistical considerations to address

- Choose those who are best equipped to work in HIV ministries wisely and prepare them well. Those who staff a congregation's HIV programs will need specialized, in-depth training and preparation. This will include both knowledge and skills.
- Mobilize resources—Work to identify resources to support your congregation's HIV programs. This needs to come from the congregation but in many instances, you may also need to identify outside resources.
- Work with other faith communities as a team. Responding to HIV offers an opportunity for building ecumenical and inter-faith programs. Such partnerships can strengthen and amplify an HIV program beyond what is possible for a single congregation to do alone.
- Consider a "3x3 Model": One of the congregations included in the WCC Case Study shared that it had developed a framework that guided their HIV programs and ministries. This framework, entitled the "3x3 Model" consists of three levels of HIV support (primary, secondary, tertiary) across the three dimensions of our lives (physical, psychological, and spiritual)

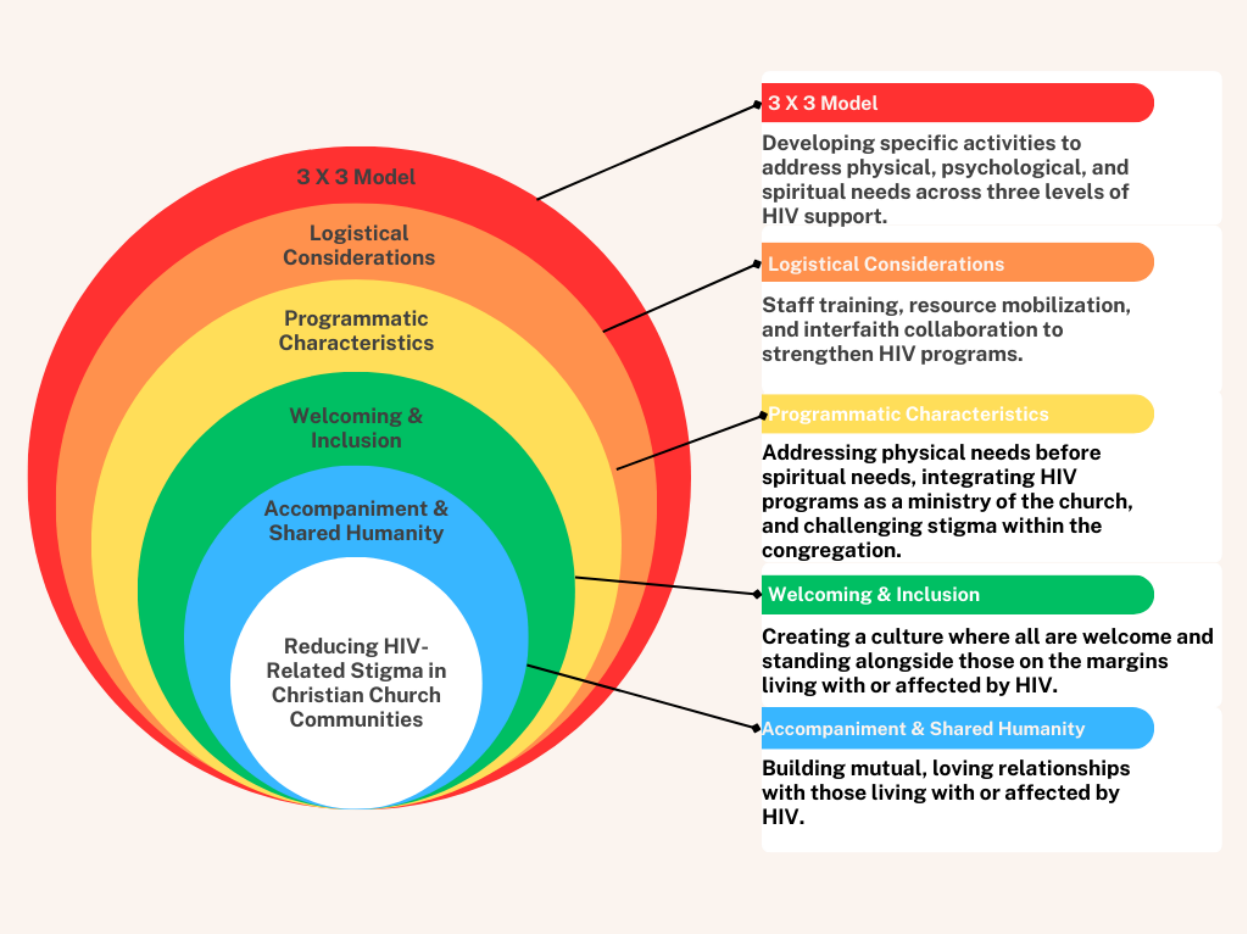
4.8 Figure 2: 3x3 Model

Support Levels/ Support Dimensions	Primary: Supporting those who are not living with HIV to avoid infection	Secondary: Supporting those living with HIV to live healthy lives	Tertiary: Supporting those experiencing severe illness and facing death
Physical			
Psychological			
Spiritual			

4.9 Five Recommendations Model

Figure 3 below is a concentric circle diagram depicting a model of five essential recommendations taken from the three categories above that are instrumental in reducing HIV-related stigma in Christian Church communities. Starting from the inside out, the first recommended step in blue is Accompaniment and Shared Humanity, the second in green is Welcoming & Inclusion, in yellow is Programmatic Characteristics, in orange is Logistical Considerations, and lastly in red is the 3x3 Model which encompasses elements of each of the four preceding recommendations.

Figure 3



CHAPTER 5: DISCUSSION

The following discussion will identify the ways in which the reviewed literature connects to the activities that the congregations that participated in the WCC case study carried out. Starting with the first recommendation of Accompaniment and Shared Humanity, followed by Programmatic Characteristics, Logistical Considerations, and finally, the 3x3 Model. It will be stated to what extent the literature review and the participating congregations of the WCC study are aligned in efforts to reduce HIV-related stigma.

Gilian Paterson, developed a framework that emphasizes that every individual, regardless of their status, is deserving of love, compassion, and dignity as a beloved child of God. Churches that adopt this approach provide support and care to those living with HIV/AIDS and reject negative attitudes and actions toward them. Patterson's framework directly coincides with the WCC Case Study recommendation of Accompaniment and Shared Humanity. Frameworks developed by Civil Society similarly address the importance of creating a space in which PLWH are not judged but cared for. And every congregation that participated in the WCC study explicitly shared how accompaniment and compassion were core principles of their HIV ministries and used the belief that all were created in the image of God to support these core principles.

HIV-related stigma and discrimination continue to affect individuals living with HIV and have far-reaching consequences on their physical and mental health, as well as their overall well-being. Sociologists and researchers have identified several strategies and frameworks that can help reduce HIV-related stigma and discrimination. Corrigan, P. W., & Rao, D. (2012) suggest that education about mental illness, advocacy for mental health rights, and contact with individuals who are successfully managing their mental health conditions can help reduce

stigma. They also emphasize the importance of creating supportive environments that reduce the impact of stigma on individuals with mental illness. None of the participants interviewed in the case study project framed their social support programs as a resource to support mental health but various participants did describe the importance of support and refer to the emotional toll that stigma took on people living with HIV.

Derose (2016) conducted a literature review and consulted with experts in the field to develop a framework that includes five key components: leadership, membership, message, methods, and evaluation. The study found that the church-based intervention led to a decrease in the mean score on the HIV Stigma Scale, indicating a reduction in stigma toward individuals living with HIV/AIDS. One clergy of a congregation that participated in the WCC study stressed how preaching the message of acceptance to congregants was essential in transforming how the congregation interacted with those living with HIV in their community.

Bradley (2018) provides valuable insights into the development of a faith-based HIV stigma-reduction intervention in a rural Southern community in the United States. The study utilized a community-based participatory research approach and involved collaboration between researchers and community stakeholders. The use of biblical principles and faith leaders as key components of the intervention was identified as effective in reducing HIV-related stigma in the community. Clergy of congregations in the WCC study also stressed how instrumental faith and scripture is in their efforts to reduce HIV-related stigma in their respective communities.

Frost (2011) emphasizes the need for stigmatized individuals to seek social support, engage in activism and advocacy, and use humor or other forms of resistance to challenge stigma. He also notes that societal interventions, such as education campaigns and policy changes, can help reduce social stigma and its harmful effects. Various congregations' programs

included these elements. All the congregations prioritized social support in their HIV ministries; many congregations offered education on HIV to members of the congregations and to the broader community.

Florom-Smith and De Santis (2012) recommend education, advocacy, and social support as critical components to reducing stigma. Education can help dispel myths and misconceptions about HIV, advocacy can help promote policies and programs that reduce stigma and discrimination, and social support can help PLWH, and their families cope with the emotional and practical challenges of living with HIV. Two congregations described how educating congregants and community members became a core tenet in their HIV -related ministries.

The use of peer educators has proven to be a powerful tool in combating HIV-related stigma. The Horizons Program SHARAN (2003) has developed a self-assessment tool, the PLHA-friendly achievement checklist, which has successfully been implemented in many countries, resulting in improved quality of care and reduced stigma and discrimination. While this is not specifically intended for Christian churches, it is similar to the programs of several congregations of the WCC study that have ministered to those living with or affected by HIV. Additionally, it coincides with the recommendation of programmatic characteristics in that it employs personnel within the respective organizations, which in this case are congregations. Nyblade et al. (2019) conducted a literature review on combating HIV-related stigma in healthcare settings and found that interventions involving both healthcare providers and PLWH were most effective. While this publication specifically is addressing the healthcare sector, congregations that participated in the study similarly involved both PLWH as well as congregants who desired to be involved in HIV-related ministries.

Parker and Aggleton (2013) and Turan et al. (2017), highlight the need to address the root causes of HIV-related stigma and discrimination through a comprehensive approach that involves changing social norms, beliefs, and practices. Their frameworks emphasize the importance of understanding the social, cultural, and political context in which HIV-related stigma and discrimination occur, and the need for multisectoral collaborations to address these issues. This framework aligns with the WCC recommendation of the 3x3 Model and each congregation that participated in the study has implemented all aspects of the model in some capacity. Specifically, the dimensions of the model are the focus of the congregations' HIV ministries. Regarding the levels of HIV support, congregations have done considerable amounts of work focusing on the primary and secondary levels. The tertiary level was actually the catalyst that motivated several of the congregations to begin their HIV-related ministries. The tragic and traumatic deaths of loved ones who suffered from AIDS and AIDS related complications motivated congregations to engage in different forms of HIV-related stigma reduction programing.

Steward (2007) stresses the need for interventions to address HIV-related stigma in India and proposes a theoretical framework that considers individual, community, and societal factors. The framework suggests a multi-level approach that includes people living with HIV in the development and implementation of stigma reduction interventions. The framework proposed by Poteat et al. (2015) in HIV risk and preventive interventions in transgender women sex workers adapts the syndemic framework to address HIV risk among transgender women sex workers. Addressing multiple health disparities and syndemic conditions that increase vulnerability to HIV is crucial in reducing HIV risk and improving the health of transgender women sex workers. Skinta (2014) proposes a framework based on mindfulness, acceptance, and compassion to

address HIV stigma at multiple levels. The study emphasizes the need to address the emotional and psychological components of HIV-related stigma in addition to the social and structural aspects. These proposed frameworks align with aspects of the 3x3 Model in that they address the physical and psychological needs of those who are living with or affected by HIV. However, the spiritual needs of these individuals are not considered, while every congregation of the WCC study focuses heavily on them.

CHAPTER 6: CONCLUSION

Drawing on academic literature and the six key themes identified in a case study of Christian congregations conducted by the Ecumenical HIV and AIDS Initiatives and Advocacy (EHAIA) Office and the Ecumenical Advocacy Alliance (EAA) of the World Council of Churches (WCC), in partnership with The Interfaith Health Program (IHP) at Emory University, this thesis compared common frameworks and strategies used in anti-stigma initiatives. The case study investigated the ways Christian congregations carry out programs to support people with HIV and HIV-related challenges, with the goal of developing resources for faith communities to begin new HIV ministries or strengthen existing ones. The purpose of this thesis was to identify successful strategies for reducing HIV-related stigma found both in Civil Society and Christian churches and connect them to that of the six participating congregations of the WCC case study.

The literature review of the HIV-related stigma reduction frameworks developed in the social sciences, civil society, and Christian churches shows that these frameworks are in many ways more similar than they are different. Each is in agreement that building a culture in which those who are living with HIV feel cared for rather than judged is essential in reducing HIV-related stigma. Each is also in agreement that addressing HIV-related stigma should be constant rather than occasional and that educating and preparing capable people who are passionate about reducing HIV-related stigma in their respective communities is paramount.

However, Christian churches are unique in their approach to reducing HIV-related stigma in that they focus on the spiritual dimensions of the lives of those who are affected by HIV. Sociologists and Civil Society tend to address the physical and psychological impacts of this stigma but do not necessarily address the spiritual needs of the people who they are serving. Although the Christian Church has historically been a driver of HIV-related stigma, particularly

due to negative views about the LGBTQ population, the core principle that we are all created in the image of God is the driving force behind the efforts of the participating congregations in the WCC case study to reduce this stigma. This core principle is preached by clergy and received by congregants to create an environment of empathy and acceptance that those who have been afflicted by the stigma of HIV have been largely deprived of.

Furthermore, the 3x3 Model can be an effective way to address this stigma because takes a holistic approach to the lives of those who are living with and affected by HIV. Additionally, most of the congregations of the case study employed each element of the model to some capacity in their approach to creating programs and ministries that aim to reduce HIV-related stigma. With this model in mind as well as the rest of the essential recommendations derived from the WCC case study, congregations who wish to begin and/or improve their efforts to reduce HIV-related stigma in their respective communities will have a widely applicable guide to assist them.

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