

AUSTRALIAN FEDERATION  
OF AIDS ORGANISATIONS

A background image of a sunset over a mountain range. The sun is low on the horizon, creating a bright glow and long rays of light that filter through the clouds and illuminate the landscape. The mountains are silhouetted against the bright sky.

# HIV & STIGMA IN AUSTRALIA

A GUIDE FOR RELIGIOUS LEADERS

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The Australian Federation of AIDS Organisations (AFAO) is the national federation for the HIV community response. We provide leadership, coordination and support on Australian HIV policy, advocacy and health promotion. Internationally we contribute to the development of effective policy and programmatic responses to HIV/AIDS at the global level, particularly in the Asia Pacific region.

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## WHY HIV IS AN IMPORTANT ISSUE FOR RELIGIOUS COMMUNITIES

HIV is a virus: the 'human immunodeficiency virus'. In a scientific sense, it is just a virus – no more or less than the multitude of other viruses that infect people every day. However, HIV is generally not regarded like other viruses. It frequently comes with 'baggage' that attracts disapproval, stigma and disgrace. Such attitudes are often informed by religious or moral values that are judgemental rather than compassionate.

During the 2011 Australian Census, more than half of all Australians reported being of Christian faith (61%). Many others (7%) reported non-Christian faiths: Buddhism (2.5%), Islam (2.2%), Hinduism (1.3%), Judaism (0.5%) and other non-Christian faiths (0.8%). The Census also shows that people born overseas are more likely to be people of faith than those born in Australia. This point is important, particularly for newly arrived migrants and emerging migrant communities who may lack social support but draw on their faith and connections to faith-based services.

Religious practice and HIV intersect in many ways. Religious beliefs shape individuals' values and behaviours. They inform how people judge their own and others' actions, how they treat others, and how they cope at times of crisis or grief.

HIV does not exist only outside religious communities. People of faith have HIV, have family members with HIV, and have friends living with HIV. Often the stigma associated with HIV makes them too embarrassed or ashamed to be open about their HIV infection with religious leaders, those providing pastoral care or others in their community.

Since the earliest days of the HIV epidemic, religious leaders and faith based organisations have made a significant contribution to HIV care and support. Many have also spoken out against stigma and discrimination based on HIV status or the behaviours associated with HIV transmission. Still, recent discussion with religious leaders and people living with HIV suggest the capacity of religious leaders and faith based organisations may be underutilised.

Australia's HIV response is a partnership involving government, non-government organisations, health care services, researchers and organisations of people living with HIV. That understanding is enshrined in the National HIV Strategy. Where do religious leaders and faith-based organisations fit?

This booklet outlines the current status of the Australian HIV epidemic, acknowledges the importance of faith in people's lives, and considers how religious leaders might further contribute to Australia's HIV response.

Persons living with HIV/AIDS are often severely stigmatized and subject to various forms of discrimination. As Christians, we believe all human beings are created in the image of God and therefore have intrinsic value and dignity.

Strategy consultation on Churches and HIV/AIDS in central and eastern Europe Memorandum of Intention, 2003

# WHAT ARE THE FACTS ABOUT HIV?

**HIV** (Human Immunodeficiency Virus) is a virus that infects cells of the immune system so that a person's body cannot effectively fight infection or disease. Seroconversion usually occurs between one and six weeks after HIV infection. At this point, some people develop a glandular fever-like illness (fever, rash, joint pains and enlarged lymph nodes), however, HIV cannot be diagnosed by symptoms. Only a blood test can determine whether a person has HIV.

Most people are unaware they have HIV when first infected because they experience no sense of illness. This has major implications for transmission as HIV is highly infectious during early infection – when most people don't know they have it.

**AIDS** stands for 'Acquired Immune Deficiency Syndrome'. AIDS describes the most advanced stages of HIV infection, defined by the occurrence of multiple opportunistic infections or HIV-related cancers.

Most people with HIV develop signs of HIV-related illness within five to ten years if they do not receive treatment but it can take a lot longer. Fortunately, most people with HIV in Australia have access to HIV specific medication (antiretroviral therapies) which slows down HIV disease progression. HIV treatments are now so effective that many people with HIV in Australia will not develop AIDS but will live long term with HIV.

We will continue to build our religious capacities to speak personally and in public about HIV without judgment and without increasing stigma.

Statement from Interfaith Forum to the 9th International Congress on AIDS in Asia and the Pacific, Bali, 2009

# HIV IN AUSTRALIA

UNAIDS suggests the global epidemic is stabilising but at an unacceptably high level. According to the *UNAIDS 2013 Global Report*, there were an estimated 35.3 million people living with HIV in 2012. The annual number of new HIV infections declined from some 3.1 million in 1999 to around 2.3 million in 2012. As a result of concerted efforts to increase access to antiretroviral medication, the number of AIDS deaths also declined from 2.3 million in 2005 to 1.6 million in 2012.

Internationally, HIV is a significant threat to development and stability. In many areas, HIV has caused a demographic imbalance due to the illness and death of many people in their most productive years, with resulting social and economic disaster for families and communities. There have been more than 25 million deaths to date.

Australia's early response to HIV and AIDS is widely recognised as being one of the best in the world. Following the identification of HIV and AIDS in Australia, federal and state governments responded pro-actively. They implemented often controversial public health strategies such as condom vending machines, needle and syringe exchange programs and, most importantly, publicly talked about the risk factors for HIV transmission. Communities also mobilised to prevent HIV transmission and provide support to those living with HIV. Communication with government was strong, and the partnership between government and communities most affected by HIV (such as gay men, sex workers and people who inject drugs) remains a distinguishing feature of the Australian response to HIV.

Australia's HIV strategy is evidence-based. Detailed surveillance information is collected and analysed to inform HIV prevention, care and treatment. All Australian states and territories require doctors and/or laboratories to notify cases of HIV diagnosis to their state health department, which then forwards that information to the Kirby Institute for Infection and Immunity in Society. Information is coded to protect client confidentiality. This careful management of data has been crucial to Australia's successful public health response.

HIV prevalence in Australia is far lower than in many parts of the world, including many other wealthy nations.

- ❖ At the end of 2012, an estimated 25,708 people in Australia were living with HIV.
- ❖ The number of new HIV diagnoses in Australia peaked in 1987, and then declined each year until 1999 when there were 724 diagnoses. Since 1999 the number of diagnoses has slowly increased each year. In 2012, 1,253 cases of HIV were diagnosed.
- ❖ The annual number of AIDS diagnoses in Australia peaked at 953 cases in 1994 and then declined rapidly. Despite many more people being infected with HIV, high uptake of antiretroviral therapies means that AIDS diagnoses in Australia have now reduced to about 50 cases each year.



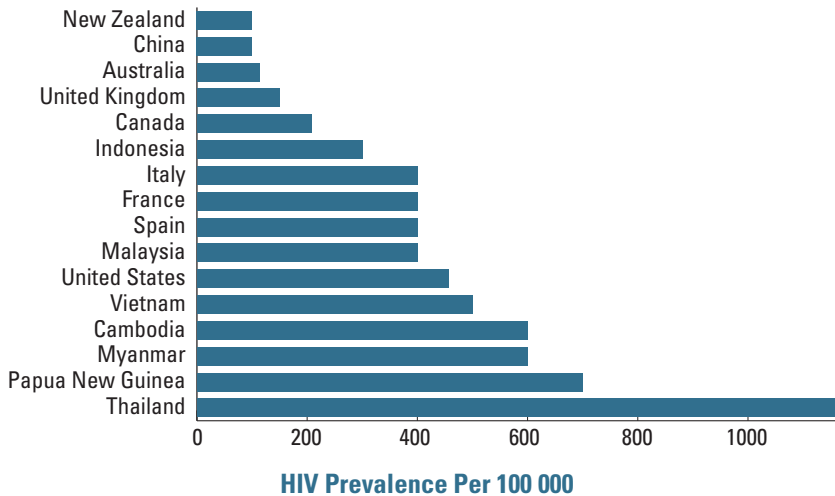
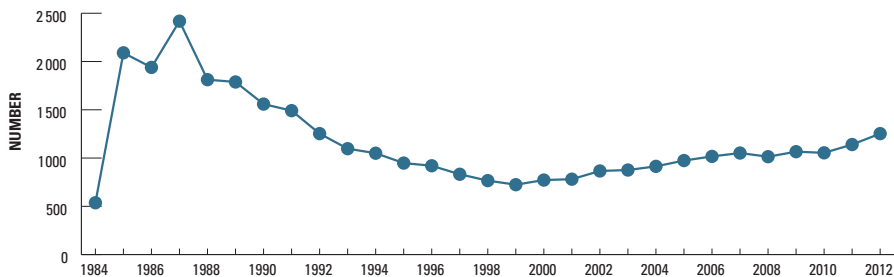


Figure 1: HIV prevalence in selected countries

Source: *HIV/AIDS, viral hepatitis and sexually transmissible infections in Australia Annual Surveillance Report 2013*



Newly diagnosed HIV infection in Australia by year

Figure 2: HIV Diagnoses in Australia, 1984-2012

Source: *HIV/AIDS, viral hepatitis and sexually transmissible infections in Australia Annual Surveillance Report 2013*

# WHO HAS HIV?

All people who engage in particular behaviours are at risk of HIV infection regardless of whether they are thought to belong to a 'high risk group' – terminology that is no longer used because it distracts attention from the core issue of HIV risk 'behaviours'. Surveillance data reflects that between 2008 and 2012 most people were infected as a result of:

## ❖ **Unprotected sex between men**

In Australia, transmission of HIV continues to occur primarily through sexual contact between men. Between 2008 and 2012, 67% of cases of newly diagnosed HIV infections were attributed to male homosexual contact (anal sex). Although there has been high uptake of safe sex practice among gay men, HIV continues to be transmitted because there are now many thousands of gay men living with HIV, not all gay men practice safe sex every time they have sex (throughout their lives), and HIV is at its most infectious during the days following infection (before people are diagnosed), when people presume themselves to be HIV negative.

## ❖ **Unprotected heterosexual sex**

Between 2008 and 2012, 25% of cases of newly diagnosed HIV infection were attributed to heterosexual contact. Some 40% of those people acquired HIV while outside Australia, in a country with high HIV prevalence (see below). The lower percentage of transmission among heterosexual people is partly because HIV is less likely to be transmitted during 'heterosexual sex' (vaginal sex) and only a very small proportion of heterosexual people in Australia are HIV infected. Approximately 10% of the 25,000 people living with HIV in Australia are women.

## ❖ **Injecting drug use**

Between 2008 and 2012, 2% of cases of newly diagnosed HIV infection were attributed to injecting drug use. This indicates the success of HIV prevention strategy among people who inject drugs: a success underpinned by the early introduction and maintenance of Needle and Syringe Programs and the contribution of peer-based education and drug-user organisations in HIV prevention.

## Newly diagnosed HIV infection

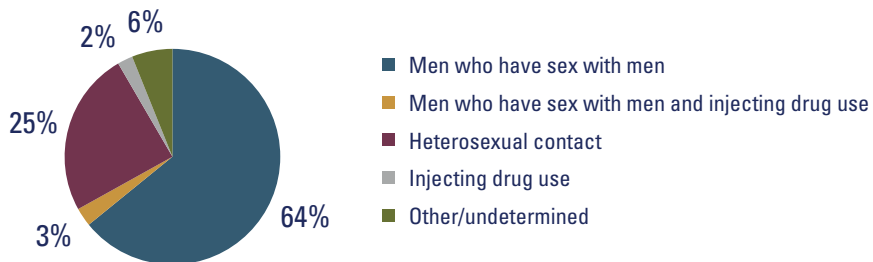


Figure 3: HIV diagnosis, 2008 – 2012, by HIV exposure category

Source: *HIV/AIDS, viral hepatitis and sexually transmissible infections in Australia Annual Surveillance Report 2013*

Two other issues of particular concern to analysts are risk associated with:

### ❖ **Traveling from or to countries with high HIV prevalence**

Between 2008 and 2012, 40% of those who had acquired HIV through heterosexual contact, acquired HIV in a high HIV prevalence country (not Australia). Some of those people acquired HIV before migrating to Australia. Others were infected while travelling: perhaps migrants returning 'home' to visit extended family and friends, business people working overseas, or 'Aussies' on holidays.

HIV infection can pose specific challenges for people from migrant communities. They may have been diagnosed in their country of origin and may not be aware of effective HIV prevention strategies or the availability of antiretroviral treatments. They may be concerned their HIV-positive status will affect their immigration status. They may not be eligible for Medicare. They may lack emotional support and be afraid to tell partners, extended family or community because they are worried they will be judged or shunned.

### ❖ **Being of Aboriginal and Torres Strait Islander descent**

The per capita rate of HIV diagnosis in the Aboriginal and Torres Strait Islander population is similar to the non-Indigenous population. Although most transmission is through sexual contact between men, a higher proportion of cases among Aboriginal and Torres Strait Islander people with HIV are attributed to heterosexual contact and injecting drug use. For example, between 2008 and 2012, 22% of Indigenous people diagnosed were women compared to 8% of diagnoses among non-Indigenous people (not exposed to HIV in a high prevalence country). 19% of diagnoses in Indigenous people were attributed to injecting drug use compared to 2% among non-Indigenous people.

There is concern about the potential for a rapid-spreading HIV epidemic initiated by injecting and sustained by high rates of sexually transmissible infections (in some communities) as has occurred overseas among Indigenous peoples and injecting drug users. Health promotion and harm reduction services can be difficult for Aboriginal and Torres Strait Islander populations to access. There is a need to address the high levels of stigma associated with HIV and STIs, particularly in remote communities, which leads to fears of disclosure and heightened secrecy.

This is the sum of duty:  
do not do to others  
what would cause pain  
if done to you.

Mahabharata 5:1517

# SNAPSHOT: LIVING WITH HIV

People living with HIV live varied lives so few generalisations are possible. However, the *HIV Futures 7* study, which surveyed more than 1000 HIV-positive Australians, found that of those interviewed:

- ❖ 71% rated their health as good or excellent
- ❖ 63% rated their general wellbeing as good or excellent
- ❖ During the previous 12 months:
  - 80% reported low energy or fatigue
  - 67% experienced a sleep disorder
  - 42% experienced confusion or memory loss
- ❖ 35% of respondents had taken prescribed medication for depression in the past six months.
- ❖ Almost all had disclosed their HIV status to at least one person, while 53% had had their HIV status disclosed to another person when they did not want it disclosed.
- ❖ 28% had experienced less favourable treatment because of HIV in relation to health services and 7% experienced less favourable treatment in relation to accommodation.
- ❖ 58% were in paid employment, the majority being in full-time work. Most of the remaining respondents described themselves as either not working or retired. Most respondents said they had either left their career or in some way reduced their career goals as a result of their HIV diagnosis.
- ❖ 29% lived below the poverty line.

# HOW IS HIV TRANSMITTED?

HIV is not transmitted by day-to-day contact in social settings, schools or in the workplace. You cannot be infected by shaking hands, hugging, using the same toilet, drinking from the same glass, playing sports with someone or by being exposed to coughing or sneezing by a person living with HIV. HIV is not spread by mosquitoes or other biting insects.

HIV is found in blood, semen, pre-ejaculate, vaginal fluids and breast milk. It can be transmitted through:

- ❖ unprotected penetrative sex (vaginal or anal)
- ❖ using contaminated syringes, needles or other sharp instruments
- ❖ blood transfusion with contaminated blood
- ❖ childbirth, breastfeeding, or from an infected mother to her child during pregnancy.

# REDUCING HIV TRANSMISSION RISK

Most religious organisations teach the sanctity of sex within marriage — providing education on abstinence and fidelity. However, there are many people, including people of faith, who are unwilling or unable to sustain abstinence or fidelity throughout their lives, thus placing themselves and others at risk. Similarly, some people decide to inject drugs despite the harms of injecting drug use being known.

HIV prevention in Australia relies on a culture of 'safe sex' (for sexual risk) and 'harm reduction' (for drug related risk), acknowledging that not all people will engage only in monogamous married relationships or refuse to inject drugs. This pragmatic approach has proven enormously successful at preventing HIV transmission over the 30 years of the HIV epidemic.

## SAFE SEX

'Safe' or 'protected' sex involves taking precautions that reduce the risk of transmitting or acquiring sexually transmissible infections including HIV. Without condoms, different sexual acts attach different degrees of risk but using condoms correctly every time one has sex is considered safe sex.

It is important that teachings on the sanctity of marriage do not undermine health promotion information, including the use of condoms as the most reliable means to prevent transmission of HIV or other sexually transmissible infections if relationships are not monogamous (on the part of both parties, who must also be HIV-negative at the commencement of the relationship).

It is also important that people, particularly young people, are not 'protected' from sex education. Years of research has failed to document any evidence that sex education of young people promotes promiscuity. To the contrary, it suggests young people who are 'protected' from sex education may commence sexual activity earlier and may be more at risk of sexually transmissible infections when they become sexually active. The issue of condom use can also be particularly relevant to faith communities as research has shown that some people of faith have struggled to tell their spouse that they have engaged in risk behaviours (sex without condoms) because they have been too embarrassed or ashamed of having failed their religious beliefs.

Some religious leaders may be uncomfortable addressing condom use directly. If so, it may be useful to involve a local medical professional or non-governmental organisation to provide information about risk of infection of HIV or sexually transmissible infections and also provide a different perspective on what's going on in the local community.

... We reject and emphasize the necessity to abolish all forms of discrimination, isolation, marginalization, and stigmatization of people living with HIV/AIDS; we insist on defending their basic freedoms and human rights.

The Cairo Declaration of Religious Leaders in the Arab States in Response to the HIV/AIDS Epidemic, 2004

Regard your neighbour's  
gain as your own gain  
and your neighbour's  
loss as your own loss.

The Prophet Lao Tzu, T'ai  
Shang Kan Ying P'ien,  
213

## ANTIRETROVIRAL THERAPY – TREATMENT AS PREVENTION

Taking antiretroviral therapy has been shown to significantly reduce (although not completely remove) the risk of HIV transmission to sexual partners. To maximise the effect of treatment as prevention, a person must: have been on antiretroviral therapy with an undetectable viral load for at least six months; have been adherent to medications (not missing any doses); be seeing a doctor for regular monitoring; and not have any other sexually transmissible infections. This approach to HIV prevention relies on advice from a person's medical practitioner.

## USING CLEAN SYRINGES AND OTHER STERILE INSTRUMENTS

People who inject drugs are at high risk of acquiring HIV because they can inject another person's HIV directly into their bloodstream. Australia's needle and syringe programs which provide clean injecting equipment have been highly successful in minimising HIV transmission through injecting drug use. Needle and syringe programs were introduced before HIV became endemic among Australian injecting drug users, resulting in low rates of HIV among injecting drug users compared to other comparable countries. The *Return on Investment 2: Evaluating the cost effectiveness of needle and syringe programs in Australia* report (2009) found that from 2000 to 2009, 32,050 HIV infections had been averted, with net financial cost savings exceeding a billion dollars.

Needle and syringe programs operate under the umbrella of 'harm reduction' which also includes peer education about safer drug use and drug treatment programs. Harm reduction strategies are not intended to condone drug use but rather to acknowledge that drug use does occur and to minimise harms that result from it.

HIV transmission risk also exists if non-sterile instruments are used for body piercing or tattooing. Instruments which penetrate the skin must be sterilised, used once, then disposed of or sterilised before use on a different person.



## **PEER EDUCATION**

Peer education has been a cornerstone of effective HIV prevention education. Peers are effective educators because they understand the culture and language of a group and can be accepted by its members. Peer-based education is likely to be more effective than education developed and delivered by other 'external' agencies, especially in marginalised communities. It has been very effective among gay men, sex workers and people who inject drugs.

## **CIRCUMCISION**

Male circumcision significantly reduces the risk of men acquiring HIV through heterosexual sex but it does not remove risk completely. Circumcised men can become infected and circumcised HIV-positive men can infect their sexual partners. Although a program of adult male circumcision is being implemented in some countries with high prevalence of HIV, this is not a strategy being pursued in Australia.

## **MOTHER TO CHILD TRANSMISSION**

Mother to child HIV transmission (sometimes called vertical transmission) can occur during pregnancy, during labour or after delivery through breastfeeding. The risk of mother-to-child transmission is reduced by treatment with antiretroviral drugs during pregnancy, caesarean section, and avoiding breastfeeding. While common in the developing world, mother to child transmission is rare in Australia, where less than 1% of babies born to HIV-positive mothers are HIV positive.

## **HIV TRANSMISSION IN HEALTH CARE SETTINGS**

Health-care workers are at risk of HIV (and other) infection as the result of handling sharp objects that might cut or puncture their skin while treating HIV-positive patients. Australian medical and associated staff are required to use standard precautions to minimise infection risk including sterilisation of instruments and disposing of sharp objects and waste. Patients may be at risk of HIV transmission from health care workers, however, such instances are very rare because health care workers have an obligation to know their HIV status and are precluded from performing exposure-prone procedures if HIV infected.

Australian blood products are tested for HIV before they are distributed to hospitals, so the risk of HIV transmission through blood transfusion is extremely low.

## **POST-EXPOSURE PROPHYLAXIS (PEP)**

Post-exposure prophylaxis (PEP) refers to a set of actions aimed at preventing infection in a person who may have been exposed to HIV. PEP may include counselling and risk assessment, HIV testing and the provision of a short course (28 days) of antiretroviral drugs with follow-up and support. Research suggests that if medication is initiated quickly after someone has been exposed to HIV, HIV infection may be averted. PEP should be made available as soon as possible and no later than 72 hours after exposure.

# TESTING FOR HIV

HIV testing allows HIV infection to be identified and facilitates access to treatment and support, often increasing quality of life and life expectancy of people living with HIV. It also lets the person know they have HIV and the necessary precautions they must use to prevent transmitting HIV to others.

HIV infection can only be diagnosed by an HIV blood test. Blood is sent to a laboratory with results usually available within a week. There is a short window period between becoming HIV infected and the infection showing up in tests. Most people who are HIV infected will test HIV positive within six weeks of exposure, although a small percentage of people take up to three months. Unfortunately, HIV is at its most contagious during this early period.

Recently 'rapid testing' has become available in some clinics. These tests are done in the clinic with results available within 30 minutes (a window period still applies if a person has been infected recently). Rapid HIV test results are always sent away for confirmation by laboratory tests as rapid testing produces a small proportion of 'reactive' (or preliminary positive) result which are incorrect.

HIV testing must be voluntary and performed with informed consent. The results are governed by privacy laws so although results are sent to a central database (to track HIV epidemiology), the results are coded and do not include patients' names. The identity of a person with HIV can only be revealed in rare circumstances following formal procedures. At some clinics it is possible for a person to have an HIV test without a Medicare Card and without giving their real name.

In the spirit of bikkur holim (visiting the sick), The United Synagogue of Conservative Judaism calls upon all of its congregations to reach out to individuals infected with the AIDS virus, their families and their friends by providing acceptance, comfort, counseling, and sympathetic and empathetic listening.

United Synagogue  
Resolutions on AIDS,  
1991

# TREATMENT FOR HIV

There is currently no cure for HIV, and best estimates put the likelihood of a vaccine or cure decades away. However, the development of effective treatments has radically changed the meaning of an HIV diagnosis. In the early 1980s, people living with HIV were expected to live only a few years but the development of antiretroviral therapies (ART) means most people in Australia diagnosed with HIV can expect to live long lives.

Antiretroviral drugs are used to treat and prevent HIV infection. They interfere with the reproduction of HIV in the body so immune cells live longer and protect the body from infections.

HIV is difficult to treat because it mutates to circumvent the effects of individual treatments. Combination antiretroviral therapy, which typically involves taking at least three drugs at the same time, makes it harder for the virus to adapt and become resistant. Taking the treatment every day at the right time of day (treatment adherence) is essential — and an ongoing challenge for many people with HIV and their treating doctors. The *HIV Futures 7* report found that of those people with HIV surveyed, 38% of those currently taking ART reported difficulties including (in order of frequency) remembering to take drugs on time, side effects, transporting medication, taking medication in public, organising meals around treatment times, and taking large numbers of tablets.

Fortunately, treatment technology has continued to improve so that most people now take only a few tablets once or twice a day, and some people take only a single tablet each day. Similarly, today's treatments have reduced side effects. If side effects occur, they are usually only experienced at the beginning of treatment and in most cases are relatively mild, don't last for very long and are easily managed. These and other improvements in treatment and care have resulted in more people with HIV taking treatment, and more people taking treatment reporting living healthy and happy lives.

It is estimated that only 50–60% of people living with HIV in Australia are currently taking antiretroviral treatment. Educational programs aiming to increase the number of people on treatment are underway. This strategy aims to improve the overall health and wellbeing of people with HIV, and also to decrease the chance of HIV being passed on to others. Antiretroviral treatment can also reduce the risk of mother to child transmission.

I am a stranger  
to no one; and no  
one is a stranger  
to me. Indeed, I am  
a friend to all.

The Prophet Lao Tzu,  
Guru Granth Sahib,  
p.1299

# THE ROLE OF RELIGIOUS LEADERS

## WHY RELIGIOUS LEADERS?

In countries around the world, religious leaders are searching for ways to respond to a disease that is not only a health problem but a crisis with profound social, economic and spiritual impact. Many religious leaders clearly want to 'do something', and examples abound of ways they have been of service. Yet in some cases, religious leaders have admitted that they have actually contributed to the spread of HIV and the stigma surrounding it by denying that it exists within their communities and congregations and by judging and rejecting people with HIV.

Faith-based beliefs and faith-based prejudice continue to impact community values and sometimes support stigma and discrimination against people with HIV. Stigma and discrimination deny human dignity and the right to fully participate in family, community and public life. In many communities, the stigma associated with HIV is so great that a culture of silence surrounds HIV infection. That increases HIV transmission risk and undermines people living with HIV across all aspects of their lives including family and community interactions, employment and health care. People with HIV who are scared others will 'find out' may not seek treatment or the support that could help them lead fuller, healthier lives. They may also be unable to access the information they need to prevent the spread of HIV to others. The 'silence' around HIV further fuels HIV risk because people are unaware that others in their community have HIV, and presume they do not need to take responsibility for their own health by only engaging in 'safe' behaviours. For service providers, efforts at prevention or care become more difficult as the HIV epidemic is driven underground.

Religious leaders are uniquely poised to 'break the silence' by acknowledging people living with HIV, ensuring their actions do not discriminate against or exclude people living with HIV, and encouraging their congregations to do the same. Religious leaders have the power to end guilt, denial, stigma and discrimination and open the way to reconciliation, healing and hope.

Religious leaders are in a unique position to alter the course of the HIV epidemic because they are able to:

- ❖ shape social values
- ❖ support enlightened attitudes, policies and laws
- ❖ promote responsible behaviour that respects the dignity of all people
- ❖ foster the process of reconciliation to bring divided families and communities back together
- ❖ provide resources for spiritual and social care and support
- ❖ promote action from the grass roots up to the national level

We concur that it does not matter how one is infected but it does matter how one is affected. . . . We also acknowledge that people living with HIV/AIDS need unconditional love and support and are not to be stigmatised and discriminated.

International Pre-conference  
Muslim Workshop on  
HIV/AIDS In the name of  
Allah, the Beneficent, the  
Merciful, Bangkok, 2004

# WHAT CAN I DO?

Where religious leaders have taken constructive action, particularly in partnership with HIV-based services, there have been significant successes preventing HIV and alleviating the distress and isolation of people living with HIV. Consider this checklist<sup>2</sup>:

## **BREAK THE SILENCE**

- ❖ Be proactive. Don't wait for a crisis before approaching the congregation or wider community. Talk about HIV and its effects, especially stigma and discrimination.
- ❖ Be accurate and clear. Speak honestly about the transmission of HIV (using scientific facts) and about treatment and care of those living with HIV.
- ❖ Initiate discussions in places of worship, within religious leadership structures, and in the broader community.
- ❖ Talk with those who are living with HIV in the community to learn of their experiences and find out their ideas about how to help end HIV stigma and discrimination.

## **END IGNORANCE**

- ❖ Be informed: Learn as much as possible about HIV by becoming familiar with scientific, social and cultural facts regarding HIV.
- ❖ Explore personal prejudices and speak about HIV in a non-judgemental way.
- ❖ Encourage others to understand how HIV is transmitted and what impact HIV is having in the local community.
- ❖ Take a public position against HIV-related stigma and discrimination.



## OFFER COMPASSION AND PROMOTE RECONCILIATION

- ❖ Use religious and spiritual teachings in a positive way. Identify and refer to religious or sacred texts to increase community understanding of HIV and provide support for people living with HIV.
- ❖ Work with other religious leaders and faith-based coalitions to find common beliefs and moral standards that can help prevent HIV and improve the lives of people living with HIV.
- ❖ Believe in the process. Be a facilitator for dialogue. Help people talk about the issues and express what they want and need.

## SUPPORT PROGRAMS AND PRODUCTIVE LAWS AND POLICY

- ❖ Determine what resources can be mobilised to support HIV services including spiritual and social counselling, health education, care and other support systems.

## INVOLVE PEOPLE LIVING WITH HIV

- ❖ Ensure access to spiritual support among people living with HIV.
- ❖ Include people with HIV in prevention and care, spiritual outreach and theological debates as a way of affirming the social acceptance, dignity and centrality of people with HIV in the HIV response.
- ❖ Be tactful and compassionate, taking care not to offend, exclude or further stigmatise.
- ❖ Hold public events with people living with HIV as a way to promote reconciliation and healing in the community.
- ❖ Above all, give people hope. Religious leaders can help people with HIV live longer, more meaningful and dignified lives.

The obligation to provide appropriate care for the sick is seen not only as one of the most universal obligations in Jewish law, but as in fact the opportunity to emulate the Divine Attributes (*Imitatio Dei*) (cf TB, Sotah 14a).

The Provision of Decent Care for Individuals Living with HIV/AIDS. Rabbi David Rosen, 2008

# A FEW WORDS ABOUT LANGUAGE

Speaking about HIV and AIDS is fraught with sensitivities. Some people find the subject difficult to talk about, so it is worth taking the time to familiarise yourself with the most appropriate language to use to avoid insults, hurt or stigmatisation. A good rule of thumb is:

❖ **Always use language that shows respect.** Use words that are inclusive, avoiding use of 'us' and 'them'.

❖ **Strive not to impose value judgements.**

Some language is derogatory and perpetuates myths or stereotypes about HIV. Do not label people as 'innocent victims' as that suggests others are guilty and 'deserved' infection. Similarly, the terms 'AIDS victim' and 'AIDS sufferer' can be insulting as they suggest powerlessness and increase stigma. Many people living with HIV do not consider themselves to be suffering. Instead they are living with this particular virus.

❖ **Be aware of the difference between the terms 'HIV' and 'AIDS'.**

There is a difference between HIV and AIDS, so the two terms should not be used interchangeably. Only HIV can be transmitted. AIDS cannot as it describes a syndrome of illnesses caused by HIV.

A person infected with HIV is described as 'HIV positive', meaning they have received a 'positive' result from a blood test for HIV infection. HIV can live in the body for years without causing immediate or obvious damage. Even after some time, a person may not have symptoms letting them know they are living with the virus.

In everything, do to others as you would have them do to you; for this is the law and the prophets.

Matthew 7:12 (NRSV)

Someone who has an AIDS diagnosis has a syndrome characterised by a severely weakened immune system and typically has debilitating symptoms. There are many effective treatments that can stop HIV developing into AIDS. Increasingly, people on treatments live a long and productive life similar to people who do not have HIV. Due to the effectiveness of modern antiretroviral treatments, AIDS diagnoses are now rare in Australia.

❖ **Use clear but sensitive language.**

Clear and accurate information about HIV can save lives so it is vital that people have a clear understanding of HIV transmission risk. Some people find particular language offensive or embarrassing. Try to get the meaning across in ways that will not offend. For example, some people are uncomfortable with the word 'sex' but may accept terms such as 'sexual relations' or 'human sexuality'. If religious leaders are able to communicate openly and honestly about a difficult subject, others will too.

❖ **Respect confidentiality.**

HIV-positive people continue to experience discrimination and sometimes violence due to their HIV-positive status. A person's HIV status should not be disclosed without their explicit permission unless it is already a matter of public record (for example, in court proceedings).

❖ **Avoid stereotyping.**

People living with HIV are a diverse population. The idea that a person must belong to a 'high-risk group' is not only wrong, it also potentially damages public health measures aiming to educate the public about high-risk *practices*. Everyone has a responsibility to minimise the risk of HIV transmission.

# LANGUAGE CHECKLIST

Some terms can be misleading or denigrating to people living with HIV. Here is a quick checklist of commonly used but problematic language, and suggestions of alternative terms and phrases.

**DON'T USE:** AIDS if the intention is to refer to HIV

**USE:** HIV infection, HIV positive, HIV or AIDS

AIDS is a syndrome encompassing a range of conditions that occur when a person's immune system is seriously damaged by HIV infection. Most people with HIV do not have AIDS.

**DON'T USE:** AIDS virus or HIV virus

**USE:** HIV or AIDS

There is no such thing as 'the AIDS virus'. There is only HIV (Human Immunodeficiency Virus): the virus that can cause AIDS. The term 'HIV virus' means 'Human Immunodeficiency Virus virus': a tautology.

**DON'T USE:** AIDS victim, HIV sufferer or AIDS sufferer

**USE:** person with HIV, person living with HIV or HIV-positive people

The words 'victim' and 'sufferer' are disempowering. Many people living with HIV dislike these terms because they are patronising and imply they are completely powerless. People do not necessarily suffer because they have HIV.

**DON'T USE:** innocent victims

**USE:** people with medically acquired HIV, children with HIV

'Innocent victims' is usually used to describe children with HIV or people with medically acquired HIV infection. It implies that people infected in other ways are guilty of some wrong-doing and deserved to be infected with HIV. This feeds stigma and discrimination and should be avoided.

**DON'T USE:** AIDS carrier or AIDS-infected

**USE:** person with HIV, person living with HIV or HIV-positive people

The term 'AIDS carrier' is highly stigmatising and offensive to many people living with HIV. It is also incorrect as the infective agent is HIV. A person cannot catch 'AIDS'.

**DON'T USE:** full-blown AIDS

**USE:** person with AIDS

This term is overly dramatic and also implies that there is such a thing as a partial case of AIDS. A person has AIDS or they do not.

**DON'T USE:** risk of AIDS

**USE:** risk of HIV infection

HIV is the virus, not AIDS.

**DON'T USE:** AIDS test

**USE:** Use HIV test or HIV antibody test

There is no test for 'AIDS'. It is diagnosed after a person experiences a range of conditions. There is only a test for HIV.

**DON'T USE:** body fluids

**USE:** blood, semen, pre-ejaculate, vaginal fluids and/or breast milk [be specific]

Confusion about the body fluids that transmit HIV causes fear and misunderstanding, and continues to trigger discrimination against people living with HIV. Only certain body fluids contain HIV in sufficient concentration to be implicated in HIV transmission. HIV cannot be transmitted through body fluids such as saliva, sweat, tears or urine.

**DON'T USE:** prostitute

**USE:** sex worker

Prostitute is a loaded and disparaging term and does not reflect the fact that sex work is a form of employment not a lifestyle. People from all walks of life work in the Australian sex industry.

**DON'T USE:** junkie, drug addict

**USE:** person who injects drugs, injecting drug user

Terms such as 'junkie' rely on a stereotyped image that is inaccurate and often greatly misrepresents drug users' varied lives. Drug dependency is a medical condition and is not, in itself, a crime. Remember, illicit drug use is only one part of an injecting drug user's life.

**DON'T USE:** high-risk group

**USE:** affected communities, high-risk behaviour

Using the term HIV 'risk group' implies that membership of a particular group is the significant factor in HIV transmission. This term may lull people who don't identify with a particular group into a false sense of security. It is high-risk *behaviours* such as unprotected sex or unsafe injecting practices that spread HIV.

# WHERE CAN I FIND OUT MORE? SERVICES

## NATIONAL HIV-BASED ORGANISATIONS

### AUSTRALIAN FEDERATION OF AIDS ORGANISATIONS

**Website:** [www.afao.org.au](http://www.afao.org.au)

**Address:** Level 1, 222 King St, Newtown NSW 2042

**Postal Address:** PO BOX 51, Newtown NSW 2042

**Telephone:** (02) 9557 9399

**Email:** [mail@afao.org.au](mailto:mail@afao.org.au)

### NATIONAL ASSOCIATION OF PEOPLE LIVING WITH HIV AUSTRALIA (NAPWHA)

**Website:** [www.napwha.org.au](http://www.napwha.org.au)

**Address:** Suite G5, 1 Erskineville Road,  
Newtown, NSW 2042

**Postal Address:** PO Box 917, Newtown NSW 2042

**Telephone:** (02) 8568 0300

**Email:** [admin@napwha.org.au](mailto:admin@napwha.org.au)

### THE KIRBY INSTITUTE FOR INFECTION AND IMMUNITY IN SOCIETY

**Website:** [www.kirby.unsw.edu.au](http://www.kirby.unsw.edu.au)

**Address:** Wallace Wurth Building,  
UNSW Australia  
Sydney NSW 2052

**Telephone:** (02) 9385 0900

**Email:** [recpt@kirby.unsw.edu.au](mailto:recpt@kirby.unsw.edu.au)

### **CENTRE FOR SOCIAL RESEARCH IN HEALTH (CSRH)**

**Website:** [www.csrh.arts.unsw.edu.au](http://www.csrh.arts.unsw.edu.au)

**Address:** Goodsell Building,  
UNSW Australia  
Sydney NSW 2052

**Telephone:** +61 (2) 9385 6776

**Email:** [csrh@unsw.edu.au](mailto:csrh@unsw.edu.au)

### **AUSTRALIAN RESEARCH CENTRE IN SEX, HEALTH AND SOCIETY (ARCSHS)**

**Website:** [www.latrobe.edu.au/arcshs](http://www.latrobe.edu.au/arcshs)

**Address:** La Trobe University, 1st floor, 215 Franklin Street,  
Melbourne VIC 3000

**Telephone:** (03) 9285 5382

**Email:** [arcshs@latrobe.edu.au](mailto:arcshs@latrobe.edu.au)

### **AUSTRALIAN GOVERNMENT DEPARTMENT OF HEALTH AND AGEING**

**Website:** [www.health.gov.au/internet/main/publishing.nsf/Content/ohp-bbvs-hiv](http://www.health.gov.au/internet/main/publishing.nsf/Content/ohp-bbvs-hiv)

**Postal Address:** GPO Box 9848, Canberra ACT 2601

**Telephone:** (02) 6289 1555

**Email:** [enquiries@health.gov.au](mailto:enquiries@health.gov.au)

## STATE-BASED HIV ORGANISATIONS

A comprehensive list of state-based HIV services, including AIDS Councils, is updated regularly on the AFAO website at

**[www.afao.org.au/about-hiv/links/australian-links/state-based-organisations](http://www.afao.org.au/about-hiv/links/australian-links/state-based-organisations)**

### AUSTRALIAN CAPITAL TERRITORY

#### **AIDS Action Council**

02 6257 2855

[www.aidsaction.org.au](http://www.aidsaction.org.au)

### NEW SOUTH WALES

#### **ACON**

Sydney 02 9206 2000 / 1800 063 060

Hunter 02 4927 6808

Mid-North Coast

- Port Macquarie 02 6584 0943

- Coffs Harbour 02 6651 6017

Northern Rivers 02 6622 1555 / 1800 633 637

[www.acon.org.au](http://www.acon.org.au)

#### **Positive Life NSW**

02 9206 2177 / 1800 245 677

[www.positivelife.org.au](http://www.positivelife.org.au)

### NORTHERN TERRITORY

#### **Northern Territory AIDS & Hepatitis Council (NTAHC)**

Darwin 08 8944 7777

Alice Springs 08 8953 3172

[www.ntahc.org.au](http://www.ntahc.org.au)

### QUEENSLAND

#### **Queensland AIDS Council**

Brisbane 07 3017 1777 / 1800 177 434

Cairns 07 4041 5451 / 1800 884 401

[www.quac.org.au](http://www.quac.org.au)



## **Queensland Positive People**

Brisbane 07 3013 5555 / 1800 636 241

Cairns 07 3013 5511

[www.qpp.net.au](http://www.qpp.net.au)

## SOUTH AUSTRALIA

### **Gay Men's Health South Australia**

08 8245 8100

[www.gmhsa.org.au](http://www.gmhsa.org.au)

### **Positive Life SA**

08 8293 3700 / 1300 854 887

[www.hivsa.org.au](http://www.hivsa.org.au)

## TASMANIA

### **Tasmanian Council on AIDS, Hepatitis & Related Diseases**

03 6234 1242 / 1800 005 900

[www.tascahrd.org.au](http://www.tascahrd.org.au)

## VICTORIA

### **Victorian AIDS Council**

03 9865 6700 / 1800 134 840

[www.vac.org.au](http://www.vac.org.au)

### **Living Positive Victoria**

03 9863 8733

[www.livingpositivevictoria.org.au](http://www.livingpositivevictoria.org.au)

## WESTERN AUSTRALIA

### **Western Australian AIDS Council**

08 9482 0000

[www.waaid.com](http://www.waaid.com)

When a sick person is overwhelmed by a life threatening condition like AIDS, of course we must give physical relief, but it is equally important to encourage the spirit to live through a constant show of love and compassionate care.

The Dalai Lama, 2006

Treat not others in  
ways that you yourself  
would find hurtful.

The Buddha,  
Udana-Varga 5.18

## LEGAL ADVICE

### HIV/AIDS LEGAL CENTRE

**Website:** [www.halc.org.au](http://www.halc.org.au)

**Phone:** (02) 9206 2060

**Free call:** 1800 063 060

**Hearing Impaired:** (02) 9283 2088

### NATIONAL ASSOCIATION OF COMMUNITY LEGAL CENTRES

**Website:** [www.naclc.org.au](http://www.naclc.org.au)

**Phone:** (02) 9264 9595

**Email:** [naclc@clc.net.au](mailto:naclc@clc.net.au)

## MULTICULTURAL HIV RELATED SERVICES

### NEW SOUTH WALES

#### MULTICULTURAL HIV/AIDS AND HEPATITIS C SERVICE (MHAHS)

**Website:** [www.multiculturalhivhepc.net.au](http://www.multiculturalhivhepc.net.au)

**Phone:** (02) 9515 5030

**Free call:** 800 108 098 (NSW country)

## SOUTH AUSTRALIA

### PERSONAL EDUCATION AND COMMUNITY EMPOWERMENT (PEACE) MULTICULTURAL SERVICES

**Website:** [www.rasa.org.au/services/couples-families/peace-multicultural-services](http://www.rasa.org.au/services/couples-families/peace-multicultural-services)

**Phone:** (08) 8245 8100

## QUEENSLAND

### ETHNIC COMMUNITIES COUNCIL OF QLD

**Website:** [www.eccq.com.au](http://www.eccq.com.au)

**Phone:** (07) 3844 9166

### QUEENSLAND HEALTH MULTICULTURAL SERVICES

**Website:** [www.health.qld.gov.au/multicultural](http://www.health.qld.gov.au/multicultural)

**Email:** [multicultural@health.qld.gov.au](mailto:multicultural@health.qld.gov.au)

**Phone:** (07) 3328 9873

## VICTORIA

### **MULTICULTURAL HEALTH AND SUPPORT SERVICE**

**Website:** [www.ceh.org.au](http://www.ceh.org.au)

**Phone:** (03) 9342 9711

### **ALFRED HOSPITAL – HIV CALD SERVICE**

**Website:** [www.alfredhealth.org.au/hivaidsservice](http://www.alfredhealth.org.au/hivaidsservice)

**Phone:** (03) 9076 3942

## WESTERN AUSTRALIA

### **METROPOLITAN MIGRANT RESOURCE CENTRE**

**Website:** [www.mmrcwa.org.au](http://www.mmrcwa.org.au)

**Phone:** (08) 9345 5755

### **MULTICULTURAL MENTAL HEALTH AUSTRALIA**

**Website:** [www.mmha.org.au](http://www.mmha.org.au)

## **INTERPRETER SERVICES**

Telephone Interpreter Service (TIS) - To use an interpreter over the telephone: 131 450

### **To book a telephone interpreter or an on-site interpreter to attend an appointment:**

<http://www.tisnational.gov.au/Agencies/Forms-for-agencies/New-Job-booking-form>

### **For Medical Practitioners to register for free interpreting services:**

Medical Practitioners Free Interpreting Registration Form:

<http://www.tisnational.gov.au/Agencies/Forms-for-agencies/Register-for-a-TIS-National-client-code>

## **HIV AND FAITH ORGANISATIONS AND NETWORKS**

### **AMERICAN JEWISH WORLD SERVICE**

[www.ajws.org](http://www.ajws.org)

### **BAHÁ'Í INTERNATIONAL COMMUNITY**

[www.bic-un.bahai.org](http://www.bic-un.bahai.org)

### **CATHOLIC AIDS ACTION**

[www.caa.org.na](http://www.caa.org.na)

### **CATHOLIC RELIEF SERVICES**

[www.catholicrelief.org](http://www.catholicrelief.org)

### **COUNCIL OF RELIGIOUS AIDS NETWORKS (CRAN)**

[www.aidsfaith.com](http://www.aidsfaith.com)

### **ECUMENICAL ADVOCACY ALLIANCE**

[www.e-alliance.ch](http://www.e-alliance.ch)

### **INERELA+ POSITIVE FAITH IN ACTION**

[www.inerela.org](http://www.inerela.org)

### **ISLAMIC MEDICAL ASSOCIATION OF UGANDA**

[www.imau-uganda.org](http://www.imau-uganda.org)

### **WORLD CONFERENCE OF RELIGIONS FOR PEACE**

[www.religionsforpeace.org](http://www.religionsforpeace.org)

### **WORLD COUNCIL OF CHURCHES**

[www.wcc-coe.org](http://www.wcc-coe.org)

The churches need to provide the leadership to prevent and to overcome HIV and AIDS, and recognize people living with the virus as precious members of the community. Sound policies have to be put in place with tangible actions.

Statement on churches' compassionate response to HIV and AIDS. Geneva, 2006

# RESOURCES

## HIV AND FAITH

### **What Religious Leaders can do about HIV/AIDS.**

UNICEF, the World Conference of Religions for Peace and the Joint United Nations Programme on HIV/AIDS (UNAIDS), 2003.

This book is a resource for religious leaders to explore ways of responding to HIV/AIDS. It includes basic information about HIV and suggests ways in which leaders can motivate action in their communities.

[www.unicef.org/publications/index\\_19024.html](http://www.unicef.org/publications/index_19024.html)

### **Faith Advocacy Toolkit - Advocacy for Universal Access: A Toolkit for Faith-based Organisations.** World AIDS Campaign, 2011.

This toolkit was written to inspire people of faith to use the strength of their communities to advocate for universal access to HIV prevention, treatment, care and support for all. It includes a background on faith-based responses to the HIV pandemic, tools for planning advocacy campaigns, and overviews existing government commitments to universal access.

[www.neac.org/files/documents/faith\\_advocacy\\_toolkit\\_pdf.pdf](http://www.neac.org/files/documents/faith_advocacy_toolkit_pdf.pdf)

### **Exploring Solutions: How to Talk about HIV Prevention in the Church.** Ecumenical Advocacy Alliance, 2008.

This guide aims to help people in churches to talk openly, accurately and compassionately about why HIV spreads and what we as individuals and communities can do to help stop it in its tracks.

[www.e-alliance.ch/en/s/hivaids/publications/exploring-solutions/](http://www.e-alliance.ch/en/s/hivaids/publications/exploring-solutions/)

### **Islam, sexual diversity and access to health services: Discussion paper.** Asia Pacific Coalition on Male Sexual Health, 2013.

This discussion paper examines why Islam matters in prevention efforts for HIV, what Islam and Muslim scholars say about MSM and transgender people, and how this impacts on the lives of MSM and transgender people and their access to health services.

[www.apcom.org/sites/default/files/Discussion%20paper-Islam%2812%29.pdf](http://www.apcom.org/sites/default/files/Discussion%20paper-Islam%2812%29.pdf)

What is hateful to you, do not do to your neighbour. This is the whole Torah; all the rest is commentary. Go and learn it.

Hillel, Talmud,  
Shabbath 31a

**HIV/AIDS Advocacy and Media Relations Manual + Stigma and Discrimination Handbook.** Religions for Peace, 2008.

This manual was developed to equip teams of trainers from religious bodies (members of national Inter-Religious Councils) to enhance religious leaders' skills developing and implementing advocacy strategies and strengthening their relations with the media.

<http://www.religionsforpeaceinternational.org/node/389>

**SAVE TOOLKIT: A Practical Guide to the SAVE Prevention Methodology.** Save the Children, INERELA+, Christian Aid, 2011.

SAVE reflects the underlying purpose of prevention programs – to save lives through education and skill development, but it is also an acronym for Safe(r) practices, Access to treatment, Voluntary counselling and testing, and Empowerment. This guide explains the SAVE approach and provides practical guidance and suggestion to incorporate SAVE into HIV and wider health programs.

[www.inerela.org/wp/wp-content/downloads/INERELA%20SAVE%20Toolkit%20Full.pdf](http://www.inerela.org/wp/wp-content/downloads/INERELA%20SAVE%20Toolkit%20Full.pdf)

**HIV Prevention: A Global Theological Conversation.**

Ecumenical Advocacy Alliance, 2009.

This book is the work of thirty-five leading theologians and practitioners from five continents and many church traditions. It aims to summarise theological reflections, promote reflection, and develop strategies for further dialogue and collaboration with communities of faith including other religions.

[www.e-alliance.ch/en/l/hivaids/publications/theological-conversation](http://www.e-alliance.ch/en/l/hivaids/publications/theological-conversation)

**Moments in Time: HIV/AIDS Advocacy Stories.** The Policy Project, July 2003.

The manual documents HIV/AIDS policy advocacy stories as a means of preserving them and making them available to develop others' capacity to design and implement a variety of creative advocacy campaigns.

[www.policyproject.com/pubs/monographs/MomentsFULL.pdf](http://www.policyproject.com/pubs/monographs/MomentsFULL.pdf)

HIV/AIDS is a crisis of enormous spiritual, social, economic and political proportions. Overcoming HIV/AIDS and the stigma that fuels its spread is a huge challenge. It requires courage, commitment and leadership; especially among religious leaders who can use the trust and authority they have in their communities to change the course of the pandemic.

What Religious Leaders can do about HIV/AIDS.  
UNICEF, 2003

**The Global HIV/AIDS Pandemic, an educational resource on the Jewish response to the pandemic.** American Jewish World Service, 2005.

This manual provides Jewish reflections on HIV and aims to inspire teaching on HIV and action to end the HIV/AIDS pandemic.

[www.ajws.org/what\\_we\\_do/education/resources/aids-module-v2.pdf](http://www.ajws.org/what_we_do/education/resources/aids-module-v2.pdf)

**Scaling up Effective Partnerships: A Guide to Working with Faith-Based Organizations in the response to HIV and AIDS.** Ecumenical Advocacy Alliance, 2006.

This publication aims to help secular organisations, government structures and multi-lateral partners to better understand faith-based organisations as a means to increase HIV prevention, treatment, care and support efforts.

[www.e-alliance.ch/en/s/hivaids/mobilizing-resources/faith-literacy](http://www.e-alliance.ch/en/s/hivaids/mobilizing-resources/faith-literacy)

**Together We Must Do More: My Personal Commitment to Action.** High Level Summit of Religious Leaders on HIV, March 2010. A statement of personal commitment by religious and spiritual leaders pledging "stronger, more visible and practical leadership in the response to HIV".

[www.e-alliance.ch/en/s/hivaids/summit-of-high-level-religious](http://www.e-alliance.ch/en/s/hivaids/summit-of-high-level-religious)

**Selection of religious statements on HIV and AIDS.** High Level Summit of Religious Leaders on HIV, March 2010.

This document contains excerpts from a selection of statements and policies made by religious leaders and international faith-based organisations about HIV and AIDS, particularly around issues of stigma, discrimination and inclusion.

[www.e-alliance.ch/typo3conf/ext/naw\\_securedl/secure.php?u=0&file=fileadmin/user\\_upload/docs/summit\\_docs/Background Documents/Selection\\_ReligiousStatements.pdf&t=1394590193&hash=62c9ae38af50d6a81b446af6e1202fbb](http://www.e-alliance.ch/typo3conf/ext/naw_securedl/secure.php?u=0&file=fileadmin/user_upload/docs/summit_docs/Background Documents/Selection_ReligiousStatements.pdf&t=1394590193&hash=62c9ae38af50d6a81b446af6e1202fbb)



**Partnership with Faith-based Organizations: UNAIDS Strategic Framework.** UNAIDS, 2009.

The framework aims to encourage stronger partnerships between UNAIDS and faith based organisations to achieve universal access to HIV prevention, treatment, care and support, which includes the integration of faith based organisations in comprehensive national AIDS responses.

[http://data.unaids.org/pub/Report/2010/jc1786\\_fbo\\_en.pdf](http://data.unaids.org/pub/Report/2010/jc1786_fbo_en.pdf)

**Framework for Dialogue between Religious Leaders and Networks of People Living with HIV.** Ecumenical Advocacy Alliance, Global Network of People Living with HIV, International Network of Religious Leaders Living with or Affected by HIV or AIDS, UNAIDS, 2014.

The Framework for Dialogue is a tool for developing joint actions and discussions between religious leaders, faith-based organizations and networks of people living with HIV at national level. The Framework is based on evidence from people living with HIV, particularly the People Living with HIV Stigma Index.

[www.frameworkfordialogue.net](http://www.frameworkfordialogue.net)

**A Strong and Active Faith Community at AIDS 2012: EAA Activity Report and Evaluation.** Ecumenical Advocacy Alliance. 2012.

Report of the faith community's input into the 2012 International AIDS Conference.

[www.iac.ecumenicaladvocacy.org/wp-content/uploads/2012/10/1210\\_AIDS2012Report\\_FINAL.pdf](http://www.iac.ecumenicaladvocacy.org/wp-content/uploads/2012/10/1210_AIDS2012Report_FINAL.pdf)

## COMMUNITY LANGUAGES AND PLAIN ENGLISH PRINT

### MULTICULTURAL HIV AND HEPATITIS C SERVICE (MHAHS)

The MHAHS website provides a variety of resources about HIV, hepatitis C and sexual health available in more than 25 languages, including Akan, Amharic, Arabic, Bosnian, Burmese, Chinese, Croatian, Greek, Indonesian, Italian, Khmer, Korean, Macedonian, Portuguese, Serbian, Spanish, Shona, Somali, Tagalog, Thai, Turkish and Vietnamese.

[www.mhahs.org.au](http://www.mhahs.org.au)

## **HEALTH TRANSLATIONS DIRECTORY**

An online directory links to online multilingual health resources from government departments, peak health bodies, hospitals, community health centres and welfare agencies.

[www.healthtranslations.vic.gov.au](http://www.healthtranslations.vic.gov.au)

## **DIVERSITY HEALTH INSTITUTE CLEARINGHOUSE**

Lists a range of materials on multicultural health, including fact sheets, reports, videos, CDs, journals, leaflets, posters and signs.

<http://203.32.142.106/clearinghouse>

## **INFORMATION FOR CALD COMMUNITIES PRODUCED BY FAMILY PLANNING WA**

A range of material relating to sexual health, including information about how to put on a condom, women's health information and information about sex and the law in a range of languages, including Arabic, Burmese, Chinese, Swahili, Thai, Vietnamese.

[www.fpwa.org.au/resourcecentre](http://www.fpwa.org.au/resourcecentre)

## **INFORMATION FOR CALD COMMUNITIES PRODUCED BY FAMILY PLANNING NSW**

A range of factsheets in several community languages providing essential information on topics including contraception and sexually transmissible infections.

[www.fpnsw.org.au/index\\_nes.html](http://www.fpnsw.org.au/index_nes.html)

## **WOMEN AND HIV FACTSHEETS**

The Women and HIV Factsheets provide basic information about HIV, and are particularly appropriate for women who have been recently diagnosed with HIV, and those from culturally and linguistically diverse backgrounds (CALD).

[www.fpnsw.org.au/625547\\_8.html](http://www.fpnsw.org.au/625547_8.html)

## **TOP TIPS: LIVING WELL WITH HIV - A PLAIN ENGLISH GUIDE**

A booklet containing information about living with HIV, along with contact information for relevant organisations. Each tip is written in a relatively brief format for readers to refer to and to assist them in finding out more information about particular topics.

[www.hivtoptips.org.au](http://www.hivtoptips.org.au)

## **INFORMATION ABOUT REFUGEE HEALTH CLINICS (RHS) IN NSW**

Information about Refugee Health Clinic services, available in Arabic, Dari, Dinka, English, Farsi, and Swahili.

[www.swslhd.nsw.gov.au/refugee/about\\_clinics.html](http://www.swslhd.nsw.gov.au/refugee/about_clinics.html)

## **HIV PREVENTION BROCHURES**

Information about how to avoid transmitting HIV, hepatitis and sexually transmissible infections. These brochures are available in simple English and Amharic, Arabic, Burmese, Chin, Chinese, Karen, Khmer, Lao, Somali and Vietnamese.

[www.ceh.org.au/our-programs/our\\_programs\\_mhss/info\\_for\\_service\\_providers/bbv\\_sti\\_resources](http://www.ceh.org.au/our-programs/our_programs_mhss/info_for_service_providers/bbv_sti_resources)

## **HEP C IN BRIEF FACT SHEETS**

A fact sheet in Australian State and Territory specific format that includes a listing of local support groups and organisations. Hep C in Brief is available in English and eight community languages.

[http://www.ashm.org.au/default2.asp?active\\_page\\_id=133](http://www.ashm.org.au/default2.asp?active_page_id=133)

## **AIDS DATAHUB COUNTRY PROFILE**

Data and information about HIV by country. Includes Data Sheets, Country Overviews in Slides, Maps and HIV related profiles of 25 countries and regions.

[www.aidsdatahub.org/country-profiles](http://www.aidsdatahub.org/country-profiles)

## **COMMUNITY LANGUAGES AND PLAIN ENGLISH AUDIO VISUAL**

### **TRANSMISSION DVD KIT**

Four short films aiming to increase understanding of hepatitis C and its transmission routes. Created for and with various CALD communities, the DVD kit uses animation and hip hop to deliver health messages. The kit includes detailed facilitator's notes to help assist with health promotion use.

[www.ceh.org.au/mhss/info\\_for\\_service\\_providers/transmission\\_iv.aspx](http://www.ceh.org.au/mhss/info_for_service_providers/transmission_iv.aspx)

Not one of you truly believes until you wish for others what you wish for yourself.

The Prophet  
Muhammad, Hadith

We ... affirm that the full realisation of all human rights and fundamental freedoms for all, regardless of their HIV status, is an essential element of the Hindu faith.

Declaration on HIV and AIDS: Hindu Leaders' Caucus. Bangalore, 2008

### **BRIDGING DIFFERENCES, ENHANCING UNDERSTANDING**

A DVD resource kit on culturally appropriate health promotion, based on a project in which Iraqi and African families discussed hepatitis C and sexual health. Further information about the DVD resource kit and order details are available at:

[www.ceh.org.au/about/projects/pages/bridgingdifferences.aspx](http://www.ceh.org.au/about/projects/pages/bridgingdifferences.aspx)

### **EVERYBODY'S BUSINESS DVD**

An audio-visual resource for trainers and educators working with people from CALD backgrounds in the area of HIV and hepatitis C. The DVDs on HIV and hepatitis C are accompanied by a facilitator's CD containing training activities and handouts in English, Arabic, Chinese (Mandarin), Indonesian, Khmer, Somali, Spanish, Thai and Vietnamese.

[www.mhahs.org.au/images/pdf/everybodybusiness-dvd-order-form.pdf](http://www.mhahs.org.au/images/pdf/everybodybusiness-dvd-order-form.pdf)

### **LIVING A POSITIVE LIFE (CD 2005)**

This multilingual HIV/AIDS audio CD captures experiences of living with HIV/AIDS. Available in Arabic, Chinese (Cantonese and Mandarin), Croatian, English, Indonesian, Khmer, Spanish, Thai and Vietnamese.

[www.mhahs.org.au/index.php?option=com\\_content&view=article&id=153&Itemid=63&lang=en](http://www.mhahs.org.au/index.php?option=com_content&view=article&id=153&Itemid=63&lang=en)

### **ABOUT AIDS CD-ROM**

The About AIDS CD-ROM provides people with basic HIV/AIDS information in an interactive format. Although designed for students learning English with the support of an English language teacher, this CD-ROM is also useful for people requiring plain English resources.

[www.fpnsw.org/products/About-AIDS-CDROM.html](http://www.fpnsw.org/products/About-AIDS-CDROM.html)

## **HEALTH CHECK DVD: HEALTH INFORMATION FOR RECENTLY ARRIVED AFRICAN COMMUNITIES IN AUSTRALIA**

This resource provides recently arrived African communities with clear information about health checks and procedures in Australia in English, Dinka, Kirundi, Swahili, Krio, Juba Arabic or Liberian Pidgin English.

View: [www.youtube.com/user/refugeehealth](http://www.youtube.com/user/refugeehealth)

## **AUSTRALIAN RESEARCH MATERIALS (IN ENGLISH) FOR AND ABOUT CALD COMMUNITIES**

### **RESOURCE MANUAL - CALD COMMUNITIES, SEXUALLY TRANSMISSIBLE INFECTIONS AND VIRAL HEPATITIS**

A resource manual for health and community service workers, produced by Multicultural Health and Support Service (MHSS) includes information on working with diverse health beliefs and levels of literacy, explaining sexual health terms and useful support services and resources.

[www.ceh.org.au/mhss/info\\_for\\_service\\_providers/bbv\\_sti\\_resources.aspx](http://www.ceh.org.au/mhss/info_for_service_providers/bbv_sti_resources.aspx)

### **BBV/STI GLOSSARY**

A glossary of terms relating to sexual health and viral hepatitis for interpreters, translators and others who work in a health setting. The glossary includes easy to understand definitions.

**Web Version:** [www.ceh.org.au/glossary](http://www.ceh.org.au/glossary)

**PDF Version:** [www.ceh.org.au/downloads/MHSS\\_glossary\\_Web-friendly\\_version.pdf](http://www.ceh.org.au/downloads/MHSS_glossary_Web-friendly_version.pdf)

## **AFAO DISCUSSION PAPER: HIV AND SUB-SAHARAN AFRICAN COMMUNITIES IN AUSTRALIA**

Available on request – email: [web@afao.org.au](mailto:web@afao.org.au)

## **DOUBLE TROUBLE? THE HEALTH NEEDS OF CULTURALLY DIVERSE MEN WHO HAVE SEX WITH MEN**

Report based on a Multicultural Health and Support Service (MHSS) convened consultative forum on the topic of culturally and linguistically diverse (CALD) men who have sex with men (MSM).

[www.ceh.org.au/mhss/info\\_for\\_service\\_providers/cald-msm.aspx](http://www.ceh.org.au/mhss/info_for_service_providers/cald-msm.aspx)

## **UNDERSTANDING LATE DIAGNOSIS AMONG PEOPLE FROM CULTURALLY AND LINGUISTICALLY DIVERSE (CALD) BACKGROUNDS**

Research report investigating reasons for late HIV diagnosis in New South Wales focusing on people from CALD backgrounds in the Sydney metropolitan area.

[https://csrhc.arts.unsw.edu.au/media/CSRHFile/5\\_CALD\\_Understanding\\_late\\_HIV\\_diagnosis\\_report.pdf](https://csrhc.arts.unsw.edu.au/media/CSRHFile/5_CALD_Understanding_late_HIV_diagnosis_report.pdf)

## **SURVEY OF HIV KNOWLEDGE AND USE OF SERVICES AMONG PEOPLE FROM CALD BACKGROUNDS 2006-2008**

Periodic survey of HIV knowledge and use of health services among people from culturally and linguistically diverse backgrounds.

[https://csrhc.arts.unsw.edu.au/media/CSRHFile/6\\_CALDperiodicsurvey.pdf](https://csrhc.arts.unsw.edu.au/media/CSRHFile/6_CALDperiodicsurvey.pdf)

## **NCHSR SOCIAL RESEARCH BRIEF, NUMBER 12: HIV, DIVERSITY AND CULTURAL COMPETENCE**

A brief report on the framework of ‘cultural competence’.

<https://csrhc.arts.unsw.edu.au/media/CSRHFile/SRB12.pdf>





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