

FAITH-BASED ORGANIZATIONS ADDRESSING HIV/AIDS IN CANADA:

A NATIONAL FRAMEWORK



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ACKNOWLEDGEMENTS

As part of its core values and beliefs, the Canadian AIDS Society (CAS) adopts a holistic approach to health, emphasizing that good health encompasses physical, emotional, mental and spiritual well-being. This holistic approach also guides the work of CAS as it supports communities and organizations that address the needs of people living with and affected by HIV/AIDS. The lived experience of HIV is often more acutely felt socially than physically. Recognizing this, CAS is committed to reducing inequity, stigma and other social factors driving the epidemic by working with all levels of government, community organizations, and people living with and affected by HIV/AIDS.

In recent years, CAS and its membership of community-based AIDS service organizations have witnessed increasing interest in HIV work coming from Canadian faith communities and faith-based organizations. Community-based responses to address HIV/AIDS can come from any number of communities. In efforts to address stigma, discrimination, homophobia, and other social justice issues driving the HIV epidemic in Canada, CAS and its membership aim to develop relationships with diverse partners to clearly communicate the needs of the HIV/AIDS community in Canada, and to articulate what can be done to support both people living with and affected by HIV/AIDS as well as the work of our community-based organizations. This document, *“Faith-based Organizations Addressing HIV/AIDS in Canada: A National Framework,”* was created in part to support the creation and development of those partnerships.

The Canadian AIDS Society also intended this document to be a resource for those working in a pastoral care context to support people living with HIV/AIDS in their communities, and to encourage faith communities to affirm people living with HIV/AIDS in a societal context. This document draws upon international resources developed for faith-based organizations and faith communities offering pastoral care for people living with HIV/AIDS.

The Canadian AIDS Society wishes to thank the Project Advisory Committee for guiding the development of this resource. Their insight and experience has been instrumental in informing this document.

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Special thanks go to Project Consultant Pattie LaCroix, and to Canadian AIDS Society staff Patrick McIntyre, Kim Thomas, and Monique Doolittle-Romas for their contributions.



ABOUT THE CANADIAN AIDS SOCIETY

Representing community-based AIDS organizations across the country, the Canadian AIDS Society (CAS) strengthens the response to HIV/AIDS in Canada and enriches the lives of people and communities living with HIV/AIDS.

CAS accomplishes this by:

- promoting education and awareness
- mobilizing communities
- amplifying the voices of Canadians living with HIV/AIDS
- engaging with Canadians on public policy
- providing information and resources



*If you want to travel quickly, go alone.
If you want to travel far, go together.*

African proverb

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1. INTRODUCTION

“No matter what religion we are a part of; people of faith are united by our belief in the sacredness of human life and compassion for our neighbours. Many faith-based organizations (FBOs) have a rich experience of providing spiritual care, support and services for people living with HIV and AIDS.”

(Source: Faith Advocacy Toolkit, World AIDS Campaign, 2008.)

Faith-based organizations (FBOs) have a history of engagement in social justice issues both in Canada and abroad. Many offer support to communities affected by HIV and AIDS. Worldwide, FBOs are effective responders to HIV as they mobilize existing worldwide and transnational infrastructures of leadership and fellowship. Globally, faith-based HIV work is established, but in Canada there remain opportunities to reach out to faith communities to help develop an understanding of HIV and its impact in Canada, and approaches to respond to HIV at the community level.

“Faith-based Organizations Addressing HIV/AIDS in Canada: A National Framework” is a resource for those working in a pastoral care context to support people living with HIV/AIDS (PLWHIV/AIDS) in their communities, and to encourage communities to affirm PLWHIV/AIDS in a societal context.

Pastoral care supports spiritual growth with the aim of sustaining whole and holy relationships with one’s faith, with each other and with community. This is achieved by affirming the dignity of each human being and recognizing that all life is sacred. The *“Faith-based Organizations Addressing HIV/AIDS in Canada: A National Framework”* resource aims to support open conversations within FBOs about responding to HIV and supporting pastoral care efforts in addressing the needs of PLWHIV/AIDS. As such, this document is not a theological discussion regarding HIV status and behaviour but rather a conversation about enhancing and extending pastoral care.

WHO IS THIS DOCUMENT FOR?

This document is intended for faith communities and FBOs that would like to begin or to strengthen their pastoral care around HIV and specifically develop and enhance pastoral care services to those living with HIV/AIDS in our communities. It can also serve as a partnering tool between community organizations, especially FBOs and AIDS Service Organizations (ASOs).

WHY THIS FRAMEWORK IS NEEDED: RATIONALE

“Powerful metaphors related to HIV/AIDS reinforce stigma and create a sense of otherness. Othering occurs when blame and shame are assigned to people living with HIV/AIDS. This sets a moral tone that contributes towards people conceptualizing PLWHAs as different, and guides thinking towards an ‘us’ and ‘them’ division... PLWHAs highlighted the importance of acceptance by their families, faith groups, friends and colleagues in helping them overcome the initial shock of discovering their status. Acceptance from others helped them accept their status and to live positively.”

(Siyam’kela. Tackling HIV/AIDS Stigma: Guidelines for Faith-based Organizations)

Faith-based organizations are important anchors and active sources of support in communities. Many FBOs promote acceptance and compassion as community values. FBOs are therefore well placed to motivate people to come together in a caring and supportive manner to address HIV. This resource addresses how we can help people who are living with the consequences of HIV infection regardless of how a person may have contracted the disease. HIV and related social issues are sometimes used to seed theological or moral discussions. This document takes a pragmatic position that HIV continues to exist in our communities even as theological and moral debates continue. This document aims to support making space in FBOs for interaction and dialogue to be fostered and developed, and to break through the barriers confronted by people working together to address HIV in their communities.

HOW THIS DOCUMENT CAN BE USED

“Faith-based Organizations Addressing HIV/AIDS in Canada: A National Framework” acknowledges the compassionate efforts of those working in a pastoral care context to attend to those infected and affected by HIV/AIDS. As such, the document seeks to provide an opportunity to respectfully discuss barriers such as HIV/AIDS stigma and lack of understanding of HIV/AIDS within a pastoral care context in order to continue to strengthen pastoral care work in our communities.

This resource can be used to:

- **RAISE AWARENESS:** increase the understanding of HIV/AIDS and issues related to HIV/AIDS such as stigma, isolation and fear;
- **SUPPORT DISCUSSIONS:** support an open dialogue on how to overcome the barriers to delivering pastoral care to PLWHIV/AIDS in our communities ; and,
- **STRENGTHEN RESPONSES:** continue strengthening the development of pastoral care efforts that address the needs of people living with HIV/AIDS and their family and friends.

READING THIS DOCUMENT

There are several acronyms used throughout this document, including:

- HIV: Human Immunodeficiency Virus
- AIDS: Acquired Immunodeficiency Syndrome
- FBO: Faith-based Organization
- PLWHIV/AIDS (or similar: PHA, PLHA, PLWHA, HIV+ people): People Living With HIV/AIDS
- ASO: AIDS Service Organization

There are also certain terms used in this document, like stigma, that may have different meanings in different contexts and as understood or experienced by different readers.

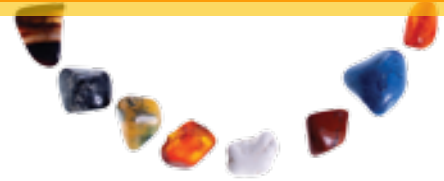
One term that will be used throughout this document is “pastoral care”. For the purposes of this document, this term is intended to describe the kind of care provided by members of faith based communities that includes some combination of spiritual and practical support. This may be known alternatively as “spiritual care”, “respite”, “assistance”, or under another term, but our intended use acknowledges that care given by caregivers often has an impact on both the body and soul of the care recipient.

In the context of this document, care recipients may be people living with HIV/AIDS and/or their family or friends. Whoever they are, the person receiving care should not be considered as a passive participant, but as a person engaged in articulating what they need.

In this document, the term faith-based organization (FBO) is used to describe organizations that are affiliated with, supported by or based on a religion or religious group. This term is broad, and may include both groups that are more formal in structure (such as individual congregations, charities, and not-for-profit businesses) and those that are less formal (like youth activity groups and discussion groups). Some religious and devotional practices (such as prayer and reflection) may play some part in the operations of the organization, but inherently religious practices (such as worship and ceremonies) are not usually as central to the activities of most FBOs as they would be for a faith community, faith group, or religion. FBOs may come from faith communities, but their works are often performed outside the faith community.

From the literature, the basis for membership in faith communities has been qualified as professional, vocational, charitable, devotional, and voluntary, among other descriptors. We recognize that there may be distinctions made within communities that are based on established and evolving systems, including customs and traditions. For the discussion that follows, we distinguish members from leaders, as leaders have been identified in the literature as having roles distinct from members. A leader has a designated formal role within the faith community or faith-based organization, with associated responsibilities to its members. Both leaders and members may find themselves called upon to serve multiple roles in faith communities and FBOs, especially as it pertains to the offering of pastoral care to people living with HIV/AIDS.





2. RESPONDING TO HIV/AIDS IN A FAITH-BASED CONTEXT

“The truth of the stories we share teaches us not only about others; it can also teach us about ourselves. Indeed, it is only in learning about ourselves that this healing is possible. People living with HIV/AIDS have shared many stories about themselves. They challenge us to change our understanding that “HIV = AIDS = death.” They are living, they are struggling, they are teaching and learning – and they want all of us to enter into a new way of understanding life in community. People living with HIV/AIDS remind us that we are all vulnerable and in need of healing. We are challenged, therefore, to break the barriers between “us” and “them” because we all live with HIV/AIDS.”

*(HIV/AIDS, Stigma and Faith-based Organizations. A Review.
Centre for AIDS Development, Research and Evaluation)*

Providing HIV/AIDS prevention education and offering pastoral care to those living with HIV and AIDS in our community is complex and can often run into dynamic road blocks of discomfort and stigma associated with HIV/AIDS. Using information and opportunities to foster dialogue about HIV/AIDS in our faith-based contexts offers a foundation upon which to support one another in our pastoral care work with HIV+ community members. HIV/AIDS happens everywhere; we are all impacted by the disease. Compassionate pastoral care service challenges attitudes that promote stigma and the denial of HIV/AIDS that persist to this day.

“Individual identity is the product of how we think of ourselves and others. This includes our attitudes, beliefs and values about our commonalities and differences in relation to others. Our sense of identity is intertwined with social and cultural ideas that allow us to understand ourselves in relation to others, including social differences linked to gender, age, class, religion, race, ethnicity, sexual orientation and physical attributes.”

“Stigma is that part of identity that has to do with prejudice – the setting apart of individuals or groups through the attachment of heightened negative perceptions and values. Stigma is a process that may occur at the individual level, but it is also influenced by social processes related to assumptions, stereotypes, generalizations and labeling of people as falling into a particular category on the basis of association. Stigma involves the social expression of negative attitudes and beliefs that contribute to processes of rejection, isolation, marginalization and harm of others.”

*(HIV/AIDS, Stigma and Faith-based Organizations. A Review.
Centre for AIDS Development, Research and Evaluation)*

Beyond being a process (as stated in the above paragraph), stigma is a form of discrimination. It is also a measurable barrier to care¹. In other words, it has been identified as a factor that prevents people from accessing the care they require to live. It is also a barrier to raising awareness about HIV/AIDS, and to sharing prevention strategies and approaches. In this sense, it is a practical problem that needs to be addressed wherever it appears. This is a challenge, as stigma is not understood or experienced in the same way across different populations. It may manifest itself differently in one culture than it does in another culture.

It is not uncommon for people to feel defensive when discussing the stigma associated with HIV/AIDS. In many instances the very act of having a conversation around HIV/AIDS stigma can expose their beliefs to reductive labels such as intolerant and hypocritical. As such, informing pastoral care through the facilitation of a conversation within a congregation or a broader-based community dialogue can often be framed by fear and hesitation.

In addition, reticence by FBOs to discuss the stigma associated with HIV/AIDS, may rest in a lack of knowledge about HIV-related stigma, an ongoing theological discourse, and/or in reflection on experiences from the beginning of the pandemic. In the early days of HIV/AIDS many faith communities were slow to respond or refused to acknowledge the disease in some cases, while in other cases faith groups directly or indirectly created an unwelcoming atmosphere for people living with HIV/AIDS. In the broader context, the societal taboo and shame around HIV/AIDS in the 1980s and 1990s likely had an impact on the persons living with HIV/AIDS and their loved ones. This may have been reflected in a reluctance to reach out to their faith communities, even to those faith groups that were more able to acknowledge and respond to the disease at that time.

Decades later, pastoral care continues to be challenged, enriched and informed by the experiences of PLWHIV/AIDS. As such, we need to be mindful that stigma and discrimination still exists to varying degrees in different contexts. It is better to address specific instances of discrimination or stigma rather than to make generalized assumptions about pervasive forms of it within faith-based organizations. Today, our pastoral care builds upon our collective experiences of the past and seeks always to be in service for the betterment of our community.

“Please respect the spiritual life of your care receiver. Volunteers put their faith into action through unconditional service, not through efforts to convert or evangelize to others. Avoid religious discussions that are apt to grow into differences of view or arguments. Instead, practice compassion and loving kindness.”

(Source: Getting Started: Sensible and Ethical Guidelines – see: Appendix B)

The commitment of faith-based organizations to HIV prevention, treatment and care is grounded in a shared tradition of reaching out to the disadvantaged, helping the sick, and promoting physical and spiritual health among congregations and through community outreach services. In response to HIV/AIDS, FBOs can:

- offer accurate and appropriate information about prevention
- provide care for those who are HIV+ or have developed AIDS and those who love them, and
- offer compassionate service modeling acceptance to combat stigma and discrimination faced by people living with HIV/AIDS.

¹ Pollini, Robin A., Estela Blanco, Carol Crump, Maria Zuniga (2011). “A community-based study of barriers to HIV care initiation.” *AIDS Patient Care and STDs*. 601-09.

“Compassion practice is daring. It involves learning to relax and allowing ourselves to move gently toward what scares us. The trick to doing this is to stay with emotional distress without tightening into aversion; to let fear soften us rather than harden into resistance. We cultivate bravery through making aspirations. We make the wish that all beings, including ourselves and those we dislike, be free of suffering and the root of suffering.”

(Pema Chodron, Buddhist Nun.)

COMMUNITY STORIES

Reflect on your experiences in your community:

- What stories can you share that speak to the challenges and opportunities faced in discussing HIV/AIDS in a faith-based pastoral care context?
- What was the hardest part about discussing HIV/AIDS in this context?
- Do you know if there are people living with HIV/AIDS in your community? What have you learned when listening to PLWHIV/AIDS?

Below are a few quotes that emerged from our first Advisory Committee call as people reflected on those very challenges and opportunities.)

“As children of God, as human beings, how can we help people who are suffering (the disease) and the consequences rather than an emphasis on the disease itself?”

“I prefer to go in the forest and work my way to the trees – express the big picture. This is about human beings, (it goes) right into the heart of our tradition (which) is about loving the human being made in the image of God; Here is how they could be suffering, here is what we could do.”

“In terms of exercising leadership, my role is to demonstrate and proclaim the idea of welcome, this person, this family needs us, let’s embrace them, let’s reaffirm that they are part of our community.”

“I am very keen on working on the stigma piece, I encounter it so regularly, we certainly still have this issue around HIV; I think it prevents people from taking the next step.”

These stories capture some of the personal challenges related to offering pastoral care:

Powerless within my faith community, we serve better those abroad than at home

I feel my faith community will always associate HIV with the Gay community. They have some interest with AIDS overseas, especially in Africa, because of the heterosexual basis for a lot of infection and the plight of orphaned children. There is a program through our overseas mission program that appears to be well-received – maybe because it is not on our doorstep but far away.

I have no influence within my faith community context, so although I agree with the position taken in this framework, I do not expect that I will influence others within my denomination. I personally do not hold out much hope for my denomination to respond apart from the belief and doctrinal positions which would be off-putting to most people trying to cope with HIV/AIDS.

Religious Beliefs Eclipsed by a Greater Message of Spiritual Care

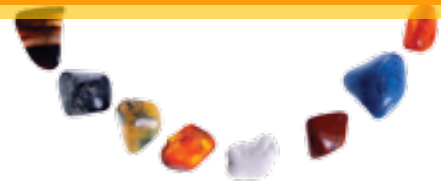
I would like to share a story about a time when I was able to transcend the common beliefs of my denomination which opposed homosexuality and homosexual behaviour even though they are not what I would personally want to see for my children or grandchildren.

A number of years ago, when I was a denominational chaplain, I met a hospital patient with AIDS who was dying. I was aware that we were both members of the same denomination, and I represented the denomination in that hospital at that time. When I met this man, his male partner was caring for him at his bedside.

As part of my care for this man, I asked him one day "How is your friend doing?"

Shortly thereafter, this man died. He had left instructions to ask me to participate in his funeral service because I had asked about his partner.

From my religious heritage it would have been easy to ignore the whole homosexual background in this man's life but I chose not to do that. I chose to acknowledge that this man had a significant other just as heterosexual people have, whether married or not. It made a difference to him and to how he may have perceived our common religious background.



3. FAITH-BASED ORGANIZATIONS: COMMUNITY CONVERSATIONS AND CARE

“Faith communities in the U.S. and globally can serve as social and spiritual support for people living with HIV/AIDS and their families. The value of caring for the sick extends to families, health care providers, and communities struggling to deal with the day-to-day needs and concerns of loved ones with HIV/AIDS. Congregations can offer specific worship services for those touched by the epidemic and encourage prayer rituals and blessings for people living with HIV/AIDS, such as prayer chains, prayer circles, a Mishebeirach blessing, or candle lightings.

People living with HIV/AIDS who are seeking pastoral care and membership in a congregation will hear their own concerns reflected in the larger prayer and worship life of the congregation. Faith communities can offer counseling, support groups, and substance abuse ministries in an affirming faith-based, pastoral environment. If clergy or lay members do not have training in HIV-related ministries, the congregation can invite trained clergy, public health providers, or local community leaders to educate them on how their congregations can begin addressing HIV/AIDS locally and globally.”

*(The Age of AIDS. A Guide for Faith Based Communities.
Religious Institute on Sexual Justice, Morality and Healing.)*

Dialogue is not about winning an argument or coming to an agreement, but about understanding and learning. Dialogue is most useful when people see a discrepancy between what is happening and what they think should be happening in the world or on an issue – yet there is no widespread agreement or shared understanding about what specifically should change.

“Dialogue is a process that allows people, usually in small groups, to share their perspectives and experiences with one another about difficult issues we tend to just debate about or avoid entirely.”

(National Coalition for Dialogue and Deliberation)

“In dialogue we affirm hope. In the midst of the many divisions, conflicts and violence there is hope that it is possible to create a human community that lives in justice and peace. Dialogue is not an end in itself. It is a means of building bridges of respect and understanding. It is a joyful affirmation of life for all.”

(Ecumenical Considerations for Dialogue. World Council of Churches.)

Dialogue can serve to facilitate open conversation on how best to discuss the stigma associated with HIV/AIDS, to raise awareness around HIV prevention and to strengthen pastoral care in our community of PLWHIV/AIDS. Dialogue can help to dispel myths about HIV/AIDS such as how people get HIV, whom it affects and how it can be treated.

In dialogue, silence can speak volumes. It can acknowledge and honour the mysterious and the sacred. There is a space for more dialogue that can be created from sitting, even for a moment, in shared silence. Unfortunately, silence can also imply judgment and can further isolate those living with HIV/AIDS and create divisions within our community. History has already shown that silence which prevents the dissemination of prevention and treatment information can amplify the tragedy of HIV. To avoid being misunderstood, share the silence and then verify or confirm what you feel happened in that silence.

Faith-based organizations play a substantial and meaningful role in community well-being because of the community context in which they are rooted. As such, there is an opportunity for FBOs to promote HIV/AIDS prevention and support for those infected and affected with the disease through worship services, pastoral care outreach, working connections with community services including local AIDS Service Organizations, youth outreach services, study groups as well as communication vehicles such as newsletters and bulletins.

“Maintain an open mind. Be accepting of others.”

(Source: Getting Started: Sensible and Ethical Guidelines – see: Appendix B)

“The most powerful thing you can hear, and the only thing that ever persuades any of us in our own lives, is when you meet somebody whose story contradicts the thing you think you know. At that point, it’s possible to question what you know, because the authenticity of their experience is real enough to do it.”

(Ira Glass, Host, This American Life)

COMMUNITY STORIES

These stories from community focus on increasing understanding within community and supporting the health and well-being of community. They also address the importance of moving from isolation to acceptance within their FBO, and the role inclusion in their FBO plays in their well-being.

Meetings and conversations, and minding my tongue

I was working for a youth-run sexual health organization, and we spoke to youth groups in different settings about a range of sexual health issues, including HIV awareness and prevention. Frequently, we were invited to speak at high-schools and post-secondary institutions, but we were also asked to speak with youth in detention centres as well as in community-based settings. The youth were grateful for the opportunity, as we attempted to make the conversation frank and honest, and create a space which was respectful and safe – always a challenge, but worth every minute.

One time, we received a request from a church-based youth group. The leader of this youth group (an adult member of the clergy) informed us that the youth group had asked to hold a discussion about HIV. The leader wanted to provide information to youth in the group, but the community could not acknowledge or condone sexual activity before marriage. Before the speaking engagement could proceed, we met to discuss what we could and could not talk about. The conversation was long, and challenging. From my perspective, it felt as though we were stuck as to how to share information about sexual health without talking about sex.

I felt frustrated, as I was being asked to give what I felt was an incomplete picture of how to prevent HIV transmission. There is a French saying that says ‘you must turn your tongue around in your mouth 7 times before speaking’ – essentially, think before you speak (with a little bit of ‘bite your tongue’). Let’s say that I worked very hard to keep the conversation respectful, and that there was a lot of ‘tongue turning’.

In the end, a solution was found, and the thing I walked away with was how important the conversation we had at that meeting was. Later, I remember thinking how hard it may have been for that youth group leader to convince the broader church leadership of the legitimacy of the youth’s request, and that it may have been many times harder than the conversation I had with the group leader. It occurred to me that the community had likely already ‘turned their tongues around’ several times before the leader and I met. And at the heart of all this was the youth’s request for ways to protect themselves, and the community’s acknowledgement that they had a role to play in filling that request, all within the context of their faith. I appreciated that I was coming to this process later in the conversation, but that I also needed to understand and respect what came before.

Community members speak:

“In our outreach to faith communities, it has been important to encourage the discussion of difficult topics, otherwise there is no moving forward. It is hard to talk about some of the topics that HIV and AIDS brings up, such as sexual transmission and drug use. In my outreach experience, sex and sexuality, particularly homosexuality, is seldom spoken of in faith communities. It can be difficult to even approach the topic of HIV (or for someone to disclose their status) if the space is not created for that dialogue to begin.”

“I work in a community based AIDS organization, but I am also a member of a faith group – and I feel that faith leaders need to talk about the real issues and the hard topics.”

Dialogue dispels stereotypes, builds trust and enables people to be open to perspectives that are very different from their own. Talking openly, accurately and compassionately about HIV can build bridges in our community. Dialogue can, and often does, lead to both personal and collaborative action.

HOW CAN FAITH-BASED ORGANIZATIONS TAKE ACTION TO ADDRESS HIV?

Actions by faith-based organizations could take the form of:

- Providing pastoral care to people living with or affected by HIV and AIDS (from offering a list of resources to a full range of care services)
- Determining what kind of education on HIV prevention would be beneficial for groups in your community
- Taking steps to overcome identified or suspected HIV stigma and discrimination in the community
- Exploring issues of injustice, stigma and discrimination, and their impacts on health and vulnerability through sermons or workshops
- Starting more dialogue groups internally and with external partners, to discuss HIV and vulnerability in and around your community
- Discussing healthy relationships and issues of sex and sexuality with all people, young and old
- Hosting and promoting participation in HIV testing and awareness days
- Raising awareness of the social issues relating to HIV such as poverty and drug use

In direct and indirect ways, these suggestions attempt to address the needs of PLWHIV/AIDS, stigma and discrimination, HIV education and prevention, and related issues. They are not exhaustive. How many more ideas can you come up with for your own community? Are there priorities that will shape the sequence of actions and activities taken by your community? Are there limits to your actions?

“But the most important aspect of the dialogue process is that it was started, people listened to one another, and we hope, people grew in their understanding of what needs to happen, in this age of HIV and AIDS, for people to have life and to have it abundantly.”

(source: Exploring Solutions. How to Talk about HIV Prevention in the Church. Ecumenical Advocacy Alliance.)

Good questions are catalytic. They stimulate thought processes, curiosity, and the desire to engage with a group, and they are central to what defines and distinguishes dialogue. In dialogue, questions are actually in many ways more powerful than answers. A question that has meaning to the people involved can ignite the whole process of learning and change.

Questions to support a dialogue that will enrich and strengthen the experience of HIV pastoral care for both pastoral care providers and PLWHIV/AIDS are provided below:

Questions for FBOs, community members and leaders:

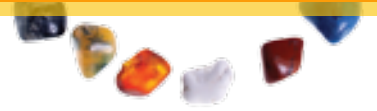
- What does our religion tell us about how to care for the suffering and for the ill?
- How does stigma and discrimination hinder HIV prevention and support?
- What could the response to HIV look like if stigma and discrimination were not an issue?
- How can our organization meet and care for those who may feel marginalized or unwelcomed in our spaces?
- What messages does (or could) our organization deliver on the subject of sexual health, and does this include messages regarding HIV testing and prevention?

Questions for pastoral care providers:

- In your experience what do you see as the greatest opportunity to strengthen your pastoral care work with PLWHIV/AIDS in your community?
- What has been your most profound learning to date from your pastoral care experience that you feel could strengthen the pastoral care FBOs offer to PLWHIV/AIDS?
- How can pastoral care address the stigma associated with HIV?
- What do you find to be most challenging when discussing your pastoral care experience with others in your FBO? What do you find to be the most affirming?
- How has your pastoral care experience with PLWHIV/AIDS informed your spiritual growth?

Questions for PLWHIV/AIDS:

- How have you experienced stigma as a person living with HIV or AIDS in your community and how has this impacted you?
- What role can pastoral care provided by a faith-based organization play in your well-being as a PLWHIV/AIDS?
- What elements of a pastoral care initiative need to be in place in order to be meaningful for PLWHIV/AIDS?



4. OUTREACH, SUPPORT AND COMMUNITY PARTNERS

“Many people turn to their communities of faith for support and guidance when they face problems and challenges in their lives. HIV and AIDS present such a challenge. Faith communities and their leaders touch the lives of many people. They have a history of using their belief system and teachings to help their members understand others and to accept differences. Faith communities and their leaders are used to advising their members about social issues and health issues like HIV/AIDS. For these reasons, communities of faith should take a lead role in responding to the AIDS crisis.”

(Responding to the Call. A Guide to HIV/AIDS Education in Faith Settings.)

Faith-based organizations have deep-rooted community service delivery and communication networks. When combined with their commitment, compassion, trustworthiness, abiding relationships, and motivation for the work that they do that is grounded in deep faith and respect, these attributes underscore the important role FBOs play in HIV/AIDS prevention, treatment and support services.

AN EXCERPT FROM “LOVE LIFTED ME”, BY DEACON JAE QUINLAN

“My church family filled in the gaps. They still had standards, but it was a more understanding environment. Our commonalities and the faith that exuded from the clergy and the congregants allowed people to be more tolerant and accepting. I was able to trust them and open myself up to get the help I needed. My health was in serious decline. Without making these changes I surely would have died.

It has been almost 15 years since I walked through those church doors. I have never experienced being passed by or ignored while in distress. When I was sick, someone was right there to nurse me back to health. When I was hungry, someone was there to feed me. When I was broke and had trouble paying my bills, God made sure someone from my community knew and helped handle that too. We have a slogan that “God is love, and love is for everyone!” My church family has exemplified that statement and taken it to a whole new level.

I continue to be amazed each day about the tremendous things we do in our community. I came up through the ranks slowly, recovering from the inside out. I had so much support with the work of mending my spirit. That work allowed me to grow from choir member to deacon in a remarkable journey. Through their love and support, my church family helped me to reach many of the goals I have aspired to over the years. Sometimes, when I sit to reflect on where I have come from to where I am now, it makes me cry tears of joy. Through renewed inspiration, faith, and support I am thriving as I live with this virus. I am a multiple cancer survivor with ten years drug free. I am sure that love lifted me! Love lifted me from the grip of addiction, love lifted me to a renewed sense of myself, and love let me know that I am love and worthy of being loved.”

(Source: Achieve. A Quarterly Journal on HIV Prevention, Treatment and Politics.)

Building partnerships between FBOs and local AIDS Service Organizations (ASOs) can serve as an ongoing opportunity to support HIV prevention and to provide services to PLWHIV/AIDS. Collaboration between FBOs and ASOs can leverage the unique strengths of these organizations. ASOs have access to current prevention, treatment and support information and local services while FBOs have access to their volunteer networks and pastoral care outreach to provide guidance and comfort to those who seek spiritual support as they face the challenges of living with HIV. ASOs and FBOs are well positioned to collectively and compassionately serve the physical, spiritual and emotional needs of those infected and affected by HIV.

Recent research² illustrates that, among other benefits, a partnership can have the potential to strengthen and protect the communities served by the organizations. However, organizations must engage the communities being served as stakeholders, and find ways to ensure their voices are heard. Expectations among and between partners and stakeholders must also be measured with goals and timelines that are shared and realistic. In order to have a reasonable chance of success, partnership development will require ongoing communication and substantial investments of time and resources from all parties.

Effective HIV prevention and support programs do not just focus on increasing knowledge to reduce the risk of HIV infection and transmission;

“A truly comprehensive approach to HIV prevention ...should...:

- *Provide complete and accurate information*
- *Address the attitudes, behaviours and social skills that people need to reduce their risk of infection and transmission of HIV*
- *Be positive and empowering*
- *Include discussions and activities that encourage positive behaviours and individual wellness*
- *Endorse and/or provide social support for people with HIV infection, other STDs or AIDS”*

(Source: Responding to the Call. A Guide to HIV/AIDS Education in Faith Settings.)

Providing pastoral care to PLWHIV/AIDS in many FBO settings requires both ***inreach*** and ***outreach***. Open dialogue with religious leaders and congregations to discuss how to create a welcoming and compassionate space for PLWHIV/AIDS is a crucial first step. This ***inreach*** or internal conversation will reveal and bring to the surface opportunities for education, information sharing, addressing fear, misconceptions and discussing stigma associated with HIV. ***Outreach*** may include collaborating with ASOs and other community-based groups and services. Being clear about the services your FBO offers and the pastoral care messages and supports you wish to offer is an essential first building block to effective outreach initiatives.

Questions for reflection and discussion for HIV pastoral care support

- What information will support our key leadership in deepening their understanding of HIV in our community?
- How can we best involve our religious leaders (elders, deacons etc) in strengthening our pastoral care?
- How can we best inform and involve members of our congregation?
- What are our guiding principles for our pastoral care of those living with HIV/AIDS in our community?
- What services are we best suited to offer in our pastoral care to PLWHIV/AIDS in our community?
- What key messages do we wish to convey based upon the teachings of our community and that address the needs of PLWHIV/AIDS in our community?

2 Derose, Kathryn Pitkin, et al (2014).“An intervention to reduce HIV-Related Stigma in partnership with African American and Latino churches”. *AIDS Education and Prevention*. 26(1), 28-42.



5. MEDITATIONS

A short selection of references is provided below in order to facilitate remembering in prayer and reflection those who are infected and affected by HIV.

“Lay not on any soul a load that you would not wish to be laid upon you, and desire not for anyone the things you would not desire for yourself.”

Baha’i faith – Bha’u’llah, Gleanings

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

Buddhism – The Buddha, Udana-Varga 5.18

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

Christianity – Jesus, Matthew 7:12

“One word which sums up the basis of all good conduct... loving kindness. Do not do to others what you do not want done to yourself.”

Confucianism – Confucius, Analects 15.23

“We are as much alive as we keep the earth alive.”

Native spirituality – Geswanouth Slahoot, Chief Dan George of Tsleil-Waututh Nation

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

Hinduism – Mahabharata 5:1517

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

Islam – The Prophet Muhammad, Hadith

“One should treat all creatures in the world as one would like to be treated.”

Jainism – Mahavira, Suttrakritanga

“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.”

Judaism – Hillel, Talmud, Shabbath 31a

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

Sikhism – Guru Granth Sahib, p.1299

“Regard your neighbour’s gain as your own gain and your neighbour’s loss as your own loss.”

Taoism – Lao Tzu, T’ai Shang Kan Ying P’ien, 213

“We affirm and promote respect for the independent web of all existence of which we are a part.”

Unitarianism – Unitarian principle

“Do not do unto others whatever is injurious to yourself.”

Zoroastrianism – Shayast-na-Shayast 13.29

*(Sources: [Faith Advocacy Toolkit: Advocacy for Universal Access: A Toolkit For Faith-Based Organizations](#),
[\(World AIDS Campaign\)](#) and [The Golden Rule, or the Ethic of Reciprocity \(Scarboro Missions\)](#))*



SAMPLE SCRIPTURE AND SACRED MUSIC RELATED TO HIV/AIDS

Participants in the Beads of Hope gathering at the Alberta and Northwest Conference United Church Women (UCW) Annual Meeting, April, 2003 identified these passages and hymns as being relevant to faith based services and activities relating to HIV and AIDS. Beads of Hope was a 2-year United Church education, advocacy, and fundraising initiative launched in 2002 as an emergency response to the global HIV pandemic. Beads of Hope pins, crafted by women from South Africa, were sold to help raise the money. Some \$2.3 million dollars – more than twice the original goal set for the campaign – was raised.

THEME VERSE OF THE BEADS OF HOPE CAMPAIGN

We are the body of Christ; when one suffers, all suffer (based on 1 Corinthians 12:26-27).

OTHER SCRIPTURE

Psalms 139 – God knows us and cares for us

Isaiah 53:3ff – He was despised and rejected by others

Micah 6:6-8 – What does God require of you?

Matthew 18:5 – In as much as you do it unto the least of these, you do it unto me

Matthew 19:19; Leviticus 19:18 – Love your neighbour as yourself

Matthew 25:31ff – When did we see you hungry and give you food?

Luke 4:16-28 – The Spirit of the Lord is upon me

Luke 9:46-48; Matthew 18:1-6; Mark 10:13; Luke 18:15-17 – Jesus accepts children

Luke 10:30-37 – The Good Samaritan

Luke 22:19 – This is my body broken for you

John 10:10 – I am come so that all might have abundant life

Revelation 21:4 – God shall wipe away all tears

HYMNS

“O Ancient Love” (VU 17)

“Stay With Us through the Night” (VU 182)

“May the God of Hope” (VU 424)

“In Loving Partnership, We Come” (VU 603)

“In Suffering Love” (VU 614)

“We Are Marching – Siyahamba” (VU 646)

VU = Voices United, the Hymn and Worship book of the United Church of Canada.

(Source: World AIDS Day, December 1. The United Church of Canada)





6. ADDITIONAL RESOURCES

A NOTE ON RESOURCES:

Your faith leadership may have already developed specific materials addressing HIV.

If so, review them and consider:

- Do they reflect current knowledge and experience?
- Do they reflect how to address HIV at the community level in Canada, or are they focused on addressing HIV outside of Canada?
- Will these materials assist you or your community in addressing HIV prevention and care in your community?

RESOURCES AVAILABLE ONLINE

[Achieve. A Quarterly Journal on HIV Prevention, Treatment and Politics.](#) Winter 2010.

[The Age of AIDS. A Guide for Faith Based Communities.](#) Religious Institute/Christian Community, 2007.

[An Intervention to Reduce HIV-Related Stigma in Partnership With African American and Latino Churches.](#) K. Pitkin-Derose et al. *AIDS Education and Prevention*, February, 2014 Vol. 26, No. 1 : pp. 28-42.

[At a Glance – HIV and AIDS in Canada: Surveillance Report to December 31st, 2012.](#) Public Health Agency of Canada, 2013.

[The Cairo Declaration of religious leaders in the Arab states in response to the HIV/AIDS epidemic, United Nations Development Program.](#) December, 2004.

[Combating HIV and AIDS Related Stigma, Denial and Discrimination. A Training Guide for Religious Leaders.](#) Religions for Peace. 2008.

[Congregation-Based Programs to Address HIV/AIDS: Elements of Successful Implementation.](#) (J. Urban Health, 2011)

[Developing an HIV Vaccine,](#) The Canadian HIV Vaccine Initiative, 2012.

[Exploring Solutions. How to Talk About HIV Prevention in the Church: A framework for Dialogue between religious leaders, faith-based organizations and networks of people living with HIV at national level.](#) Ecumenical Advocacy Alliance. 2007.

[Faith Advocacy Toolkit: Advocacy for Universal Access: A Toolkit For Faith-Based Organizations.](#) World AIDS Campaign. 2008.

[Faith-Based Approach to HIV/AIDS: Enhancing the Community Response: TRAINING GUIDELINES FOR RELIGIOUS LEADERS, COMMUNITY EDUCATORS AND THE COMMUNITIES.](#) Islamic Medical Association of Uganda, 2007.

[A Guide to HIV/AIDS Pastoral Counselling.](#) AIDS Working Group, World Council of Churches. 1990.

[Healing Begins Here: A Pastor's Guidebook for HIV/AIDS Ministry Through the Church.](#) California Department of Health Services and Statewide HIV/AIDS Church Outreach Advisory Board. 2004.

HIV/AIDS, Stigma and Faith-based Organizations. A Review. Centre for AIDS Development, Research and Evaluation, 2005.

HIV Transmission: Guidelines for Assessing Risk (2005) ; and, HIV Transmission: Factors that Affect Biological Risk (2013), Canadian AIDS Society.

Responding to the Call. A Guide to HIV/AIDS Education in Faith Communities. On Common Ground: AIDS Institute's Faith Communities Project. New York State Department of Health. 2010.

SAVE toolkit: A practical guide to the SAVE prevention methodology. The International Network of Religious Leaders Living with or Personally Affected by HIV and AIDS (INERLA+), and Christian Aid, 2012

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

Tackling HIV/AIDS Stigma. Guidelines for faith-based organizations. The Siyam'kela Project. 2003.

What Religious Leaders Can Do About HIV/AIDS. Action for Children and Young People. UNICEF. 2003.

WEBSITES:

Canadian AIDS Society: <http://www.cdnaids.ca>

Canadian Churches in Action: <http://www.churchesinaction.ca>

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

International Network of Religious Leaders Living with or Personally Affected by HIV and AIDS (INERELA+): <http://www.inerela.org>

Religions for Peace: <http://www.rfp.org/resources>

Religious Institute: www.religiousinstitute.org

People Living with HIV Stigma Index: <http://www.stigmaindex.org/>

World Council of Churches: <http://www.oikoumene.org>



APPENDIX A: SAMPLE GUIDELINES FOR HIV/AIDS PASTORAL CARE

Below is an example of guidelines developed to help pastoral care providers prepare for a home visit to a person living with HIV/AIDS in their community. After looking at this example, consider how your community might approach drafting its own guidelines.

GETTING STARTED: SENSIBLE AND ETHICAL GUIDELINES

1. Maintain trust and confidentiality.

- Do not speak about your care receiver's issues to others except to your contact within your Church HIV/AIDS Ministry.

2. Please respect the spiritual life of your care receiver.

- Volunteers put their faith into action through unconditional service not through efforts to convert or evangelize to others. Avoid religious discussions that are apt to grow into differences of view or arguments. Instead, practice compassion and loving kindness.

3. Maintain an open mind. Be accepting of others.

4. Be aware of your actions of body, speech and mind.

- Think before you act or speak.

5. Do not offer medical advice.

- Discuss with the person and their family (if applicable) before problems arise what he/she/they want done in case of emergency. Do not offer to take a person to the hospital – unless it is a prearranged transport. In case of a medical emergency, first dial (911), then the closest family member or friend, followed by notifying your contact at your Church HIV/AIDS Ministry.

6. Do not offer your opinions in family matters.

- All decisions for the person's welfare are made by them or their family – not the volunteer.

7. Do not cash checks and/or sign any legal papers with or for your care receiver.

8. Do not accept money or any gift of value.

- This may be misinterpreted by others in the family and community. Suggest a donation, monetary or otherwise, to your Church HIV/AIDS Ministry if the person or family wishes to show support and appreciation.

9. Accept a confidence carefully and honestly.

- Tell your care receiver before hearing confidential information that you may have to tell your supervisor if it involves danger to themselves or others.

10. Travel in pairs when visiting your care receiver.

- Visiting in pairs will help eliminate the possibility of being accused of doing something you did not do. ... If this problem should arise, report it immediately to the Church HIV/AIDS Ministry. Don't take it personally or be afraid to call your supervisor. They are there to assist you.

11. Report any suspicion of abuse.

- If you suspect any abuse physical, emotional, sexual, or financial – YOU MUST report it immediately to your Church HIV/AIDS Ministry. Your supervisor will report abuse to the proper authorities.

(Source: Healing Begins Here: A Pastor's Guidebook for HIV/AIDS Ministry Through the Church, 2004.)



APPENDIX B: A PRIMER ON HIV AND AIDS IN CANADA

WHAT IS HIV/AIDS?

HIV is a virus, and people can be living with HIV with few recognizable symptoms. Many people live with HIV, but living with HIV infection does not necessarily mean a person is living with AIDS.

AIDS is a syndrome, or a collection of different symptoms. People with advanced HIV disease can become more susceptible to contracting different opportunistic infections. Other factors aside, a person living with HIV must have contracted one or more of the opportunistic infections that make up the collection of symptoms known as AIDS before they are diagnosed as having AIDS.

HIV – the **Human Immunodeficiency Virus** – is a human retrovirus that attacks the immune system, resulting in a chronic, progressive illness that leaves people vulnerable to infections. As HIV infection spreads, it weakens the body's ability to protect itself from other illnesses. It does this by targeting specific cells of the immune system, known as CD4 cells, which usually defend the body from infections. These are the immune cells that alert the immune system to any infections. HIV uses these CD4 cells as hosts to create more HIV cells. HIV destroys the 'host' CD4 cell in the replication process, reducing the number of immune cells, and impairing the body's ability to fight infections. The average person has anywhere from 500-1500 CD4 cells in a microlitre of blood, but people with HIV may have lower numbers of CD4 cells because the virus has destroyed many of these cells. Symptoms of the onset of HIV disease are similar to (and frequently mistaken for) symptoms of influenza, or the 'flu'. Early HIV disease often has no visible symptoms, so people may have an HIV infection and not be aware of it.

AIDS stands for **Acquired Immunodeficiency Syndrome**. 'Acquired' means that the virus cannot be passed down or inherited genetically from your parents, but is introduced to the body by exposure to bodily fluids containing HIV. A 'syndrome' is a collection of different symptoms or signs of disease. It refers to the fact that one person living with AIDS may experience symptoms different from those of another person living with AIDS. A diagnosis of AIDS is usually given in cases of advanced HIV disease. One of the signs of advanced HIV disease is having a low number of CD4 cells. People living with HIV who have fewer than 200 CD4 cells are considered to have advanced HIV disease. People with advanced HIV disease can become more susceptible to contracting different opportunistic infections when their bodies can no longer fight infections. An 'opportunistic' infection is one that people with healthy immune systems are normally able to fight off successfully. The immune system of a person with HIV may have a harder time fighting off these infections. When a person living with advanced HIV has contracted one or more of the opportunistic infections that make up the collection of symptoms known as AIDS, only then are they diagnosed as having AIDS.

There is no cure for AIDS, and there is no vaccine to protect against HIV infection – although research in both these areas is ongoing. Fortunately, HIV treatment does exist, and it has become more effective over the years. Antiretroviral medications are used in HIV treatment to impede the progression of illness in individuals by interrupting the replication processes of HIV cells within the body. This reduces the amount of active virus in the body, which helps stabilize or even improve people's immune function.

Without any treatment, it takes approximately 10 years to progress from initial HIV infection to AIDS. People with access to effective anti-HIV treatments have seen this process slow down considerably, so many people with HIV who are receiving effective treatment may not advance to an AIDS diagnosis as quickly.

How do you get HIV?³

There are certain conditions that must exist in order for transmission of HIV to occur:

1. There must be a source of infection.
2. There must be a sufficient level of virus delivered to establish infection.
3. There must be a means of transmission.
4. There must be a host susceptible to infection.
5. There must be an appropriate route of entry to the cells that are targeted by HIV.

Other factors may alter the ability of the virus to establish an infection, but the above conditions must be met in order for HIV infection to occur.

What is a source of HIV infection?

As a virus, HIV relies on the presence of bodily fluids to move from host to host. It does not thrive outside of the body. It has been found in many bodily fluids, including urine, saliva and tears. Even if all the other conditions for transmission were met, it is most unlikely that exposure to these fluids would cause infection as the virus is not found in these fluids in sufficient quantity.

What is a sufficient level of HIV virus?

There are other bodily fluids which have been found to contain the virus in sufficient amount that exposure to these fluids may permit transmission of HIV. These are **semen, vaginal fluids, anal fluids, breast milk** and **blood**.

What are 'means of transmission' for HIV?

The main ways HIV is transmitted between people (the means of transmission) are:

- having sex (especially having vaginal or anal intercourse without a condom),
- sharing needles, syringes or other equipment when using drugs (including steroids),
- by exposure to the virus as an infant (if a child's mother is living with HIV, the baby can get the virus from exposure to bodily fluids containing HIV during pregnancy, childbirth or breast feeding),
- if you received a blood transfusion or blood product, transplanted organ or sperm donation in Canada before 1986 (since then, screening has made the risk of infection almost non-existent).

³ Canadian AIDS Society. HIV Transmission: Guidelines for Assessing Risk (2005); and, HIV Transmission: Factors that Affect Biological Risk (2013).

You cannot get infected with HIV from:

- casual, everyday contact with people, such as shaking hands, hugging, kissing
- coughs, sneezes
- giving blood
- swimming pools, toilet seats
- sharing eating utensils, water fountains
- mosquitoes, other insects, animals

Who is susceptible to HIV infection?

As HIV is a human virus, any human being is a potential host and susceptible to infection.

What cells are targeted by HIV, and what are 'routes of entry'?

HIV targets certain kinds of immune cells (including white blood cells called CD4 T-cells). These cells are normally protected from outside infection by layers of other cells including the skin on the outside of the human body, and the mucosal layers that line openings in the body. Mucosal membranes line the tracts of the reproductive system, the digestive system, the reproductive system, and the respiratory system. When infections other than HIV enter the body, immune cells activate and rush to the site of the infection to defend the body. In order to reach these immune cells, HIV must have a route of entry, which can be a break in the skin or a disruption in the mucosal membrane. Having other infections can make it easier for HIV to enter, as the targeted immune cells will congregate at the site of the infection.

Who can get HIV or AIDS?

People do not contract HIV or develop AIDS because of who they are. The virus does not discriminate, and it is not bound by geography, as HIV infections are found in every part of Canada.

It is what you do that exposes you to HIV transmission – and more importantly, the steps you take to protect yourself and others when doing it – that matters.

The Current Context of HIV/AIDS in Canada: An Overview

At a Glance – HIV and AIDS in Canada: Surveillance Report to December 31st, 2012⁴ is published by the Centre for Communicable Diseases and Infection Control at the Public Health Agency of Canada. This annual review represents an overview of the HIV/AIDS situation in Canada based on case reports of HIV and AIDS submitted by all provinces and territories.

Since HIV reporting began in Canada in 1985, a cumulative total of 76,275 positive HIV test reports have been reported to PHAC. In 2012 alone, 2,062 HIV cases were reported which represents a 7.8% decrease from the year before. This is the lowest number of annual HIV cases since reporting began in 1985.

Trends in exposure category have shifted since HIV reporting began in 1985. In the early stages of the epidemic, over 80% of all cases with known exposure category were attributed to the “men who have sex with men” (MSM) exposure category. Although this exposure category is still the predominant one in Canada, the proportion has decreased significantly over the years. In 2012, 50.3% of all adult (≥15 years) positive HIV test reports with known exposure category were attributed to the MSM exposure category.

⁴ Source: Public Health Agency of Canada (2013).

The second most reported exposure category among adults in 2012 was heterosexual contact. In 2012, more than 32%⁵ of reported HIV infections in Canada were linked to heterosexual sex between adults. Globally, 75% of HIV infections were linked to heterosexual activity. In the same year, more than 23% of new HIV infections reported in Canada were among women. Over the past decade, the proportion of female cases has remained generally stable at approximately one-quarter. Worldwide, half of all new HIV infections were among women.

The third most frequently reported exposure category among adults in 2012 was injection drug use (IDU), accounting for 14.0% of positive HIV test reports. Overall, a higher proportion of adult females than adult males acquired HIV through IDU exposure (24.5% versus 10.9%).

At the national level, distinct differences were observed between the sexes in terms of age at diagnosis of HIV and of AIDS, whereby diagnosis tended to be made at a younger age in females than males. In addition, the proportion of HIV cases among older Canadians (50 years and older) has been gradually increasing since reporting began in 1985, and males outnumber females in the older age groups, particularly in the 30 to 39 and the 40 to 49 year age groups.

5 13.2% were attributed to heterosexual contact among people born in a country where HIV is endemic (Het-Endemic), 9.9% were attributed to heterosexual contact with a person at risk (Het-Risk), and 9.6% were attributed to having heterosexual contact with someone with no identified risk (NIR-Het). These proportions varied by sex, heterosexual contact being the most reported exposure category among adult females at 73.2% versus 20.7% among adult males. The Het-Endemic exposure sub-category showed the biggest difference between the sexes, accounting for 51.8% of heterosexual contact cases among females and 28.6% among males.

