HIV and AIDS Advocacy & Media Relations

HANDBOOK FOR RELIGIOUS LEADERS
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>List of Abbreviations</td>
<td>4</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>4</td>
</tr>
<tr>
<td>Foreword</td>
<td>5</td>
</tr>
<tr>
<td>Introduction</td>
<td>6</td>
</tr>
<tr>
<td>Module 1: Overview of Training</td>
<td>7</td>
</tr>
<tr>
<td>Module 2: HIV and AIDS</td>
<td>8</td>
</tr>
<tr>
<td>2.1 Facts about HIV and AIDS</td>
<td>8</td>
</tr>
<tr>
<td>2.2 HIV Transmission</td>
<td>9</td>
</tr>
<tr>
<td>2.3 How HIV and AIDS Affect the Human Body</td>
<td>9</td>
</tr>
<tr>
<td>2.4 Preventing HIV Infection</td>
<td>10</td>
</tr>
<tr>
<td>2.5 HIV and AIDS and Children</td>
<td>13</td>
</tr>
<tr>
<td>2.6 HIV and AIDS and Gender</td>
<td>15</td>
</tr>
<tr>
<td>2.7 Stigma and Discrimination</td>
<td>18</td>
</tr>
<tr>
<td>2.8 The Role of Religious Leaders in Combatting HIV and AIDS</td>
<td>21</td>
</tr>
<tr>
<td>Module 3: Introduction to Advocacy</td>
<td>24</td>
</tr>
<tr>
<td>3.1 Concept of Advocacy</td>
<td>24</td>
</tr>
<tr>
<td>3.2 Definition of Advocacy</td>
<td>24</td>
</tr>
<tr>
<td>3.3 Role of Religious Leaders in Advocacy</td>
<td>25</td>
</tr>
<tr>
<td>3.4 Elements of an Advocacy Strategy</td>
<td>25</td>
</tr>
<tr>
<td>3.5 The Advocacy Framework</td>
<td>27</td>
</tr>
<tr>
<td>3.6 Advocacy Issues</td>
<td>27</td>
</tr>
<tr>
<td>3.7 Policy Development</td>
<td>29</td>
</tr>
<tr>
<td>Module 4: Building Advocacy Alliances through Coalitions and Networks</td>
<td>31</td>
</tr>
<tr>
<td>4.1 Coalitions</td>
<td>31</td>
</tr>
<tr>
<td>4.2 Networks</td>
<td>33</td>
</tr>
<tr>
<td>Module 5: Strategic Communication, Message Development, and Delivery</td>
<td>37</td>
</tr>
<tr>
<td>5.1 The P-Process: Steps in Strategic Communication</td>
<td>37</td>
</tr>
<tr>
<td>5.2 Elements of a Message</td>
<td>39</td>
</tr>
<tr>
<td>5.3 The One-Minute Message</td>
<td>41</td>
</tr>
<tr>
<td>Module 6: Working with the Media</td>
<td>42</td>
</tr>
<tr>
<td>6.1 Types of Media</td>
<td>42</td>
</tr>
<tr>
<td>6.2 Working with the Media</td>
<td>43</td>
</tr>
<tr>
<td>6.3 Media Tools</td>
<td>44</td>
</tr>
<tr>
<td>6.4 Media Relations and Communication Operations</td>
<td>47</td>
</tr>
<tr>
<td>6.5 Media Relations Campaigns</td>
<td>48</td>
</tr>
<tr>
<td>Module 7: Preparation of Action Plans</td>
<td>49</td>
</tr>
<tr>
<td>7.1 Developing an Action Plan</td>
<td>49</td>
</tr>
<tr>
<td>References and Additional Resource Links</td>
<td>51</td>
</tr>
</tbody>
</table>
Religions for Peace would like to express its gratitude and appreciation to HACI for its support of the pan-African advocacy program, much of which has been funded through the "Strengthening and Scaling-up HACI grant from the U.S. Agency for International Development. Additional support has been received from the Norwegian Department of International Development (NORAD). This support has enabled Religions for Peace to develop this handbook and use it for training of trainers' workshops (TOT) at national and regional levels. In developing this handbook, Religions for Peace has benefited from a review of training manuals in advocacy and media relations that are used by other organizations in Africa and is grateful for all the expertise and effort that those other materials represent.

Religions for Peace would also like to thank all the participants of the regional TOT workshops representing inter-religious councils (IRCs) from Zambia, Tanzania, Uganda, Malawi, Ethiopia, Kenya, Senegal, Ghana and Cameroon where drafts of this handbook were used and whose inputs have been incorporated into this final version.

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Finally, great thanks go to Ms. Julia Reich for her clear and elegant design; and to staff of Religions for Peace, Ms. Jane Gaithuma for in-house editing and incorporation of views from the various stakeholders, Ms. Andrea Louie for coordinating the design and production, and Mr. James Cairns and Mr. Tsegaye Chernet for overall leadership and management of this process.
Religions for Peace, a growing global network of more than 70 national and regional inter-religious councils and groups, harnesses the power of cooperation among the world’s religious communities to transform conflict, build peace, and advance sustainable development. A network of 1,000 women of faith organizations is an integral component of these structures. Guided by respect for religious differences and a belief in the power of multi-religious cooperation, Religions for Peace mobilizes religious communities to collaborate on shared concerns. Such cooperation is more powerful, both substantively and symbolically, than the efforts of individual faith communities alone.

One area of multi-religious cooperation that has been a long-standing priority is the well being of children and families. In 2000, in an effort to respond to the devastating impact HIV and AIDS was having on families and children in Africa, Religions for Peace entered into a partnership with four other organizations – Plan International, Save the Children Alliance, Society for Women and AIDS in Africa (SWAA) and CARE International (later joined by World Vision International and Network of African People Living with HIV and AIDS - NAP+)– to form the ‘Hope for African Children Initiative’ (HACI) whose mandate is to expand community-based responses to the impact of HIV and AIDS on orphans and other vulnerable children (OVC) in Africa.

Within HACI, Religions for Peace has a particular mandate to strengthen advocacy among religious communities, on a pan-African scale, to address challenges related to the AIDS pandemic that often deprive children of basic social services and even the support of their extended families, such as stigma and discrimination, abuse and sexual exploitation among other issues. Advocacy means championing a cause; creating awareness and understanding about AIDS; and working to ensure that relevant policies and programs are put in place. HIV and AIDS advocacy helps drive a more effective response globally, regionally and nationally.

This handbook, used together with the accompanying training manual, is meant to strengthen the advocacy and media relations skills of religious leaders at both national and community levels in order to expand their advocacy efforts on behalf of children orphaned and made vulnerable by HIV and AIDS (OVC), with the goal of bringing greater priority to their needs and expanding the response.
Introduction

1.1 BACKGROUND INFORMATION

The HIV and AIDS pandemic is currently the most important health, social, economic, and religious challenge facing countries worldwide. The impact of the HIV and AIDS pandemic is alarming due to the number of deaths and the extent of human suffering of those infected and/or affected by HIV and AIDS. Over 33 million people worldwide, both adults and children, are estimated to be living with AIDS.

The pandemic poses a threat to social and economic development in many countries. Twenty-four of the 25 most affected countries in the world are in Africa; the continent is home to more than 22.5 million people living with HIV and AIDS, which represents close to 70% of the global total. In 2007, an estimated 1.7 million people in the region became newly infected, while 1.6 million adults and children died of AIDS. Currently more than 15 million children under the age of 18 have lost one or both parents to AIDS, 12 million of them in Africa.¹

The impact of this loss of life differs across families and societies; however, one fact is clear. A child’s life often falls apart when she or he loses a parent. With the infection rates still rising and adults continuing to succumb to the disease, HIV will continue to cause large-scale suffering, especially among orphans and vulnerable children.

The Purpose Of The Handbook

The Handbook is intended to be a reference for those who have been trained using the *HIV and AIDS Advocacy and Media Relations* Training Manual (AMR) and who are expected to train others using the AMR training manual along with this Handbook. It is specifically designed as an additional reference for religious leaders and lay trainees giving them information and skills to help them launch meaningful advocacy campaigns at all levels of society.

The Handbook provides trainers, trainees, religious leaders and other advocates with the latest updates on issues related to HIV and AIDS, its impact on children, and advocacy work. It provides an introduction to the concept and practice of advocacy, and to building coalitions and networks as effective instruments of promoting advocacy campaigns.

The Handbook covers issues that are instrumental in building the skills of the trainers to enhance religious leaders’ engagement in policy advocacy, and it also addresses ways to develop effective messages and deliver them to relevant audiences. Finally, the Handbook offers important skills and tips on how to engage media to bring greater effectiveness to advocacy efforts. It is hoped that the Handbook, along with the Training Manual, will serve as a valuable tool to help strengthen skills within religious communities for public advocacy on HIV and AIDS and the pandemic’s particular impacts on children and families.

1.2 OVERVIEW OF THE REGIONAL ADVOCACY STRATEGY

Religious communities, and particularly religious leaders, played a key role in the advocacy strategy for Hope for the African Child Initiative (HACI) in which *Religions for Peace* was a founding partner. Religions offer networks for the dissemination of information; they can mobilize people around critical issues of concern like HIV and AIDS; and the leaders hold particular authority and influence in their societies. *Religions for Peace* was mandated by HACI to engage religious communities in joint advocacy efforts on behalf of children affected by AIDS, not just in the HACI implementation countries, but at the regional level as well. The Handbook and Training Manual on advocacy and media relations are tools developed to help advance this advocacy effort.

Overall, the advocacy strategy has five main principles:

* Stress the importance of the rights and needs of orphans and vulnerable children within the broader HIV and AIDS agenda.
* Emphasize interventions that are effective in meeting children’s needs and get them expanded.
* Encourage political commitment and concrete actions plans among African governments to address particular needs of children affected by AIDS.
* Reduce the stigma of HIV and AIDS by engaging key groups at the national level.
* Push for expanded funding at all levels for OVCs.

¹ Statistics in this section are drawn from UNAIDS/WHO, 2007 *AIDS Epidemic Update* (November 2007).
There are four key target groups to whom the advocacy messages will be directed by religious organizations:

**Local communities:** Religious leaders need to get the messages moving through their structures to the local level. This is particularly critical regarding issues of stigma and getting communities mobilized to respond in greater ways to the impact of AIDS on children. This effort will engage inter-religious bodies at the national and regional levels as well as individual religious organizations. It needs to happen both in HACI implementation countries and in many other countries where religious organizations (and particularly *Religions for Peace* structures) can be engaged.

**Governments/regional inter-governmental bodies:** Religious leaders need to work actively to ensure that the policies of national governments in Africa, as well as the regional bodies, are addressing the particular needs of children in the context of their AIDS strategies. It is critical to strengthen policies and ensure a greater commitment of resources at all levels of government. Here the national inter-religious bodies are essential, along with the *Religions for Peace* African Council of Religious Leaders (ACRL) with the support of the *Religions for Peace* regional office.

**Funding publics:** No matter how strong the level of commitment among local communities and governments, the scale of the problem of orphans and vulnerable children requires external resources if responses are to be successful. Advocacy will need to focus both on African and global sources, and will require effective collaboration not just among religious organizations, but also with other HACI partners and others. This campaign will need to engage the pan-African structures that *Religions for Peace* has developed, particularly the ACRL, as well as support from *Religions for Peace*-International at the global level.

**Religious communities globally:** Religious leaders and organizations can be effective advocates with governments and in civil society outside of Africa to encourage greater attention and more resources for the needs and rights of children affected by AIDS. These efforts will involve providing *Religions for Peace*’s structures and international governing board members, particularly those in donor countries, with useful information on the work of HACI and facilitating their involvement in advocacy coalitions in their own countries.

The outcomes of the 2002 African Religious Leaders Assembly on Children and HIV and AIDS, sponsored by *Religions for Peace* and HACI, served as the framework for the advocacy strategy engaging religious leadership at the continental and national levels. The inaugural meeting of the ACRL, held in June 2003 in Abuja, Nigeria, formally adopted the Assembly Declaration and Plan of Action as official Council documents, and the Council also endorsed a four-point advocacy strategy on HIV and AIDS.

*Religions for Peace* and ACRL continue to facilitate advocacy efforts by religious leaders at regional and national levels across Africa through HACI and a range of other partnerships and coalitions, as they play a central role in advocating on behalf of children affected by HIV and AIDS and in reducing stigma and discrimination. *Religions for Peace* continues to work closely with national inter-religious bodies and women of faith networks to strengthen advocacy efforts at the national and local level. The Council will also work with the major African religious bodies to ensure that agreements made in multi-religious forums get integrated into the HIV and AIDS strategies and policies of individual faith communities.

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**Module 1: Overview of Training**

**NOTE:** All notes and supporting information for this module are found in the Training Manual and therefore no additional information is provided in the Handbook.
Module 2: HIV and AIDS

2.1 FACTS ABOUT HIV AND AIDS

The origins of AIDS are unknown; however, it was first diagnosed in the United States in 1981. Initially, it was reported among very specific groups—homosexual men and intravenous drug users—and was causing death at an early age. This early association between AIDS and the behavior of certain groups of people led to significant prejudices and misperceptions about the disease. Such prejudices are still alive today, even though HIV and AIDS now affect men, women, children, and youth from all types of backgrounds and groups.

AIDS has been a calamity for Africa. HIV is a virus that spreads silently before it wreaks devastation and, because it is largely spread sexually, it targets young adults just as they are coming into the prime of their productive lives. Because these young adults are also starting families, AIDS has a cross-generational impact, leaving children without parents to guard and guide them, increasing their vulnerability to HIV infection, and creating a legacy of economic and social instability.

The facts:

• Human Immunodeficiency Virus damages the body’s immune system, weakening it until it can no longer fight off disease. HIV is a particularly serious infection because it attacks and destroys cells of the immune system—called T-cells or CD4 cells—which are designed to fight infections and diseases. After HIV penetrates these cells, it takes over their machinery so that it begins to produce many copies of the virus, eventually destroying the immune cells.

• HIV has the ability to mutate, which makes it especially difficult for researchers to find an effective treatment or vaccine.

• People living with HIV usually live for years without any signs of disease and look and feel healthy. A blood test is the most accurate way for a person to know if he or she is infected with HIV; saliva and urine tests are also now available.

• AIDS, or Acquired Immunodeficiency Syndrome, is the late stage of HIV infection where “Acquired” means that it is not genetically determined, “Immunodeficiency” refers to the severe depletion of immune system cells (that is, the cells that defend the body from other, even trivial infections), and “Syndrome” refers to an illness that presents itself in various forms. Advanced HIV infection weakens the immune system to the point where it cannot fight off infections as it can in a healthy state.

• People living with AIDS grow weaker because their bodies lose the ability to fight off illnesses. In adults, AIDS on average develops seven to 10 years after infection with HIV. In young children, the disease usually develops much more quickly.

• So far there is no cure or vaccine for HIV and AIDS, but the latest development of antiretroviral drugs is bringing some hope.

Antiretroviral therapy (ART) can help people with HIV and AIDS live longer, healthier lives and can help prevent transmission of HIV from mothers to their infants. Since 2003, a rapidly growing number of people living with HIV have been able to get access to this ART, but still the great majority of those living with the disease are not able to access even basic health care let alone the anti-retroviral medication.

HIV and AIDS in Sub-Saharan Africa

Although HIV and AIDS have reached almost every part of the world, no other region has been hit harder than Sub-Saharan Africa home to nearly three-quarters of the world’s people living with HIV and AIDS. By the end of 2007, over 22.5 million people in Sub-Saharan Africa were living with HIV and AIDS. In 2007, about 1.7 million adults and children died of AIDS in the region.

Among the most devastating effects of the HIV and AIDS epidemic in Sub-Saharan Africa is that it is leaving a generation of children as orphans. This jeopardizes their rights and well-being, and compromises the overall development prospects of their countries. There are more than 34 million orphans in the region today and some 12 million of them are orphaned by AIDS. By 2020, the number of children who have lost a parent due to AIDS is expected to grow to 20 million, with more than a dozen Sub-Saharan African countries facing a situation where more than 15% of all children will be orphaned, the vast majority of them by HIV and AIDS.

2.2 HIV TRANSMISSION

HIV is spread only when certain bodily fluids of an infected person come into contact with broken skin and body linings of another person, or are introduced into the circulatory system through injections or blood transfusions. Most common are blood, vaginal, and penile secretions. However, saliva, tears, and urine are not known to transmit HIV. The virus multiplies in the body so rapidly that within hours, newly infected people can spread the virus.

Specifically, HIV is spread in the following ways:

- Unprotected sexual intercourse with infected people, which is the cause of the vast majority of infections
- Transfusions of unscreened, infected blood
- Contaminated needles and syringes, most often those used for injecting drugs; 2 percent of new infections every year result from the failure to maintain sterilization in health services
- From an infected woman to her child during pregnancy, childbirth, or breast-feeding

HIV is not spread through everyday contact such as shaking hands, kissing, touching, sharing cups or plates, sharing toilets, staying in the same office or house with someone who lives with HIV and AIDS, or through swimming pools, public baths, or bites from mosquitoes or other insects.

Prevention is fundamental to defeating HIV and AIDS. Every person must know how to avoid getting and spreading the disease and should be empowered to act on this knowledge.

Advocacy campaigning should include strategies that contribute to reduced risk factors for all and especially vulnerable groups.

Co-factors

There are underlying socioeconomic causes of vulnerability to HIV, and these operate in many ways. Because HIV infection is preventable, people who have access to information and appropriate preventative measures and have the means to implement these measures will, in the future, be able to protect themselves against infection. The people who remain vulnerable are those who are denied the means of protecting themselves against HIV because of economic need, for example, or powerlessness to control the basis upon which their sexual relationships take place.

Many factors come into play here, including poverty, geographical isolation, inadequate health care, and health education as well as cultural values that compel certain practices that expose some members in the community to the risk of HIV transmission. For women, the social and economic obstacles to avoiding the risk of HIV infection are particularly great. Their position within families and societies means that they are often not free to make their own decisions about their sexual relationships or to insist upon measures, such as the use of condoms or fidelity on the part of their partner, which would reduce the risk of exposure to HIV. Cultural expectations in relation to marriage and childbirth and the absence of means of economic support outside the family unit compound the difficulties for women in avoiding exposure to the virus.

2.3 HOW HIV AND AIDS AFFECT THE HUMAN BODY

People who are infected with HIV carry the virus in certain body fluids, especially in blood, breast milk, semen, and vaginal secretions. The virus can be transmitted only if these fluids come into contact with the blood or other bodily fluids of another person. This kind of direct entry can occur through the linings of the sexual organs, through injection with a syringe, or through a break in the skin such as a cut or a sore.

HIV does not cause someone to become sick right away, although they may experience temporary flu-like symptoms after exposure. In fact, it can take seven to 10 years before someone infected with HIV sees symptoms of AIDS. During this time, a person may not know that he or she is infected, but can infect others.

Once a person has HIV, the virus gradually weakens the body’s immune system, which means that the body is less able to fight off infections.

At this stage, such opportunistic infections can easily take hold and cause death if health services and life-prolonging antiretroviral medicines are not available. The most common sicknesses that affect people with HIV are pneumonia, certain cancers, malaria, diarrhoea, and tuberculosis. Some illnesses that are not necessarily fatal can cause severe discomfort, such as thrush and cytomegalovirus, which can cause blindness.

The HIV test does not test for the actual presence of the virus in the blood. Rather, it tests for molecules,
called antibodies, which the body produces to fight off the virus. Antibodies start to appear in the blood soon after a person gets infected with the virus, but can be tested for only when they reach high enough concentrations. It can take three to six months for antibodies to show up in tests. During this period, tests are likely to be negative for HIV even if a person is infected. This is called the window period.

Newborn children of HIV-infected mothers have some of their mothers’ antibodies in their blood for about 18 months even if they are not infected themselves. For this reason, HIV tests on infants will not be accurate during this period. They can transmit this infection even if this test is still negative. HIV tests for infants need to be repeated after 18 months to ascertain their true status.

2.4 PREVENTING HIV INFECTION

Across the world, a small but growing number of countries have reduced HIV prevalence through sound prevention efforts. However, in 2006, there were still 4.3 million new HIV infections with 2.8 million occurring in Africa. Over 40 percent of new adult infections happen among young people aged 15–24. According to the latest estimates, HIV-prevention services reach only one in 10 of those most at risk.³

In an era where the world has committed to working toward universal access to HIV prevention, treatment, care, and support by 2010, there is clearly an urgent need to intensify HIV-prevention efforts in both size and scale to halt growing infection rates and sustain the gains that have already been made in the AIDS response, such as the increased numbers of people on HIV treatment. However, despite some substantial efforts in HIV-prevention activities, many countries have not shown any significant evidence of reduction in the spread and subsequent reduced impact of HIV transmission.

HIV and AIDS affect people from various backgrounds and ages, but the most vulnerable are young people and people from low-resource settings. However, the most affected segment of the population is young adults, particularly young girls and women. Some of the major contributing factors include socio-cultural practices such as early sexual debut, wife inheritance, male and female genital cutting as a means of initiating the youth into adulthood, and sexual life. Religious leaders are well placed to mitigate the impact of HIV and AIDS through these cultural factors by encouraging alternative cultural rites.

Preventing Transmission through Sexual Contact

Having unprotected sexual intercourse with a person who is living with HIV is the most common mode of HIV transmission. The frequency of exposure, the presence of cuts and sores on sexual organs, and the amount of virus in the semen or vaginal fluid are all contributing factors in HIV transmission through unprotected sex. STIs that are present with sores are an important predisposing factor. Studies have shown that proper treatment of opportunistic infections reduces the chances of infection. One does not have to be engaged in unacceptable, unlawful, or morally inappropriate behavior to be infected through sexual contact.

The spread of HIV through sexual contact can be prevented through a combination of practices that have been popularized as the ABC approach:

**Abstinence:** Not having sexual relations. This is the only certain way to prevent transmission through sexual contact.

**Being faithful:** Having sexual relations with only mutually faithful uninfected partners.

**Condoms:** Using condoms correctly and consistently in situations where a couple is discordant (i.e., one person is HIV-positive and the other is HIV-negative), or when partners don’t know their status, can be an effective way to prevent transmission of HIV.

There are additional methods that can make sexual intercourse safer, particularly preventing and treating STIs when they occur as they greatly increase the risk of getting and spreading HIV.

³ UNAIDS/WHO, AIDS Epidemic Update: December 2006
Religious leaders and communities provide moral guidance in helping people make decisions that can protect them from contracting HIV and AIDS. In all religions, there is a focus on promoting the sanctity of sex within marriage, so abstinence and mutual fidelity are a natural part of their prevention messages. It is well known that religious communities have different positions on condom use, so prevention programs need to be conducted in a manner that respects the relevant doctrines and teachings of each particular religious tradition. As part of this moral guidance from religious communities, people have the right to receive accurate scientific and medical information on how HIV is spread and how it can be stopped so that they can act in ways respectful of conscience as it is informed by their respective religious beliefs.

The following are challenges in preventing sexual transmission of HIV:

- Sexual relationships are strongly influenced by social and cultural factors that may make prevention difficult. For example, women may be powerless to refuse sexual relations with their husbands, even if their husbands are infected with HIV.
- Women and children are most often victims of abuse or rape.
- Poverty often forces people to make choices that increase risk; for example, women become commercial sex workers, or are trafficked.

Preventing Transmission through Blood

HIV can also be transmitted when a person is exposed to HIV-contaminated blood through blood transfusions, injections, body cuts, and other skin-piercing procedures. (A spouse, best friend, family member, or a respected community leader may transmit HIV to another person in this way.) The most common routes are:

- injections/needles, such as sharing needles, using intravenous drugs, or sustaining injury from contaminated needles or other sharp objects
- cutting tools, such as using contaminated skin-piercing instruments (scalpels, needles, razor blades, tattoo needles, circumcision instruments)
- transfusions by receiving infected blood or blood products or transplant of an infected organ (this is minimized by health personnel by following universal HIV infection prevention through blood)
- contact with broken skin by exposure to blood through cuts or lesions

The spread of HIV through blood transfusions can be prevented by: undertaking only essential blood transfusions; using only blood or blood products that have tested negative for HIV; and using sterile needles and other equipment for the donation of blood or blood products.

The spread of HIV through needles, syringes, and cutting instruments such as razor blades and knives can be prevented by: avoiding injections in favor of pills or liquid medicine whenever possible; not sharing needles and syringes; and using only new, sterilized, disposable, or autoclaved needles and syringes. Whether in immunization and health services or elsewhere, sterilizing surgical equipment and using other standard precautions in health services, such as safely disposing of used needles, should be a standard practice. Communities need to be educated to demand single-use needles.

To prevent HIV transmission through blood, the challenges are:

- lack of testing facilities for donor blood
- lack of adequate medical supplies (needles, instruments, gloves)
- lack of education on transmission among health workers

Preventing Mother-to-Child Transmission (PMTCT)

The chance of an infected mother transmitting the virus to her baby during pregnancy or birth is about 15–30 percent. The virus can pass from mother to baby through the placenta. Strategies to reduce MTCT include primary prevention of HIV infection among women, family planning, antiretroviral intervention, restricted use of invasive obstetric procedures during vaginal delivery, and provision of infant-feeding options.

The spread of HIV from parent to child can be minimized by ensuring that women do not become infected with HIV; encouraging people to seek voluntary and confidential counseling and testing to determine their HIV status and to get guidance on family planning; providing timely antiretroviral
therapy to pregnant women with HIV in accordance with medical practices; providing clean and safe delivery services; providing safe and locally acceptable alternatives to breast-feeding for women living with HIV; and providing treatment, care, and support to women living with HIV or AIDS and their families. Caesarean section where possible may be advised.

After birth, the baby will have many antibodies that its mother produced, including HIV. This does not mean that the baby has HIV. Children must be tested at 18 months or as recommended to see if antibodies are still present. If they are, the baby probably has HIV. Some babies with HIV die within a few years, while others grow up and live many years with HIV.

Breast-feeding is important for a baby’s health. Mother’s milk contains many nutrients and protects the baby against disease. Unfortunately, breast milk from an infected mother can contain HIV. The estimated added risk of HIV infection from breast milk is about 15 percent for infants whose mothers have established HIV infections. The current WHO/UNAIDS/UNICEF guidelines state that for HIV-positive mothers who choose to breast-feed, the safest choice is to breast-feed exclusively, meaning not feeding the baby other foods or liquids, even water, to reduce the risk that the gut may be damaged and transmission may become more likely. Breast-feeding is recommended for three months only and then switching to a breast-milk substitute or formula.

Other options include:
- breast-feeding in the generally recommended way
- using heat-treated expressed breast milk
- wet nursing by a HIV-negative woman
- using formula to replace breast-feeding

Challenges to prevention of MTCT include:
- a lack of awareness among people about this transmission route
- women’s unwillingness to be tested for HIV infection
- a lack of antiretroviral medications and their high cost, if available
- a lack of healthy drinking water to mix with the powdered formula in many African communities
- the risk of stigma and discrimination for women in areas where breast-feeding is the norm
- poverty could force mothers to dilute the formula, leading to malnutrition

There are also other social and behavioral factors that can contribute to preventing the spread of HIV:

Greater Involvement of People Living with HIV in Prevention Efforts

People living with HIV are the greatest champions for prevention. Prevention strategies have been more effective when they have meaningfully involved people living with HIV in their design, implementation, and evaluation. The principle of Greater Involvement of People Living with HIV and AIDS (GIPA) in the AIDS effort was formally recognized at the 1994 Paris AIDS summit when 42 countries agreed that ensuring their full involvement at national, regional, and global levels will stimulate the creation of supportive political, legal, and social development.

Religious leaders can involve PLWHA in all parts of their advocacy strategies, including during trainings, sermons, home-based care, and psychosocial care.

Stigma Reduction

Religious leaders first need to understand what HIV and AIDS are all about, and that they are not necessarily a consequence of sin in order to contribute to reducing and eventually eliminating the stigma and discrimination associated with the disease in their congregations and community at large.

On the social level, stigma can cause target audiences to view those with or at risk of HIV and AIDS as the “other” or “them,” perpetuating notions that such an epidemic could not happen to themselves. BCC programs can result in audiences rejecting AIDS-prevention messages when stigma is not addressed.

On the individual level, ignoring stigma can cause people to decide not to seek VCT or other medical care, including care regarding MTCT.

HIV Testing for Prevention: Know Your Status

Many people are worried about contracting HIV and AIDS. They may understand that certain behaviors put them at risk for contracting the virus. HIV testing can be an important part of prevention efforts. A medical practitioner may recommend a test based on the patient’s behavioral history and/or clinical findings such as STIs. HIV and AIDS are sensitive and emotional issues in many countries, and often people living with HIV are stigmatized in the community. HIV testing should always be voluntary and confidential.
Voluntary Counseling and Testing (VCT) is a supportive process between a client and counselor, often a health provider. However, in some testing services, counseling is not available or is inadequate, and often people will go to their clergy for counseling either before or after testing, so it is important for religious leaders to understand the VCT process. To meet the counseling needs at the VCT centers, the centers may partner with the religious leaders and faith-based organizations, and train and equip them with the necessary counseling skills for HIV and AIDS. This, in turn, will be a great resource for VCT centers, especially where counseling is unavailable or inadequate.

Increasingly, VCT is recognized internationally as an effective and pivotal strategy for both prevention and care. VCT is an effective and cost-effective strategy for facilitating behavior change, and it can serve as an important entry point to care and support. VCT is thus a valuable component of comprehensive HIV and AIDS programs among national AIDS-control strategies. VCT helps people learn about HIV transmission, practice safer sex, get an HIV test, and, depending on the result, take steps to avoid becoming infected or infecting others. Within care programs, HIV test results and follow-up counseling mean that people can be directed toward relevant care and support services, such as treatment for tuberculosis and sexually transmitted infections, and treatment for opportunistic infections, treatment with antiretroviral medication, and prevention of mother-to-child transmission. In addition, wider access to VCT may lead to greater openness about HIV and AIDS and less stigma and discrimination.

It is important to note that Antiretroviral Therapy drugs (ART) are increasingly becoming available, and religious leaders should enhance their campaign to promote community awareness and preparedness for ART. Once people are aware that treatment for HIV is available, they are likely to go for VCT, which promotes self-disclosure and reduction of denial. The more HIV-positive people in the community, the less stigma and discrimination.

The major barrier to VCT is fear of stigma; women in particular can face violence and loss of security in the form of shelter, food, and relationships. It is particularly important to ensure and maintain confidentiality at all times when dealing with both men and women. However, all efforts should be made to promote disclosure for men and women. Counseling itself is labor intensive and requires training and supervision to assure high quality.

In Sub-Saharan Africa, evidence and experience have shown that rapidly increasing the availability of antiretroviral therapy leads to greater uptake of HIV testing. Kenya, for example, has seen a dramatic increase in people going for testing and counseling in 2000-2004.

In VCT the counselor does the following:

- Determines the patient’s HIV knowledge and corrects any mistaken beliefs about HIV and AIDS
- Assesses the person’s risk by discussing past behaviors
- Explains the test and the meaning of test results, including how the results will be given
- Gets the patient’s consent or permission to give the test

In HIV testing the challenges include:

- the fear that if one is tested, the results will not be anonymous
- the fear if one tells one’s family or partner that he or she has HIV, there may be negative consequences (especially for women), including blame for the disease, violence, abandonment, or community stigma and discrimination
- the possibility that men and women may lose their jobs
- how to handle the information if one’s test proves to be positive

### 2.5 HIV AND AIDS AND CHILDREN

Between 80 percent and 90 percent of HIV infections occur in the 15–49-year-old group, which is particularly devastating as this is the most productive age group, thus affecting countries’ socioeconomic development. Most people in this age group are raising children, so as parents become ill due to HIV and AIDS, it has significant impact on their children, who are often forced to drop out of school to take care of their siblings and sick parents. It is traumatizing for children to watch their parents slowly die. When patients die, often relatives rob the children of their deceased parents’ property; the children are left in the care of grandparents or siblings; or the children can end up fending for themselves.
This impact of AIDS on people of reproductive age is increasing the numbers of orphans at such a rate that communities cannot rely on traditional means to care for these children. Communities’ inability to respond adequately and appropriately to the situation has resulted in children’s social, psychological, and economic deprivation.

Because of the sickness and death of adults, children now head a large number of households. Children’s immediate physical and emotional health is affected, and HIV will have a long-term impact on their development and future prospects.

Studies have noted that many orphans refuse to divulge their parents’ actual cause of death. They fear that by associating their parents’ death with AIDS, they would be objects of ridicule and discrimination in the community. A majority of the children claimed that their parents had been bewitched, but there were indications that their parents actually died of AIDS. Children have to bear the trauma of seeing their parents weakened day by day due to HIV and AIDS and finally die.

Orphans and Other Vulnerable Children (OVC)

As noted earlier, one of the most devastating impacts of HIV and AIDS is that the pandemic is making orphans of a whole generation of children, jeopardizing their health, their rights, their well-being, and sometimes their survival.4

The vulnerability of children starts well before the death of a parent. Children living with caregivers who have HIV and AIDS will often experience many negative changes in their lives and can start to suffer neglect, including emotional neglect, long before the death of the parent or caregiver. The economic impact of HIV and AIDS illness and death has serious consequences for an orphan’s access to basic necessities such as shelter, food, clothing, health, and education. Orphans run greater risks of being malnourished than children who have parents to look after them.

The AIDS epidemic also contributes to deepening poverty in many communities; the burden of caring for the vast majority of orphans falls on already overstretched extended families, particularly women or grandparents with meager resources. Without a real safety net, street life is the recourse for many orphans, who often suffer from poor health, trauma, and psychological distress, making them more vulnerable to abuse and exploitation.

The Impact of Orphans on Families, Households, and Communities

The HIV and AIDS epidemic has deepened poverty and exacerbated myriad deprivations. With an increasing number of families falling ill, the number of children who require protection and support is soaring; the responsibility of caring for orphaned children is therefore a major factor in pushing many extended families beyond their ability to cope.

Many countries have families headed by grandmothers and/or the children themselves. Households with orphans are likely to become poor because of the increased dependency ratio. There is a notable increase in the burden on female-headed households. Despite all of this, children must not be denied their basic rights as children and human beings, hence the need for increased advocacy for the most critical livelihood needs such as education, shelter, food, clothing, love, and protection.

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Child-Centered Approaches to HIV and AIDS

Child centeredness is basically a point of view, an ideology of the development community working with children. A child-centered approach views the child as an individual, one who has something divine and unique. The approach takes into consideration the age, characteristics, interests, and abilities of the child. A child-centered approach means that children are actively involved and participate throughout the process. An example of this is the Child-to-Child Approach, which is of, for, and by the children. Children are the greatest losers in the HIV and AIDS epidemic because of their inherent vulnerability in their need for protection, their lack of skills, and their dependency on adults.

Involving Children

Children and young people have the capacity to address pertinent issues affecting them, including HIV and AIDS, FGM, and basic rights. They can competently contribute to and transform their families and communities if they are well facilitated. Child-centered approaches thus seek to enable them to make a difference and be effective change agents in fighting HIV and AIDS in their communities.

It is important to appreciate that children can be partners in analyzing, planning, implementing, and evaluating activities. Meeting and listening to children to learn from their experiences regarding HIV and AIDS is invaluable. The meetings should use child-centered participatory tools such as drawings.

The results of listening to the children can be documented and analyzed in relation to:
- what the children can communicate about HIV and AIDS
- the children’s perspectives on HIV and AIDS
- using children’s constructive ideas for advocacy

2.6 HIV AND AIDS AND GENDER

The term “gender” is used to describe the various characteristics assigned to women and men by a given society. The term “sex” refers to the biological characteristics of women and men. Gender roles reflect behaviors and relationships that societies believe are appropriate for an individual based on his or her sex. Gender roles are learned rather than inherent, and vary from culture to culture and from generation to generation. They can change over time due to a variety of factors such as economic, education, technology, religion, and political structures.

Gender roles are a powerful feature of social organization in not only describing how men and women are expected to behave, but also influencing power relations, decision-making authority, and individual responsibility.

It is important for religious leaders to bear in mind the way in which gender roles affect the AIDS crisis: The sexual subordination of women makes it much more difficult for them to avoid infection. Biologically young women are more prone to infection, and their low social status and cultural expectations of sexuality further compound their vulnerability.

Men are part of the solution to the HIV pandemic, and need to understand how their actions contribute to the spread of HIV and AIDS. They need to play an active role in promoting their own health as well as protecting their partners from HIV infection, and advocacy can reinforce this process. Advocacy initiatives that target young boys are increasingly being seen as valuable in promoting more gender-equitable relationships.

Another important dimension of gender and HIV and AIDS is that of gender-based violence and discrimination against women and girls, which makes them vulnerable and unable to negotiate safer sex. Sexual violence and coercive sex, which often carry a high risk of infection, must also be addressed.

Studies confirm that women who are living with HIV and disclose their status often face further violence and discrimination. Advocacy initiatives should focus on eliminating all forms of violence against women and on campaigning to change laws where appropriate.

Advocacy for gender-sensitive programming will help identify the different needs of men and women, boys and girls. Advocacy aimed at empowering women and giving them more negotiating skills is an important tool for combating HIV and AIDS as well as promoting women’s rights. More specifically, advocacy aimed at improving women’s access to education and to economic resources, such as training, legal reform, and credit schemes, can contribute to women’s overall decision-making power within households and in sexual relationships.
CASE STUDY: WHO KILLED SHUNILA?5

Shunila was born in the rural Silhet Province of Bangladesh. She was married at fifteen to a remote cousin whom she hardly knew, and moved to Dhaka. On the day her third daughter was born, her husband (who had another wife anyway) beat her and threw her into the street with her three little girls and nothing else. She was not quite twenty at the time.

Sick and bleeding, Shunila had nowhere to go and her family were unlikely to take her in, even if she’d had the money or the strength for the journey. A woman rejected by her husband is a disgrace to the community. She survived on the street for three months. It was when the baby, Yami, became desperately ill with diarrhoea that she heard about Jibon, a refuge and day care centre where abandoned, battered or widowed women and their children could get health advice. That was six years ago.

Shunila became a member of the group of women who meet at Jibon. The biggest enemy to health, they recognized, was not disease but sheer poverty. What was the good of bringing Yami back from the dead when the family had nowhere to live, no money to buy food and no real hope of either? She’d be ill again and again, and eventually, sooner rather than later, she’d die.

The women developed a number of small moneymaking schemes, and Shunila learned to work with straw, making coloured floor mats. Still the children got ill, and medicines were expensive. At first, the project bought medicines from a local pharmaceutical factory making basic drugs. The factory was closed down, and they had to use imported drugs at many times the price. They put together a demonstration against the closure of the factory. When they came to the centre the next morning, they found their looms had been broken up and their tools stolen.

When Shunila first came to Jibon, one of her ambitions was to make enough money to allow her to bottle-feed little Yami, which she’d been told at the hospital was the best way to ensure that she grew up strong and healthy. But the weekly health education class at Jibon emphasized the benefits of breastfeeding so strongly that Shunila was convinced. She now works with a group, based at Jibon, which is trying to promote breastfeeding among local women. This may sound pretty obvious in a country where over 80 per cent of people live below the poverty line, and where few people have clean water for sterilization. But big companies still encourage poor women to bottle-feed, in spite of the expense.

One afternoon, after Shunila and others had been chatting with women waiting in line at the hospital antenatal clinic, some men followed them down a side street, beat them unconscious, and left them.

Another thing, Shunila has AIDS. She might have got the virus from her husband, who was a truck driver. But then, during the time between leaving her husband’s home and arriving at Jibon, trying to keep herself and her children alive, she had a couple of sexual encounters with men building the road. They’d paid enough to feed the children for another day. Maybe she contracted AIDS then. She looks back on those times. They had to eat. How else could they have survived? She is lucky, she says. She’s lucky she’s never been raped, like many of the women who belong to the little group of HIV+ women meeting at Jibon.

But even when she was married, being sexually available was part of the deal, wasn’t it? She’d assumed when she saw white vaginal discharge that her husband was going with other women, but she laughs gently at the idea that she might have dared refuse him, “At least,” she says, “I’ve got my own work now. Making pictures for a living, I can afford to make my own choices. I don’t have to worry about passing the sickness on to other people. The children do not have the sickness. But it’s for them I…” She doesn’t finish her sentence.

In November, I heard that Shunila had died. Her little girls are effectively orphans. And I wonder what will become of them now.

Factors in Gender and HIV and AIDS

The following gender-based factors have fueled the spread of HIV and AIDS:

Economic factors: Economic dependency and insecurity are at the core of the gender dynamics of HIV and AIDS. For both married and unmarried women, their comparatively limited access to and control of economic assets increase the likelihood of their:

- inability to negotiate safer sexual practices
- exchanging sex for money (survival sex)
- staying in a relationship they perceive to be violent or risky

In many societies, women’s and girls’ responsibilities for family and community care have increased as a result of the HIV and AIDS pandemic as they are called upon to meet the demands for care that exceed the capacities of health systems.

Sociocultural factors: There are many sociocultural norms that prevent both women and men from obtaining critical information about HIV and AIDS. For example, many societies have a culture of silence regarding sexual matters and an emphasis on virginity for women and girls. In many cultures, notions of masculinity are associated with machismo. There is a feeling of aggressive masculine pride that emphasizes multiple sex partners and a presumption of sexual knowledge. Some cultural practices, which have sexual components or connotations such as female genital cutting (FGC), widow inheritance, and ritual cleansing, also increase vulnerability to HIV and AIDS.

Legal factors: Gender discriminatory legal and regulatory frameworks, especially those in the areas of reproductive health, marriage, coerced sex, rape, sexual abuse, inheritance and succession, access to property rights, and land tenure, have repercussions on gender-based vulnerability and risk factors.

They may also reduce PLWHAs’ access to HIV services and treatments. In many countries, women lack legal recourse and experience discrimination in legal rights and protection. Many systems of law favor male ownership of property assets. Some legal systems do not protect victims against sexual violence between intimate partners. And many legal systems, by outlawing homosexual practices, drive the lifestyle underground, which can cause risky behavior.

Physiological factors: Because of anatomical differences, women are many times more likely than their male sexual partners to contract HIV and other sexually transmitted infections (STIs). There is also a 20-40 percent risk of mother-to-child transmission.

Questions
Who killed Shunila?
What killed Shunila?
Was it, as medical science might tell you, a virus?
Was it, as some religious people might say, immorality?

Answer
The real problems that faced Shunila were neither medical nor moral ones; they were a whole complex range of factors that govern the infrastructure of many poor women’s lives, not just in Bangladesh but also within the Third World. It is woven into the fabric of all societies, rich and poor, in the closing years of the 20th century. WHO’s report, Bridging the Gaps, spells it out starkly. “For most people in the world today,” it says, “every step of life from infancy to old age is taken under the twin shadows of poverty and inequity and under the double burden of suffering and disease.”

Shunila was not just desperately poor. She lived in a culture where women marry young and have little status. She was virtually uneducated, and without marketable skills. She produced girl children when sons were wanted. The laws failed to prevent her husband from beating her, and she had no means of claiming a share of matrimonial property. She was part of a family system that rejects women who come to grief, without any safety net within the health and welfare system to compensate, and in confronting the power of multinational companies, she brought upon herself the violence that sometimes supports that power.

It’s this kind of complex burden that provides opportunities, in the case of so many women, for HIV infection. The most pressing moral issue for Shunila was to keep her little family alive for a few more days.

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6 World Bank, Gender and Development Group, HIV and AIDS and Gender Equality, Gender, and Development Briefing Notes, July 2003.
(MTCT), which is the main cause of infection for the 3.2 million children living with HIV and AIDS worldwide.

Key issues to consider on HIV and AIDS and gender:
- What are the differences in gender roles, access to resources, legal protection, and decision making that affect women and men's abilities to protect themselves against HIV and AIDS?
- Do educational system interventions incorporate a gender-sensitive approach to learning about HIV and AIDS prevention at an early age?
- Do sectoral ministries incorporate relevant gender issues into their HIV and AIDS policies and strategies?
- Are there policies that address the rights of the girl and boy child—for example, access to formal education and gender-focused information? How do capacity-building programs for public and private sector workers and civil society participants address gender issues?
- Do vulnerable male and female children get equal opportunities for care, support, and education?
- Are there evidence-based, gender-related intervention efforts that require advocacy by religious leaders?
- How do capacity-building programs for public and private sectors, workers and civil society participants, address gender issues?
- Do monitoring and evaluation assess different impacts on males and females, and include gender-sensitive indicators?
- What is the role of religious leaders in relation to gender and HIV and AIDS?

2.7 STIGMA AND DISCRIMINATION

HIV and AIDS-related stigma and discrimination are a combination of several co-occurring behavioral patterns that, though not unique to HIV and AIDS, have had probably the greatest expression in relation to stigmatizing the syndrome. Unfortunately, the behavior patterns have a profound effect on the preventive strategies for HIV infection and the reversal and mitigation of HIV and AIDS and AIDS-related impacts.

The stigma and resultant shame related to HIV and AIDS causes families and communities to deny the existence of the two conditions within their midst. This, within the religious context, is usually in the form of a wall of silence around the disease and continuously and persistently excluding those infected and affected from participating fully in the worship and other activities of the faith community. This discrimination may be extended to spouses, children, and other family members of the infected and the affected person.

As the community continues to deny the problem and discriminate against those infected, affected, and their families, it misses several chances to take remedial action. In the first instance, by these actions, the religious leader, congregation, or community scares individuals from being tested to find out their status. If, unfortunately, such individuals are infected, but have not been tested, then they can unknowingly spread the disease to uninfected people. The individuals fear that when they are tested and the results are positive, they, too, will face similar ostracism, persecution, and discrimination. The fear of shame and stigma thus causes inaction.

Then there are those who are tested and discover that they are positive and, due to similar fears, also remain silent. They thus fail to seek information and services that will assist them to live healthily, both in mind and body and eventually are more likely to develop full-blown AIDS with the attendant costs and strain that is physically, financially, emotionally, and socially debilitating. At this stage, many individuals and families are driven by desperation to take wrong actions. For example, they may seek witchdoctors and other quacks, take vengeful actions, and, in a few cases, even commit suicide. Others decide to live in denial.

That is why in summary, attention is focused on stigma, denial, and discrimination and other resultant aspects such as shame, inaction, and wrong actions.

In the past, programs dealing with HIV and AIDS have too often not had meaningful impact as they failed to address the issues of stigma and discrimination. In a few instances where an attempt was made to tackle it, it was very difficult to develop and measure interventions as it was felt that stigma and discrimination were too rooted in the context-specific culture and behaviors of local communities. However, studies in various communities have shown that these behavior patterns have striking resemblance regardless of the communities practicing them.
Definitions

Stigma

“Silence kills, stigma kills. We should not want those living with HIV to be the modern equivalent of the biblical leper who had to carry a bell and a sign saying, ‘I am unclean’.”
—Archbishop Desmond Tutu, July 2004

According to UNAIDS, HIV and AIDS-related stigma is the “the process of devaluation” of people either living with or associated with HIV and AIDS. This stigma is derived from the historical and contemporary association of HIV and AIDS with what society considers socially unacceptable behavior, and because these conditions are perceived to be incurable, unalterable, severe, and degenerative, leading to physical disfigurement or death.7

However, there is no one basic, agreed-upon definition of stigma, and other definitions refer to the “discrediting of a person” based on membership is a group or having certain physical characteristics, or of these attributes being a “token of disgrace.”

Acknowledging this diversity of descriptions, a publication by the Ecumenical Advocacy Alliance and World Council of Churches proposes ten broad-based principles on which a definition might be based, such as the contextual and social character of stigma, that stigma exacerbates inequalities, and that levels of stigma can change over time.8

Stigma is also reinforced by fear driven primarily by a perception of risk or the threat of infection with an incurable or potentially fatal disease. Epidemics that present an overt threat to the values of a community are especially likely to evoke stigma because stigma is used to “enhance or secure social structuring, safety and solidarity or reinforce societal or community values by excluding divergent or deviant individuals.”9

In the religious context, HIV has often been stigmatized due to perceptions that because the virus is most frequently transmitted sexually, those living with the virus are sinners or leading immoral lives and are thus paying the wages of their sinful behaviors.

Fear of contagion is not necessarily reduced by general knowledge of how HIV is transmitted. As shown by studies in several countries and testimonials by PLWHA, even health workers who are quite knowledgeable about the modes of transmission will at times exhibit fear and irrational behavior, which ends up stigmatizing PLWHA. Only in-depth knowledge and appreciation of how HIV is not transmitted and the vulnerability of the HIV virus in the open environment have been shown to reduce this fear.

Although most stigma is directed at individuals, families, or local communities, sometimes tribes, districts, countries, and regions can also be stigmatized. For example, Sub-Saharan Africa is often described as a region where HIV is “rampant” or “runaway” in the foreign media, which perpetuates a misconception labeling a significant population in a negative light as immoral, lacking in self-control, or ignorant.

Stigma reinforces and strengthens existing prejudices and social stereotyping. Thus, women, orphans, PLWHA, particular nationalities, and some social classes will face increased prejudicial action that often leads to increased inequalities and fuels the spread of HIV infection within the target group.

Shame

Shame is the internalization of guilt by an individual or family for bringing themselves or their communities into disrepute. Shame is a powerful tool in society to force members to conform to societal values and norms. Shaming or loss of face is the degradation of an individual in the eyes of society for failing to adhere or falling below the acceptable standard of behavior within that society.

Within many societies in Africa, the loss of face associated with shame is a powerful determinant in behavior patterns. Public naming and shaming of individuals practically makes them pariahs within their communities.

The same is true within the context of HIV and AIDS. Individuals are shamed and made to lose face and thus are coerced into having negative feelings about themselves for being infected and affected. Community perceptions such as sexual immorality, promiscuity, questionable decisions, lack of self-control,

8 Gillian Paterson, AIDS-Related Stigma: Thinking outside the Box, the Theological Challenge. Ecumenical Advocacy Alliance and World Council of Churches, p. 3–5, 2005.
prostitution, and other behaviors that do not conform with societal norms are seen as causes of being infected or affected. Shame is especially a gendered factor. Women are more likely to have or be forced to feel ashamed for failing their husbands, children, families, or community even though not all HIV infections are caused by an individual’s failure.

Such individuals or families are made to feel that they have failed their communities and, as such, they should “pay penance” by excluding themselves; not expecting or demanding social respect, dignity, and acceptance; or being expected to do more than other members of society or, in faith communities, their congregations by worshiping, praying, tithing, or being more pious than other members of the same congregation.

**Denial**

This is a term used to denote a state where an individual, family, institution, community, or nation refuses to acknowledge the presence and threat of HIV and AIDS within their lives and interactions. In some areas, denial and silence regarding HIV have been the norm for years. People do not want to admit that a fatal disease spread by behaviors branded as immoral could be rampaging through their community or country.\(^{10}\)

Until the mid- to late 1990s, a denial of the global nature of the pandemic was still evident. Those in denial will convince themselves that the infection cannot affect them since they are good, pious, faithful to their spouses, live in a good neighbourhood, etc., and therefore they cannot be infected or affected.

At the individual level, self-pity is the driving force of denial. At the family and community level, denial is driven by cultural, ethnic, racial, and class considerations. Within faith communities, some faiths have higher levels of denial than others. Many religious leaders may deny the existence of the disease within their congregations for fear that high prevalence rates may indict them for failing to uphold the morals of their congregation or faith community. Some, in fact, have shared fears of congregants deserting congregations on seeing increased HIV and AIDS-related activities. Congregational responses, undertaken by a few individuals in the congregation, may also be muted or lack integration with other services and activities within the congregation because the community or religious leader may not want to appear too keen on HIV-related issues.

This denial of the presence and threat of HIV and AIDS is responsible for low uptake of HIV and AIDS-related services, including prevention, voluntary counseling and testing, treatment, care, and support services. Failure by many faith congregations to commence HIV and AIDS-related activities within their institutions as shown, for example, by a lack of volunteers, is driven by the denial that the condition is an important factor in that congregation.

**Discrimination**

Discrimination is a worldwide phenomenon that is not unique to HIV and AIDS. Discrimination is the unjustifiable differential action taken and words uttered by individuals toward others, their families, communities, tribes, races, or nations because of their race, gender, age, religion, socioeconomic status, or health condition. Such actions and words have the intention or effect of demeaning, deriding, or subjugating the individuals concerned.

According to UNAIDS, discrimination is different treatment given to individuals who, within a particular culture or setting, have certain attributes seized upon and defined by others as discreditable and unworthy. It is thus the progression from stigma, which marks that person with an undesirable attribute, to giving them differential treatment.

In relation to HIV and AIDS, discrimination is also spurred by the false notion that PLWHA are waiting to die and therefore do not need education, jobs, skills upgrading, good medical care, property, good clothes, entertainment, friends, marriage, and other factors of normal living. Discrimination is stigma in action.

Vulnerable groups—including women, widows, children, physically or mentally challenged people, and the poor—are at higher risk due to historical or cultural practice because they have lower social status. Children are especially at risk of discrimination by association. This is where children of parents living with HIV and AIDS are discriminated against because of their parent’s or parents’ condition. Due to inadequate knowledge of HIV and AIDS, it is erroneously assumed, even by well-educated people, that such a child is automatically HIV-positive.

Examples of discrimination include:

• accusing a disadvantaged group as responsible for the spread of HIV and AIDS
• health care workers refusing to care for those living with HIV and AIDS
• refusing to buy vegetables from a market woman who is living with AIDS
• firing an employee because he or she is living with AIDS
• children refusing to play with a small boy because his mother died as a result of AIDS
• community condemnation of people living with HIV and AIDS

As a result of stigma and discrimination, people are cast out from their families and left alone to face HIV and AIDS. Stigma and discrimination obstruct prevention efforts and provision of support for orphaned and vulnerable children.

2.8 The role of religious leaders in combating HIV and AIDS

Religious leaders are central in their communities. They have strengths, credibility, and respect, which offer them the opportunity to make a real difference in combating HIV and AIDS. To respond to this challenge, religious leaders must increase tolerance and compassion in their communities and encourage the government to be more responsive to the needs of the infected and affected. Religious communities need to double their efforts and urge communities and governments to address the challenge of OVC. To this end, religious leaders have the potential to offer healing, hope, and a friendly environment for OVC as well as infected and other affected members of the communities.

Religious leaders who are in close and regular contact with all age groups in society and who are highly respected exert a powerful influence on the priorities of society and the policies of its leadership. Religious leaders can play a key role in reducing the stigma and discrimination associated with HIV and AIDS. Where religious leaders and those associated with faith-based organizations speak out truthfully and take action, they can make a difference. As trusted and respected members of society, religious leaders are listened to. Their actions set an example. Religious leaders are in the unique position of being able to alter the course of the epidemic because they can:

• shape social values
• promote responsible behavior that respects the dignity of all people and defends the sanctity of life
• increase public knowledge and influence opinion
• support enlightened attitudes, opinions, policies, and laws
• redirect charitable resources and raise new funds for spiritual and social care, prevention, and other forms of support
• promote action from the grassroots up to the national level
Other measures that inhibit the spread of HIV and AIDS or help to deal with the suffering they cause include advocacy for justice and human rights, the empowerment of women, the training of counsellors, and the creation of “safe spaces” where people can share their stories and testimonies. In addition, all societies, whether developed or developing, need to address practices such as drug abuse and commercial sex activity, the increasing incidence of child sex workers, and the root causes of destructive social conditions such as poverty, all of which fuel the spread of HIV and AIDS.

Strategies for prevention and care may fail if those affected by HIV and AIDS play no part in designing or carrying them out. From the beginning of the pandemic, religious communities and other related institutions were active in education, prevention programs, and care for people living with HIV and AIDS. According to the World Council of Churches’ Central Committee Statement of 1996, the challenges posed by AIDS require both a global and a local response. A full range of interrelated approaches is called for. Effective methods of prevention include sexual abstinence, mutual fidelity, and other safe practices in relation to blood transmission and needles. Education, including education for responsible sexual practices, has been shown to be effective in helping to stop the spread of the infection.

Religious people are called to respond with love to everyone, especially those who are suffering. People living with HIV and AIDS have many physical, emotional, and spiritual needs. However, PLWHA are frequently afraid to approach their religious leaders for fear of facing condemnation, rejection, and judgement, with the result that many lack the spiritual care and support they need and deserve. The stigma and discrimination of people living with HIV and AIDS have grown out of the mistaken link, often made in religious thinking, between sexuality and sin. It includes the widely held assumption that HIV is always contracted as the result of “sinful” sexual relations, and the additional tendency to regard sexual sin as the gravest of all sins. Consequently, people living with HIV and AIDS are subjected to a greater stigma that sets them apart from the so-called “lesser” sinners. (It should also be stressed that HIV transmission does not result solely from sexual activity, and that unhygienic methods of collecting blood, failing to screen blood donations, and using shared needles for injecting drugs can also cause HIV transmission.)

Sometimes religions have hampered the spread of accurate information or created barriers to open discussion and understanding. Furthermore, religions may unintentionally reinforce prejudicial attitudes if they neglect issues of HIV and AIDS because they occur predominantly among certain ethnic, minority, or racial groups. These groups may be unjustly stigmatized as the most likely carriers of the infection.

To be effective and to help reduce the stigma and exclusion associated with HIV and AIDS, any response from religious communities must be undertaken in a spirit of humility, knowing that it is difficult to fully understand the scope and significance of the HIV and AIDS pandemic. It requires openness to new information, in-depth discussion of sensitive issues, and readiness to learn from the experience of others in order to develop a more adequate response to the challenges posed by HIV and AIDS today.

Specific Actions by Religious Leaders

Prevention for themselves and others: All life is sacred. Take personal responsibility for sexual behavior; encourage and support loving, just, and honest relationships; and embrace and adopt behaviors that avoid the transmission of HIV. Speak out for enactment of policies and legislation of laws that support PLWHA, orphans, and vulnerable children.

Pastoral care: Equip religious leaders to support all people, especially those living with HIV, in life-sustaining relationships with their creator and their community. Spiritual care is the ministry of religious institutions concerned with the well-being of individuals and communities. Spiritual care enables people to live a life of wholeness. It provides understanding, encouragement, and physical support through the members and organizational structures of religious communities.

Counseling: Encourage voluntary and confidential testing and counseling for HIV. Promote the establishment of support groups and other counseling services for the sick, the dying, the bereaved, and those who are orphaned.

Death and dying: Train congregations to provide holistic care for the dying and prepare families to continue to survive; offer rituals that honor the dead and promote the well-being of those who survive; train religious leaders to counsel and protect the rights of those who survive, especially women and children.

Leadership: Model a bold and compassionate community and institutional leadership at every level of society to address power, culture, stigma, and discrimination, and to be a voice for the voiceless or those who are vulnerable. In particular, encourage leadership among the laity and women regarding HIV and AIDS.

Break the Silence
- Talk about HIV and AIDS and its effects, especially stigma and discrimination. Raise discussions in churches, mosques, temples, and other places of worship; within religious leadership structures; in teaching and training institutions; and in the broader community.
- Talk with those who are living with HIV and AIDS to find out how to help end discrimination against them.

End Ignorance
- Become knowledgeable about the scientific, social, and cultural facts regarding HIV and AIDS.
- Encourage others to find out what social factors drive the epidemic and what impact HIV and AIDS are having in the local community. Use the information to speak out for PLWHA and for vulnerable and orphaned children.

Offer Compassion and Promote Reconciliation
- Use spiritual teachings or religious scriptures to emphasize compassion, healing, and support for people living with HIV or AIDS.
- Work with other religious leaders, faith-based coalitions, and community leaders to find common beliefs, spiritual teachings, and moral, legal, and social standards that can help prevent HIV and alleviate the suffering of those affected by AIDS.
- Work together to decide what common theological and ethical standards can be emphasized. Use the challenge of AIDS as an opportunity for spiritual growth to care for one another, to support the living and the dying, and to appreciate the gift of life.

Advocate/Initiate Programs and Legislation
- Determine what money and personnel can be mobilized from internal and external sources to support community-based programs for spiritual and social counseling, health education and care, and services and other support systems.

Involve People Living with HIV and AIDS
- Include people living with HIV and AIDS in prevention and care, spiritual outreach, and theological debates to affirm and enhance their dignity. Engage in religious reflections on HIV and AIDS that lead to reconciliation among individuals and within communities.
- Hold public events together with people living with HIV and AIDS that will lead to reconciliation and healing in the community.
- Religious leaders can help people with HIV and AIDS live longer, more meaningful, and dignified lives. When the time comes, they can prepare people to meet death and provide comfort and support to surviving family and friends.

Religion plays a central, integrating role in social and cultural life. Through personal contact, the spoken, broadcast or printed word, and through religious symbols, ceremonies and traditions, the world’s religions reach out to virtually every community in the most remote corners of the earth.

—ALLISON FOOSE MYEZA, AIDS BRIEF FOR PROFESSIONALS, RELIGIOUS LEADERS
Module 3: Introduction to Advocacy

3.1 Concept of Advocacy

Advocacy is an organized effort to influence decision making. People who attempt to inform decision makers and to influence their decisions are called advocates.

Advocacy is a process of communication that is different from the mere dissemination of information and education (IEC). Advocacy goes beyond this to seek support, commitment, and recognition from policy and decision makers and the general public about the problem.

The first requirement in advocacy is solid factual information, which can be drawn from situation analyses, research studies, government statistics and other data sources to show the reality of HIV and AIDS in a given context. Based on this information, advocacy work should include creating awareness of the magnitude and seriousness of the problem, reducing discriminatory practices, removing policy and other barriers to prevention and care activities, and campaigning for effective and sustainable action. It should aim to influence the highest authorities in the country to provide leadership, political support, and commitment.

Advocacy is important in HIV prevention, treatment, and care as it can enable things to be done:
- by raising awareness, knowledge, and understanding among the general population about HIV and AIDS
- by encouraging the mobilization of resources and commitment for the implementation of the STI/HIV program
- by initiating and supporting campaigns for making antiretroviral drugs widely and cheaply available
- by promoting good policies and practices
- by promoting knowledge about HIV and how it is spread
- by reducing the stigma of people living with HIV and AIDS
- by upholding the rights of HIV-positive people
- by strengthening solidarity between NGOs and people living with HIV and AIDS
- by involving people living with HIV and AIDS in education and prevention, where they have a key role to play

In detail, each individual advocacy plan should comprise the following elements:
- The issue(s) to be addressed
- The target audience, e.g., government officials, policy makers, religious leaders, employers, health professionals, communities, media, etc.
- Expected results, e.g., clear government policies on HIV and AIDS, government commitment to information and services, review of laws and practices, clear HIV and AIDS policies and practices at workplaces, etc.
- Suggested activities, e.g., gather information, develop fact sheets, join other activist organizations, and conduct sensitization meetings with media, lawmakers, and religious and community leaders

3.2 Definition of Advocacy

There are as many definitions of advocacy as there are groups and networks advocating for one issue or another. However, these varied definitions do share common concepts – advocacy is organized and targeted around specific issues; it is directed at influencing policies, laws, regulations and funding decisions; it is concerned with power relations; and it seeks to mobilize people and organizations. The following examples give some flavor of how advocacy has been defined:

"Advocacy is the act or process of supporting a cause or issue. An advocacy campaign is a set of targeted actions in support of a cause or issue. We advocate a cause or issue because we want to build support for that cause or issue; (2) influence others to support it; or (3) try to influence or change legislation that affects it." (IPPF advocacy guide, 1995)

"Advocacy is speaking up, drawing a community’s attention to an important issue, and directing decision makers toward a solution. Advocacy is working with other people and organizations to make a difference." (Center for Development and Population Activities – CEDPA)

"Advocacy is a process that involves a series of political actions conducted by organized citizens in order to transform power relationships. The
3.3 ROLE OF RELIGIOUS LEADERS IN ADVOCACY

The role of religious leaders in advocacy is based on their social influence, mobilizing capabilities, and access to leadership, among other things. Interventions by faith-based organizations in many countries have also proven that these organizations are veritable agents of grassroots mobilization for HIV and AIDS prevention and impact mitigation.

See Section 2.8 above for more details of how religious leaders can get involved in advocacy efforts related to HIV and AIDS.

3.4 ELEMENTS OF AN ADVOCACY STRATEGY

There are nine elements of an advocacy strategy.

Element 1: Define Issues Requiring Advocacy

Social problems like HIV and AIDS are large and complex, so for an advocacy strategy to be effective it is important to analyze the problem and look for the specific, concrete issues that are most in need of advocacy. For example, it could be lack of access to ARVs or how property grabbing affects care and support for children orphaned by AIDS. Advocacy around these issues is more likely to have some impact than advocacy for “more action on AIDS.”

Once you identify and prioritize 1-2 key issues, the rest of an advocacy strategy is organized around those issues through the elements that follow below.

Element 2: Set Advocacy Objective

A clear objective makes it easy to convince others of what you want to do. The advocacy objective will state:

- what you want to change in terms of policy
- how the change will be effected
- who will make the change
- when the change will be made
- where applicable—by how much

Element 3: Collect Data to Verify Your Claims

- Figures and pictures speak louder than words.
- Collect information that will back up your objective statement.
- This information will also be useful when you are designing your messages.
- Present methods of information gathering.
- Use available scientific data, e.g., from national/global surveillance surveys, demographic surveys, etc.

Benefits of using data, case studies, and single incidents:
- Gives mental image
- Can bring issue closer to home (case studies)
- Gives magnitude of the problem (data)
- Makes monitoring and evaluation easier
- Facilitates development of messages

Challenges/problems in using data:
- Not readily available
- Available, but format may not be compatible
- Lack of skills to analyze or utilize the data
- Unwillingness to share the data
- Expense of collecting your own data

Sources of data and other information will include:
- libraries and resource centers (document review)
- newspapers and magazines
- police and hospital records
- community reports/records
- congregational leaders and religious coordinating bodies
- direct data collection through surveys, interviews, etc.
- government surveys, reports, and research

Methods of Getting Information

Key informants: Through interviews you can get
information from a few individuals in the community who are particularly knowledgeable about the issue. They command respect, are deemed credible, and can speak for their community. Religious leaders can be a key source of information.

Surveys: Using a structured or semi-structured questionnaire, you can collect information through a survey. You need a reasonable and scientifically sound sample size in order for your information to be credible.

Case studies: By studying and documenting examples of activity over time, e.g., HIV-positive street mothers, you can provide strong illustrations of the impact of the problem being addressed in the advocacy strategy.

Focus group discussion: By bringing together a group of six to 10 people to discuss an issue, e.g., how AIDS affects widow’s inheritance in the local community, you can get information on how people perceive the impact HIV and AIDS has on issues that are the focus of your policy advocacy.

Element 4: Identify the Audiences of Your Issue
For a well-designed advocacy campaign, you need to know whom to target. These are divided into two categories: Primary (your target) and secondary (influencers). You also need to understand the audience’s attitudes, beliefs, knowledge about the issue, and their current priorities.

- Identify the top policy maker, i.e., the primary audience.
- Identify who influences the key decision maker, i.e., the secondary audience.

Element 5: Build or Join Coalitions
Advocates need to build networks among people who are interested in the same issue. Often you can achieve more in a group than you can alone. Identify other religious groups/NGOs/CBOS with similar interests that can work together.

Element 6: Develop Audience-Specific Messages
You need to develop a message to which each of your audiences will respond. This is the most effective way to build awareness about your issues and get support. Different audiences require different messages, which have to be carefully designed and must be target-specific—that is, the message for the primary audience will be different than the message for the secondary audience.

Element 7: Mobilize Resources/Fundraising
Advocacy requires resources. Some issues take a lot of time to resolve. Sustaining an effective advocacy effort requires investing time and energy in raising funds or other resources to support your work. You need to plan how you will raise the required resources.

Element 8: Take Action
Once the objectives, audiences, and messages have been determined and resources found, it is time to implement the planned activities.

There are many methods of reaching an audience that can be part of the action plan, such as personal visits, meetings, phone calls, letters, fact sheets, newsletters, newspapers, magazines, radio, television, posters, and banners.

Element 9: Monitor and Evaluate Your Activities
Monitoring and evaluating your activities will help you to determine whether or not you are succeeding in your efforts. The findings can also help you to improve your strategies.

What is evaluation?
Evaluation is a means of assessing the process and outcomes of an activity. It looks at what and how; it compares what you expected to happen with what really happened; and it looks at how things were done. Evaluation should be part of a network’s very first plan. Although it is frequently overlooked, evaluation must be an integral part of the entire action plan right from the start.

There are two kinds of evaluation: process and outcome. Process evaluation measures how you are doing things. Outcome (or product) evaluation measures your progress and how well you have accomplished your goals.

Why evaluate?
Effective evaluations can:
- account for what has been accomplished
- promote learning about which action strategies are working and which are not
- provide feedback to inform decision making
- assess the cost-effectiveness of different strategies
- position high-quality projects for future funding opportunities
- contribute to policy development
Developing an evaluation framework
In any evaluation, fundamental issues must be addressed. These would include the following:

- Rationale: Why did we take this direction or action in the first place?
- Impacts and effects: What has happened as a result of this activity?
- Goal achievement: Has the activity achieved what was expected?
- Value for effort: Was the outcome of the activity worth the expenditure of effort and resources?
- Alternatives: Are there better ways of achieving the desired result? If we make mistakes or encounter problems, how can we avoid them next time?
- Next steps: How do we plan to use the evaluation findings for continuous learning?

3.5 THE ADVOCACY FRAMEWORK

Stage 1: Clarify the Issue for Policy Solution
There are several problems and challenges in HIV and AIDS, but not all of them will require advocacy. As you analyze the issues that are priorities in your setting related to HIV and AIDS, be sure to focus advocacy efforts on those issues that have policy dimensions and are not dealing with problems in the implementation of programs.

Stage 2: Develop Policy Solutions
The issue may have more than one policy solution. Select the one most viable solution.

Stage 3: Build Political Will
You have an issue and a solution. Now you have to build political will. Identify and convince key decision makers to support the issue and decide in your favor.

Stage 4: Find Convergence
The issue, solution, and political will need to come together for action to succeed. As an advocate, you must be alert for these opportunities when they open up.

3.6 ADVOCACY ISSUES

Human Rights
The protection of human rights is essential in safeguarding human dignity in the context of HIV and AIDS and in ensuring an effective, rights-based response to them. An effective response requires the implementation of all civil, political, economic, social, and cultural rights. Public health interests do not conflict with human rights. On the contrary, it has been recognized that when human rights are protected, fewer people become infected and those living with HIV and AIDS and their families can better cope with HIV and AIDS.

When HIV first strikes, countries often go through a phase of denial and do not accept that the HIV and AIDS problem warrants serious attention. During this time the citizens are denied their rights to information and services and find themselves becoming the victims of a disease that their own governments have not recognized as a national disaster. The United Nations Human Rights Convention articulates all basic human rights.

Stigma and Discrimination
See the material in section 2.7 above.

Involving People with HIV and AIDS
Involving people living with HIV and AIDS in policy design, planning, and the implementation of AIDS-related work is an important aspect of advocacy. Doing so will increase the relevance of such work; reduce discrimination; help the needs of people living with HIV or AIDS to be recognized; assist in the process of de-stigmatizing HIV and AIDS; enable a greater understanding of the impact of HIV and AIDS; and present a human face to AIDS.

People living with HIV and AIDS also have a key role to play in education and prevention. Discrimination against such people is widespread, and involving them is a vital element in changing attitudes.

HIV Testing
Religious organizations should advocate for good-quality, voluntary, and confidential HIV testing and counseling to be made available and accessible, and discourage mandatory testing.
Parent-to-Child Transmission of HIV

Parent-to-child transmission of HIV is the most significant source of HIV infection in children under the age of 10. Since 1998, UNAIDS has recommended that pregnant women who are HIV-positive should be offered a short antiretroviral course that has been shown to reduce transmission by at least 50 percent when used properly.

Faith-based organizations (FBOs) and non-government organizations (NGOs) should advocate for their governments to integrate such prevention interventions into existing reproductive health services.

Other points to bear in mind:
• You are dealing with a controversial subject. Welcome this and try to turn it to your own advantage.
• Avoid any illegal or unethical activities.
• Hold policy makers accountable for commitments.
• Keep a record of successes and failures.
• Monitor public opinion and publicize positive changes.

Children and Young People

As many African countries continue to face economic and social challenges, minimal budgetary allocations are directed toward children’s programs, even those related to HIV and AIDS and OVC. The United Nations Convention on the Rights of the Child (UNCRC) clearly defines the basic rights to which every child is entitled, and it can serve as the basis for an advocacy agenda targeting children.

In developing countries, up to 60 percent of new HIV infections are among 15-24 year-olds. Because of biological and social factors, young girls are especially vulnerable. In some places, among 15-19 year-olds, two girls are infected for every boy. Advocacy can contribute to reducing girls’ vulnerability and in bringing about social change.

Furthermore, the drastic increase in the rate of infection among women means a corresponding increase in HIV-infected babies born to them. In 2000, there were 1.4 million children under 15 living with HIV, although some of these were infected by sexual activity rather than by their mothers.

Many young people are put at risk of HIV because they are denied access to HIV education, information, health care, and means of prevention—access that adults usually have. This is a violation of the rights of children and adolescents to nondiscriminatory education and health, as well as a violation of their right to express their own views and to seek, receive, and impart information and ideas of all kinds.

Advocacy can play a key role in ensuring that education on sexual and reproductive health issues, including HIV and AIDS, is provided in schools and in settings where out-of-school youth meet. Such information needs to be supported with appropriate and accessible sexual and reproductive health services for adolescents.

Studies have shown that sex education and HIV education do not encourage sexual activity. In fact, evidence shows that when young people are given complete information on sexuality, it can help them to feel comfortable about themselves and in control of the decisions they make. Where sex education is comprehensive, more young people practice safer sex or choose to postpone sex. Special efforts should be made to provide this education to children who are hard to reach, such as children of minorities, indigenous peoples, and street children.

Young people often face special difficulties in accessing services. Inconvenient hours, legal hurdles, inaccessibility, and high costs are among the factors...
that can severely curtail young people’s ability to use services. Advocacy can be a useful tool to effect changes to break down barriers that young people face when accessing services.

All sexual exploitation and abuse, including that involved in the sale of children, child prostitution, and early marriages, increase the risk of STI/HIV infection. Efforts made to stop these practices should integrate HIV concerns. Public information campaigns against child abuse and sexual exploitation, as well as education campaigns aimed at families, children, and adolescents, should explain the risks of infection, the means of protection, and the services available if infection occurs. HIV and AIDS advocacy campaigns aimed at young people can benefit from young people’s participation in the design, implementation, and evaluation. Successful strategies include peer education. Every effort should be made to involve young people.

3.7 POLICY DEVELOPMENT

A key element in policy development is to understand whether a problem is due to lack of proper guidance and rules from the government or organization, or the authorities’ failure to enforce the rules. For example, in many countries where the government has a policy of free primary education, lack of enforcement of this policy may cause many children to be deprived of education. The policy solution must be one that can be resolved only through action.

It is helpful to define some key terms used in the policy development process:

- **Problem** = the gap between what is desired and the existing situation
- **Solution** = a specific answer or way of answering the problem
- **Policy issue** = a problem or situation that an institution or organization could resolve through policy
- **Policy solution** = an answer that requires policy or law for resolution; the policy solutions directly addresses the policy issue

Policies are not made just by members of Parliament or church councils—people who are policy makers. They often result from the efforts of many groups and their constituents who encourage, persuade, and put pressure on the policy makers. We refer to these people as policy influencers; they provide the technical expertise, field experience, and advocacy efforts that inform and persuade policy makers to act. An organization may not be able to implement the policy solution on its own, so networking and coalition-building skills are critical. Working in coalitions or through networks can help religious leaders identify policy issues and solutions.

Spending time, money, and effort to influence policy development is not always practical or appropriate. The following table indicates occasions when you should consider working to develop a policy and when you should not.

<table>
<thead>
<tr>
<th>WHEN TO DEVELOP A POLICY</th>
<th>WHEN NOT TO DEVELOP A POLICY</th>
</tr>
</thead>
<tbody>
<tr>
<td>When an issue affects an entire country or organization or a large segment of the population</td>
<td>A policy already exists, e.g., some public health policies sufficiently cover HIV and AIDS issues</td>
</tr>
<tr>
<td>There is a clear need for organizational guidance on acceptable behavior</td>
<td>A problem can be resolved through existing administrative or management channels</td>
</tr>
<tr>
<td>There is no consistent way of dealing with an issue; it is dealt with differently every time it occurs</td>
<td>The time and resources required to develop a policy far exceed the capacity of an organization or coalition</td>
</tr>
<tr>
<td>Resources are not distributed to benefit everyone</td>
<td>Circumstances are so unfavorable that there is a serious risk of a negative response</td>
</tr>
<tr>
<td>A new situation arises that requires special consideration</td>
<td>Regularly followed procedures already fit most people’s needs</td>
</tr>
<tr>
<td>Greater attention to this issue will bring real benefits</td>
<td></td>
</tr>
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</table>

Not all problems have a policy solution. For example, some problems can be overcome through training or by better management. Even if developing a policy is the best solution, the policy will not solve the problem if it is just a “paper policy.”
Partners in Policy Development and Advocacy

The following groups are ones that can be important to work with in HIV and AIDS policy and advocacy activities:

Program Managers and Staff

Program managers and program staff have important roles in the development of HIV and AIDS-prevention policies because:

- they are close to communities; they can identify HIV, AIDS, and STI issues; and assist in documenting the prevalence of particular problems and thus provide an information base for developing or revising policies
- they can bring issues that affect their target audience to the attention of policy makers
- they can join or build coalitions that can demonstrate collective concern about an issue
- as policies are being created, they can publicly show their support for their adoption
- field staff and program managers may eventually implement activities in the context of adopted policies so they can help shape how policies are applied and offer feedback for policy makers

Technical Specialists, Analysts, Planners, and Advisors

As policy influencers, specialists and analysts can use their skills to collect and present data about the issues or use their expertise to suggest options for addressing the issues.

Advisors to policy makers are important policy influencers. Often they have direct access to policy makers, or provide them with critical information and may even recommend actions for the policy makers to take. Advisors to policy makers can include the president of a large women’s organization, or a university professor who is known for his or her interest and expertise on this issue, or the editor of a daily newspaper.

Coalitions

Coalitions\textsuperscript{13} are groups of people or organizations that share a common concern and agree to work together to achieve a common goal. Coalitions may be temporary alliances formed to influence a specific decision or they may be long term, designed to exist for years.

They are necessary for creating and sustaining political will and commitment for a new policy because they can:

- represent the interests of many groups
- increase the power and influence of advocacy efforts

Media\textsuperscript{14}

The mass media can create public awareness about the need for a policy or the existence of a bad policy. It can also target decision makers and interest groups with information about the policy issue.

Print media: As literacy levels increase, the print media can gain greater importance in informing people. Articles written by authorities, letters to the editor, and editorials can influence many readers, including decision makers.

Broadcast media: Radio and television have a large outreach and can play a direct role in advocacy with the general public. For example, televising the involvement of the head of state or other dignitaries in an HIV and AIDS-prevention event emphasizes the national importance of HIV prevention.

Web-based media: This is increasingly gaining currency and is most popular with the younger generation—for example, participation in online discussions, blogs, and chats. You can be your own publisher by having a Web site to publish and raise awareness on HIV and AIDS.

Communities: These would include people infected and affected by HIV and AIDS. Community leaders and members are often the key to successful advocacy work and policy development. Their involvement is crucial because they can:

- arouse public interest and awareness of HIV and AIDS issues in the community
- build interest and support at the grassroots level
- make a call for action
- apply pressure to gain support from politicians

Policy Makers

Policy makers sometimes make policies themselves, but often they are not aware of particular problems or gaps in existing policy. Therefore, the policies they adopt are often based on the ideas and concerns of the groups and individuals discussed above.

Also, policy makers may:

- be leaders in shaping public opinion
- act when they recognize a problem
- build support for implementation of policies

\textsuperscript{13} See Module 4 for additional information on coalitions and networks

\textsuperscript{14} Also see Module 6: Working with the Media.
Module 4: Building Advocacy Alliances through Coalitions and Networks

In seeking to be effective advocates on OVC and HIV and AIDS issues, religious leaders will need to form alliances with those in other sectors. An alliance is a mutually beneficial relationship formed between two or more parties to pursue a set of agreed-upon goals or to meet a critical need while remaining independent. The parties agree to cooperate in carrying out activities where each brings different strengths and capabilities to the arrangement. There are two types of alliances:

- **Coalitions**: Groups of organizations that work together in a coordinated fashion toward a common goal.

- **Networks**: Individuals and organizations that associate with each other around a common issue to share information, develop strategy, and identify possibilities for joint action.

For our purposes, a network will mean a loosely formed alliance, while a coalition will have a more formal and structured arrangement.

### 4.1 Coalitions

A coalition is a group of organizations that is formed for a specific purpose. Coalitions enlarge the base of support for policies, alternatives, and initiatives among a broad range of groups.

#### Types of Coalitions

Coalitions come together for a specific goal, and when that goal has been achieved, usually the coalition disbands or sets a new goal. Occasionally, such temporary coalitions grow into more permanent structures, becoming federations or partnerships that are incorporated with a staff and board of directors.

Whether a coalition is permanent or temporary, it can take on one or more of the following characteristics:

- **Formal**: In formal coalitions, the members join the coalition, pay dues, and are identified as coalition members on the letterhead, coalition statements, etc.

- **Informal**: There is no official membership in these coalitions, so members are constantly changing. With the membership turnover, the issues and tactics of the coalition may sometimes also shift.

- **Geographic**: This coalition is based on a geographic area such as a school district or a region of the continent.

- **Multi-use**: This coalition works on a number of issues or advocacy objectives during the course of its existence. However, for strategic and organizational purposes, the coalition may choose to work on only one objective at a time.

- **Single issue**: This coalition works on one issue or objective. Sometimes alliances can evolve between organizations that usually oppose one another; however, they can come together and agree to work together on a single issue.

#### Forming Coalitions

The objective of forming coalitions is not just to keep in touch with other groups as in networking, but also to build up and expand the support base in order to become more effective and more forceful.

The formation of coalitions is aimed at achieving alliances to broaden the support for action on an issue. The wider the coalition of allies, the more power and influence it will have in making a difference. Coalitions of people with different backgrounds and skills can achieve credibility in a way that single organizations may not be able to.

If you decide to form a coalition, consider two different ways to form one:

1. **Have an Open Meeting**

   This is one of the most common ways to organize a coalition quickly. It is used for informal coalition building. Use this technique for coalition formation only if your advocacy objective is flexible. You can invite a broad array of organizations or publish an announcement of the meeting in specific media forms. Tailor your invitation to reach a broad or narrow group as required.

2. **Assemble the Coalition by Invitation Only**

   This technique is used to create more solid, long-term coalitions. The issue and agenda are more likely to stay focused on your objective, and you can select the groups that will bring prestige, power, resources,
and energy to your effort. The disadvantage of this technique is that the coalition will not be as broad or its members as numerous.

You will want to meet with each group individually to introduce the coalition idea and discuss their possible participation. Once you have met with all potential members, you can hold the first meeting to officially kick off the new coalition.

Joining Coalitions
The following hints will help you benefit from any coalition you join.

- Understand clearly who is running the coalition, who the members are, and what the goals and positions are before you join.
- Be sure you understand clearly the financial, programmatic, and staff support you and your organization will be expected to contribute.
- Make sure you and your organization have the time and resources to participate.
- Find out exactly how your organization will benefit by being involved. Learn what the coalition will offer you; e.g., Will your organization have opportunities to present its work through the coalition? Will you gain access to decision makers or the media?
- Make a commitment to participate. A coalition will not be responsive to your needs and requests unless you are willing to do your share. In addition, you cannot have a voice in decisions unless you are at the meeting to speak up.

Running an Effective Coalition
Once you have formed a coalition, the work begins. Below are some hints to strengthen your coalition and keep it running smoothly and effectively.

- Keep in personal contact with key coalition members and make sure that all members are informed regularly of developments on your issue, actions taken by the coalition, or other items of interest. Most organizations join coalitions to have access to information on a timely basis, so continual flow of information is essential.
- Get to know all the coalition members well so as to be properly informed about their positions and opinions. These might be quite different from yours.
- Achieve consensus among coalition members on short- and long-term goals. Do not set goals and objectives that are too ambitious. Choose an objective that the coalition can achieve in a timely manner. An early success will help build confidence, credibility, and support your group.
- Involve powerful coalition members in all decision making. If a key organization or individual is left out of a decision, you may have to revisit the decision and, in extreme cases, you risk losing that group or individual.
- Keep coalition meetings brief and on a regular schedule. Lengthy meetings will discourage people from attending; meeting too often can cause “meeting fatigue.” Have a time limit and a clear agenda for all meetings. In addition, facilitate discussion to make sure that all are heard. Always circulate a sign-in sheet.
- Develop subgroups strategically to take on specific tasks. Do not let the number of subgroups grow uncontrollably because your members will be spread across too many groups or will burn out.
- Do not avoid troublesome issues. Difficult issues must be discussed openly at meetings or they will split apart your coalition. If the issues are too contentious, you can talk individually to the parties who disagree and try to develop a solution, or you can involve an outside mediator or facilitator.

Advantages and Disadvantages of Working in Coalitions

Advantages
- Enlarges your support base; you can win together what you cannot win alone
- Increases financial and programmatic resources for an advocacy campaign
- Magnifies existing resources by pooling them together and by delegating work to others in the coalition.
- Enhances the credibility and influence of the campaign, as well as that of individual coalition members
- Helps develop new leadership
- Broadens the scope of work
- Assists in individual and organizational networking to leverage influence

Disadvantages
- Distracts from other work and can take time away from regular organizational tasks
- May require accommodation with other, more powerful organizations; larger or richer organizations can have more say in decisions
If the coalition process breaks down, it can harm everyone’s advocacy by damaging members’ credibility.

- May require compromise of positions on issues or tactics
- You may not always get credit for your work; sometimes the coalition as a whole gets recognition rather than individual members; coalitions should strive to highlight their members as often as possible.

4.2 Networks

A network brings together individuals, groups, or organizations that share a common goal and want to work together to achieve it. The members have at least one thing in common. Networks are useful and powerful tools for achieving shared goals. However, developing networks is not quick or simple. It is a long-term process to build lasting relationships. There may not be an immediate reward for all efforts made in the short term, but there is value in the process itself and it is clear that religious organizations need to do more in this direction. Once new relationships are built with those who should be allies, they need nurturing and reinforcing. Networking—sharing information—is one way of doing this. And as well as seeking support, religious organizations must lend support to other organizations on relevant issues of importance to them.

Benefits of Networks

- Provides a ready-made audience for ideas
- Provides support
- Offers updated information
- Provides access to a variety of resources and skills
- Pools limited resources for the common goal
- Forms the platform for possible joint action

Basic Elements of Forming a Network

- Establish a clear purpose or mission
- Involve individuals and organizations who share the vision and mission
- Build a commitment to participatory processes
- Organization: Clarify roles, compile a skills inventory and a communication system
- Leadership: Share leadership functions, set realistic goals and objectives, foster trust and collaboration
- Meetings and documentation: Meet only when necessary, keep attendance lists and minutes, discuss difficult issues openly
Building an Advocacy Network

Step 1: Who should be in your network?
You will want to get to know people and organizations that are working toward the same objective as you are. Include people who can influence decision makers in your network and also the decision makers themselves if possible.

Step 2: How do you meet potential network members?
It is important to build an open and trusting relationship from the beginning. This can be done in several ways:
• Collaborate on projects of mutual interest.
• Assist them with special projects.
• Share information with them.
• Attend their meetings and invite them to yours.

Step 3: How can you get them interested in your ideas and objectives?
As you get to know them, discuss your ideas or objectives with them. Be open to their suggestions and ideas; it is helpful when others feel that they have some ownership of the idea. When they support the idea, they will be much more interested in helping you.

Step 4: How can they help you?
When you are ready, ask them to do something small and specific to help you reach your objective. As your relationship is strengthened, you can ask them to do more. But remember that it is a two-way street and the more they do for you, the more you should do for them.

Networks and HIV and AIDS
The constantly changing nature of the global AIDS pandemic demands an evolving response. To remain a relevant force in this environment, AIDS networks must adapt accordingly. Consequently, networks rarely stay the same for long. They are constantly changing in terms of their purpose and how they work together to achieve it.

Change is never easy and there are no formulas to ensure success. Three factors to help networks remain relevant and vital while operating in a changing environment are:
• sustaining commitment
• communication
• dealing with and resolving conflict

Sustaining Commitment
Commitment can be affected by many factors. Divergent views or social/religious/political/ethnic differences can affect attitudes. Trust and respect, therefore, need to be cultivated. When establishing coalitions, it helps to clarify the purpose, goals, responsibilities, and expectations, as well as to have open and clear communication and decision making. Appropriate systems and organizational structure also help to ensure that things will work effectively. If conflicts occur, they need to be resolved. Openness to evaluation and review of how things are going enables the coalition to see problems and progress, make needed changes, and helps keep everyone involved and committed.

It is important to be aware of the signs of waning commitment: missing meetings, people not doing the things that were agreed to, negative attitudes, infighting and reluctance to contribute significant resources, to name a few. Networks that make clear what is expected of members are more likely to sustain commitment among members than networks that do not.

How members work together in pursuing their mutually held sense of purpose also affects members’ commitment to a network. Setting ground rules for how network members want to interact, for example, helps to establish an atmosphere of trust and mutual respect. Trust and mutual respect help build group cohesiveness. Similarly, defining a clear and open decision-making process, developing an effective communication plan, and choosing an organizational structure that is appropriate to the needs of the network and its members are essential in the process of building and sustaining commitment among members of the network in achieving its purpose.

Some networks, particularly those that have organizational members, feel a need to define what is expected of their member organizations more explicitly. One practice that is increasingly popular is the “Letter of Commitment” whereby each member representing an organization is asked to obtain a letter from the governing body or senior staff person that outlines the nature of the organization’s commitment to the network.

A letter of commitment should state the following:
• The organization’s commitment to the purpose, goals, objectives, and activities of the network
• What the organization expects in return for its participation in the network
• How much time the organization’s representative may commit to the network
• That the organization recognizes that this commitment is part of the representative’s job
• The level of resources that the representative and the organization can commit, e.g., funds, in-kind contributions, and other staff and volunteer time, connections, and expertise

Letters of commitment clarify authority and help to mobilize the needed resources to achieve goals and objectives. Pushing for commitment may scare potential partners, yet without the letters, partners may not fully commit to the network.

Communication

The focus on developing a communications plan ensures effective internal communication. How information is exchanged is a vital activity in networking. This is especially true when the network is undergoing change in why and how it does its work.

Below are factors that have an important impact on the process of information exchange, including the frequency of communication and the amount of information. Understanding these factors will help members make better choices about the who, what, why, and where of their communications.

Frequency of Communication

How often people communicate within the network has a significant impact on motivation, productivity, and how they feel about being involved. Although most networks tend to communicate less frequently than they need to, it is just as detrimental to be in touch too often. When planning the frequency of communication in a network, keep the following in mind:
• The larger the network, the greater the need for formal guidelines.
• The more specific the task, the more frequent the interaction, i.e., when organizing a special event such as a workshop that requires the coordination of a large number of details, frequent communication is required to ensure efficiency).
• Match the frequency of communication with the delegation style of the communicator (i.e., if people have been asked to take responsibility for a certain area, they should be allowed to do it without constant review).
• Match the frequency of communication with the purpose of communicating.

Amount of Information

How much information is communicated has a significant impact in how those receiving the information feel about it and what they do with it. Large packages of written material rarely motivate people to take immediate and enthusiastic action. Long telephone conversations packed with a variety of facts, figures, gossip, and general discussion are not likely to result in a clear path toward decision making. On the other hand, brief communications have their own pitfalls, including opportunities for miscommunication and misinterpretation.

Keep the following suggestions in mind when deciding how much information people need:
• Distinguish between what people need to know and what would be nice for them to know. If you have a lot of information, include only the “need to know.”
• When you are sharing a lot of information, include a one-page summary or a one-minute overview that announces clearly what the content is all about.
• Pay attention to how the information is packaged and distributed. Make the information manageable so it will not overwhelm the recipient. Two inches of paper in a brown envelope will probably be moved to the bottom of the reading pile.
• Include specific instructions about how people should deal with the content. Should they read and critique? Respond immediately? When? How?

Dealing with and Resolving Conflict

Although members of a network are committed to a common purpose, they may approach tasks and decisions quite differently. This is particularly true when the network is going through a process of change in deciding what and how they will do things differently. As noted above, constant change is a feature of networking in the field of HIV and AIDS. Conflict in networking is, therefore, inevitable. A constructive approach to this reality is to expect it and develop the skills to resolve it.

The potential sources of conflict include:
• Assumptions and perceptions
  Different people view the same situation and see it differently because their past experiences, personal beliefs, and values differ.
• Individual values, needs, and goals
  One person’s values, needs, and goals may conflict with another’s values, needs, and goals.
• **Organizational values, needs, and goals**
  The values, needs, and goals of the organization may conflict with the values, needs, and goals of the network or other members.

• **Emotions**
  Powerful emotions such as fear, anger, and frustration often block communication or distort perceptions, leading to conflict with others.

• **Competition**
  Struggles for time, money, attention, performance, and personal or group success can be healthy or destructive.

• **Lack of information or clarity**
  Members perceive that they do not have all the information or do not understand the information. People also understand things differently and all of this can result in conflict.

• **Individual communication styles**
  Insensitive or inappropriate interactions can create resistance. An aggressive approach that belittles others usually causes conflict. An over-accommodating and passive nature can also cause frustrations that lead to conflict.

The following steps could serve as a guideline for a conflict-resolution process:

**Step 1:** Decide who will facilitate the process for resolving the conflict. Ask a group member or a third-party facilitator, mediator, or arbitrator to lead the group. Alternatively, hold an outside session just for those directly involved in the conflict.

**Step 2:** Review the current situation, define facts, and revisit the results you need to achieve. Ask “If we want to achieve these results, what must we do about this conflict?” and then determine which issues the network must resolve to do its work.

**Step 3:** Ask the parties involved in the conflict to define their needs.

**Step 4:** Search for alternatives and their implications.

**Step 5:** Decide on the solution and action steps for implementation.

**What if this does not work?** Sometimes personal hostility and other conflicts cannot be resolved. Then it is important to explore alternative approaches.

**Confront the situation outright:** Call a meeting and insist that the disagreeing individuals agree on a process to settle the dispute. Consider an outside facilitator. If settlement is impossible, create a working agreement and agree to disagree while working together in the network. This can and does work.

**Confront the situation through people of influence:** Collectively, ask important people (members of the governing body or other members) associated with each of the warring individuals and/or organizations to intervene. This option allows the conflicting parties to fight in another more appropriate arena than the network.

**Work without the fighting parties:** Prolonged periods of conflict among specific members can be stressful for all network members and can damage the network itself. When all else fails, consider working without the people and/or organizations involved in the seemingly irresolvable conflict. Few networks are so dependent on one or two people or organizations that it would not survive if the fighting parties left the network.
Module 5: Strategic Communication, Message Development, and Delivery

5.1 THE P-PROCESS: STEPS IN STRATEGIC COMMUNICATION

Communicating strategically requires a clearly defined strategy with specific goals established in advance. The P-Process is a framework designed to guide communication professionals as they develop strategic communication programs.

This step-by-step road map leads a communication program from a loosely defined concept about changing behavior to a strategic and participatory program with a measurable impact on the intended audience.

Step 1: Analysis

Analysis is the first step in developing effective communication programs, but this step does not need to be long and detailed if the program is built upon well-documented past experiences.

Program staff need to understand the problem, the people, their culture, existing policies and programs, active organizations, and available communication channels. Usually much of the situation analysis is available from demographic, epidemiological, sociological, and economic studies, and accessing such data will speed up the steps below:

Situation Analysis
Determine severity and causes of problems
Review existing health and demographic data, survey results, study findings, and any other information available on the problem.

Identify factors inhibiting or facilitating desired changes
Consider the basic, social, cultural, and economic challenges that the program would like to address.

Develop a problem statement
Develop a clear statement that sums up the problems to be addressed.

Carry out formative research
Listen to understand audiences’ needs and priorities. Conduct baseline research, both quantitative and qualitative, to establish the current status and accurately measure the program’s progress and final impact.

Audience/Communication Analysis
Conduct a participation analysis to identify partners, audiences, and field-workers

At the national and international level, identify partners and allies to help initiate policy change and strengthen communication interventions. At the community level, segment the primary, secondary, and tertiary audiences. Identify field-workers and change agents.

Carry out a social and behavioral analysis at the individual and community levels
Assess knowledge, attitudes, skills, and behaviors of participants at the individual level using data from formative research and additional in-depth studies, if required. Identify social networks, sociocultural norms, collective efficacy, and community dynamics (including leadership patterns) at the community level.

Assess communication and training needs
Analyze audiences’ media access and use; the capacity needs of local media and traditional media, NGOs, and communication agencies; the organizational capacity of partners and allies; and other resource needs. Determine the availability of communication materials and skills development needed for interpersonal communication and counseling.

Step 2: Strategic Design

Establish communication objectives
Set objectives that are SMART, i.e., Specific, Measurable, Attainable/Achievable, Realistic, and Time-bound.

Develop program approaches and positioning
Select a behavior-change model upon which to base the program. Explicitly state the assumptions underlying the basic strategy and approach. Explain why and how the program is expected to change the advocacy issue being addressed. Position the program clearly to enhance response.

Determine channels
Consider a coordinated multimedia approach that includes community mobilization and interpersonal communication.
Draw up an implementation plan
Develop a work schedule with regular benchmarks to monitor progress. Prepare a line-item budget. Complete a management plan, including partners’ roles and responsibilities. Make sure all involved know what is expected.

Develop a monitoring and evaluation plan
Identify indicators and data sources to monitor program implementation as well as audience reaction to it. Select the study design to measure the outcomes and assess impact.

Step 3: Development and Testing

Develop message concepts
This step may involve the development of guidelines, tools, toolkits, possibly including facilitation manuals for group interaction or training manuals.

Pretest with audience members and gatekeepers
Test concept with stakeholders and representatives of the audiences to be reached.

Revise and produce messages and materials
Make changes based on pretest results for messages, stories, or participatory processes that are not understood correctly, not remembered, or are not socially or culturally acceptable.

Retest new and existing materials
Retest materials to ensure revisions are done well and

make final adjustments before replication, printing, or final production. Combine science (analysis, strategy), art processes, and the facilitation of group action.

Step 4: Implementation and Monitoring

Produce and disseminate
Develop and implement a dissemination plan that may include local government, NGOs, the private sector (as appropriate), and the media for maximum coverage.

Training trainers and field workers
Focus on building institutional capacity and teamwork as well as individual skills.

Mobilize key participants
Share information, results, and credit with partners, allies, and communities. Keep everyone involved and motivated toward the strategic goal.

Manage and monitor programs
Check program outputs to ensure quality and consistency while maximizing participation. Track existing statistics and conduct special operational studies using surveys, focus groups, observation, and other techniques to measure outputs as well as audience reaction.

Adjust program based on monitoring
Use data-form monitoring to make mid-course corrections or adjustments in activities, materials, and procedures and to fine-tune program components.

Step 5: Evaluation and Replanning

Measure outcomes and assess impact
Many evaluations measure outcomes to determine if the desired change has occurred in knowledge, attitudes, or behavior among the intended audience, or in a given policy relevant to the program. More rigorous study designs assess impact, which links the change in outcome to one or more intervention activities.

Disseminate results widely
It is important that everyone involved be aware of the program’s impact, whether it is positive or not. Share impact results widely with partners, allies, key stakeholders, the media, and funding agencies.

Determine future needs
Results demonstrate where follow-up is needed and where program activities can be extended.
**Revise or redesign the program**

Staff may have to return to the analysis stage if the situation changes markedly or if new causes are found for problems.

Throughout the process, keep the following in mind:

**Participation:** A strong communication program should fully engage multiple stakeholders at all levels.

**Capacity strengthening:** A successful plan considers ways to build capacity at the institutional and community level.

### 5.2 Elements of a Message

#### Content

The content is the central idea of the message.

- What is the main point you want to communicate to your audience?
- What single idea do you hope the audience will take away from your message?

Content should attempt to answer the following questions:

- *What* do you want to achieve?
- *Why* do you want to achieve it?
- *How* do you propose to achieve it?
- *What action* do you want the audience to take?

#### Language

Language refers to the words you choose to communicate your message. It can also refer to the actual language you use (English, Kiswahili, French, etc.).

- Is the word choice clear, or could various audiences interpret it differently?
- Is the language appropriate for your target audience? Obviously you would use a different language when appealing to university researchers than you would when communicating to a youth group. Be careful not to use offensive words.
- Use words that conjure up images and raise emotions, such as empathy for suffering children.
- Use familiar words the audience will understand and identify with.

#### Source/Messenger

This is the person who will deliver the message. He or she should be presentable, credible, articulate, know the issue thoroughly, be available, etc.

Religious leaders are presumably seen as credible to the target audience. However, sometimes it may be useful to involve representatives of the community affected by the policy change, or others who have the potential to contribute in the effort as messengers from within your congregation.
**Message-Delivery Formats**

The format is the method, medium, or communication channel that will be used to deliver the message for maximum impact. The format used will be one that is most suited to the audience.

Which formats of message delivery are used by religious leaders?

Consider the most compelling format to reach your target audience, such as a signed petition, a face-to-face meeting, or a TV/radio advertisement.

The most common format for religious leaders is the initial face-to-face meeting during formal and informal gatherings, and using the pulpit to sensitize policy makers. This would be beneficial before getting into petitions, radio, or television.

There are different ways to deliver advocacy messages. Common tactics vary from country to country and from different religious/faith-based organizations. However, it is useful to have an exhaustive list to spark new ideas and foster creativity, including the following:
- Face-to-face meetings
- Executive briefing packages
- Public rallies
- Fact sheets
- Policy forums
- Public Service Announcements (PSA)
- Posters or flyers in public places
- Petitions
- Public debate
- Press releases and press conferences
- Contests to design posters, slogans, etc.

The next step is to identify which tactics are most appropriate for specific target audiences. For example, consider high-level policy makers. Which tactics are most likely to have an impact on a policy maker? Given that policy makers often have little disposable time, answers may include briefing packets, fact sheets, face-to-face meetings, policy forums, etc.

Several factors can help determine the most appropriate or effective format or tactic, including:

**Cost**

Mass media, such as radio or television, can be very costly, so religious advocacy groups should seek out free or reduced-cost opportunities to use mass media.

**Risk**

Risk is an element that separates advocacy from IEC or public relations work. When an NGO or a network goes public with an advocacy issue, especially a controversial one, there is always the chance that its reputation will be tarnished. Certain advocacy tactics entail more risk than others do. Public debates and live forums that highlight both sides of an issue can turn into heated events. Nevertheless, risk can be minimized by careful planning, selection of speakers, rehearsals, etc. Religious organizations tend to have a lower risk perception because of their high level of credibility among their members and the respect they command within the broader society for their responsibility to protect the moral, spiritual, and social well-being of their “flock.”

**Visibility**

A religious or faith-based network may choose to use a contact or connection to raise the visibility of an event. Perhaps a celebrity or high-ranking public official is willing to visit a project site or attend a church/mosque/temple or other religious meeting place. This may provide an excellent opportunity to recruit other decision makers to participate in the event or visit the venue and promote a particular advocacy objective.

**Timing and Place**

Consider the timing of a message and the place of delivery. When and where will you deliver your advocacy message?

Advocacy messages are effective when delivered at times of increased public debate. It increases community dialogue and discussion.

Is there an electoral campaign underway that might make policy makers more receptive than usual to your message? Are there other political events that you can link up with to draw more attention to your issue? Some advocacy groups connect their communication strategies to events like Day of the African Child, International Women’s Day, or World AIDS Day. In some countries different religious and faith groups are invited to pray during national events. This can be a good opportunity to share an advocacy message and join others who are committed to the same. A good example is when Catholic Archbishop Ndingi Mwanza-Nzeki of Nairobi joined the president of Kenya in a popularly known message to fight AIDS that regularly appears in the Kenyan media (both radio and TV).
5.3 The One-Minute Message

It is often necessary to present a clear and concise message in a limited time frame. Advocacy groups often invite journalists to be present when messages are delivered to policy makers. If there will be a mass media presence at the advocacy event, it is all the more important to present the message in a tight package.

In order to maintain the attention of a policy maker or the viewing public, an advocate should be able to communicate his or her main idea in 30–60 seconds. Use the following approach for delivering a one-minute message:

**The One-Minute Message**

Statement • Evidence • Example • Call to Action

When constructing or tailoring a message for a TV appearance or a newspaper interview, this simple model will help the speaker to focus:

**Statement:** This is the central idea of the message. In several strong sentences, the advocate should present the essence of his or her message.

**Evidence:** Support the statement or central idea with some facts. The speaker should use data that the audience can relate to, such as the health statistics from the local department of health, or HIV statistics from the national AIDS council.

**Example:** Provide an example to illustrate and bring the message home. A good example can raise the level of communication from informing the audience to motivating or moving them to action.

**Call to action:** After presenting the statement, supporting evidence, and the illustrative example, the advocate should present several clear steps that the audience can take to rectify the problem.

**Example of a One-Minute Statement**

Read the following example from an advocacy group working on domestic violence.

**Statement:** The national policy that bans the expulsion of pregnant girls from schools in Kenya must be implemented on a district and community level as girls forced to leave school suffer long-term social and economic disempowerment.

**Evidence:** While the policy of forced expulsion has been revised by the Ministry of Education to reverse this policy, nearly 27 girls are expelled from Kenya schools due to pregnancy every day.

**Example:** Our NGO provides training and education support for young girls forced out of school due to pregnancy. Wangari is one of our clients. She was forced out of secondary school when she became pregnant with her first child and was unable to find work to feed either her child or herself. Wangari is just one example of the widespread effects of expulsion due to pregnancy.

**Call to action:** The district Ministry of Education offices must implement the revised policy that allows pregnant girls to continue schooling and enact measures to inform and enforce this policy through headmasters or headmistresses.

The drama of AIDS threatens not just some nations or societies, but the whole of humanity. It knows no frontiers of geography, race, age, or social condition…. Only a response which takes into account the medical aspects of the illness as well as the human, cultural, ethical, and religious dimensions of life can offer complete solidarity to its victims and raise the hope that the epidemic can be controlled and turned back.

—Pope John Paul II, AIDS Brief for Professionals, Religious Leaders
Module 6: Working with the Media

6.1 TYPES OF MEDIA

Media refers to channels or modes of communication, whether printed or electronic. Media can be information and education tools. The different forms of media can be owned and operated by various kinds of entities such as commercial businesses, nonprofit organizations, academic institutions, and religious institutions. This last category is important to remember as many religious communities own and operate all the types of media listed below and they can be very important (and sympathetic!) channels that religious leaders can use in their advocacy and public information efforts.

Generally, media are divided into two main types: electronic and print. Electronic media include:

- radio
- television
- film and video
- Internet/Web-based

Print media include:

- newspapers
- magazines
- journals
- newsletters
- other publications such as comics and brochures

The institutions and organizations that produce these various types of media are made up of diverse groups of professionals that play distinct roles. In developing strategies for working with the media, it is important to know the major categories and the different responsibilities they have in producing news and information—for example, the difference between trying to get a story placed and trying to influence the editorial position of a newspaper. Here are some of the important groups:

- reporters
- columnists
- feature writers
- editorial boards
- commentators
- news page subeditors
- editors-in-chief
- correspondents
- producers
- station managers
- program managers
- media house owners
- journalists’ associations
- journalism professors
- ministry of information officials
6.2 WORKING WITH THE MEDIA

Public communication is one essential component in an effective advocacy campaign on HIV and AIDS, and the media are essential tools for reaching large numbers of people with your message. It is inevitable that religious leaders will need to work with media at some point in their advocacy efforts. There are both advantages and disadvantages to working with media, so it is important to develop a strategy for building relations with the media that can maximize the advantages and minimize the negatives. This section outlines how to establish, maintain, and promote constructive relationships with the various media so you can use their power and influence effectively to persuade decision makers and achieve the objectives of an advocacy campaign.

Working with the media can offer these advantages in conveying one’s message to the public:
- Influence government policy and legislation
- Raise the profile of your cause or organization
- Build credibility
- Recruit members and supporters
- Inform the public about the issue and change public attitudes
- Extend the reach of your message and cause
- Improve communication between the media and religious organizations
- Increase the frequency and accuracy of reporting on HIV and AIDS issues

Without a good strategy, media coverage could offer some disadvantages:
- Spread false information about HIV and AIDS
- Distort the intentions behind advocacy efforts
- Create unnecessary fear or panic
- Create greater public criticism of leaders or organizations
- Expose contradictions and weaknesses
- Have a negative effect on political and financial support for HIV and AIDS programs

Understanding How the Media Operate

One of the greatest challenges for those working with the media is understanding accurately how and why the media behave the way they do. Understanding some of the key points below may not make working with the media easier, but it will certainly reduce much of the frustration that is caused by misperceptions and expectations that media will never fulfill.15

The media are not simple transmitters of information; they act as filters in deciding what is reported based on their own interests, which are sometimes driven by cause, profit, or business reasons, or by what is deemed the most “interesting.”

Journalists are in the business of telling stories that they think people will want to hear or read, so they will always choose the “interesting” over the “important.”

Journalists are looking for “the five C’s of news” in writing their stories:
- Conflict
- Contradiction
- Controversy
- Colorful language
- Characters

These C’s are neutral—they can work in your favor or against you, but the more of them you have in your advocacy messages, the more likely your story will be told.

Journalists want good stories; they do not seek to help or harm the source of their information or the characters in their story, but they will not avoid helping or harming you or your cause in telling the story.

Building Effective Relations with Media

With a clear understanding of why the media behave as they do, it is then possible to work on building effective relationships with them. This does not happen by itself, however. It requires a strategy to be proactive and to establish the relationship on your own terms as much as possible. Some key elements of this strategy are as follows:

Set goals: Know what you want to accomplish through the media, and be realistic; these goals should be focused on advancing the overall objectives of the advocacy campaign.

Get to know individual reporters: Find out who covers HIV and AIDS as well as religion at the local newspapers, radio, and TV stations, etc. Make personal contact to find out what they are interested in and to share the work you are doing.

Become known as a dependable source: Build a reputation as a source of good information and analysis.

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of things that are happening around these issues.

**Know the “rules”:** Learn how deadlines work, when reporters need information, and what kind of information is most helpful to them. Meeting journalists halfway to help them succeed at their jobs will make them more likely to support your effort to publicize information about your cause.

### 6.3 Media Tools

**Press Releases**

A press release is a concise, attention-getting news bulletin that describes an event or issue of significance. Write a press release when something newsworthy happens to your campaign or issue.

You can issue a press release to:
- announce results of a research effort or campaign
- publicize your reaction to a new rule or law
- celebrate important anniversaries and/or historical events
- announce formation of a new project, organization, or intervention

**How to write a press release:**
- Use newspaper style
- Use short, fact-filled sentences and paragraphs
- Include the five W’s in your first paragraph: Who? What? Why? When? Where?
- Introduce the most essential information in the first paragraph
- Paragraphs should appear in order of priority
- Attribute your quotes to a named, specific person or organization
- Be concise; the press release should not exceed one page
- Print your logo on the press release; eye-catching paper or logos will help your group’s release to stand out among the many others that journalists receive
- Don’t be afraid to stress the controversial aspects of your campaign as these will help you get good coverage and make your case
- Include a contact name and telephone number

**Press/Media Advisory**

This is done for the purpose of alerting the media to some upcoming function or event. It is not yet news, but will be later on. The purpose is to get the media to put this in their diaries or files and to be present when the story breaks. Some examples of situations where you might issue a press release are to announce:
- an upcoming meeting or public activity
- the launch of a campaign
- the appointment of new board members

**Press Conferences**

Hold press conferences if you have a “hot” news item or must respond quickly to a fast-breaking news story. Call a press conference if:
- you are releasing a major report, finding, or information
- a national newsmaker or celebrity comes to town
- you have a major announcement

Here are some things to keep in mind to ensure that your press conference is effective:
- Respect journalists’ time and try to begin and end the press conference on schedule.
- If more than one person is making a statement, there should be a moderator or master of ceremonies in charge on the platform who begins and ends the news conference and controls it.
- With multiple speakers, each person should be clear on his or her statement and how it supports the core message of the event; messages should be determined ahead of time.
- The opening statements should be brief as reporters like to get to their questions.
- Print reporters often will save their challenging questions until after the news conference is over to avoid sharing information with TV and radio reporters. Therefore, the most difficult questions may be asked when you are off guard. TV and radio reporters may want a one-on-one interview with one or two speakers after the conference to ask four or five questions that recap the main points of what was said.
- The moderator needs to exercise strong direction to prevent reporters from arguing with each other or asking questions at the same time.
- Follow-up questions are allowed and it is poor form not to answer, although they can be dangerous. If a reporter is badgering, stand your ground and do not explode because that is what will go on air. Say, “I have answered that to the best of my ability. Next!”
Opinion Features/Op-Ed

Opinion features are opinion editorials (op-eds) or longer pieces written by someone in your campaign or organization on the issue for which you are advocating. They appear on the newspapers’ editorial page or features section.

Op-eds should be between 500 and 1,000 words, crisp, and if they are provocative, they will be more likely to be published. Ask for guidelines from the editors on how they would like to run the op-eds. It is important to speak to the editors first before writing the op-ed. You can even discuss what angle to take if you are able to develop a relationship with the editor.

Letters to the Editor

Letters to the editor can be written in response to a recent article or feature published by the newspaper. In the letter, state your opinion, whether you agree or disagree with the piece, and provide supportive or substantive information for your stand. The letter must:

- be well written, clear, and concise
- adhere to the length recommended by the paper (usually around 100 words)
- aim to make only one point per letter; end on a challenging note such as a call to action
- include your organization’s faith or campaign name and your position in it
- include your name

Photo Opportunity

This can be organized during meetings, workshops, etc. A photographer can also take pictures of HIV and AIDS functions such as awareness workshops, advocacy campaigns, and seminars and circulate it to the media with a story. These are particularly effective if a very high-profile person is appearing in your community or at your event as local media will be interested in at least showing a photo or footage of that person’s presence, even if they don’t cover the story or event in detail.

Interviews

Making leaders or spokespeople from your organization or coalition available for interviews can be an effective way to get more information into the media about your advocacy campaign, but it is important to know how to engage reporters in an interview to ensure that you get your message across in a positive and effective way. There are some common mistakes that lead to ineffective interviews, often leaving interviewees feeling that they have been misquoted or manipulated:

- **Behaving as if the interview is a private conversation:** It is always a public event regardless of how private the setting might feel.
- **Behaving as if the interview is about answering questions:** An interview is an opportunity to present your message and provide quotable phrases and points. It is better to think of an interview as a presentation that is interrupted by questions.
- **Being imprecise:** Using a lot of pronouns, sentence fragments, and jargon will cause confusion, but also often lead to the reporter trying to determine what you were actually trying to say. Most of the time “misquotes” are actually situations in which a person who was being imprecise or vague was accurately quoted.

To be most effective in getting your message communicated in an interview, you should consider the following points:

- Keep your focus on the audience that will read, hear, or see the interview, not on the person conducting the interview. Do some thinking and research before an interview to think about who is likely to be reading the newspaper, listening to the radio or TV program, etc., in which you will appear.
- Stay in control and be clear about what you can control and what you cannot. You can control yourself, your words, and the agenda; you cannot control the journalist, his or her questions, or whether the interview will ever appear in a story or report.
- To control the agenda, make sure you are clear on what you will say, how you will say it (do it in a way that will get quoted—remember the five C’s), and how to create opportunities to say it.
- Prepare what you will say, think about who your audience will be, and the three most important things you want them to know. Write these down as the three key topic sentences and then come up with a few good examples or illustrations that bring these points to life. Don’t get caught up in background information.
- Present your points clearly. Introduce the three points, summarize them, and then elaborate, and take every opportunity in the interview to come back to these key points.
- Control the words. Don’t fall into typical traps, such as

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as a forced choice. Don’t accept the choices; don’t speculate on hypothetical statements; don’t let reporters paraphrase what you are saying; quickly correct a wrong word or mistake made by the reporter; and don’t repeat any inflammatory words used by the reporter, even (and especially) in denial. These keys will help you conduct effective interviews in any medium. The following sections offer a few additional tips for specific types of interviews: TV, radio, and print/newspaper.

**TV Interviews**
- Be aware that TV distorts some things in predictable ways; what looks comfortable in real life does not come across that way on TV. A slight lean forward looks straight and comfortable; a smile looks neutral, a broad smile looks comfortable and confident; a dynamic voice seems natural, not exaggerated.
- Use gestures and voice variance to create interest and energy in what you are saying.
- Get to your message points quickly since you may have only a brief time to get them across.
- Imagine the face of someone you like on the camera’s lens, and then explain your message points to that person. If the interviewer is in the room, look at him or her and not at the camera.
- Be as natural as you would normally be in expressing yourself facially and with slight head movements, remembering that your entire face, neck, and part of the chest area are filling a small space (the TV screen). You should not be overly mobile.
- It is very common for technical problems to happen. The station may lose feed, meaning you or the anchor cannot hear or see each other. Do not look startled or panicked if this happens; keep your composure until you get a cue from the producer over your earpiece or the cameraman that you are linked up again.
- Treat taped interviews as if they are live. Do not stop and say, “Can I try this again?”

**TV Talk Shows**
- Watch the program you will be on ahead of time to see how guests are treated as well as how the furniture is positioned and the color scheme.
- At the beginning of the show, once you are in your seat, think of the microphone as “live” even though they say you are not on the air yet. You never know when the camera is on or the microphone is “hot.”
- Look at the host, knowing that he or she will not likely be making much eye contact with you.
- Look at the camera only if you are on a call-in program and are answering questions. Then the floor director will likely point you to the proper camera. Talk to it as you would talk to a person with appropriate eye contact and facial expression.
- As quickly as possible, get to the message points you wish to make by finding a way to answer a question that has some relevance to your points. Use your hands to emphasize points.
- TV appearances have little to do with real journalism. It is mostly acting and the minute you are on, it is about how you appear and how you handle tough or silly questions. If you seem confident, well groomed, not easily ruffled or defensive, then you will be a welcome guest in someone’s living room.
- Have your energy high without appearing nervous or hyper. Don’t swivel in your chair.
- If you are asked two or three questions at one time, answer the one you want, ignore the ones you don’t like, and use questions to get back to your key messages. It’s not your job to remember each question and if the host really wants to know, he or she will ask again.
- Don’t jump into an answer that you might regret. You can take a few seconds and think about your answer. Buy time by saying, “interesting question” or something to that effect.
- Do not offend the host! He or she is there because of ratings; the audience likes the host, and he or she will be back on the next show, but you won’t be.

**Radio Interviews**
- Good interview techniques on radio are similar to TV, but everything is conveyed through your voice since there is no visual image, so vary all three dimensions of your voice—volume, speed, and pitch.
- Even though you cannot be seen, smile and gesture when speaking as this puts energy in your voice and helps emphasize key points.
- Use short answers and stories—30 seconds at the most—and speak in complete sentences, using vivid words.

**Newspaper Interviews**
- You control the words that get written in a
reporter’s notebook. If it is not in the notebook, it won’t be in the story, so make sure you are getting the words and quotes you want into the notebook.

- Try to keep your responses unemotional. You lose control of an interview if you respond in kind to what you perceive as a personal attack. On the other hand, it is okay to object to a line of questioning you believe to be unfair. Just do it dispassionately and with as much reason as you can muster.
- When possible, provide concise written material without exaggeration. Give your own definitions for terms. More often than not, those are the definitions that will be used in newspaper stories. Provide documents that will make and reinforce your case.
- It is okay to seek a meeting with an editor or a group of editors if you feel that you are not getting your points across to a reporter.
- If you object to something written about you or your organization, it is entirely appropriate to call the reporter and discuss the points of disagreement.
- Whenever possible, take notes during an interview, especially a phone interview. If you feel that it is necessary, make your own audiotape of an in-person interview.

General Tips for Dealing with Reporters

- Respect deadlines. Ask when the reporter needs the information, then make sure you get back to him or her by that time.
- Never go off the record as interviews are always “public.”
- Give concise, to-the-point answers in clear and vivid language. Try to give 10–20-second answers that are easy to edit.
- Craft your messages in the way that journalists write: conclusions first (your topic sentences); context second; examples third; and the background last, if at all.
- Practice ahead of time by asking yourself the questions you hope will not be asked, then answer them.
- Be friendly, but keep your sense of authority.
- Do not be afraid to say “I don’t know” to a question. If it is a question you cannot answer, say so and direct the reporter to another source of information. Just don’t say it too often.
- Ask an interviewer what he or she means if you do not understand the question. Do not speculate unless this is part of your agenda.

- Remember interviewers and reporters always have the last word since they edit your answers after you are on tape or in the notebook. Put your viewpoints across in a manner that lends itself to an editing process that will reflect positively on you.
- Be aware of your body language. Do not fidget, drum your fingers, play with your jewelry, or act nervous.
- When asked a question that requires some thought, it is fine to take time to think about your answer. Do not jump in and later have regrets because your answer was not succinct, because you did not speak to the issue, or because you were incorrect.

6.4 Media Relations and Communication Operations

As your organization or advocacy coalition seeks to get information into the media and shape what is written or broadcast, there are a number of key functions that will need to be carried out to implement the media relations strategy.

Ideally, there would be someone who can serve as a full-time Media Relations Officer (MRO) to do these tasks, but in any case the functions outlined below need to be assigned to someone who has the skills to carry them out effectively.

The Role of Communications or Media Relations Officer (MRO)

- Research key issues and topics to determine how to craft messages
- Prepare press releases
- Organize press conferences
- Release information and pitch stories to relevant media
- Monitor press coverage
- Disseminate press coverage within the organization
- Analyze and report on the effects of press coverage to senior people in the organization
- Create new contacts in media organizations and serve as the link between the organization and external actors

In addition to these direct media tasks, the MRO also plays an important role in building and sustaining a positive public image and reputation of the organization or coalition and its key leaders by doing the following:

- Preserve and build goodwill and a favorable image, an important asset to faith-based organizations, which require a good reputation to attract donor
2. Planning
For a campaign to work, it must be carefully planned based on the information developed in step 1. The planning stage needs to include:
- framing the objective or goals of the campaign
- considering various approaches or actions
- assessing the risks and benefits involved in each alternative
- completing a detailed plan with clear assignments of responsibility and a timeline with key dates and deadlines
- developing indicators to evaluate the success of the campaign
- preparing the budget and mobilizing the necessary resources
- securing necessary approvals, permits, etc.

3. Communication
An MRO does the following:
- Coordinates all the media outreach and pitches stories and interviews
- Implements the plan of action, evaluating each step along the way to see whether there is a need to adapt or change the approach
- Uses the various tools for print and broadcast: press release, video news release, press kits, photographs, film, video tapes, press conferences, and interviews

4. Evaluation
Evaluation determines whether a media campaign is successful or not. If a measurable goal was set and clear indicators developed, then an evaluation technique should be able to measure success in reaching the goal. Some common techniques include:
- tracking the number of press releases and events held and how many are taken up in various media
- using questionnaires, focus groups, or other types of discussion feedback to gauge whether the public heard about and was influenced by the messages of your advocacy campaign
- establish a file of press cuttings (from print articles, Web sites, and tape from radio and TV) and analyze how key messages were covered and the tone of the coverage (positive, negative, or neutral)
Module 7: Preparation of Action Plans

7.1 DEVELOPING AN ACTION PLAN

There are several ways of developing an action plan. However, the most important thing is to ensure that realistic plans are made and that the necessary preparation is done before the implementation date.

During the training, the trainer explains that action-plan worksheets have been developed to guide the action-planning process. Refer the participants to the Action-Plan Worksheet in their handouts. Point out that this is a step-by-step plan to help them implement some kind of advocacy or media-related activities within the next six months as part of their individual and organizational activities. The activities identified should require minimal resources and be accommodated within existing work plans.

**Figure 3: A Sample Action Plan**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Date</th>
<th>Duration</th>
<th>Resource Required</th>
<th>Expected Outputs</th>
<th>Expected Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
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<td>2.</td>
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</tbody>
</table>

What each of the above means:

**Activity:** This means the actions that will be planned upon completion of training by each religious leader.

**Date:** This is the actual point in time set for each activity or action planned.

**Duration:** This is the exact length of time or interval or period that each activity planned will take.

**Resource Required:** This means material, funds, or even expertise needed to complete each activity.

**Expected Outputs:** These are likely or possible returns or yields that are realized immediately after the particular activity is undertaken (e.g. number of people trained.)

**Expected Outcomes:** These are likely or possible results or consequences that are realized after some time elapses (longer term) following the activities (e.g. policy change resulting from advocacy.)
### Module 7

**Activity Date**  |  **Duration**  |  **Resource Required**  |  **Expected Outputs**  |  **Expected Outcomes**
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12. | | | | |

**Action Plan Chart**
References and Additional Resource Links


AIDS Control and Prevention (AIDSCAP) Project. Partnership with the Media.


Helft, Lisa. Wisdom from within, Creativity from Each Other: Interactive Methods to Teach Just about Anything. June 2000.


ADDITIONAL RESOURCE LINKS

CARE, www.care.org

Ecumenical Advocacy Alliance, www.e-alliance.ch


Hope for African Children Initiative, www.hopeforafricanchildren.org

Religions for Peace, www.religionsforpeace.org


United Nations Joint Programme on HIV and AIDS (UNAIDS), www.unaids.org

World AIDS Campaign, www.worldaidscampaign.org

Religions for Peace • Handbook for Religions Leaders on HIV and AIDS Advocacy & Media Relations