

# WORKING ON THE MARGINS

Unexpected church-based responses to HIV



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**Tearfund** is a Christian relief and development agency building a global network of local churches to help eradicate poverty.

Tearfund has over 20 years' experience working with churches and faith-based organisations in the response to HIV. It currently supports over 130 HIV projects, spanning prevention, treatment, care and support.

### Working on the margins: unexpected church-based responses to HIV

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# Working on the margins

The vital role that faith-based organisations are playing in responding to the AIDS pandemic is now widely recognised.

The Christian church is an existing and sustainable grassroots network with unparalleled reach and authority in many local communities. It has a traditional remit of care for poor people, particularly widows and orphans. It presents unique advantages as a partner in the global response to HIV. The local church has the potential to effectively disseminate information, influence attitudes and values, mobilise thousands of volunteers, advocate with and on behalf of the vulnerable and reach marginalised populations that other agencies find it difficult to reach.

It must be acknowledged that the church itself has contributed to stigma, through judgmental attitudes towards those living with HIV, and there remain challenges to be addressed, particularly around issues of gender and sexuality. But already in communities across the world, local churches are providing vital services and sustainable care to those living with or affected by HIV.<sup>1</sup>



Ganga (left), a *hijra*, at an IMCARES (Inter-Mission Care And Rehabilitation Society) skills training session for people living with or affected by HIV in Mumbai, India.

Photo: Timothy Gaikwad



## Unexpected responses

This document highlights some examples of more unexpected church-based responses to HIV, which address secular preconceptions about the church's role, attitudes and limitations. They also present a challenge to the church itself about fulfilling its biblically-inspired social justice mandate. It focuses on three case studies where Tearfund's faith-based partner organisations are working with local churches to reach highly exposed and marginalised groups:

- women affected by sexual violence in the Democratic Republic of Congo,
- the *hijra* (transgender) communities involved in sex work in India,
- male groups in Uganda: rural drinking clubs and the *boda boda* men (motorcycle taxi drivers) in Kampala.

These case studies demonstrate the comparative advantages the church has in working among these marginalised groups in response to HIV. They also highlight some of the inherent challenges, and how these are being addressed. They invite decision makers to reconsider their assessment of the church's potential to reach marginalised groups, overcome stigma and discrimination and promote universal access to comprehensive prevention, treatment, care and support.

<sup>1</sup> Taylor N (2006) *Working together? Challenges and opportunities for international development agencies in the response to AIDS in Africa* Tearfund

Sandilands M (2007) *Transforming lives: church-based responses to HIV* Tearfund

## Key learning

Key learning from these case studies includes:

- The **grassroots presence** and **relational strengths** of local churches enable them to access the most marginalised people in their communities.
- The **potential for inter-denominational and inter-faith co-operation** to reach the wider faith community.
- The **meaningful involvement of people living with HIV**, and marginalised groups, in churches and faith-based NGO programmes can address stigma and transform paradigms within faith communities.
- The position of respect and influence that local pastors hold within communities means that **it is vital that judgmental attitudes and misinformation amongst church leaders are addressed**.
- Where these are transformed, **church leaders can play a key role in providing information and addressing HIV stigma and gender injustice in communities**. This helps reduce vulnerability to infection and removes barriers to universal access.
- The distinctive value of the **social inclusion and holistic care and support** provided by churches and faith-based organisations.

With thanks to:



# The case studies

'This world  
rejects us,  
but here we find  
acceptance.'  
Revati, a *hijra*

## Working with women affected by sexual violence in DRC

The Democratic Republic of Congo (DRC) is experiencing a significant HIV epidemic. HIV prevalence within the conflict-affected North Kivu province in eastern DRC is estimated at 5.5% for Aru and 4.8% for Goma. **The key drivers are poverty and gender discrimination, particularly the endemic sexual violence** which is an element and a legacy of the armed conflict. Rape has been used systematically as a weapon of war. For more than 50% of sexually active girls in North Kivu, their sexual debut was non-consensual. There is also a lack of communication on HIV, and lack of access to treatment as public health services in this area have collapsed. Prevalence is highest and rising among young people aged 15–24, with particular vulnerability amongst girls. Levels reach 20% among women subjected to sexual violence in eastern DRC.<sup>2</sup>

**HEAL Africa (Health, Education, Action and Leadership)** is a Christian NGO based in a hospital in Goma. It works throughout North Kivu and Maniema provinces to address the physical, economic, social and emotional consequences of gender-based violence. It reaches those affected through a network of volunteers from local churches who are trained as counsellors. They identify women who have been sexually abused or are suffering from fistula,<sup>3</sup> and refer them to appropriate treatment. In 2007,

the hospital in Goma carried out 294 fistula repair surgeries and 1,642 women received primary care for sexual violence, including HIV post-exposure prophylaxis. As well as receiving counselling and medical care, women learn income-generation skills to help them reintegrate into the community.

To have a significant long-term impact on health, **it is necessary to tackle the root causes of the violence, and address attitudes which stigmatise survivors of rape.** HEAL Africa works with all of the local faith-based communities (Protestant, Catholic, Muslim and Kimbanguist), as well as local and national government and international organisations, to engage and transform these conflict-affected communities. More than 2,300 community leaders have been educated on the damage caused by sexual violence. In Maniema province alone 6,100 women have received counselling, 5,887 women have received medical care and over 39,000 people have received community education on gender, sexual violence and HIV.

## Working with *hijra* communities in Mumbai, India

There are an estimated 2.5 million people living with HIV in India.<sup>4</sup> Stigma remains high and those living with HIV are often abandoned by their family and are unable to access treatment in hospitals. **IMCARES (Inter-Mission Care And Rehabilitation Society)** is a Christian NGO working with local churches in response to HIV amongst the poorest communities in Mumbai, India. IMCARES aims to raise awareness and transform community attitudes towards people living with HIV. Through its work with local churches, IMCARES is able to access marginalised communities within the slums who are rarely reached by government services, including sex workers and *hijra* (transgender) communities.

Local churches are an integral part of the community and therefore often have access to marginalised populations that other agencies find difficult to reach.

Photos: Maggie Sandilands / Tearfund





There are about 1 million hijras in India. Hijras are considered as a 'third gender' — neither man nor woman. Most are physically male or intersex, but some are female. Hijras usually refer to themselves as female, and dress as women. Although they are often referred to in English as 'eunuchs', relatively few have any genital modifications.<sup>5</sup>

**Most hijras live on the margins of society** with very low social status and few opportunities for employment. Many get their income from performing at ceremonies, begging, or through sex work. They often suffer police harassment. There are no 'third gender' rights in India. As with transgender people in most of the world, they face extreme discrimination in health, housing, education and employment, wherever bureaucracy is unable to place them into male or female gender categories.

HIV prevalence among hijras is high; it is estimated that nearly half of the 250,000 hijras in Mumbai are living with HIV.<sup>6</sup> There is no support network for marginalised groups like this, particularly for those who are sick with HIV-related illnesses. Because of widespread stigma and conservative social attitudes around sex, politicians and policy makers in India are often reluctant to engage with these 'hidden' populations. IMCARES has been working among the hijra community in the Mahim and Charkop slum areas for more than a decade. They have provided direct care for 21 hijras living with HIV, but the programme has had much wider impact within the community. By building relationships with hijras, **IMCARES and the churches it works with are breaking down stigma both within the church itself and in the wider community.** This enables marginalised communities to access services.

## Working with male groups in Uganda

In Uganda, more than 100,000 people contract HIV each year. Some 945,000 Ugandans are currently living with HIV: over half of these are women. A third of adult deaths are due to AIDS-related illnesses, and there are nearly 1 million children orphaned because of AIDS.<sup>7</sup>

HIV programmes often focus on women and children, but **male involvement is crucial in any effective response to HIV.** In many areas, gender inequalities mean that it is men who have power to make decisions, and programmes such as prevention of mother-to-child transmission (PMTCT) are more effective if men are involved and informed.<sup>8</sup> Women's community groups may be well-established and willing to discuss issues such as sexual health, and children can be targeted through schools, but there is often no comparable forum for men. Although church leaders are usually men, church congregations are predominantly made up of women and children, so reaching men is also a challenge for the church.

**ACET Uganda (AIDS Care, Education and Training)** is a Christian organisation working in HIV prevention, care and treatment. They have been seeking ways to reach out to vulnerable groups such as the *boda boda* men (motorcycle taxi drivers) in Kampala, and male drinking groups in rural Mbale. By developing friendships and working through local church volunteers, they have been able to reach these highly exposed groups with prevention messages.

2 Background information and figures from: International Rescue Committee (2007) *Mortality in the Democratic Republic of Congo: an ongoing crisis*; and HEAL Africa (2006) *Gender and violence against women*, and *Gender and HIV* – two KAP (Knowledge, Attitudes and Practice) research projects conducted in North Kivu.

3 A fistula is a hole between a woman's vagina and her bladder or rectum. It is caused by violent rape or long obstructed labour and results in permanent incontinence of urine and/or faeces. Most women who develop fistulas are abandoned by their husbands and ostracised by their communities because of their inability to have children and the smell caused by the incontinence.

4 UNAIDS (2007)

5 According to The Humsafar Trust (Mumbai), only 8% of hijras visiting their clinic are *nirvaan* (castrated).

6 Survey by Dai Welfare Society, a Mumbai-based NGO run by hijras

7 UNAIDS (2007)

8 Attawell K (2008) *Scaling up prevention of mother-to-child transmission of HIV* Tearfund

# Reaching marginalised communities

The church represents an independent civil society network already established at both grassroots and international levels. Tearfund's faith-based partner organisations connect with more than 15 million Christians in the South. The sheer number of churches in many of the areas most affected by the pandemic means that they can play a key role in reaching and impacting communities in the response to HIV. Local churches are already involved in communities that governments and development agencies find hard to reach, such as remote rural areas and slum communities.

## Access to communities

The Christian church is the most widespread network in Uganda, with churches even in the smallest villages. By working through the local churches, ACET Uganda has access into these remote rural communities. ACET was asked by the District Medical Officer (a local government official) of Mbale to bring its HIV prevention programme to men in local drinking clubs. The officer had thought that, as Christians, ACET would not be interested in working with these men; however ACET agreed to his proposal. ACET was already involved in these

communities, through churches and schools, but was looking for a way to reach men in particular with comprehensive HIV messages.

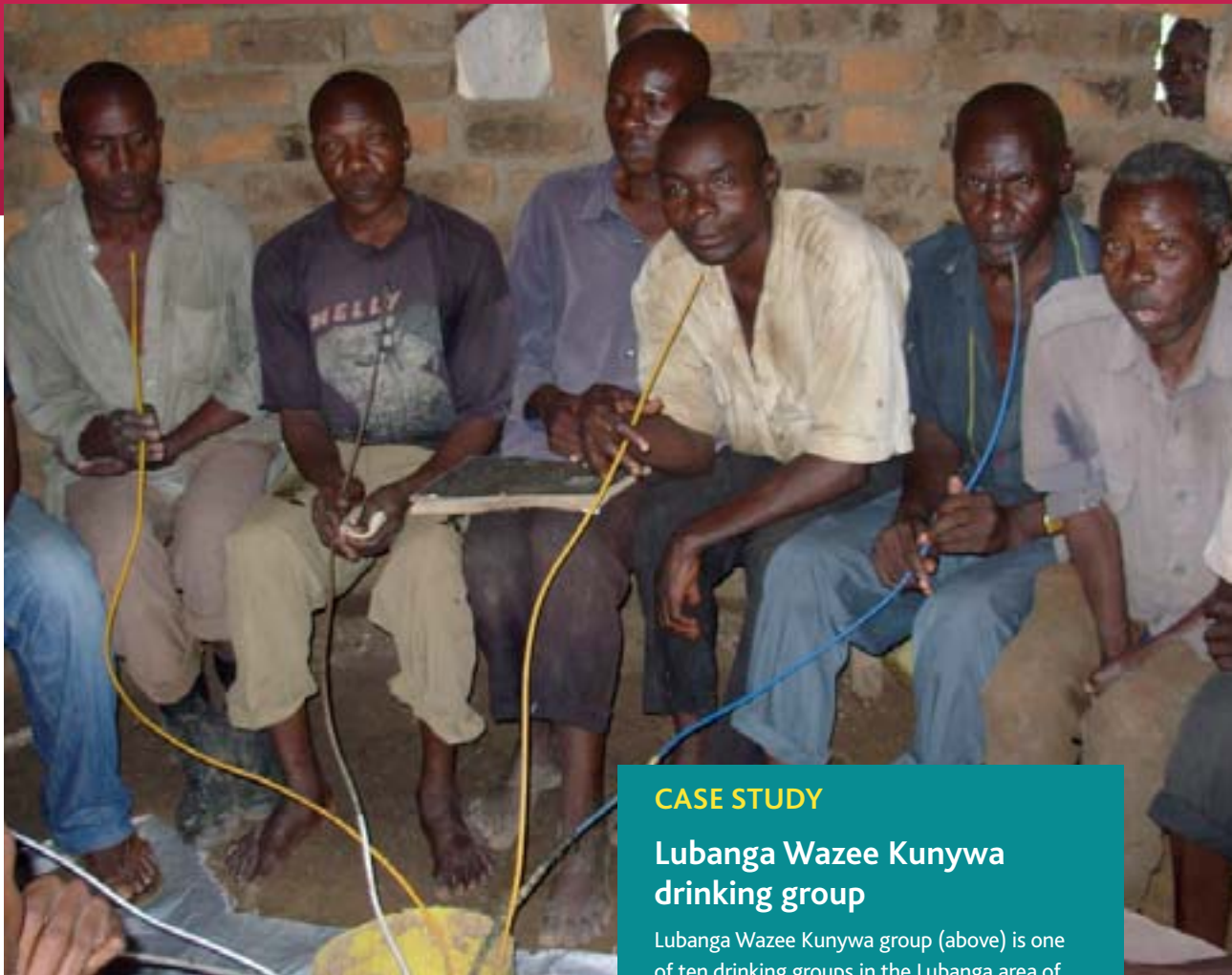
These drinking clubs are common in villages throughout this area. Members meet up each evening to talk and drink home-brewed local liquor from a communal pot. There is a loose organisational structure, as each club has fees to join and a leader. ACET respected and worked through this structure, by first approaching these leaders. Although they did not see HIV education as an immediate need, the leaders were willing to listen, because ACET was already well-known for its work within the local communities. The ACET volunteers who provide the HIV education sessions are local pastors and church volunteers. In these rural areas, church leaders have a position of considerable influence and respect within the community, so people are willing to listen to them. When other (secular) organisations had tried in the past to reach these groups, the groups were unwilling to participate and demanded payment for their time. The drinking group leaders not only scheduled time into the group meetings for the ACET volunteers, but also, on their own initiative, decreed that there would be no drinking until the education session was over. ACET is currently working with 25 drinking groups.

'The church has got all categories of people – youth, children, men and women. It is a way to reach everyone, and mobilise people. At first it was difficult to talk about HIV, but we saw that if you hide, you just die. We are all affected – we were burying church members who had died of AIDS. So now Christians accept we should talk about it.'

Pastor Wambede  
Nelson, Uganda

## Breaking down social barriers

IMCARES has been working on health and HIV awareness programmes in the Mahim and Charkop slums of Mumbai for the past ten years. They reach out to the *hijra* (transgender) communities there,



Lubanga Wazee  
Kunywa drinking club  
in Mbale, Uganda.

## CASE STUDY

### Lubanga Wazee Kunywa drinking group

Lubanga Wazee Kunywa group (above) is one of ten drinking groups in the Lubanga area of Mbale, Uganda. It has 28 regular members. They welcomed Pastor Wambede Nelson to join them to talk, because they knew him as a local pastor. At first they were surprised that the pastor wanted to talk about HIV. They had heard about HIV, but were reluctant to think about it. Now their attitudes have changed dramatically, and they are adopting safer sexual practices. As one member said: 'Before we didn't care, but now we want to take care of our bodies, and protect ourselves, our behaviour has changed.'

Each member contributes 100 Ugandan shillings each time they meet. Now they put some of this money towards an income-generation project they have started to help those affected by HIV in their community. As this is a social group, they are very motivated to do this work, because it is their own friends who are affected. They are also taking the message to other local groups. As one member said: 'Now we are spreading the "gospel of ACET" wherever we go. When we go drinking somewhere else we talk about HIV and what we have learned. Other drinking groups are willing to listen to us because they see the changes here.' In fact, they even challenge the local churches now, saying: 'Look, we have started doing development work before you – the drinking groups are quicker at catching up with this information!'

many of whom are involved in sex work. Initially it was not very easy, as being seen with the hijras meant that the staff were also verbally abused in public. They persevered because they believe that the church is called to care for and identify with the poorest, most marginalised and rejected people in society.

At first, the hijras looked at IMCARES as 'one of the many NGOs who just come and go'. It took some time to gain their trust. It was the consistency, perseverance and personal care of this faith-based approach that convinced them over time. IMCARES workers did not look down on hijras or treat them as 'different', but valued them as people. They did not try to impose their religious beliefs. As one of the IMCARES staff explained, 'We respect them as they are.'

Because of the combined stigma of transgender identity and HIV, when hijras are sick with HIV-related illness they are often abandoned by everyone, including their peers. It was at such times that the other hijras witnessed IMCARES workers touching and caring for them, washing them, dressing their wounds, feeding them, and advocating publicly on their behalf. This changed their attitudes towards IMCARES and over time the staff and volunteers have been accepted by the hijra community.



Photo: Margaret Salmon

Women waiting for surgery at the HEAL Africa hospital in Goma.

## Reaching the grassroots through faith networks

According to HEAL Africa, 90% of people in DRC identify themselves as Christians, across the various denominations. HEAL Africa trains volunteers from local churches as counsellors, to identify and help women who experience rape or fistula. This grassroots network enables it to reach women who are rejected and marginalised in villages throughout this inaccessible and conflict-affected area. Women are referred to the hospital in Goma for treatment, and HEAL Africa doctors also travel into the rural areas to perform surgery and train staff at local hospitals and health centres.

The counsellors are selected by the Nehemiah Committees, which HEAL Africa has set up in the areas it works. The Nehemiah Committees are inter-faith groups of ten community members, both men and women, representing different tribes and community groups. There are 57 Committees throughout North Kivu and Maniema provinces and the number continues to grow. This strong partnership with local communities makes HEAL Africa unique among the NGOs working in eastern

DRC. The Nehemiah Committees help identify women in their communities who have been raped and are in need of counselling and medical attention. They mobilise the community to participate in health education seminars and are working together to address the attitudes which contribute to or condone violence against women, and which stigmatise those who have survived rape. By working through the Nehemiah Committees, HEAL Africa enables villages to work together to rebuild their communities, instead of relying on outside agencies for help.

## INVOLVING THOSE AFFECTED

### Expert patients

HEAL Africa provides antiretroviral (ARV) treatment for children living with HIV, mostly orphans. It is currently pioneering an innovative response to the problem of ensuring adherence to medication, in the form of 'expert patients'. These are women who have undergone treatment at the hospital and who are living with HIV themselves. As volunteers, they go and visit the guardians of the orphans, teaching them about living with HIV, checking that the children are well cared for and that they are taking the medication. Since they are living with HIV themselves, they understand all the issues involved and can provide advice and encouragement. The expert patients are given a small amount of money to cover travel expenses. Twice a month they have meetings at HEAL Africa to discuss any problems.

Many of the families do not want a doctor or nurse from the hospital to visit them at home, because that could reveal to their neighbours that they are affected by HIV, and they fear the stigma. Since the expert patients are members of the community they are able to visit without arousing suspicion. Rebecca, one of the expert patients, explained her motivation to help: 'I see the children in the clinic, and I have to help because I am in the same situation. It is good to be able to help someone else.'

# Transforming attitudes: addressing stigma

Tackling the root causes of vulnerability is essential to reduce HIV infection rates. The church has a position of respect within communities, and a voice in shaping behaviours and attitudes. When stigma, myths and misconceptions within the church are addressed and transformed, then churches have unique potential to transform attitudes within the community in response to HIV.



Photo: Maggie Sandilands / Tearfund

ACET volunteers provided HIV training at this church in rural Mbale, Uganda, which has transformed attitudes. As one church member explained, 'We used to fear people who were infected. Now we don't fear if someone is sick, instead we can assist them. We didn't have information before but now we know how to care for someone who has HIV.' They are also passing on the message to other churches in neighbouring villages. There are around 1,500 Christians in this area.

## Transforming the church

In many places, the church's initial reluctance even to discuss the issue of HIV has long since been overcome by the scale of the pandemic. Often, however, churches remain reluctant to discuss openly issues of sexual health or comprehensive prevention methods including condom use and needle and syringe exchange. The church has itself contributed to stigma and discrimination through harmful messages around gender and judgmental attitudes towards those living with or affected by HIV. These attitudes need to be transformed.<sup>9</sup>

### INVOLVING THOSE AFFECTED

#### Speaking out

Madame Eulalie Rutiba is a nurse at a local health centre in DRC, in charge of the programme to prevent mother-to-child transmission. According to Madame Rutiba, 'Stigma is a great problem here.' Women who find out they have HIV through pre-natal tests are often too afraid to tell their husbands, and hide their medicines. Madame Rutiba is living with HIV and is one of the first people in this area to be open about her status. She is able to encourage and support these women. Madame Rutiba speaks publicly in churches about HIV prevention, and living positively with HIV. She also speaks out about sexual violence. She works with local churches because, as she says, 'It's where you find everyone. People go to church to listen and learn. HIV is a problem for the whole world, for every church.'

<sup>9</sup> Tearfund is working together with partner organisations to develop a theologically-based understanding of issues of gender and evidence-informed methods of prevention. Evans D (2008) *Transforming approaches to HIV prevention in Nigeria* Tearfund, and Sandilands M (ed) (2006) *Footsteps 69: Sexual health* Tearfund.

## Working with faith leaders

When HEAL Africa began its HIV prevention programmes in 2001, it was hard to talk about HIV in the church. The attitude was that those living with HIV were 'sinners' or 'under a curse'. In some areas people would not go into the home of someone living with HIV. HEAL Africa began by working with religious leaders of all faiths to train them to enable the church and other faith groups to respond

### CASE STUDY

#### Inclusion and dignity in the church

Pastor Dharmendra from the Living Hope Church in Mumbai describes how his congregation came to know a hijra called Hemu. 'Hemu was very sick. One neighbour who attends our church informed us and invited us to pray for Hemu. We went to her house. She was skin and bones – she was dying. We prayed for her.'

The pastor and other church members encouraged Hemu to be tested for HIV. When the test result was positive, her elder brother was so furious that he wanted to throw her out of the house. There is still stigma surrounding HIV, particularly when added to the stigma of the hijra lifestyle. The pastor stepped in to mediate. 'We counselled her and educated the family about HIV. The brother's heart was changed. Now Hemu lives with her family.' Church volunteers began to visit Hemu regularly. They also gave her food as the family was very poor. Pastor Dharmendra continues: 'Hemu started to feel better and also began attending our church. Our church was too far for her to travel to, and so we referred her to another church in the neighbourhood. Hemu is now 33 years old and works in the hospitality industry and is living a dignified life. There are no symptoms of HIV-related infections.'

Living Hope Church asked IMCARES to help them start an HIV project among their community, including the hijras. This is an encouraging indication of the increasing willingness of churches here to engage with hijras and others whom they would traditionally reject because of their lifestyle. Pastor Dharmendra explains, 'There are many like Hemu who have not experienced real love. We as a church must stand with them – they too need to be loved and respected. We share God's love with them and give them dignity. The church must look at them with God's point of view.'

compassionately to the issues surrounding the epidemic. Over 1,370 religious leaders were trained and 60,742 people attended the HIV education seminars throughout Goma, Masisi and Rutshuru territories in 2007 alone. Now pastors are speaking openly about HIV in their churches and visiting people living with HIV in their homes.

## Public acceptance

IMCARES staff in Mumbai are breaking social conventions by being seen in public with hijras. This challenges and transforms attitudes within the community, as well as instilling in hijras a sense of worth and self-confidence. Rather than simply inviting them to attend meetings at their offices or churches, IMCARES staff go to their homes and accept their hospitality. IMCARES staff state that their motivation is the biblical example of Jesus, who publicly associated with those whom society rejected, challenging and changing the attitudes of the people around him. One staff member reported: 'IMCARES staff and volunteers come from various church backgrounds but when they gather together to serve the hijras, this is church in action. It has the power to transform attitudes among the hijras, among the church, and in the wider society.'



Photo: Timothy Gaikwad

*Hijras alongside staff and beneficiaries at an IMCARES support group meeting.*

# Gender and justice

Increasing respect for the rights of women, and their status in society is vital to addressing sexual and gender-based violence, and thus reducing the high vulnerability of women to HIV infection. To do so requires the transformation of social attitudes and behaviour on issues of gender and HIV stigma. A key to that is informing and engaging local churches and faith leaders, who are often arbitrators of community opinion.

## Addressing gender injustice

HEAL Africa has initiated a Gender and Justice programme to tackle the problem of sexual and domestic violence in DRC, at both the judicial and community levels. Articles 14 and 15 of DRC's national constitution uphold women's rights to be free from all forms of discrimination and from sexual violence. New laws have been introduced concerning rape.

However, the constitution and law often have no real impact in the remote and conflict-affected rural areas. Even in Goma, although over 1,700

10 Human Rights Watch (2002) *The war within the war: sexual violence against women and girls in eastern Congo*

'The church is the key to give back hope and a sense of value to those who have had it taken away. The Bible says we are all made in the image of God, both men and women. HIV does not change that.'

Pastor Samuel Mayele,  
HEAL Africa



Photo: Maggie Sandilands / Tearfund

Gender inequalities make women more vulnerable to HIV.

cases of rape have been registered, there are still no convictions. Sexual violence is a characteristic of the conflict and usually carried out by armed combatants. But an issue of growing concern is how sexual violence is now becoming endemic within communities, in the prevailing climate of impunity and culture of violence.<sup>10</sup> Rapes go largely unreported and many women do not even seek medical treatment because of the stigma that surrounds those who are known to have been raped. Rape survivors are often rejected by husbands and family. To address these social attitudes and bridge the gap between legislation and practice, the Gender and Justice programme works through churches, schools and other local groups to educate communities about the new constitution and their rights under the law. It aims to change attitudes towards gender, promoting respect for the rights of women and preventing sexual violence within the family and community.

## Human rights and faith understanding

Religion and religious texts have too often been used to justify gender inequalities that leave women increasingly vulnerable to HIV. The Gender and Justice programme targets pastors and other faith leaders because of the influence they have at a local level. The discussion-based training refers to the new legal code, alongside both the Bible and the Koran as well as traditional proverbs, to address these misconceptions within the wider faith framework. One pastor at a training workshop commented, 'It

helps us to discuss sensitive issues that we could not talk about.'

Mediating the human rights concepts through a theological understanding helps to engage the whole community. Richard Malengul, a lawyer who was involved in developing the Gender and Justice programme, explained: 'The church is the key to reaching the community. In DRC the majority of people identify themselves as Christian. People listen to the church leaders. So when you work with the church you can reach a large number of people and your message will be heard. Churches have schools and provide social services such as health centres,

so if the pastor endorses you, you have authority to work there too. Also the church is a stable structure. It remains in the community long-term, so people can receive the same message continuously.'

As well as churches, the programme is also working with parents to tackle issues like girls' education. A curriculum is being developed for teachers in primary and secondary schools on the subjects of gender and justice, incorporating creative elements such as music, drama, art and dance. They are also providing training for local lawyers relating to gender violence and the difficulties in applying the law.



Despite new legislation and publicity campaigns, there remains a culture of impunity around sexual violence in DRC. Working through local churches to promote gender equality and change attitudes at the community level can help to bridge the gap between legislation and practice.

# Building relationships

'We talk about HIV, but it is not just about HIV – it is about life in all its fullness. We are interested in these men as people, as friends.'

Paul Kato, ACET  
Uganda

HIV is a relational issue. Stigma and discrimination mean that people living with HIV are often rejected by family and friends. The church is a community, and thus, where damaging myths and misconceptions within the church are addressed, its focus on restoring relationships can make a distinctive contribution to the response to HIV. The hope, sense of belonging and reaffirmation of individual worth that faith and the church community can provide often result in clear improvements to mental, physical and emotional health.

Stigma and discrimination are not broken down purely by providing information. It is important to build relationships with people before they will hear and engage with the message. These relationships are essential for redressing the damage that stigma and rejection have caused, particularly amongst communities that are already marginalised. The transformative power of individual relationships to change attitudes should not be underestimated. When a local pastor, who is respected by the community, visits a person who is sick with HIV-related illness in their home, it gives a powerful message of acceptance both to that person and to the wider community. The active involvement of people living with HIV, including church leaders, in programmes is also vital to changing attitudes.

## Working relationships

The distinctive relational strength of a faith-based response enabled ACET's work with the *boda boda* men (motorcycle taxi drivers) in Kampala. *Boda boda* men are often stigmatised, but ACET staff developed friendships with those who worked for them as regular drivers, which enabled them to reach this highly exposed and marginalised group with HIV prevention messages. Paul Kato of ACET explained, 'We talk about HIV, but it is not just about HIV – it is about life in all its fullness. We are interested in these men as people, as friends.' Kenneth Katende is one of ACET's regular drivers, which is how he found out about their programme offering HIV training alongside English literacy skills. He went to his colleagues and encouraged them to join. Although they felt they already knew about HIV, they were



Photo: ACET Uganda

The *boda boda* men trained by ACET Uganda as peer educators do not necessarily share a faith, but they are not surprised that Christians are talking about sex and HIV. Ishmael, a Muslim, says: 'It is their responsibility! They have to love people, so of course they should be telling us how to stop AIDS.'

'I come to the IMCARES centre because I find love here. They touch us, they love us, they care for us. We feel accepted and not rejected. This world rejects us, but here we find acceptance.'

Revati, a *hijra*

## INVOLVING THOSE AFFECTED

### Peer-to-peer training

ACET focuses on encouraging the active involvement of the communities it works with. The *boda boda* men who have received HIV training take time out from work to go to tell other groups of *boda boda* men. They talk about the symptoms of sexually transmitted diseases including HIV. They explain prevention methods including condom use, and the importance of testing, particularly to ensure prevention of parent-to-child transmission. When they are asked questions they can't answer they come back and ask ACET.

The *boda boda* men feel that they own this programme now and feel a sense of value and self-esteem because they are able to share this knowledge with others. As Kenneth says, 'This is our work. We need to go to these communities. We are the best ones to tell others, because we are colleagues.' They wear T-shirts with the logo, 'Do you know about STDs and HIV? Ask me!' and they also pass on information about HIV prevention to the wide variety of people who take the taxis.

interested to learn English. As the programme went on, they realised that they were lacking important information about HIV. Kenneth explains, 'Every family in this area has lost someone, but we still don't know the facts. Programmes like this can reduce HIV. We don't have the capacity to treat people but at least they can get this message and stop the spread of HIV.'

### Valuing individuals

IMCARES' focus is on the quality of personal care rather than maximising beneficiary numbers. Building relationships with the people they reach out to gives staff and volunteers the opportunity to talk about sensitive issues like HIV. They help people to access voluntary counselling and testing (VCT). Though a

government doctor may only have limited time for counselling, the volunteer can follow up and spend time with them after the test, to answer all their questions and provide emotional support.

*Hijras* are shunned and feared by the community and often rejected by their families because of their sexual orientation. Many *hijras* are involved in sex work, which also puts them even further on the margins of the society. Nobody wants to be seen with them in public. When IMCARES staff and church volunteers spend time with them, are seen in public with them, listen to them and care for them with their own hands when they are sick,



Kala, a *hijra* and former sex worker, speaking at an IMCARES meeting.

Photo: Timothy Gaikwad



Photo: Maggie Sandilands / Tearfund

Dusabe is 21. Four years ago, she was found suffering from a fistula by counsellors who came to her village. They brought her to Goma for surgery, which was successful. She says, 'When I came, I was without hope. I was alive, but I was in despair and did not think I could ever be healed... Now I have been made well.' As well as medical treatment and rehabilitation, HEAL Africa provides a community for those like Dusabe who cannot return home due to the conflict.

hijras feel accepted as humans. This can help restore a sense of worth and belonging. It also begins to transform community attitudes by example. Over the years not only the staff but all the other beneficiaries of the IMCARES centres have come to accept hijras as equals. They are invited to all the centres' programmes and sit alongside the rest of the community. One of the hijras commented, 'Here I feel very good because we are loved here.'

### Restoring relationships

In cases of sexual violence in DRC, many women are then abandoned by their husbands and families because of the stigma of rape, fear of HIV or because of the smell caused by fistula. In DRC, people's sense of worth is founded in belonging within the community, so alongside surgery to repair the physical injuries, the isolation and rejection that these women suffer also need to be resolved before they can heal. One young woman, who suffered a fistula as a result of a violent gang-rape, described how, 'My brothers and sisters wouldn't even look at me. They said that I stank. I felt forgotten.'

HEAL Africa works through the Nehemiah Committees and local churches to transform attitudes and combat stigma, to ensure support and acceptance for survivors of sexual violence. Where women wish to return to their family, local pastors play a vital role providing ongoing marriage counselling and family mediation in order to restore relationships that have been damaged by stigma and rejection.

### Providing community

HEAL Africa provides a community called 'Grounds for Hope' for women who cannot, or do not want to, return home after surgery. Women stay there because of the ongoing violence in their home areas, or the rejection they have experienced, or because their fistula repair has been unsuccessful. The women live together and support themselves through the income-generating skills such as sewing, which they learn while waiting for surgery. Sarah, one of the women in this community, explains, 'It is good to live in community here, we can share with each other and I consider these women to be my sisters and parents.' The pastor from the hospital visits regularly to offer counselling support, and some of the women attend a local church. Nyirangirimana, another of the women, says, 'My faith is important – it helps me. We go to the local church – they always welcome us.'

### Relational support

When women arrive at HEAL Africa's hospital for treatment after sexual violence or fistula, they meet the counsellors first. These are women from local churches, who reassure them and prepare them to face medical treatment. The relational support provided by these volunteers is vital. Doctors are over-stretched and do not have the time for building individual relationships, but the women are often hugely traumatised when they arrive and need this support. As one counsellor says, 'The most important thing we give is encouragement.'

# Universal access

By addressing stigma and providing information, churches can play a key role in promoting universal access to prevention, treatment, care and support.

## Comprehensive prevention

A comprehensive prevention framework involves the promotion of safer practices, as well as other evidence-based approaches to prevention, such as ensuring access to testing and treatment, prevention of parent-to-child transmission (PPTCT), universal medical precautions, and so on. These targeted interventions have to be promoted alongside broader factors for enabling HIV prevention, such as challenging the low status of women and overcoming gender-based violence.

Churches often find it difficult to talk about sex and safer practices, particularly condom use. These case studies show a holistic and evidence-based faith response to HIV prevention. Tearfund and its Christian partner organisations share a basis of faith which enables them to engage the church on sensitive issues. These organisations are working to develop the capacity of church leaders to inform and protect those who are vulnerable to HIV, and to tackle the injustices that cause such vulnerability.

**'It is still difficult for pastors to talk about condoms, and there is still a problem of gender. Pastors need to speak about equality. But the church is the way for things to be changed, because people trust the pastor, so if he understands these issues then people will listen.'**

**Pastor Samuel Mayele,  
HEAL Africa**

## Providing care and support

Where initial fear and stigma around HIV has been overcome, many churches are playing a key role in mobilising volunteers to provide home-based care and support for people sick with HIV-related illnesses. Because the church is an established and permanent structure within the local community, this care is sustainable. These case studies provide examples where the church is reaching out in unexpected places, and providing care and support for marginalised, non-church groups, such as the hijras in Mumbai.

## Holistic approach

Faith-based care often goes beyond secular provision, because of its holistic approach. HIV is not simply a medical issue, and cannot be adequately addressed through purely medical responses. It has wide-ranging physical, mental and psycho-social impacts for the communities and individuals infected or affected. Also, it is an issue that cannot be dealt with in isolation but requires that issues of gender, poverty, wider health and healthcare provision, education and food security are also addressed.

As well as medical treatment, HEAL Africa provides professional psychiatric counselling, spiritual support, and income-generation skills training for the women waiting for surgery. These new skills give the women income-earning potential, which provides them with some independence and improves their social status, helping them to reintegrate as they return to their communities.

Pastor Samuel Mayele is a chaplain at the hospital in Goma. Where it is requested, he provides spiritual counselling for the women who are waiting for surgery, or recovering afterwards. He spends time each day visiting the women, listening to them, praying for them and encouraging them. He has received HIV training at HEAL Africa so he can help

women who have tested positive to come to terms with their diagnosis. Pastor Mayele admits that ten years ago, along with many other church leaders, he thought that AIDS was a punishment from God. Now he believes the church can play a vital role in the response to HIV, particularly in the context of sexual violence. He says, 'Food and clothes and medical assistance are not enough to change what people feel inside. The church is the key to give back hope and a sense of value to those who have had it taken away. The Bible says that we are all made in the image of God, both men and women. HIV does not change that. The church can promote human dignity, and acceptance of others.'

In Mumbai, the holistic approach is valued by the hijras. Baby Dancer is a Guru (head of a group of hijras). She often refers other hijras to IMCARES for HIV care, predominantly for emotional and spiritual support. Another hijra, Kala, is actively involved in the support group for people living with HIV. She is a Christian and goes to a local church where they have started a prayer group run by the hijras themselves.



Photo: Maggie Sandilands / Tearfund

## CASE STUDY

### Providing hope

Sarah came to HEAL Africa six years ago, when counsellors came into the rural areas to identify women in need of treatment. She says, 'Before, I was hopeless. I thought my life was over. Now, even though my fistula is not yet healed, I have hope. I am glad when the pastor comes and talks about God. The love of God is the only way I have hope.'

The hope provided at HEAL Africa is not just spiritual but practical. Most of the women say that the skills they have learned there help to restore their self-esteem, which was so damaged by the trauma and rejection they have endured. As Sarah says, 'Something great changed in my life – I learned to sew. Now I have a skill, and I can make clothes for myself. I feel more confident. I feel happy now.'

### Access to treatment

Much of IMCARES' HIV work focuses on addressing stigma and discrimination against those living with HIV, particularly around access to treatment. Many hospitals in India were initially reluctant to admit patients with HIV. IMCARES staff and church volunteers often accompany hijras to hospitals to ensure they are admitted and cared for.

The hijras themselves are often reluctant to be admitted to hospital because of the gender issue. They do not want to be registered as a male in a hospital and yet have to do so. They want to be in a women's ward, but have to live with the men. IMCARES does not try to advocate on these issues, but instead advocates amongst the hijras about the importance of treatment.

Women waiting for surgery at HEAL Africa learn practical skills such as sewing, which will help them to earn income and reintegrate into their communities.

# Working together to address challenges

While faith-based approaches present many distinctive advantages in the response to HIV, the church alone does not have the capacity to meet all the needs. The goal is not for the church to create parallel structures, but to work in partnership with government and other agencies, and aligned to national priorities. Networking with other agencies and service providers can address the limitations, and strengthen the quality, of church-based responses. Where churches, NGOs and governments work together according to their respective strengths, people living with HIV will have better access to treatment and care.

## Service provision

Addressing stigma and discrimination removes barriers to universal access to prevention, treatment, care and support, but does not ensure service provision. An ongoing challenge is that in many poor rural areas, healthcare structures and services are still lacking. Building relationships with other organisations and service providers ensures that gaps in capacity are met.

The men in the drinking clubs in the rural Mbale region of Uganda identified the lack of local service provision. One said: 'Now we know about HIV and want to protect ourselves, but we don't know if we have it.' They would like to be tested and know their status, but there is no VCT (voluntary counselling and testing) provision locally. ACET is working with the AIDS Information Centre to provide free mobile VCT in this area.

In the rural areas of North Kivu province, DRC, there are no VCT centres and little access to antiretroviral (ARV) treatment. Even in Goma there is insufficient provision. HEAL Africa can carry out HIV tests within the hospital in Goma, but provides ARVs only for children. Rape victims who come for treatment are provided with counselling and testing for HIV. If the women test positive and need ARVs, they are then referred to Médecins du Monde (MDM), another local NGO that provides ARVs. By networking in this way, HEAL Africa can ensure that people's needs are met. Expanding the role of church in advocacy could help bring central government resources to eastern DRC.

## Inter-faith co-operation

HEAL Africa is a Christian organisation but seeks to engage wider civil society in order to have greater impact at a local and national level. It works alongside local and national government authorities, INGOs, and faith leaders from all different faiths, through the Nehemiah Committees. One Muslim leader in the Nehemiah Committee in Kayina commented, 'Before this, we didn't know that we could work with Christians, but since the committee was formed, we have become brothers and sisters.' This inter-faith cohesion builds local unity and has been vital to accessing communities, and beginning to address the complex challenges of gender injustice and sexual violence.

## Integrated responses

HEAL Africa's hospital does not work in isolation but is integrated into the national health system. It works with 48 local health centres and six hospitals throughout the region to develop their capacity to treat survivors of sexual violence. In September 2007, it was recognised by the Ministry of Health as a Tertiary Referral and Training Hospital. HEAL Africa also provides regular training for its many volunteers, including counsellors and faith leaders, to equip them with the necessary skills and information to ensure a good practice response to HIV.

# Conclusion

These case studies demonstrate how the church has moved on from its initial stigma and inertia in response to HIV. They show churches and faith-based organisations going beyond their traditional 'niche areas' and engaging in unexpected and innovative responses to HIV. They are reaching out to the most marginalised communities to end stigma, provide good-quality holistic care and enable universal access.



Photo: Timothy Gaikwad

The church's unique position within communities and its ability to access and engage with these marginalised populations identifies it as a vital partner in the response to HIV. Its potential in advocacy is still unmet, but as an established civil society network at grassroots and national level, the church has the ability to reach communities that governments find it hard to reach, and to network isolated local responses into an integrated whole. These examples demonstrate the potential of the church working in co-operation with governments, health providers and NGOs, as well as across denominations and with other faith groups.

There remain ongoing challenges to church responses, including the need to engage with issues the church traditionally finds difficult, such as sexuality and gender. These responses should inspire churches to address these challenges in order to fulfil their biblical mandate in favour of the most marginalised people in communities. The church has often contributed to the stigma that allows HIV to

spread, and condoned the gender inequalities that make women more vulnerable to infection. However, these case studies show that it also has the power to redress and transform these attitudes. Tearfund is committed to working alongside churches and faith-based partner organisations to tackle these challenges. Its shared basis of faith enables it to address these sensitive issues from a theological as well as a public health perspective.

The examples given here still remain the exception rather than the rule, but they demonstrate the potential of the church, when it is engaged, informed, adequately resourced and supported, to impact the most marginalised communities in response to HIV. Tearfund's faith-based partners connect with 15 million Christians in the South, and the church is a widespread and influential presence in many of the areas most affected by the pandemic. If these responses were to become mainstream, this impact could be multiplied worldwide.

*Boda boda* men who have received HIV training from ACET Uganda are now reaching other groups with HIV prevention messages.



Photo: ACET Uganda



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