

Project Briefing

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Key points

- Faith-based Communities (FBCs) may be the first port of call for local people during a crisis, and often continue to provide HIV-services
- Humanitarian actors need to help FBCs build up their emergency capacity on HIV services
- To work effectively with humanitarian actors, FBCs should address stigma, theological misunderstandings and discrimination

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Collaboration between faith-based communities and humanitarian actors when responding to HIV in emergencies

Fiona Samuels, Rena Geibel and Fiona Perry

Faith based communities (FBCs) (Box 1) provide 40% to 50% of healthcare in developing countries (African Religious Health Assets Programme, 2006). One in five organisations working on HIV programmes are faith-based (World Health, 2004). While their role in responding to HIV is recognised, FBCs have unexploited capacity for the delivery of HIV prevention, treatment and care.

This is partly because some humanitarian organisations do not value the role of FBCs. Concerns include fears that funds are awarded on the basis of ideology rather than the effective delivery of health services. They worry that FBCs are unable to provide HIV prevention services without a religious agenda; or may have preconceived ideas about FBC capacity or approaches. But there is growing evidence to balance these misconceptions, such as a World Bank evaluation of 155 health facilities in Uganda, which found that faith-based health providers supplied better services than government facilities (Global Health Council, 2005). More evidence is needed on the role of FBCs in responding to HIV in humanitarian crises.

A collaborative study between ODI, World Vision and Tearfund in 2009 aimed to generate such evidence. It consisted of a global literature review followed by field studies in Democratic Republic of Congo (DRC), South Sudan and Kenya – countries selected to provide a range of country, emergency and HIV contexts. A qualitative methodology was used; informants included people affected by the emergency, People Living with HIV (PLHIV) and members of the FBC. This briefing presents key findings and recommendations for the faith community and humanitarian actors. The study focused only on responses within the Christian community.

Box 1: Faith-based communities

UNAIDS distinguishes three levels:

- Informal social groups or local faith communities, such as women's or youth groups.
- Formal religious communities with an organised hierarchy and leadership, such as Muslims, Hindus or Christians, and subdivisions such as Sunni Islam, Theravada Buddhism or Catholic Christianity.
- Independent faith-influenced non-governmental organisations, such as Islamic Relief and Tearfund; and such networks as the Ecumenical Advocacy Alliance, Caritas International, World Conference of Religions for Peace and the International Network of Religious Leaders Living with HIV (INERELA+).

While other religious communities also engage in HIV-responses, this is the subject for another study.

Faith communities and HIV prevention

The study found no systematic HIV-training for the clergy and that there is a wide spectrum of faith-based approaches to HIV. These range from denying its existence and condemning those infected, to establishing home-based care, initiating PLHIV associations, and offering church premises for mobile HIV-testing and HIV campaigns. According to study respondents, the opinions of religious leaders have changed substantially in the past five to ten years, though rural parishes lag behind as fewer HIV awareness campaigns and trainings reach these areas. Many religious leaders share messages about HIV prevention with congregations and are aware of

the increased threat of HIV that those congregations, particularly women and girls, face during a crisis.

In terms of the added-value that churches can bring to HIV-programming, responses included the following: they can use their structures and networks to obtain emergency funds; they can spread messages; they can provide access to HIV prevention and treatment services for rural or marginalised communities; they can maintain projects during insecurity because their staff tend to be local volunteers; they provide higher quality, and consistent services than government facilities. As one religious leader in South Sudan said: 'Community has confidence in the church. More attend VCT [voluntary counselling and testing] managed by a faith organisation than the government. They trust we will stay confidential.' They can provide spiritual care and refuge; they preach love and encourage kindness; and they can mobilise limited local resources to support vulnerable children, PLHIV and families.

However, HIV initiatives managed by the local religious community can have shortcomings. Some leaders misinform congregations on HIV and there are reports from Kenya and DRC of them encouraging members to stop taking ARVs to allow God to heal them. Interdenominational competition limits collaboration and learning; the demands on local people to participate and volunteer are sometimes too great and staff rarely have the skills required for HIV interventions, proposal writing, and reporting. Few pastors have been trained in HIV-related counselling or trauma recovery techniques. In addition, religious leaders may disapprove of family planning and the church often prohibits sex outside marriage, making it difficult to help youth who are already sexually active. Churches are also reticent about traditional gender roles and harmful traditional practices, according to respondents.

HIV in emergencies

The spread of HIV in fragile states and humanitarian emergencies depends on many factors, including pre-emergency HIV prevalence and service availability, main modes of transmission before and during the emergency, duration and nature of the emergency, the level of disruption to health and other basic services and the coping strategies people use during the emergency (Samuels, 2009).

Women and children are the most vulnerable in these situations. Children are greatly affected by violence and crime whether abused themselves or having watched other perpetrators and grow up in an environment without role models, moral leadership or understanding of social interactions and behaviours which could contribute to the prolific level of sexual and gender-based violence in post-conflict and fragile state settings (Perry, 2009). The case studies show that violence against women increased during insecurity. Other studies also show that violence continues with peace, becoming more

domestic in nature (AIDS, Security, and Conflict Initiative, 2009). Many women use transactional sex (sex in exchange for basic necessities) both during and after a crisis to survive. Respondents also spoke about increases in consensual sex in camps for internally displaced people (IDPs): 'People were looking for a place to comfort themselves', according to a focus group discussion in Kenya.

Stigma about HIV and AIDS is high and deters people from disclosing their HIV-status and seeking treatment and support. 'Resources were scarce and families did not want to be burdened by a chronically ill family member', said a respondent in DRC.

FBCs in emergencies

Planning and response. The study found insufficient preparedness for HIV responses during emergencies among FBCs. Few local religious initiatives have contingency plans or enough funds for emergency responses. Even so, their responses in emergencies have proved critical, partly because they can mobilise short-term funds rapidly through their national and international networks. The church is often the first port of call for people affected by emergencies – people look to churches and religious leaders for material and spiritual support, as well as security updates. In Kenya, pastors became human shields during the ethnic violence, and churches became shelters for those displaced. 'Religious leaders are looked to for guidance and advice. Most people go to church. The displaced seek out their church to get assistance,' said a respondent in DRC. In some cases, churches have taken the lead in registering people for assistance.

There were reports in all three case studies of mission clinics and hospitals staying open when other facilities, including government hospitals, had shut, though there were times when all health services and programmes were disrupted by conflict. In other cases, the church increased its capacity: in South Sudan, partners of the Diocese of Torit expanded the Catholic Church's capacity during the war to manage schools and health facilities.

Because many religious-affiliated medical services are flexible, human resources were transferred to priority areas including rape response and HIV testing. Their ability to provide mobile services and involve community outreach workers was also critical. In Kenya, for instance, PLHIV were reluctant to attend the local clinic because of the concentration of people from a different tribe in nearby IDP camps. Addressing this, the APHIA II project provided a team of staff from different ethnic groups who were viewed as neutral outsiders and could, therefore, conduct home visits and run mobile units.

The study shows that the continuous presence of churches during conflict builds trust amongst local communities. Churches acted as mediators between communities and aid organisations; helped to mobilise groups to implement activities; and negotiated

safe passage for humanitarian actors. In Kenya, for instance, the local faith community mobilised youth, who were perpetrating many crimes at the height of the emergency, by involving them as gatekeepers, security guards and relief distribution monitors.

But not all churches inspire trust, and the study found accounts of pastors helping only those from the same ethnic or political group. There were even stories of desperate people changing religion to gain better access to assistance.

Recovery and reconciliation. While many respondents believe the church is well placed to contribute to peace-building and to spearhead reconciliation efforts, others see its involvement as problematic, given a possible history of inter-denominational competition and partisan behaviour.

While community participation fosters project sustainability, volunteerism in fragile states may be under threat as more families lack food and an income. Churches may have a greater ability to leverage volunteers: 'Getting volunteers through churches was easier, as they see volunteerism as doing something for God', said one NGO representative in DRC, and many volunteers saw their work as a religious calling and social duty. But they still voiced a need for economic compensation.

Many respondents felt that the church has a role to play addressing gender discrimination, which leaves women and girls vulnerable in general, and particularly in emergencies. According to the religious leaders interviewed, gender is difficult to address within the church. However as one religious leader in Nairobi said: 'We need to address gender, HIV challenges, and build our capacity to deal with early child marriage and female genital cutting'. This is mirrored by women describing the church as a place to receive hope and comfort: 'We may feel ashamed to share our stories of rape or living with HIV, or husband dying of HIV, but we know the pastors will listen', was one comment from a focus group discussion in DRC.

In camps for refugees and IDPs, the local religious community often engages youth in recreational activities. According to study respondents, this gives youth the chance to discuss sexuality, HIV and faith. However, messages about adolescent sexuality and faith may be inconsistent; some churches insist on abstinence, while others talk openly about abstinence, faithfulness, and condom use.

Interdenominational collaboration. Christian groups have various organisational forms, such as local church congregations, national denominations or dioceses, development departments within a denomination, and associations of churches. Collaboration can occur across these levels, across denominations, and between Christian organisations and humanitarian actors more generally. Umbrella organisations to coordinate church efforts exist in all three countries; yet lack of resources often limits real interdenominational collaboration.

Collaboration with humanitarian actors. There

are examples of collaboration between international humanitarian actors and local Christian communities. In DRC, for instance, the Catholic Church has developed an HIV national plan and will roll this out at the Diocese level. Parts of this may be supported directly by humanitarian actors (e.g. World Food Programme); or through Catholic development agencies (e.g. Cordaid); or be implemented through Diocesan Office of Medical Works.

Challenges exist: churches rarely have the necessary human resources to build relationships with international agencies; skilled church leaders may be overstretched; and humanitarian actors may see churches as obstacles to services such as condom distribution. While humanitarian actors have some level of reporting against their accountabilities, churches tend to focus on activities rather than results, according to respondents, and lack project management, monitoring and documentation.

Recommendations

While there are examples of humanitarian actors working with the local religious community, this could be strengthened by drawing on the comparative advantages of each group, i.e. funding, technical expertise and capacity-building from the humanitarian actors; and community trust, local access, extensive networks, and quality services from the religious community. Mechanisms could include joint training and the production and distribution of HIV materials and guidelines. There are entry points for collaboration and for humanitarian organisations to build the capacity of FBCs on HIV response in humanitarian settings:

- 1. Initiate HIV emergency preparedness and disaster risk reduction initiatives.** Humanitarian organisations could help to build the capacity of FBCs on disaster risk reduction by engaging youth, unemployed men, and female heads of households in sustainable livelihood initiatives, alongside HIV community service projects, with a strong focus on PLHIV, ensuring they are recovering adequately from emergencies. Further training for FBCs should include disaster risk reduction, emergency preparedness and how to incorporate HIV and AIDS into humanitarian planning responses.
- 2. Mobilise the Church to address stigma and detrimental cultural practices.** The church needs stronger skills and resources to address gender dynamics, domestic violence, tribal reconciliation, and the involvement of men in HIV testing and treatment. Humanitarian actors and governments need to support more HIV training for religious leaders, particularly in rural health zones. International faith-based communities can help to build the capacity of churches, using proven Christian-based facilitation tools to tackle misconceptions of HIV, address stigma and discrimination towards PLHIV, enhance family dialogue, and



Overseas Development
Institute

111 Westminster Bridge
Road, London SE1 7JD

Tel +44 (0)20 7922 0300

Fax +44 (0)20 7922 0399

Email
publications@odi.org.uk

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improve relationships with humanitarian actors.

3. **Scale-up initiatives for children and youth.**

Family tracing and physical security are essential components of any projects focused on children and youth in countries recovering from conflict. Humanitarian actors should work with FBCs to develop a comprehensive strategy for children and youth, focusing on their rights to survive, be safe, belong, and develop. Components could include life skills training, peer education, mentorship, family dialogue, basic education, vocational training, and adolescent-friendly reproductive health services.

4. **Mobilise FBCs to tackle gender-based sexual violence (GBSV).**

Some FBCs provide medical and psychosocial support for women who have been raped and a growing number work with families to prevent social abandonment, exclusion, and marital separation as a result of violence against women. Yet, prompt reporting for medical and legal purposes remains low and most funding for GBSV in crisis focuses on short-term immediate response rather than prevention, social reintegration, and female empowerment. Donors and humanitarian actors need to advocate for longer-term social change, protection, and skills-building programmes for women and girls. Trusted members of the local religious community are well placed to initiate dialogue on gender roles and social norms, work with households to promote rapid response to and reporting of violence against women; and become a voice for women.

5. **Invest in faith-based youth teams and community outreach.**

Churches in many communities already provide care and support for PLHIV and vulnerable households. Nevertheless, there need to be more HIV services that are closer to those that need them and the church is well positioned to reach remote areas. Building local skills in HIV prevention, care, and counselling is possible through religious networks. The uniform build-

ing of capacity for faith-based youth outreach workers will create an interface between health facilities and communities, and local human resources to call upon during crisis. International humanitarian FBCs can draw on their global experiences to develop a Christian-based training programme and framework appropriate for fragile state health systems.

6. **Strengthen inter-denominational bodies.**

Inter-denominational projects can have greater reach and intensity and can work collectively on disaster risk reduction. There is a need to promote inter-denominational coordination to combine resources, improve coverage and expand disaster risk reduction programmes.

This research revealed responses towards HIV during crises by the faith community that have succeeded. These draw heavily on the human resources of local staff and networks of the local religious community. Regrettably, few churches have emergency preparedness plans or sustainable humanitarian funding and few collaborate routinely with humanitarian actors. Collaboration with other denominations is also limited, as is collaboration between international FBCs and local religious communities due to short-term funding.

FBCs provide many social services during crisis. Most respondents stressed their importance in HIV prevention and care, stressing that it was critical for religious leaders to be involved in HIV responses, given their authority. However, divergent messages lead to confusion, denial, and misconceptions about HIV, particularly in rural areas.

It is crucial that humanitarian stakeholders collaborate with FBCs by understanding their role in the community and their skills in leadership, influence and key services. In order to increase the effectiveness of interventions, humanitarian actors need to work with FBCs and help them reach their full potential in responding to HIV in humanitarian settings.

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In 2009, ODI, World Vision and Tearfund carried out a study on the role of Faith-based Communities (FBCs) in responding to HIV during emergencies. The study focused only on responses in the Christian community and consisted of a global literature review followed by field studies in Democratic Republic of Congo (DRC), South Sudan and Kenya. Informants included people affected by an emergency, People Living with HIV (PLHIV), humanitarian actors and members of FBCs. This document aims to give humanitarian actors a better understanding of the role of FBCs in responding to HIV in emergencies. Practical recommendations will be developed to help FBCs respond to HIV more effectively in humanitarian settings.

Written by Fiona Samuels, ODI Research Fellow, Rena Geibel, Consultant, and Fiona Perry, Global HIV advisor for emergencies, World Vision. For information, contact Fiona Samuels (f.samuels@odi.org.uk) or Fiona Perry (fiona_perry@wvi.org).