

# Grace & Light - Who we are



## Headlines

In Grace and Light we believe we have a distinctive contribution to make to the struggle against HIV and AIDS, and it is the aim of this introduction to show what this is. Before we glance at the movement's origins, we will try to set out some 'headlines', three aspects of our approach and one aim.

First, *our approach is Christian*. The original vision from which Grace and Light emerged was that of a theologian, Mark Hopkins. It came through thinking biblically about HIV and AIDS, independently of mainstream thought and practice. We believe that the HIV/AIDS pandemic is more than a medical emergency: it is also a spiritual and moral crisis. Indeed, we believe that the spiritual and moral issues go deeper than the medical ones, so that it is appropriate to start constructing a response with them. This may be unconventional, but we are convinced it is valid: as Christians, should we get anywhere with a subject before seeing how our faith may come into it? But we have gone on to dialogue with and learn from the mainstream, medically-centred approach to HIV/AIDS. In Grace and Light we believe that medical personnel and theologians both have expertise of different kinds, and each should listen to the other in developing a Christian approach.

Secondly, *our approach is church-centred and holistic*. We believe this follows from adopting a Christian approach. The church is God's new society, to be fully revealed as such when creation is renewed, but already bringing a totally new kind of life into the midst of fallen creation. Quite apart from pragmatic advantages such as the church already being there on the ground, there is the fundamental consideration that as Christians our new lives are lived first of all in the new family into which we are born again in Christ. Everything in Grace and Light – voluntary counselling and testing (VCT), prevention, care and support, education and changing attitudes to HIV and AIDS are our five main concerns – is handled either in or from the local church (for certain things such as medical treatment the church needs to turn to outside resources). This is why openness about HIV status is central to Grace and Light: integrated church-based HIV/AIDS ministry hasn't happened yet because it is only possible when people living with HIV are known as such in their churches.

Thirdly, *our approach is African*. We have mentioned the fact that both medical and theological expertise are needed, but in fact a third contribution is also vital, the socio-cultural. Africa is not the West, and, for example, the individualism that makes confidentiality such an important value there should not be transposed uncritically. Africa values community, and crises such as bereavement are faced communally. Thus to assume that it is in people's best interests to continue with a set up in which they have to face the bereavement-like experience of discovering they are HIV positive alone or virtually so is to say the least questionable. Though the original vision was that of an expatriate in only his second decade in Nigeria, Grace and Light is led by a Nigerian, Mrs Tassie Ghata, who brings to it long and varied experience in AIDS ministry as well as inside cultural knowledge; and she has shaped that initial vision from an early stage. The Board to which she is accountable is over 80% Nigerian too.

Fourthly, *our aim is to defeat the HIV/AIDS pandemic*. We do not think that we can do it on our own – indeed, we are particularly eager to work with others because we believe that such co-

operation will help in achieving the goal. But in Grace and Light we are not content to feel that we are simply doing something to help: we believe that when the church in all its denominations starts to wield effectively the weapons we will discuss shortly, on a large enough scale, the epidemic can be defeated. But that can only happen if we move as fast as possible across Nigeria and beyond. For the problem is that HIV/AIDS is a moving target – a swiftly moving target. We cannot defeat it unless we move even faster – any hesitation and it will leave us floundering still further behind in its wake. Anything that might slow us down will translate into losing more lives – by the thousands – and we consider that unethical. That includes taking time to perfect our methods before applying them widely (though we do evaluate and improve as we go along). So we try to maximise the impact of money entrusted to us, for example by working mainly with volunteers using the pre-existing infrastructure of local churches. We also prefer to help many people effectively rather than a few brilliantly.

Combining these four 'headlines', this is what we get: *Grace and Life aims to defeat the HIV/AIDS epidemic through helping local churches fight it holistically, in line with the biblical gospel and African culture.*

## **The Story So Far**

The vision for this interdenominational church-centred HIV/AIDS movement came on 13 March 2003. At the time Mark Hopkins was grieving over someone he had only recently accepted and known as a daughter, but whom he had loved fiercely with all his heart. Patience Chule had just died of AIDS, and the short time he spent with her changed Mark from being a spectator to a participant in the struggle with the HIV/AIDS epidemic. Three things had emerged clearly from their interaction, and together they are the key weapons in the Christian arsenal for this battle. The vision simply consisted of a way to combine and deploy them.

The first weapon is the gospel. Patience herself truly received Christ only when, very late on, she tested positive for HIV; she then told her husband Ayano to share the gospel with her family, and in the weeks after she died Mark joined him in so doing. Patience's death opened one person after another up to receive it. Mark understood then that, as well as being a terrible tragedy, AIDS could open doors for the gospel – in the pattern set by Jesus' death, God builds his greatest achievements on the worst this spoilt world can do.

The second weapon is openness. Patience and Mark discussed and agreed on it almost as soon as she knew her status. Mark instinctively knew that this was in line with the gospel, and all our later study and thinking has borne this out. In Christ we are to walk in the light, not the darkness – which is the natural environment of sin. God's grace wipes out all the sin of those who come to him for it – and Patience knew that applied to her too. The first plan was for her to go into the open when she recovered sufficiently to get into HIV/AIDS ministry, but when she saw another outcome looming she shifted openness to her funeral – so her AIDS became part of the message there.

The third weapon is love. Mark had made abounding in love more and more his prayer for 2003 after reading Philippians 1.9 on New Year's Day, and he came to understand that Patience was the beginning of God's answer. On their last day together they were finally both comfortable in that father-daughter love. The stronger the bond, the deeper the wound when those united by it are torn apart – and love too was a theme woven into all Mark said at the funeral. In God's grace it also became part of the vision for the new model for HIV/AIDS ministry embodied in Grace and Light.

From the moment the vision came, Mark felt compelled to act upon it – driven by the Holy Spirit. He developed it into a proposal for a pilot project, shared this with several people with relevant experience, modified it a bit, and then set about trying to implement it. One need was for counsellors, and it was this that brought him to Tassie Ghata's office at Spring of Life, Evangel

Hospital on April 9. She grasped the idea, volunteered on the spot, and recruited lab personnel to do the tests too.

With Mark, Tassie and Ayano working together, the new approach was tried out in five churches in May-June 2003. In their application in Grace and Light the three weapons become three commitments. Preaching the gospel is an important emphasis in the first meeting in each church. While challenging people to faith in Christ we make it clear that accepting it is a condition for joining Grace and Light. We will give VCT to any who are willing, but ours is a Christian approach to HIV and AIDS, and only Christians are in a position to take it – in the power of the Spirit, in the new life shared with Jesus. The second commitment is the one that is truly new, and challenging: in joining Grace and Light people agree that the results of their tests will be out in the open from the start. Testing on what we call the second track is confidential, but all who test in order to join Grace and Light share their results, and that is only the start of an immediate commitment to radical openness. We would not ask this of anyone were it not accompanied by a third commitment: all who join Grace and Light agree in advance to support and care for each other in Christian love, living with or without HIV, especially by meeting together in small groups on a weekly basis to be accountable for their lives. This is also innovative, and perhaps even more significant: it makes the second commitment possible, and contributes at least as much as the other two commitments to the potential Grace and Light has to transform in turn individual lives, churches, society and the course of the epidemic.

The pilot project showed us that the idea could work: some 250 people, an average of about 50 per church, joined Grace and Light initially, and about 80 more did so when we held a new testing session after three months. What is more, the branches of Grace and Light have continued to function, and small groups have continued to meet, ever since. We have evaluated the pilot project and found areas of weakness which we are addressing, though the overall verdict was overwhelmingly positive.

Always mindful of the fact that time is not on our side, we have moved on, beginning to work toward making Grace and Light a national movement. We have so far trained five teams of volunteers, working in four states, and these have all begun to move into new churches. We have also trained leaders who are assembling volunteer teams in five more cities; once these are trained and operational, we will be at work in eight states. We aim to have up to twenty members per team, covering at least eleven responsibilities between them – leading, mobilising (taking Grace and Light into churches), speaking, counselling, testing, home based care, accountability group support, education, advocacy (problem solving and publicity), accounting and record keeping. Our intention is that these teams be multi-denominational and take maximum advantage of previous training and experience for each role. In the case of care and accountability, the main emphasis will be on our volunteers training members in each new local church branch. Our aim is to develop and expand the volunteer training programme, as this is the central thrust of our effort to combat the HIV/AIDS epidemic.

In parallel with this we have proceeded with organisational development. We have put together a Board of Directors, recruited trustees, adopted a constitution and are in the process of registering with the Corporate Affairs Commission as an NGO. We have five full-time staff so far, and have rented offices from the Great Commission Movement off the Bauchi Ring Road in Jos. Under Tassie's leadership they are moving ahead on various fronts: training volunteers, acquiring test kits and anti-retroviral drugs, equipping the office, and producing a brochure amongst others, as well of course as sustaining and increasing our work in churches.

## **Our Methods**

We launch Grace and Light in local churches through a series of introductory meetings. As this sequence is crucial to us, we keep it under constant review.

The first meeting, called the vision meeting, takes place on a Sunday morning so that we can speak to the entire congregation. The main focus is on preaching the gospel and introducing our other principles of openness and love, but we precede this with some basic HIV and AIDS awareness, and close by explaining our programme and showing people why they should join us.

At the vision meeting people are encouraged to sign up for testing. That takes place at the second or commitment meeting. There we give both group and individual pre-test counselling. A special concern in the individual counselling is to make sure that everyone has properly understood the three commitments (to Christ, openness on HIV status and support group membership) and makes an informed decision on whether to join Grace and Light or test on the second, confidential track. The tests are carried out during the commitment meeting by volunteer Christian lab personnel on the church premises. Our early practice was to bring results to another meeting, the openness meeting, up to a week or so later, but we are trying out combining these two in a single meeting. When that is done, only those who test within Grace and Light stay on to the part of the meeting at which the results are shared, while others who tested get their individual post-test counselling elsewhere. At the openness meeting all who test positive get individual post-test counselling, and are also able to choose 'pairs' – people who test negative who will be their first resource persons, even accompanying them home from the meeting – and representatives on the committee that will look after Grace and Light in that church. Meanwhile, before praying and choosing other committee members, those who test negative receive joint post-test counselling where possible followed up by brief individual counselling, mainly to check people's continuing risk of infection and need for further testing. The last thing in the openness meeting is a word of encouragement, for which all members are together again – the way they will be from then on.

The final meeting of the opening sequence, the support meeting, sets the remaining elements of the support system in place and trains members how to function within it. They are put in small groups with people of their own gender and, wherever possible, marital status and age too. There they are accountable to each other weekly, first of all for their sexuality but for all other aspects of their lives too – we hope that these groups will fuel revival in the churches in the same way as John Wesley's band meetings did in eighteenth century England. Grace and Light has a particular focus on conquering the HIV/AIDS pandemic, but it also has a wider goal – "to see the transforming grace and power of the gospel of Christ spread through Africa" as our vision statement puts it.

## **Some Issues**

Here our aim is to address a number of points that we have seen to be sensitive, and thereby lay a foundation for better understanding and further interaction with others involved in HIV/AIDS ministry.

## **Co-operation**

We have already said that we are interested in working alongside others rather than try to take on HIV/AIDS single-handed. That means principally that we want to co-operate with others in all that we do, and we will soon go into explaining that, but it also means that we leave certain things entirely to others – something we will say a word about first. Our focus is on Christians, whereas HIV spares no section of the community – that means that Muslims, traditionalists and even nominal Christians will be left in other hands (though we hope these may benefit indirectly through the overall societal impact we are aiming for, and perhaps too by learning from our methods). Secondly, our approach is church-centred, which means that we will not get involved in other valid approaches, e.g. school- and community-based ones.

To get back to co-operation proper, a model we are finding useful in explaining how we see our relationship with churches developing is that established by the Boys' and Girls' Brigades. Obviously their focus is different, but the way in which we and they operate has many parallels, and it may be useful to discuss it since they are widely known and accepted organisations. Firstly, they are focused on particular aspects of the life of a local church – so are we. Secondly, like them we are interdenominational. Our chairman and five initial staff come from five different denominations, and our volunteers and Board members come from many more – between us we cover a very broad spectrum. We do not exclude any Christian denomination on principle; rather, we include a basic understanding of the gospel in our doctrinal basis so that any who do not share it can see that they will not be able to work with us. In it two points are paramount: that salvation is by God's grace, given to us by him as all our sins are wiped away from our account; and that salvation is through sharing in Jesus' cross in order to share in his resurrection too. The first of these points sweeps away the basis for stigmatisation, while the second rejects the denial of any place for ill-health and suffering that can be found in the prosperity gospel.

A third parallel with the Boys' and Girls' Brigades is that we, like they, aim to be a sub-group within local churches, run by and for their members, and yet at the same time a wider organisation with norms that all branches will adhere to and resources upon which all branches can draw. This model also means that the potential cohesion, strength and impact on HIV and AIDS is far greater than if each local church or denomination were operating independently. We believe strongly that such co-operation will achieve far greater results and is in the interests of the wider church – and we believe that many denominations and local churches will see that too.

This means that we are interested in partnering denominations at every level. The local church is obviously vital, since it is there that the real work is done. But the central denominational level is also very important, and intermediate levels have their place too. We talk with ministers and their leadership teams in local churches (and only enter them with their active support), along with any person or committee with a responsibility for HIV/AIDS, where such has been put in place; centrally we hope to interact with both main denominational leadership and HIV/AIDS specialists.

Denominations apart, we will network with other Christian agencies involved in HIV/AIDS ministry wherever we go. At this stage at any rate, we are focussing on our core programme of integrating VCT, care and support, prevention, education and attitudinal change within local churches, and are looking to develop partnerships with organisations offering medical facilities or services to people living with HIV and AIDS that we do not offer.

Thirdly, we intend to continue to dialogue with others in HIV/AIDS ministry in the hope that we will learn together by pooling our insights and experience. Early in 2004 we organised and hosted a forum for this purpose, as a result of which we introduced changes in our methods – and we believe that others can learn from us as we continue to learn from them.

## **Urgency and Quality/Quantity**

This issue came up briefly in our fourth headline. Because the HIV/AIDS epidemic is a huge and rapidly worsening crisis we see the need to act fast, and we believe that our urgency is in keeping with established medical emergency practice. From lifting speed limits and other rules of the road for ambulances in emergencies (through intelligent assessment of relative risks), to paramedics treating conditions in the community that would otherwise be treated by doctors in hospitals (setting up drips on the streets!), to triage in major emergencies, the medical community recognises the principle of making compromises where the overall cost/benefit analysis points to a need. But HIV/AIDS is an emergency on such a huge scale that it is an immense challenge to do this consistently.

Let us take one example, HIV testing. Taking people to existing VCT centres adds transport costs and time investment, and these can lead to a reduction in the number of people who are tested, particularly in remote areas. Setting up, equipping and manning additional centres would help get more people tested. But for the cost of operating one such centre for a year, we could train many teams of volunteers who will go on operating at negligible cost for many years, any one of which will have a wider reach than a fixed centre. The centre might be able to address other STDs as well as HIV, with superior equipment in better conditions. But the volunteers would do much more than VCT (they would pursue our holistic, ongoing church-based attack on HIV/AIDS), and the number of people they could reach would be far greater. What should we do? The answer to us seems obvious, so long as a huge gap remains between the resources available and the amount that needs to be done (a situation unlikely to change in any foreseeable future, especially when the importance of inevitably costly anti-retroviral drug treatment is factored in). To accept the less than ideal testing environment of church vestries is more than worthwhile to enable us to test and further help far greater numbers. The ambulances need to get there on time.

This urgency principle doesn't mean that speed is an absolute. Our constitutional aim on establishing church branches includes the phrase "to do so as fast as is consistent with doing it well". We want to ensure that the quality of the people we train, and the quality of the training and ongoing supervision and resources we give them, means that the good they do far outweighs the negative impact of the mistakes and failures that can never be entirely avoided.

## **Radical Openness**

The radical openness about HIV status we require of members from the start has been the point on which we have been challenged most – to a large extent because it has not been well understood. It is not what some have supposed. We do not make any public announcement that a member has tested positive – the only announcement is in the restricted setting of a meeting of fellow Grace and Light members, people committed to supporting those of their number living with HIV and AIDS. Our members living openly with HIV and AIDS (MLOWHA) are then responsible for sharing their status with people close to them (not every passing acquaintance). In this they receive help and take the time they need – and meanwhile other members do not do the job for them. The end result is not that the whole world knows our members' status, but that no one mustn't know, and the fact that anyone does know it isn't a problem to our MLOWHA. Whether our members go on to testify about their status in a public setting is entirely up to them (we would only expect this in the case of volunteers).

Radical openness does increase the already considerable stress of receiving a positive result to the test, and to Western culture in particular this can look like overburdening people. We respond to this with a number of arguments on different levels, which to us are cumulatively compelling. On the basic level of assessing the difficulties faced by people who test positive, we say that the mainstream (Western derived) approach saddles people with a different additional burden, one that we spare them, that of having to handle the shock of a positive result on their own, or very nearly so, rather than in the supportive environment in which Africans expect to meet such challenges. We believe that in the long run this continuing burden will usually do much greater damage than the comparatively brief shock of opening up. Hearing that you are HIV positive is a kind of bereavement. The massive rallying round that takes place in bereavement makes a huge difference to people – without that comfort bereavement is terrible. The culture of stigmatisation would deny that comfort to people infected with HIV, but in Grace and Light we create a supportive environment, one also capable of helping our MLOWHA counter the stigma. Confidentiality on the other hand definitely lands people in under-supported or even virtually unsupported bereavement.\*

That argument has of course two sides to it, and some people in especially difficult circumstances will do better with the mainstream approach rather than ours (something that may well emerge in pre-test counselling if not before). Our principles go deeper. We have two big arguments. One is that since openness is a major key to getting on top of the epidemic (this is widely accepted), then the more radical and faster the openness, the sooner we are likely to have an impact on infection rates. There are two main mechanisms at work here. One is that increasing the visibility of HIV/AIDS increases people's readiness to take precautions against infection. This is a reason why people in eastern and southern Africa are starting to factor HIV and AIDS into their thinking more than people in West Africa, where the epidemic hasn't yet achieved such visible impact. Since HIV takes years to produce obvious symptoms, visibility is at least five years behind the reality of infection – unless we can put as much symptom-free HIV into the open as possible.

The second mechanism is that there will be massive benefits from overcoming the stigma/shame syndrome on HIV and AIDS, which, alongside immorality, is one of the great forces fuelling the spread of the epidemic. We believe the best and quickest way to overcome it is to confront it directly. We have already seen enough to sense that in doing so we will find that the stigma isn't as powerful as we fear, and can be brought down with our spiritual weapons.

The second big argument is that only radical openness can unite all arms of HIV and AIDS ministry into a seamless holistic strategy centred in the local church, something we believe to be a tremendous step forward. In conventional approaches there has been a gap between education and awareness on the one hand, and care and support on the other. In Nigeria the latter are rarely found in the local church, hardly at all before people are in full-blown AIDS, and even then usually within limitations set by a continuing framework of confidentiality. Between awareness and care lies VCT, the third point at which people interact with others over HIV. Almost all people who test positive (again, this will not normally be in the local church) immediately go under cover, a cover from which most do not properly emerge even in dying. Only in the approach adopted by Grace and Light can VCT, prevention, care and support, education and attitudinal change (attacking stigma) all be fully integrated in the local church.

This integration is only possible because we do not allow space for any disappearing under cover after testing positive – radical openness is the crucial link holding the chain together. Others who emerge from cover some time after knowing they have HIV are able to access the care and support we offer in Grace and Light, but the fact remains that the safety net we hold out to them is held together by radical openness.

Deepest of all is our conviction that our approach is built on the gospel rather than on an attempted 'christianising' of the secular approach of the modern West. HIV/AIDS would be nowhere but for what we have no bones about calling immorality or sin, and denouncing as such. However, Jesus and his gospel handle such sin not by pharisaic stigmatisation but with a message of full forgiveness, restoration and hope. We insist upon grace: since God holds nothing against any believer in Christ, how can we do so? We encourage people to stand without shame, because shame dies with the person who shared Christ's death and has no place in the new person who shares Christ's resurrection.

There is no longer any reason for the person concerned to deny, cover up or justify that past, nor for others to accuse or excuse it according to taste. It is finished. Even the continuation of the past into the present is treated in the same fashion, as we will do all we can to help members of ours who fall into fornication or adultery get back onto their feet rather than condemn and reject them. Christ calls us out of the world's darkness into his light. In addition to that, we show how the gospel leads into a new kind of life, a shared life, one with Christ, one with each other, in which the bond is love – real love, that is love that expresses itself in practical ways such as caring for the sick.

## Conclusion

There we have reached the heart of Grace and Light – our deepest wish, greater even than our passion to conquer HIV/AIDS, is to be a revival movement helping the church become again what it started out as, a new community set free by the gospel to live in the light and love of God.

*\* It should be well understood that we do not breach the principle of confidentiality, defined as “the ethical and/or legal duty of the health care professional, and other professionals such as lawyers and social service providers, not to disclose to anyone else, without authorization, information that was given to, or obtained by the professional in the context of his/her professional relationship with a client.” (Opening up the HIV/AIDS Epidemic, UNAIDS, November 2000, p. 30; emphasis ours). The same source goes on to add: “In the context of HIV/AIDS confidentiality applies to a person’s HIV/AIDS status and requires that health authorities should seek the consent of the person infected for the disclosure of his/her HIV/AIDS status to others.” Radical openness in GLI is always freely consented to by members, a consent we make sure of through individual pre-test counselling. It should also be emphasised that all our individual counselling is confidential; the only thing that is not confidential is the test result of people who become members of Grace and Light.*