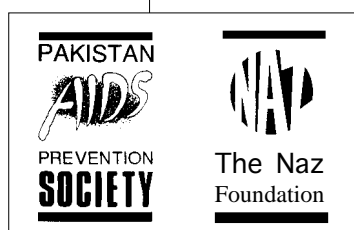


Developing Appropriate Strategies

Consultation Meeting Of Representatives From
Non-Governmental Organisations Working On HIV/AIDS
Prevention And Care Issues Within Muslim Communities

26th-29th October 1995, Karachi, Pakistan

Final Report



Meeting co-organised by the Pakistan AIDS Prevention Society and The Naz Foundation

Sponsored by the WHO - Global Programme on AIDS

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The consultation meeting was organised to explore the specific needs of people living within Muslim countries and communities for accessible and appropriate HIV/AIDS prevention and care services, where Islamic values and beliefs play a strong cultural and social role and exert a considerable influence upon the nature and content of these services.

Representatives from non-governmental organisations working in the field of HIV/AIDS prevention and care in a range of Muslim countries and communities participated in a series of working groups to discuss and evaluate the personal, psycho-social, medical, political and religious impact of HIV/AIDS and the education, prevention, support and care services available within their countries/communities

Participants discussed the suitability and applicability of current HIV/AIDS programmes and services and the impact of cultural and religious values within Muslim countries and communities affecting such services. Issues explored included such of good practice, provision of appropriate HIV/AIDS education and prevention, behaviours leading to possible HIV/STD transmission, empowering communities to develop community-based AIDS service organisations and provision of appropriate care and support for people living with HIV/AIDS.

Identifying gaps and shortcomings in current service provision and exchanging visions of ideal standards and religious values, the participants developed a series of recommendations on good practice, appropriate education, prevention, treatment and care. These recommendations will guide government and non-governmental agencies in developing policies and practices in these areas.

Introduction

- Developing Appropriate Strategies** ■ A Consultation Meeting Of Representatives From Non-governmental Organisations Working On HIV/AIDS Prevention And Care Issues Within Muslim Countries and Communities, Karachi, Pakistan, 26th-29th October, 1995, was organised by the Naz Project and the Pakistan AIDS Prevention Society. The Consultation Meeting was sponsored by the Global AIDS Programme, World Health Organisation.
- Organisers** ■ Mr Shivananda Khan of the Naz Project and Mr Shouket Ali of the Pakistan AIDS Prevention Society formed the organising team for the consultation. Opening presentations were made by Mr Khan and Mr Ali as well as Dr Sharaf Ali Shah, Director of the AIDS Control Programme of the Government of Sindh, Pakistan. Closing remarks were made by Mr Khan, Mr Ali, Dr Sharaf Ali Shah, Dr. Birjees Masher Kazim, Programme Manager, National AIDS Control Programme of Pakistan, and the Chief Justice of Pakistan, His Excellency Sarjad Ali Shah.
- Participants** ■ 47 participants from Azerbaijan, Bangladesh, Egypt, Ethiopia, India, Indonesia, Malaysia, Morocco, Pakistan, Sudan, Tunisia, Turkey, as well as from Muslim communities in Canada, Germany, Norway, UK and USA, took part. They were selected in their capacity of working for community-based non-governmental HIV/AIDS organisations in providing education, prevention and/or support and care and with a view of including a broad representation from a range of Muslim countries and communities.
- Process** ■ The number of people affected by HIV and AIDS is increasing in many Muslim countries. Recognising that the political, social, cultural and religious frameworks of these countries create specific issues in developing appropriate education, prevention and support services, the aim of the meeting was to bring together representatives from non-governmental community-based AIDS service organisations working in a number of Muslim countries and communities in a consultative process. During the process, Muslim religious values and beliefs, psycho-social and cultural frameworks, personal behaviours that could lead to HIV transmission, medical practices, and human rights within a Muslim context, were identified and explored. Further, participants looked at a range of strategies to halt the spread of HIV within Muslim countries and communities, as well as ensuring that appropriate treatment and care were available for people living with HIV/AIDS, developing a series of guidelines and recommendations for implementation.

Women’s Reproductive and Sexual Health

Working definition	Participants developed a working definition of women’s reproductive and sexual health stating that concepts of reproductive health must include the following issues: family planning; maternal health, including anti-natal and post-natal health care; sex practices and behaviours; infertility; appropriate treatments and counselling for STDs/HIV/AIDS; breast feeding and implications for mothers with HIV; nutrition and socio-economic conditions; inequality and empowerment of women to take control of their own bodies and health. Participants went on to state that sexual health should include the physical, emotional, and mental health of the person. In a Muslim context, reproductive health would include sexual health.
Custom and culture	Traditional customs and cultural practices can often lead to sexual and other behaviours that may be different from Islamic teachings and these practices may have a significant role to play in a HIV epidemic, while having a more powerful impact upon women’s reproductive and sexual health than religious values. These practices often have no Islamic sanction, but are often given religious validity by patriarchal power structures and cultural beliefs. Further, men have often used religiously framed sanctions without any real Islamic basis, to disempower women .
Islam and social reality	Islam teaches the equality of women and men, and acknowledges women as sexual beings in their own right. However, the social reality for women is different. It is often one of disempowerment, abuse and marginalisation, where women are not in a position to address their own reproductive and sexual health. From the time of her birth, the female child is usually less favoured than the male, with resultant impact on their general health and education levels, whilst in some Muslim countries, female “circumcision” is used as a method of controlling female sexuality. Such attitudes have easily led to male sexual practices and behaviours that increases the vulnerability of women. It was also noted that in several societies, women who have been raped have been deemed to be adulterous according to Shari’a law, because witnesses could not be found to verify the rape.
Marriage	Marriages are arranged, and very often girls are not consulted. Too often the wife-to-be is a very young girl, or adolescent, physically and psychologically immature, with a significant difference in age between her and her future husband. Such an early marriage for a girl can lead to major psychological and physical difficulties, particularly in terms of sexual intercourse and pregnancy.
Female virginity	It is a religious expectation that both partners will enter into marriage as virgins. With the honour of a family bound up with the female’s virginity, it is a woman’s sexuality and its expression that is controlled. For women to break the virginity code is to bring shame on the family and potential loss of honour. Such attitudes have resulted in the honour killings of women.
Male virginity	For men it can be different, which has led to levels of pre-marital and extra-marital sex which can be socially sanctioned and excused, even though it is against the Muslim ideal. Further, because of increasing delays in the age of marriage of men for economic reasons, many unmarried males access sex either through sex workers or amongst themselves.
Divorce	Issues of polygamy, the possibilities of remarriage of women because of divorce or the death of the husband, and <i>Mut’a</i> (temporary) marriages were also raised as issues of concern in the context of HIV/AIDS, where cultural practices will often conflict with religious ideals and so increase the possibilities of STD/HIV transmission. There were concerns regarding the right to divorce if a spouse was HIV positive or living with AIDS. It was felt that this right was exercised more by men than by women. Too often divorce penalises the women substantially, and she is blamed for any breakdown of her marriage further stigmatising and victimising her. <i>Mut’a</i> marriages can carry risks for the sexual transmission of HIV, because of the frequency of such temporary “marriage” partners. For many women, the ability to negotiate safer sex with their husbands, temporary or otherwise, does not exist.

Male sexual behaviours

Participants also explored male sexual attitudes and behaviours, including pre-marital sex, extra-marital sex, and male to male sex and their potential impact upon women's reproductive and sexual health. It was accepted by participants that in all Muslim countries these behaviours existed to some extent. With very little, if any at all accurate education on STDs/HIV, the awareness of risks is very low. This places women in a very vulnerable position. At the same time women and men have a tremendous lack of knowledge about their own, and each other's bodies, sexualities, HIV, STDs and AIDS. This can have a dramatic impact upon sexual practices and behaviours and increases the risk of transmission of HIV/STDs. This is further complicated with sex and sexual behaviours being taboo subjects, where there is almost no discussion on these issues. Too often women do not have access to appropriate terminology, and many sexual terms are abusive and sexist. Formal terms tend to be Western imports and are not easily translated into local equivalents. Meanings and contexts may then be confused and misunderstood.

Knowledge of the Holy Qu'ran

There was a major concern that many women have no knowledge of what the Holy Qu'ran has to specifically say about these issues. Too often religious and community leaders make statements based on cultural taboos and traditional customs, rather than on Islamic teachings. It was understood that the Holy Qu'ran does speak of both reproductive health and the wife's right for sexual pleasure with her husband, and these were seen in the context of both an individual's and the community's physical, mental and social health.

Male Reproductive and Sexual Health

Definition	Participants discussed male sexual behaviours in Muslim countries which led to a debate on the definition of a Muslim. The discussion indicated that there was a general lack of awareness about Islam and what the Holy Qu’ran states. It was also felt that many religious teachers do not know enough about the Qu’ran and the various schools of thought and interpretation.
Religion and culture	It was also acknowledged that within Muslim countries sexual behaviours such as pre-marital, extra-marital sex, as well as men who have sex with men, existed to some extent. This led to a debate on the differences between religion and culture. While Islam promotes the Muslim ideal, sometimes social and cultural practices indicate other behaviours.
Behaviour versus identity	Further, different cultures will have different frameworks of self identity. In Muslim countries, identity is not framed by a sense of individuality, but rather that of community. This has an affect on language and the understanding of words, particularly Western words. The terms heterosexual and homosexual would have different constructions and meanings for the cultures in Muslim countries. It was therefore important to separate behaviour from identity, not so much who a person is, but what they do. Promoting reproductive and sexual health in this context would therefore mean dealing with behaviours where the social constructions of sexual behaviours in these countries could potentially lead to very risky sexual practices. Such constructions would include issues of marriage as a community duty, arranged marriages, procreation as a duty, and personal identity subsumed as part of a family and community identity.
Public versus private	Participants also agreed that in all Muslim countries and communities, there will always be men who may call themselves Muslims in public, but whose private practices may well differ from the Muslim ideal. These practices may well include risky behaviours leading to possible HIV transmission. By only following a HIV/AIDS prevention strategy that demands obedience to the Qu’ran, may well lead to such issues not being effectively addressed, and result in increasing rates of STD/HIV transmission.
Knowledge of the body	Many men have insufficient knowledge of either their own or the female body, their functioning and development. A great number of myths and traditional beliefs exist about the body which need to be effectively addressed through education for the promotion of male reproductive and sexual health. There is very little sex education which can lead to inappropriate and sometimes risky sexual practices.
Poverty	Poverty, social inequality and lack of empowerment were also of major concern. General health will be poor, and access to medical and social care may be very difficult. Poverty may generate behaviours that lead to increased risks, such as commercial sex work, drug use, lack of sexual hygiene, nutrition and diet, which all affect reproductive and sexual health. Furthermore economic conditions delay marriages and this delay may increase the risks and demands for pre-marital sex.
The Shari’a as a deterrent	Addressing the reproductive and sexual health needs of people who practice sex outside of marriage was debated. In societies where the framework of shame is predominant, where discussions of sex is taboo, where the Muslim ideal of sex only within marriage is promoted, such behaviours will always be hidden and difficult to access. Using the Shari’a as a deterrent strategy was discussed but participants also felt that while this may work for some, for others, it would only drive these behaviours further underground. Punishment and deterrence were felt to be a partial solution and would not eradicate such behaviours totally. Participants felt that what was needed was the development of perhaps a more pragmatic approach towards STD/HIV/AIDS education and prevention. This was defined by having two on-going strategies, one with public campaigns that promoted the Muslim ideal on sexual and other behaviours, the other a “discrete” prevention strategy that addressed the actual behaviours being practised by some men.

Intravenous Drug Use

- Injecting drug use and poverty** ■ Participants recognised that illegal drug use does exist in a range of Muslim countries where this could be prevalent because of the easy availability of drugs. At the same time injecting drugs is increasing. Syringes are being shared amongst several people without being cleaned. This increases the risks for HIV transmission through unclean syringes and needles. Poverty, unemployment and the easy availability of drugs were all factors leading to this increase use. It was also felt that general “frustration” of young people could cause them to turn to drugs.
- Rehabilitation programmes** ■ Rehabilitation programmes exist to some extent but too often they treat drug use only as a medical or criminal condition. In many cases, imprisonment, lashings, and sometimes death have been used as deterrents. Participants felt that this approach did not address the issues effectively nor did it work in reducing the levels of drug use.
- Abstinence** ■ Drug use has psycho-social dynamics which are not often taken into account and education about drug use was seen as very poor and ineffective. Abstinence as a strategy through religious and legal sanctions and punishment with compulsory de-toxification programmes, whilst it may work for some, does not work for all, and therefore harm minimisation could also be used as a complimentary strategy. This would also mean the provision of more effective education around safer injecting techniques, access to sterilisation of syringes and needles, access to clean needles through needle exchanges, and so on. These two strategies should be seen as complimentary approaches towards reducing drug use as well as preventing the spread of HIV infection.
- Strategic approach** ■ There needs to be a more coherent and strategic approach to drug use and rehabilitation programmes. There were discussions around the provision of employment for ex- drug users, vocational training, and access to education and effective after-care programmes. Issues around human rights abuse, discrimination, isolation and rejection from family and community also need to be effectively addressed.
- Religious leaders** ■ Religious leaders, families and communities should also be provided with education and awareness, whilst treatment and care should be seen as a family issue as much as the individual drug user’s issue.

Young People

- Definition** ■ Participants discussed the definition of “young people” within cultural contexts. It is important to understand and contextualise definitions and meaning within the appropriate cultures so that relevant models of education and prevention can be developed following on from custom and tradition as much as religious values.
- Adolescent life education** ■ Concerns were expressed that young people have little knowledge about their own bodies, the impact of puberty and sexual behaviours. Too often they accept myths from peers as much as from adults which can have drastic effects on their mental, physical and sexual health. There is no provision for adolescent life education. There is also a lack of appropriate knowledge about religious teachings in terms of the rights and duties of young people with regard to marriage, sexual behaviours and social responsibilities. At the same time young people exist in many different social spaces, including schools, colleges, working environments, and streets. They also exist in different living environments, rural or urban, and in different economic groups. It is important to address all these social spaces with appropriate education.
- Poverty and young people** ■ With growing economic changes in a number of countries, the increasing urbanisation, migration from rural areas to towns and cities, high unemployment, poverty, and very often poor education, many young people, with the need to support their families and themselves, are easy prey to victimisation and abuse through employment and/or sexual exploitation. It should also be acknowledged that sexual abuse and child prostitution occur, and that child labour can be symptomatic of a social attitude that sees children and young people as objects of labour to be used.
- Decision making** ■ Young people are also marginalised in decision making about their own future. Sex education, empowerment, better social conditions, educational and employment opportunities all needed to be addressed together with young people

Medical Systems and HIV Antibody Testing

- Lack of knowledge** ■ There is a marked lack of basic knowledge about STDs, HIV/AIDS, sexualities and sexual health issues within the medical professions, including hospital doctors, general practitioners, and nursing staff. This ignorance has led to the fear of and the stigmatisation of, not only those infected with STDs/HIV or those living with AIDS, but also those who may be attending a clinic for testing for STDs/HIV. Because of this, many of those who need such services are denied them, or will not access them.
- Medical facilities** ■ Medical facilities are often very poor, inadequate, and unhygienic, and can themselves create conditions for the spread of HIV. These include testing sites, blood banks, general injection procedures, surgical wards, operating theatres and so on. There is a lack of facilities for the diagnosis of HIV/AIDS, leading to possibilities of misdiagnosis and under-reporting of cases.
- Blood donors** ■ The promotion of voluntary blood donations is inadequate while many blood banks have poor facilities for hygiene and sterilisation of equipment, leading to increased risks for transmission of HIV amongst blood donors as well as blood recipients. Testing of blood donations, either voluntary or commercial, is often poor, if existent at all. In some regions, paid blood donors provide a significant amount of the blood supply available and because of economic conditions, paid blood donors are often at risk from the very system which pays them. Donors may also be practising other risky behaviours which could lead to HIV infection. Blood supplies can also be surrounded by levels of corruption where blood banks may be able to obtain their clearance certificates without having to ensure their facilities are appropriate or adequate. There are also significant issues around possible HIV transmission regarding organ transplants and donations of semen and ovum because of lack of screening.
- Ethics of drug trials** ■ In poor countries, experimental drugs and vaccine trials may have inadequate protocols. The ethics of various trials may also be questioned. Sometimes drug companies wish to test a range of products in poor countries which will not be accessible to people in these countries because of the final costs. At the same time, “quacks” and some traditional healers have given the impression that AIDS is a curable disease. This can encourage high risk behaviours.
- Training** ■ Very little training is given towards developing appropriate counselling for people affected by HIV/AIDS, or living with HIV/AIDS. Pre-test and post-test counselling facilities are often not available and where counselling is offered there is often inadequate training provided for the counsellors. In addition, confidentiality as a right is often abused. As new forms of testing for HIV are being developed, including saliva and urine tests, the rapidity of results and the ease of such tests can lead to indiscriminate use with inadequate safeguards and counselling.
- Human rights** ■ The apparent conflict between individual rights and community rights with regard to HIV/AIDS and the issues of confidentiality needs to be urgently addressed in a balanced and just way. Human rights should be seen within this context.

Family

- Religious education** ■ Effective religious education, it appeared, is not being given to families. Too often traditions and customs were sanctified by local religious leaders without verification from the Holy Qu’ran. Issues around multiple wives, divorce, parental arguments, domestic violence and gender inequalities all have a detrimental impact on the family stability, creating an acrimonious environment which will affect the children. Family counselling is not available. Such issues need to be addressed appropriately as part of a broader educational framework.
- Parenting skills** ■ Further, many parents lacked good parenting skills, and with the added shame surrounding sex and sexual behaviours, find it extremely difficult to communicate these issues to their children. Because of the lack of sex education, and the reluctance or inability to discuss taboo subjects, husbands and wives are often ignorant of each other’s bodies and of sex, and are unable to pass accurate information onto their children.
- Economic conditions** ■ Economic conditions can also lead parents to placing their young children in employment to increase the family income. This means that many children do not have access to education or proper care. In other situations both parents may be working, and children have to fend for themselves during the working day with a lack of proper attention and supervision.
- Living with HIV/AIDS** ■ In the context of a member or members of a family living with HIV/AIDS, other family members may not have the skills or support to cope. Issues around finance, grief, the funeral, death of a child, or death of a parent or parents need to be addressed. Because of their fear and shame some families won’t accept an individual member who is HIV infected or living with AIDS . The individual person may be rejected and thrown out of the family home, and sometimes even physically abused. Also because of the fear that AIDS may generate in local communities, families and individual members of families affected by HIV/AIDS may become isolated and victimised by local people. Communities are not educated about HIV/AIDS and may believe myths about HIV/AIDS. Such stigmatisation and victimisation adds to the considerable burden that families have to bear in such situations.
- Definition of a family** ■ Participants considered that the definition of “family” should perhaps be more fluid and include nuclear structured families of two parents and children, joint and extended families, as well as non-traditional families such as single parents, where one spouse has divorced the other or has died.

Human Rights, Ethics and Law.

- Rights and obligations** ■ Participants debated the rights and obligations of the individual, constitutional law and religious guidelines, and community rights, in regard to human rights.
- Religious and political contexts** ■ The debate has major political and historical contexts in that for many Muslim countries, human rights have been seen as a means to undermine Islam. This creates specific difficulties with issues of individual behaviour and morality which is sometimes seen as conflicting with Muslim ideals and codes of behaviour. Islam's rules and obligations are based on sustaining the community with individual choice and behaviour subsumed within that community.
- Shame and HIV/AIDS** ■ In Muslim countries, shame plays a major role in constraining behaviours. Because of the type of publicity AIDS has had, the whole arena of HIV/AIDS is surrounded by shame and fear which has led to a lack of confidentiality and substantial human rights abuses, such as unnecessary isolation, imprisonment, loss of or denial of employment, loss of housing, insurance and denial of access to medical treatment. Furthermore people living with HIV/AIDS have often been denied treatment because of this fear and shame. Such fear has also generated calls for mandatory testing of those defined as "high risk groups", even though it has been shown in countless studies that mandatory testing is not justified medically, socially or economically, and is an abuse of human rights. These issues must be addressed through education and awareness, and where necessary through legal approaches, if we are to ensure that people affected/infected with HIV/AIDS or living with AIDS are supported.
- Individual versus community** ■ While there was an apparent conflict between the rights of the community for protection against HIV infection and the rights of the individual in the context of confidentiality, participants felt that these two frameworks needed to be seen in a complimentary context, particularly because so much shame and fear was attached to the issues of HIV/AIDS.

Living with HIV/AIDS

- Stigmatisation** ■ Many people living with HIV/AIDS are stigmatised and isolated unable to access medical treatment and good quality care. Apart from the costs of treatment which are often beyond the ability of many people to pay, attitudes amongst clinicians and other medical staff can be condemnatory and fearful. Confidentiality is often not maintained, which can lead to public ostracism for the person.
- Families** ■ Families of those infected with HIV or living with AIDS can often further marginalise them because of their own fears, sense of shame, or the attitude of the neighbourhood, and may not accept a member living with HIV/AIDS. Where families do care and try to provide a compassionate and caring environment, very often there are no support structures for them to do so.
- Counselling** ■ Very little counselling or support is available for people living with HIV/AIDS, or for their families and friends. Care and support systems need to be developed. Issues around death and dying, grief and bereavement, child care, adoption, financial support, access to medical care, funeral arrangements and so on need to be appropriately and adequately addressed. If it is a parent, or parents, living with HIV/AIDS, they will have concerns about the future of their children. Issues of institutional homes, adoption, other family members taking care of the children, financial support, education of the children, and so on, will also need to be addressed.
- Support groups** ■ Because HIV/AIDS is still often seen as a medical issue only, the psychological and social dimensions are often ignored leaving individuals treated as a medical condition and not as human beings. One of the consequences is that people living with HIV/AIDS are isolated where there is a need to meet others also living with or affected by HIV/AIDS for mutual empowerment and building self-esteem. This coming together enables HIV/AIDS affected people to share information, explore models of developing care, find out about the latest treatments, and develop networks for mutual support. Encouraging the development of mutual support systems and self help groups can offer people living with HIV/AIDS an enabling environment and develop a sense that they are cared about as individuals and families.
- Care systems** ■ Further, with the numbers of people living with AIDS increasing rapidly in many countries, medical care systems will become increasingly overwhelmed. This will mean that many people will die from AIDS at home or on the streets. Home and community care systems are lacking in this area of services.
- Human rights** ■ Human rights abuses for people living with HIV/AIDS is a constant factor for many. Such abuses include abuse on the street, refusal to treat people with HIV/AIDS, and dismissal from employment. Often they may well be legal sanctions against people with HIV/AIDS. Passports may be stamped. Movements maybe curtailed. Marriage refused. At the same time access to charitable funds is very difficult because of religious and community attitudes towards AIDS.
- Vulnerability** ■ Because there is no cure for AIDS, people living with HIV/AIDS can be highly vulnerable to those offering “cures” for a price. This means that much needed finance, which should go towards supporting themselves and their families, is wasted on these “cures”. Many general practitioners, doctors and others in the medical profession promote such “cures”. Further, while there may be a growing number of non-governmental agencies working on HIV prevention, there are very few concerned with people living with HIV/AIDS. Some of these agencies are at even times AIDS phobic and will not deal with people living with HIV/AIDS, increasing the sense of stigmatisation and isolation. Religious and community leaders also display ignorance and fear and can generate psychological, if not physical, violence in the community against those affected by HIV/AIDS.

- **Lack of institutional support** Government institutions at national, regional and local level, as well as others, often develop policies and strategies around HIV/AIDS without consulting those most affected, and those most likely to be affected. Agencies are often isolated from people living with HIV/AIDS and therefore cannot truly represent their interests or develop appropriate strategies for care, support and treatment.
- **Shame** Issues of shame affects the lives of many people living with HIV/AIDS. Islam prohibits discrimination against Muslims who are ill and promotes community duty to take care of all people who are ill. Muslim societies have a moral obligation to enable people with AIDS to live and die with dignity.

Minorities

Muslim community	Islam states that there is only one Muslim community, but the reality of people’s lives in many countries is that there are minorities based on ethnic, cultural, and linguistic differences. These minorities will often be treated differently from the majority community, and for many, are stigmatised and vulnerable.
Definition of minority	The term “minority” in Muslim communities should not only define those who are non-Muslim, but also those who are culturally and socially considered different, where often they are significantly marginalised. People migrating from different regions and localities to areas where they represent a minority in the host region or locality can also be considered minorities. There are also situations where Muslim communities exist in wider non-Muslim societies through migration and emigration.
Poverty and minorities	Minority communities often make up the poorer sections of society, politically powerless, with less access to education, health and social services, housing and employment. Because of their disempowerment, these communities have a lower level of community-based organisational development.
Service development	Where there is any service development around HIV/AIDS it has been contextualised within the needs of the host culture, society or community. This has meant that minority communities do not access these services because of social, cultural and linguistic reasons which can mean a increased risk of HIV transmission.
Suspicion of agencies	Agencies working with minority communities can often be looked upon with suspicion by those in authority, while a lack of appropriate skills may mean that the ability to organise, develop appropriate strategies and develop funding proposals will also be limited.
Silenced communities	The voices of minority communities are often not heard and their specific needs not recognised. They cannot participate actively in decision making and what services and programmes exist for them are often imposed rather than arising from the communities themselves.
Stigmatisation	People from minority communities living with HIV/AIDS become doubly stigmatised and marginalised. They cannot access the essential services around treatment, care and support where culture, language and origins create barriers that for many are insurmountable.

Networking

- Isolation of agencies** ■ Often groups, networks, and service agencies operate in isolation from each other. This leads to duplication of education resources, ineffective methodologies of working, lack of appropriate information and, to some extent, competition for resources. Agencies working with Muslims in one locality, region or country may have learned a wide variety of lessons dealing with the complexities of the issues. Other agencies in other parts of the world may be able to learn from these experiences and implement them in their own programmes. It is therefore very important that agencies should work together, form alliances, actively network with each other, and share information. HIV/AIDS while being localised is also a global pandemic.
- Limited resources** ■ With limited resources available in the fight against HIV/AIDS, cost-effective methods for developing education prevention and support could arise from such networks. Networking enables the development of appropriate skills, empowerment, access to appropriate training, as well as availability of appropriate education and prevention materials.
- Mechanisms for networking** ■ Participants felt that there was a need to develop mechanisms for a range of networking forums which could lead to developments of effective management, expertise, methodologies, cost-effective utilisation of resources, and strategic approaches. These networks should look at local, regional, national and international forums which community-based agencies could access and actively participate in through appropriate mechanisms. In particular, as agencies working with Muslim communities, the issues of concern can be more readily understood, appreciated and articulated within shared and mutual agendas.

Other Issues

Social unrest ■	In many Muslim countries there are significant civil disturbances which is placing considerable strains on medical and social systems, increasing the need for blood supplies and blood products. Difficulties with social unrest so that agencies cannot function effectively, and other social priorities, are having a major impact on the ability of governmental and nongovernmental agencies to address the issues of HIV/AIDS.
Government sensitivity ■	The political use of Islam has created social tensions and conflict which form barriers to the development of appropriate and effective programmes on HIV/AIDS education, prevention and care. Governments sensitive to these tensions may find it inappropriate to develop HIV/AIDS prevention strategies particularly where they deal with sexual and drug using behaviours. The issues of religiously illicit behaviours already makes the social and political environment difficult to openly discuss sex, sexuality, and sexual behaviours, and because of these contentious issues, shame, and the myths around HIV/AIDS, there is a marked social tension between HIV/AIDS workers and religious leaders. This has meant that HIV/AIDS programmes cannot be properly implemented to best ensure a reduction in the rate of increase of STD/HIV transmission.
Religion and culture ■	Participants strongly felt that religion and cultural practices were interwoven in complex frameworks where often cultural practices were given religious sanction, even though they may not have any support within Islam. There was a need to separate out these dynamics if effective community-based HIV/AIDS education and prevention was to develop.
Diversity ■	There is an immense lack of data on actual sexual behaviours and their diversity within Muslim communities. Too much reliance is placed upon ignorance and assumptions based upon Muslim ideals. This creates difficulties in developing appropriate strategies for the prevention of HIV. Such programmes cannot assume that sexual behaviours are only taking place between husband and wife (or wives).
Lack of appropriate skills ■	Participants also recognised that many people working in HIV/AIDS service organisations do not have appropriate skills around management, financial control, monitoring and evaluation, developing appropriate programmes and outreach work. Actual knowledge of HIV/AIDS within these agencies is at times poor.
Donor agencies ■	Many HIV/AIDS agencies are dependent upon funding from a range of local, regional, national and international donors. There was a perceived risk that agencies can become donor dependent, which could lead to agendas being taken over by the donor agency. Concerns about the sustainability of non-governmental organisations were expressed, both in terms of access to funding support as well as to technical skills. At the same time participants expressed concerns regarding the application of international guidelines on a range of HIV/AIDS issues to local, regional and national levels. Monitoring, ensuring appropriate and just implementation, and the existence of legal frameworks and penalties for non-compliance were issues that were raised.
Safe environments ■	Participants also strongly felt that unless there is a “safe” environment to work in, HIV/AIDS education and prevention will be extremely difficult. Achieving such an environment will mean working closely with religious and political leaders.

Conclusion

- Moral predicament** ■ HIV/AIDS affects all aspects of human concern, including personal reproductive and sexual health, medical practice and treatment, religious values and ethics, politics and human rights, the individual, family and community. However, this moral predicament is nowhere as pronounced as in Muslim countries and communities. Politicians, religious leaders and policy makers may often deny the impact of HIV/AIDS, stating that AIDS is a curse of western decadence or that it poses no threat, since it is confined only to drug users, homosexuals and sex workers whose existence in Muslim countries or communities is often denied. This means that some Muslim countries and communities are often inadequately prepared to deal with HIV/AIDS and its consequences where strategies and programmes to provide education, prevention and support are often ineffectively developed. Such denial creates ignorance and fear which can lead to increasing rates of infection and death.
- Denial** ■ Participants recognised that these denials were based upon upholding the Muslim ideal of sexual behaviour as an act only permissible within marriage. This should be viewed as a denial of recognition to those who transgress the limits of the Muslim ideal, for to follow Islam means a strict adherence to its religious rules and behavioural mores. However, based upon experience of working in the field, participants believed that the existence of other behaviours which do not follow the Muslim ideal exist in Muslim countries. Like any other country or community, there will be those who use drugs and alcohol, there will be men who have sex with men, women who have sex with women, and both female and male sex workers, although these activities may well be more limited, less visible and contoured in different psycho-social frameworks.
- Cultural taboo** ■ Further, the public discussion of sex, sexual behaviours and sexualities is a cultural taboo which adds to the invisibility of such behaviours and the denial of their existence. Participants felt that this muteness on sex and other behaviours is leading to many unwarranted deaths because of AIDS. The Consultation Meeting strongly felt that this silence needs to be broken to save lives.
- Ideal versus reality** ■ Participants clearly understood that the chasm between ideals and realities is the biggest challenge for Muslim countries and communities in facing the implications of HIV/AIDS. It was strongly felt that there was an urgent need for all Muslims to recognise these issues, and that Governments should address these problems, informing their citizens about HIV and AIDS and develop appropriate local strategies and programmes to reduce the spread of HIV infection within their countries, as well as ensuring the provision of compassionate and appropriate care and support for people living with HIV/AIDS and their families.
- Social frameworks** ■ Within Muslim countries and communities, dealing with issues of reproductive and sexual health, where religious values, beliefs and practices play a strong cultural and social role can be very problematic. The political, social, cultural and religious frameworks of these countries and communities create specific difficulties in developing appropriate discussion, education, prevention and support. Participants recognised that HIV/AIDS forces us to focus on highly contentious issues since HIV is primarily a sexually transmitted infection. Further in many Muslim countries, there are other issues, such as ineffective blood screening, inadequate testing facilities, lack of knowledge by the health care profession, social stigmatisation and victimisation. As a consequence very little has been done to develop compassionate and appropriate models of prevention and care in such settings.
- Muslim community** ■ Participants realised that while religious leaders will speak of a one world Muslim community as a Muslim ideal, the reality can be different. As one participant stated “being a Muslim woman living in Indonesia is not necessarily the same as being a Muslim woman living in Saudi Arabia”. While different countries and communities share certain Islamic values, beliefs and practices, local cultural traditions and customs also play a significant role in the shaping of behaviour and practice. Policy makers and organisations need to understand the differences between basic Muslim ideals and local, as well as personal, practices in the development of appropriate education, prevention and care strategies.

- Promotion of Muslim ideals** ■ Participants believed the promotion of Muslim ideals should be a central part of any education strategy to raise awareness of HIV/AIDS by following the teachings of the Qu'ran, that is through abstinence, and faithfulness within marriage. However, it was also recognised that there will be those for whom these are essentially public acts of obedience, while in private, other behaviours may well come into play. This implied that a strategy based ONLY on an Islamic response to HIV/AIDS by promoting the Muslim ideal for personal behaviour and practice, would not necessarily significantly reduce the spread of HIV. Other strategies would **ALSO** be needed that could address the difference between the Muslim ideal and the actuality of some people's individual behaviours.
- Empowerment of NGOs** ■ It was felt that nongovernmental agencies should be empowered to deliver locally appropriate prevention and community care services, where Governments and religious institutions may feel restricted by the political, religious and social implications of the issues involved, particularly in the arenas of sexual and drug using behaviours which are often not visible to the broader community, and thus much more difficult to access. This would require affected individuals and groups, to be empowered towards developing responsible behaviours, which can only be achieved if they are actively involved in appropriate STD/HIV prevention strategies. Further marginalised groups and communities, such as women, youth, ethnic and cultural minorities, migrants and immigrants, low income groups, as well as behaviourally specific groups, and those living with HIV/AIDS should also be actively involved in developing appropriate prevention and care strategies for their communities, if such strategies are to be effective. Such processes of empowerment would require adequate funding, access to appropriate training and skills enhancement, as well as programmes for networking at local, regional, national and international levels, with advocacy support for those affected by or living with HIV/AIDS.
- Blood supplies** ■ However, issues around the non-sexual transmission of HIV are within the scope of government through public discussion and action. They reflect public health issues for adequate testing of blood and blood supplies and adequate sterilisation procedures in health care and blood giving settings, and appropriate treatment and care. Governments should ensure that their populations are adequately protected and provided for through appropriate legislation and enforcement in terms of medical practice, access to appropriate testing, counselling, treatment and care, blood supplies and the provision of culturally and linguistically appropriate HIV/AIDS awareness and education which would involve religious leaders and the promotion of the Muslim ideal.
- Individual or community** ■ Participants recognised the issues regarding individual rights and community rights. While many see these rights as oppositional, it was felt that they were complimentary and should be seen as working together to protect the individual, the family and the community. Legislation and it's enforcement, with appropriate advocacy structures should be developed to deal with abuses.
- Compassionate concern** ■ Further, participants strongly felt that it was religiously incumbent upon all Muslims to ensure support for compassionate concern and care in providing support for people living with, and affected by, HIV/AIDS.

Introduction ■ The challenge of AIDS confronts all countries and communities globally. Governmental and nongovernmental agencies, as well as secular and religious institutions, should work together to face this challenge if we are going to reduce levels and rates of infection, and the numbers of people that may die from AIDS.

Muslims are not immune to HIV. The impact of AIDS should no longer be denied. While it was recognised that there are many other priorities that confront governments and communities, the development of the AIDS pandemic will have a devastating impact upon health, social and economic structures, unless it is confronted now. Developing appropriate strategies to effectively deal with HIV/AIDS requires understanding, compassion, pragmatism, cooperation, goodwill and a willingness to learn from each other. The following recommendations are aimed towards developing that sense of goodwill and cooperation.

1. GOOD PRACTICE

Complexity ■ AIDS is not only a medical condition. It involves personal, social, cultural and religious issues that are complex, diverse and challenging. HIV/AIDS confronts people with their religious beliefs, sense of morality and ethics, relationships with each other, gender relationships and inequalities, family and community, economic empowerment and development, political frameworks as well as personal psycho-social issues. Developing appropriate strategies that confront the challenge of HIV/AIDS means approaching prevention and care services in ways that ensure a holistic understanding of these issues, where strategies are based taking all these factors into account.

Cultural diversity ■ The concept of a one world Muslim community should also recognise and acknowledge the cultural diversity in and between Muslim communities and countries. This diversity can lead to differences between religious values and cultural beliefs, private practices which can lead to personal behaviours different from the Muslim ideal. The development and implementation of strategies and services related to HIV/AIDS should take these differences into account. Appropriate needs assessments should be conducted, taking into account the range of existent risky behaviours, as well as health and social structures that impact upon HIV transmission and the treatment, care and support of those infected and/or affected by HIV/AIDS, prior to development and implementation of work at all levels.

Illicit behaviours ■ Whilst it is recognised that Muslim ideals demand obedience to the teachings of the Qu'ran in both personal and social behaviours, this expectation is not always fulfilled. Behaviours exist which are illicit in terms of the Qu'ran and some of them carry the risks of HIV transmission.

HIV education and the Qu'ran ■ In this context, HIV education campaigns should include asking members of communities to obey the teachings of the Qu'ran, where religious leaders can actively participate in HIV/AIDS education strategies, promoting Muslim values and concepts on abstinence before marriage, saying no to drugs and alcohol, and observing faithfulness in marriage.

HIV prevention ■ But such campaigns should recognise that these religious instructions on their own will not stop HIV infection completely. Issues around inadequate protection of blood supply, inadequate surgical and injection procedures, as well as the invisibility of much of the intravenous drug use and sexual behaviours within a community or country will ensure this. It will therefore be necessary that HIV prevention programmes should include strategies that work with marginalised individuals and groups who are legally and religiously prohibited, such as drug users, sex workers and men who have sex with men. Because of the religious political and social issues that such intervention work may raise, it is important to recognise that different and non-public strategies need to be developed for such interventions.

Religious leaders	<p>The Qu’ran speaks of compassion and support for any member of the community who is ill. Mosques and religious leaders should be involved in educating society, tackling those aspects relating to the prevention and control of diseases, including AIDS and all sexually transmitted diseases, taking into account the sound principles of freedom, human rights, social welfare and cohesion, personal relationships and family life. Charitable funds collected by Mosques and governments should also be targeted to those affected by HIV/AIDS to provide treatment, care and support.</p>
Imposition of programme	<p>It is very important that HIV/AIDS services, should not be imposed upon communities but arise from affected communities themselves. Such programmes should be specific to the needs of the community and individual members of that community. Members of these communities should be actively involved in developing responses to HIV/AIDS, by encouraging them to form their own nongovernmental education, prevention and support agencies. This requires a financial commitment from funding bodies towards long term planning and support for these initiatives.</p>
Building allies	<p>Through regular meetings, negotiations and confidence building measures, it is possible to develop trust, empowerment and rapport with key people in the community, as well as governmental, nongovernmental, and community-based organisations with community and religious leaders. Allies at all levels, including religious leaders, influential people, the business community and the media should be identified and mobilised so that they can support and legitimise the work of nongovernmental and community-based agencies and aid in the dissemination of appropriate information to the community.</p>
National AIDS Programmes	<p>National AIDS Programmes in collaboration with other government and nongovernment agencies, at local, regional and national levels should work together to formulate effective and appropriate policies on HIV/AIDS. They should consult the affected communities on issues to do with drug use, sexualities, sexual behaviours and HIV/AIDS and empower them to participate in decision making to develop policies and programmes. In order for this to effectively occur, specific strategies should also be developed that incorporate and integrate the issues of HIV/AIDS into the priority agendas of communities and government, for example, alleviating poverty, women’s issues, youth education, reproductive health and family planning and within the existing health care systems.</p>
Monitoring of agencies	<p>All agencies providing HIV/AIDS education, prevention and support, should be effectively monitored for their quality of services, their accessibility, as well as financial accountability. Effective models of peer evaluation of local community based HIV/AIDS services should be developed in response to concerns as to whether such organisations have the skills, knowledge and expertise to provide such services, especially around sexual and drug-using behaviours and related issues. This could be achieved by ensuring that such affected communities participate in the monitoring process. However, in order to ensure that these agencies can deliver a high quality of service, it is essential that appropriate skills training be offered to the policy makers of these agencies, management boards, staff and volunteers. Such skills training should include issues on developing appropriate outreach programmes, community involvement, designing education and intervention strategies, needs assessments, project management, grant writing, financial management, monitoring and evaluation, and educational resource development.</p>
Human rights	<p>The debate regarding community rights versus individual rights in the context of human rights has become oppositional, whilst these should be seen as complimentary. Often “community rights” have been used as a framework for the abuse of the human rights of individuals and families. It is therefore essential for the development of advocacy programmes for the protection of the human rights of people living with HIV/AIDS and other affected individuals and groups of families, women, children, and men . There</p>

Recommendations

should be a range of campaigns to educate the general population against discriminatory attitudes towards HIV/AIDS and there should also be a review and repeal of any discriminatory laws affecting women, children and men, whether based on gender inequalities or personal practices. Women's social, economic and political status makes them extremely vulnerable to HIV infection, so there should be effective development to engage with women's organisations in uplifting the socio-economic-political condition of women, while the development of HIV/AIDS policy should not negate in any way the evolving achievements of women's rights.

HIV surveillance ■

An effective surveillance system should be established at governmental level to find the prevalence of HIV/AIDS both within communities and amongst those who may be engaged in high risk behaviours. However, such HIV antibody testing must be approached in the context of confidentiality and human rights. Inadequate testing protocols can lead to discrimination, victimisation and the abuse of human rights.

Drug treatment trials ■

Many human based trials for new drug treatments and therapies are first tested in "developing" countries prior to their use and availability, usually in "first world" countries. The costs of these new treatments and drugs are often prohibitive, which makes them inaccessible to people living with HIV/AIDS in the countries in which the trials were first conducted. Inadequate protocols on these experiments means that people's rights to access to appropriate information and withdrawal from such treatment and drug trials are abused. It is essential that fair trials are made and available to all in an equitable manner and that all people have access to the results irrespective of cost.

2. APPROPRIATE EDUCATION AND PREVENTION

- Contribution of religious leaders** ■ The valuable contribution that religious leaders can make in promoting Muslim ideals and behaviours, such as sexual abstinence before marriage and faithfulness within marriage, is recognised. This would also mean ensuring that women and men are fully educated on their true rights and obligations as based upon the Qu’ran. Misconceptions arising from cultural values and traditional customs which have been incorporated into personal and social practices and given religious sanction need to be exposed and challenged. This would include female circumcision and gender inequalities. It is the duty of every Muslim to acquire knowledge, including knowledge on HIV/AIDS and to work in their communities promoting healthy living.
- Prevention strategies** ■ However, it is also recognised that there may well be those who do not always abide by the Muslim ideal. To be fully effective, prevention strategies should incorporate the means to stop the spread of HIV infection. This should include the availability of cheap, good quality condoms, targeted programmes that work by modifying risky behaviours in terms of the transmission of HIV/STDs, sterilisation of needles and surgical equipment in health centres, all blood supplies screened for HIV, and “needle exchange” programmes linked to treatment services for intravenous drug users. Prevention and outreach strategies to be effective should focus on behaviours and not on labelled groups such as sex workers, drug users, and men who have sex with men . Labelled people do not necessarily practice high risk behaviours. To facilitate such work, free confidential telephone lines should be made available where individuals can access appropriate information. These lines should be staffed by individuals adequately trained in dealing with reproductive and sexual health issues, as well as intravenous drug use.
- Needs assessment** ■ In order to understand and map out possible routes of HIV transmission in any given community, it is essential that a variety of needs assessments and action-based psycho-social behavioural research should be conducted, so that effective education and prevention strategies can be developed. It is essential that culturally appropriate methodologies be developed for such research, and that this research should be conducted through peer interventions and community-based groups in order to ensure validity of data, an appropriate analysis of the data, and adequate protocols on confidentiality.
- Public education** ■ HIV/AIDS education should include generic public information campaigns as well as specifically targeted resources for a wide variety of work, social, economic and behavioural groups, such as medical staff, family planning clinics, religious leaders, educational staff, factory workers, hotel staff, sex workers and so on. This would also mean educating and updating all health and social care workers skills with regard to prevention, care, management, counselling and related issues on HIV/AIDS. It is also essential to educate policy and public opinion formers as well as the media.
- Sex education** ■ HIV and AIDS reveals a number of very sensitive subjects, such as sexual behaviours, pre and extra marital sex, men who have sex with men and intravenous drug users. Because these issues are often taboo, to publicly discuss them creates issues of shame, fear, anger and hostility which will lead to resistance and denial. Education and prevention strategies should look at methodologies of empowering individuals and groups to address these issues for themselves. Part of this strategy should involve sex education as part of “life education”, in educational establishments such as schools, colleges and universities, as well as the education of parents. Within Islam it is recognised that it is the parent’s responsibility to provide their children with effective sex education but this is not always done. Appropriate peer education initiatives should be encouraged and supported and individuals and families should be able to access premarital counselling on reproductive and sexual health issues. Safe spaces should be developed where individuals and groups can gain access to confidential information a well as discuss issues around sexualities and reproductive and sexual health within an appropriate religious and cultural context.

Recommendations

- Legal rights of women** ■ There should be religious and civil education programmes on the legal rights of women and children. Opportunities for formal and informal education of girls and women should be enhanced and made more accessible as a right. This right should also be available for marginalised women, such as rural women, women involved in commercial sex and migrant women. Such education should include reproductive and sexual health as a part of family planning and HIV/AIDS issues.
- Working together** ■ It is essential for the whole community to work together to ensure that education strategies are effectively implemented to prevent the spread of HIV. Society as a whole should be mobilised in creating appropriate awareness of HIV/AIDS. Electronic and print media, cinema and theatre, political and religious leaders, doctors and hakims, business and union leaders, should all be involved in such educational campaigns. Religious, political, community and business leaders should be offered awareness programmes on HIV/AIDS and related issues in order to incorporate them into community education. This will require the imaginative development of educational materials that are appropriate to the behavioural and educational levels of the targeted audience. Learning resource materials should incorporate several ways of achieving safe behaviours including abstinence, faithfulness of partners, cleaning needles as well as condom use and changing behaviours where deemed appropriate. Strategies which focus on abstinence and faithfulness as the Muslim ideal, should also look at harm minimisation for those who cannot attain this ideal.
- Migrants and minorities** ■ With the growing urbanisation of Muslim societies, there have been mass movements from the rural to urban areas, as well as movements of people from one country to another. Within some countries, there are significant minorities. Programmes should be developed that address the specific needs of minorities and migrants that are appropriate to their languages, beliefs and cultures. This may well involve international as well as local cooperation in addressing these needs.
- Funding** ■ Development of educational and prevention programmes should be adequately funded and resourced for the broad range of communities in appropriate languages relevant to the differing communities. Funding strategies should be on a long term basis supporting community development as a process and should be made available to develop effective services which are managed by members from the affected communities. There is a need to ensure that the educational strategies include a commitment to work in partnership with people living with HIV/AIDS in a supportive environment.
- Educational formats** ■ These education and prevention strategies should utilise a wide number of formats including posters, electronic and print media, leaflets, videos, audio-cassettes, theatre and so on. They should acknowledge the differing levels of literacy in communities, gender issues, differing sexual behaviours, and religious frameworks. Such education and preventive frameworks should work with specific groups who share specific behaviours. These groups can be accessed through utilising members of these groups themselves to develop outreach programmes.
- Prisons** ■ Prisons and other forms of incarceration should develop appropriate services around HIV/AIDS. This policy would include children's homes, mental institutions, and drug rehabilitation centres, while all hospitals, clinics, and community care centres should ensure that HIV/AIDS services are available, appropriate and specific to the needs of individuals and the communities they serve.

Networking ■ Networking is an essential component for the development of appropriate strategies and their implementation in HIV/AIDS education, prevention and care. Such networking involving community based agencies providing these services should be financially supported and appropriate forums for local, regional, national and international meetings should be developed. These networks would enable community based agencies to share information, resources, and skills regarding HIV/AIDS and Muslim communities. It was suggested that an international network of Muslim community based agencies be developed, and that an international network of Muslim peoples living with HIV/AIDS should also be established. Participants also recommended that finance should be given to establish these two networks, and that further meetings of the participants of the Consultation meeting, with others, should also be supported.

3. SUPPORT, TREATMENT AND CARE

- Right to support and care** ■ All people living with HIV/AIDS have the right to appropriate and compassionate treatment, care and support that respects confidentiality and human rights. It is a religious duty of all Muslims to ensure that infected and affected people have access to good quality care and support whether medical, psychological, social or economic. A balance needs to be maintained between the rights of the individual and the rights of the community. Government regulations and laws should be formulated and made enforceable with regard to any discrimination and abuse. Legal and human rights should be protected by these laws and regulations and advocacy programmes for people living with HIV/AIDS with regard to their legal, civil and human rights need to be encouraged and financially supported.
- Counselling** ■ HIV/AIDS can have a devastating affect on individuals and their families. Stigmatised through infection and illness, the psychological, economic and social impact has major implications for their continued wellbeing. Specially trained counsellors should be available to provide psychological and practical support for infected and affected individuals, friends and families. Part of this process of counselling would include access to appropriate treatment and care, financial support, the rights and responsibilities of people living with HIV/AIDS, and referrals to appropriate agencies, including support and self-help groups. Such groups should be encouraged and facilitated through financial and social support, where confidentiality can be maintained in their provision. This range of counselling and support systems should be developed with government and nongovernment agencies as well as the community, creating enabling and supportive environments.
- Economic impact** ■ The economic impact upon individuals and families affected by HIV/AIDS can be devastating. The loss of income can create major burdens in terms of accessing health care, food, housing and other needs. Support programmes for people living with HIV/AIDS should include not only psychological, medical and social frameworks, but also financial, both for themselves and their families, to ensure that a reasonable quality of life is maintained. Access to health care should be made affordable and accessible.
- Financial support** ■ Funding should be provided to enable families affected by HIV/AIDS to access resources with regard to their specific needs. Such needs may well include housing, home-help, drop-in facilities, trained counsellors, economic support, and medical care. This could be achieved through a Social Care Fund established by governmental and Muslim institutions.
- Community care** ■ As the numbers of people living with AIDS increases, so the development of effective community and home care programmes becomes an urgent necessity. This requires the training and support of care providers from within families and extended family networks to ensure an acceptable degree of home base care for people living with HIV/AIDS creating enabling conditions for the provision of such support. Community care programmes should offer counselling, financial support, home care, befriending services, and safe, confidential social spaces for people living with HIV/AIDS who can come together for mutual support and self-help. Counselling should explore grief and bereavement, family values, access to adoption, rights and responsibilities, and other issues that affect people living with HIV/AIDS and their families. Vocational training and employment opportunities should also be made available for individuals and families affected by HIV/AIDS where necessary, so that the economic impact of HIV/AIDS can be limited.

Access to treatment ■

Access to non-allopathic forms of treatment should be considered a right for people living with HIV/AIDS and be made accessible and affordable. Research on traditional medical systems should be strengthened and supported in terms of their impact upon HIV/AIDS. This means that information on such treatments, as well as those allopathic drugs currently available should be available in appropriate languages. Access to information is vital if the person living with HIV/AIDS can effectively participate in making appropriate choices about treatment and care. Alternative methods of support and care should be encouraged, such as befriending, self-help groups, affected family networks and so on. Alternate family structures could be devised and accepted where parents may have died from AIDS, and children, infected or otherwise, have no family support because of their status. Appropriate support and care programmes for children affected by HIV/AIDS is an urgent necessity.

Testing ■

Facilities for testing for HIV/AIDS should be made available in all major hospitals and clinics, and remain accessible to every one. This will mean ensuring that the principles of confidentiality are maintained and that appropriate pre and post test counselling is offered to all. All needles and invasive instruments should be sterilised before use. All blood supplies should be tested for HIV infection before transfusion. Voluntary blood donations should be encouraged, while organ, semen and ovum donations should be tested for HIV infection before transplantation. Health care standards must be improved in order to ensure prevention of non sexual transmission of infection.

Working papers

1. 1. The Silent Killer: AIDS and the Muslim World
Dr. Munawar A, Anees
Paper presented to the 8th International N+Bioethics Symposium, Tokyo, December 1993
2. Response to the above paper by Shivananda Khan for The Naz Project, April, 1995
3. The Role of Religion and Ethics in the Prevention and Control of AIDS - Consultation Document produced by WHO Eastern Mediterranean Regional Office, 1992
4. Sexuality and Sexual Health in South Asia
Document produced by Shivananda Khan for The Naz Project, 1993
5. A Dialogue Between Two Believers - a discussion on Muslims and homosexuality.
Reproduced from the Abu Nuwas Newsletter, 1994
6. Cultural Constructions of Male Sexualities in South Asian Cultures
paper produced by Shivananda Khan for The Naz Project, 1995
7. Sexuality & Eroticism Among Males In Muslim Societies
Edited by Arno Schmitt and Jehoeda Sofer
A collection of essays. Booklet printed 1995
8. Compact on Human Rights Initiative -
APCASO, 1994
9. AIDS, health and human rights
Professor Jonathan Mann, March 1995, reproduced from the RS Journal
10. Planning and Evaluating Strategies for AIDS Health Education Interventions in the Muslim Community in Uganda
Paper reproduced from AIDS Education and Prevention, The Guilford Press, 1995
11. AIDS - The Epidemic Past, Present and Future in the Middle East reproduced from TB & HIV, January, 1995
12. Can Culture Stop AIDS In Its Tracks?
Article reproduced from The New Scientist, 11 September 1993
13. The Islamic Perspective On Sex Education
Reproduced from the Sex Education Forum Report, 1995
14. Report on the International Community of Women Living With HIV/AIDS
Pre-Conference Meeting at Cape Town, South Africa, March 1995
15. Information Document: a collection of a number of relevant press articles from:
Global AIDS News, AIDS Analysis-Asia, WorldAIDS, AIDS Action

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