



ISLAM AND THE AIDS PANDEMIC

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by

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DECLARATION

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I, **FAROUK AMOD** (Student Registration no. 7913924) do hereby declare that my D. Phil. thesis entitled:

Islam and the Aids Pandemic

is the result of my own investigation and research and that it has not been submitted in part or in full for any other degree or to any other University.


Signature

05/04/2004
Date



DEDICATED


to

my beloved mother and the family

and

my late father who inspired us to the right way

by his example



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INTRODUCTION

The early days

“In June of 1981 we saw a young gay man with the most devastating immune deficiency we had ever seen. We said, ‘We don’t know what this is, but we hope we don’t ever see another case like it again.’” — Dr Samuel Broder, USA.

The year 1979 was a watershed in the epidemiological history of the planet. Following a concerted campaign by the World Health Organization (WHO), the last naturally occurring case of smallpox had been tracked down in Somalia in October 1977. After a two-year period in which no other cases (apart from laboratory accidents) were recorded, WHO formally announced in December 1979 that the global eradication of smallpox was complete.

In the same year, a patient in a New York hospital was in the final stages of a long and mysterious illness characterized by repeated attacks of chance infections which are usually, easily repelled by the body. Cross-checks with other US hospitals revealed not only an alarming number of similar cases, but also a steep rise in hospital admissions of patients suffering from illnesses which pointed to the collapse of the immune system. Because of this, the new disease was called Acquired Immunodeficiency Syndrome or AIDS. Thus, simultaneously with the elimination of one of the historical scourges of mankind, smallpox, the world stood on the edge of another pandemic.¹

¹ Smallman, M, et al. (1992). *London International Atlas of AIDS*. Oxford. Blackwell Publishers, p. 6.

AIDS is, by definition, the end-stage disease manifestation of an infection with a virus called the Human Immunodeficiency Virus (HIV). The virus infects mainly two systems of the body, namely the immune system and the central nervous system, and disease manifestations are principally consequent on damage to these two systems.²

AIDS is an impairment of the body's ability to fight disease. It leaves the affected individual vulnerable to illness that a healthy immune system might overcome. The name appropriately defines the condition. It is acquired, that is, not inherited or genetic, but associated with the environment. Immune refers to the body's natural system of defence to combat disease, while deficiency indicates that the system is incomplete or lacking. A syndrome is a group of particular signs and symptoms that occur together and characterize a disorder. AIDS patients are susceptible to diseases called opportunistic infections. These are illnesses due to organisms commonly found in the environment and harmful only to individuals with a weakened immune system. Thus, as its name states, AIDS is a syndrome, not a single disease or malignancy, with a broad clinical spectrum that ranges from severe infections and death to hidden disease states and includes milder forms with possibly more hopeful prognosis.³

The AIDS epidemic surfaced in the last quarter of the twentieth century. Within less than two decades this epidemic reached pandemic proportion, affecting millions of people in over 190 countries. One of the most perplexing aspects of AIDS as an infectious disease is the fact that clinical sign and symptoms rarely appear until several years after the

² Schoub, B.D. (1994). *AIDS and HIV in Perspective: A Guide to Understanding the Virus and its Consequences*. Cambridge: Cambridge University Press, p. 19.

³ Gong, V. (Ed.) (1985). *Understanding AIDS: A Comprehensive Guide*. Cambridge: Cambridge University Press, pp. 1-4.

initial infection and it eventually leads to death. Thus far, no cure has been found for AIDS.

AIDS has probably aroused more concern, stimulated more funding and research, and attracted more media coverage worldwide, than any other health issue. The World Health Organization (WHO) set up a Global Programme on AIDS in February 1987. In its first two years this programme had a budget of US\$88 million, more than the WHO's entire budget for the 14 year campaign to eradicate smallpox.

The major avenue for contracting the HIV infection in the world is through intimate sexual contact. This means that HIV infection is mainly a sexually transmitted infection (STI) and thus it can be regarded as a lifestyle disease. The global response to this pandemic is the promotion of safe sex through the use of condoms. An attempt is made in this dissertation to explore whether Islam offers other options to curb the spread of this deadly disease.

The objectives of this study are to:

1. examine HIV/AIDS and its mode of transmission;
2. assess the impact of HIV/AIDS pandemic to the family and society in general;
3. analyse the moral values and legal aspects of sexual behaviour in Islam;
4. explore the Muslim initiatives in trying to curb the spread of HIV/AIDS.

Chapters one and two briefly give an overview of the global impact of the HIV/AIDS pandemic. These two chapters serve as a basis for the main part of the dissertation. Chapter three discusses the measures that Islam proposes to curb the spread of HIV/AIDS. Chapter four deals with the Muslims' initiatives in addressing the issue of HIV/AIDS. Chapter five presents the Government of South of Africa's response to the HIV/AIDS pandemic. The final chapter looks at other religious communities' response to the HIV/AIDS pandemic.

Chapter One

ORIGIN AND TRANSMISSION OF HIV/AIDS

In the period between October 1980 and May 1981, five young men, all active homosexuals were treated for biopsy-confirmed *Pneumocystis carinii* pneumonia (PCP) at three different hospitals in Los Angeles, California, USA. Two of the patients died. All five patients had laboratory-confirmed previous or current *cytomegalovirus* (CMV) infection and *candidal mucosal* infection. This was the first report of a disease that would become known as the Acquired Immunodeficiency Syndrome (AIDS) and it appeared in the “Morbidity and Mortality Weekly Report” of the Centres for Disease Control (CDC) in Atlanta, USA on 5 June 1981. A month later, the July issue carried a similar report of twenty-six homosexual men, twenty from New York and six from California with a very uncommon cancer tumor called Kaposi’s sarcoma (KS). Thus it was at the beginning of 1980 that the few cases of homosexual male patients with unusual infections and tumors heralded an epidemic of one of the most devastating of all diseases. From its very beginning the most striking feature of the AIDS epidemic in the USA and in other Western countries was its dominance in the male homosexual population.¹

AIDS was first recognized as a new and distinct clinical entity in 1981. The medical question of how AIDS originated as a disease has confounded doctors and researchers

¹ *AIDS and HIV in Perspective*, op.cit, pp. 2-4.

(Johnson & Vieira, 1987). It manifested itself first in 1981 among homosexual males in the USA and was first recognized as an epidemic in Africa in 1983. It is possible that the disease may have manifested itself independently in several parts of the world.² What is uncontested is that the disease of AIDS was first recognized in the USA and only somewhat later was the epidemic as such observed in Europe and the African continent.³

The general consensus among medical scientists and practitioners is the belief that the Human Immunodeficiency Virus (HIV) is the only necessary and sufficient agent in the aetiology or causation of AIDS. This belief is also endorsed by national and international health organizations.⁴ This is the established view and anyone who does not accept it is regarded as a dissident. There is an increasing number of dissident medical scientists and also AIDS patients who are questioning this belief and these views will be discussed at the end of the chapter.

The overwhelming evidence points to the Human Immunodeficiency Virus (HIV) as the specific etiologic agent for AIDS. HIV is a RNA retrovirus. Epidemiologic proof of the HIV as the cause of AIDS generally follows revised guidelines based on Koch's original postulates. These very conservative and restrictive axioms serve as the basis for establishing a micro-organism as the etiologic cause of a disease.⁵

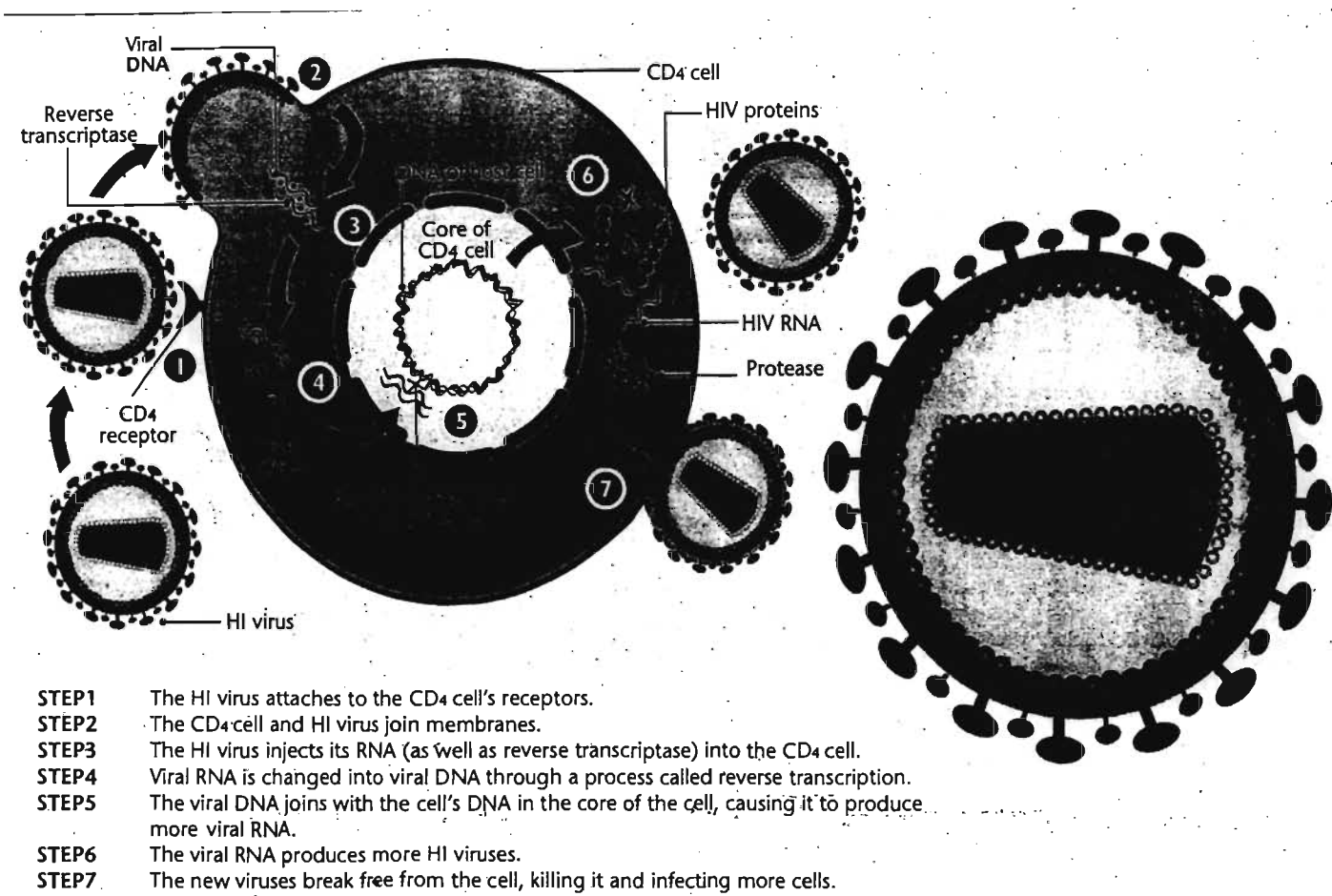
² Lewis, M A, et al. (1989). *AIDS in Developing Countries: Cost Issues and Policy Trade offs*. Washington: Urban Institute Press, pp. 24-25.

³ *AIDS and HIV in Perspective*, op. cit. p. 12.

⁴ Badri. M. (1999). *The AIDS crisis: A Natural Product of Modernity's Sexual Revolution*. Durban: Islamic Medical Association of South Africa. IMA, p.1.

⁵ Shannon, G W, et al. (1991). *The Geography of AIDS: Origin and Course of an Epidemic*. New York: The Guilford Press, pp. 14-15.

HIV mainly attacks and destroys white blood cells, especially T helper lymphocytes, in the blood and lymph system.⁶



Courtesy of the *Sunday Tribune* – “Perspectives” dated 9 June 2002, p. 1

⁶ *AIDS in Developing Countries*, op.cit., p. 17.

HIV infection is caused by two strains of the Human Immunodeficiency Virus, namely, HIV-1 and HIV-2. Within HIV-1 are at least nine slightly different subtypes or clades, each predominating in different parts of the world, although researchers have found increased dispersion in recent years. HIV-2, which is less infectious and progresses more slowly, is found primarily in West Africa, although it, too, is spreading to other regions. HIV-1 is the most common form of HIV, and is hereafter referred to simply as HIV.⁷

One of the most perplexing aspects of AIDS as an infectious disease is the fact that clinical signs and symptoms rarely appear until several years after the initial infection.⁸

The AIDS virus was discovered by Professor Luc Montagnier and his colleagues at the Institut Pasteur, Paris, in 1983 and given the name lymphadenopathy associated virus (LAV). In 1984 Dr Robert Gallo and his co-workers described the development of cell lines permanently and productively infected with another AIDS virus isolate, which, in line with two previously described retroviruses, HTLV-1 and HTLV-11, they referred to as HTLV-III. LAV, HTLV-111, and the other viruses since isolated from patients with AIDS and AIDS related disease in America, Europe and Central Africa are all the same virus, and this is the virus now called HIV. Around 1985 another retrovirus, different from HIV, was recognized in patients with West African connections (contacts). This virus, referred to by the Paris investigators as LAV-11 and now as HIV-2, is also

⁷ Ainsworth, M, et al. *Confronting AIDS : Public Priorities in a Global Epidemic*. Washington: The World Bank Policy Research Report.

⁸ Devita Jr, V T, et al. (1997). *AIDS: Etiology, Diagnosis, Treatment and Prevention*. New York: Raven Publishers, p. 8.

associated with AIDS and AIDS related disease.⁹ By the end of 1985 tests were available for antibodies which develop as a result of infection (HIV).¹⁰

1.1. TRANSMISSION OF HIV

HIV can be transmitted through body fluids in three ways, namely, through sexual intercourse, through blood and materno feotal routes. Transmission as a result of sexual intercourse account for about three quarter or 75% of all HIV infections worldwide.¹¹ This means that HIV infection is mainly a sexually transmitted infection (STI). In industrialized countries, HIV transmission has occurred primarily through homosexual intercourse and blood-to-blood contact among intravenous drug abuses.¹²

Since early cases of AIDS in the West were homosexuals, it was assumed to be a “gay plague” (in the USA it was known as GRID, Gay Related Immune Deficiency).¹³ In sub Saharan Africa, AIDS is primarily a heterosexually transmitted disease. Heterosexual intercourse, in fact, accounts for over 80% of African HIV cases.¹⁴ AIDS is a promiscuity disease. The more sexual contacts with different partners, the greater the risk of contracting HIV, or any other venereal disease for that matter.¹⁵ Sexually transmitted infections, particularly those associated with genital ulceration, enhance the

⁹ Adler, M.W. (1991). *ABC of AIDS*. London: British Medical Journal, p. 4.

¹⁰ Aggleton, P, et al.(1990). *AIDS: Individual, Cultural and Policy Dimensions*. London: The Falmer Press, p. 137.

¹¹ *AIDS: Etiology, Diagnosis, Treatment and Prevention*., op. cit., p. 103.

¹² Green, E C. (1997). *AIDS and STDs in Africa: Bridging the gap between Traditional Healing and Modern Medicine*. Pietermaritzburg: University of Natal Press, p. 1.

¹³ Edelston, K. *Countdown to Doomsday*. (1988). Johannesburg: Media House Publication, p. 37.

¹⁴ *AIDS and STDs in Africa*, op .cit., p. 2.

¹⁵ *Countdown to Doomsday*, op. cit., p. 38.

efficiency of HIV transmission (Wasserheit 1992; Laga et al. 1993) and also may thus facilitate transmission of HIV during genital intercourse (Nsubuya et al. 1990).¹⁶

The second route of HIV transmission is via infected blood. As with certain other STI, HIV infection can be transmitted through blood (or infected blood products, donated organs and semen). In industrialized countries, the blood supply has been made safe, but in some parts of the developing world, blood safety is still problematic, although steadily improving. A major problem in the developed and developing world is HIV transmission resulting from the use of contaminated injection equipment (needle) by drug users. In Western Europe, this transmission route has accounted for about 44% of AIDS cases.¹⁷ It is now widely recognized that the shared use of non-sterile injecting equipment by intravenous drug users represents another major route of transmission for the spread of the HIV virus.¹⁸

Most children acquire their infection before or just after birth. Infection may be acquired in utero through the maternal circulation, at the time of delivery by inoculation, ingestion of blood or other infected body fluids, or soon after birth through breast milk. It is still uncertain whether the virus is transmitted through breast milk. In *utero* transmission has been clearly demonstrated and is thought to be the major route of infection. The best estimate of the risk of transmission of HIV infection from an infected mother to her infant is about 25%-30%. This is based on prospective follow-up studies, from birth, of children born to HIV seropositive women. There is no evidence that caesarean delivery

¹⁶ *AIDS and STDs in Africa*, op. cit., pp. 7-9.

¹⁷ *AIDS : Etiology, Diagnosis, Treatment and Prevention*, op. cit., pp. 103-104.

¹⁸ *AIDS : Individual, Cultural and Policy Dimensions*, op. cit., p. 143.

offers protection. The increase in the number of women with HIV infection is paralleled by an increase in paediatric infections. The increasing number of intravenous drug users with AIDS is of great concern as nearly half of the children with AIDS who were infected perinatally were born to (women) intravenous drug users. In combination with heterosexual spread, the fact that around one third of drug users are women, leads to the further problem of vertical spread to newborn children.¹⁹

Intensive epidemiological studies of HIV infection have shown that it is not transmitted in the community by casual or intimate non-sexual contact. In fact, HIV carriers in the community present no risk to others from normal day-to-day contact. Hence, HIV infection and AIDS are not contagious.²⁰

1.2. SPREAD OF HIV/AIDS

Several factors have contributed to the spread of HIV/AIDS as a worldwide pandemic. The relative frequency of the separate factors is unknown but conceptually it is easy to see ways in which the disease could spread across regions. Business travel and tourism may well be the leading factors in the spread of HIV/AIDS from region to region. Asymptomatic carriers present the greatest risk of unknowingly infecting others through sexual contact. Prostitution is widespread in many large international cities. Prostitutes who do not insist on the use of prophylactics are likely to contract HIV and pass it on to their domestic and foreign clients, thereby providing an important conduit for the spread

¹⁹ *ABC of AIDS*, op. cit. Vol. 2, pp. 59-61.

²⁰ *Ibid.* Vol. 2, pp. 47-48.

of HIV/AIDS. Migration is another likely factor. Migrant labourers have been a source of transmission among rural regions in Africa, and the common practice of males migrating from rural areas to cities while the family remains behind has been another. Temporary migrants such as travelling soldiers and trades people are also potential HIV propagators. The use of imported blood and blood products in transfusion is yet another factor, although less well documented.²¹

1.3. ORIGIN OF HIV/AIDS

Several theories have been advanced on the origin of HIV/AIDS, some from the bizarre to the more plausible. The following are some of them:

- i) According to the astrophysicist Sir Fred Hoyle, the HIV is of extraterrestrial origin. (McClure and Schulz; 1989)²² Hoyle and his colleague, C. Wickramasinghe propose that it (AIDS) is an epidemic sparked off by biological matter which exists in the upper atmosphere and is pulled to ground level by the patterns of global atmospheric circulation. They suggest that comets carrying additional particles periodically augment viral particles in the upper atmosphere. With this vast biological cloud effectively raining on the human race, it is inevitable that some viruses will “take” and infect

²¹ *AIDS in Developing Countries*, op. cit. pp. 24-25..

²² *The Geography of AIDS*, op. cit. p. 34.

populations. Having worked out this model for the seasonal epidemics of influenza, it was relatively easy for them to apply it to AIDS.²³

- ii) There have been a few conspiracy theories. The most frequently heard is that the virus was created artificially, either deliberately as a biological warfare weapon by the “doctors of death” at Fort Detrick, Maryland, USA or accidentally by molecular biologists in a recombinant research laboratory of some sort in the USSR or Eastern Europe. (Anonymous; 1988a)²⁴
- iii) Some researchers had argued that HIV developed from the African green monkey and infected those who ate monkey’s meat. Simian immunodeficiency virus (SIV) which is similar to HIV-2 does infect some African monkeys, but they do not get AIDS. This fact and the high incidence of infection of people in Central Africa had led to the opinion that HIV originated there and mutated to become virulent for humans. (R. Gallo; 1993)²⁵ The reason for doubting the Green Monkey Theory is that, as SIV is closer to HIV-2, the theory would predict that HIV-2 would have appeared first. However, this is not the case as the original AIDS epidemic is based on HIV-1 and the relatively smaller HIV-2 epidemic only appeared later. Thus

²³ Adams, J. (1989). *AIDS: The HIV Myth*. London: Macmillan London Limited, pp.165-166.

²⁴ *The Geography of AIDS*, op. cit. p. 34.

²⁵ Umeh, D.C. (1997). *Confronting the AIDS Epidemic: Cross-cultural perspectives on HIV/AIDS Education*. Trenton: Africa World Press, Inc., pp. xv-xvi.

the Green Monkey Theory would leave the origin of the original HIV-1 unexplained.²⁶

- iv) The earliest suggested timing for the occurrence of AIDS is that of Ablin et al. (1985) who comment on references to “AAA” disease in the literature of ancient Egypt. “AAA” can be translated either as poison or semen. Ablin and his co-workers speculate that this is a possible prototype AIDS which may have forced/reinforced the homosexual taboo of ancient Egypt.²⁷ Egyptologists have recently expressed doubts about the grounds for identifying this with parasitic hematuria (in other words, with schistosomiasis), as was suggested sixty years ago by Bendix Ebbell and supported by the excellent medico-philological analysis of Frans Jonckheere. However, this attempt to identify it with AIDS is even more daring, since it rests solely on the serious nature of the disease and on the fact that it had an effect on semen and/or the male generative organs.²⁸ The current application of HIV proviral DNA amplification techniques to mummified remains dating to 3500 BC may resolve this speculation.²⁹
- v) Some researchers believe that certain types of sexual behaviour could have resulted in the emergence of the HIV infection. For instance, M.D. Grmek in

²⁶ Hubley, J. (1995). *The AIDS Handbook : a guide to the prevention of AIDS and HIV*. London: Macmillan Education Ltd., p. 21.

²⁷ *London International Atlas of AIDS*, op. cit., p. 123.

²⁸ Grmek, M.D. (1990). *History of AIDS: Emergence and Origin of a Modern Pandemic*. Princeton: Princeton University Press, p. 110.

²⁹ *London International Atlas of AIDS*. op. cit. p. 123.

Chapter 14 of his book under the heading “The liberalization of morals” states the following which is quoted freely below:³⁰

It is certainly true that the epidemic had broken out in American homosexuals not because they had ‘sinned against nature’, but because, as a group, they had been more prone to promiscuity than heterosexuals...

American homosexuals created the conditions which, by exceeding a critical threshold, made the epidemic possible. They were a sort of ‘cultural medium’ that permitted virulent strains of HIV to emerge...”

In the 1970s, an extraordinary proliferation of clubs, bars, discotheques, bathhouses, sex shops, travel agencies, and gay magazines allowed the community to ‘come out’ and adopt a whole new repertoire of erotic behaviour, out of all measure to any similar past activities...

It was estimated that by 1982 there were about ninety-eight thousand (98 000) homosexuals in San Francisco, of whom almost half lived in a particular part of the city centre. Never in human history had one city known such a concentration of homosexuals, or such promiscuity. The search for physical pleasure and multiple partners passed for fundamental expressions of individual rights...

³⁰ *History of AIDS: Emergence and Origin of a Modern Pandemic*, op. cit. p. 168-169.

Studies showed that most American homosexuals living in large cities had several dozen sex partners each year; mean figures of 80 to 100 partners were not rare and some mounted into the hundreds. About 10% of homosexuals interviewed had had sexual contact with over five hundred (500) persons during their lives. In medical terms, the almost immediate result was an increase in the 'classic' sexually transmitted infections, notably, syphilis and gonorrhea; of certain viral diseases, such as hepatitis, herpes, and cytomegalovirus; and intestinal parasites such as amebiasis. Skin disorders of an otherwise relatively rare nature, and chronic diarrhea, became the daily lot of homosexuals. The rise in these disorders preceded the AIDS outbreak, and already indicated the point at which the epidemiologic situation was ready to explode...

It was thus in the crowded ranks of the American homosexual community that the AIDS virus finally passed the point of no return in its epidemic spread.

Another researcher, Jean-Paul Escande, a French physician characterized the AIDS situation as follows:³¹

AIDS is not a divine lightning bolt, but its advent shows that, when a community profoundly changes its life-style, a certain number of diseases will crop up without fail; the excesses of sexual liberalization among homosexuals are probably responsible for the biological modification that fostered the rise of AIDS...

³¹ Ibid. p. 170.

While the origin of HIV remains a mystery, the future prevention of HIV infection and ultimately AIDS, remains the challenge. To date, there exists no conclusive scientific evidence for locating the exact origin of the HIV. The search continues...

1.4. AIDS DENIAL

The recognition that HIV is the cause of AIDS was not easy for some to accept. A small group of scientists have persisted in denying this etiology despite the overwhelming evidence for causation. One reason why some have been reluctant to accept that AIDS is an infectious disease caused by HIV is the very prolonged induction period combined with a very high mortality rate. Most infectious diseases occur after a short induction period. The definition of AIDS as an amalgamation of clinical outcomes ranging from tuberculosis and chronic diarrhea to lymphoma and Kaposi's sarcoma also causes confusion for those considering HIV as the single etiologic cause. The clinical definition becomes logical only if it is recognised that AIDS is fundamentally an irreversible destruction of the immune system. All of the other outcomes are secondary to the immune destruction. HIV is also transmitted in exactly the same way as clinical AIDS – by blood, by sexual contact, and from mother to infant. These are some of the reasons why most accept that HIV must be the cause of AIDS.³²

Opponents of the HIV as the AIDS disease agent (Duesberg; 1989) appear to base their arguments on the most strict interpretation of Koch's postulates, disregarding the state of

³² *AIDS: Etiology, Diagnosis, Treatment and Prevention*. op. cit., p. 11.

medical knowledge and technology regarding the complexity and capabilities of the virus as well as the ability to locate the HIV.³³

1.5. DISSIDENT VIEWS

There is an increasing number of medical scientists, AIDS patients, and also our President Thabo Mbeki, together with a few of his ministers, who are questioning the belief that HIV only is the causation of AIDS. Some writers on AIDS are referring to this questioning as the AIDS Reappraisal Movement. For instance, Professor Luc Montagnier (the first person to discover the HIV) now suggests, with Professor Gilbert that HIV is relevant but not the sole causative factor; other co-factors must be involved in triggering the disease process.⁴

i) Alan Cantwell

Alan Cantwell, (AIDS research author) a Los Angeles dermatologist, believes in the theory that a so-called “pleomorphic” bacteria – one which passes through several stages in which it changes its shape – is responsible for causing cancer, including Kaposi’s sarcoma. He states that he has identified such a microbe in lesions of Kaposi’s sarcoma. “Could it be possible,” he states, “that scientists have been overlooking important

³³ *The Geography of AIDS*, op. cit. pp. 14-15.

³⁴ Lachman, S.J. (1991). *The Emergent Reality of Heterosexual HIV/AIDS*. South Africa: Lennon Limited, p. 30.

bacteriologic findings in AIDS, by concentrating heavily on the virus theory of AIDS?”³⁵ He realised that the HIV hypothesis did not answer the questions that AIDS posed. He stated that scientists clearly avoided the issue of what was causing Kaposi’s sarcoma in the (HIV antibody) negative patients. He wondered how a new virus could possibly cause a century-old form of cancer. He stated that there was absolutely no direct link between (HIV) infection and the development of Kaposi’s sarcoma and this fact didn’t seem to deter most AIDS experts who insisted that the new virus (HIV) was the sole cause of AIDS. Alan Cantwell’s argument is that AIDS may be caused by a bacteria and that the pursuit of the virus before other possible causes of AIDS were fully examined meant that evidence pointing to a bacterial origin of AIDS was overlooked.³⁶

ii) Peter Duesberg

Peter Duesberg is regarded as a world leader in the field of molecular virology. In the 1970s he defined the genetic nature of retroviruses and produced a “genetic map” which is true of all retroviruses. In March 1987 his paper on “Retroviruses as Carcinogens and Pathogens: Expectation and Reality” was published in one of the world’s major cancer journals, *Cancer Research*. In this paper he questioned the causal link of HIV to AIDS.

During the course of his research he could find no record in the considerable scientific literature of any measurement of what is referred to as the “virus titre”. This is a measurement of the parts of virus per millilitre (thousandths of a litre) of blood. He

³⁵ *AIDS: The HIV Myth*. op. cit. p.11.

³⁶ *Ibid*, pp. 67-68.

managed to get this information from Jay Levy, a cancer researcher who informed him that it was between 0 and 10^2 per millilitre. He then questioned how does a virus which infects as few as one in 100 000 cells cause a generalised infection? He argued that it is present in so few cells and if the virus was virulent and did kill cells and if it were to kill its share of T-cells every twenty-four to forty-eight hours, it would hardly ever match or beat the natural rate of T-cell regeneration.³⁷ He further stated in his research paper that there is no evidence that the virus titre or the level of virus infiltration increases during the acute phase of the disease. He also noted that the virus is absent from Kaposi's sarcoma (this concurs with A. Cantwell's view). He does not accept HIV to be cytotoxic as he believes it is biochemically inactive. He stated that there has been no report in the literature describing the virus ever to be active in a patient, only in cell culture and the virus continues to be dormant even when patients are dying from AIDS. This is one of the main reasons why he does not believe HIV to be the cause of AIDS.³⁸ He believes that HIV does not play a direct causal role in AIDS but is merely present as a "passenger" virus.³⁹

Many in the HIV community in the USA believe that HIV is not the sole cause of AIDS, that there must be co-factors, suggesting the overuse of antibiotics, poverty, substance use, and the chronicity of other infections. Many believe that the medical establishment aligned with pharmaceutical companies is fraudulent, that anti-retroviral therapies are a cruel hoax. Clearly, the medical establishment and holistically oriented practitioners

³⁷ Ibid, pp. 72-74.

³⁸ Ibid, p. 83.

³⁹ *AIDS and HIV in Perspective*, op. cit. p. 11.

seem in diametric opposition. There is no indisputable answer in this clash of belief systems.⁴⁰

iii) Thabo Mbeki

Mr Thabo Mbeki, the President of South Africa has also questioned the link between HIV and AIDS. He has been reported in the news media as stating that he was not convinced that HIV was the single virus causing AIDS or deaths attributed to AIDS.⁴¹ He has been criticised by medical scientists, health experts and AIDS activists for his view on HIV/AIDS. His view on AIDS has been regarded by the AIDS establishment, as supporting the dissidents. (Refer to the Cartoon on the following page - Courtesy of *The Mercury*. Durban, 12 July 2000).

At the 13th International AIDS Conference which was held in Durban from 9 July 2000 to 14 July 2000, a declaration that HIV causes AIDS was signed by five thousand (5 000) medical personnel. In order to seek clarity on this issue, he has set up an International AIDS Advisory Panel made up with scientists who believe that HIV causes AIDS and those who disagree with that view. The panel will investigate various aspects of HIV/AIDS and report its findings to the government. Having thrown doubts on accepted scientific knowledge, there are possibly more questions than answers.⁴²

⁴⁰ Dansky, S.F. (1994). *Now Dare Everything: Tales of HIV-Related Psychotherapy*. New York: Harrington Park Press, p. 85.

⁴¹ "Mbeki stands by his decision on HIV" in the *Daily News*, Durban. 17 April 2000, p. 2.

⁴² *The Emergent Reality of Heterosexual HIV/AIDS*, op. cit., p. 30.

DUNN'S DAY



Chapter Two

IMPACT OF HIV/AIDS

AIDS knows no geographical boundary
AIDS recognizes no race
AIDS respects no religion
AIDS understands no language
AIDS rejects all class distinctions
AIDS is not sexist
Because it eventually kills all its victims. (Farouk Amod)

2.1. IMPACT OF THE AIDS PANDEMIC

AIDS is the one acronym or abbreviation that requires no translation throughout the world as it has become the most deadly sexually transmitted disease ever to confront humanity. Few disease have highlighted the interaction between human behaviour, health and disease as AIDS has done. The potential for the loss of many lives in large sections of humanity has never been so great as is the case with this disease.

The early days of HIV/AIDS pandemic were filled with myth – heterosexual women and men believed themselves to be safe because this was a “gay disease”, women believed themselves safe because, “only men get AIDS”, children were believed to be safe from HIV infection because, “only adults became infected”, and persons of colour believed themselves to be safe because, “AIDS is a white man’s disease”. Within a short time, these beliefs began to dissolve as heterosexual women and men, children as well as

adults, and persons of colour along with Caucasians, became infected with the virus known as HIV.¹

Over the past two decades the HIV has spread silently throughout the world, profoundly affecting the lives of men and women, their families and communities, and societies. It has already taken a terrible human toll, not only among those who have died but among their families and communities. The appearance of HIV/AIDS has touched many aspects of our society and our daily lives. It has prompted the best in behaviour and action from people, as well as provoking the most extreme and irrational behaviour.

The reaction of blame and denial has been widespread, with people in all countries wanting to locate the source of the epidemic elsewhere, or to blame marginal population groups. AIDS is being blamed on gays, or on drug addicts, or on Blacks. Britain has blamed African students, the USA has blamed Haitians, Africa has blamed Europe (and vice versa), Japan has blamed foreigners, the French right has blamed Arab immigrants.²

AIDS has probably now becomes one of the most formidable of all diseases in human history. AIDS has four cardinal features which together make it a uniquely formidable disease. Firstly, it is infectious and transmissible from person to person. Secondly, that once infection occurs, it follows an inexorable course to disease and eventually to death in most, if not all, cases. Thirdly, that all persons infected with the HIV apparently remain infectious; that is, they are able to transmit the virus to others to a greater or

¹ *Confronting the AIDS Epidemic: cross-cultural perspectives on HIV/AIDS Education*, op. cit., p. 5.

² Jackson, H. (1988). *AIDS: ACTION NOW-Information, Prevention and Support in Zimbabwe*. Harare: AIDS Counselling Trust, p. 5.

lesser extent, for the rest of their lives. Fourthly, that the reservoir of infection, that is the total sum of people infected who can also act as a source of infectious virus to others, is constantly and progressively expanding as the epidemic spreads to involve more and more individuals.³ Thus it has become the deadliest pandemic affecting societies throughout the world.

2.1.1. Sexual Behaviour and Intoxicants

Intoxication with any drug including alcohol is associated with impaired judgement which can lead to increased risk taking regarding HIV/AIDS.⁴ There is an extensive literature indicating that, in many societies, sexual behaviours are interwoven with the recreational use of mind-altering drugs. In societies where alcohol is legally available, bar-rooms, hotels and other licensed premises are popular places for seeking sexual partners. Unwanted pregnancies, sexually transmitted infections and unprotected sex have all been linked to the disinhibiting effects of alcohol and other drugs.

There is a well-established link between bar-rooms or other drinking locales and sexuality. Many bars are frequently used as “pick-up” places and some are clearly defined as singles bars, gay bars, or in relation to other specific sexual categories.⁵

Transmission of HIV to the heterosexual population seems certain to continue. Infected bisexual men and parenteral drug users of both sexes will transmit HIV to the broader

³ *AIDS and HIV in Perspective*, op. cit., p. 17.

⁴ Siegel, L. (1988). *AIDS and Substance Abuse*. (New York: The Haworth Press. 1988. p. 6.

⁵ Plant, M. AIDS, (1990). *Drugs and Prostitution*. London: Routledge, pp. 1-4.

heterosexual population, where it will continue to spread as a result of high sexual activities.⁶

AIDS is a very easy disease to avoid. To be infected, we have to go out and “catch it”; it does not come after us. It is mainly a venereal disease because the principal means of disseminating HIV is sexual intercourse.⁷ Thus we can clearly see that prostitution and intoxicants contribute directly and indirectly to the rapid spread of HIV/AIDS in society throughout the world. Infections with HIV/AIDS are serious and urgent problems worldwide with broad social, cultural, economic, political, ethical and legal implications.

2.1.2. Rising Rate of Orphans

AIDS mainly affects working-age adults, resulting in adverse consequences for their children and, to a lesser extent, other family members. The changes in population structures where young to middle-age adults are lost due to AIDS will result in large number of orphans, as well as children in adopted families, growing up with less adult attention than might otherwise have been the case. This is becoming evident in many countries where the pandemic has taken a firm hold. In some situations, children will receive little or no adult attention. There is a danger that these orphans growing up without parents, and badly supervised by relatives and welfare organisations will be at greater risk than average risk to engage in criminal activity. Thus, increasing number

⁶ *AIDS and Substance Abuse*, op .cit. p. 125.

⁷ *Countdown to Doomsday*. op. cit. p. 37-39.

AIDS orphans, who grow up without parental support and supervision, may turn to crime and this could also lead to dramatic increase in the number of street children.⁸

2.1.3. Decrease in Households Resources

An individual infected with HIV/AIDS will require medical care and possibly special food, thus increasing demands on household resources and this will be aggravated by the high cost of drugs. If the infected person is a working adult, illness and death will reduce household production capacity, resulting in a decline in household income. Thus, households are caught in a double bind of needing more resources at the very time when these may be reduced. There has been one in-depth study of a rural village in Tanzania which showed that AIDS-affected households are generally pushed into poverty.⁹

As the disease progresses and financial resources are used up, people will begin spending their savings on medication and will eventually begin cashing in their insurance policies and selling their capital items. In rural areas in Southern Africa, the sale of cattle and farming equipment is already known to occur.¹⁰ This situation is possibly occurring in other parts of the world, particularly in developing countries where poverty is so rife. Thus HIV/AIDS plays a significant role in increasing poverty.

⁸ Whiteside, A. and Sunter, C. (2000). *AIDS: The Challenge for South Africa*. Cape Town: Human & Rousseau, pp. 95-97.

⁹ Ibid, pp. 88-91.

¹⁰ Ibid, p. 85.

2.1.4. Reduction of Labour Force

The HIV/AIDS epidemic affects and poses one of the greatest challenges to the economy of a country. The epidemic claims some of the best business leaders, managers and a great number of workers at all levels of the production system. HIV/AIDS-related absenteeism, loss of productivity and the cost of replacing workers lost to AIDS, threatens the survival of numerous business and industrial sectors of the increasingly competitive world market. In order to help in preventing the spread of HIV/AIDS and to provide a safe environment in the workplace, some countries including South Africa have now introduced an AIDS Workplace Policy. This is also to ensure that all workers' rights are respected and the company functions with few disruptions. Everyday the virus that causes AIDS infects many people in all parts of the world, most of them young or middle-aged adults on whom families, communities and economies depend.

AIDS primarily kills young and middle-aged adults during their most productive years, that is, adults in the economically active age group. An increase in illness and death in a population will inevitably have serious economic and social consequences. HIV/AIDS is more prevalent among the economically active part of the population, thus affecting economic activity through a loss of skills and experience. Labour productivity will decrease owing to absenteeism and illness of workers, and unit labour costs will increase as firms pay more for medical aid, group life or disability coverage. As the epidemic progresses, the sheer number of illnesses, death and orphans will be greater in many parts of the world. This means that the demand for assistance and health care as the epidemic develops will be greater. Concurrently the human resources that are expected

to provide these services will, in turn, be depleted by the epidemic. Hence countries will be waging an uncivil war against an invisible enemy more ruthless than any human adversary.

The state health system will experience much higher demands being placed on it and this may lead to deterioration in the level and quality of service. Also government resources and spending may be diverted from infrastructural projects into care and prevention programmes.¹¹

The HIV/AIDS epidemic has had a significant impact on the social-economic life of people around the world. The cost of drugs and hospital and medical care reduces the financial status of people and also places a financial burden on them. Economic activities in some countries are affected because of reduced labour force caused by HIV/AIDS illness or death. For instance in Uganda and Tanzania, coffee and other cash crops remained unharvested in 1991 due to an agricultural labour shortage resulting from mounting AIDS death (Scheer, 1992). This scenario is bound to worsen as the number of HIV/AIDS patients begins to mount in different parts of the world. In developed nations with social welfare services, the demands on these departments have increased tremendously due to an increased number of HIV/AIDS patients. Among the developing nations in Africa and also in parts of Asia, the extended family systems have broken down because AIDS kills the economic elite, leaving their children to the care of

¹¹ Ibid, pp. 66-108.

grandparents. The responsibilities of sick relatives and their children overburden friends, family and society in general.¹²

AIDS has put enormous pressure on health and other budgets. It will make existing health problems more severe, and it will cause widespread ill-health and death among what is normally the healthiest sector of the population, that is, adults aged 20-49 years. These people form the backbone of any country's economy, and they are breadwinners for their families. No country can afford a continuing high death rate among this group, particularly as it includes many professional and skilled workers.¹³

2.2. Ethical Dilemmas

HIV/AIDS has raised many ethical, legal and political issues. There has been considerable discussion on issues of confidentiality and informed consent, individual and collective rights, the mother's right and the rights of her unborn child, mandatory testing for HIV, and policies to protect the rights of people who are either HIV positive and/or have full blown AIDS. These vexing questions on HIV/AIDS have continued to generate varied opinions from politicians, researchers, students and AIDS activists.¹⁴ People with HIV/AIDS experience discrimination in schools, housing, employment, hospitals and other public institutions. Mandatory testing of athletes and people in other professions that involve group participation is controversial. The issue of confidentiality and disclosure of HIV/AIDS status arose because of fear, stigma and taboo associated with

¹² *Confronting the AIDS Epidemic*, op. cit. p. xviii.

¹³ *AIDS: ACTION NOW*. op. cit., p. 2.

¹⁴ *Confronting the AIDS Epidemic*. op. cit. p. 139.

it. HIV/AIDS-related issues have generated several legal actions in different courts around the world. Litigations have arisen regarding discrimination in schools, patient care, employment, housing, infected blood, and a host of other aspects.¹⁵

AIDS has become the most complex public health challenge confronting modern society. It has raised basic questions about the rights of individuals versus those of society, about the role of government, and about the nature of societal responses.¹⁶ It is rare to witness an epidemic that requires a reorganization of hospital services to patients, and a rethinking of hospital and administrative policy, particularly regarding issues such as patient confidentiality and the handling of patient information. Such has been the case with HIV/AIDS epidemic.¹⁷ Few communicable diseases have provoked public fear, political concern and human wastage as HIV/AIDS has. The pandemic has provoked social discrimination and rejection of infected people, and given rise to medical screening procedures which have raised serious human rights and technical concerns.¹⁸

Ethical issues regarding HIV/AIDS also have legal implications. For instance, do people who are infected with HIV have special responsibilities towards their sexual partners? A court in Larnica, on the small Mediterranean island of Cyprus, has jailed a man who has AIDS because he knowingly infected a British woman with HIV-1 through unprotected sexual intercourse. In July 1997, a Finnish court found an American guilty of 17 charges of manslaughter, after he knowingly infected 5 women with HIV-1. He was sentenced to

¹⁵ Ibid, p. xviii.

¹⁶ Knipe, M.H. and Rector, R. (1996). *Crossing Borders: Migration, Ethnicity and AIDS*. London: Taylor and Francis, p. 92.

¹⁷ Pinching, A.J. (1986). *Clinics in Immunology and Allergy – AIDS and HIV Infection*. London: W.B. Saunders Company. Vol.6. No.3, p. 661.

¹⁸ *Crossing Borders: Migration, Ethnicity and AIDS*, op. cit., p. 31.

14 years imprisonment. These and other similar cases have prompted the British government to consider the creation of a new offence of recklessly transmitting HIV.¹⁹ Also, the compensation for patients infected by blood or blood products has become a hot political topic in many countries.

In another development, the Australian Medical Association is at the centre of controversy over its draft plans to allow doctors to breach confidentiality if their patients refuse to tell their sexual partners they have HIV infection or AIDS.²⁰

In July 2001, a high court judge in Johannesburg, South Africa ordered a man to pay his wife nearly R1 million in damages for infecting her with HIV.²¹ An increased understanding of HIV/AIDS will limit the varied ethical arguments that engulfs the real issues militating against effective prevention of HIV/AIDS in the society.²²

HIV infection and AIDS challenge the human being to adapt to the myriad of changes that it brings into one's life. These changes occur in the physical, psychosocial, environmental, cultural and spiritual domains of functioning.²³ AIDS is a challenge that requires each of us to reconsider our traditions, morals and values and to respond positively to the pandemic.²⁴

¹⁹ Lachman, S.J. (1997). *Heterosexual HIV/AIDS as a Global Problem: Towards 2000*. Johannesburg: Pharmaceutical Society of S.A., pp. 209-210.

²⁰ Ibid, p. 255.

²¹ "Pay your wife R1m for giving her AIDS" in *Sunday Times*, dated 15 July 2001, p. 1.

²² *Confronting the AIDS Epidemic.*, op. cit., p. 139.

²³ Johnson, J.A. (1990). *Productive living Strategies for People with AIDS*. New York: Harrington Park Press, p. 3.

²⁴ WHO. (1991). *AIDS prevention through health promotion: facing sensitive issues*. Geneva: World Health Organisation, p. 67.

Chapter Three

ISLAM AND HIV/AIDS

Islam is a comprehensive way of life because its values, principles, rules and regulations deal with every facet of life. If we look at the religions or philosophies before the advent of Islam, we find that their outlook is essentially otherworldly. All forms of pleasure were to be avoided in order to live an ascetic life to achieve spirituality. In contrast, the modern secular ideology that is dominant in most parts of the world, negates the spiritual and emphasises on everything worldly. It is a materialistic civilisation with a hedonistic culture that places great emphasis on the gratification of the self. Islam strikes a balance between these two extremes. It integrates both the spiritual and material world into a harmonious and balanced, integralistic way of life. This integration is manifested in its principle of *Tawhīd* (Unity) which permeates the entire fabric of Islam with its fountain-head being the Unity of the Creator. From the Unity of the Creator flows the unity of creation – the unity of humanity – and the unity of the human personality.¹

The characteristic feature of Islam is that it integrates all aspects of the human personality, be it spiritual, physical, moral, aesthetical and intellectual, into a balanced and coherent, practical way of life. It balances the spiritual with the mundane by integrating both, in that, everything that is physical also has a spiritual dimension, thus there is no conflict between the two.

¹ Ansari, M.F.R. (1997). *The Qur'anic Foundation and Structure of Muslim Society*. Karachi: World Federation of Islamic Missions. Vol. I, pp. xxv-xxviii.

For example, *ṣalāh* (the five daily obligatory prayers) is a physical act but at the same time it has a spiritual dimension, namely, developing God-consciousness and the same can be said of fasting and the other aspects of Islam. Human life cannot be separated into watertight compartments, as any deficiency in one aspect would impact negatively on all aspects of the human personality. Furthermore, no act by itself can be seen to be purely spiritual or moral or physical on its own. Because Islam is a way of life, it cannot be compartmentalised and therefore, we cannot practice or over emphasise one aspect of Islam to the exclusion of others. For instance, we cannot say that we will regularly pray (*ṣalāh*) but at the same time we do not practice the moral values of Islam such as abstaining from drinking, gambling and other forms of vices. In such an instance, prayer (*ṣalāh*) becomes meaningless and we only delude ourselves. For us to attain the full benefit of Islam's protection from all social ills, including HIV/AIDS, we have to practice all its aspects in totality. As the *Holy Qur'ān* states:

“O you who believe! Enter into Islam whole-heartedly...”²

Therefore, any solution must be holistic in nature operating at multiple levels and multiple dimensions. All aspects of the Islamic way of life, be it *ṣalāh*, *sawm* (fasting during the holy month of *Ramaḍān*), *ḥajj* (pilgrimage to Makkah), etc. ultimately serve to develop the human personality in all its dimensions towards perfection of the individual on the one hand and the development of a healthy and harmonious society on the other. This in turn means that for a healthy society to develop, the individuals

² *Al-Baqarah*, 2:208.

have to have healthy moral personalities. At the same time a healthy society would enhance the development of healthy individuals. Spiritual development in Islam is inextricably bound to moral development which is why it places such great emphasis on moral and social purification. Islam has made it the mission of Muslims to purify society of all evils by constantly enjoining what is right and forbidding what is evil. In this regard, the *Holy Qur'ān* states:

“Let there arise out of you a band of people, inviting to all that is good, enjoining what is right and forbidding what is wrong...”³

It is in the light of this worldview that we have to understand the solution that Islam provides for all kinds of ills in general and HIV/AIDS in particular.

Because HIV/AIDS is primarily a sexually transmitted infection, sexual regulation in whatever form becomes an integral part of Islamic prevention. Let us look at some ways as to how Islam aims to regulate social and sexual behaviour that is conducive to HIV/AIDS prevention. Not only does it prohibit sexual relationships outside the bounds of matrimony, but also provides guidelines for safeguarding against sexual impropriety in society. In the prohibition of extramarital sexual relationship the *Holy Qur'ān* states:

“Nor come near to zina (illicit sexual intercourse): For it is a shameful (deed), and an evil, opening the road (to other evils).”⁴

³ *Āl 'Imrān*, 3:104.

⁴ *Banī Isrā'īl*, 17:32.

This means that any conduct or behaviour that is conducive to the development or promotion of any sexual impropriety, is forbidden. This refers to all levels of social conduct. Hence the promiscuous intermingling of men and women is not allowed in Islam in order to obviate any forms of temptation. The intermingling of men and women must be undertaken with purity of motives and ensuring that unnecessary temptation is prevented. In this regard the *Holy Qur'ān* states:

“Say to the believing men that they should lower their gaze and guard their modesty: that will make for greater purity for them...”⁵

“And say to the believing women that they should lower their gaze and guard their modesty; that they should not display their beauty and ornaments except what (must ordinarily) appear thereof...”⁶

It is in this regard that Islam prescribes a dress code for both men and women in order to prevent unnecessary sexual excitement or temptation. Hence all sorts of flirtatious behaviour or provocative attire is disallowed. Islam safeguards the dignity of men and women by forbidding all forms of sexual harassment and exploitation, be it in the advertising field, entertainment industry, business or the workplace. It maintains that the sexual urge should be fulfilled in marriage only and therefore condemns all form of sexual perversions including all forms of pornography and prostitution.

⁵ *Al-Nūr*, 24:30.

⁶ *Al-Nūr*, 24:31.

For an HIV/AIDS awareness and prevention programme to be successful in the Muslim community, it has to be rooted in the Islamic value system. Islam, as a way of life has built in safety mechanisms and protection from all kinds of social ills. Any deviation from its moral principles and practice will result in dire consequences depending on the nature of the deviation. In other words, if a person does not practice the Islamic values in his day-to-day life, then the consequences are of his wilful doings and not the fault of Islam. Let us very briefly look at some aspects of how Islam acts as a natural barrier against social ills, including HIV/AIDS.⁷

a) *Īmān* (Faith)

An Islamic prevention programme should capitalise on the deep belief that Muslims have in the Absolute Power and Mercy of *Allāh* (SWT) Who creates and controls everything in the universe; Who knows every secret in all creation and from Whom nothing is hidden. This belief is deeply rooted in all Muslims whether they are “sinners” or “saints”. A firm conviction in the belief of *Allāh* (SWT) as the origin of all life must evince itself in total submission to His laws. *Allāh* (SWT) alone can be the source of human values and morals and thus submission to His guidance must be manifested in all aspects of the person’s life. A successful AIDS prevention programme should use this level of God consciousness to bring about a positive change in attitude and sexual behaviour, particularly among those who are prone to deviate from sexual morality. Because HIV/AIDS is primarily transmitted sexually, the values of Islamic sexual morality should be promoted and encouraged to help and

⁷ *The AIDS crisis: a natural product of modernity’s sexual revolution*, op. cit., pp.183-190.

guide people to avoid any behaviour that could lead to HIV/AIDS. The belief that God sees everything and everyone is accountable to Him for all their actions, should be emphasised and this could further strengthen people's resolve to abstain from activities that can lead to HIV/AIDS. The *Holy Qur'ān* warns:

*“He (Allāh) knows what is secret and what is yet more hidden”*⁸

Any behavioural change would be unsuccessful unless the individual is self-motivated and strong willed to modify his or her behaviour. Hence, strengthening of God-consciousness, that is, *īmān* serves as a potent force for self-restraint. Also, faith in a Loving, Forgiving and Merciful Creator acts as a powerful influence for positive changes in attitude and lifestyle. Therefore, God-consciousness (or religious awareness) should be an integral part of any HIV/AIDS awareness and prevention programme.

b) *Ṣalāh* (Obligatory Five Times Daily Formal Prayer)

In Islam, the five daily prayers are compulsory on every Muslim so that they can develop God consciousness and maintain this at all times. The consciousness of the Creator must translate at the practical level in the performance of ones duties and responsibilities. Hence, one is reminded five times daily to fashion ones conduct in accordance to His commands. The five daily prayers are deliberately placed at strategic times during the course of the day and the early part of the night in order to

⁸ *Ṭā-Hā*, 20:7

protect the people from temptations to commit any immoral activities like drinking alcohol, drug taking, *zinā* (illicit sexual intercourse) etc. If the performance of daily *ṣalāh* is strongly inculcated in the life of a Muslim then this can act as a safeguard from indulging in all kinds of high-risk behaviour that could lead to HIV/AIDS. For instance, if a person is inclined towards these high-risk activities, then the thought of performing prayers could make him or her have a rethink and thus prayer can have a restraining effect. The *Holy Qur'ān* states:

“And establish regular prayer: For prayer restrains from shameful and unjust deeds...”⁹

Five times a day we seek *Allāh*'s (SWT) help and guidance when we recite *Sūrat al-Fātiḥah* from the *Holy Qur'ān* in our *ṣalāh*:

“Thee do we worship and Thine aid we seek: show us the straight way, the way of those on whom Thou hast bestowed Thy Grace. Those whose (portion) is not wrath and who go not astray.”¹⁰

Even when faced with difficulties or hardships, we are taught to turn to *Allāh* (SWT) for help, in the words of the *Holy Qur'ān*:

“I am one overcome: Do Thou then help (me).”¹¹

⁹ *Al-Ankabūt*, 29:45.

¹⁰ *Al-Fātiḥah*, 1:5-7.

¹¹ *Al-Qamar*, 54:10.

Also, when faced with evil suggestions or temptations, we should seek refuge in the Creator, as the *Holy Qur'ān* states:

“And if (at any time) an incitement to discord is made to thee by the Evil One, seek refuge in God. He is the One Who hears and knows all things.”¹²

Thus, *ṣalāh* develops a strong, moral personality in an individual, that is vital in the fight against HIV/AIDS.

c) *Sawm* (Fasting)

Fasting, especially during the holy month of *Ramaḍān*, can play a role in the holistic approach to a HIV/AIDS prevention programme. During this period, all Muslims, including those who are weak of faith, fast regularly and many of them have used this fasting period to give up their vices and shortcomings with success. Fasting develops will power and self-restraint from within and also boosts the will to change and this can help those who are engaging in high-risk behaviour to change their attitude and sexual behaviour in order to avoid HIV/AIDS infection. The Prophet Muḥammad (s.a.w.s.) is reported to have advised young unmarried people to fast often during the course of the year, in order to protect themselves from temptation to

¹² *Hā Mīm al-Sajdah*, 41:36.

commit *zinā*, as fasting helps to control a person's *nafs* (lower desires). The *Holy Qur'ān* states:

*“O you who believe! Fasting is prescribed to you as it was prescribed to those before you, that you may learn self-restraint.”*¹³

Hence, we cannot discount the beneficial effects of fasting in an AIDS prevention programme.

d) *Ḥajj* and *‘Umrah* (Major and Minor Pilgrimage)

Millions of Muslims from every part of the world visit the holy land of Arabia for the pilgrimage of *ḥajj* and *‘umrah* every year. Whilst *ḥajj* is confined to a specific time of the year, *‘umrah* is observed throughout the year. Hence, this international gathering of Muslims can be exploited to promote an Islamic HIV/AIDS awareness and prevention programme to all pilgrims. The programme could be promoted as part of a literature campaign, as well as talks on HIV/AIDS during the congregational sermons, as part of:

*“Enjoining what is right, forbidding what is wrong”*¹⁴

The HIV/AIDS messages can be given in the different common languages spoken by most Muslims in the world. Every pilgrim would take home that message to every

¹³ *Al-Baqarah*, 2:183.

¹⁴ *Āl ‘Imrān*, 3:104-110.

part of the world in which they reside and in turn propagate it to their families and friends. A panel of Muslim scholars and experts could draw up an Islamic HIV/AIDS awareness and prevention programme using the latest scientific information and technology to make it dynamic and appealing, particularly to the youth who are most vulnerable to high-risk behaviour. This programme could become a universal Islamic response to the AIDS pandemic throughout the world. It could be implemented in any part of the world where Muslims reside, irrespective of them being in the majority or minority. This programme could be promoted among Muslims via the local masajid and religious gatherings in any country. Imagine what impact this Islamic HIV/AIDS prevention programme could have globally on Muslims! Who knows? Maybe, even the secular West might realise the wisdom and positive results of this programme and might adopt it! Thus, Islam has a built in forum or platform, both locally and internationally, to promote its value system in any part of the world and the *hajj* and *‘umrah* institutions form the largest international gathering of people to achieve this. The *Holy Qur’ān* states:

“And complete (perform) the hajj or ‘umrah in the service of God”¹⁵

e) Some Prohibitions

- i) Islam like many other religions has certain prohibitions which it regards to be harmful to human nature and society. It has a balance view on life hence there

¹⁵ *Al-Baqarah*, 2:196.

is no extreme in the public or private life of a Muslim. The *Holy Qur'ān* states:

*“Thus have We made of you an Ummah (nation) justly balanced.”*¹⁶

Islam recognises the natural urges of human beings and it has created lawful and healthy channels for its fulfilment without endangering the individual or society. It prohibits monasticism (monk hood) and encourages marriage to develop a healthy moral society. The *Holy Qur'ān* states: *“And marry those among you who are single...”*¹⁷

Marriage in Islam offers protection to spouses from contracting HIV/AIDS because it restricts all sexual relationships to marriage only and forbids it outside marriage. Any deviation from this moral code; that is, having sexual relationship before marriage or having extramarital relationship, will make a person vulnerable to contract sexually transmitted diseases (STI) and HIV/AIDS infection because they are sexually transmitted. Because of this danger to one's health and to the breakdown of family life, Islam forbids any sex outside marriage. Unfortunately, in the secular world, sex is traded as a commodity – something that can be bought or sold, therefore it has lost its value, sanctity, purity and beauty of marriage. Whilst in Islam, sex is something that is pure because it sanctifies and beautifies the union between a man and a woman in marriage. Islam promotes fidelity in marriage and

¹⁶ *Al-Baqarah*, 2:143.

¹⁷ *Al-Nūr*, 24:32.

chastity outside marriage because it wants to develop a healthy moral society.

The *Holy Qur'ān* states:

*“Let those who find not the wherewithal (means, match) for marriage, keep themselves chaste, until God gives them means out of His Grace.”*¹⁸

In the wake of the AIDS pandemic, there is a call by a number of Christian groups in some Western countries, including our country, asking young people to abstain from sex until marriage. Some of these groups even have their members signing a chastity pledge. The Roman Catholic Church also promotes the moral values of abstinence before marriage and faithfulness thereafter.¹⁹

In 1984, King Goodwill Zwelithini revived the annual “Reed Dance” ceremony by Zulu maidens, in KwaZulu-Natal in South Africa, to fight the spread of AIDS among young people. This age-old Zulu ceremony is to educate and restore good morals and behaviour in young women and includes virginity testing.²⁰ Local politicians have urged young women to observe this culture of preserving their virginity and self-discipline, stating that it would help to curb the spread of the killer HIV/AIDS.²¹

¹⁸ *Al-Nūr*, 24:33.

¹⁹ “Condom strategy is wrong: Bishop” in the *Daily News* dated 30th July 2001, p. 3.

²⁰ “Reed Dance expects 10 000 maidens” in the *Daily News* dated 22nd August 2001, p. 3.

²¹ “Practice of virginity testing ‘helps curb AIDS’ in the *Daily News* dated 13th August 2001, p. 3.

In America, the pro-abstinence movement is very active in urging young people to practice chastity. Abstinence Clearinghouse is an umbrella organisation that mobilises leaders of the pro-abstinence movement who promote their messages in schools and get teens to sign virginity pledge cards. This movement is becoming very popular with its messages being advertised in big screen television that plays pro-abstinence commercials on a continuous loop and its logos such as, “Virginity Rules; Abstinence in Motion; Worth the Wait; Truth 4 Youth; The Best Sex is in Marriage” etc. being displayed at all its meetings and functions. It has now become a very powerful body with federal funding from the White House, to the value of \$135 million for the year 2003, for funding abstinence-only educational programmes. Abstinence Clearinghouse is also networking in Africa, with a third of the American government’s \$15 billion Global AIDS Bill earmarked for the abstinence message. The pro-abstinence movement have now taken their messages to Las Vegas, which is regarded as the biggest “Sin City” in the world.²² Thus, we see that many communities are now resorting to instil sexual morality into their lives, in the wake of the AIDS pandemic. This certainly is in keeping with the Islamic value system.

- ii) Islam, like the Judeo-Christian religions prohibits sexual relationship between same sex partners, that is, homosexuality and lesbianism, as this practice goes against human nature. The *Holy Qur’ān* states:

²² “Selling abstinence in Sin City” in the *Sunday Tribune* dated 6th July 2003, p. 19.

“Do you commit lewdness such as no people in creation (ever) committed before you? For you practice your lusts on men in reference to women: you are indeed a people transgressing beyond bounds.”²³

Similar prohibitions are found in the Jewish and Christian scriptures. In fact in their scriptures it is stated that God destroyed the cities of Sodom and Gomorrah because of their lewdness.

There is a growing body of opinion supporting the theory that the AIDS virus is a classic blood-borne viral disease like hepatitis B. In both, AIDS and hepatitis B, anal intercourse (homosexuality) is a causative factor. Another very interesting finding is that the receiving person treats semen from a different person as a foreign substance or antigen. This will stimulate the body receiving the semen to produce antibodies against it. In the case of a homosexual receiving semen in his rectum, the antibodies triggered were found to be of the auto-antibody type which are not only directed against the foreign semen but also against the cells of the body of the receiving homosexual. Strangely though, the cells attacked were found to be particularly the T-lymphocytes responsible for immunity (Daniel: 1986)²⁴. It has also been confirmed that during anal sexual intercourse, exposure to the partner's faeces can predispose to HIV infection (Daniel: 1986)²⁵.

²³ *Al-A'raf*, 7:80-81.

²⁴ Badri, M. (1998). *The AIDS Dilemma – A Progeny of Modernity*. Durban: Islamic Medical Association of South Africa, p. 36.

²⁵ *Ibid*.

AIDS was first discovered in five young men, all active homosexuals, in October 1980 in Los Angeles in the USA. From its very first beginnings the most striking feature of the AIDS epidemic in the USA and in other Western countries was its dominance in the male homosexual population.²⁶ Since early cases of AIDS in the West were homosexuals, it was assumed to be a “gay plague”. In the USA, it was known as Gay Related Immune Deficiency (GRID).²⁷ One retrospective analysis identified cases of AIDS in homosexual men as early as 1978 (Selik, et.al, 1984). Since HIV infection can precede AIDS by several years, homosexual men in the USA may have been infected with HIV as early as the mid-1970s (Jaffe, et.al, 1985b).²⁸

From the above information, it becomes abundantly clear why Islam forbids homosexuality as it regards it as a grave danger to human beings and to the well-being of society.

- iii) Islam forbids the taking of any intoxicant that includes alcohol, drugs or any substance that clouds your senses or judgement. As impaired judgement can seriously lead a person to commit any kind of evil, which he or she would not normally do, it is forbidden in order to protect the individual and society from its harmful effects. Examples of such are drunken driving, rape, murder, breakdown of family life, crimes, etc.

²⁶ *AIDS and HIV in Perspective*, op. cit., pp. 2-4.

²⁷ *Countdown to Doomsday*. op. cit., p. 37.

²⁸ *Clinics in Immunology and Allergy – AIDS and HIV Infection*, op. cit., p. 449.

Intoxication with any drug including alcohol is associated with impaired judgement which can lead to promiscuity and hence increase the risk of HIV infection.²⁹ Individuals often take these drugs in order to lose their inhibitions. The result is an increased willingness to participate in “risky behaviours” which increases the chances for their exposure to HIV/AIDS. Considerable clinical evidence exists to suggest that alcoholics are more susceptible to infection than teetotallers. There is reason for concern that alcohol ingestion might reduce the effectiveness of an individual’s immune defence against HIV.³⁰ A not so well known association is that many mood altering chemicals (like alcohol and drugs) are speculated to be co-factors, increasing susceptibility to the causative agent (HIV) and aiding in the progression of the disease (AIDS). This may be because many mood altering chemicals including alcohol are, like AIDS, immuno suppressive.³¹

The California Legislature (in the USA) has also addressed drug use as a possible co-factor affecting the progression from HIV infection to the development of clinical AIDS. California law requires establishments that sell “poppers” to post a sign warning that inhalation of alkyl nitrates may be harmful to health, may affect the immune system, and has been associated with the development of Kaposi’s sarcoma, an AIDS-related cancer.³² It is now widely recognised that the shared use of non-sterile injecting equipment,

²⁹ *AIDS and Substance Abuse*, op. cit., p. 5.

³⁰ *Ibid*, pp. 47-54.

³¹ *Ibid*, p.15.

³² *Ibid*, p.126.

by injecting drug users, represents a (second) major route of transmission for the spread of the HIV virus.³³

Thus, Islam forbids all kinds of intoxicants for obvious reasons, and as mentioned above. The *Holy Qur'ān* states:

*“O you who believe! Intoxicants and gambling, (dedication of) stones, and (divination by) arrows, are an abomination (evil), of Satan’s (devil) handiwork. Eschew (shun) such (evil) that you may prosper.”*³⁴

Any response to the HIV/AIDS pandemic must be based on a worldview. If one looks at the model of prevention in most Western countries, we can see that it is based essentially on a secular worldview. To the secularist, HIV/AIDS is a serious inconvenience in the sexual revolution of their way of life. This is what Bill Clinton, the past President of America, had to say to his people “Our common goal must ultimately be a cure for all those who are living with HIV and a vaccine to protect the rest of us from the virus.”³⁵ There is no talk of lifestyle change or behaviour modification to avoid those activities that predisposes a person to STI and HIV/AIDS. That is the stance taken by the secular governments in the West. Hence, their solution is aimed

³³ AIDS : Individual, Cultural and Policy Dimensions, op. cit., p. 143.

³⁴ *Al-Mā'idah*, 5:93.

³⁵ *The AIDS Crisis: a natural product of modernity's sexual revolution*, op. cit., p. 131.

primarily to find a magic cure and continue life as usual in the sexual revolution. This is more like treating the symptoms of a disease instead of the actual cause. In such a world view where physical gratification is the main objective, there is no room for morality and their only solution is “safe sex”, that is, use condoms and avoid high risk activity, as the only qualification.

The response to the HIV/AIDS pandemic in Islam can only be appreciated and understood within the world view of Islam. An Islamic approach to AIDS prevention must be holistic in nature and not emphasise only one or two aspects. It must be non-judgemental, free of any stigma and not label any person. It must also include new strategies evolving from Islam as a way of life and a worldview, such as its uncompromising position against zina; alcohol consumption; drug taking; immoral activities in the form of advertising and entertainment; sexual abuse and exploitation, especially of women who must be empowered to guard their sexuality from abuse. As part of a holistic approach, it must develop strategies to deal with the challenges of a secular culture, that promotes uninhibited sexual behaviour. It must devise and develop healthy alternatives to channel the energies of Muslims, particularly the youth, into productive activities such as drama; sports; alternative forms of entertainment that do not violate any moral values and are still enjoyable; developing creativity in arts and crafts; involvement in educational, social and welfare programmes; youth clubs; etc. Muslim scholars and activists need to apply themselves earnestly in developing a HIV/AIDS awareness and prevention programme using the latest scientific

information and technology that is holistic, dynamic, appealing and which can provide alternatives to the secular attractions that confront or entice people, particularly the youth, who are most vulnerable. It should include capacity building programmes for AIDS educators and workers, as well as care and support for people living with HIV/AIDS and AIDS orphans. In short, it must be from multisectoral level to grass-root level, from the micro to the macro level, whereby every Muslim, including youth and children, must be empowered in the *jihād* (striving) against HIV/AIDS.

Chapter Four

MUSLIM INITIATIVES

The first reported case of a Muslim who died of AIDS was in the Cape in 1986.¹ Then, in 1993 the first Muslim infant died of AIDS and that was an indication that the HIV/AIDS was already prevalent in the Muslim heterosexual community.² As more and more Muslims begin to adopt the Western value lifestyle, we can expect an increase in the number of HIV/AIDS infection. The question is, what are we doing about this and how do we prevent this catastrophe in the *Ummah* (Muslim community).

It has become most pragmatic among many health and social workers worldwide that HIV/AIDS awareness and prevention programmes should be sensitive to the cultural and beliefs of the different ethnic groups. It is more effective to develop and implement health education programmes that are adapted to the community's existing practices and beliefs rather than exchange them to fit the programme.³ In regard to this, let us examine what is the Muslim response to HIV/AIDS in our country. This research has been confined to those Muslim organizations that have a specific and structured programme in HIV/AIDS awareness and prevention. This does not exclude any Muslim individuals who may be actively working in HIV/AIDS on their own or as part of other non-governmental organizations (NGO) and also, those other Muslim organizations that may be promoting HIV/AIDS awareness and prevention incidentally during the course of their particular activities.

¹ *Journal of the IMA of South Africa (JIMASA)*. April 1997, p. 34.

² *Journal of the IMA of South Africa (JIMASA)*. April 1997, p. 35.

³ *Journal of the IMA of South Africa (JIMASA)*. April 1997, p. 36.

4.1. THE ISLAMIC MEDICAL ASSOCIATION OF SOUTH AFRICA

The Islamic Medical Association of South Africa (hereafter known as the IMA) was established to provide a forum for Muslim health care workers to develop their Islamic consciousness by providing voluntary medical care to the less fortunate and needy people in the country, irrespective of race, colour and religion. It was formed in July 1974 as *Lajnatul Aṭibbā'* (The Doctors' Committee) and as its activities and membership increased over the years, it was transformed into the IMA in September 1979.⁴

The IMA is, mostly probably, the first Muslim organization in the country to be actively involved in HIV/AIDS work on a national level. For instance, at its 11th Annual Convention held in Lenasia in June 1991, it had a special session on "HIV Disease" whereby the following papers of a clinical and general nature were presented and discussed:⁵

- 1) Clinical manifestations of HIV
- 2) Laboratory diagnosis and serology of HIV
- 3) Genital-ulcer disease – impact on AIDS
- 4) Natural history and management of HIV/AIDS
- 5) Attitudes of health workers to HIV/AIDS
- 6) Counselling the HIV/AIDS infected patient
- 7) Islamic Response to HIV disease

⁴ Amod F. IMA of S.A.- *Sterling Service. 27 years of health care*. Durban. IMA of S.A. 2001, p. 8.

⁵ *IMA 11th Annual Convention Brochure*. June 1991. p. 22.

Subsequently, it has included in every convention thereafter, a session or a report on HIV/AIDS either as a special workshop session or in the general programme of the convention. For example, Dr M. Badri of Sudan delivered a paper on “AIDS Crisis: An Islamic Perspective” at the 15th Annual Convention in July 1995 which was held in Cape Town. It is the first organization to draw up and publish, in December 1991, a leaflet on HIV/AIDS awareness and prevention from an Islamic perspective. Also during that time, a *Jumu‘ah Khuṭbah* (Friday congregational prayer talk) on HIV/AIDS was drawn up and circulated to all its branches to have it read in all the *masājid* (mosques) in South Africa.⁶

The HIV/AIDS leaflet is entitled “What you need to know about AIDS” and contains *interalia* information on the following:⁷

- 1) What is AIDS?
- 2) What is AIDS caused by?
- 3) Why is AIDS a public problem?
- 4) What does the virus do?
- 5) How is the disease spread
- 6) How do you get AIDS?
- 7) Is there a difference between HIV and AIDS?
- 8) AIDS and the health worker
- 9) How to combat AIDS?
- 10) The solution

⁶ *Bulletin of the IMA (BIMA) Pamphlet*. December 1991.

⁷ IMA Leaflet. What you need to know about AIDS. Durban. 1991.

The solution given on the abovementioned HIV/AIDS leaflet is based on the Islamic value system, namely:

- a) Sex outside marriage must be vehemently discouraged
- b) Chastity before marriage must be vigorously promoted
- c) Fidelity during marriage must be upheld at all cost
- d) All social and cultural organizations must work collectively to encourage people to uphold sexual morality.

The IMA organized a very successful AIDS Awareness Day in KwaZulu-Natal (KZN) and Gauteng on 24 January 1992 and in the Western Cape (WC) on 14 February 1992. The *Jumu'ah Khutbah* on these two days was given by an IMA member or by the *Imām* (congregational prayer leader) in about two hundred *masājid* throughout the country. A model *Khutbah* on HIV/AIDS was prepared by the IMA executive committee and given to the various persons to use as a basis for the talk. The talk proposed an Islamic solution to the HIV/AIDS pandemic, namely: no pre-marital sex; no extra-marital sex; no promiscuity and no homosexuality. Over 100 000 HIV/AIDS leaflets published by the IMA were distributed on these two days throughout the country. Members were encouraged to purchase extra copies of this leaflet for free distribution to their patients from their consulting rooms as part of promoting the Islamic solution to the general population of the country against the HIV/AIDS pandemic. This leaflet is still available for free distribution. The IMA members received positive comments, support and

encouragement from the Imams (leaders), trustees of masajid and from members of the congregation at the success of this AIDS Awareness Day campaign.⁸

Dr F.S. Kalla of the IMA presented a paper on HIV/AIDS at an AIDS Symposium held in Khartoum, Sudan which was organized by the IMA of Sudan in February 1994. He described a profile of paediatric problems of AIDS in the peri-urban areas and concluded that a multidisciplinary team approach which includes social and religious workers, was needed for addressing the problems posed by HIV/AIDS.⁹

Dr A. Harneker presented a paper on "AIDS and Homosexuality" at an IMA Conference in Indonesia in October 1996. He pointed out that all major religions regard homosexuality as an evil and a great sin. In his presentation he stated *interalia* that we need to:¹⁰

- a) propagate the Islamic teachings on human sexuality
- b) counteract the intellectual debate on homosexuality being normal
- c) give insight to patients so that their attitudes are positively influenced
- d) encourage them to change their behaviour
- e) give them hope and remind them of Allah's mercy and forgiveness.

Thus we can see that the IMA had already started in earnest its HIV/AIDS awareness programme of education and prevention long before the government could launch its

⁸ *Bulletin of the IMA (BIMA) Pamphlet*. March 1992.

⁹ *Bulletin of the IMA (BIMA) Pamphlet*. April 1994.

¹⁰ *Bulletin of the IMA (BIMA) Pamphlet*. November 1996.

Religious AIDS Programme (RAP) to co-ordinate the role of religious organizations in various socio-health issues with top priority being given to the fight against the AIDS pandemic in the country.

The IMA held its first HIV/AIDS seminar for health care workers on 23 August 1998 at Johannesburg. More than sixty delegates from the various parts of Gauteng, North West and Mpumalanga provinces attended. Clinical lectures of a high standard were presented and included dermatology, haematology and paediatric aspects of HIV/AIDS. The Islamic perspective on morality, counselling and legal aspects was discussed as well. The burial guidelines were also presented and discussed.¹¹ These guidelines were later published and distributed by the Muslim AIDS Committee (MAC) in July 2000. Seminars on HIV/AIDS are regularly conducted for health care workers in order to better equip them to manage and treat HIV/AIDS patients. Attendance for these workshop programmes secures six Continued Professional Development (CPD) points for all participants. The seminars are very popular and have been held in places such as Johannesburg, Lenasia, Rustenburg, Welkom, Ladysmith, Umtata, Mafikeng, Durban and Western Cape areas. Medical discussions also include, HIV affecting various organ systems, burial guidelines, ethical and moral issues, etc.¹²

In April 1998, as part of its educational campaign on HIV/AIDS, the IMA published a booklet entitled *The AIDS Dilemma – A Progeny of Modernity* by Malik Badri, on the occasion of its 18th Annual Convention held in Cape Town. The text of this publication

¹¹ *Sterling Service 27 years of Health Care*. op. cit. p. 91.

¹² Bulletin of the IMA (BIMA) Pamphlet. February 2000.

was based on his presentation at the inaugural symposium on “Islam and the Challenge of Modernity, historical and contemporary contexts” held in August 1994 in Kuala Lumpur, Malaysia and at the 15th Annual Convention of the IMA of South Africa held in July 1995 in Cape Town. In September 1999, they republished Malik Badri’s 300-page book - *The AIDS crisis: a natural product of modernity’s sexual revolution*. This book was first published in Kuala Lumpur, Malaysia in 1997.

The IMA participated in the 13th International AIDS Conference which was held in Durban from the 10-14 July 2000. A number of its members, including the writer, attended as delegates, the proceedings, sessions, workshops and talks. The IMA had an exhibition booth at the venue displaying their work and literature on HIV/AIDS awareness campaign from an Islamic perspective. It also hosted the Ugandan delegation who attended the AIDS Conference as “Ambassadors of Hope Mission” between the period 9-17 July 2000 in Gauteng, Western Cape and KwaZulu-Natal. During their stay in Durban, they spoke on their success story on HIV/AIDS on the national Indian and Zulu radio stations. They were also interviewed on a television programme that was broadcasted to the rest of Africa during the AIDS Conference. Their HIV/AIDS programme had won the international UNAIDS Best Practice award in October 1998. They had made their fight against the HIV/AIDS pandemic a “jihad”(earnest striving) in their communities.

The Durban branch of the IMA arranged for them to meet and have discussions with about fifteen Muslim organizations. They also addressed the Muslim public through the Friday *Khutbah* at the largest *masjid* in Durban and in Phoenix. A successful workshop

was organized with a group of Muslim organizations. They also shared their experiences in an interfaith programme which was organized together with the World Conference of Religion and Peace (WCRP) and government representatives. Much interest and awareness was generated focusing on how the Ugandan Muslims managed to reduce the HIV/AIDS statistics. This was the important lesson shared by the “Ambassadors of Hope Mission” to South Africa. The IMA in Durban was able to reach out to various sectors of the community, namely, the educators; *da‘wah* workers; youth organizations; ‘*ulamā*’ bodies; doctors and other health care workers; women’s groups and other non Muslim organizations. Much attention was on how Islam could be used as a model in HIV/AIDS prevention.¹³

On the occasion of the 13th International AIDS Conference, the IMA reprinted two booklets for distribution during the conference. The booklets were based on two chapters from Malik Badri’s 300-page book - *The AIDS crisis: a natural product of modernity’s sexual revolution*. The booklets are: *AIDS Prevention: Role of Governments, the Media and Organisations* and *AIDS Prevention – Failure in the North and Catastrophe in the South: A Solution*. As part of its literature campaign against HIV/AIDS, it also in conjunction with the Islamic Forum, Muslim Youth Movement (MYM), Islamic Propagation Centre and ALBARAKA Bank published a message on HIV/AIDS called, “Buckle Up” in the form of an Islamic *du‘ā* (supplication) which was available in a A2 size colour poster or leaflet form and five thousand of each copy was printed for free distribution during the AIDS conference.”¹⁴

¹³ *Bulletin of the IMA (BIMA) Pamphlet*. October 2000.

¹⁴ *Sterling Service 27 years of Health Care*, op. cit., p. 94.

The aim of its literature campaign was to promote the Islamic viewpoint on HIV/AIDS prevention not only to South Africans, but to the international community that was present at the conference. The message is so potent and beautifully projected in colour with road safety signs on a yellow background. It is reproduced as Appendix 1.

The IMA is actively involved in the government's Religious AIDS Programme (RAP) which was launched in September 1996 as a National NGO under the Department of National Health. Its purpose is to provide a forum whereby all religious communities can work together in HIV/AIDS awareness and prevention programmes. Moulana E. Bham from the Jamiatul Ulama (religious body) of Gauteng represents the Muslims nationally whilst Dr E. Mohamed is the IMA national representative serving on the National Council of RAP. There are also provincial representatives appointed by the IMA annually.¹⁵

In September 1997 the IMA in Gauteng initiated a Muslim HIV/AIDS programme by enlisting the assistance and involvement of the Islamic Careline and the Jamiatul Ulama and formed the Muslim AIDS Committee (MAC). The aim of this committee was to draw up and implement a Muslim AIDS Awareness Programme (MAP) for Muslims. Its members were trained as AIDS Educators by the Department of Health and material from the World Health Organisation (WHO) was adapted for Muslims and incorporated with an Islamic perspective into the MAP. These trained members then introduced the Muslim HIV/AIDS programme into the other major regions of the IMA, namely, KwaZulu Natal and Western Cape and trained their volunteers as AIDS Educators through a series of

¹⁵ Ibid, p. 36

workshops and programmes. These regions have adapted the MAP programme to suit the needs and situations in their particular regions. The three major IMA regions where the HIV/AIDS programme is being earnestly implemented are as follows:

4.1.1. The IMA of Gauteng

Its members initiated the Muslim HIV/AIDS programme and formed MAC for this purpose, therefore, its activities will be discussed as part of MAC under a separate heading.

4.1.2. The IMA of KwaZulu-Natal

Its members participated in an AIDS Awareness Day which was held in the Oval Shopping Centre in Ladysmith in December 1995. This was organised by the various groups from that town. IMA leaflets on HIV/AIDS were freely distributed to the general public and posters depicting the Islamic preventative aspects of HIV/AIDS were displayed at its stands. These highlighted *interalia*, the promotion of chastity before marriage, fidelity during marriage and the eradication of sexual promiscuity, namely, "Condoms are not the answer;" "Prevention is better than Protection;" "Act positive to stay negative." Dr S. Khan of the IMA gave one of the keynote addresses. He highlighted the preventative aspects and stated that the use of condoms is not 100 percent safe from HIV infection. He also stressed that there should be no discrimination against people who have HIV/AIDS.¹⁶

¹⁶ *Bulletin of the IMA (BIMA) Pamphlet*. February 1996.

The members of the Ladysmith branch hosted a successful workshop on HIV/AIDS for women on 4th October 1998 in Ladysmith. Ms S. Nawab from MAC was invited to conduct the workshop. Participants included members of the medical and legal profession, educators, members of the local branch of Hospice, beauticians, housewives and students. Some of the issues that were discussed included the following:

- a) Attitudes towards HIV/AIDS
- b) HIV/AIDS facts
- c) Islam and sexuality
- d) Prevention of HIV/AIDS
- e) Living and dying with AIDS
- f) The way forward

Group discussions amongst the participants were included and this made it very interesting and informative. At the end of the workshop, participants were presented with the “Muslim AIDS Awareness Workshop” manual.¹⁷

An AIDS Awareness workshop was held on the 9 June 1999 at the Durban IMA office as a start to their HIV/AIDS campaign for KwaZulu Natal.¹⁸ Representatives from various organisations such as the Islamic *Daw‘ah* Movement, *Al Ansar* Trust, Women’s Cultural Group, Gift of the Givers Careline, *Jamaatun Nisa*, *Sunni Jamiatul Ulema*, Soofie Group,

¹⁷ *Bulletin of the IMA (BIMA) Pamphlet*. February 1999.

¹⁸ Interview with Dr S. Cassim. April 2002.

IMA members and several individuals attended. A total of 30 delegates were present at the workshop. Ms S. Nawab from MAC presented an overview of the ethical and moral dilemmas facing the Muslims regarding HIV/AIDS. Lively discussions and interaction prevailed throughout the sessions.¹⁹ Subsequently, a follow up intensive three day training workshop was held on the 12-14 July 1999 at the Durban office where a qualified AIDS educator from MAC trained twenty volunteers. These people from various Muslim organisations qualified as AIDS educators at the end of the three day workshop and became responsible to train others. The campaign was aimed at inculcating a sense of pride in the Islamic code of conduct with a strong emphasis on the family and also, a sense of compassion for the people living with AIDS; for the innocent AIDS orphans; and to join other groups who had taken up the challenge against HIV/AIDS. The AIDS awareness campaign had been promoted in the following ways:²⁰

- a) *Masājid* – pre-*Khuṭbah* talks were delivered in seventeen *masājid*²¹ in Durban and surrounding areas and a national AIDS Awareness Drive had been planned for the 26 November (1999) in all the *masājid* in South Africa, and subsequently this was achieved.
- b) Media – an article on HIV/AIDS was published in the national Muslim newspaper, *Al Qalam*. Talks on HIV/AIDS were presented in the local Muslim radio station, *Al Ansar*, during their *Ramaḍān* broadcast; in the national

¹⁹ Bulletin of the IMA (BIMA) Pamphlet. July 1999.

²⁰ Interview with Dr S. Cassim. April 2002.

²¹ Interview with Dr E. Khan. April 2002.

community radio station, Radio Lotus; and in the local community radio station, Radio Phoenix.

- c) Women groups – HIV/AIDS awareness and prevention talks were delivered to women groups in Overport, Phoenix, Isipingo, Verulam, Kwa Makuta, Umbogintwini, Pietermaritzburg, Port Shepstone and Newcastle. By October 2000, over five hundred women were empowered with the Islamic viewpoint on HIV/AIDS.
- d) Religious Field Workers (*du‘āt*) – through networking with various Muslim dawah organisations, about four hundred workers²² were educated with the Islamic perspective on HIV/AIDS awareness and prevention programme in order to effect behaviour change in people, especially with those who are at high risk.
- e) Community Awareness – public talks on HIV/AIDS awareness were delivered to the general populace in Durban, Phoenix, Chatsworth, Stanger, Shallcross, Port Shepstone and Newcastle. By October 2000 the AIDS message had reached over two thousand five hundred people.²³ A seminar for health care professionals was conducted at the Durban office in November 1999 regarding the medical aspects of HIV/AIDS, namely, on diagnosis, treatment options and prevention. The Islamic viewpoint on HIV/AIDS was presented at the State President’s Partnership Against AIDS forum in Durban in November 1999; at the Chatsworth Child Welfare programme in December 1999; and at the M.L. Sultan Technikon workshop in April 2000.

²² IMA HIV/AIDS Committee Report. September 2000.

f) Schools – initially, workshops on HIV/AIDS for educators from Muslim schools were conducted in the Durban and surrounding areas. Teachers were trained as AIDS educators and to implement a five lesson programme that was drawn up for learners. Principals were approached with a view to include the HIV/AIDS awareness programme in their school curriculum. Later, this initiative was extended to some public schools in the Durban areas as well as tertiary institutions such as the M.L. Sultan Technikon and the medical school at the University of Natal. By October 2000, this programme had reached areas in Pietermaritzburg, Port Shepstone, Stanger and Newcastle. The school programme consists of five sessions of one hour each over a period of five weeks. Each session has a worksheet and evaluation at the end for pupils to complete. The programme covers the following aspects which are very briefly stated below.

- i) Session one: self concept enhancement
- ii) Session two: what is AIDS
- iii) Session three: who is an AIDS carrier
- iv) Session four: attitudes
- v) Session five: sex and sexuality and the Islamic perspective

From October 2000, the HIV/AIDS programmes have been taken over by *Baytul Nur* which is a community project and social wing of the IMA of KwaZulu-Natal. It has its own office and staff in Durban since October 2000 and has been offering professional

²³ *IMA HIV/AIDS Committee Report, October 2000.*

counselling and training for substance abuse, domestic violence, child abuse, marital conflict, divorce, mental health problems and adolescent problems. It also deals with any social or community issues that may arise from time to time. Since June 2001, it has been very actively involved in the promotion and implementation of the HIV/AIDS programmes in a more structured way in KwaZulu-Natal. All staff and volunteers working in the area of HIV/AIDS have on going training through workshops, seminars and conferences. The social workers, psychologists, mental health workers, doctors and volunteer trainers provide excellent services.

The activities, projects and HIV/AIDS programmes of *Baytul Nur* (IMA of KwaZulu-Natal) are implemented at the primary, secondary and tertiary levels of intervention where urban, peri-urban and rural areas are accessed. The three levels are summarised as follows:²⁴

1. Primary Level

- a) Awareness, education and information for school learners, This incorporates strong components of life skills as well. ±400-600 learners are reached per month (ages 10 years – 20 years).
- b) Awareness education and information for communities, groups, organisations and interested parties. Four full day workshops per month (80 participants per month).

²⁴ Interview with Ms S. Hoosen. July 2002.

- c) University programmes: UND Medical school, UDW Health services - ± 260 students (\pm ten workshops per year).
- d) Four one-day HIV/AIDS Community Awareness days, reaching 1 500 persons per day. Talk by HIV/AIDS Educator-interactive day.
- e) Specific workshops on HIV/AIDS skills for counselling – four workshops for the year (20 participants).
- f) One 3 day Train the Trainer workshop per year – 40 participants. All aspects of HIV/AIDS covered.
- g) Two workshops for Religious Leaders – dealing with the Islamic Teachings and HIV/AIDS (40 participants).
- h) Educational programmes at 4 clinics by Community Health worker on VCT and reduction of MTCT.
- i) Organisational consultation – a service provided to empower other organisations.

2. Secondary Level

- a) Therapeutic groups – for young people who are at high risk – experimentation with sex, rape and assault – stress the spiritual injunctions and principles.
- b) Pre- and Post-counselling of clients – telephonic and face-to-face.
- c) Voluntary counselling and referral for test by local IMA medical staff – Doctor at hospital that sees women for testing and follow up.
- d) Training for home-based care and infection control, etc.

- e) Networking and collaborating with other organisations is the key at this level of service provision.

3. Tertiary Level

- a) Ongoing counselling for HIV positive women – support, medical care and spiritual care (weekly counselling).
- b) Therapeutic groups for HIV positive women. Support and care – plan for the future (once a week). Very spiritual in nature.
- c) Home based care by community health worker – helping to bath, turn and provide support (weekly).
- d) Crisis counselling for traumatised persons.
- e) Referrals to hospital, district surgeons, and police for rape and assault persons for prophylaxis care. All letters and recommendations done through *Baytul Nur*.
- f) Proper referrals to Department of Welfare for HIV/AIDS grant applications and follow-ups. HIV/AIDS grants can be accessed.
- g) Placement of children into appropriate institutions and follow-ups.
- h) Telephonic Hotline Counselling for HIV/AIDS.

Baytul Nur (IMA of KwaZulu-Natal) in collaboration with the South African Dawah Network held a successful three-day AIDS Awareness Training Programme as part of the 5th Regional Sisters Skills Camp at the Inchanga Islamic Centre from 2 to 4 July 2001. Personnel who were previously trained as AIDS Educators by members of MAC,

conducted the various programmes. A total of forty-eight women from Zimbabwe, Malawi, Lesotho and throughout South Africa participated in the programme. Hence, it was an international training programme on HIV/AIDS awareness. These women were mostly from rural areas who represented various Muslim organisations and institutions. The participants realised the urgency and need to convey what they had learnt to their particular communities and were eager to initiate their own HIV/AIDS programmes. All the participants qualified as AIDS Educators and received certificates.²⁵ The programme during the three-day period covered the following topics:

- a) HIV and AIDS
- b) Impact of AIDS in society
- c) Stages and symptoms
- d) Immune system
- e) Transmission
- f) Prevention
- g) Treatment
- h) Testing and counselling
- i) Psycho-social implications of HIV infection
- j) Planning and presentation of programmes

A school awareness programme on HIV/AIDS has been initiated from January 2001.²⁶

²⁵ *Bulletin of the IMA (BIMA) Pamphlet*, August 2001.

²⁶ Interview with Ms S. Hoosen, July 2002.

This full day programme has been conducted in many primary and secondary schools in state and Muslim schools in the Durban areas. Learners need to be empowered with the knowledge on HIV/AIDS therefore this programme is an ongoing activity that is available to any school that requests it. Substance abuse is incorporated in the programme because it has a strong impact on the spread of HIV. The following aspects are covered in the basic programme which is adapted from time to time to suit the level of the learners or the needs of the school concerned.

- a) Know yourself – who am I?
- b) What is HIV/AIDS?
- c) How did this virus come about?
- d) How is the virus spread/not spread?
- e) Draw a person who is HIV positive
- f) Talk by HIV positive person
- g) Talk on drug addiction/substance abuse
- h) How I must not get this virus into my body?
- i) HIV/AIDS – impact/statistics
- j) Care and support for people with AIDS
- k) Draw poster on HIV/AIDS/drugs
- l) Questionnaire/Evaluation worksheets

The first three- day Train-a-Trainer workshop in KwaZulu-Natal was held at the Durban office of the IMA in July 1999 and was conducted by a member from MAC. Subsequently, *Baytul Nur* has been conducting this workshop at its office and the

programme has been adapted to suit the particular needs in KwaZulu-Natal which has the highest prevalence of HIV/AIDS infection in the country.²⁷ This training programme is open to the general public which includes Muslims and non-Muslims. It is conducted whenever there is a group of about thirty people available. The objective of this workshop is to equip and empower participants with the necessary knowledge and skills to train others in the community in HIV/AIDS education and awareness. At the end of the training period, each participant qualifies as an AIDS Educator and receives a certificate. The programme covers the following topics over the three-day period.

- a) Introduction: draw HIV positive person – video presentation – questionnaire.
- b) Statistics and Impact on HIV/AIDS: awareness on individual, family, community-political and economical implications.
- c) Exploring attitudes: awareness of attitudes towards people who are different – paradigm shift towards empathy and care for people with AIDS.
- d) What is HIV/AIDS: transmission, immunology, treatment and testing.
- e) Voluntary Counselling and Testing (VCT) and Mother to Child Transmission (MTCT): how VCT is done and where resources are available – explore the latest information on MTCT.
- f) Living with HIV/AIDS: HIV positive person

²⁷ Interview with Ms S. Hoosen. July 2002.

- g) Role of religious organisations: accepting, educating and assisting people with AIDS at different religious institutions and organisations – video presentation.
- h) Human rights and HIV/AIDS issues: rights of people with AIDS.
- i) Pre/Post-Test counselling.
- j) Home-based Care: how to assist people at home.
- k) Death and dying: focus on different stages of dying and how to handle loss and bereavement.
- l) Training techniques: identify skills, responsibilities on attitudes for effective education on HIV/AIDS.
- m) Groupings: groups plan programmes using a variety of techniques.
- n) Presentations by groups: feedback and discussion – draw HIV positive person.
- o) Conclusion: way forward, evaluation, presentation of certificates.

The IMA *Baytul Nur* started a Hot Line Counselling service on all social issues including HIV/AIDS from September 1999.²⁸ This is an intake service where the client telephones and discusses the problems and an appointment is made if the client can visit the office; otherwise the follow-up is done telephonically. The hot line is a crisis counselling service that is conducted during normal office hours only. They receive about eighty calls on average per month from people from all walks of life, from different religious and race groups regarding various types of problems. Staff and volunteers provide advice, counselling and support to clients whereby their confidentiality is respected at all times.

²⁸ Interview with Ms F. Abdulla, October 2002.

A referral service is also included depending on the situation and if the need arises, the client is referred to the nearest organisation or institution for further specialist treatment.

In February 2001, *Baytul Nur* introduced a Life Skills Programme on HIV/AIDS/STI (sexually transmitted infections) for adolescent pupils in schools. HIV/AIDS facilitators and intern social work students from the University of Durban-Westville (UDW) conduct this programme. It consists of ten sessions, one per week with a peer group consisting of about ten to twelve pupils. This is an ongoing activity that is conducted at schools wherever or whenever there is a request for it; and at times different schools are approached by *Baytul Nur* to have this programme conducted as part of their co-curricula activity.²⁹ The sessions are designed to encourage active pupil participation by way of group discussions, brainstorming by pupils, exercises, drawings and role-playing. It is intended that the skills and knowledge learnt by the pupils in the peer groups will be cascaded to the rest of the pupils in the classes. The following aspects are covered in this programme.

- a) Session 1: Introduction, planning of programme – questionnaires – assessment with pupils.
- b) Session 2 : Self-esteem/skills development, focus on knowledge, attitudes.
- c) Session 3: What is STI/HIV/AIDS
- d) Session 4: How is HIV contracted/not contracted

²⁹ Interview with Ms S. Musthapa. October 2002.

- e) Session 5: Summary of previous sessions – issues that crop up and those not fully understood/that need clarification are discussed.
- f) Session 6: What is AIDS - symptoms – adults/children – myths, focus on empathy, care and support of people with AIDS.
- g) Session 7: Assertiveness
- h) Session 8: Different cultural/religious and value issues.
- i) Session 9: Adequate protection – religious/cultural values – universally acceptable options – demonstration.
- j) Session 10: Termination and evaluation.

AIDS Educators from the IMA have been invited to participate in the University of Natal's HIV/AIDS programme every year for first year medical students since May 2001.³⁰ They form part of a group of twenty AIDS Educators from different NGO. Workshops on different aspects of HIV/AIDS are conducted with groups of ten students and five such sessions of two hours each are done for each group. The University facilitator draws up the topics and aspects of the HIV/AIDS programme. The sessions are followed up with assignments and projects which carry a mark and these marks form part of their examinations.

From June 2001, one-day workshops on HIV/AIDS/STI have been conducted regularly on a monthly basis at the offices of *Baytul Nur*.³¹ Invitations are sent from time to time to both state and Muslim schools requesting two teachers per school to be trained in this

³⁰ Interview with Ms A. Doolarkhan. January 2003.

³¹ Interview with Ms S. Hoosen. July 2002.

workshop so that they can empower pupils with this knowledge. This workshop equips teachers with the necessary information, skills and creative tools that can be used for pupil development in awareness and prevention. Muslim organisations are also invited to send their staff for training at this workshop. This workshop is also open to any group, business, company, organisation or individual from the general public who wishes to acquire this training. Muslim community ladies also regularly attend this workshop from the peri-urban and rural areas who in turn promote awareness and prevention and train others in their respective communities. There are three variations of this workshop which are adapted from the basic programme to suit the different needs of participants. The basic programme of this workshop covers the following aspects for the day:

- a) What is HIV/AIDS?
- b) HIV/AIDS in South Africa and Sub Sahara Africa : global and statistical overview – video presentation.
- c) AIDS: transmission – immune system – test – treatment.
- d) What are STI: transmission – prevention?
- e) Impact of HIV/AIDS: individuals – groups – family – community.
- f) Attitudes: ethics – values – judgements – becoming more empathetic, warm and compassionate.
- g) How to do a profile on social responsibility?
- h) Draw HIV positive person: discussion.
- i) Questionnaires/Evaluations/Certification.

A Home-based Care Workshop on HIV/AIDS was initiated in June 2001 with community health workers and about twenty-five Muslim women from peri-urban and rural areas around Durban.³² The training enables participants to provide a valuable service to HIV/AIDS patients as well as to terminally ill patients at home. The workshop is conducted regularly on a monthly basis at the *Baytul Nur* offices with about twenty-five ladies from the peri-urban and rural areas around Durban. These trained participants in turn train family members and others in their respective communities in home-based care thus providing palliative care to those in need. In this way many people get empowered with this knowledge and training in the community and cascades it to others as well. Muslim organisations are also invited to send their staff for training in this workshop. The one-day workshop consists of the following aspects

- a) Recap previous workshop.
- b) Family Types : extended families – child headed households – foster care.
- c) Poverty; Isolation; Inability : how to deal with these issues.
- d) Acceptance of Diagnosis; Disclosure to living with HIV/AIDS; Helping the family and individual to cope.
- e) Prevention measures: community involvement and responsibility.
- f) Hospice care: if available – how to access – hospitals, clinics, day care centres.
- g) Prevention from infections.
- h) Evaluation/Certification.

³² Interview with Ms S. Hoosen. July 2002.

In September 2001, the HIV/AIDS Counselling and Skills Development Workshop was introduced.³³ This workshop is designed for any member of the general public, Muslim or non-Muslim, from any sector of society, who wishes to empower himself or herself with the relevant knowledge and skills to educate and train others in HIV/AIDS counselling. The qualified participants then promote this training in the workplace among staff members or at community organisational level. In April 2002, four such workshops were conducted at the University of Durban-Westville with first year social work students and in July 2002, a group of about thirty male and female nurses of mixed religious groups from Durban and surrounding areas attended this workshop. This workshop is an ongoing activity that is conducted at the office of *Baytul Nur* as soon as a group of about twenty-five participants are available. The training covers the following aspects:

- a) Introduction
- b) What is HIV/AIDS Counselling?
- c) Different types of counselling
- d) Video on counselling
- e) Skills for pre- and post-test counselling for HIV/AIDS
- f) Role play: Pre-test counselling
- g) Motivation for VCT
- h) Counselling for HIV positive pregnant women and alternatives available
- i) Role play: Post-test counselling
- j) Evaluation/Certification

³³ Interview with Ms S. Hoosen. July 2002.

A half-day HIV/AIDS Community Awareness Programme is conducted for the general public at community functions and fairs.³⁴ This programme is tailored to suit the gathering and the occasion. It was introduced in March 2002 and is an ongoing activity that is conducted whenever and wherever there is a request for it. The general programme covers the following aspects:

- a) Analysis of HIV/AIDS in KwaZulu-Natal
- b) What is HIV/AIDS
- c) Talk by HIV positive person
- d) Questions and answers
- e) Drug abuse and HIV/AIDS
- f) What is our responsibility towards care and support for people with AIDS
- g) Closing statements and summary
- h) HIV/AIDS message from people with AIDS

In March 2002, *Baytul Nur* (IMA) initiated the first KwaZulu-Natal Muslim Leaders Consultation on HIV/AIDS.³⁵ The main purpose was to achieve greater involvement and better co-ordination from Muslim communities in their HIV/AIDS education and preventive programmes at regional and grassroot levels. The objective of this consultation is as follows:

- i) To meet with all religious leaders.

³⁴ Interview with Ms S. Musthapa. August 2002.

³⁵ Interview with Ms S Hoosen. July 2002.

- ii) To share experiences so far gained regarding the KwaZulu-Natal Muslim community response to HIV/AIDS.
- iii) To discuss and articulate the Islamic contribution to HIV/AIDS prevention.
- iv) To discuss and articulate the Islamic contribution to HIV/AIDS care and support.
- v) To discuss and articulate the Islamic contribution to mitigating the impact of HIV/AIDS.
- vi) To discuss and articulate strategies for strengthening, expanding and evaluating the regional and national Muslim community response to HIV/AIDS.

The following topics were discussed at this one-day workshop:

- a) Objectives of the Consultation
- b) Situational analysis of HIV/AIDS in KwaZulu-Natal – Guest Speaker
- c) Group Discussions:
 - i) Contribution of Islam to HIV/AIDS prevention
report back – discussion
 - ii) Contribution of Islam to care and support for people infected and affected by AIDS
report back – discussion
 - iii) Contribution of Islam to mitigating the socio-economic impact of AIDS
report back –discussion

- d) Strategies for strengthening, expanding, co-ordinating and evaluating the national and regional Muslim community response to HIV/AIDS
- e) Evaluation

It is envisaged that this type of workshop will be held from time to time as the need arises to co-ordinate and have a united Muslim response to HIV/AIDS.

In January 2003, it introduced a training programme on HIV/AIDS awareness and education for all the staff of its four clinics in KZN, namely, nurses and administration staff. The programme is conducted on different aspects of HIV/AIDS once every six weeks with about twenty people. It is held at the office on a Sunday because the clinics are open from Monday to Saturday. It is a full day workshop primarily for training and re-training of its staff and covers the following aspects.³⁶

- a) HIV/AIDS and the Law (children)
- b) Prevention of MTCT (mother-to-child-transmission)
- c) Voluntary Counselling and Testing (VCT)
- d) Home-based care
- e) Family planning
- f) Information on HIV/AIDS for awaiting patients at clinics
- g) Child abuse and Prevention of HIV/AIDS
- h) Community health and Community work

³⁶ Interview with Ms S. Hoosen. September 2003.

From January 2003, all counselled orphans who need placement, irrespective of them being HIV positive or not, are referred to the As Salaam Educational Institute. A unit with a house-mother has been established for them. This is open to all religious groups and includes orphans from HIV/AIDS infected parents. The orphans range from 6 years to 18 years and are provided with schooling, food, accommodation and medication by the As Salaam Educational Institute. Presently (September 2003) there are four orphans living at the institute.³⁷

Baytul Nur networks with all Muslim organisations in the country; with national and provincial government structures; WCRP; HIVAN, International Family Health (U.K.) and all local NGO.

4.1.3. The IMA of Western Cape

In the early nineties, the HIV/AIDS awareness campaign had been conducted in the form of talks in the *masājid*, public lectures, seminars and Muslim media, especially the community radio stations. In February 2000, a HIV/AIDS sub-committee was formed to introduce the Muslim AIDS Programme which was already being implemented in Gauteng and KwaZulu Natal. However, the campaign earnestly began in a more structured way in June 2000 when members of MAC initiated its one-day HIV/AIDS awareness workshop for health workers, educators, students and religious leaders.³⁸ Since

³⁷ Interview with Ms S. Hoosen. September 2003.

³⁸ Interview with Ms K. Dhansay. July 2002.

then, a number of these workshops have been conducted for men, women and youth in the Western Cape.

In June 2002, members of the MAC introduced the first three-day train-the-trainer workshop in the Western Cape. There were twenty-one participants from diverse backgrounds which included educators, religious leaders, counsellors, health care workers and a person with AIDS. Guest speakers included persons from St. Luke's Hospice, IMA Home-based Care, Gender Project Community Law Centre from the University of Western Cape who dealt with the legal aspects of HIV/AIDS, and a personal testimony from a person with AIDS. The following topics were discussed at this workshop:

- a) Attitudes towards HIV/AIDS
- b) HIV/AIDS FACTS
- c) Sex, Sexuality and Islam
- d) Basic Home-based Care
- e) Testimony from people with AIDS
- f) Legal aspects of HIV/AIDS
- g) Death and dying
- h) Training techniques
- i) Evaluation/Certification

There were certain aspects that generated much discussion, especially around some legal points relating to confidentiality and disclosure. It was felt that while the law protected

the person who was HIV positive, it offered little protection to the unsuspecting spouse. For instance, if, despite the attempts on the part of the health care provider and counsellor, the infected person still refuses to tell the partner, does the legal requirement of confidentiality supercede the moral obligation to inform the partner! It was felt that certain aspects of the law appear to be in direct conflict with one's moral obligations and Islamic principles. This aspect requires further deliberation on the part of Muslims in order that a clear cut ruling can be given to Muslim health care workers so that both the rights of the infected and affected can be respected without violating the moral principles of Islam. The participants were also eager for follow-up training in the medical perspectives of HIV/AIDS, home-based care, precautions to be taken at the *ghusl* of a *janāzah* (washing of the deceased person) and lay counselling. Upon completion of the workshop programme, the participants received their AIDS Educator certificates which made them the first group in Western Cape to be trained in the Muslim AIDS Programme.³⁹ Since then the HIV/AIDS awareness programme has been implemented through the following ways:

- a) Community Forums : This is an ongoing activity and has been conducted through the following community events, namely:
 - i) In October 2000, a panel discussion to an audience of over two hundred people was held. Topics included discussions on attitudes, facts on HIV/AIDS, the Islamic response to HIV/AIDS, universal precautions and burial guidelines.

³⁹ *Bulletin of the IMA (BIMA) Pamphlet*. August 2001

- ii) In July 2001, a workshop for religious leaders was conducted on the medical perspectives of HIV/AIDS.
 - iii) A community workshop was held in August 2001 on “Early Childhood Development Educators” to create awareness around HIV/AIDS among parents, care givers and teachers of young children.
 - iv) In September 2001, a community seminar was organised to highlight the global problem and implications of HIV/AIDS, with an emphasis on the effect and response of the Muslim community.
- b) Media campaign: this has been done by way of presenting regular programmes on “Radio 786”, a Muslim community radio station, and submitting regular articles on HIV/AIDS in “Muslim Views” and in the IMA newsletters. A programme on the Muslim response to HIV/AIDS was also presented on the SABC programme called “Heart and Soul”.
- c) One-day HIV/AIDS awareness workshops and three-day train-the-trainer workshops are conducted regularly wherever and whenever the need arises or are requested.
- d) Seminars on HIV/AIDS for health care professionals are held regularly. Medical doctors and dentists secure CPD points for their attendance and participation in these seminars. Topics cover various aspects on HIV/AIDS and include prevention and treatment options.
- e) Networking with local, national and international AIDS organisations, both Muslim and non-Muslims; facilitating inter-faith workshops;

presenting papers at local and international conferences on HIV/AIDS in order to share information and exchange ideas.⁴⁰

4.2. MUSLIM AIDS COMMITTEE (MAC)

In the Gauteng province the HIV/AIDS programme is conducted by the Muslim AIDS Committee, hereafter known as MAC. It comprises of members of the Islamic Medical Association (IMA), Islamic Careline and the *Jamiatul Ulama*.⁴¹ This organisation was formed in September 1997 when the Islamic Medical Association of Gauteng initiated the HIV/AIDS programme by enlisting the assistance and involvement of the Islamic Careline and the Jamiatul Ulama. It was part of the Religious AIDS Programme (RAP) of the national government. Dr Ebrahim Mahomed is the chairperson of MAC as well as the national co-ordinator of the HIV/AIDS programme of the Islamic Medical Association of South Africa.⁴² The Islamic Careline administers the programme of MAC whilst the *Jamiatul Ulama* ensures that it is in accordance with the laws of *Shari'ah*. Hence it is a joint project of these three organisations in the Gauteng province. MAC members were trained as AIDS educators by the Department of Health and funded by them.

MAC is a non-governmental organisation operating on a national, provincial and community level and has the following objectives:⁴³

⁴⁰ Interview with Ms K. Dhansay. December 2002.

⁴¹ Interview with Ms S. Nawab. January 2002.

⁴² Interview with Dr E. Mahomed. January 2002.

⁴³ Muslim AIDS Committee Leaflet. February 1999.

- 1) To sensitize, mobilise and equip Muslim communities to become involved in AIDS prevention, using a value-based approach.
- 2) To sensitize, mobilise and equip Muslim communities to become involved in the care and support of those infected or affected by AIDS.
- 3) To offer AIDS education based on moral values (abstinence before marriage and faithfulness within marriage) to the broader community.
- 4) To implement a comprehensive life-skills programme for Muslim youth so that they can make Islamically motivated choices for their future.
- 5) MAC welcomes Muslim organisations and individuals to join them in the global struggle against HIV/AIDS.

MAC members train all volunteers for the HIV/AIDS programme, counsel HIV/AIDS patients and arrange care giving to AIDS patients.

Community awareness is conducted through public talks and the mass media. The AIDS awareness programme, which is referred to as MAP (Muslim AIDS Awareness Programme), has been promoted on, "Radio Islam" and "The Voice" in Gauteng; "Radio 786" in Western Cape; the national "Radio SAFM"; "Channel Islam" which is an international satellite radio station; also on the national SABC television programme called "Credo" and "For goodness sake."⁴⁴ As part of community awareness, a leaflet on

⁴⁴ Interview with Ms S. Nawab. January 2002.

AIDS awareness from an Islamic viewpoint has been published and contains *interalia* information on the following:⁴⁵

- 1) Some basic information on HIV/AIDS
- 2) A message to Muslim youth.
- 3) Love and respect yourself and your Creator
- 4) Marriage
- 5) What about having children?
- 6) Pregnancy out of wedlock
- 7) Promiscuity, sexually transmitted diseases and AIDS
- 8) The solution

This leaflet has been printed (100 000 copies) and freely distributed throughout the community and it has also been translated into the Zulu and Sesotho languages.

In September 1997 a survey was conducted in the Muslim community through the assistance of various community organisations and schools to ascertain the level of HIV/AIDS awareness. The analysis of the survey showed a lack of knowledge about HIV/AIDS in the community and this necessitated the implementation of an awareness programme. Subsequently, material on AIDS from WHO was adapted for the Muslim community and various community organisations were presented with this Muslim AIDS Awareness Programme (MAP).⁴⁶

⁴⁵ Muslim AIDS Programme Leaflet, February 1999.

⁴⁶ Interview with Ms S. Nawab, January 2002.

MAC has initiated one-day AIDS awareness workshops for the members of the community. These workshops cover discussions on the following topics:

- 1) Attitudes towards AIDS and people living with AIDS (PWA)
- 2) Facts about HIV/AIDS
- 3) Sexuality and Islam
- 4) Death and dying

These workshops have been held at schools, with community organisations, with the general public and as well as with inter faith groups. This has been an ongoing activity from September 1997 and thus far (June 2003), more than one hundred of these workshops have been conducted in various parts of the Gauteng province, namely Azaadville, Benoni, Klerksdorp, Pretoria, Newclare, Heidelberg and Rustenburg. MAC has also introduced and initiated these one-day workshops with the members of the Islamic Medical Association of KwaZulu-Natal from July 1998 and with the IMA of Western Cape from April 2000. Personnel from MAC have trained IMA volunteers in KwaZulu-Natal and Western Cape. This workshop is available to any organisation or group that requests it.⁴⁷

Train-a-Trainer workshops are conducted over a period of three days where upon completion of the course the participants are certified as AIDS Educators and they in turn train others as AIDS Educators. This intensive training programme includes the use of audio-visual materials; guest-speakers, who are specialists in their respective fields; and

⁴⁷ MAP Narrative Report. January 2002.

reading manuals to facilitate the education of HIV/AIDS. MAC members have conducted these workshop courses in different parts of the country. The trained volunteers have become very active in their respective areas. Regular reports and feedback from the AIDS Educators are evaluated and monitored. There are ongoing workshops in Lenasia, Mayfair, Springs, Witbank, Roshnee, Azaadville, Brits, Durban, Ladysmith, Cape town and Pretoria.⁴⁸ The workshops cover the following topics:

- 1) Attitudes
- 2) Sex and sexuality
- 3) Sexually transmitted infections
- 4) Basic facts about HIV/AIDS
- 5) HIV testing
- 6) Living and dying with AIDS
- 7) Home-based care
- 8) Legal aspects
- 9) Basic counselling skills
- 10) Training techniques
- 11) Checklist for workshops
- 12) Examples of required material

A comprehensive Lifeskills Programme which includes awareness on HIV/AIDS has been drawn up for primary and high school pupils by MAC. Although this is based on the Department of Education's life skill programme, it is presented from an Islamic

⁴⁸ MAP Narrative Report. January 2002.

perspective. These programmes have been implemented in all Muslim schools in the Gauteng areas from June 2001. Negotiation and consultation has taken place with the Gauteng Provincial Department of Education to have these life skill programmes accredited. One-day workshops have also been conducted at many state schools as part of life skills programme on HIV/AIDS awareness and these have been presented from an inter faith point of view.⁴⁹ A Skills Training workshop for potential facilitators was conducted before the implementation of these programmes and volunteers also attended intensive training in counselling and working with children. Therefore trained facilitators present these life skill programmes in schools.

The primary school life skill programme covers the following topics:

- 1) I'm special
- 2) My body
- 3) Germs and viruses HIV/AIDS
- 4) Feelings
- 5) Decision making
- 6) Cultural diversity (senior primary pupils)

The high school lifeskill programme covers the following topics:

- 1) Self concept enhancement
- 2) Attitudes and AIDS fact
- 3) Sex and sexuality: The Islamic Way

⁴⁹ Interview with Ms S. Nawab. January 2002.

- 4) Communication skills
- 5) Decision making

The life-skill sessions are conducted once a week for five weeks. The duration of each session is one hour and fifteen minutes. The sessions incorporate the use of experiential exercises, lecturing and audio-visual materials. Learners are given homework after each session. This homework gives them the opportunity to internalise the material and practice on some of the skills learnt. Each pupil completes an evaluation form that is tailored for each session at the end of each session. This gives the facilitators the opportunity to evaluate the learners' performances and to target problematic areas that they may be experiencing. A report is submitted to the school after the completion of the life-skills programme. Areas of concern and problems experienced by learners are discussed in the report and a list of recommendations is also included.

Separate workshops on substance abuse and study skills are also available to schools on request. Young audiences have found these life skill programmes challenging, engaging and enlightening.⁵⁰

MAC members have held public talks on "HIV/AIDS and Women "and" Drugs and

⁵⁰ MAP Narrative Report. July 2001.

HIV/AIDS in various areas of Gauteng and this is an ongoing activity as part of the AIDS awareness campaign in the community. The talks cover the following aspects.⁵¹

- 1) The primary mode of transmission
- 2) HIV/AIDS statistics
- 3) Why women are more susceptible to HIV
- 4) Muslims role

The prevalence and impact of HIV/AIDS was addressed with business leaders and relief organisations in June 2001. Various meetings were also held with regards to obtaining funds from the business community for the Muslim AIDS Programme (MAP). The talks covered the following aspects:⁵²

- 1) Socio-economic impact of HIV/AIDS
- 2) Rights of employers and employees
- 3) The responsibilities of Muslim businessmen

In July 2000, MAC published the following guidelines for *ghusl al-mayyit* (ceremonial washing of the deceased) as a precaution against HIV/AIDS infection. This was first presented at the IMA seminar on HIV/AIDS in August 1998, and is as follows:

⁵¹ Interview with Ms S. Vaid. May 2002.

⁵² Interview with Ms S. Vaid. May 2002.

- 1) Avoid direct contact of fluids and secretions from the *janāzah* (deceased) on to your skin and mucous membranes (eyes, mouth, etc.)
 - a) Therefore use rubber gloves, goggles and masks.
 - b) Use double gloves if you have abrasions or cuts on your hands.
 - c) In cases where blood or fluid oozes from the *janāzah* and hosepipes are used, wash gently to prevent splashing of fluid.
- 2) Use plastic aprons and boots to prevent spillage onto your clothes.
- 3) Water from the *janāzah* should be disinfected with chloride of lime, before it is disposed off.
- 4) Disinfect linen and clothing if contaminated, by soaking it in sodium hypochlorite solution (1:10). The same solution can be used to decontaminate any other area or surface.

N.B. – The HIV virus is stable at room temperature in both wet and dry states. Therefore thorough disinfection and sterilization is necessary.

These guidelines have become necessary due to an increase in HIV/AIDS awareness in the community. These guidelines have been distributed to *masājid* and burial societies in particular, in a laminated sheet so that it can easily be displayed on their notice boards.⁵³

In October 2001, members of MAC facilitated a National Religious Association for Social Development (NRASD) training workshop in Lenasia for religious leaders. This intense training programme was held over two full days from 08h00 to 16h00. Religious

⁵³ MAP Narrative Report. July 2001.

leaders from the Muslim, Jewish, Christian, Hindu communities and African Traditional Religious Groups attended this workshop. The object of this workshop was to develop an inter faith HIV/AIDS programme.⁵⁴ The programme covered the following topics:

- 1) Attitudes: HIV/AIDS
- 2) HIV/AIDS: More than the basics
- 3) Living with HIV: Emotional impact
- 4) HIV positive people share experience
- 5) “Curved Balls” (questions directed at participants)
- 6) Home-based care
- 7) Orphan care
- 8) Understanding the need of the community: Local AIDS action
 - a) of people living with or affected by HIV/AIDS
 - b) counselling
 - c) care
 - d) community needs
- 9) What can we do
 - a) within our congregation
 - b) within the community
- 10) What can we do. Practical planning
- 11) Feedback and questions
- 12) Evaluation

⁵⁴ Interview with Ms S. Vaid. May 2002.

In the first weekend of April 2002, MAC initiated and organised a two-day Muslim Consultation AIDS Programme workshop in Johannesburg. The objective of this workshop was to actively involve Muslim community leaders to participate in the campaign against HIV/AIDS. Religious leaders, youth, women, health professionals and Muslim non-governmental organisations (NGO) were invited to participate in this first Muslim consultation workshop on HIV/AIDS. The two-day workshop covered the following topics:⁵⁵

- 1) Introduction and sharing of experiences
 - a) Gauteng
 - b) KwaZulu Natal
 - c) Western Cape
- 2) Explanation of structure and format of programme
- 3) Break up into workshop groups
 - a) Experiential exercise and report back in groups
- 4) The Islamic perspective of HIV/AIDS and its prevention
- 5) The Islamic perspective of HIV/AIDS care and support
- 6) The Islamic contribution to managing the socio-economic impact of HIV/AIDS
- 7) Strategies for strengthening, expanding, co-ordinating and evaluating the National Muslim Community response to HIV/AIDS
- 8) Break up into workshop groups
 - Group 1: Contribution of Islam to HIV/AIDS prevention

⁵⁵ Interview with Ms S. Vaid. May 2002.

- Topics
- Abstinence from sex for AIDS prevention
 - Being faithful in marriage for AIDS prevention
 - Condom use for AIDS prevention
 - Drug abuse avoidance to prevent AIDS

Group 2: Contribution of Islam to care and support

- Topics
- Stigmatization of HIV/AIDS
 - Care for people living with HIV/AIDS (PWA)
 - Counselling and spiritual care for PWA
 - Bereavement

Group 3: Contribution of Islam to managing the socio-economic impact of HIV/ AIDS

- Topics
- Economic support for PWA
 - Orphan care
 - Income generating incomes
 - Protection of legal rights of those affected and infected by HIV/AIDS

Group 4: Strategies for strengthening, expanding, co-ordinating and evaluating the National Muslim Community response to HIV/AIDS

- Topics
- Initiating, expanding and strengthening the Muslim community response to HIV/AIDS
 - Co-ordination of the Muslim community response to HIV/AIDS

- Evaluation of the Muslim community response to HIV/AIDS
 - Resource mobilization
- 9) Report back of workshop groups
- Group 1 to Group 4
- 10) The way forward and resolutions

The following are the final resolutions agreed upon at the first National Muslim Consultation on HIV/AIDS, dated 6-7 April 2002, Johannesburg:⁵⁶

- Educate ourselves and the community about Islamic morals, i.e. following *Qur'ān* and *Sunnah*.
- Develop sustainable programmes to support our projects.
- Be role models (morally and ethically) in our community.
- Continuously upgrade and disseminate knowledge on the pandemic and related policies.
- Embrace an attitude of impartiality and non-judgementalism.
- Dedication, commitment and spiritual upliftment for those infected as well as those affected.
- Empathise with people living with HIV/AIDS.
- Work solely for the pleasure of *Allāh* (SWT) and be proud and confident of Islamic teachings.
- Be supportive of disadvantaged communities.

⁵⁶ Interview with Ms S. Vaid. May 2002.

- Build infrastructures to enable effective monitoring of mother-to-child-transmission and voluntary counselling and testing.
- Empower the infected and affected with coping and management skills.
- Encourage people living with AIDS to share experiences. Use our differences to strengthen and not to divide ourselves.
- Be proactive in HIV/AIDS orphan care and support.
- Commit our organizations to deal with HIV/AIDS as a human rights issue.
- Provide manpower in the form of medical personnel to assist in the diagnoses, treatment and follow up of patients with HIV/AIDS.
- Educate people on various related topics through the medium of workshops.
- Allow for the effective and appropriate use of anti-retrovirals when necessary for those infected with HIV/AIDS.
- Challenge the media about conflicting and “immoral” messages that are propagated.

In July 2000, a delegation from the IMA of Uganda attended the 13th International AIDS Conference in Durban. This group called itself the “Ambassadors of Hope” because their community had achieved great success in their campaign against the spread of HIV/AIDS through their programme called “AIDS education through Imams.” MAC initiated and organized an intensive programme for this group where they shared their experiences through public talks, video shows, meetings and workshops with religious and community leaders and Muslim organizations. Various programmes in Gauteng, KwaZulu Natal, Eastern and Western Cape were successfully organized and much networking was achieved. MAC was able to procure funding from UNAIDS in order to

ensure the success of this programme. This was evident by the approval of strategic government departments such as welfare, health and education.⁵⁷

MAC is involved in negotiations with the business sector in the Muslim community for two much needed projects, namely:

- 1) A HIV/AIDS mobile clinic for care and support in the greater Johannesburg area that would target informal settlements or under privileged areas.
- 2) A holistic day-care centre for treatment and management of people with AIDS and their families.

As can be expected, these two projects require a great deal of time and effort and not forgetting money. MAC is committed to establishing these services in order to promote its programme as well as assisting in the national plan for HIV/AIDS care and support services. In the meanwhile it is in the process of establishing and promoting the use of the IMA mobile clinic services in the Kliptown and Pretoria areas respectively in Gauteng.⁵⁸

In December 2002, a revised leaflet on AIDS was published and 5000 copies of this reader friendly leaflet has been distributed at their workshops and public talks. Also, 20000 yellow glossy bookmarks with a message to the youth was published in December 2002. This has been distributed to pupils as part of the life skill programme. See appendix E for a copy of the book-marker. Both the revised leaflet and book-marker

⁵⁷ *MAP Narrative Report*. Undated.

⁵⁸ *MAP Narrative Report*. January 2002.

have a strong Islamic message of abstinence, namely, "Faithful Sex rather than Fateful Sex" and "Be Wise...Moralise." The new-look and revised, yellow AIDS leaflet discusses the following aspects in a question and answer style:⁵⁹

- a) What causes AIDS?
- b) How does HIV cause disease?
- c) How does HIV spread?
- d) How is HIV not spread?
- e) How long does it take to develop full-blown AIDS?
- f) How can HIV be detected when a carrier shows no symptoms of infection?
- g) The Solution (Islamic response)



On 1 August 2003, MAC established a home for destitute mothers and children infected with HIV/AIDS, in Mayfair, Johannesburg, in the Gauteng province. It is called the MAP Care Centre. The private home was donated by a Muslim family and consists of three bedrooms to house about four mothers and twelve children. The Muslim community has donated fixtures and fittings for the home as well as finance, to provide meals and medication for the residents and to pay the basic cost of maintaining the home. Because there is no home catering for the needs of Muslim HIV/AIDS patients, MAC decided to establish a home with an Islamic environment for them. Its staff has been counselling Muslim HIV/AIDS patients who have been living in non-Muslim homes, and for such patients it has been regularly providing halaal food parcels. In some cases it had to make

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⁵⁹ AIDS – Some Basic Information Leaflet. MAC. December 2002.

funeral arrangements for those Muslim patients who had died whilst living in non-Muslim homes, and one mother has left behind an eight year old orphan child. It is for all these reasons that it decided to establish a home for destitute Muslim HIV/AIDS patients, to cater for their needs. Services to the home include accommodation, food, medication and counselling as well. It is working towards making the home self-sufficient by offering skills training to the residents, in order to empower them to do something meaningful in their lives and earn some money at the same time; for example, organise schooling for their young children, sewing class, cooking lessons, flower arrangements, making AIDS bead-badges for selling, etc.⁶⁰

Presently (September 2003) a house-mother with her baby is supervising the home which has a Muslim HIV/AIDS infected family with their two year old baby living there. It does screening of patients that would be living in the home, and the criteria is that the patient must be destitute and HIV positive and be referred by a doctor, social worker, clinic or a hospital. The patient can be a mother and her child/children, an orphan child or an individual female. Although the home is primarily for Muslim patients, non-Muslims will be accommodated so long as they respect the Islamic ethos and they will be free to practice their religious beliefs.

The health needs of the residents of the Centre will be the responsibility of the IMA of Gauteng. Volunteer doctors that are living close to the Centre have been approached to render their services at the Centre and a roster has been drawn up for this purpose. Protocols for emergency care, persons on call and treatment guidelines, which would

⁶⁰ Interview with Ms A. Hathurani. September 2003.

include antiretroviral treatment, have also been drawn up. The need to provide a nurse is also something that the IMA will have to look into, as well as funding of the salary for such a person. Counselling and testing of CD4 and VL will also be conducted to monitor the in-patients at the Centre. Funding for the day-to-day care of the Centre has been approved by the Department of Social Services, after funding proposals were submitted to various health and welfare departments. The *Jamiatul Ulama* of Gauteng has confirmed that the cost of CD4, VL and antiretroviral treatment could be paid for from *Zakāt* funds which will be available from the IMA doctors and the *Jamiat*.⁶¹ In this regard, the government is busy drawing up detailed plans to provide antiretroviral treatment to HIV/AIDS patients and hopes to start this from October 2003.⁶²

All the residents have to sign and abide by the code of conduct of the Centre; that is, no drinking, smoking or drugs are allowed; responsibilities for household chores on a rotation basis; sign an indemnity form when leaving the premises in order to protect the Centre from any liability that may arise in case of a mishap, etc. The code of conduct covers the following areas which is briefly outlined below.⁶³

- a) Admission
- b) Personal hygiene
- c) Leaving the premises
- d) Visitors
- e) Religion

⁶¹ *HIV/AIDS Sub-Committee Report* for the 64th Council Meeting of the IMA of South Africa. September 2003.

⁶² "AIDS plan on the starting blocks" in the *Sunday Times* dated 28th September 2003, p. 4.

⁶³ Interview with Ms A. Hathurani. September 2003.

- f) Ethnic group
- g) Theft
- h) Pregnancy
- i) Abuse
- j) Children
- k) Grants
- l) Duties
- m) Use of telephone
- n) Termination of residency

The future plan is to establish a similar type of home for males because there is a need for this, as MAC counsels many HIV positive males who are also destitute and require the same type of care.

In June 2003, a HIV/AIDS awareness workshop was conducted in a Muslim high school in Middleburg and a similar one was also conducted in September 2003 in a Muslim high school in Klerksdorp. The workshops were conducted separately for boys and girls, and another for teachers and parents. These two-hour workshops are conducted at the invitation of schools that do not have a HIV/AIDS life-skill programme in place and deal with the following aspects.⁶⁴

- a) Facts on HIV/AIDS
- b) Modes of transmission

⁶⁴ Interview with Ms Z. Gani. September 2003.

- c) Statistics on HIV/AIDS
- d) Attitude to PWA (people with AIDS)
- e) Sex and sexuality
- f) Prevention (Islamic response)

From January 2004, MAC will be introducing and implementing a new HIV/AIDS awareness and prevention programme for high school youths from grade 10 to grade 12. The life skill programme is called “No Apologies” and MAC facilitators are being trained in this programme by a Durban Christian group called, “Focus on the Family” who has introduced this abstinence programme in the country. This character-building, abstinence-until-marriage curriculum seeks to help students understand how personal character and an abstinence decision work together to enable them to make healthy choices throughout their lives. One of its primary goals is to communicate that, sex saved for marriage is the safest and healthiest choice. It develops character and teaches teenagers refusal skills, to help withstand pressure from peers to engage in sexual activity, drug and alcohol use, and other high-risk behaviours. Good judgement, courage and self-control are some of the qualities promoted throughout the “No Apologies” programme. The culture in which we live in, is teeming with sexual images, inappropriate messages and dangerous advice about sexuality. A complete section of “No Apologies” is dedicated to guiding young people to an appreciation of the sublime attack of the media on their minds, and trains them on how to be “vigilant”. Each of the six units is filled with interactive activities for the participants. There are also parent/teen discussions after each unit in order to encourage open lines of communication between teenagers and their parents. This is an excellent programme on abstinence, which is part of the Islamic

response, and the writer has recommended it to the HIV/AIDS Co-ordinator of the IMA of KZN to have this programme included as part of their life skills programme.

The facilitator will use the 200-page curriculum manual from an Islamic perspective with the aid of transparencies and worksheets, to conduct the two hour interactive workshop with the students. It is to be introduced in both Muslim and state high schools in the Johannesburg, Benoni, Azaadville, Roshnee, Springs and Lenasia areas in the Gauteng province. It will be conducted separately for boys and girls, with about thirty students per session, once a week for six weeks, and all students from grade 10 to grade 12 are to be exposed to this programme. At the end of the six sessions, the students will be encouraged to sign a Pledge of Abstinence. The programme focuses on the following areas which are briefly outlined below:⁶⁵

a) UNIT 1

Topic: 30 minute video based on personal teen testimonies –

Introduction to all the issues facing teenagers today

Review and discussion questions

Activity: Key video messages

Youth and pre-marital sex – the reasons

b) UNIT 2

Topic: We all want healthy relationships

Activity: Love, lust or infatuation

⁶⁵ *Focus on the Family No Apologies – the truth about life, love and sex.* Hillcrest. Educational Resources. Hillcrest..A. 2000.

Life goals and dreams
Obstacles to meeting goals
We are unique – the human person
Who will make the difference
Rating your character
Parent/teen discussion questions

c) UNIT 3

Topic: Media literacy

Activity: Culture clips and newsbites

How hooked to the media are you
The lyrics matter – anatomy of a media kid
How to argue with a story
Parent/teen discussion questions

d) UNIT 4

Topic: Pre-marital sex has consequences

Activity: Statistics are real

Sexual progression
The decision - pre-marital sex
STI – if pillows could talk
Parent/teen discussion questions

e) UNIT 5

Topic: Abstinence – it works every time

Activity: What is abstinence

Practicing refusal skills against negative peer pressure

Responding to negative peer pressure

Famous lines and great “no” answers

Creative dates and safe boundaries

Alcohol and drugs = No Future

You can begin again

Parent/teen discussion questions

f) UNIT 6

Topic: Marriage does matter

Activity: How do I know the timing is right

Finding the right marriage partner

Marriage and problem solving

Parent/teen discussion questions

MAC has drawn up a new pamphlet on HIV/AIDS specifically for men titled, “Can Men Assist in the Fight Against AIDS.” This is the first time a Muslim organisation has produced a HIV/AIDS pamphlet targeting males, and it is probably the first such pamphlet in the country, directed especially to the male population. It is directed to all husbands, fathers, brothers, sons and friends, from an Islamic perspective with the motto, “Men can make a difference” and “Let us change from taking risks to taking responsibility”. Presently, this pamphlet is awaiting confirmation for publication, from the key role players regarding its content. It is to be printed (50 000 copies) in November

2003 and distributed to all the *masājid* in the country for their congregations. The content covers the following aspects:⁶⁶

- a) Did you know – statistical facts?
- b) What are the challenges facing men in regard to HIV?
- c) What can you do to change the course of the epidemic?

MAC is now known as MAP (Muslim AIDS Programme), as it had begun developing into a national organisation from the year 2002 onwards. It has branches in Carolina; in Cape Town, which is part of the IMA Western Cape; in Durban, which is part of *Baytul Nur*; and presently (September 2003) new branches in Port Elizabeth, Klerksdorp and Potchefstroom are being negotiated.⁶⁷ MAP has been a pioneer in drawing up a Muslim AIDS programme on HIV/AIDS in the country and has promoted it to Muslim organisations throughout the country. Many of these organisations have adapted the programmes of MAP to suit their situations and needs.

MAP networks with many other Muslim and non-Muslim organisations, both nationally and internationally by sharing information. It works closely with the IMA of Uganda and the Malaysian AIDS Directorate. It is part of the AIDS Consortium which is an umbrella body of national and international AIDS organizations. It is a member of President Thabo Mbeki's "Partnership against AIDS" national programme.

⁶⁶ Interview with Dr E. Mahomed. September 2003.

⁶⁷ Interview with Ms S. Nawab. September 2003.

It has formed strong links with the National Religious Association for Social Development (NRASD) and the National Association of People with AIDS (NAPWA). The Malaysian AIDS Council has requested assistance and training of its religious and community leaders. Members of MAP are also involved in the South African National AIDS Council (SANAC) activities. MAP's HIV/AIDS programme is in the process of being highlighted in a UNO publication called "Strategies for Hope." This input will be regarded as the South African Muslim response to the HIV/AIDS pandemic and is based on an interview conducted by Mr Glen Williams, a UNAIDS representative.⁶⁸

It is evident that since its inception, MAP has provided invaluable service and constructive input at national and international level. Volunteers, sponsorships and donations provide many of the services. The awareness of the Muslim community regarding the HIV/AIDS pandemic has been raised considerably by the above efforts. Schools and other faith groups have very well received the slogan provincially and nationally: "Save Sex rather than Safe Sex". It seems that many people share the view that abstinence is the only approach to take in order to stem the tide of the HIV/AIDS pandemic. MAP is available to present papers, public talks or conduct workshops in order to mobilize communities and to spread the message that the Islamic lifestyle is the best prevention of HIV/AIDS, and in Islam, prevention is the best cure.

4.3. MUSLIM YOUTH MOVEMENT OF SOUTH AFRICA

The Muslim Youth Movement (MYM) was formed in December 1970 in Durban. It is

⁶⁸ Interview with Ms S. Vaid. May 2002.

based on the ideology of Islam as embodied in the *Holy Qur'ān* and the *Sunnah* (practice) of the Prophet Muḥammad (s.a.w.s.). It soon developed into a national organization throughout the country with the youth rallying to the call to strive for the realization of Islam as a comprehensive way of life. It is a movement that is striving for total change in the lives of the people of this country.⁶⁹ Over the years, it had established many projects, which today have become fully independent organizations, such as the IMA of South Africa, South African National Zakah Fund (SANZAF), Islamic *Da'wah* Movement (IDM), *Al Qalam* (newspaper) and Association of Muslim Accountants and Lawyers (AMAL).

Its HIV/AIDS programme began in June 1999 when it sent two of its delegates to the IMA KwaZulu-Natal AIDS Awareness workshop at their Durban office. At that workshop its two delegates qualified as AIDS Educators. Since January 2000, a female AIDS Educator began promoting the HIV/AIDS awareness programme in rural areas around Durban, especially among the non-Muslim women in their Zulu language. These women later requested that their men should also attend these programmes. Subsequently, the men were invited to these workshops, but unfortunately there was resistance from them as they felt that their women were becoming cleverer.⁷⁰ The half-day workshop was held every fortnight in different areas with about an average of ninety women per session. The responses were very positive and welcomed by the women as it empowered them with knowledge on HIV/AIDS awareness. Briefly, the programme covered the following aspects:

⁶⁹ Muslim Youth Movement Leaflet. February 1991.

⁷⁰ Interview with Mr A. Essop. January 2003.

- a) Facts on HIV/AIDS
- b) Modes of transmission
- c) How it is not spread
- d) Universal precautions
- d) Islamic prevention

Unfortunately, this HIV/AIDS awareness programme came to an end in June 2001 when the female AIDS Educator got married. The writer has strongly suggested to the leadership of the Muslim Youth Movement to resuscitate this activity as it has provided a valuable service to the rural communities. It is hoped that this will materialize in the near future.⁷¹

The second AIDS Educator from the Muslim Youth Movement assisted the IMA AIDS Educator in their HIV/AIDS school programme in two schools in May 2001. This volunteer has also occasionally presented a talk on HIV/AIDS at the MYM Islamic youth camps which are held thrice a year.⁷² Guest speakers are invited from time to time to present a talk on HIV/AIDS at these camps.

From November 2002, it has initiated a project with a group of volunteer Muslim ladies who visit HIV/AIDS patients at hospitals on a weekly basis. These ladies provide counsel and support to these patients and the Movement also provides fruit to these HIV/AIDS

⁷¹ Interview with Mr A. Essop. January 2003.

⁷² Interview with Ms Y. Sayed. March 2003.

patients. The group visits patients at Prince Msheni, King Edward and Mahatma Gandhi hospitals in Durban. At the request of the hospital administration, the Movement feeds the HIV/AIDS out-patients when they come to collect their medication once a week. It has also given these out-patients a food hamper to the value of R80 for the Christmas period (December 2002) all these patients were non-Muslims from the Zulu speaking community. All the HIV/AIDS patients, as well as the hospital staff, appreciate this gesture from the Movement. This aspect is an ongoing activity and is made possible by the financial support from the Muslim business people.⁷³

The MYM works closely with inter-faith groups on HIV/AIDS awareness programmes and attends regular meetings and workshops in order to share information and exchange ideas. They also liaise with provincial and national government structures that deal with HIV/AIDS and participate in their programmes.

4.4. WAQFUL WAQIFIN FOUNDATION

Waqful Waqifin translated into English as Gift of the Givers was formed in August 1992 to provide relief in every possible way for any disasters, either man-made (like war) or natural, to any human being affected in any part of the world, irrespective of religion, race, colour and language. One of the first official projects that it embarked on was the construction of a mobile hospital in 1992 to serve the patients who were victims of the war in Mostar in Bosnia. This was the first state of the art containerised mobile hospital in the world and served over 70 000 war victims and continues to provide service until

⁷³ Interview with Mr A. Essop. January 2003.

today. Since then, the Foundation has expanded its activities by providing containerised primary health care clinics in different parts of the country to serve the poor and needy as well as the disadvantaged communities. By December 2002, thirteen such containerised clinics have been constructed and stationed in various parts of the country and these can be transported anywhere in the country as they are mobile.⁷⁴

The Foundation, since its inception in the early 1990s, has been providing relief to millions of people in the country as well as in different parts of the world by way of food, medicines, clothing, building material, basic utensils, water purifying tablets and medical equipment. All relief aid is given to any person in need, irrespective of religion, race and language. Some of the projects of the Foundation are education; health; feeding scheme for school children; food hamper relief, which includes a farmer's pack to enable the family to be self-sufficient for subsistence farming; computer project; electronic literacy and telephonic careline services on all social issues including HIV/AIDS.⁷⁵

The Gift of the Givers Careline service was introduced in May 1997. This free telephonic counselling service is available from Monday to Friday from 09h00 – 12h00 and is conducted by trained volunteers on a roster basis. They receive about 100 calls on average per month from people from all walks of life on various problems. Over one hundred people have been trained by December 2002 to provide this service. Initially, the first group of volunteers was trained by the Pietermaritzburg Lifeline organisation and thereafter the Foundation has conducted their own training using the services of different

⁷⁴ Interview with Dr I. Sooliman. January 2003.

⁷⁵ Interview with Dr I. Sooliman. January 2003.

experts in the field. The training also includes a session on HIV/AIDS which covers the following aspects:

- a) What is HIV/AIDS?
- b) Transmission of HIV/AIDS
- c) Symptoms of HIV/AIDS
- d) Treatment options
- e) Prevention of HIV/AIDS
- f) Referrals for support and health centres

The Careline HIV/AIDS telephonic counselling service was initiated in October 1998 because of the number of calls it received from people who had contracted HIV/AIDS and also from families that were affected by this. Callers are at liberty to make an appointment to discuss their problems with a counsellor at the offices of the Foundation which is based in Pietermaritzburg. The careline services are offered to all people irrespective of their religion, race and colour. If need be, the callers are referred to other structures in their area for further treatment, namely, clinic, rehabilitation centre, support group, self-help scheme group, etc. Client confidentiality is maintained at all times.⁷⁶

Members of the Foundation realised that there was a need for them to be trained in HIV/AIDS therefore they attended the training that was offered by the IMA in KwaZulu-Natal in June 1999. At the end of that training, eleven volunteers qualified as AIDS

⁷⁶ Interview with Ms Z. Sooliman. January 2003.

Educators. Since then, a structured programme on HIV/AIDS awareness has been put in place and this is as follows.⁷⁷

A three-day workshop on HIV/AIDS awareness was initiated in August 2000 and is available for volunteers who wish to qualify as AIDS Educators. The training is conducted with a group of about twenty people at a time. Many people from different organisations, race and religious groups have already completed the training and qualified as AIDS Educators. This workshop was also specifically conducted for the Department of Education (Pietermaritzburg) with a group of twenty-eight teachers in August 2000. This workshop is also available in Durban to any persons or groups that request for it. A qualified AIDS Educator mostly conducts the workshop at the offices of the Foundation whenever a group is available.⁷⁸ The workshop covers the following aspects:

- a) Exploring attitudes to HIV/AIDS
- b) Facts on HIV/AIDS
- c) Modes of transmission
- d) VCT and treatment options
- e) Video presentation on HIV/AIDS
- f) Session with people with AIDS
- g) Home-based care/infection control
- h) Death/bereavement/counselling
- i) Sexuality

⁷⁷ Interview with Ms Z. Sooliman. January 2003.

⁷⁸ Interview with Ms Z. Sooliman. January 2003.

- j) Prevention options
- k) Legal and ethical issues
- l) Psycho-social implications
- m) Evaluation/certification

An HIV/AIDS awareness workshop was initiated in September 1999 for the members of the general public. This is usually conducted at its offices with a group of about fifteen people at a time. Sometimes, organisations, ladies or youth groups request for this at their venue so that they can be empowered with the knowledge on HIV/AIDS awareness. This workshop is conducted whenever there is a request for it or when a group is available.⁷⁹ It covers the following topics:

- a) Self concept/introspection
- b) Attitudes to HIV/AIDS
- c) Facts on HIV/AIDS
- d) Modes of transmission
- e) Treatment options
- f) Sexuality

An awareness programme on HIV/AIDS for young learners commenced in April 2001 and is conducted at schools that request it. It is a three-hour programme and is designed for learners from grade six to grade twelve. The sessions are conducted with a class of about forty pupils at a time and are adapted to suit the level of the learners. The

⁷⁹ Interview with Ms S. Sooliman. January 2003

Foundation has conducted this programme in many schools in Pietermaritzburg and also in a number of schools in the greater Durban area. It is an ongoing activity that covers the following topics:⁸⁰

- a) Self concept/goal setting
- b) Attitudes to HIV/AIDS
- c) Facts on HIV/AIDS
- d) Treatment options
- e) Precaution/infection control
- f) Sexuality
- g) Assertiveness/self esteem
- h) Reflection/worksheets

A life-skills programme was initiated in September 2000 for high school pupils. This is a three-day workshop which is offered to schools that request it. It is conducted with a peer group of about forty pupils from the school, namely, prefects or representative council of learners (RCL). These empowered learners in turn cascade the information to other pupils in the school. The topics are tailored to suit the needs of the school and its community. Certificates are handed to pupils upon completion of the three-day workshop. This programme has been conducted in about forty schools thus far (April 2003) in the greater Durban area from Port Shepstone to Stanger. The general programme covers the following topics:⁸¹

⁸⁰ Interview with Ms Z. Sooliman. January 2003

⁸¹ Interview with Ms S. Vadachia. May 2003.

- a) Self concept
- b) Introspection
- c) Problem solving
- d) Conflict management
- e) Assertiveness training
- f) Coping skills
- g) Substance abuse
- h) Sexuality
- i) Relationships
- j) Study skills
- k) Motivation
- l) Goal setting
- m) HIV/AIDS awareness
- n) Evaluation/certification

The life-skills programme is also conducted in Pietermaritzburg with pupils, adults, staff of institutions, volunteer counsellors of the Foundation and inmates at the Howick halfway-house centre. The topics are tailored according to the needs of the groups. Counselling services are also provided on a once a month basis to the inmates at the Howick halfway-house centre.⁸²

⁸² Interview with Ms Z. Sooliman. May 2003.

In December 2002, the Foundation was approached by East Coast Radio (a regional radio station based in Durban) with a request to join them as a partner in their Toy Story Campaign for Durban and Pietermaritzburg. This campaign is conducted during the December festive period on a yearly basis and it entails providing meals, treats and toys to AIDS orphans. The Foundation participated in this campaign and procured most of the funds and goods from the Muslim community and the balance from the general public. It provided hot meals, toys, sweets, fruit, cool drinks, ice-creams and soaps to the AIDS orphans in Pietermaritzburg at the Royal Show ground on 6 December and in Durban at Kingsmead Sports Stadium on 9 December. The excess goods were also distributed to AIDS orphans in Newcastle. It is envisaged that this campaign will also be repeated for the December 2003 festive period with the participation of the Foundation.⁸³

The Foundation participates in World AIDS Day and has been involved since 2000 onwards. It joins other religious organisations and gives an Islamic message of hope on HIV/AIDS. It distributes soaps, cotton wool, jik, vaseline and food hampers to AIDS orphans and their families.⁸⁴ The Foundation works closely with various other organisations in HIV/AIDS awareness and prevention.

4.5. THE MUSLIM SEAMEN INSTITUTE

The Institute began its activities in October 1990 with the intention of providing the Muslim seamen with hospitality, guidance and assistance of various kinds whilst they are

⁸³ Interview with Ms Z. Sooliman. January 2003.

⁸⁴ Interview with Ms Z. Sooliman. May 2003.

stationed at the Durban harbour. This is the first such Muslim organisation in the country that provides these services to the Muslim seamen as no such organisation has existed before this. It is also probably the only such Muslim organisation in the world that provides such services to the Muslim seamen.⁸⁵

The Institute provides the following services to the Muslim seamen:⁸⁶

- a) Provision of *Ṣalāh* (prayer) facilities
- b) Provision of *ḥalāl* (permissible) meals
- c) Provision of *Ramaḍān* meals
- d) Provision of transport for *Jumu'ah Ṣalāh*
- e) Establish mini Islamic libraries in the ships
- f) Establish interaction forums between the seamen and the local community
- g) Assist in solving wage disputes on behalf of seamen
- h) Emotional counselling services
- i) Assistance in cash or kind to seamen who are stranded
- j) Visit injured seamen at hospitals and provide them with support and food hamper
- k) Revitalise the spirit of Islamic consciousness of the seamen by providing free audio/video Islamic tapes
- l) HIV/AIDS awareness and prevention programme

⁸⁵ Interview with Mr S.A. Khan. January 2003.

⁸⁶ Interview with Mr S.A. Khan. January 2003.

In March 2001, the Institute initiated its HIV/AIDS awareness programmes when its president qualified as an AIDS Educator after attending the three-day HIV/AIDS training programme of the IMA in KwaZulu Natal. The reason for initiating this programme, as part of its services, is to highlight the dangers of contracting HIV/AIDS through immoral behaviour as sailors are at a high risk due to the nature of their employment. The programme is mostly directed to those ships that have Muslim seamen on board. The programme is basically a talk given on HIV/AIDS awareness and prevention to all seamen on board irrespective of rank, race, religion and language. Sometimes the talk is conveyed in the languages of Urdu or Arabic through the assistance of an interpreter on board. The talk, which is called the Harbour AIDS Programme, covers the following aspects:

- a) Very brief history of AIDS
- b) Statistical facts on HIV/AIDS
- c) What is HIV/AIDS?
- d) How it is spread?
- e) How it is not spread?
- f) Prevention
- g) What happens to persons infected with HIV/AIDS?

The following message is strongly emphasised, namely, "The West says, Safe Sex but the Islamic message is Save Sex For Marriage." A short question and answer session is held after the talk to remove any doubts. Islamic literature and stickers on HIV/AIDS are handed out to all the seamen. The response from the seamen is very appreciative after

their initial shock of ignorance on HIV/AIDS. Some of the officers do research on this topic and have a more detailed discussion on this when they next meet the president of the Institute. This shows that the talk has made a great impact on them to do research and further empower themselves on HIV/AIDS. Thus far (September 2003), over six thousand seven hundred (6 700) seamen have been empowered with the knowledge on HIV/AIDS awareness and prevention.⁸⁷ The Institute works in consultation with the IMA on HIV/AIDS awareness and prevention programmes.

4.6. POSITIVE MUSLIMS

This organisation was founded in June 2000 and established its office in January 2003 in Cape Town. They are committed to raising awareness about AIDS and offering support to Muslims living with HIV/AIDS. Their primary focus is to provide support for those who have already been affected and to educate Muslim communities to prevent the spread of HIV/AIDS. Their approach to prevention includes, but is not limited to, abstinence from sex outside marriage, faithfulness during a relationship and the use of condoms in appropriate circumstances.⁸⁸ (It is important to note that Islam allows sex within marriage only – writer's comment)

Their activities cover the following three areas, namely, Research, Support and Awareness and Education.⁸⁹

⁸⁷ Interview with Mr S.A. Khan. February 2003.

⁸⁸ Positive Muslims Leaflet. December 2000.

⁸⁹ Positive Muslims Quarterly Report. March 2003.

a) Research Forum

- i) Interested researchers on HIV/AIDS have been put into a focus group and their first meeting was held on 15 March 2003. Sixteen researchers of whom eight delivered presentations of varying standards attended it. It was agreed at that meeting to make it a quarterly event; to develop an internet discussion list; and that all researchers should supply basic information about their work to the office for their records and the website.
- ii) Webscan – to scan the internet web for all references to HIV/AIDS and Muslims/Islam with the intention to categorise these with a brief paragraph on the significant sites.
- iii) HIV Prevalent Studies Project – a research on HIV/AIDS prevalence in the Muslim community in order to form a base to present intervention strategies inside the Muslim community.
- iv) Faghmeda Miller Scholarship – this is in honour of the courage of Ms F. Miller, an innocent victim of AIDS, who was the first Muslim to publicly declare her HIV/AIDS status. It is to promote scholarship inside the Muslim community about HIV/AIDS for a Master's student whose dissertation subject will be shaped and whose research will be used by the organisation.

b) Support and Counselling

- i) The support group for people with AIDS (PWA) started meeting from 9 February 2003 and this has continued every fortnight thereafter. The group consists of about eight people who meet

regularly at the office for their group therapy sessions. Individual counselling is also conducted at the office with people with AIDS, on a regular basis.

- ii) Telephonic counselling has been an ongoing process, especially when people with AIDS are in a crisis, they make use of telephonic counselling extensively. Members who are too ill, as well as those who are unable to attend the support group, make use of this service. Those who wish to remain anonymous also make use of this service.
- iii) Other forms of counselling includes home visits for moral and personal support; clinic visits; and prison visits when a member of the support group has been imprisoned.
- iv) Developing a “buddy” system (a one-to-one friend who will be around on an ongoing basis) and offering spiritual support. Thus far (July 2003) collation of information for the first phase of the manual has been completed as well as the selection criteria for buddies.
- v) Other forms of assistance includes, networking with SANZAF who provide food parcels to some of the people with AIDS, assisting a local clinic in Retreat, in Western Cape, to form a support group for their area, and helping to access affordable treatment for people with AIDS.

- c) Education and Awareness
- i) Conducting workshops and presentation of talks in schools, masajid and factories in order to create and deepen an awareness among Muslims, about the prevalence of HIV/AIDS in all communities, the ways in which HIV/AIDS is contracted and ways of avoiding it.
 - ii) During August 2001, six volunteers conducted eight workshops for women from various socio-economic backgrounds on the topic, "AIDS, Islam and Women". The programme took into account the religious and cultural sensitivities of the participants. These workshops covered issues such as vulnerability of women, HIV/AIDS and Islam, abuse, myths of HIV/AIDS and empowered women to negotiate their sexuality within the dominant culture of patriarchy.⁹⁰
 - iii) The organisation hosted a workshop on 4 February 2003 that was conducted by a visitor from the Quilt Making Project in the USA, on the different therapeutic effects of the quilt, and as an educational and awareness raising tool. On 8 March 2003, the support group celebrated International Women's Day at the office by conducting a workshop on making a quilt in memory of people they have lost due to HIV/AIDS.
 - iv) On 26 March 2003, they co-hosted a one-day conference for Faith Based Organisations who work in Reproductive Health and HIV/AIDS at the University of Cape Town Lung Institute. This

⁹⁰ Positive Muslims Leadership in South Africa Report. June 2003.

conference was attended by thirty delegates from the religious sectors and was organised in partnership with the IMA of Western Cape.

- v) They have published a number of articles in the Muslim press as well as in international inter-faith publications distributed throughout Africa. They have also promoted their activities on local Muslim radio stations in the Western Cape. They have published 50 000 leaflets on HIV/AIDS and Islam and have distributed these at various *masājid* in Western Cape with copies also placed in many doctors' surgeries.⁹¹ The leaflet covers the following aspects and the text has been adapted from NAZ (London).⁹²

- a) Who is this leaflet for?
- b) Is HIV a threat to Muslim communities?
- c) Do Muslims need HIV and AIDS education?
- d) Islam's view on human life and health
- e) Does the issue of modesty permit us to talk about sex?
- f) How Muslims should act in this time of crisis?
- g) What is HIV?
- h) What is AIDS?
- i) Can you tell if a person is HIV positive?
- j) How does HIV get into our bodies?

⁹¹ Positive Muslims – A firm basis for AIDS work among Muslims Report. June 2003.

⁹² Positive Muslims. HIV/AIDS and Islam Leaflet. December 2000.

- k) Is blood transfusion safe?
- l) Can you get HIV through everyday contact?
- m) How can you protect yourself from HIV?
- n) How should Muslims behave towards people who are living with HIV or AIDS?
- o) HIV/AIDS and Islam

The organisation lobby all the relevant structures, both in government and in civil society, particularly among Muslim religious leadership, for greater support for people with AIDS and a deeper awareness of the need for openness and empathy. Whilst their work is primarily among Muslims, they are committed to working with all other progressive groups working with HIV/AIDS.⁹³

4.7. SISTER HANIEFA B. ALLEE

She qualified as a nursing Sister in 1972 and worked in Durban and Cape Town for a while. From 1974-1977, she worked in a hospital in Dallas, USA and upon her return has worked in various hospitals in Durban and Cape Town. She is presently employed at the McCord Hospital in Durban. She has been involved in voluntary work with the IMA since 1985 and with the IMA mobile clinic in Inchanga, KZN from 1998. She co-ordinates the nursing services for all the IMA clinics in KZN, including the mobile service.

⁹³ Positive Muslims Leaflet. December 2000.

She has been involved in HIV/AIDS work since 1987 whilst working as an occupational health and safety practitioner in the clothing industry. All her work, talks and activities are motivated by her commitment to Islam and she draws inspiration, especially from *Sūrat al-Ma'ūn* in the *Holy Qur'ān* (107), whilst her spiritual mentor is Dr A.R. Karrim. Thus she always tries to project the Islamic perspective in all her activities.⁹⁴

During 1986, her friend in Cape Town was diagnosed as HIV positive. Her family rejected this person and she accommodated and supported her. That person is still living with HIV, but positively, in KZN. Her experience prompted her to empower herself with basic information on HIV/AIDS, and led to her involvement in HIV/AIDS work. It made her aware of the high risks that people were taking with their lives, especially in her work environment. She then started an HIV/AIDS awareness programme in the factories, whose staff were mainly women of Asian and African origin. That grouping necessitated her to draw up leaflets in English and Zulu languages to re-enforce her HIV/AIDS message. She experienced many challenges in promoting her HIV/AIDS programme. She realised that women, who were the majority of staff in the clothing industry, did not have the power of decision-making; that is, they could not have the freedom to decide on safe sex practices, and that problem was compounded by male dominance and the cultural practice of plurality of spouses. Also, most of the male spouses lived in single sex hostels in Durban which seriously disrupted family life and contributed to the problem. In order to sensitise their male spouses, she started conducting open days in the various factories over the weekends, where free eye tests, diabetes and hypertension tests were offered to encourage their participation in the HIV/AIDS awareness programme. Lunch was also

⁹⁴ Interview with Sister H.B. Allee. September 2003.

provided with little gifts of sample medicines from sponsoring companies. During the course of the screening process, she realised that many males had signs and symptoms of STI infections and such persons were referred for treatment. The talk was primarily directed to the male audience and briefly covered the following aspects.⁹⁵

- a) Personal hygiene
- b) STI – symptoms and where to get help
- c) Facts on HIV/AIDS
- d) Modes of transmission
- e) Safe sexual practice including dangers of multiple partners
- f) Income-generating activities such as “door size gardening”

A separate talk was devised for the women audience because of cultural sensitivities and included the above aspects together with child-rearing skills. The programme was of a half-day duration and was conducted at various factories that were under the management of the company that she worked for. It was conducted every fortnight over the weekends. The open day programme attracted community leaders such as teachers, traditional leaders, civic organisations and other community based organisations, who attended out of curiosity. This in turn led to them inviting her to their communities to present her HIV/AIDS programme and train other members of the community, who would cascade the information to the rest of the community. She continued with this activity from 1987 up until 1998, when she resigned from the clothing industry. She also compiled a leaflet on HIV/AIDS in October 1989, to promote awareness among all the staff in the factories

⁹⁵ Interview with Sister H.B. Allee. September 2003.

under the management of the South African Clothing Industry. The leaflet covered the following aspects:⁹⁶

- a) What is HIV?
- b) What is AIDS?
- c) What causes AIDS?
- d) How is AIDS spread?
- e) How is AIDS not transmitted?
- f) How you can get HIV/AIDS?
- g) How to prevent AIDS?
- h) How you can tell if you have this virus?
- i) Where to go for testing?

In February 1998, she was employed as a general manager of the Chatsworth Child and Family Welfare Society. She was also the HIV/AIDS co-coordinator for that society. In order to initiate her HIV/AIDS programme, she managed to obtain the sponsorship of a medically fitted container from a shipping company called SAFMARINE and then applied for funding from the Department of Health, KZN for her programme. After procuring funds, she started a vigorous campaign to educate and empower the Chatsworth community on HIV/AIDS. The medically fitted container was used for voluntary counselling and testing purpose and also to obtain samples of blood from patients for testing. The programme was conducted once a month at the premises of the above-mentioned society, with about twenty people from the general public, who in turn

⁹⁶ HIV/AIDS Information for all Staff. Sister H.B. Allee. October 1989.

trained others upon completion of the course. Hence, it was a train-the-trainer type of programme to empower the community on HIV/AIDS. The programme was spread over six days with five days spent on intensive training on home-based nursing care and covered the following aspects.⁹⁷

- a) Facts on HIV/AIDS
- b) Modes of transmission
- c) Infection control
- d) Precautions
- e) Voluntary counselling and testing
- f) Home-based nursing care

She conducted home visits of HIV/AIDS patients to provide care and support as well. She was also requested by various organisations to conduct the same training programme to their members, namely, the Police Services in Chatsworth, Chatsworth Community Care Centre, the Chatsworth Hospice and various religious organisations from the Christian and Hindu communities. The programme was conducted from 1998 up to the time when she took up employment at McCord Hospital in January 2001. She still conducts this programme in Chatsworth in the evenings but in a different format. In June 1998, she compiled a leaflet entitled, “Stop and Think – HIV/AIDS Kills” which was published by the Chatsworth Child and Family Welfare Society. Five thousand of the

⁹⁷ Interview with Sister H.B. Allee. September 2003.

leaflets were distributed to high school pupils in Chatsworth and surrounding areas as part of her awareness campaign. The leaflet covered the following aspects:⁹⁸

- a) What is HIV?
- b) What is AIDS?
- c) Can I get AIDS?
- d) Where does AIDS come from?
- e) How do we get AIDS?
- f) You cannot get AIDS from
- g) How to protect yourself?
- h) What happens to us if we get AIDS?
- i) Where to get help?

She introduced the Caring for the Carer programme in January 2001, at McCord Hospital for all the nursing staff. It deals with HIV/AIDS education, VCT and anti-retroviral provision and is conducted by her once a week. She compiled a forty page information manual on this programme in September 2002, which is handed to all the staff for their reference. It covers the following aspects which are briefly outlined:⁹⁹

- a) Social history of HIV/AIDS
- b) Facts on HIV/AIDS and Immune System
- c) HIV/AIDS Test

⁹⁸ Stop and Think – HIV/AIDS Kills Leaflet. Sister H.B. Allee. June 1998.

⁹⁹ Caring for the Carer Manual. Sister H.B. Allee. September 2002.

- d) High risk behaviour
- e) Symptoms and early signs of HIV/AIDS
- f) Infection control
- g) VCT and HIV/AIDS counselling
- h) Common HIV associated conditions in young children
- i) Sexually Transmitted Infections
- j) Priority Issues

As a member of the provincial board of the Democratic Nursing Organisation of South Africa (DENOSA) and with the commitment to HIV/AIDS education, she initiated a HIV/AIDS programme for all the nurses in all the eight regions of KZN. This programme is conducted at the different regions in KZN, once a month and is based on the Caring for the Carer programme. She compiled a thirteen page booklet (Module 1) on this programme in August 2001. This booklet, which is titled, "KZN Nurses initiative against HIV/AIDS" is distributed to all the participants for their information.

She has initiated a peer workshop on HIV/AIDS awareness and prevention from March 2001, for primary and high school pupils in Chatsworth and surrounding areas. Ten schools are requested to send ten pupils and an educator each, to this full day workshop. Hence, it is conducted with about 100 pupils at a time at the Chatsworth Hospice.

Occasionally, if a school has adequate facility, it would be conducted at that school, as was the case with Merebank Secondary and Chatsworth Secondary schools. The participants are expected to cascade what they have learnt, to other pupils in their

schools, especially the message of abstinence. In September 2002, she, together with the Representative Council of Learners' (RCL) AIDS Committee of Chatsworth Secondary School, compiled a fifty page booklet on HIV/AIDS as a guide, which contains aspects of her workshop together with the group discussions, as well as other relevant information on HIV/AIDS. A separate booklet is compiled after each workshop is held, and the information is based on the discussions held at that particular workshop. A copy of it is given to each of the participating schools of that workshop, at a function held at their school. The schools are at liberty to make more copies of this booklet. Thus far (September 2003) about forty schools have been exposed to this programme and it covers the following basic aspects.¹⁰⁰

- a) Learners perception on HIV/AIDS
- b) The adolescent in perspective
- c) Life and the impact of HIV/AIDS
- d) Facts on HIV/AIDS
- e) Transmission of HIV/AIDS
- f) Vulnerability of women
- g) High risk behaviour
- h) Universal precautions
- i) Group concerns and relevant answers

She has the Public Relation Officer for Chatsworth Hospice since February 1992 and as such, she is closely involved with dying, death and bereavement including palliative care,

¹⁰⁰ Interview with Sister H.B. Allee. September 2003.

for the terminally ill at the hospice. Domiciliary care, that is, home-based care, is a major focus in hospice care. She conducts home visits in and around Chatsworth from her list of about forty patients who are terminally ill with AIDS. Her patients are both male and female but more female, with nine being under 19 years of age whilst the oldest is 53 years old. She provides support, care and counselling to these patients. She assists their families by advising them on infection control measures, nutritional advice, care and management of the patient. She represents the patients and their families in welfare agencies, to fast track their grants. She also makes representation with community members to provide food and clothing for families, wherever and whenever the need arises. Her patients call on her at any hours for help or advice. She helps needy families with funeral arrangements in the event of a death and sees the families through the bereavement process.¹⁰¹

From June 2000, she has introduced an intensive training programme on home-based nursing care for the general public. This is conducted once a month over five full days consecutively, with a group of about twenty people at the Chatsworth Hospice. She has compiled a sixty page manual on this programme, which is given to each participant for their information and reference. At the end of the training, each participant is given the manual and certificate, which qualifies them to train others in home-based nursing care, and in this way the community gets empowered. The course covers the following aspects which is briefly outlined.¹⁰²

¹⁰¹ Interview with Sister H.B. Allee. September 2003.

¹⁰² Home-based Nursing Care Manual. Sister H.B. Allee. June 2002.

- a) Characteristics of a carer/volunteer
- b) Brief guidelines for home-based care
- c) Bill of rights of all patients
- d) Infection control
- e) Bed bath including cleaning of body parts – eyes, mouth
- f) Pressure area care
- g) Management of bed patient
- h) Feeding of patient
- i) Postural drainage (cleaning the lungs of mucous)
- j) Dressing of patient
- k) Administering medication
- l) Understanding the body including different body systems
- m) Setting up a home care programme
- n) Support group activities

As a HIV/AIDS co-ordinator for the Chatsworth Hospice, she conducts a train-the-trainer programme on awareness and education for the general public of Chatsworth and surrounding areas. The training programme of 18 hours is spread over six weeks, on every Monday evening from 6:00 p.m. – 9:00 p.m. with an average of about twenty five people per session. Upon completion of this training programme, all the participants are awarded a certificate which qualifies them as AIDS Educators. Each person signs a pledge at the end of the course called the, “Pledge of Service” to promote what they have learnt to their families, friends, neighbours, colleagues and the community at large. At the back of the pledge is printed a poem titled, “What AIDS cannot do” which she has

compiled from different sources (Refer to Appendix C and D). She has also compiled a 100-page manual on this course which is broken up into four modules and this is given to each participant as they complete the modules. She also conducts this training programme for religious and community based organisations who request for it, to have their members trained in HIV/AIDS. For instance, she has conducted this programme at the following places:

September 2002 – Ecumenical Church of Chatsworth

November 2002 – Apostolic Church of South Africa (Chatsworth)

January 2003 – Yellowwood Park Tamil Institute

July 2003 – Velankania Church (Chatsworth)

The 18 hours training programme covers the following aspects which is briefly outlined below:¹⁰³

- a) Social history of AIDS
- b) Disease causing germs
- c) Facts on HIV/AIDS
- d) Transmission of HIV - window period – infection
- e) The immune system-T-Cell response-sero-conversion
- f) What is safe practice/high risk behaviour?
- g) Understanding culture and human beings
- h) Basic counselling skills

¹⁰³ Interview with Sister H.B. Allee. September 2003.

- i) Basic home-based nursing care
- j) Humanness – values – attitudes
- k) Sexually transmitted infections

Over the years she has organised many half-day seminars on HIV/AIDS and related issues, at different places and with different religious organisations, CBO and NGO as the need arises, which is determined by the participants who attend her different programmes. The seminars are for the general public and are conducted at least four times every year with guest speakers and specialists delivering lectures on the relevant topics. This is an ongoing activity and some of the topics covered thus far are:

- HIV/AIDS – Pregnancy and Women Empowerment
- Pre-marital Voluntary Counselling and Testing for HIV/AIDS
- Religion, AIDS and Partnership-building
- “Families taking care of their own” – in HIV/AIDS and Sexuality Education.

Whilst working for the clothing industry, she had initiated a yearly AIDS Awareness Day for World AIDS Day from 1994 to 1997, at all the five factories under the management of the South African Clothing Industry. The programme for the day consisted of the following events.¹⁰⁴

- a) A poster competition organised for all first-aid workers with prizes for the first three best original posters

¹⁰⁴ Interview with Sister H.B. Allee. September 2003

- b) Distribution of red ribbons to all employees
- c) Distribution of HIV/AIDS pamphlets to all employees
- d) AIDS educational films were shown during the course of the day.

Subsequently, since 1998, she has been organising seminars to commemorate World AIDS Day with the topic based on the theme for the year, and this is an ongoing annual activity. In November 2000, she had compiled a leaflet on, "HIV/AIDS and your Life" which was published by the Chatsworth Child and Family Welfare Society. Five thousand of the leaflets were distributed to the public, as part of the World AIDS Day programme. The leaflet covered the following aspects:¹⁰⁵

- a) What is HIV?
- b) What is AIDS?
- c) What does the virus do?
- d) How is the disease spread?
- e) People who have HIV/AIDS need love, care, understanding and tolerance
- f) How you cannot get AIDS?
- g) How to protect yourself?
- h) The facts

She has been involved with the IMA Clinics since 1985 onwards, and conducts health education sessions for all its four clinics in KZN, and this is done through health educators who have been trained by her. These sessions are done intermittently between

¹⁰⁵ The Silent Killer Leaflet. Sister H.B. Allee. November 2000.

8:00 a.m. to 11:00 a.m. daily, at all the clinics by the health educators, whilst waiting patients are given a meal. She monitors the progress of health educators once a week. The health session covers the following aspects:¹⁰⁶

- a) Personal and oral hygiene
- b) Facts on HIV/AIDS
- c) Facts on sexually transmitted infections
- d) Modes of transmission
- e) Precaution and prevention (Islamic option)
- f) Prevention and care of diarrhoea, lice infection, skin infection, etc.

She is also the IMA Clinics Nursing Director and works closely with the pharmacy, administration, human resource and dawah departments of the IMA. She facilitates and co-ordinates “open days” at all the clinics, on a regular basis with the assistance of the Clinics Committee. The half-day programme for “open day” at the clinics is held once a year for each of the four clinics, and entails the following for the general public:¹⁰⁷

- a) blood pressure monitoring and advice
- b) blood sugar monitoring and advice
- c) general complaints and advice
- d) talk on HIV/AIDS/STI
- e) meals provided

¹⁰⁶ Interview with Sister H.B. Allee. September 2003.

¹⁰⁷ Interview with Sister H.B. Allee. September 2003.

She networks with national and provincial government structures; political and religious organisations; USAIDS; HIVAN; Baylor University AIDS Division (USA); Ugandan Hospice; AREPP Education Trust; etc. She writes articles on HIV/AIDS for the local tabloids, Sunday Tribune and other organisational magazines. Her efforts have been recognised by the Rotary Club of Chatsworth and the National Department of Health for voluntary services rendered, and also the South African Nursing Association, which is now known as DENOSA, who presented her with a gold medal on 3 November 1995, for rendering excellent services in the field of HIV/AIDS. She was chosen as the top nurse in KZN and represented the province in the final, for the country's top nurses in the highly-regarded Khomanani Health Worker Excellence Award in July 2003. She was elected as the second top nurse in the country for this prestigious award. DENOSA has also honoured her in recognition of her HIV/AIDS activities, by publishing her photograph on the front cover of their national monthly magazine called, "Nursing Update" in the September 2003 issue.¹⁰⁸

4.8. MS FIONA KHAN

Ms Fiona Khan is an accomplished writer and a home executive with three children. She has been very actively involved in various programmes on HIV/AIDS awareness and prevention since 1994 onwards. In December 1994 she joined the Shallcross (a suburb in south Durban) local clinic staff in the promotion of community awareness on HIV/AIDS through the use of floats; street processions; presenting videos on HIV/AIDS to students

¹⁰⁸ Interview with Sister H.B. Allee. September 2003.

from the local areas in and around Shallcross; and presenting public talks to community members. She continued with this effort and involvement up until the end of June 1998.¹⁰⁹

In July 1999 she attended a three-day workshop on HIV/AIDS which was organized by the IMA of KwaZulu-Natal and qualified as an AIDS Educator. Thereafter, she involved herself in HIV/AIDS counseling at the Shallcross Community Care Centre on a random basis where she counselled about five people a week on average. She still does counseling in HIV/AIDS wherever and whenever her services are needed. In January 2000, she volunteered her services to the Chatsworth Hospice in south Durban and presented motivational talks on HIV/AIDS awareness once a week to patients and their family members. In August 2000, as a guest speaker at the Shallcross Community Hall, she delivered a talk on the impact of HIV/AIDS in women. The Shallcross Women's Group organized that programme.

In September 2000, she organized the first HIV/AIDS Conference in Shallcross through the Shallcross Community Care Centre.¹¹⁰ People from all walks of life in and around Shallcross were invited; namely, business leaders, community and religious leaders, labourers and management, medical personnel and the general public. Unfortunately, none of the high school pupils or their teachers attended the conference although they were all invited. The objectives of the conference were, to raise awareness on HIV/AIDS and its prevention to make people aware of healthy living and healthy lifestyle. About a

¹⁰⁹ Interview with Ms F. Khan. March 2003

¹¹⁰ Interview with Ms F. Khan. March 2003

hundred people attended this one-day conference which was held from 02:00 p.m. to 08:00 p.m. It covered the following areas:

- a) Talks on HIV/AIDS by different religious leaders
- b) Clinical aspects of HIV/AIDS by IMA doctors
- c) Role play on HIV/AIDS by children
- d) Nutrition and diet by medical personnel
- e) Breast feeding awareness

In November 2000, she spoke on the impact of HIV/AIDS on the Muslim community at the Shallcross Hall at a *Na'ith* (Urdu poetry recital) function organized by Ms Z. Khan. At that function she suggested that the Muslim community should seriously think about pre-testing and counseling on HIV/AIDS before marriage.

In March 2001 the Nelson R. Mandela School of Medicine at the University of Natal initiated for the first time an HIV/AIDS programme for their first year students as part of the curriculum. She was part of the IMA of KwaZulu-Natal group of AIDS Educators who presented workshops on various aspects of HIV/AIDS for the years 2001 and 2002.

From August 2001 she has initiated a two-day workshop on HIV/AIDS awareness and prevention programme for primary school pupils from grades 3-7, with the first one held at Simla Primary in Shallcross at the school's request. This programme is conducted on a regular basis wherever and whenever there is a request from any school. Thus far (March 2003), she has conducted this programme in ten schools in the Durban south region. She

also conducts a workshop on HIV/AIDS for teachers upon such requests from schools. During the Readathon Week, she delivers a motivational talk on HIV/AIDS at different schools in the KwaZulu-Natal province. The two-day workshop on HIV/AIDS awareness and prevention for schools cover the following aspects:

- a) Body image
- b) Self awareness
- c) Family dynamics
- d) School environment
- e) Good touch and bad touch
- f) Hygiene and cleanliness
- g) Facts and myths on HIV/AIDS
- h) Role play on HIV/AIDS
- i) Universal Precautions
- j) Nutrition
- k) Sex and sexuality

In December 2001, she delivered a talk on HIV/AIDS awareness and prevention at the Gandhi Park which was organized by the Chatsworth Community Care Centre to about five hundred people. At this function she recited a poem on HIV/AIDS which she had composed. This poem was later published by the abovementioned organization. This poem was also recited at the August 2002 Lovelife Challenge held at the University of Natal by a high school pupil. It won an award and was one of the outstanding poems in that category. This poem is included as Appendix 2.

From 1995 onwards, she has been writing and publishing children's story books and has a number of titles to her credit. In March 2002, she launched three fully illustrated educational story books for children at the University of Natal. Two of these books are based on emotional intelligence and are titled, "The Magic Calabash" and "The Grasshopper who could not jump." The third book is on HIV/AIDS and is titled "Hi! I am HIV Positive." This book is the first fully illustrated book on HIV/AIDS for children in South Africa and it is also for the first time that the transmission of the AIDS virus has been simplified in children's literature. The book is written in a story form and is about a little girl who is HIV positive and is living on a farm with her mother who is also HIV positive. Her mother is a health worker who works at the AIDS Care Centre in the village. It deals in a simplified way about prejudices experienced by HIV positive people; how the HIV virus attacks the body; some facts on how it is spread and how it is not spread; good touches and bad touches; some universal precautions; and a message to leave sex for after marriage.¹¹¹ She wishes to adapt this book for a full length feature animation film on HIV/AIDS in the near future. Her books are available at all book stores nationally and have received wide publicity by being reviewed in many magazines and journals.

On 7 March 2002, Ms Nancy Richards from Radio SAFM interviewed her on the impact of HIV/AIDS in children and on 24 April 2002, Ms Salma Patel from Radio Lotus interviewed her on the same topic. On 16 May 2002 she held a meeting with about fifty primary school principals from the Durban south region at the Chatsworth Teachers Centre where she presented a talk on HIV/AIDS in children. Briefly, the talk was centred

¹¹¹ F. Khan. (2002). *Hi! I am HIV Positive*. Durban. Washesha Publications.

on the attitude of staff to pupils who are infected and affected by HIV/AIDS and on the importance of including an HIV/AIDS awareness programme in the school curriculum. She participated in the Women's Day celebration and spoke on the abuse of women and HIV/AIDS. This function was organized by the eThekweni (Durban) Metro Council on 9 August 2002 at the Natal Playhouse for the general public.

In July 2002 she drafted a trainer's and student's manual on HIV/AIDS from an Islamic perspective. This has yet to be published and implemented. Its target groups are the students, tertiary institutions, religious organizations, NGO and individual trainers. The course content covers the following areas:

- a) Social Sciences: interaction and socio-psychotherapy – gender and bias, patriarchy, legal, human rights and labour practices – myths/facts and statistics, attitudes, pre-post test counseling, VCT, conflicts and crisis
- b) Human Anatomy: male and female, sex and sexuality
- c) The AIDS virus and Immunology: stages of transmission, infection and progression
- d) Health Education: opportunistic diseases, a brief overview of respiratory, circulatory and digestive systems
- e) Family planning and mother to child transmission: testing, types of tests, role of health sector
- f) Death and dying
- g) Home-based care
- h) Alternative therapy and the role of religious leaders and traditional healers

- i) Prevention and universal precautions
- j) Training techniques: school and community projects
- k) Substance abuse
- l) Nutrition

In April 2002, she conducted a workshop for nursing students on HIV/AIDS in children, from a religious perspective, at the University of Natal Nursing School. The topics included, mother to child transmission; anti-retroviral drugs; VCT; pre- and post-test counseling and home-based care. This workshop was also conducted at the Protea Nursing School in Chatsworth in June 2002 to a class of about fifty nursing students. This workshop is conducted whenever there is a request for it.

At the University of Durban-Westville in May 2002, she presented a writing workshop on HIV/AIDS to post-graduate students. The workshop entailed teaching students the skills to write stories on HIV/AIDS and included a talk on basic HIV/AIDS education. In July 2002, a paper on “Emotional intelligence and its impact on cognitive development in those who are infected and affected with HIV/AIDS” was presented by her at the International Convention Centre in Durban at the First International Emotional Intelligence Conference. This paper was also presented at the IMA Convention in July 2002.

In August 2002, a general workshop on HIV/AIDS was conducted for volunteers and staff at the Highway Hospice in Durban. The topics included, HIV/AIDS in children;

story telling for children; role play; community programmes and home-based care. The home-based care programme covers the following aspects:

- a) Role of volunteer
- b) What to do at home
- c) The care giver – you and the patient – roles and responsibilities
- d) The body – how it works – identify own and others needs
- e) Hygiene – dressings/wound care and bathing
- f) Feelings – understanding – individual and group needs, anxiety and depression
- g) Sexuality – talking about bodily and emotional functioning, relationships, safer sex practices
- h) Support – special care – comfort
- i) House-keeping-bedmaking, house cleaning, bed pans
- j) Basic nursing – medication, medical equipment, moving people – information on diseases/HIV/AIDS – its spread/progression, the immune system, avoidance, managing common symptoms, etc.
- k) Nutrition – eating for optimum health, good nutrition
- l) Death and dying – preparation of affected, care for dying, family help during and after death
- m) General caring rules
- n) Precautions – burn out, infection, universal precautions
- o) Resources – general health, medical care, recovery or stability
- p) Safe environment

- q) Difficult issues – confidentiality, who and when to tell
- r) General education – stages of disease, stages of loss, general health and nutritional practices, positive outlook, common symptoms – nausea, weakness, mental confusion, infection, general guide on personal care and medicine use, administration of drugs, safe use – when to use drugs.
- s) Counselling – what is counseling, what is listening, social and cultural aspects of HIV/AIDS

In August 2002, she conducted a general workshop on Emotional Intelligence and HIV/AIDS to students of the Durban Institute of Technology. The aim was to empower students with the knowledge of HIV/AIDS, gender issues, personal emotions and conflicts, choices and consequences and personal development.

Subsequently, after the publication of the children's story books, she has written and published educational books on literacy and life skills which incorporates HIV/AIDS awareness. This is based on the new National Curriculum Statement for the country. These books, which were launched in September 2002, cover the entire foundation phase which is from grade R to grade 3 and includes a teacher's manual plus charts and task cards. The Department of National Education in the country has now accepted these books as core life skill material for the foundation phase in primary schools.¹¹² The children's storybooks written by her have become supplementary reading material for the foundation phase. The series cover the same topics but the contents have been graded to

¹¹² Interview with Ms F. Khan. March 2003.

suit the level of the learners. UNESCO has accepted these lifes-kill books as well.¹¹³ It covers the following topics:

- a) Me, myself and I
- b) Body image
- c) Self awareness
- d) Senses
- e) Family
- f) Good touches and bad touches
- g) Hygiene/Cleanliness
- h) Universal precautions
- i) Nutrition
- j) Interaction with emotional intelligence
- k) Relationships
- l) Death and dying
- m) Memory box
- n) Community and social development

In December 2002, she participated in the eThekweni Metro Council's AIDS Awareness campaign for the youth. This function was held at the Durban City Hall for the general public. She addressed an audience of about a thousand people and spoke on people's attitude to HIV/AIDS. Her topic was "Being positive about being positive for those who are infected and affected."

¹¹³ Interview with Ms F. Khan. May 2003.

From June 2003, her book, “Hi! I am HIV Positive” is being promoted in all the clinics that are under the Department of Health, KZN, and this has been extended to the clinics in the public hospitals as well. It is to be used by the clinic staff for counseling of children and to promote the HIV/AIDS message to the community. It is to be translated into the Zulu language by the publishers for the rural communities in KZN. It is promoted together with twenty-two A3 size charts, on the different parts of the body, different diseases like malaria and tuberculosis, and on HIV/AIDS.

She participated in a workshop for Artists against AIDS, organized by the Centre for HIV/AIDS Networking (HIVAN) at the University of Natal in August 2003. One aspect of the workshop was the teaching of the skill to make “paper prayer”, and another aspect was the making of a documentary film on Artists against AIDS called “Deadly Myths”. She featured in this documentary film, reciting her AIDS poem; expressing her thoughts on different myths; stating how she became active in HIV/AIDS work and spoke on the impact of HIV/AIDS in the Muslim and Indian community. Other artists also featured in that documentary.

She has written another two books in August 2003, relating to HIV/AIDS titled, “The Greatest Love of All”, which deals with death and dying whilst the second book is titled, “Sticks and Stones”, which deals with child abuse. These two books are readers for the intermediate phase, in the areas of Literacy and Life Orientation. She has also drawn up books for the intermediate phase (grade 4 to grade 6) based on the new National Curriculum Statement, in the learning areas of English (home language), Mathematics, Science, Life Orientation and Art & Culture. These books include a teacher’s guide for

each learning area, and all these books are to be translated into the Zulu language by the publisher. The draft copies of these books have already been submitted to the Department of National Education for approval as core material, for grade 4 to grade 6 and are to be published by the end of September 2003.¹¹⁴

She networks with various organizations and structures. Some of which are the following, IMA; WCRP; Religious Leaders Forum; Department of National Health and Education; South African Congress of Early Childhood; International Women Against Abuse; various Muslim organizations and NGO bodies.

4.9. THE UGANDAN MUSLIM COMMUNITY

The HIV/AIDS awareness and prevention campaign initiated by the Islamic Medical Association of Uganda (IMAU) in the Muslim community of Uganda has been so successful that it won the UNAIDS Best Practice Collection Accolade in October 1998 for its service to the Ugandan community. It is for this reason that I have included their efforts, as I believe we can learn much from their experience in HIV/AIDS awareness and prevention.

The IMAU is a non-governmental organisation which was established in 1987 and has over three hundred Muslim health care providers which include doctors, dentists, pharmacists and other paramedical staff. It is spear-heading the HIV/AIDS prevention

¹¹⁴ Interview with Ms F. Khan. September 2003.

programmes within the Muslim communities and has pioneered the first HIV/AIDS awareness and prevention programme for Uganda's Muslim community.¹¹⁵

It started the HIV/AIDS awareness and prevention campaign in the Muslim community in September 1989 by holding a National AIDS Education Workshop to discuss strategies for HIV/AIDS awareness and prevention within the Muslim community. The workshop was attended by every district *Qāḍī* (religious head) in Uganda among others. At that workshop the Chief *Qāḍī* officially declared a *Jihād* (striving to one's utmost) on AIDS within the Muslim community. This declaration of support from the highest level of Uganda's Muslim community was a critical first step in mobilizing the Muslim community in the fight against AIDS.¹¹⁶ Following the national workshop, the IMAU organised AIDS education workshops for the *Qāḍī* in several districts to discuss AIDS prevention issues with their *Imāms* (*masājīd* leaders) in their districts. The Imams in turn discussed these issues with the congregations at their *masājīd*.

After those initial experiences, it was realised that further efforts should be targeted at the behaviour of individuals and families. In order to reach those people, the *Imām* was recognised as the key person to be used. The Imam is the usual teacher of behaviour in their community and he performs all intimate family ceremonies like marriage and burials. He also teaches many Islamic behaviours that are supportive of AIDS prevention such as forbidding fornication and adultery. It was therefore postulated that if the Imam was given appropriate training in health education and provided with the necessary

¹¹⁵ Interview with Dr M. Kagimu. July 2000.

¹¹⁶ *AIDS education through Imams. UNAIDS case study*. UNAIDS. (1998), p. 12.

logistical support, he was likely to influence the behaviour of the community. These ideas were discussed with the top religious leaders in the districts and all agreed that the Imams needed training on how to combine Islamic teachings with health education. They also needed assistance to help them to visit homes and transport in the form of bicycles to enable them to be mobile within the community. The Imams and their assistants needed some motivators for their work. In order to help them to generate a little income to compensate for some of their work, it was decided to provide local hens for rearing as the minimum motivators.¹¹⁷

Extensive dialogue between the health professionals and religious leaders at those early workshops revealed the need to design an AIDS education project to reach Muslim families through educators trained and sanctioned by the Imams. In 1992 the IMAU designed and initiated this project which was called the Family AIDS Education and Prevention Through Imams (FAEPTI) Project. Two districts with high Muslim populations were selected for the pilot project. A baseline survey was done to assess the level of knowledge, attitudes and behaviour regarding HIV/AIDS in the target communities. A curriculum was then developed to include various AIDS related topics such as HIV transmission and prevention; behaviour change; safer sex; AIDS and gender; AIDS and sexuality; communication skills; and the teachings of Islam on all those issues. The method of using the curriculum was by guided discussion in which the facilitator asked the relevant questions and the participants gave appropriate response. Twenty-three IMAU trainers were trained in how to use the curriculum and they in turn trained the Imams and their assistants. The trained Imams and their assistants who were called

¹¹⁷ *Journal of the IMA of South Africa (JIMASA)*, December 1996, p. 80.

Family AIDS Workers (FAW) then started visiting homes and educating families about HIV/AIDS using the same curriculum and a similar method of education.

In the first two years of the project, over three thousand community educators were trained to serve approximately four hundred *masājid*. After two years of project implementation, a follow-up survey was conducted to assess any changes that had occurred in knowledge, attitudes and practice. It was found that among those exposed to the project, there was a statistically significant increase in knowledge of transmission and prevention, and risk perception to practices of circumcision and ablution of the deceased. In addition, there was a significant reduction in sexual partners reported by both males and females exposed to the project and increased condom use. Even extramarital partners were fewer among those exposed to the project.¹¹⁸

The FAEPTI Project was launched in two districts, namely Mpigi and Iganga in 1992 and spread to ten districts within five years. The project has worked with leaders at eight hundred and fifty *masājid* and had trained six thousand, eight hundred community volunteers who have made personal visits to one hundred and two thousand (102 000) homes. This was followed in 1995 by Community Action for AIDS Prevention (CAAP) in Kampala, the capital city. This project was conceived as an urban companion to FAEPTI. CAAP workshops train teams from *masājid* as well as churches plus social groups like bicycle transporters. The project design has taken into account the density of urban populations and focuses on community groups as well as individual families. IMAU has also reached out to Muslim children through a separate initiative, namely, the

¹¹⁸ *Journal of the IMA of South Africa (JIMASA)*, December 1996, p. 80.

Madressa AIDS Education and Prevention (MAEP) Project. This project helps the Imams and their assistants to provide AIDS education to children through a special curriculum designed for informal schools attached to *masājid*, called *Madrasah* Schools.¹¹⁹

The FAEPTI Project

This innovative project helps the Imams to incorporate accurate information about HIV/AIDS prevention into their spiritual teachings. It also trains the teams of volunteers to provide education, basic counselling and motivation for behaviour change through individual home visits. As HIV is spread primarily through sexual intercourse, modifying current or future sexual behaviour is the focus of IMAU's effort to prevent HIV transmission. The Imam, as a respected leader in the community and head of the *masjid*, is the recognised teacher and model for social behaviour within the Muslim community. His teaching occurs during congregational prayers and at intimate family ceremonies such as marriage, birth and burial. For this reason, IMAU committed itself to promoting behavioural change at the community level, using the *masjid*, the Imam and selected community volunteers as the focus of their activities. Therefore the most effective way to support an AIDS education effort was to combine public health messages with Islamic teachings. It also acknowledges the important role of parents, teachers and peers in discouraging high-risk behaviour.¹²⁰

¹¹⁹ *AIDS education through Imams*, op. cit. p. 13.

¹²⁰ *Ibid*, pp. 13-14.

In the planning phase, the Imams requested that community volunteers be trained as their assistants to help further take the project to the household level. The Imams also requested bicycles to help their teams to move around the community, and income-generating activities to sustain volunteer motivation. A baseline survey was conducted in Mpigi and Iganga districts because these have the densest concentration of Muslims in Uganda and funding for this pilot project was obtained from USAID. The survey determined the need to develop sensitive and appropriate messages regarding HIV/AIDS awareness and prevention for Muslim communities.

In each district, five-day training workshops were designed for Imams and their selected team of volunteers: two assistants (one male, one female) and five Family AIDS Workers (FAW). The District *Qāḍī*s and County *Shaykhs* also participated. The workshop curriculum was supplied by the Ministry of Health, with special modifications made for the Muslim community based on the findings of the Baseline Survey. Twenty-three IMAU trainers were trained to conduct the workshops. Workshop participants studied basic facts about HIV/AIDS, as well as: STI, risk perception, principles of behaviour change, safer sex, AIDS in relation to gender and adolescence, principles of communication, counselling, and the role of the community in sustaining AIDS prevention activities. The workshops also trained participants in how to conduct home visits to discuss AIDS-related issues with members of their communities. Teams from each of the 200 *masājīd* in Mpigi attended a workshop, as did teams from half of the 400 *masājīd* in Iganga. Each team member was made responsible for visiting 15 homes each month to pass on the AIDS information and to make themselves available for counselling and consultation. In order to facilitate movement, a bicycle was given to each *Imām* for

his use and that of his team. The District *Qāḍī*s, the County *Shaykhs* and their assistants were also given bicycles. Each FAW was given two local hens, or the financial equivalent, to start an Income-Generating Activity (IGA). IGA provided incentive for the volunteer work demanded by the project.¹²¹

Who does what?¹²²

District *Qāḍī*

The District *Qāḍī* supervises *Imāms* and works with IMAU to ensure that the project is properly implemented. He periodically visits different counties to assess the project's success and address local concerns. If a *masjid* team is having difficulty working together, the District *Qāḍī* is often asked to intervene.

Imām

The *Imām* visits families individually and also teaches about AIDS during public ceremonies. The Imam relates risk-avoiding behaviour back to religious teachings. The Imam supervises his assistants and FAW. Each *masjid* team comes together at the end of each month to discuss any difficulties they had during family visits and how best to address these problems.

Imām assistant

One male and one female assistant are chosen by the Imam to help him carry out his work. *Imām* assistants supervise FAW as well as make individual family visits. Imam assistants visit families already reached by FAW, to ensure that correct information is

¹²¹ *AIDS education through Imams*, op. cit., pp.15-16.

¹²² *Ibid*, p. 16.

being shared. If problems are noted during these follow-up visits, the Imam assistant meets with the FAW to address the problems.

Family AIDS workers

Five male and female community members are chosen by the masjid community to be Family AIDS Workers. Generally respected by their peers and also viewed as approachable, FAW visit homes and teach families about modes of HIV transmission and ways to prevent infection. Over time, FAW are consulted about problems that arise with spouses and sometimes counsel couples. They receive questions about the use and availability of condoms and are often asked to discuss sensitive issues with youth.

Community action for AIDS prevention

The Community Action for AIDS Prevention project (CAAP) in Kampala takes advantage of the urban setting to jointly train religious and community leaders of many faiths. Due to the density of the population in their communities, trained Muslim and Christian leaders place less emphasis on home visits and more emphasis on spreading AIDS education messages through group talks at *masājid*, churches, and Local Council meetings. CAAP reaches beyond religious leaders and trains groups of bicycle taxi drivers (*boda boda boys*) and market vendors to pass on information about HIV/AIDS through their interaction with the public – at market stalls and while delivering passengers to their destinations.

***Madrasah* AIDS education and prevention project**

In most parts of the world, the majority of new HIV infection is in children and in young

people between the ages of 15 and 24. In 1995, IMAU developed an AIDS education programme for Muslim youth to address a lack of information in this most vulnerable sector of Uganda's population.

The *Madrasah* AIDS Education and Prevention Project, funded by the United Nations Children's Fund (UNICEF), works with 350 *Madrasah* schools in Kamuli and Mpigi Districts. *Madrasah* schools are informal schools attached to *masājid* and teach young people important principles of Islamic culture and behaviour. Approximately 50 children ranging up to 15 years of age attend each school. Classes include in-school as well as out-school youth. *Madrasah* teachers are *Imāms* or Assistant *Imāms* and some are members of the Uganda Muslim Teachers Association.

IMAU and UNICEF developed an AIDS education curriculum with 36 lessons, each of which can be covered in a 40-minute session on a Saturday or Sunday morning. The curriculum is tailored to be age-appropriate for classes of mixed age groups. The AIDS education session is taught in addition to the religious topic addressed that day.

Madrasah students learn about HIV/AIDS transmission, prevention and control. They are shown how to care for AIDS patients and encouraged to help people in their own communities suffering from AIDS. Teachers and their assistants organise activities that include music, drama, and games. Parents and guardians are encouraged to talk to their children about HIV/AIDS.

IMAU gives training in the use of the AIDS Education Curriculum to 24 supervisors in each district. The supervisors, who themselves are *Imāms*, County *Shaykhs* or selected assistants, pass on their training to two *Madrasah* teachers from ten different *masājid*.¹²³

The AIDS education curriculum covers the following aspects:

- a) Understanding adolescence
- b) Adolescent friendships
- c) Peer pressure
- d) Understanding sexuality
- e) Facts and myths about HIV/AIDS
- f) Islamic teachings on safe sex
- g) Responsible healthy living
- h) Breaking the stigma
- i) Peer counselling
- j) Building positive dreams
- k) Discussing AIDS with parents

Income-generating activities (IGA)

IGA are a popular component of the FAEPTI Project. IMAU believes that increasing individual and family income is an important factor in reducing the likelihood of HIV infection. Families with higher incomes are more likely to educate their children. Their children, in turn, are more likely to find gainful employment and understand the dangers

¹²³ *AIDS education through Imams*, op. cit. p. 20-22.

of high-risk behaviour. Lack of meaningful activity is often cited as a condition that puts young people at risk for AIDS.

At the beginning of the project volunteers were given money to buy two hens. This was later modified and each was given two female goats. In many cases the hens and goats multiplied to benefit the volunteers effectively. Other IGS were started from the sales of the multiplied goats and hens. Other IGA are, collecting honey from beehives, buying and selling fruit, making clay bricks, stone crushing, basket weaving, brick laying, etc.¹²⁴

“Income generation is not simply an economic issue. It is part and parcel of the strategy for fighting against HIV and AIDS. That is why we use HIV/AIDS as an entry point into the whole area of development.”

*Dr. Omwony-Ojwok
Uganda AIDS Commission*

“Poverty fuels AIDS and AIDS brings poverty. If we are to fight AIDS we must develop our communities.”

*Sheikh Saidi Bifamengo
Acting District Khadi, Kamuli*

Empowering women

There is an important link between a woman's ability to make choices about her life and her susceptibility to HIV infection. Women participating in IMAU's AIDS education projects say that they have learned self-respect and this helps them avoid high-risk

¹²⁴ AIDS education through Imams, op. cit. p. 24.

behaviour. They also say that having their own source of income has made it easier to stand up for themselves, in the face of unfaithful husbands.

It is a custom in many Muslim homes, particularly in the villages, that women are not supposed to work outside the home. IMAU's focus on educating women and encouraging their Income-Generating Activities met initial resistance. As time passed, more conservative community members saw that progress for women meant progress for everybody.

IMAU involves women at every level of its AIDS education activities. The Imam is required to have a female as well as a male assistant, and Family AIDS Workers (FAW) are comprised of equal numbers of men and women.

Project staff agrees that it is the women volunteers who are the most interested and effective participants. Female FAW find that women in their communities are willing to confide in them about important issues regarding HIV/AIDS that they would never raise with their husband or the Imam.

Female FAW also play a critical role in reaching out to and educating teenage girls, who in Uganda are considerably more likely to be infected with HIV than boys their own age. (The numbers balance out between the sexes as they grow older.)

Encouraging the formation of women's groups and offering incentives for IGA is at the heart of IMAU's efforts to empower local women. Many women say that their IGA keep

them from looking outside their marriages for other partners to contribute to expenses, such as school fees. They also say that if they are financially dependent on their husbands, they fear standing up to him because he may throw them out, leaving them destitute. This is one reason why women who suspect that their husbands have been unfaithful do not refuse his advances or insist he wear a condom.¹²⁵

“If women have their own income they are more likely to buy the things that they admire with their own money. They are less likely to go outside their marriage looking for someone else to provide the things they admire.”

*Halima Nantakyika
Family AIDS Worker,
Nawanyango, Kamuli District*

Overcoming hurdles

Controversy over the condom

Perhaps the most difficult issue has been sensitizing Muslim leaders to the important role that the condom plays in preventing transmission of the HIV virus.

Some religious leaders argued that condom education would promote sex outside marriage, which is against Islamic law. They refused to accept this topic in the project curriculum.

In order to encourage wide participation in the FAEPTI Project, IMAU took a cautious approach and removed the topic of the condom from the workshop curriculum in the first

¹²⁵ *AIDS education through Imams*, op. cit. p. 27.

year. In its place, IMAU held a dialogue with Muslim leaders to listen to and address their concerns about condoms.

In this dialogue, IMAU stressed that the condom was only being promoted as AIDS protection after the failure of a first and second line of defence: abstaining from sex and having sex only within marriage.

IMAU argued that the third line of defence should not be ignored because human beings have their weaknesses, as witnessed by girls becoming pregnant before marriage and the many cases of sexually transmitted infections (STI). Married people who ignore condoms often leave orphans behind and this destroys communities.

IMAU argued further that knowing about condoms does not mean that people will use them indiscriminately. Muslims know about alcohol but that does not mean that they drink it.

IMAU emphasised that the condom not only protects against STI but can be used for family planning by married couples. IMAU noted that several Muslim countries manufacture condoms for their own reproductive health programmes.

Although the Muslim leaders feared that knowledge of the condom would bring promiscuity, IMAU made it clear that many things used irresponsibly are harmful, even food. Using this analogy, IMAU made the important point that communities need to understand responsible eating so that they do not endanger their lives.

At the end of the dialogue, the Muslim leaders agreed that education on the responsible use of the condom was acceptable within Islamic teachings and necessary to defend communities against AIDS. The condom education component was re-inserted in year two.¹²⁶

IMAU networks with other organisations in the country such as TASO (The AIDS Support Organisation) and the AIDS Information Centre in its fight against HIV/AIDS. IMAU projects such as FAEPTI, CAAP and MAEP have contributed to significantly higher levels of HIV/AIDS awareness and prevention within Muslim communities in Uganda. They attribute the success of their HIV/AIDS awareness and prevention campaign to Islam as it provided the basic administrative structure with voluntary community workers to reach individuals and families. Also its teachings are supportive of health education on HIV/AIDS prevention. This means that Islamic teachings can be successfully used as a practical model in HIV/AIDS awareness and prevention and the fact that their Islamic campaign on AIDS prevention won the UNAIDS Best Practice is proof of this.

4.10. FIRST INTERNATIONAL MUSLIM LEADERS CONSULTATION ON HIV/AIDS

The Islamic Medical Association of Uganda (IMAU) in conjunction with the Uganda Muslim Supreme Council (UMSC) held the First International Muslim Leaders

¹²⁶ *AIDS education through Imams*, op. cit. p. 30.

Consultation on HIV/AIDS from 1-4 November 2001 in Kampala, Uganda. More than one hundred participants from over twenty-one countries from Africa, Asia, Middle East and North America attended. The participants included Muslim leaders at various levels including women, youth, and health professions, *Imāms*, *Muftīs* and government leaders. The consultation served as a forum for sharing experiences, advocacy, strategic planning and training of trainers for strengthening and expanding the Muslim community response to HIV/AIDS both in Uganda and internationally.¹²⁷

The theme of the conference was: Strategies for strengthening and expanding the national and international Muslim community response to AIDS. The motto of the conference was: Commitment to the *Jihād* on AIDS means self discipline to prevent AIDS and care for the infected and affected using Allah's guidance. The programme that was held over four days is briefly summarised as follows:

Session 1: Introduction and sharing experiences

Experience from Uganda; video show: the long *Jihād* – a bitter battle against AIDS – discussion of the video

Experience from Senegal/South Africa/Malaysia

Keynote address: Islamic approach to HIV/AIDS prevention and control

Representatives from UNAIDS/USAIDS/Uganda AIDS Commission

Session 2: Group Work

Group discussions

Presentation of discussion and general discussion

¹²⁷ Bulletin of the IMA (BIMA) Pamphlet. December 2001.

Theme: Contribution of Islam to the ABCD of HIV/AIDS Prevention

Group 1: Topic: Abstinence from sex for AIDS prevention

Questions for discussion:

1. What Islamic teachings are there to support abstinence from sex to avoid AIDS.
2. What factors cause some people to succeed in abstaining from sex to prevent AIDS
3. What problems cause some people not to abstain from sex to avoid AIDS
4. What solutions are there to overcome these problems.

Group 2: Topic: Being faithful in marriage for AIDS prevention

Questions for discussion:

1. What Islamic teachings are there to support faithfulness in marriage to avoid AIDS
2. What factors cause some people to succeed in being faithful in marriage to prevent AIDS
3. What problems cause some people to fail to be faithful in marriage whether these marriages be monogamous or polygamous
4. What solutions are there to overcome these problems

Group 3: Topic: Condom use for AIDS prevention

Questions for discussion:

Similar type as in group 1/2

Group 4: Topic: Drug Avoidance : Avoiding narcotic drug use to prevent AIDS

Questions for discussion:

Similar type as in group 1/2

Session 3: Group Work

Group discussions

Presentation of discussion and general discussion

Theme: Contribution of Islam to Care and Support

Group 1: Topic: Stigmatisation of HIV/AIDS

Group 2: Topic: Care for people with AIDS (PWA)

Group 3: Topic: Counselling and Spiritual care for PWA

Group 4: Topic: Bereavement

Questions to be discussed for all groups:

Similar type as in group 1/2 in session 2

Session 4: Group Work

Group discussions

Presentation of discussions and general discussion

Theme: Contribution of Islam to Mitigating the socio-economic impact of AIDS

Group 1: Topic: Economic support for PWA

Group 2: Topic: Orphan care

Group 3: Topic: Income generating activities for AIDS related activities

Group 4: Topic: Protection of legal rights of those affected by HIV/AIDS

Questions to be discussed for all groups:

Similar type as in group 1/2 in session 2

Session 5: Group work

Group discussion

Presentation of discussion and general discussion

Theme: Topic: International Muslim community response to AIDS

Group 1: Topic: Initiating, strengthening and expanding the Muslim community response to AIDS

Group 2: Topic: Co-ordination of the Muslim community response to HIV/AIDS

Group 3: Topic: Evaluation of the Muslim community response to HIV/AIDS

Group 4: Topic: Resource Mobilisation

Questions to be discussed for all groups:

Similar type as in group 1/2 in session 2

Session 6 : Plenary Session

Theme : The Way Forward and Resolutions

Topic : The way forward

Questions to be discussed:

What is the way forward for:

1. sharing experiences of the Muslim community response to AIDS
2. AIDS prevention from the Islamic perspective
3. AIDS care and support from the Islamic perspective
4. mitigating the socio-economic impact of AIDS from the Islamic perspective
5. initiating, strengthening, expanding the national and international Muslim community response to AIDS

Closure

4.11. SECOND INTERNATIONAL MUSLIM LEADERS CONSULTATION ON HIV/AIDS

The Second International Muslim Leaders Consultation on HIV/AIDS was held in Kuala Lumpur, Malaysia from the 19-23 May 2003 and was organised by the Malaysian AIDS Council. The theme of the consultation was: The Caring Ummah : Transforming the Response. The goal statement of the consultation was: To initiate, support and strengthen sustainable Muslim leaders' response to HIV/AIDS. The papers presented by the delegates and the discussions were centred around the following objectives.

- a) To explore the feasibility of creating a Muslim leaders' HIV/AIDS network
- b) To discuss the role and use of faith in response towards awareness and prevention of HIV/AIDS
- c) To explore the application of Islamic principles/teachings in response to prevention, care and support of HIV/AIDS
- d) To discuss the creation of a positive and enabling environment to mitigate stigma and discrimination
- e) To discuss and address the vulnerability and impact of HIV/AIDS on women, orphans and children.

The programme was held over five days and is briefly summarised below:

Day 1: Welcome remarks
 Opening speech
 Video presentation

Creating a caring Ummah : Transforming the response

HIV/AIDS : What do you know about it

From Kampala to Kuala Lumpur

(speakers from South Africa, Malaysia, Uganda and Nigeria)

Day 2:

Plenary One: Theme: Protecting human dignity

Stigma and discrimination: A violation of dignity

Does testing help prevention

Human dignity: An Islamic perspective

Workshop

Plenary Two: Theme: How can Islamic teaching reduce vulnerability

What is vulnerability

Open secrets

Challenges ahead

Workshop

Dinner lecture : A global perspective : AIDS in the Muslim

World

Day 3:

Plenary Three: Theme: Drug use: What is the Islamic Perspective on

Harm Reduction

Islam, Drugs and HIV/AIDS : Meeting demands

Supplying needs

Confronting challenges and meeting realities

Women and drugs

Drug users in Muslim communities

Workshop

Plenary Four: Theme: Sexual health and sexuality: A gift from Allah

Sex as a gift from Allah

Sexuality in Islam and the issue of sexual violence

Sexual orientations : Addressing realities

Workshop

Dinner Lecture : Religious leaders in challenging HIV/AIDS –

experiences from other faith traditions

Day 4: Plenary Five: Theme: What is the role of Muslim leaders

Rayaat Masjid : Muslim and community leaders

Challenges and responsibilities of Muslim leaders of Masajid and

Muslim leaders

Challenges and responsibilities of Muslim leaders

Workshop

Plenary reports

Day 5: Youth voices

Chief rapporteurs' report

Closing speech: charter, action plan

Souvenir presentation

Closure

Chapter Five

THE SOUTH AFRICAN GOVERNMENT'S NATIONAL STRATEGIC PLAN FOR HIV/AIDS AND STI

The HIV/AIDS epidemic is the most important challenge facing South Africa (SA) since the birth of its new democracy. The government has, therefore, made the fight against this scourge a top priority. Hence, it has chosen a multi-sectoral approach as a lead strategy in combating the HIV/AIDS epidemic. The Strategic Plan has been developed with the participation of many stakeholders. Key priority areas have been identified and sectors are expected to plan their interventions in line with these priorities. The implementation of the Strategic Plan requires enormous resources. Therefore, all sectors including Government Ministries, Non-Governmental Organisations (NGO), the private sector, religious organizations, people living with AIDS (PWA) and donor organizations have been urged to devote resources towards the fight against HIV/AIDS.

The document is a broad national strategic plan designed to guide the country's response to the epidemic. It is a statement of intent for the whole country, both within and outside government. It is recognized that no single sector, ministry, department or organization is by itself responsible for addressing the HIV/AIDS epidemic. It is envisaged that all governmental departments, organizations and stakeholders, including faith-based organizations, use this document as a basis to develop their own strategic and operational plans so that all initiatives can be harmonized to maximize efficiency and effectiveness.¹

¹ *HIV/AIDS and STI – Strategic Plan for South Africa 2000-2005*. Department of Health. Pretoria. May 2000. p. 5.

5.1. SITUATION ANALYSIS²

a) **Major causes and determinants of the epidemic in South Africa**

The immediate determinants of the epidemic include behavioural factors such as unprotected sexual intercourse, multiple sexual partners, and biological factors such as the high prevalence of sexually transmitted infections. The underlying causes include socio-economic factors such as poverty, migrant labour, commercial sex workers, the low status of women, illiteracy, the lack of formal education, stigma and discrimination. The national HIV/AIDS and STI Strategic Plan must address all these immediate determinants and underlying causes.

b) **Tuberculosis and HIV/AIDS**

Closely linked to the HIV/AIDS epidemic, is Tuberculosis (TB) which is fuelled by HIV infection. TB is also the most frequent cause of death in people living with HIV. In South Africa, approximately 40-50% of TB patients are infected with HIV. In some hospitals in South Africa, the HIV prevalence in TB patients has been recorded as over 70%.

c) **Sexually Transmitted Infections**

There is compelling evidence of the importance of STI as a major determinant of HIV transmission. There are approximately 11 million STI episodes treated annually in South Africa, with approximately 5 million of these managed by private general practitioners. Even without the HIV epidemic, STI pose an important public health problem.

² *HIV/AIDS and STI – Strategic Plan for South Africa 2000-2005*, op. cit. pp. 8-10.

5.2. RECOMMENDATIONS

In response to the above analysis the following are some recommendations that have been addressed:

- a) Appointment of HIV/AIDS Co-ordinators in each province and supporting regular training and meetings to facilitate programme implementation.
- b) Establishing an Inter-Ministerial Committee on AIDS. This Committee consists of Ministers and Deputy Ministers and meets on a monthly basis to discuss HIV/AIDS and provide political direction and policy guidance to the HIV/AIDS and STI Directorate.
- c) The launch of the Partnership against AIDS by the President to broaden and formalize the participation by all sectors including religious organizations in response to the epidemic.
- d) The development of an HIV/AIDS policy by the Department of Education (DOE) for learners and educators. This makes HIV/AIDS education a component in the curricula of all secondary (high) schools.
- e) The development of other national policies including the Syndromic Management of STI and post-exposure prophylaxis (PEP) following occupational exposure to HIV.
- f) The establishment of the South African AIDS Vaccine Initiative. This initiative seeks to develop an effective, affordable preventive vaccine for universal use in South Africa and Southern African Development Community (SADC) countries by 2005.

- g) The establishment of the South African National AIDS Council (SANAC), a multi-sectoral body that will oversee the national response to the epidemic and the implementation of the Strategic Plan. The SANAC facilitates collaboration between government and all other sectors.
- h) The establishment of a national interdepartmental HIV/AIDS committee that developed HIV/AIDS workplace policies and minimum HIV/AIDS programmes for all government departments.
- i) The development of a Strategic Framework for the South African AIDS Youth Programme.
- j) Improved collaboration between HIV/AIDS and STI and TB programmes in the area of policy formulation and advocacy.

The national response is to be managed by different structures at various levels. Each government ministry will have a focal person and a team whose responsibility is planning, budgeting, implementing and monitoring HIV/AIDS interventions. It is also recommended that all other sectors, including parastatals, NGO, the private sector, faith-based organizations, youth and women will have dedicated HIV/AIDS focal persons.

5.3. PRINCIPLES

The following principles for HIV/AIDS and STI prevention, treatment and care efforts for the country have been adopted in the National AIDS Plan.

- a) People with HIV and AIDS shall be involved in all prevention, intervention and care strategies.
- b) People with HIV and AIDS, their partners, families and friends shall not suffer from any form of discrimination.
- c) The vulnerable position of women in society shall be addressed to ensure that they do not suffer discrimination, nor remain unable to take effective measures to prevent infection.
- d) Confidentiality and informed consent with regard to HIV testing and test results shall be protected.
- e) Education, counseling and health care shall be sensitive to the culture, language and social circumstances of all people at all times.
- f) The Government has a crucial responsibility with regard to the provision of education, care and welfare of all people of South Africa.
- g) Full community participation in prevention and care shall be developed and fostered.
- h) All intervention and care strategies shall be subject to critical evaluation and assessment.
- i) Both government and civil society shall be involved in the fight against HIV/AIDS.
- j) A holistic approach to education and care shall be developed and sustained.
- k) Capacity building will be emphasized to accelerate HIV/AIDS prevention and control measures.

- 1) STI prevention and control are central elements in the response to HIV/AIDS.

5.4. GOALS, OBJECTIVES AND STRATEGIES

- a) The primary goals are to:
Reduce the number of new HIV infections (especially among youth); and,
Reduce the impact of HIV/AIDS on individuals, families and communities.
- b) The following general strategies will be stressed:
An effective and culturally appropriate information, education and communications (IEC) strategy;
Increase access and acceptability to Voluntary HIV Counselling and Testing;
Improve STI management and the treatment of opportunistic infections and promote increased condom use to reduce STI and HIV transmission;
and
Improve the care and treatment of HIV positive persons and persons living with AIDS to promote a better quality of life and limit the need for hospital care.
- c) The Strategic Plan is structured according to the following four areas:
Prevention;

Treatment, care and support;

Human and legal rights; and monitoring, research and surveillance.

In addition, the youth will be broadly targeted as a priority population group, especially for prevention efforts.

5.5. PRIORITY AREAS AND GOALS

The following section focuses in more detail on those strategies to be pursued in order to bring about meaningful change in the spread of the HIV/AIDS epidemic in South Africa.

a) Priority Area 1: Prevention

Goal 1: Promote safe and healthy sexual behaviour

Goal 2: Improve the management and control of STI

Goal 3: Reduce mother-to-child transmission (MTCT)

Goal 4: Address issues relating to blood transfusion and HIV

Goal 5: Provide appropriate post-exposure services

Goal 6: Improve access to Voluntary HIV Counselling and Testing (VCT)

b) Priority Area 2: Treatment, Care and Support

Goal 7: Provide treatment, care and support services in health facilities

Goal 8: Provide adequate treatment, care and support services in communities

Goal 9: Develop and expand the provision of care in children and orphans

c) **Priority Area 3: Research, Monitoring and Surveillance**

Goal 10: Ensure AIDS vaccine development

Goal 11: Investigate treatment and care options

Goal 12: Conduct policy research

Goal 13: Conduct regular surveillance

d) **Priority Area 4: Human and Legal Rights**

Goal 14: Create an appropriate social environment

Goal 15: Develop an appropriate legal and policy environment

The implementation of the HIV/AIDS and STI Strategic Plan is essential to ensure the achievement of the national goals. The Strategic Plan should be used in developing national, provincial and district operational plans taking into consideration existing financial and human resources. It must be presented to key role players within each province as a Provincial Strategic AIDS Plan. The establishment of appropriate structures at district level is important to ensure the implementation of the Plan. Hence District HIV/AIDS Committees must be established and should include community-based committees that represent major role players with the relevant community in the field of HIV/AIDS. These committees should include local government to ensure the integration of HIV/AIDS and STI and TB issues and development plans. It is vital that this include non-health issues as part of HIV/AIDS and STI planning, such as transport and poverty alleviation.

The Strategic Plan must be reviewed every twelve months at national and provincial levels. It will be monitored by specific measurable targets and indicators, and supplemented with additional monitoring, including national, provincial and local behavioural surveys. These surveys will measure changes in HIV related risk behaviours including condom use, delay of sexual initiation among youth, HIV incidence and the number of sexual partners. Monitoring will ensure that activities are being implemented according to the plan, also to assess performance and seek corrective measures, and to identify strengths and weaknesses in the response programme and activities. The National Department of Health has overall responsibility for the implementation of the Strategic Plan within the provincial structures.

The Strategic Plan provides a broad framework for government, NGO, business, labour, women and all sectors of society. Each sector should develop more specific plans based on their role, activities and their specific strengths. The HIV/AIDS and STI Strategic Plan is a living document and will be subjected to regular critical review. This will be undertaken at the national, provincial and district levels with input from all stakeholders.³

5.6. INVOLVEMENT WITH RELIGIOUS LEADERS – RAP

The new democratic government of South Africa came into being in April 1994. In the following year, in May 1995, it initiated a national organization called the Religious AIDS Programme (RAP) to get religious leaders involved in HIV/AIDS programme. It

³ *HIV/AIDS and STI – Strategic Plan for South Africa 2000 – 2005*, op. cit. , p. 11-27.

was launched in September 1996 as a National NGO under the auspices of the Department of Health where by all religious role players joined the Minister of Health in consultation to define the possible role of religious organizations in various socio-health issues, especially HIV/AIDS. The national co-ordinator went from province to province to set up regional inter-faith groups in order to promote the HIV/AIDS programme of education and prevention.⁴

RAP comprised of different religious organizations and its programme involved the training of volunteers, at least one person per religious group, as AIDS Educators by the Department of Health. These trained volunteers from the different religious groups would then co-ordinate and promote the AIDS programme in the various community organizations and schools. Thus, RAP gave impetus to religious organizations to initiate their own HIV/AIDS programme in their communities using the training as a basis. The IMA and the *Jamiatul Ulama* in Gauteng represented the Muslims.⁵ The Muslim AIDS Committee (MAC) was the first Muslim organization to take up this challenge and have a few of its members trained as AIDS educators. They in turn trained others in the various Muslim organizations in the country. RAP is now no more in existence and the government has initiated a new structure in its place as part of its National Strategic HIV/AIDS Plan (2000-2005).

⁴ *Sterling Service 27 years of Health Care*, op. cit. p. 36.

⁵ *Ibid*, p.36.

5.7. INVOLVEMENT WITH FAITH-BASED ORGANISATIONS – FOHAP

The Minister of Health in Johannesburg officially launched the Faith Organisations in HIV/AIDS Partnership (FOHAP) at a multi-faith gathering on 31 March 2003. It forms an important aspect of the government's national Partnership Against HIV/AIDS which is part of the National Strategic HIV/AIDS Plan. It is a government-structured organization, unlike RAP which was a national NGO. More than a hundred delegates from all faiths and all regions of the country attended the Faith in Action National Indaba (gathering) in Durban from 5-6 March 2002, where the goal was to establish a National Interfaith Task Team to co-ordinate and facilitate HIV/AIDS activities across faiths. The objectives of the FOHAP National Indaba were as follows:⁶

- a) To critically reflect on the current responses of Faith-Based Organisations (FBO) to HIV/AIDS, and explore the key challenges facing this sector in its HIV/AIDS initiatives.
- b) To provide a platform for sharing ideas and experiences to assist participants in their future HIV/AIDS planning.
- c) To facilitate networking and collaboration across faiths, and between this sector and broader HIV/AIDS initiatives.

Following the National Indaba, a series of consultative workshops was organized, one in each province, as a joint project between the Department of Health's AIDS Action Plan,

⁶ *FOHAP Pamphlet*. Department of Health. Pretoria. March 2003.

the USAID-funded POLICY Project and the faith-based sector. The aims of the FOHAP Provincial Workshops held between July-November 2002 were as follows:⁷

- a) Understand how FBO can link with the National Strategic HIV/AIDS Plan (2000-2005).
- b) Map existing structures and activities, reaffirm existing inter-faith structures and establish forums where none are present.
- c) Ensure the broadest cross-faith representation possible on FOHAP structures.
- d) Explore essential strategies for intervention using six spheres of activity – leadership, care, spiritual, counseling, death and dying and prevention.
- e) At the workshops nine provincial committees were elected that will help guide the sector in its HIV/AIDS response.

The National Faith-Based Task Team comprises of three members – each from a different faith community – drawn from provincial structures in the nine provinces. FOHAP structures were recently established around the country and will relate closely with the Department of Health. This will ensure good collaboration and support, and facilitate the co-ordination of activities in line with the National Strategic Plan on HIV/AIDS. The three main goals for supporting the faith-based sector are:⁸

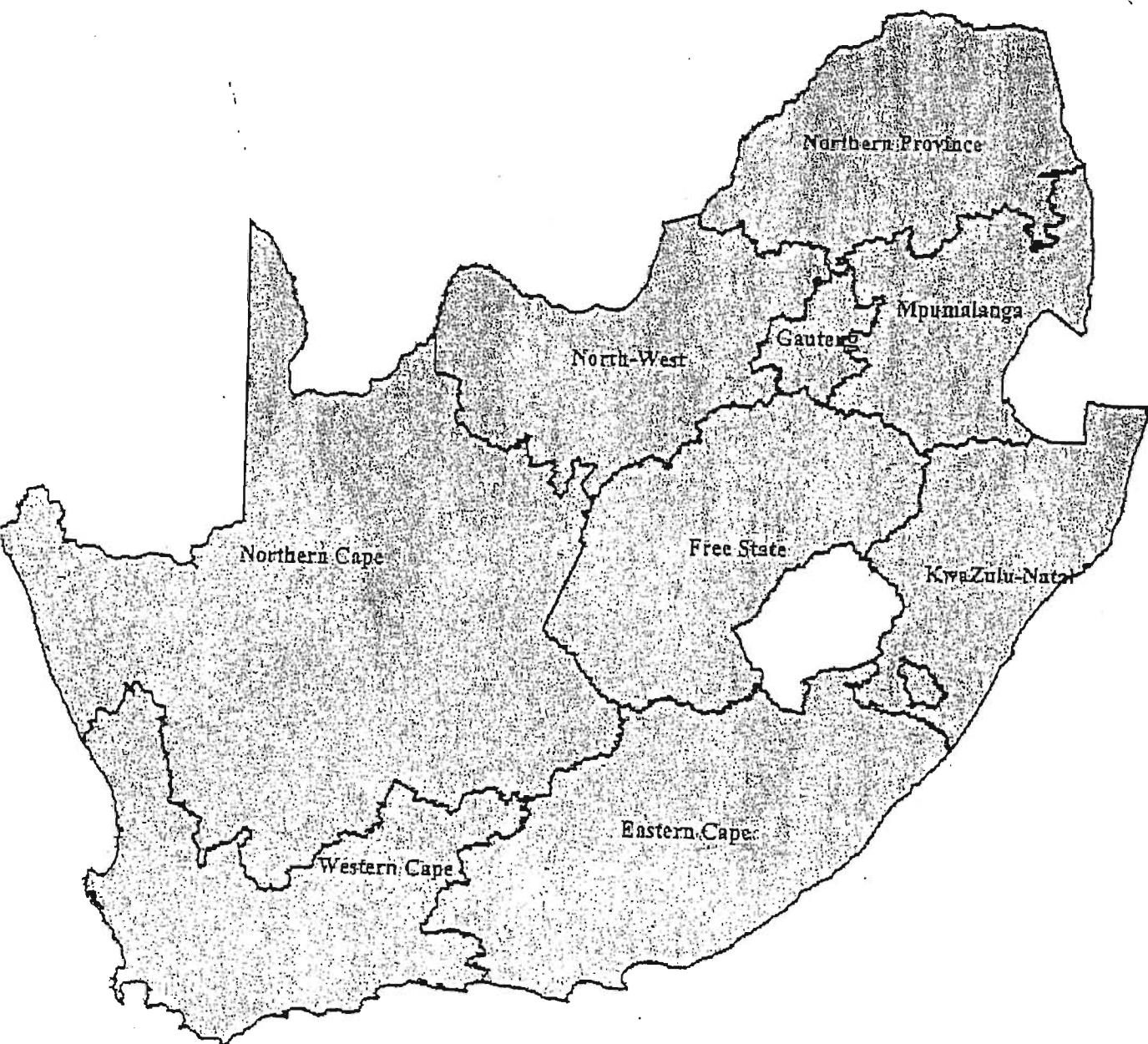
⁷ Ibid.

⁸ Ibid.

- a) To develop leadership competencies and project management skills among FBO in HIV/AIDS programmes.
- b) To strengthen coalition building and inter-faith collaboration in HIV/AIDS related activities.
- c) To popularize faith-based activities in HIV/AIDS related programmes and activities.

FOHAP structures will assist government to engage in more appropriate resource allocation and will also contribute to the development of clear, well-targeted messages suited to the country's diverse, multi-faceted society.

Government will provide support to strengthen faith-based HIV/AIDS programmes and will fund best practice projects to help develop models to inform service provision more widely. Because no community is unaffected by HIV/AIDS, an all-inclusive partnership-based approach is being adopted throughout the country. The powerful influence of faith leaders, combined with the depth and breadth of the reach of the numerous faith-based organizations, makes it imperative that the sector unites behind a single common cause, namely, meeting the challenge of HIV/AIDS and improving the lives of all those infected and affected by it. The following map represents the nine provinces that make up South Africa.



Chapter Six

OTHER RELIGIOUS RESPONSES TO HIV/AIDS

This chapter focuses on the responses to HIV/AIDS by some religious organizations in KwaZulu-Natal (KZN), whose activities are mostly concentrated in the greater Durban and surrounding areas, in order to appreciate a broader view of the Muslim response to HIV/AIDS.

6.1. DIAKONIA COUNCIL OF CHURCHES

The Durban churches established the Diakonia Council of Churches in 1994, merging the former Diakonia and the Durban and District Council of Churches. The aim of the merger was to develop a more effective inter-church witness, and to strengthen the effort of the two bodies by uniting them into a single new organization. It is an inter-church agency, working with churches and church organizations to promote justice, development and peace. It comprises of sixteen different churches from different denominations that also have their churches in other parts of the country. Its activities are concentrated in the greater Durban and surrounding areas from the north coast to the south coast of KZN. Its role as an organization is to work with its member churches and organizations in God's work of transforming society and its environment. It tries to achieve this through prayer, consultation, facilitation, training, networking, providing resources and models.¹

¹ *Diakonia Council of Churches Leaflet*. Durban. January 2003.

In March 1994, it started a programme to mobilize its member churches to develop a response to HIV/AIDS. It helps the churches to develop a theological response; encourage the churches to respond to orphans and people living with AIDS (PWA); and help to change attitudes and behaviour through working with area-based church AIDS co-ordinators and youth leaders in set community churches. It primarily gets the different churches together with NGO and CBO (community based organizations) to discuss what services the NGO and CBO are already providing to people living with AIDS. This is done to ascertain where and how they can help them to discuss HIV/AIDS awareness and perception in their communities. A basic HIV/AIDS information workshop is conducted with the church people. It covers the following aspects.²

- a) What is AIDS?
- b) What causes AIDS?
- c) What happens to a person infected with HIV?
- d) How do you get HIV/AIDS?
- e) Can AIDS be treated/cured?
- f) How do you know if you have HIV/AIDS?
- g) You cannot get AIDS by
- h) Preventing AIDS – blood to blood; mother to child; sex
- i) What if you have AIDS?
- j) What can our Church do about AIDS?

² Interview with Ms T. Semple. August 2003.

The above aspects are discussed in conjunction with thirteen posters on HIV/AIDS. The workshop is conducted with people from the different churches who in turn conduct it with people in their geographical communities. At the end of the workshop, a suitable date is decided whereby all the participants are taken on an exposure visit to an already existing church response so that they can see what the different responses are and choose how they would like to respond to HIV/AIDS in their geographical communities. When they have decided on a response, Diakonia then tries to assist them in formulating a practical programme. Each response will vary, therefore each programme will be different – for instance, some might choose to work with AIDS orphans or PWA or in awareness and prevention, etc. A key person is chosen from that group of church people to be a network coordinator and whose function is to ensure the church denominations are meeting regularly and networking with those involved in HIV/AIDS, thus avoiding duplication of services. The organization meets the individual coordinators in their community and organizes regular bi-monthly meetings for all the coordinators in order to exchange information and ideas. At those meetings, a guest speaker is invited to discuss topical issues and time is also allocated for spiritual reflection.³

The organization draws up a World AIDS Day liturgy of about fifteen pages for all the churches on its mailing list, namely, 376 ministers. It is based on the current theme of World AIDS Day. A workshop is first conducted with the clergy before the liturgy is distributed so that the ministers get information on how to successfully conduct the World AIDS Day service. As part of the World AIDS Day programme, a breakfast

³ Interview with Ms T. Semple. August 2003.

briefing is held with a prominent guest speaker who addresses all the people of Diakonia on the theme of World AIDS Day. The liturgy is evaluated every year.⁴

As part of the AIDS programme, workshops on important issues like obtaining social grant; personal documents, etc. are conducted with church people who in turn empower the rest of the community. This is conducted by way of inviting the relevant role players of the important issue at hand to be discussed, example, officials from the Home Affairs, Social Welfare, etc. The organization also draws up liturgical resources on HIV/AIDS for member churches. These include prayer books and bible studies. A monthly publication called "AIDS Update" has been launched in August 2003 which looks into current issues that are focused in the media; prayer; information on how the church can be involved in HIV/AIDS; forthcoming events and current publications of Diakonia. This publication is distributed to all the AIDS coordinators, the AIDS Advisory Committee and the people involved in HIV/AIDS work.⁵

6.2. THE RAMAKRISHNA CENTRE OF SOUTH AFRICA

The Centre is a socio-religio-humanitarian organization that was founded in 1942 in Durban and has been providing social welfare services among the poor and needy. The Centre has grown over the years and has fifteen branches in the different parts of KZN and a branch in Lenasia, in Gauteng. It began its AIDS awareness programme in 1985 by printing charts and booklets in English and Zulu on HIV/AIDS information taken

⁴ Interview with Ms T. Semple. August 2003.

⁵ Interview with Ms T. Semple. August 2003.

from the literature of the health department. These were distributed in rural clinics, doctors' rooms, African schools and handed to local chiefs in the areas of Inanda, Kwa Mashu and from Verulam to Ngoma in the north coast of KZN.⁶

One of the divisions of the Centre is the Ramakrishna Clinic that was established at the Centre in 1959 in Durban. It has been providing voluntary medical services to disadvantaged people from all religious groups. Over the years its services have expanded into other peri-urban and rural areas of KZN. The services depend on the local circumstances and the needs of the community. Doctors, health care workers and other paramedical staff are enlisted from the Centre's Hindu congregation. The clinic has been active in HIV/AIDS programmes since 1992 and has embarked on various projects. It conducts regular paediatric camps in the rural area of Etete on the north coast of KZN. Twelve medical doctors and forty support staff including medical students, laboratory technicians, pharmacists and dental therapists are in attendance. Medication is dispensed free of charge and up to about 600 patients may be attended to on any one day. Paediatric clinics are held at an informal settlement in Effingham Heights in Durban and in a sub-economic suburb of Northdale in Pietermaritzburg. Adult medical camps are also held in Etete and Chatsworth in Durban which include screening and diagnostic services. At the various clinics, patients suspected of having HIV infection are counseled and referred to appropriate agencies. Many of these patients present symptoms and signs suggestive of HIV positivity such as fungal infections, wasting and lymph node enlargement. Appropriate therapy for the opportunistic infections are given. In addition,

⁶ Interview with Swami Saradananda. August 2003.

a tuberculosis screening procedure has been adopted and patients are referred to local clinics or hospitals.⁷

Members of the clinic provide regular, voluntary hospital consultative services at Osindisweni, St Marys and Mahatma Gandhi Hospitals. These are district level hospitals with little or no specialist support. Additional hospitals that are served from time to time include Ladysmith, Eshowe and Estcourt Hospitals. During the year of 2002 consultants at these hospitals saw a total of 1215 patients. Many of the inpatients at these hospitals are HIV positive and have opportunistic infections or full-blown AIDS. Tuberculosis with its protean manifestations is common. The clinic does not have resources to provide anti-retroviral therapy.⁸

The Centre provides counselling services including pre-post testing by trained counsellors at the Mahatma Gandhi hospital, the Verulam Frail Care Centre and at its clinic in Durban in areas of HIV/AIDS, para-suicide, terminal illness, addiction, abuse and marital conflicts.⁹ When an AIDS patient dies then the Centre provides food at the funeral, bereavement counselling to the family and a food hamper for three months. Food hampers are also provided to HIV/AIDS outpatients on the advice of the nurse at the Phoenix Highway Hospice.¹⁰

⁷ *Ramakrishna Centre HIV/AIDS Projects Report*. May 2001.

⁸ *Ramakrishna Clinic Annual Report*. December 2002.

⁹ *Ramakrishna Clinic Annual Report*. December 2002.

¹⁰ Interview with Swami Saradananda. August 2003.

The Centre has constructed two residential blocks at the Ekusizaneni Children's Home in Kwa Mashu at a cost of R150 000. It also provided fifty-two beds, curtains and furnishings for the orphans.¹¹ It is supporting two other children's home in Kwa Mashu as well. The children who range from 4 years to 18 years are victims of violence, abuse and AIDS orphans, and many of them are HIV positive. The Centre provides medical care, food, clothing and has developed fresh produce gardens at these homes for the children.¹²

The Centre conducts talks on HIV/AIDS awareness and prevention at schools on an ad hoc basis where six schools are visited per year in central Durban and in the north coast of KZN. The 30-minute talk is conducted with about thirty pupils. It covers infection control, facts on HIV/AIDS, behaviour change, nutrition and positive life. Educational charts in the Zulu language with messages on HIV/AIDS and safe sex are distributed in Zulu medium schools as part of education awareness. Educational talks on HIV/AIDS is also conducted at some African churches through the medium of a Zulu interpreter in the north coast areas of KZN. An official from the Centre participated in a talk show on HIV/AIDS on Radio SAFM, and on Radio Lotus in August 2000.¹³

A talk on HIV/AIDS awareness and prevention from a Hindu perspective is conducted at the various branches of the Centre over the year. It is delivered by a team of medical personnel using audio visual material. This talk is also delivered at the gatherings of other Hindu organizations when requested for it. It is based on Swami Saradananda's

¹¹ *Ramakrishna Clinic Annual Report*. December 2002.

¹² Interview with Swami Saradananda. August 2003.

¹³ Interview with Professor V.B. Jogessar. August 2003.

book, "AIDS-Hindu perspectives" which was published by the Centre in 1992. The book deals with scriptural injunctions relating to moral, ethical and social values consonant with a healthy lifestyle. The talk also covers the following aspects:

- a) Facts on HIV/AIDS
- b) Modes of transmission
- c) Abstinence
- d) Sexual morality
- e) Attitude of PWA
- f) Care and support for PWA
- g) Prevention

Hinduism, like Islam, Christianity and Judaism is opposed homosexuality and promotes marriage between men and women in order to develop a healthy moral society.¹⁴

6.3. COUNCIL OF KWAZULU-NATAL JEWRY

The Council comprises of all the Jewish organizations in KZN. From February 1999, an aspect on HIV/AIDS awareness and prevention was introduced in their Youth Peace Forum training programme. Invitations are sent to various schools from Durban and surrounding areas from its list of about ninety schools requesting their participation. This one day training programme is conducted with about one hundred high school pupils in a session, at the Durban Jewish Club. Sometimes it is conducted at schools that

¹⁴ Interview with Professor V.B. Jogessar. August 2003

specifically request for it. It is a full day training programme and participants are expected to cascade the information that they have learnt, to other pupils in their schools. This programme is an ongoing activity that is conducted about four times a year and it covers the following aspects:¹⁵

- a) Human rights
- b) Children's rights
- c) Gender issues
- d) Peace education
- e) Conflict resolution
- f) HIV/AIDS
- g) Life skills

In June 2002, a peer education-training programme was initiated on HIV/AIDS awareness and prevention for high school and senior primary pupils. This training programme is conducted over two full days with about seventy-five pupils in a session, at the Durban Jewish Club. Upon the completion of this training programme, the participants receive certificates which enable them to empower other pupils in their schools with the knowledge they have acquired. The programme is conducted once or twice a year depending on the number of participants available. This programme has been adapted from the IMA 3 day train-the-trainer workshop and covers the following topics:¹⁶

¹⁵ Interview with Ms P. Meskin. August 2003.

¹⁶ Interview with Ms P. Meskin. August 2003.

- a) Statistics – impact of HIV/AIDS
- b) Exploring attitudes
- c) AIDS – facts and knowledge
- d) VCT and MTCT
- e) Living with AIDS – HIV positive person
- f) Pre-post test counselling
- g) HIV/AIDS and human rights
- h) Death and dying
- i) Home-based care
- j) Role of religious organizations
- k) Training techniques
- l) Planning and group presentations
- m) Conclusion – evaluation – certification

From 1999, it has been celebrating World AIDS Day. Invitations are sent to various schools requesting their participation and about one hundred pupils participate in this programme which is observed at the Durban Jewish Club. Pupils create quilts for the celebration, which are distributed to AIDS orphans. As part of HIV/AIDS awareness, pupils recite poetry and present plays, sketches and dance items on World AIDS Day.

Talks and workshops are conducted at various times with the different sectors of the Jewish community, namely, senior citizens, men's lodge, women's groups, etc. Interfaith AIDS service is conducted at the synagogue as well. The Victor Daitz Foundation from

the Jewish community endowed the Chair in HIV/AIDS Research in 2001, at the Nelson R. Mandela School of Medicine in Durban.¹⁷

The E-Khaya Project is an initiative of the World Conference on Religion and Peace (WCRP), Interfaith AIDS Forum and the Medical Care Development International (MCDI), which is loosely based on the Kibbutz system. WCRP is an interfaith organization that is active in fifty countries throughout the world. MCDI is a primary health care NGO. Two other NGO, namely, the Sisterhood of Temple David and the Union of Jewish Women are also giving assistance to this project. E-Khaya, which means “my home” in the Zulu language, has a holistic approach to the question of AIDS orphans and other vulnerable children in that it provides capacity building for the whole community so that the community becomes the family of the orphans. By caring for all the vulnerable and disadvantaged children in the community, one does not discriminate against any group and in fact, creates a bond amongst them all. The most important aspect of this project is that the community owns it and they must take responsibility for it. WCRP and its various partners are merely facilitators as the twenty-five members of the committee, which includes the various sub-committees, take all the decisions.¹⁸

In February 2003, the first E-Khaya project opened its doors in Mavela Centre in Ndwedwe, KZN. The project started by providing a crèche specifically to allow heads of Child-headed households to attend schools knowing that their siblings are well cared for. The crèche caters for children from one year to six years and provides meals for them as

¹⁷ Interview with Ms P. Meskin. August 2003.

¹⁸ E-Khaya Project Report. WCRP Interfaith AIDS Forum. February 2003.

well as for those older siblings who attend school. A vegetable-planting programme has been established and the children have already started benefiting from the harvest of vegetables that are grown. The vegetable garden is cared for by volunteers from the Community Committee as well as by some of the older children. An income-generating programme has been also launched whereby various skills are being taught and skills that are already within the community are being developed. This programme is conducted in the form of a co-op with encourages each member to be productive because money is paid to those who produce the goods. The money received for each article is divided into three portions, namely, one portion is used to cover the cost of materials, one for the producer and the third portion goes into the community account to provide for things that the community and the children need. This arrangement has been agreed by the committee members who manage the whole programme and is a part of capacity building for the community. The community is making many different types of bags, educational toys, greeting cards, clothes, jewellery and many different types of crafts with beads and carvings.¹⁹

The MCDI has set up a home-based care programme for people who need help and care, particularly those in the last stages of AIDS. Women in the community are trained in this course and are given a home-based, care-pack to care for the sick. WCRP, together with some of its partners has set up a support programme for the caregivers called "Time Out for Caregivers." These people will be given some kind of a fun activity every two months but hopefully later, on a monthly basis. It will take the form of a bus ride to the beach for a picnic, or to a concert or just have a special lunch and relax together. It is

¹⁹ E-Khaya Project Report. WCRP Interfaith AIDS Forum. February 2003.

important to care for the caregivers as they provide a valuable service in the community. Para-legal assistance is also rendered to the community to help them to access grants, particularly for the children. Future programmes include setting up a mentoring programme for the child-headed households, to assist them with accessing grants, help with school fees, and skills training that will provide an income for them. The next E-Khaya project will be the Nyuswa site in Ndwedwe also, depending on the availability of funds.²⁰

6.4. AFRICAN TRADITIONAL RELIGIONS

At the outset, I must confess that I have not been successful in obtaining any information on the African Traditional Religions response to HIV/AIDS although I have contacted numerous organizations including the Department of Traditional and Local Government Affairs in Ulundi, KZN. The information that I present below is based on an interview with Dr I.S. Mekoa, Senior Lecturer, School of Religion and Culture at the University of Durban-Westville.

According to Dr I.S. Mekoa, there is no organized response from the African Traditional Religions with regards to HIV/AIDS. Unlike the other religions, the African Traditional Religions do not have any organized body. According to him, the reason for this is the result of centuries of suppression of the African Traditional Religions and Culture. When the colonialists arrived in South Africa they began converting the African people to Christianity and denigrated African Traditional Religions and Culture. Many people

²⁰ E-Khaya Project Report. WCRP Interfaith AIDS Forum. February 2003.

were converted in this way. This contributed to there being no organized religious body for the African people. However, various traditional African institutions have tried to deal with the question of HIV/AIDS – for instance, traditional doctors who are commonly known as sangomas through their organized body called the Traditional Healers Association of South Africa. Most of the terminally ill HIV/AIDS patients have been to sangomas and some have recovered. African patients would consult conventional doctors but they would also consult the sangomas.²¹

The understanding of what constitutes HIV/AIDS in African traditional thought differs from the Western scientific understanding. In African understanding, sickness or illness (including HIV/AIDS) is not a scientific matter that can be diagnosed and be cured scientifically. Sickness or illness is a religio-cultural matter. Religiosity is not important in conventional medicine whilst in African medicine it is important and this is the difference between the two. The African patients will seek a religious cause for their sickness or illness as they believe sickness or illness is a form of punishment. This is where religious inquiry comes in. An African traditional healer (sangoma) must find out the religious cause of such sickness or illness (including HIV/AIDS). The cause of sickness or illness in religious terms can be due to witchcraft, broken taboos, the work of the ancestors or not observing traditional norms and values, and hence the result is punishment from the Divine. The sangoma will then prescribe a cure which may include herbs, religious rituals and observances of certain prohibitions or directions. The

²¹ Interview with Dr I.S. Meko, Senior Lecturer, School of Religion and Culture, University of Durban-Westville. August 2003.

sangoma also makes preventative measures to assure the patient that the trouble will not come again and these measures will involve religious steps and observances.²²

Thus, there is a problem between the African traditional healers (sangomas) and the conventional doctors in co-operating against HIV/AIDS because of the different understanding of what constitutes sickness or illness. Conventional medicine operates from a scientific basis whilst African medicine from a religious basis. The Medical Research Council of South Africa in Cape Town organized a conference in July 2003 on the co-operation between the African traditional healers and conventional doctors on HIV/AIDS. At that conference, the African traditional healers were requested to submit their medicine for scientific testing. To the African people, a cure is something that is revealed by the Divine and not something that you can manufacture in the laboratory. Cure to them is given by faith and therefore it cannot be subjected to scientific analysis. Hence, there is a problem of understanding between these two groups. Another problem for co-operation between these two groups is the question of patent for their traditional medicines. African traditional healers claim that the conventional doctors might not give them due credit and recognition for their medicines, hence the reluctance to co-operate. Nevertheless, the Department of Health has a unit on co-operation with the African traditional healers because they recognize that the healers have a clientele that they are serving. What a conventional doctor calls HIV/AIDS will be interpreted differently in African traditional medical thinking and a cure will be given to the African patient from the sangoma to cleanse the blood.²³

²² *Some African Thought on Matters of Health and Welfare*. Dr I.S. Mekoa. August 2003 (unpublished paper).

²³ Interview with Dr I.S. Mekoa. August 2003.

On 20 March 2002, the government summoned all the traditional leaders to a meeting and requested that they should take part in its HIV/AIDS programme. All the leaders agreed and that led to the launch of a provincial traditional leaders campaign. In September 2002, a HIV/AIDS campaign was launched in Ulundi, KZN with the formation of seven clusters designed to interact with the communities. Unfortunately, no programme has been launched yet (August 2003) at grassroot level due to lack of time.²⁴

The World Health Organisation (WHO) has declared August 31 as the first African Traditional Medicine Day. The regional director of WHO has appealed to both western and traditional medicine groups to work towards a system of integrating traditional medicine into mainstream health systems. Ms P. Koloko from Hammarsdale in KZN, is a leader in the field of traditional medicine and is internationally known for encouraging dialogue between the two groups. She is a qualified nurse with many years of experience and has been a research assistant at the university of Durban-Westville. She is also the President of the African Traditional Healers Association of South Africa. She has made numerous trips to America, Canada, India and Germany to lobby for local medicinal plants to be absorbed into conventional medicine and to teach in their specialist institutes and faculties. She states that traditional medicine and western medicine have been integrated into one health care system in China and they also exist side by side under one national structure in the Phillipines. Vietnam and Japan have begun working on a national framework as well, whilst in South Africa, it is only until very recently (July 2003) that the possibility of combining the two have been considered. There are 200 000 traditional healers (sangomas) in South Africa and traditional medicine is estimated to be

²⁴ Interview with Mr C. Mbokazi. August 2003.

worth about R2.3 billion a year, she adds. She believes that there should be a partnership with western medicine as many medicinal plants are already being used by international drug houses. However, traditional medicine needs to be evaluated before it can become acceptable to the public. In this regard the Medicines Control Council has established a unit dealing with complimentary medicine and has earmarked more than 10 000 substances for evaluation and regulation, especially immune boosters which could prolong the progression from being HIV positive to full-blown AIDS.²⁵

²⁵ "Herbs that Heal" in the *Sunday Times Extra* dated 31st August 2003, p. 5.

CONCLUSION

At the 14th International AIDS Conference held in Barcelona, Spain, from 7-12 July 2002, the international community was informed by AIDS researchers that:

Unless effective methods of preventing the spread of the disease (HIV/AIDS) are quickly put in place, another 45 million people will become infected within the next 8 years. Some 29 million of those new cases could be prevented through better education about HIV.¹

With the global eradication of smallpox in the world in 1979, humanity was suddenly plunged into another type of epidemic, more deadly and devastating than any other known before. What initially began as an unexplained disease primarily among homosexuals in the USA and Western countries soon began to spread among bisexuals, heterosexuals, men, women and even children in different parts of the world. Within a short period of time it became a widespread epidemic, which today has become a pandemic affecting millions of people from all walks of life in over 200 countries throughout the world. Whilst the scientific world is desperately trying to find a cure for this scourge, the HIV mutates, as recent research has shown, into different strains in different parts of the world. Recent developments in obtaining a vaccine are still in the experimental stages with South Africa being one of the leaders

¹ *The Economist*. London. 8 July 2002.

in trying to develop a vaccine against HIV/AIDS. The government has established the South African AIDS Vaccine Initiative (in 1998) which seeks to develop an effective, affordable preventive vaccine for universal use in South Africa and the SADC countries by the year 2005. This initiative resulted in a joint venture with a USA biotech company called AlphaVax and a team of S.A. virologist in the development of the first AIDS vaccine on the HIV strain called subtype C variant, the most common strain of the HIV/AIDS virus prevalent in Southern Africa. The human trial of this vaccine has already begun in the USA on 29 July 2003 and if all goes well, then the South African arm of the study will probably begin human trial in October 2003. It will be South Africa's first AIDS vaccine trial on humans and this vaccine is regarded by the scientists as one of the most promising in the world. More than 20 AIDS vaccines are already being tested in humans or are being poised to enter human trials around the world.² In the meanwhile, we can only hope and pray that a cure is found very soon.

Regarding the International AIDS Advisory Panel that was established by our President Thabo Mbeki in the year 2000, a 134 page report was submitted in April 2001, which failed to resolve any of the key controversies that led to the formation of the panel, among them, whether HIV actually causes AIDS. Instead, it proposed a series of further experiments around the reliability of HIV testing and a review of AIDS data.³ Hence, in the absence of any conclusive proof, the established thesis that HIV causes AIDS, has to be accepted and our government has based its responses on

² "AIDS vaccine trials begin" in *The Mercury*. Durban dated 31st July 2003, p. 5.

³ "Report by AIDS panel whips up a storm of criticism" in *Pretoria News* dated 6th April 2001, p. 5.

that thesis. It has adopted the ABC approach – A being for Abstinence; B for Be Faithful; C for Condomise.

One of the most perplexing aspects of AIDS as an infectious disease is the fact that clinical signs and symptoms rarely appear until several years after the initial infection. This is what makes AIDS a deadly disease because a HIV carrier can unknowingly infect dozens of people through the transmission of body fluids. Researchers have stated that transmission as a result of sexual intercourse accounts for about 75% of all HIV infections worldwide. Thus, without a HIV blood test, which is the only way to ascertain whether a person is HIV positive, the ignorant carrier becomes a spreading time-bomb by infecting others, who in turn unknowingly may infect many others, and it is in this way that the epidemic has become a pandemic in the world. All AIDS researchers agree that the only way to stem the tide against this pandemic is through behavioural change, that is, from a high risk activity to safe behaviour. This simply put, means that you have to bring back morality in your life if it is lacking and this is what Islam has been promoting to its followers for the last 1400 years. Another major route of HIV transmission is the sharing of injecting equipment by drug users who may not even be aware that they are infected with HIV and in this way spread it to many other drug users. In Western Europe, this mode of transmission has accounted for about 44% of AIDS cases. Alcohol also plays an important, although indirect part, in the spread of HIV infection. Persons consuming alcohol lose their inhibitions very quickly and become easily susceptible to engage in high-risk activities that predispose them to HIV infection. Islam has

forbidden all forms of intoxicants, be it alcohol or drugs and thus it has installed safeguards, among others, for both these two major routes of HIV transmission.

AIDS is the one abbreviation that requires no translation throughout the world, as it has become the most deadly sexually transmitted disease to confront humanity. In the early days of the pandemic, everybody was blaming everyone else for this disease, as much ignorance prevailed regarding its origin. The spread of HIV/AIDS has devastated the lives of many people and their families, communities and societies throughout the world. AIDS has now probably become one of the most dreadful of all diseases in human history and the most deadly pandemic affecting societies throughout the world. Yet AIDS, is a very easy disease to avoid because it is not contagious. To be infected, we have to go out and contract it; it does not come after us. It is primarily a venereal disease because the principal means of disseminating HIV is sexual intercourse. Infection with HIV/AIDS is serious and urgent problems worldwide with broad social, cultural, economic, political and legal implications.

AIDS mainly affects working-age adults because they are the most sexually active, resulting in dire consequence for their children which will further result in large number of orphans. This could lead to a dramatic increase in the number of street children who may turn to crime in order to survive. Already, we have child-headed households whose schooling is neglected and who live on handouts. Infected individuals with HIV/AIDS will require medical care which is costly and this will result in a decline in household income. This factor will push families further into poverty and we see this happening in many parts of Africa and Asia. The epidemic

affects and poses one of the greatest challenges to the economy of a country. HIV/AIDS-related absenteeism, loss of productivity and the cost of replacing workers lost to AIDS, threatens the survival of numerous business and industrial sectors of the increasingly competitive world market. Everyday, the virus that causes AIDS, infects and kills many people in different parts of the world, most of them young or middle-aged adults who are in the economically active age group on whom families, communities and economies depend. These AIDS death seriously affect economic activity through the loss of skills, expertise and experience. As the epidemic progresses, the sheer number of illness, death and orphans will be greater in many parts of the world. Hence, the expectations of assistance and health care will increase as the epidemic spreads but the human resources that are expected to provide these services will, in turn, be depleted by the epidemic. Thus, countries will be waging a battle against an invisible enemy more ruthless than any human foe.

The country's health services will experience greater pressure being placed on it to provide medical care to those infected and affected by HIV/AIDS and this may lead to a decline in the level of quality of service. Also, the country's resources and spending may be diverted from much needed infrastructural projects, into care and prevention of HIV/AIDS programmes and hence, the country may become poorer. In many parts of Africa and Asia, the extended family systems have collapsed because AIDS kills the breadwinners, leaving their children to the care of grandparents who themselves have no income and have been relying on the breadwinners for support. Thus, it is a vicious cycle of illness, poverty and death for many of these people.

HIV/AIDS has raised many ethical, legal and political issues. There has been much discussion on issues of confidentiality and informed consent, individual and collective rights, the mother's right and the rights of her unborn child, mandatory testing for HIV, and policies to protect the rights of people who are either HIV positive or have full-blown AIDS. Mandatory testing of athletes and people in other professions that involve group participation is controversial. These vexing questions on HIV/AIDS have continued to generate varied opinions from politicians, researchers, students and AIDS activists. People with HIV/AIDS still experience discrimination in schools, employment and other public institutions. The issue of confidentiality and disclosure of HIV/AIDS status arose because of fear, stigma and taboo associated with it. HIV/AIDS-related issues have produced several legal actions in different courts around the world. Litigations have arisen regarding discrimination in schools, patient care, employment, housing, infected blood and a host of other aspects. AIDS has become the most complex public health challenge confronting society today. It has raised basic questions about the rights of individuals versus those of society, about the role of government, and about the nature of societal responses.

Ethical issues regarding HIV/AIDS also have legal implications. For instance, do people who are HIV positive have special responsibilities towards their sexual partners? How far do we take confidentiality if the infected persons do not disclose their HIV status to their partners? Do the innocent spouses have a right to know whether their partners are infected with HIV? Can someone be criminally charged for knowingly infecting someone with HIV/AIDS? What rights do health care workers

have in protecting the infected persons' spouses if they do not disclose their HIV status to their spouses? What rights do the public have with regards to HIV/AIDS status and disclosure? For instance, in Nelspruit, South Africa, a woman is suing her doctor because he failed to warn her that she had tested positive for HIV during her pregnancy. The doctor admitted not disclosing her status to her because he did not want to "tell her that she was going to die." The Health Professions Council of South Africa ruled that her doctor's conduct was not "improper or disgraceful."⁴ These are serious questions that need urgent answers from the law makers, both Muslim and secular jurists.

The South African government has chosen a multi-sectoral approach as a lead strategy in combating the HIV/AIDS epidemic, by developing the National Strategic Plan for HIV/AIDS and STI with the participation of many stakeholders. It is a broad national strategic plan designed to guide the country's response to the epidemic. Key priority areas have been identified and all sectors, including NGO and religious organisations are expected to plan their interventions in line with these priorities. Its primary goals are to reduce the impact of HIV/AIDS on individuals, families and communities. The plan is structured according to the following four areas, namely, prevention: treatment, care and support: human and legal rights: monitoring, research and surveillance.

⁴ "Pregnant woman's doctor 'did not tell her she had HIV'" in the *Sunday Times* dated 21st September 2003, p. 5.

After the new democratic government came into power, it initiated in May 1995, a Religious AIDS Programme to get religious leaders involved in HIV/AIDS programmes, so that it could be implemented in the different religious communities of the country. As part of its National Strategic Plan, it initiated a new structure in its place in March 2003, called FOHAP. This structure forms an important part of the government's Partnership Against HIV/AIDS, and its goal is to co-ordinate and facilitate HIV/AIDS activities across all the different faiths in the country. Many religious organisations have become part of FOHAP and are involved in various aspects of HIV/AIDS in different parts of the country.

The Muslim response to HIV/AIDS is varied by the different organisations throughout the country. Whilst most of them are working within their particular region, the IMA, through its infrastructure, is involved at a national level. There are also a few individuals who are also very actively involved on their own and working in their particular areas. Most of the organisations are involved in the field of HIV/AIDS education, awareness and prevention programmes whilst some are also involved with PWA, home-based care, counselling, telephonic careline services and research. The IMA is the first Muslim organisation in the country since June 1991, to be actively involved in HIV/AIDS work on a national level. Its Gauteng branch initiated and formed together with the Islamic Careline and the *Jamiatul Ulama*, the Muslim AIDS Committee (MAC), which is now known as MAP (Muslim Aids Programme). MAP (MAC) was the first Muslim organisation to have some of its members trained as AIDS Educators by the Department of National Health. They adapted the material on HIV/AIDS from WHO with an Islamic perspective, and

presented this to the Muslim community as the Muslim AIDS Awareness Programme. They then began training others as AIDS Educators in the various Muslim organisations throughout the country with this programme. Subsequently, many of these Muslim organisations have adapted this programme to suit their particular situations and requirements.

Although the Muslim response has been presented from an Islamic viewpoint by these organisations and individuals, no discrimination has been made between Muslim and non-Muslims. The programmes are open to everyone from the general public and in fact, many non-Muslims have benefited and have been trained in the various programmes and also qualified as AIDS Educators for their particular communities. The Muslim response by the various organisations and individuals have been recognised and appreciated by the various government structures and non-Muslim NGO. For instance, the WCRP was so impressed with the 3 day train-the-trainer programme of the IMA (KZN), that they have adapted it as part of their response; the African Forum of Reproductive Health and HIV/AIDS was impressed and encouraged by the lifeskill programmes of MAP, that they have offered MAP the opportunity to have their lifeskill manuals published and be used by other faith based organisations; the University of Pretoria has had interviews with members of MAP in Gauteng as they are thinking of using MAP as a best practice model in a publication that they are researching – further meetings have been scheduled with MAP members; Ms F. Khan's lifeskill manuals in the learning area of Life Orientation for the foundation phase from grade R to grade 3 have been accepted as core material by the Department of National Education, as well as by UNESCO; Sister H.B. Allee's

photograph appeared on the front cover of the monthly magazine of DENOSA (September 2003) called, "Nursing Update", in recognition of her work in HIV/AIDS, and she also won the Khomanani Health Worker Excellence Award, as the country's second top nurse.

The response by Muslim organisations and individuals on the various aspects of HIV/AIDS is being promoted in the following ways, in no particular order:

- 1) conventions and conferences (local and international)
- 2) seminars (medical and general)
- 3) different types of training programmes
- 4) different types of workshops
- 5) counselling services including VCT and MTCT
- 6) telephonic careline services
- 7) home-based care
- 8) support group for PWA
- 9) home visit to PWA
- 10) hospital visit to PWA
- 11) literature (pamphlets, charts, posters, stickers, bookmarkers, booklets, story books, educational/training manuals, etc.)
- 12) media (radio, television, video cassette, internet)
- 13) lifeskill programmes (primary and high schools)
- 14) programme for visiting seamen (Durban harbour)
- 15) *Jumu'ah Khutbahs*

- 16) public talks (organisations, women groups, different communities, general public)
- 17) programme for tertiary institutions
- 18) training for staff (professional and general)
- 19) programme for World AIDS Day
- 20) programme with non-Muslim NGO
- 21) research (conducting and presenting)
- 22) Care Centre Home for HIV mothers, children and orphans
- 23) door to door visit by *Imāms*

Muslim organisations participate in the Muslim Consultation on HIV/AIDS Programme which is held from time to time in Gauteng and KZN provinces. This workshop is conducted in order to achieve greater involvement and better co-ordination from the Muslim communities and organisations in their HIV/AIDS programme. They also participate in the International Muslim Leaders Consultation on HIV/AIDS to share information and exchange ideas. They have learnt from the successful experience of the Ugandan Muslims and in this regard, an attempt is being made by MAP in Gauteng to encourage some Imams, to spread the Islamic message on HIV/AIDS to the community through home visits (on a door to door basis). Should this project be successful, then it will be promoted in the other parts of the country. The Muslim response to HIV/AIDS in the country is extensive and covers a wide field in relation to other NGO. The various Muslim organisations and those few individuals must be lauded for their sterling services, commitment and sacrifice. Much is being done by them, however, much is still to be done if we are to stem the

tide of this pandemic in our country, as HIV/AIDS can infect or affect anyone and everyone, Muslim and non-Muslim, adult or child, male or female.

Dr Nafis Sadik, Special Envoy of the Secretary-General for HIV/AIDS in Asia and Pacific, stated at the second International Muslim Leaders Consultation on HIV/AIDS, on 20 May 2003, in Kuala Lumpur, Malaysia, that “so far, the rates of HIV/AIDS infection have remained low across the Muslim World, with prevalence rates of less than 1% in countries with predominantly Muslim populations, and similarly low rates among Muslim minority populations in other countries. This is due to certain practices of observant Muslims that offer protection against the spread of HIV/AIDS.” This obviously refers to the Islamic lifestyle that is practiced by the majority of Muslims. However, not all Muslims practice the Islamic lifestyle and we get those who engage in high risk activities which predisposes them to HIV infection. If this is not checked, then it can spread into the rest of the population at large, for example, in Malaysia, most of the HIV/AIDS infection among Muslims is due to drug abuse. A broad Islamic AIDS response should have an effective rehabilitation programme to help such people to overcome their addiction.

We know that HIV/AIDS is far more common among the poor because of a number of socio-economic factors. Also, those infected with HIV are more likely to develop full-blown AIDS as a result of the co-existence of other diseases such as malaria and tuberculosis which further compromise the immunity. Also, poor people are less likely to have the education and information, which empower people to protect themselves. An Islamic AIDS response should help these people, and promote

income-generating activities that will help to satisfy their needs and thus restore their dignity, instead of giving them handouts only.

We must address the issue of gender inequality in the Muslim community, as recent findings have shown that gender inequality heightens the vulnerability of women, girls – and ultimately, even children to the infection and all its consequences. Issues of sexuality, sexual violence and vulnerability are often related to the contentious question of gender equality and fair treatment of the woman as daughter, sister, wife and companion. Family members, especially women, must be empowered with the knowledge of their rights and responsibilities to challenge the abuse that occur within families. The role of all family members – male and female – are equally important in providing protection, security and harmony in the home.

The delegates at the last International Muslim Leaders Consultation on HIV/AIDS were informed that new trends in the epidemic reveal that faithful, monogamous wives are now becoming infected with HIV, when their husbands bring home the virus. This trend is not confined to non-Muslim homes but Muslim homes as well. What protection does the faithful Muslim wife have if her husband is a drug addict, promiscuous or consumes alcohol? How is the '*Ulamā*' and the *Ummah* protecting her, from receiving a death sentence from her infected or possibly infected husband, who engages in these high risk activities which predisposes a person to HIV infection? Does she have the right to refuse him sex? Can she demand that he uses a condom? In order to protect herself, can she insist that he has a HIV blood test, if she believes or very strongly suspects him of engaging in any high risk activity? These

are very serious questions that need urgent answers from the '*Ulamā*' and Muslim jurists, who must give clear cut guidance if we are to prevent the spread of HIV/AIDS in the Ummah.

Marriage in Islam is a civil contract whereby both partners are free and equal and it is based on mutual respect, love and trust. An Islamic AIDS programme should empower women with their full Islamic rights, especially their sexuality. They must be given sexual health knowledge and be free from practices that prevent them from controlling their bodies and deciding the terms on which they have sex. In other words, they should be empowered to negotiate their sexuality, within an Islamic framework without any coercion. Islamic compassion and mercy require us to act with integrity and mutual respect in our sexual relationship with our spouses. Should screening be imposed on potential brides and grooms to ensure that they are free from HIV infection, thus protecting them from passing the HIV to their spouses and even to their future offsprings? Certain countries encourage this, whilst in Malaysia it is optional. In our country, a Muslim female AIDS worker and an Alim have already suggested screening. A broad Islamic response should offer confidential voluntary screening and counselling for prospective couples, should they wish to have it, as a step in the prevention of the spread of HIV/AIDS in the *Ummah*.

Many issues raised by HIV/AIDS have significant theological as well as ethical aspects. For instance, what is the duty of the Muslim health care worker to the innocent spouse, of an HIV infected person who does not disclose his/her HIV status? Does the Muslim health care worker respect confidentiality and let the

innocent spouse get infected, or betray the confidentiality in order to protect the innocent spouse, and get into trouble with the secular law of the country? Therefore, religious leaders and scholars must provide answers and in this way make an important contribution to societal efforts, to grapple with the choices and dilemmas arising from HIV/AIDS. Religious perspectives on HIV/AIDS can offer broad frameworks of understanding and commitment so necessary to deal with these complex issues. Religious and community leaders must be the catalyst to transform the response to HIV/AIDS. We can no longer deny the fact that HIV/AIDS is slowly becoming a growing problem in the *Ummah*. The religious leaders have a moral duty to be proactive and not remain as spectators of this growing problem. They need to impress upon communities at grass-root level of their moral duty to support voluntary work in HIV/AIDS and help and treat people with AIDS as fellow human beings who are ill. In fact, there are a number of *Aḥādīth* where the Prophet Muḥammad (s.a.w.s.) is reported to have exhorted the Muslims to care for, visit, help and even pray for good health for those who are sick or ill. The victims of HIV/AIDS, whether Muslims or non-Muslims, need sympathetic understanding, kindness and benevolent care, as the epidemic has as yet no cure, and is likely to lead to their death. The Islamic notion of the protection of life requires that we overcome denial or complacency, prejudice or blame, stigma or discrimination. The elimination of these attitudes will help to remove vulnerability and reduce harm. We cannot be judgemental of people with AIDS because many of these could be innocent victims or victims of circumstances. As the Noble Prophet Jesus (AS) is reported to have said, "Judge ye not, lest ye be judged." As part of a broad Islamic response,

Muslims should develop strategies to care for members of their congregations that are infected or affected, but may be embarrassed or afraid to come forward.

For an HIV/AIDS awareness and prevention programme to be successful in the Muslim community, it has to be rooted in the Islamic Value System. An Islamic approach to HIV/AIDS must be confronted in an open-minded and compassionate manner; be broadly based; holistic in nature; non-judgemental, free of any stigma, prejudice, blame or discrimination; and open to all people, irrespective of race, language and religion. It must involve religious and community leaders; '*ulamā*' and jurist; all Muslim organisations (that is, welfare, cultural, social, medical, legal, educational, religious, business sector, etc.); as well as people with AIDS, as they can make positive input based on their practical experience. It must include new strategies evolving from Islam as a way of life and a worldview, such as its uncompromising position against *zinā*; alcohol consumption; drug taking; immoral activities in the form of advertising and entertainment; sexual abuse and exploitation, especially of women who must be empowered to guard their sexuality from all forms of abuse. As part of a holistic approach, it must develop strategies to deal with the challenges of a secular culture, that promotes uninhibited sexual behaviour. It must devise and develop healthy alternatives to channel the energies of Muslims, particularly the youth, into productive and enjoyable activities such as drama; sports; alternative forms of entertainment that do not violate any moral values and are still enjoyable; developing creativity in arts, crafts and literature; involvement in educational, social and welfare programmes; youth clubs; etc. Muslim scholars and activists need to apply themselves earnestly in developing a HIV/AIDS programme

using the latest scientific information and technology that is dynamic and appealing, and which can provide alternatives to the secular attractions that confront and entice people, particularly the youth, who are most vulnerable. It should include capacity building programmes for AIDS educators and workers, as well as care and support for people with AIDS and AIDS orphans. As part of a broad initiative, it should include a rehabilitation programme; voluntary screening and counselling; and income-generating activities to uplift and empower those in need. It needs to be innovative in resource mobilization to include funding from government, NGO, international agencies like UNAIDS and also from wealthy Muslim governments. In short, it must be from multisectoral level to grass-root level, from the micro to the macro level, whereby every Muslim, male and female, including the youth and children, must be empowered in the *jihād* against the HIV/AIDS pandemic. And *Allāh* (SWT) knows best.

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14. Mr A.K. Ahmed – Positive Muslims – Western Cape.
15. Mr F. Bayat – City Health Department – Durban.
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44. Ms S. Willan – Health Economics HIV/AIDS Research Division – University of Natal –Durban.
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don't allow aids to take your life.

Buckle Up!



Our Lord, We beseech Your



In the name of Allah, Most Kind, Most Merciful

Grant us the courage, the wisdom and the understanding to lead a life of virtue and grace. Help us accept Your guidance in our search for a life of health, happiness and prosperity.

Help us understand the sacredness of love and the preciousness of sex within marriage. Give us the strength to avoid illicit sex and protect our society from the harm it brings.



help

Help those of us who have aids, from whatever cause, whether through our own carelessness or through some misfortune beyond our control, to recover from this disease.



Help us not hurt others or ourselves. In particular, let us not cause hurt to our children. If through our selfishness we harm our own children what hope is there for our society as a whole.

Help us discover a cure for aids but above all help us realise that our safety lies not in masking our permissiveness, but in behaviour that is both a protection and a healing.



Beseeching Your mercy we ask You to come to the assistance of those devastated communities, crumbling families, orphans left by the disease and those working tirelessly assisting the poor, the sick, the destitute and the needy and seeking of Your healing. *Ameen.*



Why get into a tunnel and then look for a light at the end of it when there was light at the beginning. Put your faith back into faithful sex before it leads to a dead end.

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APPENDIX 2

THE LAMENT OF HIV/AIDS

Your pleasures are promiscuity and immorality,
boozing and doping.
An evil clothed in heavenly ornaments.
The work of minds and bodies of basely man.

A mouth to speak, that speaks too much
of slander and debauchery, procrastination and lamentations.
Eyes you have but cannot see
for you see yourselves in the eyes of human err.
Ears you have but cannot hear.
What you do hear are pleasurable moans of sighs of an encompassed coition.
Noses you have but cannot smell
the heady scent of sensual draught. (*pronounced draft*)

Hands with which you cannot feel
the ominous relish with which I feast.
Insidiously festering, multiplying, transgressing
Weakening, overpowering
YOU – YOU – YOU!!!
You got me there remember!

Was it not your God, and yours and yours that told you?
Open your eyes and turn from darkness to light?
From the authority of evil to goodness?
You are like fingers, different in color, size and shape.
You belong to the same hand.
The hand of Man!
I did not ask to be inside your putrid body.
You are my parasite.

I am not yours!
I live, breathe, work, and hey, joke at your expense!
Whose folly? Yours or mine?
Feet are yours but, you cannot walk.
Are you trying to run away from me?
I have you on a leash.
I utter no sound, for you do all that for me
For as I bask in your misery and my glory...
You are the victim, I the predator.
You seek and I hide. I seek and I conquer.
Your children are my trinkets.
Your deaths, my medals of glory.
Those that vanquish me are like me. I am HIV. I am AIDS!

To all those that are trusting...
I am insidious.
I look for you.
My soul thirsts for you.
My life has grown laboriously feint with longing.
Without a host...
dry, exhausted...
THERE IS NO MAN!

@ FIONA KHAN.2002

“PLEDGE OF SERVICE” OF AN HIV / AIDS WORKER

During this programme I have learnt that HIV / AIDS is an incurable disease. It has killed more people than all the wars put together. It is our enemy. It unashamedly strips human beings of every shred of their dignity making them powerless.

It knows no bounds

It affects the rich, the poor, the educated and uneducated

It has no respect for colour, creed or status.

I TODAY PLEDGE

To take all issues on HIV/Aids seriously.

To help educate my family, my friends, my neighbours, my work colleagues and my community at large on HIV / Aids.

I will keep in confidence all issues brought to me by those affected and infected by HIV / Aids.

I will treat all those coming to me for help with dignity and respect.

If I don't have answers, I will persevere to look for answers.

I am convinced that HIV / Aids is a behavioral disease by far.

I therefore will assist to stop its spread with every IOTA of my being.

As a Community worker in the religious sector, I take this pledge freely in the name of God Almighty and upon my honour.

A MESSAGE TO YOUTH

Dear Brother and Sister ...

Growing up as a young person in today's modern world can be quite challenging. Not only do you have to contend with your studies and peer pressure; there are also the challenges of drugs, raves and HIV/AIDS. All of this is enough to leave you overwhelmed and confused...Here are some suggestions to help you cope...

- Know who you are ...A Muslim, first, last and always. You, therefore have the potential of becoming a very enlightened human being, full of joy and serenity, finding contentment through submission to the will of Allah.
- Remember why you are here... to recognise and worship Him alone.
- Remember where you are going... to the life hereafter via the bridge of death, where it will be time to account for our deeds.
- Love and respect yourself and your Creator. By respecting yourself you will learn how to respect others.
- Choose your friends wisely. They can have tremendous influence on your attitudes and behaviour.
- Keep away from smoking, drugs and alcohol at all costs. Know that drug abuse is the quickest route to misery and self-destruction. Your body and indeed your very life are an amanat (trust) from Allah and one cannot abuse it. "Every intoxicant is haram (forbidden)" (Sahih Muslim.)
- Remember that you don't need to break the commands of Allah to have fun.
- Preserve your chastity, your modesty, your dignity and your virginity at all costs. Abstain from sex outside of marriage under all circumstances.
- Know that true love finds its highest expression in the institution of marriage, blessed by Allah. Nabi (S.A.W.) is reported to have said: "I have not seen anything giving greater joy between couples than the institution of Nikoah."



- Remember that sex before marriage:
 - * Is against Allah's perfect plan for you.
 - * exposes you to STD's, HIV/AIDS, unwanted pregnancy and abortion.
 - * leaves deep emotional scars and increases the risk of divorce.
 - * incurs Allah's wrath and judgement and robs you of Allah's blessings.
- We all want freedom...Remember that "a person who has no limits has no freedom." The limits set by Islam enable us to lead happy, fulfilling and morally correct lives. Freedom affords us choices and with choices comes responsibility. In other words being free means being willing to accept the consequences of the choices we make in life.

**CHOOSE WISELY...CHOOSE
THE STRAIGHT PATH!**

BE WISE...MORALISE!

"May Allah bless you and keep watch over you, and may you have the comfort of knowing His merciful caring for you and that your soul is safe in His hands" Aameen

For more information please contact:

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